MEDICARE REFORM

BACKGROUND INFORMATION

May 24, 1999

THE WHITE HOUSE

WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. ~~All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries.~~ Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). ~~It would save about $9 billion over 10 years~~ and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	**123.0**
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	**164.1**
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
$10,000 LIMIT*	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**141.6**
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**188.8**
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	**134.8**
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	**179.9**
Premiums		***$16***	***$20***	***$21***	***$24***	***$27***	***$34***	***$36***	***$39***	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.

- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A $0.50 tax (on top of your budget's $0.55 tax) would generate about $45 billion in revenue from 2000-09.

- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline ($240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

ILLUSTRATIVE PACKAGES. On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare Income-Related Premium ($80/100)	-25	Modernize Medicare Income-Related Premium ($80/100)	-25	Modernize Medicare Income-Related Premium ($80/100)	-25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions:**		**Additions:**	
Income-Related Premium ($60/90)	-7	Tobacco Tax	-45	Surplus	**-90**
More Provider Cuts	-7	Income-Related Premium ($60/90)	-7		
Raise Deductible to $150 and index	-10				
Subtotal:	**-24**		**-52**		
Drug Benefit:		**Drug Benefit:**		**Drug Benefit:**	
$5,000 Limit 50% Premium: $24/$48*	**+123**	$5,000 Limit 67% Premium: $16/$32*	**+164**	$5,000 Limit 67% Premium: $16/$32*	**+154**
		$10,000 Limit 50% Premium: $31/$55*	**+142**	$10,000 Limit 67% Premium: $21/$36*	**+189**
		No Dollar Limit 50% Premium: $24/$58*	**+135**	No Dollar Limit 67% Premium: $16/$39*	**+180**
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-30**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

** This amount is a necessary "cushion" pending final cost estimates. Drug estimates assume about $5 billion in savings from state maintenance of effort.

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

MEDICARE REFORM:
BRIEFING BOOK

THE WHITE HOUSE

WASHINGTON

May 24, 1999

INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling, Bruce Reed, Chris Jennings, and Jeanne Lambrew

SUBJECT: Medicare Policy Development Update

NEC and DPC continue to develop Medicare reform policy options for your consideration. We will soon be meeting with you to discuss these options and to receive your guidance. In the meantime, we thought that you might be interested in reviewing some of the attached background information that has been prepared for internal and, in some cases, external briefings for Members of Congress and their staffs. It addresses most, but not all, of the topics under review. As we continue to address policy issues and options, we will forward you additional information.

Policy Development Status. Following the conclusion the Medicare Commission and the recently-released Medicare Trustees' report, we have been working intensively to evaluate the strengths and weaknesses of the Breaux-Thomas reform proposal and the advantages and disadvantages of various alternatives to it. Your White House, OMB, HHS, and Treasury Medicare advisors are reviewing numerous reimbursement and structural reform concepts, drug benefit designs, and offset options to strengthen the financial status of the program and to help pay for benefit improvements. Cost estimates are being run and re-run to reflect the Trust Fund's new baseline (which is now scoring reduced savings for individual policies), new design options of interest to your advisors, and evolving reform positions of key Members of Congress, aging advocates, and health care providers. In preparation for our upcoming policy discussions, you will find:

- Tab 1 contains our Medicare "walk-through" document that is being used for Members of Congress and their staff to detail the strengths and weaknesses of both the Medicare program and the recommendations made by Senator Breaux and Congressman Thomas.

- Tab 2 includes the memo that we gave you in advance of the Senate Democratic retreat that highlights the major issues.

- Tab 3 provides an update of Congressional interest in and action on Medicare, which was produced in collaboration with Larry Stein.

- Tab 4 encloses a background briefing document on premium support and options to inject more competition in the Medicare program. We are closely examining alternatives that meet our objectives of making Medicare more efficient and reducing costs while not undermining the traditional fee-for-service program. (Also attached is the original premium support concept article by Robert Reischauer and Henry Aaron.)

- Tab 5 provides a summary of our talking points on the use of the surplus for Medicare – in particular the common myths and our responses to them.

- Tab 6 includes detailed background information on the status of prescription drug coverage for older and disabled Americans as well as a discussion of the major moving pieces of any drug benefit design.

- Tab 7 includes some background facts on options involving beneficiary contributions to Medicare. These include the income-related Part B premium as well as fact sheets on various services for which cost sharing changes are being considered.

- Tab 8 provides specific back-up facts and trends that strongly support your contention that an increase in the eligibility age without an explicit policy that assures there is not an increase in the uninsured ill advised and flawed policy.

- Tab 9 explains the issues confronting rural beneficiaries under the Breaux-Thomas proposal -- a critically important issue in the Senate and amongst the conservative Democrats most willing to be open to broader Medicare reforms.

- Tab 10 includes your response to the March 30th, 1999 Trustees report on the status of Medicare, and our general talking points supplementing your comments. It also contains your comments responding to the Breaux-Thomas proposal and the general talking points on the topic, your State of the Union comments on Medicare, your AARP speech outlining your principles for reform, and the back-up paper that was released around the speech.

We hope that you will find this information to be useful in preparation for our upcoming meeting with you on Medicare reform options.

PHOTOCOPY PRESERVATION

PHOTOCOPY
PRESERVATION

MEDICARE:

ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

April, 1999

***

MEDICARE: ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans:** About 34 million elderly and 5 million people with disabilities receive Medicare.

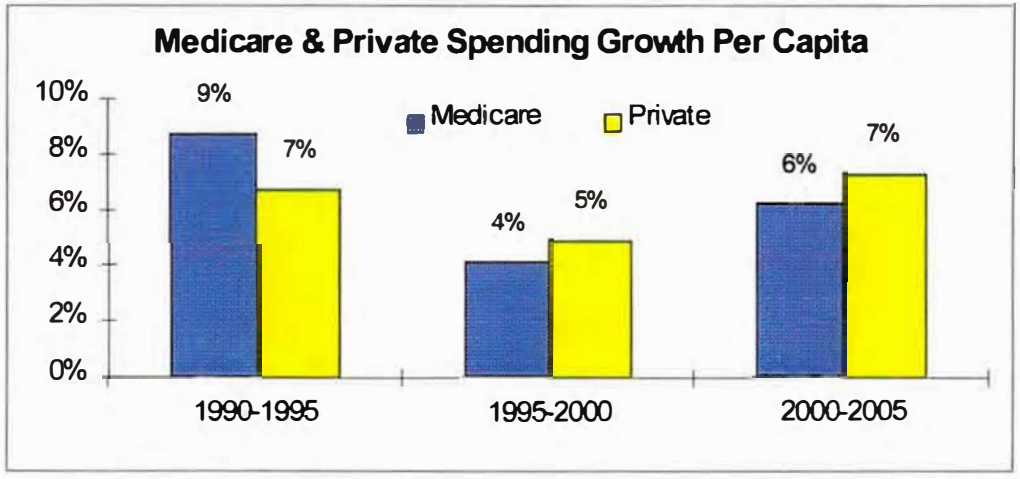
- **Helps those who would otherwise be uninsured:** Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty:** Since 1965:
  - Life expectancy of people at age 65 has increased by 20 percent (79 to 82 years)
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

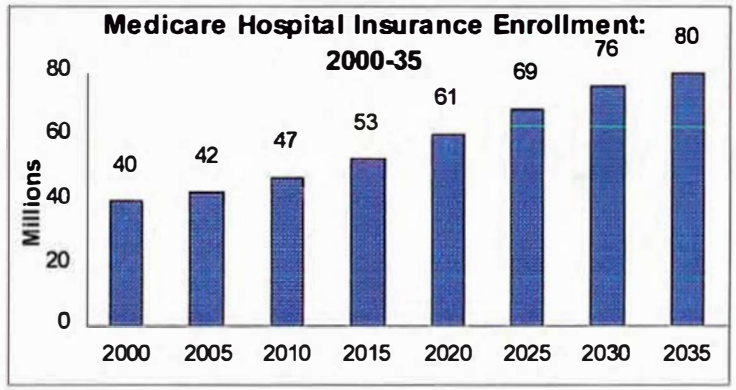
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999. Through commitment to a strong economy, coupled with actions that improve Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015.

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. The slow Medicare spending growth is expected to continue through 2002 -- when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.



- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare trust fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits**: Medicare's benefits are not very generous. In particular:

  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.

  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.

  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.

  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.

- **Insufficient private tools for reducing costs**: Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:
  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). This is:
  - One-fourth of BBA 1997 savings (CBO: $386 billion over 10 years); and
  - One-third of amount from committing 15 percent of the surplus to Medicare ($343 billion over 10).

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
*BUDGET SAVINGS**	*+6*	*-66*

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare:** The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

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

  - Making Medicare's traditional plan more competitive: It recommends that Medicare adopt many of the competitive management tools that are used in the private sector.

  - Rationalizing Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries:** The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their health care needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area.

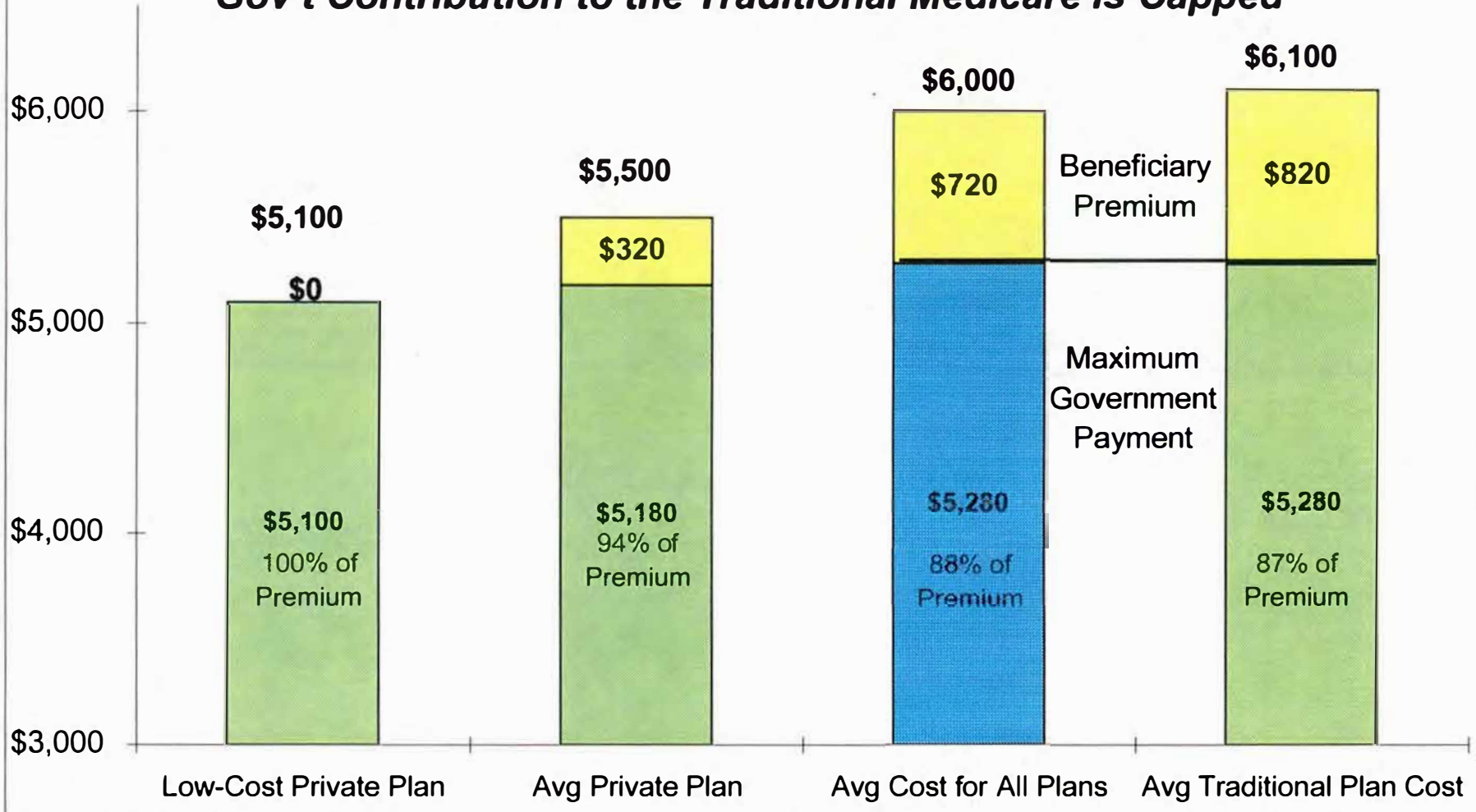
- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries, who generally have access to managed care, would not be protected against higher traditional program premiums. They would also likely pay more for private plans, since plans would raise premiums for beneficiaries to compensate for government payments that do not fully account for local costs, which are higher in most urban areas.

- **Unclear commitment to defined guarantee of benefits:** Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** Since traditional Medicare premiums would rise under this proposal, so, too, would Medicaid costs since states pay for premiums for low-income beneficiaries.

Breaux-Thomas Premium Support Proposal

Gov't Contribution to the Traditional Medicare is Capped



Beneficiaries would pay about $720 under current law

Total Annual Bid for Medicare Services

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

- **Not a Medicare benefit.** One of Medicare's strengths is that it provides health services to all beneficiaries, regardless of their residence, income or health status. By not providing a drug benefit through Medicare, the Breaux-Thomas proposal does not modernize Medicare. Instead, it restricts eligibility to beneficiaries with incomes below 135 percent of poverty (about $11,000 a year for a single senior) through a means-tested, Medicaid benefit.

  - **Helps only a fraction of beneficiaries without drug coverage:** Nearly 60 percent of beneficiaries without any drug coverage would not qualify. For example, a widow with $11,500 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

  - **Fewer people enroll in Medicaid programs:** Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program.

- **Medigap and unsubsidized options are unworkable.** The Breaux-Thomas proposal would also require all Medigap plans, private managed care plans, and traditional Medicare to offer drug coverage. However, without premium assistance, the costs would likely be high, so that only those with high drug costs would sign up. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or it would become impossible to offer the coverage altogether.

OTHER SHORTCOMINGS OF THE BREAUX-THOMAS PLAN

- **Does not address Medicare's long-term solvency**: The Breaux-Thomas proposal ignores the need for new revenues to finance the care of the growing numbers of beneficiaries. According to Commission staff, the plan's net Medicare savings of around $100 billion over 10 years would extend Medicare's solvency for about 4 years. Probably about half of that effect results from the shift of graduate medical education out of Medicare Part A. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **Raises the age eligibility for Medicare**: The most rapidly growing group of the uninsured is ages of 55 to 65. Raising the Medicare eligibility age without a policy to prevent even more uninsured would exacerbate this problem.

- **Includes an unlimited home health copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits. For the over 1 million beneficiaries who have more than 60 visits per year, this copay would represent a large financial burden.

- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. This does not produce Federal budget savings and does not assure that teaching hospitals are funded to continue their important mission.

- **Creates new bureaucracy:** A separate Board would oversee premium support, using new staff to approve benefits packages and rates in every single plan, decide on service areas, enforce financial and quality standards among other activities. Not only would it have little accountability to Congress, it would remove billions of taxpayer dollars from traditional government oversight.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare:**
  Neither the President nor his four appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conforms to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;
  - Maintaining and modernizing Medicare's guaranteed benefits, including a prescription drug benefit; and
  - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare**: Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:

  - Competitive pricing for services like medical supplies; and

  - Selectively contracting with lower-cost, high-quality providers.

- **Examining other policies to reduce overpayment and increase competition**: The Administration will also examine specific options to reduce fraud, constrain costs and make both the traditional program and managed care payments more competitive and efficient.

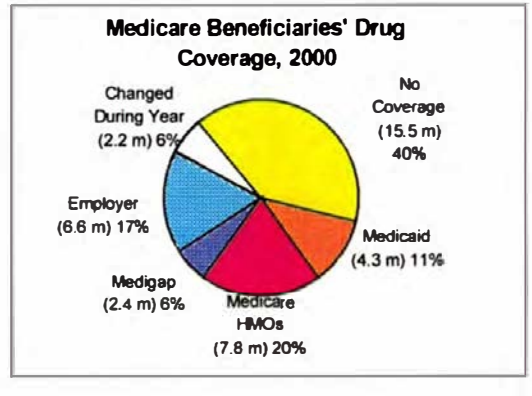
MAINTAINING AND MODERNIZING MEDICARE'S GUARANTEED BENEFITS

- **Ensuring that Medicare's guarantee is strong**: Medicare protects some of our most vulnerable citizens -- the elderly and people with disabilities -- from excessive health care costs. Proposals to strengthen Medicare must not do so at the expense of this guarantee to a defined set of benefits.

- **Providing a long-overdue prescription drug benefit**:

  - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.

  - Existing coverage is unstable and expensive: Those beneficiaries who have private coverage are vulnerable, since employers are dropping retiree coverage and Medigap is becoming more costly and less accessible.



  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable.

DEDICATING PART OF THE SURPLUS TO MEDICARE

- **Providing new financing by dedicating part of the surplus to Medicare:** The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years. This amount would equal $686 billion over the period and extend the life of the trust fund for another decade.

  - Investing now prevents larger problem later: Even though the Medicare shortfall is projected to accumulate to over $1 trillion over the next quarter century, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing later.

  - One-time, fixed contribution: The plan does not create an unlimited tap on general revenues. Instead, it invests a fixed proportion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees.

  - Funded by the baby boom generation -- not tomorrow's workers: The surplus was largely created by the baby boom generation, and makes sense as a one-time funding source for Medicare. In contrast, waiting until future generations are faced with raising taxes to support Medicare would shift this burden to younger and low-income workers.

2

PHOTOCOPY PRESERVATION

PHOTOCOPY PRESERVATION

KEY MEDICARE ISSUES

Breaux-Thomas Proposal and the Medicare Commission. Despite failing to receive the endorsement of the Medicare Commission, Senator Breaux and Congressman Thomas have committed to introducing their Medicare reform proposal and may do so as early as next week. Their proposal's centerpiece is a premium support option that changes the way that Medicare pays health plans, including traditional Medicare. It includes a limited, although inadequate prescription drug benefit. And, most notably, it does not include your surplus proposal or any explicit commitment to add needed new financing for the Medicare program to deal with the doubling of the beneficiary population – from 40 to 80 million over the next 35 years.

Our major criticism of the premium support proposal is that its design, according to the Medicare actuary, would explicitly increase Medicare premiums for the traditional program by between 10 and 20 percent. This would have the effect of financially coercing Medicare beneficiaries into HMOs – not encouraging them through lower premiums for private plans. Although the Breaux-Thomas proposal maintains the current premium for beneficiaries who live in counties with no private plan options, this exemption would, for the first time in Medicare history, create different premiums for traditional Medicare based on where a beneficiary lives. Moreover, it creates a false sense of security – should even one plan small HMO enter an area, the premium protection would end. This would leave some beneficiaries the "choice" of joining the new plan or paying 10 to 20 percent more to stay in traditional Medicare. Other criticisms of the Breaux-Thomas plan include: the lack of any new financing, raising the age eligibility to 67 percent without any policy to protect against increasing uninsured, and a Medicaid rather than Medicare prescription drug benefit that only helps beneficiaries whose income is below $11,000 (single), and, while some limited copays may deserve consideration, they have an open-ended 10 percent home health copay that could impose significant costs on the sickest beneficiaries.

Publicly, we have praised Senator Breaux for tackling such an important challenge and thanked him for including certain policies like the modernizing the traditional program and recognizing the importance of prescription drugs. However, as we commend Senator Breaux for his constructive contributions, we also point out the shortcomings in his plan. As we do this, we reiterate your statement that it is incumbent upon us to put forward an alternative that: (1) makes Medicare more efficient and competitive; (2) maintains and modernizes Medicare's guaranteed benefits, including a prescription drug benefit; and (3) assures adequate financing by dedicating part of the surplus for Medicare.

Status and Timing of Reform Plan. While we have been careful to not commit to any specific release date for your proposal, we have said that you wish to get it out with enough time left for the Congress to act this year. With this in mind, we are working toward having a plan available for public presentation as soon as mid-June. We are scheduled to meet with you in early June to review options and present recommendations.

If asked about timing, we would recommend that you say that it is your hope to get the proposal out early this summer and preferably in June. However, you should reiterate that you do not think it is wise to commit to a specific date; it is far more important that we get the policy work done right, have all the provisions scored by the Medicare actuary, and develop and implement an effective roll-out of the policy with the Democratic Leadership and others.

Provider Concerns about Balanced Budget Act. Provider savings will not be easy to come by this year, since all major provider groups have launched a campaign not just against additional savings for reform, but to support "give backs" from the Balanced Budget Act itself. Even conservative Democrats like Senators Conrad, Moynihan, Baucus and Bingiman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, home health care providers and others.

Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. Administrative actions would be the priority since, pending OMB approval, this spending would neither require legislation nor offsets. Moreover, acting administratively rather than legislatively could avert, or at least postpone, opening up the Balanced Budget Act which could drain away the resources necessary to help fund a prescription drug benefit. We are examining legislative options for your consideration, bearing these risks in mind. If we conclude that administrative actions are inadequate, limited legislative fixes could help avoid a negative response to your Medicare reform proposal.

In response to questions, we would recommend that you acknowledge the many serious concerns being raised by providers about their financial status. You can advise the members that we are reviewing these concerns carefully to evaluate whether there is justification for administrative and/or Medicare interventions. If there is, we believe that we should include them. You should advise them, however, that it would be dangerous to open up the BBA in the absence of detailed evidence that Medicare is the problem and should be the solution. If we over-react or act prematurely, we risk starting a bidding war that could seriously undermine our recent successes in strengthening the Medicare program and balancing the budget.

SPECIFIC POLICY ISSUES:

Competitive Alternatives to Premium Support. Modernization can be divided into two categories: modernization of the traditional Medicare program and competition among managed care plans. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also think that these ideas are worth pursuing.

Most of the controversy, however, surrounds whether there can be competition in managed care that avoids the downside (higher traditional Medicare premiums) of the Breaux-Thomas plan. We are reviewing policies for price competition in managed care that meet several criteria: the traditional Medicare premium is protected to avoid financial coercion into managed care; Medicare's benefits are clear and strongly guaranteed; and competition is based on price and quality, not benefits which are easier to manipulate to attract healthy beneficiaries. Although these options do not produce large savings, they have the potential to bridge the differences between advocates of premium support and the traditional program. Supporters could view this as a step in the right direction since, for the first time, beneficiaries could get lower premiums for choosing low-cost plans. Opponents could be assured that their major concern about premium support – that it undermines traditional Medicare – has been addressed. Conversely, conservative Democrats could argue that it does not go far enough, while base Democrats could

continue to fear that Republicans will hijack the proposal to set us on the path towards a capped voucher system that privatizes Medicare.

Given the sensitivity of this issue, we recommend that you simply state that you are examining all options, but will not veer from your principles. Specifically, you will reject competition that results in higher traditional Medicare premiums but you are also open to new ways to inject more competition into the Medicare program. You can stress the importance of choice, not coercion.

Drug Benefit: Design. All health care providers and experts agree that a plan to reform Medicare for the twenty-first century must include prescription drug coverage. Prescription drugs have become an essential part of health care. They complement medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitute for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and offer new treatments where there previously were none (e.g, drugs for HIV/AIDS). Their importance will grow as the understanding of genetics increases. The potential for health improvements and possibly lower health care costs is greatest for the elderly and people with disabilities, whose health conditions often can be effectively managed through drugs.

Although the Breaux-Thomas plan acknowledges the importance of prescription drug coverage, it provides an affordable option only for beneficiaries with incomes below 135 percent of poverty ($11,000 for a single beneficiary). Moreover, the current sources of coverage for Medicare beneficiaries – retiree health insurance and Medigap – have become more expensive and less accessible. Those beneficiaries with coverage have seen the amount of this coverage decline. Less than half of beneficiaries enrolled in Medicare managed care have coverage for expenses above $1,000 or 2,000. This makes targeting only the uninsured or low-income inefficient and inequitable. As such, we are examining options that provide a voluntary, affordable Medicare insurance option for all beneficiaries.

The challenge is to design a drug benefit that is meaningful and affordable to both the program and its beneficiaries. We are also contemplating an option to provide for catastrophic coverage once the cap is met. It is important to note that, whatever design we chose, beneficiaries can use the 10 to 15 percent discount that the private contractors or pharmacy benefit managers (PBMs) get through negotiation before during and after the coverage ends. This is a big advantage for beneficiaries who now buy drugs at retail prices. Medicaid would pay for the premiums and cost sharing for low-income beneficiaries through the QMB and SLMB programs.

A number of Senators have strong opinions on how the drug benefit should be designed. Senators Kennedy and Rockefeller proposed a more costly benefit that includes both some up-front coverage (20 percent coinsurance after a $200 deductible, up to $1,500 in spending) and some catastrophic coverage (0 percent coinsurance after $4,200 in total expenses or $3,000 in out-of-pocket spending). This reflects the desire to ensure that beneficiaries with low to moderate costs are helped while protecting the sickest. You should praise them for their leadership on this issue. Senators Graham and Wyden suggest that costs should be reduced by either raising the deductible, limiting the types of drugs covered, or restricting the coverage to low-income beneficiaries only. We have concluded that these are unworkable or flawed approaches, but would also recommend that they be acknowledged for their interest in this issue.

We feel it is important to not signal the direction of our benefit, but you should know that we are currently exploring an option with no deductible, where we would pay half of the costs of prescription drugs up to $5,000.

Drug benefit: Costs and Offsets. The options that we are considering have 10-year costs that fall between $150 and 200 billion, significantly less than Kennedy-Rockefeller legislation whose costs are at least $300 billion over 10 (note: we do not advise that you discuss numbers with Senators since they are not public). These costs are net of beneficiary premium payments.

Your advisors have been striving to fully fund the prescription drug benefit from savings from competition, providers, and beneficiaries. However, the constraints on these savings options make it clear that only a very limited drug benefit can be financed in this way. As such, we are examining options for additional financing that include an additional tobacco tax, a portion of the surplus dollars dedicated to Medicare, and/or additional provider and beneficiary contributions.

Some Congressional Democrats (mostly the base) have advocated for using either part of Medicare's 15 percent, or an extra amount from the surplus, for prescription drugs. The primary rationale is the enormous contribution that Medicare has made to the balanced budget and surplus; the Medicare Trustees and the Congressional Budget Office project that Medicare spending is over $200 billion lower than originally projected when the BBA was passed. It also appears possible that the trust fund could still be extended to 2025 or so with approximately one-third of the surplus used for the drug benefit. Others, particularly the moderate Senators and the Blue Dogs, have expressed concerns that this would undermine your surplus framework. Instead, they recommend proposing additional tobacco tax revenue for the benefit as well as larger beneficiary and provider cuts. Some within your economic team would advocate taking this approach as an opening position, recognizing that the surplus would likely be used to fund the benefit in the bill that gets signed. We are examining these options' policy or political viability. Since there is a clear split in Congress, and differences of opinion among your budget advisors as well, we suggest that you avoid any comments on financing sources at this point, bur reassure the Senators that our plan will be fully, credibly financed.

Surplus for Medicare Solvency. A few Senators (Breaux, Kerrey, Hollings) and some conservative House members continue to express concerns over dedicating 15 percent of the surplus to Medicare. In Senator Hollings' case, it stems from a belief that this is more of a budget game than a serious approach buying down debt. Senator Breaux adopts the same IOU criticism, but the primary reason for his current opposition is that he believes that it fractures his bipartisan coalition for his reform package, since Republicans are adamantly opposed to the surplus dedication. Only Senators Breaux and Kerrey voted against using the surplus for Medicare in the budget resolution.

Clearly, major structural reform, program savings and beneficiary contributions combined cannot offset the costs associated with the doubling of Medicare enrollment that will occur when the baby boom generation retires. In fact, if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be limited to below inflation, 3 percent per year -- in every year -- to get to 2025. Every independent Medicare expert affirms that greater revenue is needed to fund the program into the future (note: 15 percent of the surplus gets to 2027 on the 1999 trustees' baseline). This rate is well below projected

private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode.

Senator Kerrey argues as if the general revenues going to Medicare would somehow be reserved for non-defense discretionary if they were not dedicated to Medicare. Most feel, however, that without a "Medicare block," the general revenue would go to a fiscally irresponsible tax cut as opposed to a fiscally responsible plan to pay down debt and to help Medicare solvency.

Income-Related Premium. We are contemplating an income-related premium in our policy review. You have supported this policy in the past (1992, 1993, and 1997) as a progressive form of increasing beneficiary contributions in the context of an acceptable package of broader reforms. In the past, our support has been conditional on several parameters. First, the 75 percent premium subsidy would not be fully phased out, in order to keep high-income beneficiaries in the program. Second, it should target truly high-income beneficiaries and be indexed to keep up with inflation (an earlier version of the Commission plan began at $24,000 for single beneficiaries, $30,000 for couples, affecting about 30 percent or 12 million beneficiaries, which is problematic). And, third, it should be administered by Treasury since it can collect this premium more efficiently than HHS, thus producing more revenue.

Large numbers of moderate/centrist Democrats and Republicans strongly support the income-related premium as do elite validators (other than those who consider Medicare a pure social insurance program). Interestingly, the far left of the Democratic party (Gephardt, Waxman, Kennedy) and the far right of the Republican party (Senator Gramm) oppose this proposal. The Democrats' main arguments are that the income-related premium opens the door to means-testing since it could easily be lowered in the future, and if it only hits the highest income, it does not raise enough revenue to justify the policy. In contrast, Senator Gramm insisted that the income-related premium be dropped from the final Breaux-Thomas proposal because he believes it to be a tax that affects one of the Republican core constituencies.

Given your past support for this policy and the need to come up with beneficiary as well as provider savings, you probably should indicate an openness to the income-related premium if asked. Almost all of your advisors support this. The base Democrats concerns can be allayed somewhat if you reassure them that it will be targeted truly at the higher income beneficiaries. More importantly, it is useful to remind them that it is much more progressive than an across-the-board premium increase or aggressive cost sharing increases, which would be needed to raise comparable contributions.

Cost Sharing. The Breaux-Thomas proposal includes reforms intended to rationalize Medicare's patchwork of cost sharing. In some cases, this means adding copays where none exist, and other, it is reducing excessive or unnecessary cost sharing. Specifically, it would eliminate preventive service cost sharing and hospital copays after 60 days, and create one, combined, budget-neutral deductible of $400 (today, the Part A deductible is $768 per hospitalization and $100 for Part B). It would also add an unlimited home health copay of 10 percent and 20 percent lab and nursing home coinsurance. Finally, it would prohibit Medigap from covering the new $400 deductible. Although the intent was to produce a budget-neutral package, it ended up saving $20-40 billion over 10 years.

Centrist Democrats are inclined to support beneficiary cost sharing because they believe it has a positive impact on excess utilization of services. Base Democrats argue that it will not affect utilization since most beneficiaries have supplemental coverage, and for those without coverage, it will significantly increase costs.

Your advisors are reviewing options with the primary goal of simplifying Medicare's cost and making it more similar to that of private health plans. We are contemplating eliminating cost sharing for preventive services (since cost sharing discourages use); rationalizing the nursing home copay (from nearly $100 per day for days 21 to 100 to a straight 20 percent coinsurance); and adding a new Medicare option to purchase (without subsidies) lower cost sharing (a Medicare version of Medigap). This last option, of eliminating the need for supplemental coverage by offering better coverage within Medicare, is widely recommended by experts like Bob Reischauer and Laura Tyson. Additionally, we are reviewing options to add copays where there currently are none: a reduced, capped home care copayment and 20 percent coinsurance on clinical lab services. This package of cost sharing policies could either be budget neutral or save money, which may be justifiable in the context of adding a new prescription drug benefit.

If asked, we would recommend that you be non-committal in this area, but acknowledge that cost sharing options are being considered.

Age Eligibility Increase. The Breaux-Thomas proposal would increase the Medicare age eligibility from 65 to 67. Some support this policy, arguing that it conforms Medicare to Social Security. However, Social Security provides the option for a partial benefit at age 62 and through age 67. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62 and no specific coverage option for people ages 65 to 67.

Per your guidance, we are opposing this policy for several reasons. First, people in their early 60s are already at risk of becoming uninsured. The fastest growing number of uninsured Americans are those between the ages 55 and 65. One recent study projects that the number of uninsured ages 61-64 will increase by over 40 percent by 2005 (from 3 million to 4.25 million). As a consequence, people ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. It was for these reasons that you proposed allowing certain people ages 55 to 65 to buy into Medicare. As a note, Senator Daschle feels strongly that you include this budget proposal in your Medicare reform plan as well.

These problems would be worse for people ages 65 to 67 if they did not have Medicare. Nearly one in ten or about 4 million Medicare beneficiaries are age 65 to 67. If they were to lose Medicare and their uninsured rate is the same as that of 64 year olds, it could be assumed that nearly 600,000 people would become uninsured. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance. This policy would also likely increase employer and state Medicaid costs, since these payers would continue to be the primary insurer for these beneficiaries.

Some proponents of raising the age eligibility have suggested that these problems can be avoided if coupled with a Medicare buy-in for people ages 66 and 67. It is true that, relative to the

coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in. The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about $27,000 for a single), the cost of subsidies would be high.

There appears to be a growing recognition of the shortcomings of increasing Medicare's eligibility age. As a consequence, although the Finance Committee supported this provision in 1997, it is unclear whether this policy could pass today. In fact, Senator Breaux has recently indicated that he would likely drop this provision from his package. We would therefore recommend that you reiterate your strong opposition to this policy, particularly since there is no viable policy to address the problems that recent studies affirm will occur.

3

PHOTOCOPY PRESERVATION

CONGRESSIONAL UPDATE: MEDICARE REFORM

We continue to develop Medicare reform options for your consideration that include your 15% surplus proposal, provisions that make the program more efficient as a purchaser, cost sharing rationalization proposals, and of course, a prescription drug benefit. The Democrats, particularly in the Senate (and Senator Daschle himself), have indicated a strong desire for you to develop an alternative to the Breaux-Thomas proposal. Although the House Democrats are more reluctant to contemplate a true reform package, they have recently indicated some willingness to consider one as their desires for a new prescription drug benefit has increased.

There have been two recent developments have tended to dampen the appetite for Medicare reform for many Members of Congress. First, the Trustees' report projecting that the Medicare Trust Fund exhaustion date has been extended to 2015 has reduced momentum to act quickly on this issue. Second, a lobbying campaign by virtually every major health care provider in the Medicare program has been launched to repeal or moderate Balanced Budget Act (BBA) of 1997 reform/savings provisions. At a time when Members are contemplating reinstating provider savings, they are increasingly uncomfortable with considering another round of proposals that will lead to additional provider payment reductions.

However, concerns about potentially inadequate provider payments, have not decreased the desire of many Members to support the one modernization proposal that has the most potential to require a substantial up-front investment -- a prescription drug benefit for Medicare beneficiaries. Moreover, any bipartisan agreement on the distribution of the surplus would almost inevitably lead to a discussion about Medicare financing and reform. The following is a summary of where the Congress appears to be positioning itself on the Medicare issue.

The House of Representatives: Overview. Until recently, base Democrats in the House saw no value in engaging in a Medicare reform debate beyond the one that pits the use of the surplus for Medicare against its use for tax cuts. They remain highly skeptical that any good can emerge from an attempt to work out a Medicare reform package with the Republicans. They view premium support concepts to be vouchers in camouflage, which simply shift more cost and risk from the program to beneficiaries. Even those few who might be open to reform do not trust the Republican Chairmen, the Senate Finance Committee and to some extent the Administration to draft legislation with the best interest of beneficiaries (as well as their own political interest) in mind.

While the general mistrust of Republicans remains strong, Leader Gephardt recently has become much more open to supporting the development of a Medicare reform alternative. In fact, just this past Thursday, he is now saying that a Medicare reform proposal, particularly one with a meaningful drug benefit, represents the single best opportunity for the Democrats to define the party with the public and particularly the elderly. Having said this, while Mr. Gephardt's interest in reform and prescription drug coverage has increased, his (and his caucus's) willingness to offset its cost has not risen at an equivalent rate. For this reason, he is now suggesting that a significant portion of the benefit costs to be paid for by the surplus.

"Blue-Dog" Democrats are, as expected, open to reform. They support beneficiary contributions in this context, in particular the income-related premium, a home health care copayment, and in some limited cases an increase in the retirement age to 67. However, they appear to be skeptical about our proposal to dedicate 15 percent of the surplus to Medicare, have little interest in financing an excessively costly prescription drug benefit, and seem primarily interested in responding to provider complaints about BBA 1997. While they think it is important for the Administration to provide a viable Medicare reform alternative, it is not at all clear that they wish to position themselves with us.

The House Republicans are taking a "follow-the-Senate's lead" strategy. They are too nervous to seriously engage on tough reforms unless it is clear there is sufficient Democratic cover for it. In the interim, they appear to be reaching out to health care providers and some "Blue Dog" Democrats, attempting to entice them with a host of BBA 1997 provider "fixes" (Congressman Thomas is holding out hope for about $10 billion over 5 years), perhaps in return for an endorsement of the Breaux-Thomas premium support model and a new, independently appointed Board to replace HCFA as the primary administrator of Medicare.

House of Representatives: Ways and Means: Congressmen Stark, Rangell, and Cardin have been particularly interested in Medicare reform issues. Congressman Stark's primary concern is the BBA savings. He and other Democrats (like Gephardt) are trying to hold the line on a major provider spending bill in order to keep financing available for the new prescription drug benefit and to avoid a bidding war over who can give the most back to providers. Congressmen Rangell and Cardin, in contrast, are concerned about teaching hospitals being hurt too much by the BBA. Our general response is that we are closely examining the effects of the BBA, and we will examine all issues and options, but have made no final decisions about the plan.

Senate: Overview. In contrast to the House, moderate Democrats and Republicans, particularly on the Finance Committee, have been much more open to reform in general and the Breaux-Thomas premium support proposal in particular. As has been the case in the past, there continues to be a relatively strong inclination among Finance Committee Members -- Democrat and Republican alike -- to support general reform ideas like competition, some increased cost sharing, and an income-related premium. For the first time in memory, however, the Members' openness to beneficiary cuts seems to significantly exceed their support for provider reductions.

Clearly, the concerns raised by numerous health care providers have become the most significant source of the declining comfort with and interest in Medicare reform. Members who just weeks ago were strongly advocating for "reform" (e.g. Senators Domenici and Frist) are now spending much of their time formulating their response to numerous complaints by health care providers' complaints (hospitals, teaching facilities, home health agencies, nursing homes, and managed care plans) that the Balanced Budget Act of 1997 cut payments too deeply.

While the provider concerns are almost certainly overblown, the Congressional response to them could well undermine both the BBA and the opportunity to achieve a credible amount of savings for Medicare reform. At the same time, there is some reason to believe that some provider "fixes" may be warranted and certainly necessary to get the Congress and the provider community focus on the greater good of any Medicare reform proposal.

There is also a growing concern about specifics in the Breaux-Thomas proposal. The more Senators learn about the design of the Breaux-Thomas proposal, the less they like it. In particular, there is increasing opposition to the implicit increase in Part B premiums for the traditional program, the extension of the BBA 1997 provider cuts, the eligibility age increase, the Medicare direct medical education transfer, the unlimited home health copayment, and the fact that the Commission's projection of $100 billion in savings over 10 years is less than a third of your surplus proposal and would impact only minimally on the program's financial integrity.

Despite their misgivings about the Breaux-Thomas proposal, Senate Democratic Members have made it quite clear that they need a substantive alternative to support in order to oppose it. As such, there is growing interest in learning about what you are going to propose. There is an apparent split among Democrats in the Senate over their comfort for using the surplus to offset the costs of the prescription drug benefit. The base Democrats (Daschle, Rockefeller, Kennedy) would be supportive of its use, while more conservative Senators (Kerrey, Conrad) may not. For this reason, tobacco revenue is receiving more attention as a stand-alone or supplement to the surplus as a financing source for prescription drugs (having said this, some question whether this could be sold as a credible financing mechanism).

The Senate Republicans are divided in their Medicare positioning. Some are standing with Senator Breaux because his plan reflects their priorities and provides Democratic cover for doing so. Others are focusing on BBA reforms, and a few are waiting for your proposal to determine whether there is hope for a bipartisan bridge that would not only achieve Medicare reform but reach closure on the allocation of the surplus.

Breaux-Thomas Update. This week, Senator Breaux and Congressman Thomas are scheduled to testify before the Senate Finance Committee. Senator Breaux's staff has indicated that that Senator will not be unveiling legislation but instead highlight the virtues of applying the FEHBP model to the Medicare program. While he may provide a few more details about the Breaux-Thomas proposal, the only specific announcement that the staff suggested he would make would be dropping the eligibility age increase provision.

In recent weeks, the Senator has informed us about his desire for his and your proposal to eventually merge together. In addition to dropping the eligibility age increase, the Senator has also indicated that he may drop his proposal to transfer out direct medical education payments out of the Medicare Trust Fund ("because it will be necessary to respond to Moynihan's concerns on this front"). He also informed us that he understands our concerns about his premium support proposal and is very open to changes to it as long as what is eventually produced is validated as "true reform." In addition, the Senator indicated that he would like to drop his Medicaid drug benefit and replace it with a Medicare prescription drug benefit for all beneficiaries, providing beneficiaries with a 25 percent subsidy (we are contemplating a 50-75% subsidy to keep the premiums to around $20 per month). And finally, Senator Breaux underscored his strong belief that there should be a new Board to administer private health plans outside of the Health Care Financing Administration (HCFA) – a position that Donna Shalala and Nancy-Ann Min DeParle adamantly oppose.

Prescription Drug Coverage. The one "reform" issue that continues to attract a good bit of interest is the one that will require the most new resources -- prescription drug coverage. The recent introduction of the Kennedy, Rockefeller, Dingell, Stark, Waxman Medicare Prescription Drug Coverage Act has further focused attention on the benefit shortcomings of the Medicare program. Our actuaries estimate that, even without its Medicaid expansion, its fairly generous benefit will cost over $300 billion over 10 years--far more than anything we are contemplating.

Interestingly, some of the more conservative Democrats, Congressman Allen (D-ME), Congressman Barry (D-AR), and other Blue-Dog Democrats continue to support legislation that requires drug companies to give Medicare beneficiaries access to the same discounts that the DVA and other agencies receive though the Federal Supply Schedule receive. Such an approach would reduce prescription drug prices to the elderly and people with disabilities by about 15-25 percent, although it would not provide insurance coverage for these products. This approach is appealing to these Democrats because it does not force them to find offsets to pay for the insurance coverage, but still increases access to medications by lowering their prices. Such an approach, because it so closely resembles price controls, is viewed with contempt amongst the pharmaceutical industry. They also fear it because it forces a debate solely around their prices -- not on the cost of providing for a new prescription drug benefit.

Reconciliation. In their budget conference agreement, the Republican leadership did not give instructions on Medicare reform – in essence, leaving Medicare out of budget reconciliation and without the protections in the Senate from filibusters, etc. AARP indicated in a meeting with us that this was their pre-condition for supporting the Republican House budget. Others have suggested that they simply did not want to make themselves vulnerable to arguments that they are using Medicare cuts to support a tax cut. Regardless, the practical effect is that it is out of reconciliation and thus a true bipartisan agreement will be needed to pass Medicare reform.

Ongoing Congressional Consultation. We continue to meet with individual Members, particularly on the Senate side, who are most likely to be advocates of Medicare reform. We do not believe very many have locked in on any particular position and are therefore open to our outreach. By the first week in June, we will have met with most of the Senate Finance Committee Members, as well as a good number of swing Democrats who will be influential with the caucus. We will keep you informed of developments.

PHOTOCOPY
PRESERVATION

4

PHOTOCOPY
PRESERVATION

BACKGROUND MEMORANDUM ON COMPETITION IN MEDICARE

The focal point of the Medicare Commission was its premium support proposal and its advocacy for additional market-oriented purchasing policies in the traditional Medicare program. This memo briefly summarizes the issues and options associated with competition in Medicare. It does not include (as yet unavailable) cost estimates; instead it provides a brief summary of current purchasing practices within the Medicare program, a review of premium support and the Breaux-Thomas proposal, and alternatives to it.

I. COMPETITION IN THE CURRENT MEDICARE PROGRAM AND PREMIUM SUPPORT

Medicare Today. Medicare spending in 1998 and the first part of 1999 has been very low, and the outlook for Medicare's solvency has improved significantly. In 1993, the Medicare Hospital Insurance Trust Fund was projected to be insolvent in 1999; today, it is projected to become exhausted in 2015. The long-term shortfall (75-year actuarial deficit) has been reduced by two-thirds. The positive news regarding the trust fund can be attributed in large part to three major factors: the enactment of Medicare reforms in 1993 and the 1997 Balanced Budget Act (BBA); the strong economy that has increased revenues and decreased inflation; and success in combating Medicare fraud. Despite these improvements, the retirement of the baby boom generation will overwhelm Medicare. As a result, the program not only will need new financing, but also the tools with which to constrain costs to make it more capable of meeting this demographic challenge.

Provider Payments in Traditional Medicare. Currently, the traditional fee-for-service Medicare program cannot use negotiation, competitive bidding, and other market-oriented approaches to reduce costs. For example, since Medicare is a major purchaser of durable medical equipment, it could probably pay less through competitive bidding than through the current rate schedule. Virtually all of Medicare's provider payments are set through statute, with no flexibility to adopt different payment practices, even if they are more efficient.

Your past and present budgets have included a number of policies to improve the efficiency and competitiveness of the traditional program, but the Congress has usually opposed these policies. This is because providers understandably fear that their reimbursement rates would be less under competitively set rates. An important contribution of the Medicare Commission was an acknowledgement of this issue. Nearly all Commission members agreed that the traditional program should be given the kind of flexibility and management options that the private sector uses. Although CBO has not assumed much savings from these types of policies in the past, our actuaries estimated that a list of policies to modernize fee-for-service Medicare could reduce Federal costs by as much as $14 billion over 10 years, adding a year of life to the Trust Fund.

Medicare Managed Care Payments. Similarly, competition plays virtually no role in setting private managed care plan rates. Medicare pays private plans a county-specific rate based roughly on the local fee-for-service per capita costs. All plans in an area get paid the same rate – if their costs are higher, they may charge a higher premium, and if their costs are lower, they offer extra unstandardized benefits like prescription drugs and preventive services in order to attract a larger market share.

Few analysts would argue that this system is efficient or fair. Before the BBA, Medicare overpaid plans, partly because of the link to the traditional program in high-cost, urban areas. As a result, Medicare typically lost money with increased enrollment in managed care (this should be reversed with the BBA changes). This is exacerbated by the fact that the government does not pay less for low-cost plans – instead, plans use excess payments to provide extra benefits. In 1998, 83 percent of plans offered eye exams, 67 percent offered drug coverage, and 37 percent offered dental benefits – none of which are covered by Medicare. Managed care plans use these extra benefits to attract enrollees. However, plans typically offer extra benefits that younger, less sick beneficiaries prefer, so the competition is over which plan can attract the best risks, not offer the lowest price. This is why advocates of managed competition (e.g., Enthoven, Reischauer, Altman) encourage competition based on price and quality, not benefits.

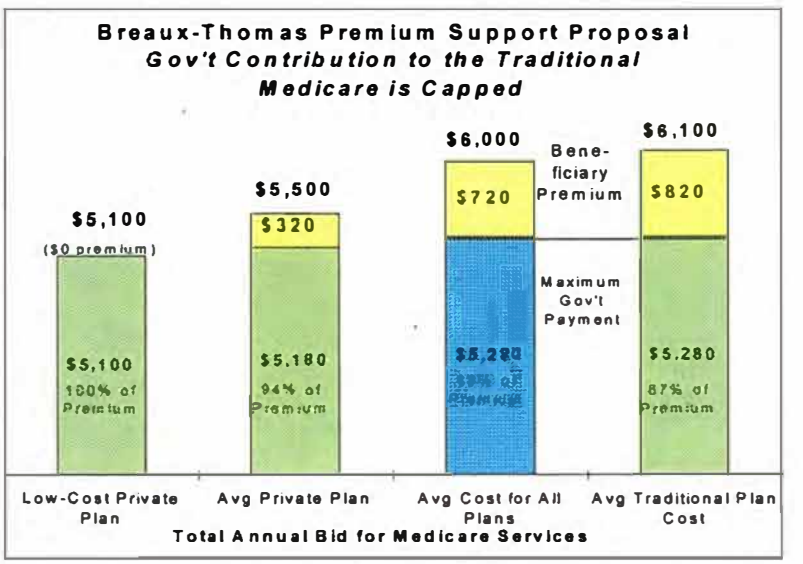
The current system also is unfair since it implicitly subsidizes extra Medicare benefits only for plans in certain parts of the country where payment rates are high. Over 11 million beneficiaries -- mostly in rural areas -- do not have access to any private plans and thus the extra benefits that they offer. Another 5 million beneficiaries have only one plan option, and typically that plan offers fewer, less generous benefits than plans in high-cost, competitive areas. Even beneficiaries with access to private plans face unfair choices – e.g., either stay in traditional Medicare without affordable drug coverage or join an HMO to get the subsidized coverage.

Premium Support. In a 1995 article (attached), Robert Reischauer and Henry Aaron described a concept called premium support. Their goal was to create incentives for beneficiaries to choose efficient health plans and for providers to provide high-quality care at a low cost. Additionally, they sought to improve Medicare benefits, eliminating the need for the inefficient and expensive Medigap system, and to give beneficiaries the same quality and choices that privately insured people have. Under premium support, "Medicare pays a defined sum toward the purchase of an insurance policy that provided a defined set of services." In other words, it maintains the program's guarantee of a defined, improved set of benefits (including a prescription drug benefit), but limits the government contribution to create an incentive for beneficiaries to seek care from efficient plans. To ensure that the limit on government payments is reasonable, it is based on the average (or median) bid in an area for both fee-for-service and managed care plans. Beneficiaries choosing plans whose bids are higher than average would pay more -- those choosing lower-cost plans would pay less.

Premium support resembles a traditional voucher program since government payments would be limited – even for the fee-for-service program. As such, beneficiaries would bear greater risk for excessive Medicare cost growth. However, there are some critical differences between premium support and a voucher proposal. Premium support includes a guarantee of defined benefits; even if the government contribution is limited, health plans must provide Medicare benefits. Also, the beneficiaries would not face as great a risk for unexpected health care cost inflation. This is because the maximum government contribution is not arbitrarily set; it is based on a percent of actual Medicare spending. If Medicare costs go up, so does the maximum government contribution (similar to what happens in Medicare Part B, where the government pays 75 percent of costs).

How savings are achieved. Savings from premium support could be achieved in several ways. First, since the maximum government payment is linked to the average bid, government spending would be lower if more people enroll in private plans, thus lowering the national average over time. Second, under most premium support models, the government would pay less for lower-cost plans (rather than a flat dollar amount for all plans regardless of costs). Thus, it gets savings by paying a lower rate when beneficiaries choose low-cost plans. And third, premiums for traditional Medicare could be higher than current law, raising revenue from the beneficiaries who remain in fee-for-service. Under virtually all premium support models, the traditional plan premium would be higher than the average premium, making it a "high-cost plan." Thus, additional revenue would be raised from higher premiums – particularly since all analysts assume that even under the most optimistic scenario only a minority of beneficiaries will enroll in private plans. Whether and how much premium support saves from these three mechanisms depends on its design.

Breaux-Thomas Proposal. The Breaux-Thomas proposal included a premium support model that loosely resembles the Reischauer-Aaron concept. Under its outline, the government would pay health plans a percent of plan costs up to a limit -- the national weighted average bid (a dollar amount based on the per capita costs of the traditional program and the private plan bids, adjusted for enrollment). A beneficiary choosing an average cost plan would pay the same premium as under current law (about 12% of Parts A and B costs, $720 in the chart). Beneficiaries would pay more for plans above the national average -- including the traditional program -- and less for lower-cost plans. Plan costs would not be based on the same, standardized benefits – instead, they could vary their benefits within certain limits. Additionally, to help constrain geographic variation, the government would pay for only part of local costs for private plans.



Our greatest concern with the Breaux-Thomas premium support proposal is its increased premium for the traditional program and its reliance on savings from this higher premium. Our actuaries estimate that their plan would increase traditional Medicare premiums by 18 to 30 percent above current law (10 to 20 percent if traditional program savings are included). This results because traditional Medicare costs would likely be higher than the national average premium. Beneficiaries would pay the current 12 percent premium ($720 in the chart) plus every dollar that the traditional program exceeds the average ($100 in the chart). While under some circumstances this premium increase could be justified (e.g., if the plan included a significant improvement in Medicare benefits), it appears to be a pure cost shift in this model.

During the Commission process, Senator Kerrey among others expressed concern about this premium hike, especially for beneficiaries without any private plan options. To allay this concern, the final version of the Breaux-Thomas plan allowed beneficiaries in areas without private plan options to pay current-law premiums for traditional Medicare. As a consequence, for the first time in Medicare history, beneficiaries would pay a different premium for the same traditional program, depending on where they live. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should one plan enter the area.

Urban beneficiaries would not fare much better under the Breaux-Thomas proposal. Because of their access to private plans, they would not be protected against higher traditional program premiums. And, because the proposal would only partially adjust for geographic cost variation, the government would pay for only part of plans' higher costs in urban areas. This would probably result in plan cost shifting to beneficiaries.

II. Options for Managed Care Competition

The Breaux-Thomas premium support proposal has flaws in its design but addresses a serious issue in Medicare. Your advisors believe that there are options for reforming Medicare managed care payments that reduce Federal costs, improve efficiency, and protect the premium for the traditional program. This section describes key policy parameters and options for a competitive approach to managed care payments. All options are structured to prevent the premium for beneficiaries choosing the traditional program from rising. The goal of protecting the traditional program premium is unanimously shared by your advisors. Any approach that we adopt should produce savings through competition, not by implicitly raising the Medicare premium. However, it should be noted that by protecting the traditional program's premium, any option probably would not be considered premium support by those who advocate for it. Additionally, there will be less private plan enrollment and savings without the steep financial incentive to join managed care that results from the higher traditional program premium.

These options being considered also assume that Medicare benefits are guaranteed and explicitly defined; that plan payments are fully adjusted for risk of the beneficiary and local costs; and that private plans have some flexibility in reducing beneficiary cost sharing. Since risk adjustment under current law will not be fully phased in until 2004, this would probably be the earliest implementation date. Another major assumption in the options is that the government splits the savings with beneficiaries when they choose lower-cost plans. This does not occur under current law, since the government pays a flat rate for all plans. The beneficiaries get 100 percent of the plans' lower costs in the form of extra benefits. It is possible to give beneficiaries 100 percent of the savings back in the form of lower premiums rather than extra benefits. However, to ensure government savings from managed care, the options assume that both the government and

beneficiaries pay less for lower-cost plans. The examples give beneficiaries 80 percent of the difference between the national average premium and the plan's bid (the government gets 20 percent of the reduced cost). Our actuaries suggest that the government cannot take more than 25 percent of the savings from lower-cost plans, since taking a higher cut would discourage beneficiaries from choosing private plans in the first place.

Setting the Maximum Government Contribution. As stated earlier, the difference between premium support and a voucher proposal is that the maximum government payment is set as a percent of actual Medicare spending, not some arbitrary, budget-driven factor that could shift greater risk to beneficiaries. However, exactly how this maximum is designed determines the extent to which competition occurs, beneficiaries choose private plan options, and the government saves. There are three major options for the setting the government contribution, described below.

Option 1: Based on Average Private Plan Bids: Under this option (see chart 1), the government contribution would be based on the regional average of private plans' premium bids, excluding the traditional Medicare program. Private plans would bid for Medicare benefits, and an average bid would be calculated. Beneficiaries choosing plans whose bid is higher than this regional average would pay more, those choosing lower-cost plans would pay less. The traditional program's premium would be set as under current law and it would not be used in setting private plans' payments. As a result, fee-for-service is completely protected from competition. This resembles a current competitive pricing demonstration underway in Phoenix and Kansas City.

- **Pros**

  Most straightforward way of protecting the traditional program's premium since it is totally separate from the competition. Also, it could be characterized as nationalizing the current competitive pricing demonstration.

  May be the only option that the most liberal of Democrats in Congress would at least initially support.

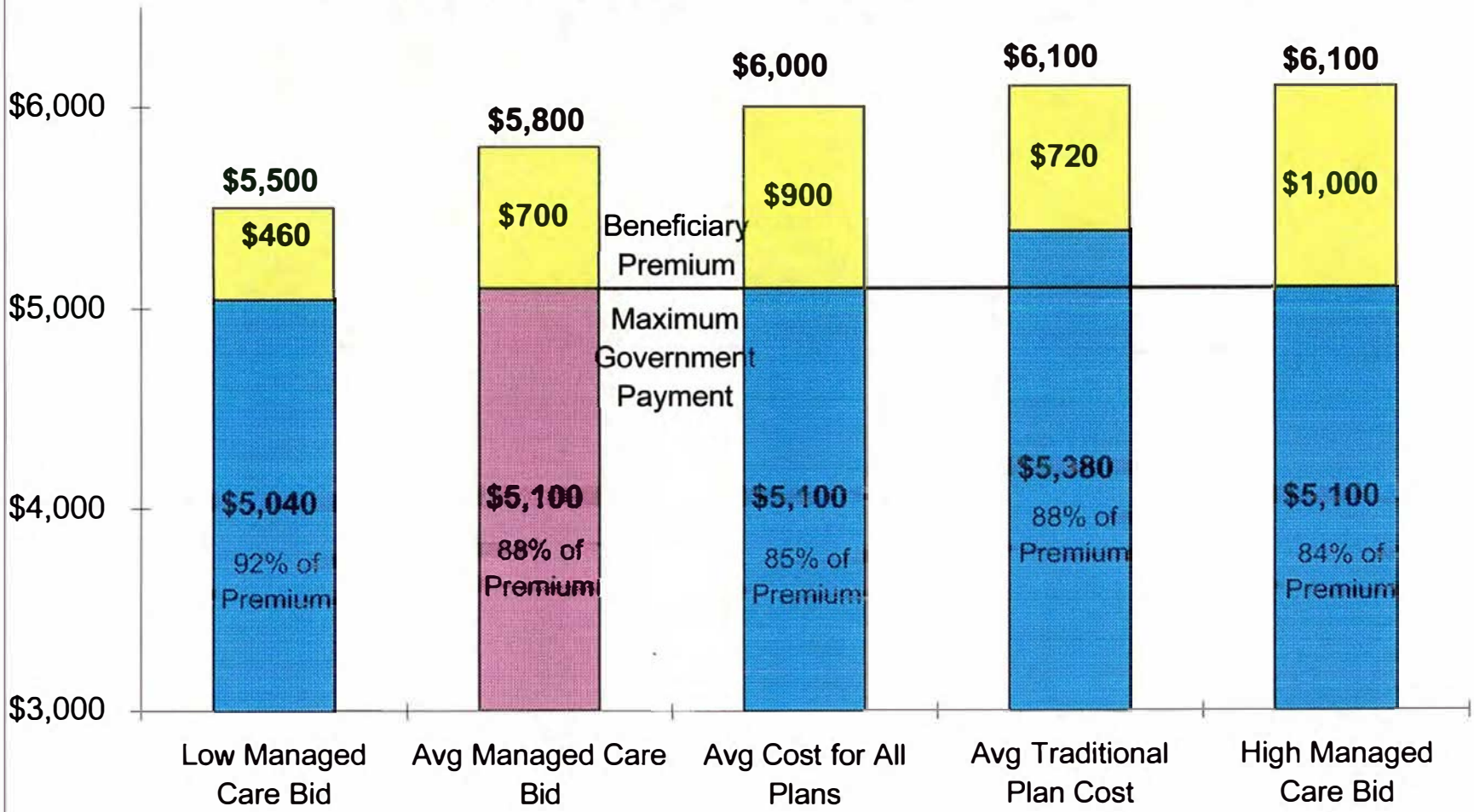
- **Cons**

  Potential for instability since there would be great volatility in the average payment in areas with few plans. This means that beneficiaries' premiums would vary considerably from year to year. Also, it creates the possibility that a plan can low-ball its bid, pulling down the government contribution, driving out other plans and raising premiums for most beneficiaries. As such, it has no supporters in the Administration.

  Most likely to result in lowest participation by managed care plans since payment rates would be the lowest. As such, most likely to be opposed by the managed care industry.

Option 1: Payments Based on Private Plans' Bids

Traditional Medicare Premium Set Separately



Note: $720 is approximately current law.

Option 2: Based on Average Costs of All Plans: Under this option, the government contribution would be based on the average of all plan bids (including traditional Medicare), weighted by enrollment (see chart 2). This resembles the Breaux-Thomas proposal, with one important exception: the premium for traditional Medicare would be set using current law, not the average costs, to avoid higher traditional program premiums.

- **Pros**

  Because of its similarities to the Breaux-Thomas proposal, this option most clearly highlights its shortcomings – we can point out how our proposal has the competitive incentives without the financial coercion.

  Much more stable than Option 1 since it maintains link in payments to traditional Medicare. Using the average cost also keeps private premiums on par with those for traditional Medicare.

  Saves from both reduced payments to private plans and increased enrollment, which lowers the average and thus the payment schedule.

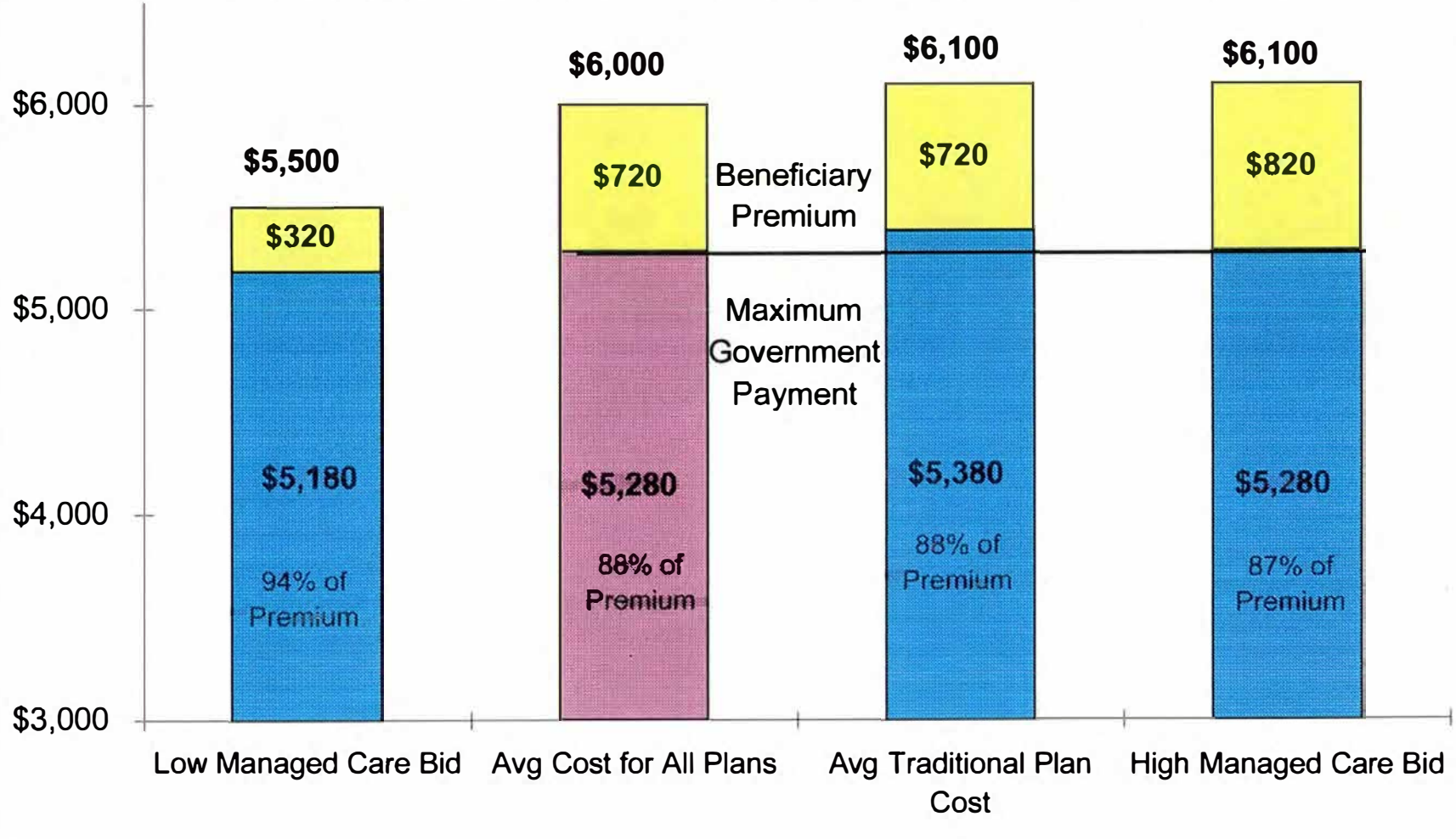
- **Cons**

  Because it is the closest to the original Breaux-Thomas model, it is the most vulnerable to being modified into an unacceptable premium support plan.

  Over time, if private plan enrollment is high and/or bids are low, the average costs would be reduced, as would the government payments. Although this would produce greater savings, it would also make the traditional program a better deal for beneficiaries relative to a private plan with the same costs.

Option 2: Payments Based on All Plans' Average

Traditional Medicare Premium Protected / Private Plans Not



Note: $720 is approximately current law

Option 3: Based on Average Traditional Program Costs But Payments to Private Plans Reduced Consistent with Current Law: This option would maintain current plan reimbursement (discounted traditional program costs) but substitute competition between unstandardized extra benefits with competition on price / premiums. Beneficiaries' premium for the traditional program would be set as under current law (see chart 3).

- **Pros**

  Least disruptive of current managed care payment policy and thus most attractive to HHS.

  Requires no special rules to protect the traditional premium, making it less vulnerable to movement towards the Breaux-Thomas proposal. At the same time, it leaves Option 2 available if compromise towards Breaux-Thomas is necessary.

  Keeps private plan premiums in line with the traditional program premium, limiting the criticism that the traditional program is getting a special deal which makes it attractive to the Treasury Department.

- **Cons**

  Still subject to the criticism that the private plan payment schedule is linked to the unrelated traditional program costs. Thus, if traditional program costs rise faster than private premiums, the maximum government payment to private plans would also rise.

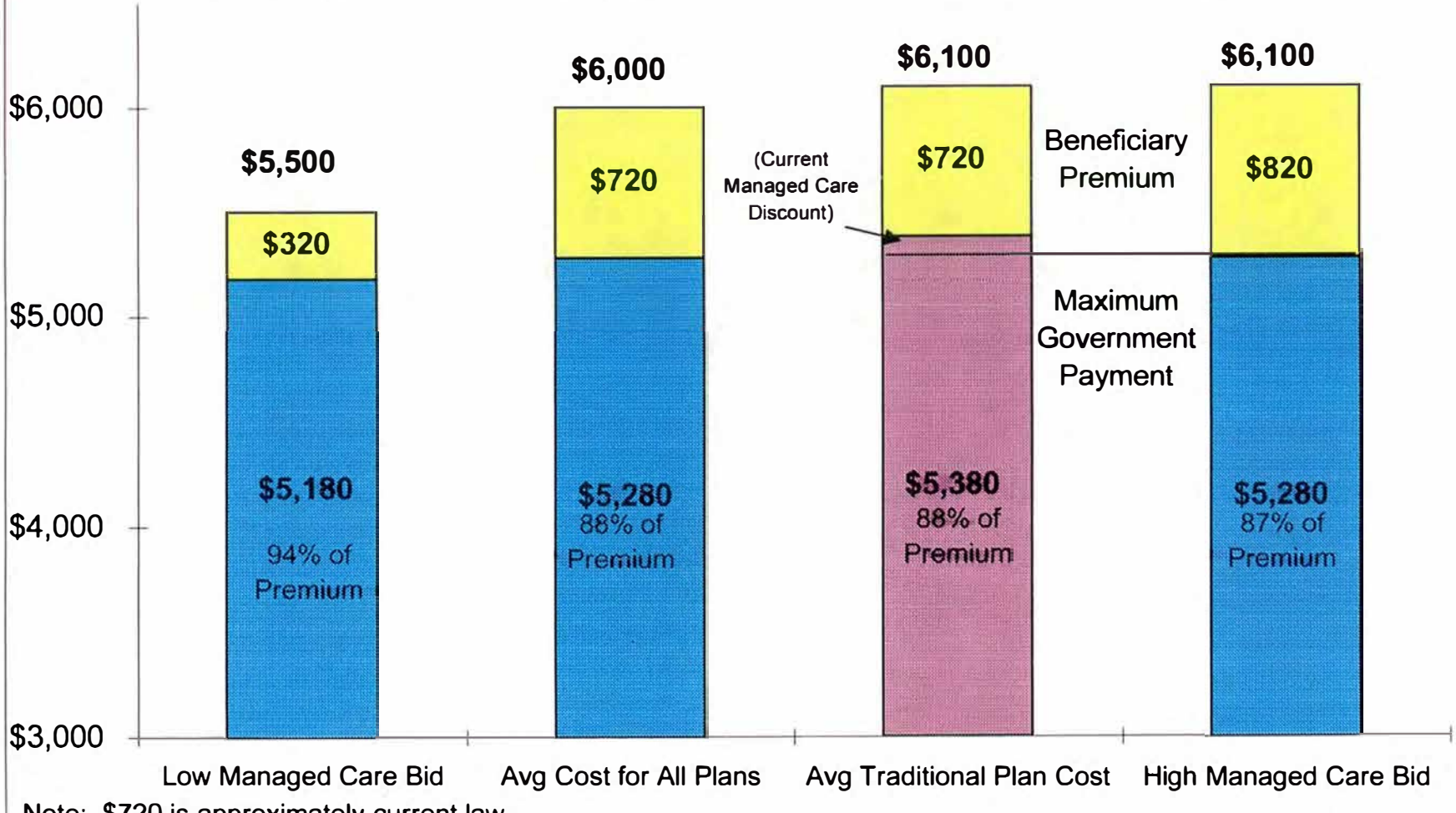
  Harder to explain as a viable alternative to the Breaux-Thomas plan.

  Could be viewed as too incremental

Options 2 and 3, according to preliminary estimates, save about $10 billion over 10 years (from 2004 when implemented to 2009).

Option 3: Payments Based on Traditional Medicare

Traditional Medicare Premium Automatically Protected



Note: $720 is approximately current law.

Under current law, managed care plans are paid a discounted amount based on the local traditional fee-for-service plan costs

HEALTH AFFAIRS

Winter 1995

Medicare Analysis

The Medicare Reform Debate: What Is the Next Step?

by Henry J. Aaron and Robert D. Reischauer

Abstract: Medicare costs are rising faster than projected revenues. Action to close the emerging deficit is inescapable. We propose converting Medicare from a "service reimbursement" system to a "premium support" system. These changes would resemble many that are now reshaping private employer-based insurance. Our reform would encompass not just the "public" Medicare program but also the "real" Medicare, which includes the supplemental plans to which most Medicare beneficiaries have access. Approved plans would have to offer stipulated services. We review numerous technical issues in moving to a new system that cannot be solved quickly and that preclude quick budget savings.

Medicare is at the core of two current policy debates. One centers on the steps needed to balance the federal budget over the next seven to ten years. The other focuses on how existing entitlement programs might best be modified to cope with the retirement of the baby-boom generation, which will begin at the end of the first decade of the twenty-first century. Cuts in Medicare undertaken to balance the budget now will probably contribute only modestly to meeting the second, more serious challenge; realistically, measures designed to deal with the consequences of the baby-boom generation's retirement will contribute little to short-run deficit reduction. This paper describes a reform proposal designed to address the second of these issues: the long-range future of Medicare.

Five central facts will shape the debate on the future of Medicare. First, Medicare enjoys overwhelming support among the American electorate, a popularity that is well deserved because the program has achieved all of its designers' major objectives. Second, the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts. Third, legislative reform of the entire health care system is now off the political agenda and likely will remain so for years to come. Fourth, there exists a strong and broad consensus against raising taxes. Fifth, dramatic changes are taking place in the way health care is financed and delivered for the non-Medicare population.

The implications of these facts are straightforward. First, before changes are made in Medicare, policymakers will have to assure the general popula-

Henry Aaron is director of the Economic Studies Program at The Brookings Institution. Robert Reischauer, formerly head of the Congressional Budget Office, is a senior fellow in that program.

Health Affairs, Volume 14, Number 4

tion and beneficiaries alike that the reforms will not compromise the attributes of the program that the public values so much. Second, Congress will have to act soon to restore Medicare's financial viability. Third, the measures that Congress adopts will not be part of any major legislative effort to reform the overall health care system. Fourth, most, if not all, of the budgetary savings on Medicare will come from reducing federal payments to providers and raising costs to beneficiaries, not from raising Medicare payroll taxes. Fifth, congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.

Popularity And Success: A Brief History Of Medicare

Two views on how to provide assistance. Before the enactment of Medicare, few retired elderly or nonworking disabled persons had reliable health insurance coverage. The private insurance that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. The elderly and disabled feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it. To address these problems, President Lyndon Johnson proposed the Medicare program in February 1964.

The debate around this initiative displayed two conflicting principles about how government should act when private-sector services are inadequate. One view is that government should assist only those persons who are too poor to buy the service. The principle behind this approach is that, with few exceptions, markets should be permitted to allocate all goods and services. A compassionate society should provide aid to the destitute. But this assistance should disturb the operation of markets as little as possible, it is argued, because markets have intrinsic virtues, such as efficiency and consistency with the principles of personal autonomy and freedom.[1]

The other view holds that the best way, on balance, to provide some types of assistance is through a universal entitlement—aid available without regard to personal income or means but based on some more or less objective indicator of need. Advocates of this approach invoke arguments based on social solidarity or efficiency; they simply assert that, despite the value of markets in other contexts, certain goods and services should be provided to everyone at some basic level.

When Congress approved Medicare, it embraced the second philosophy by establishing a universal entitlement to stipulated benefits for everyone age sixty-five and older who has worked in a job subject to payroll taxation or who is a spouse of an entitled worker.[2] At the time, some Republicans and southern Democrats opposed this view and agreed to support Medicare

only if other Democrats would embrace a companion program of health care benefits available only to those with incomes and assets below quite modest levels. The Republican program, Medicaid, replaced various state programs of health care assistance for the poor with an open-ended federal matching grant that imposed various federal mandates and restrictions. The compromise legislation, which incorporated both programs, passed in the House of Representatives by a vote of 307 to 116 on 27 July 1965 and in the Senate by a vote of 70 to 24 the next day. President Johnson signed the Social Security Amendments of 1965, as this momentous legislation was so ingloriously called, on 30 July 1965.

Political alignments have changed over time. A new cadre of conservative representatives and senators now sees Medicaid not as the preferred method of financing health care for the indigent but as federal meddling in a domain in which states should not be hindered and as an element of a welfare system that works to the long-term disadvantage of those whom it is intended to help. They would like to see Medicaid transformed into a block grant under which each state would be given a fixed sum that it could use with few federal restrictions to provide health care services to the indigent. Some also would convert Medicare from a universal entitlement into means-tested assistance. Several proposals along these lines would impose higher costs on participants with high incomes; others would provide a voucher to assist participants who wanted to leave the program to buy private coverage in the marketplace.[3]

Growth in popularity and costs. Together with supplemental (Medigap) policies, Medicare has provided elderly and disabled persons with access on a nondiscriminatory basis, and with an unrestricted choice of providers, to the same health services that workers and their families enjoy. Moreover, beneficiaries are heavily subsidized.[4] Thus, the program's extreme popularity is understandable. The public's support for Medicare is reflected in the positions taken by politicians, few of whom seem prepared to acknowledge that Medicare benefits may need to be cut. However, it is clear that something fundamental will have to be done to modify the program because of the unsustainable growth of its projected costs.

The explosive growth of Medicare costs is neither new nor mysterious. Almost from its inception, Medicare has proved to be more costly than anticipated. The projection that the Health, Education, and Welfare actuaries made in 1965 that in 1990 the Hospital Insurance part of Medicare (Part A) would cost $9.061 billion, less than one-seventh of its actual level, has often been used to underscore this point.[5] Over the 1970s Medicare expenditures grew at an annual rate of 17.5 percent and in the 1980s at 12.1 percent; costs are projected to grow at a rate of 10.3 percent in the 1990s. While growth per enrollee has been rapid, Medicare grew less rapidly than

national or private health care spending over 1984–1993.[6]

Some of the program's overall growth is attributable to increases in the number of beneficiaries, which has expanded by about 2.5 percent per year since 1968. Not all of the increase in beneficiaries reflects increased numbers of aged persons—the original focus of the program; legislation passed during the 1970s added disabled persons and persons suffering from end-stage renal disease (ESRD) to the program.

Benefit expansion also has contributed some to the growth in costs. For example, to the list of covered services Congress has added hospice care; mammography; Pap smears; hepatitis, influenza, and pneumococcal pneumonia vaccines; and kidney dialysis and transplants. Administrative actions also have expanded services; the redefinition of allowable home health and skilled nursing facility services has contributed significantly to cost increases in recent years.

Although benefits have increased somewhat over the program's thirty years, the Medicare benefit package remains comparatively parsimonious. In contrast to typical employer-sponsored insurance, Medicare provides no benefits for outpatient drugs and provides poor catastrophic coverage. In addition, Medicare deductibles and copayments for inpatient hospital services—currently $716 for the first day of hospitalization and $179 per day for hospitalization of more than sixty but fewer than ninety-one days per year—are far higher than those of typical private insurance plans.[7] Like most private health plans, Medicare does not cover long-term nursing home services and does not provide dental or vision coverage. It does, however, pay for home health services and short-term skilled nursing facility services. Medicare's benefit package is less generous than about 85 percent of private health plans. The program covers only about 45 percent of the total annual health care bill of the elderly, who, on average, spend considerably more out of pocket on health care than the nonelderly spend.[8] Medicare benefit cuts would only increase these disparities.

The major contributor to the explosive growth of both Medicare and other health care costs has been the increased capabilities of medicine. The proliferation of medical technology has produced many new diagnostic tools, procedures, treatments, and drugs. Few people advocate policies that might dampen this source of cost growth, nor would it be reasonable to deny Medicare participants the fruits of medical advances available to those with employer-sponsored or private health insurance.

Some Considerations Relevant For Reform

Successful and sensible Medicare reform must build on an appreciation of the way in which the current program operates, of its central charac-

teristics, and of the larger health care environment of which it is a part. Reformers must be aware of the limited contribution Medicare now makes to covering the health care expenditures of the aged and disabled, the program's bifurcated structure, the limited role of managed care, the potential under the existing payment structure for pernicious competition on risk selection, the uncertainty of cost projections, and the interaction between Medicare and Medicaid.

Public Medicare and "real Medicare." The federally financed Medicare benefit package is not the health insurance plan that most Medicare participants actually live with. Approximately 65 percent of elderly and disabled Medicare participants also are covered by employer-sponsored retiree plans or private Medigap plans, or both.[9] These plans supplement Medicare, usually by covering deductibles, copayments, some prescription drugs, and hospitalization beyond ninety days.[10] In addition, approximately 16 percent of Medicare participants also have some sort of Medicaid coverage. About 12 percent are categorically eligible (Supplemental Security Income recipients) or meet state Medicaid eligibility standards.[11] For these "dual eligibles," Medicaid pays Medicare Part B premiums, deductibles, and copayments and covers services—primarily prescription drugs and long-term care—that are covered by Medicaid but not Medicare. For those with incomes below the poverty line who are not dually eligible (qualified Medicare beneficiaries, or QMBs), Medicaid pays Part B premiums, deductibles, and coinsurance. The key point is that persons who are covered one way or another by Medicaid, like those with Medigap and retiree policies, face low or no deductibles and little or no cost sharing.

The public Medicare system, therefore, does not define the health care system in which most Medicare-eligible persons participate. Instead, most live with a hybrid system that comes in two forms, both of which have the public Medicare program as their base. For most, the hybrid is a blend of Medicare, which is available to most elderly and disabled persons for very modest premiums (now $46.10 per month), and employer-sponsored retiree coverage or private Medigap insurance. This version has a benefit package that is much more generous than that of Medicare alone. However, if a former employer is not paying at least part of the cost of the supplemental coverage, the cost of this version of the hybrid is considerably more than the cost of Medicare alone. Monthly Medigap premiums average about $70.[12] The second form of the hybrid, a blend of Medicare and Medicaid, offers even more generous benefits and costs the beneficiary less than Medicare alone or the other form of the hybrid.

Most discussion of Medicare reform focuses on the public program alone, not the hybrid system. But because the large majority of beneficiaries live with the coverage and incentives of the hybrid system, sensible policy

change can be formulated only by considering how best to transform the entire system. Not doing so risks adopting ineffectual reforms or reforms that have unintended consequences, which can be illustrated by examining a commonly advocated policy for reducing Medicare costs: increasing the Part B deductible and raising coinsurance.

In most private insurance plans, deductibles and coinsurance serve to discourage the use of low-benefit care. Deductibles also spare insurers the administrative cost and spare the insured person the added premiums to cover the cost of processing many small claims. Because the Medicare Part B deductible is relatively low, its effect in these respects is limited. At $100 a year, it is well below the typical deductible for private insurance and only one-eighth what it was in 1967 relative to annual average per capita charges. The coinsurance for most Part B services, 20 percent, is similar to that of private plans. However, some services, such as clinical laboratory, home health, and skilled nursing facility services for the first twenty days, require no coinsurance. Some critics of the current system have suggested that increasing the Part B deductible, extending coinsurance to all services, and raising it to 25 percent would curtail the use of low-benefit services and reduce administrative costs. Federal spending thereby would be held down and concentrated on more costly episodes of illness.

Under current arrangements, however, Medicare deductibles and coinsurance do not serve their intended purposes, and increasing them would not have the intended effects. Except for the 18 percent who lack supplemental coverage, Medicare beneficiaries do not face coinsurance because retiree supplements, Medigap, or Medicaid typically pays it.[13] Many supplementary policies also pick up the Part B deductible. Increases in coinsurance or deductibles, therefore, would not materially reduce use of low-benefit care or deter nuisance claims. Instead, retiree policies and Medigap vendors would liberalize their coverage of coinsurance and deductibles and would boost premiums. A few people might drop Medigap coverage or buy less-generous coverage, and they might demand somewhat fewer medical services. But most Medicare beneficiaries would either keep their supplemental coverage and pay the higher premium or let Medicaid pay the higher coinsurance and deductible.

While doing little to reduce low-benefit services and nuisance claims, increases in coinsurance and deductibles would transfer costs from the Medicare trust fund to Medicare eligibles (for those with Medigap insurance), their former employers, or other accounts in the federal budget and the states. While such transfers may or may not be desirable, there may well be better ways to accomplish them.

One implication of the foregoing discussion is that retiree, Medigap, and Medicaid coverage actually increase the budget cost of Medicare, by short-

circuiting the economizing effects of deductibles and cost sharing on demand and administrative costs. Supplemental insurance increases Medicare costs by raising the use of Medicare-covered services, but these added costs do not show up in the premiums for these policies.

To reform the hybrid, public/private Medicare system that people actually use and pay for, it will be necessary to consider the systemic effects of changes in the public program. Reform of Medicare should not be confined to the public program but should encompass rules affecting the sale and pricing of supplemental policies.

The A and B of Medicare reform. Part A of Medicare pays for inpatient hospital care, home health care, hospice care, and limited skilled nursing services; Part B pays for physician services, outpatient hospital and clinic care, laboratory and other diagnostic tests, and other services. Persons age sixty-five and older who are eligible for Social Security or Railroad Retirement benefits, those who have received disability benefits for two or more years, and those with ESRD are automatically entitled to Part A benefits.[14] Whether or not they are eligible for Part A, all persons age sixty-five and older may join Part B by paying a monthly premium; so too may disabled and ESRD participants in Part A.

Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete. Services once provided only in hospitals on an inpatient basis are now provided routinely on an outpatient basis, in physicians' offices, or even at home. The line between care provided during a hospital stay and that provided after discharge is increasingly blurred. Yet reimbursement for inpatient hospital care under the diagnosis-related group (DRG) system and that for outpatient hospital and physician services under the resource-based relative value scale (RBRVS) system and other fee schedules remain distinct and serve to reinforce a structure for the delivery of care that is becoming anachronistic. This payment system is not easily integrated with managed care arrangements and capitated payment systems.

No good case can be made, in our judgment, for perpetuating Parts A and B of Medicare. To the extent that the public sector has a legitimate role to play in the financing of health care for the elderly and disabled, that interest is common across the range of covered medical services. The distinction that Part B is "voluntary" is close to meaningless, because 97 percent of the participants in Part A elect to participate in Part B.[15]

The distinct methods of financing Parts A and B—the former with a payroll tax and the latter through premiums and regular appropriations—have created different political and economic dynamics for the two parts. Part A enjoys the advantage of an earmarked tax and is subject to the

discipline that stems from the fact that outlays cannot, in practice, exceed revenues from that tax plus accumulated reserves and the interest earnings of those reserves. Congress originally declared that it intended to charge eligible households half of the cost of Part B. However, Congress lacked the political will to deliver on that promise, thereby freeing Part B from the budgetary discipline that has driven the debate about Part A. Any major reform of Medicare should unify Parts A and B. The consolidation should not, however, be used as an opportunity to relax the limited fiscal constraints under which the program now operates and tap into general revenues to support Part A.

Fee-for-service and risk contracts. Medicare is rapidly becoming the last remnant of relatively unmanaged fee-for-service care in the United States. As of 1995 a majority of nonelderly Americans with private health insurance were covered under one form or another of managed care.[16] This extremely elastic term includes health maintenance organizations (HMOs) in their various forms and preferred provider organizations (PPOs). Health care delivery, financing, and risk-sharing arrangements are blooming in huge numbers and riotous diversity.

Except in Medicare. Medicare participants can enroll in one of three delivery and financing arrangements. More than 90 percent "choose" the traditional fee-for-service arrangement.[17] Managed care plans that are reimbursed on the basis of reasonable costs serve another 2 percent, and managed care plans that are paid on a capitated basis (risk contracts) serve 7 percent. Under these risk contracts, plans provide the Medicare benefit package for 95 percent of the average cost of fee-for-service Medicare benefits in their county (adjusted average per capita cost, or AAPCC).[18] The number of Medicare beneficiaries covered by such plans is increasing, but their penetration is projected to lag far behind the penetration of this form of payment for the nonaged population.

The use of Medicare risk contracts varies widely across the United States, reflecting the huge geographical variation in the availability of managed care plans, the limited information that is provided to participants about their options, and the lack of familiarity among the elderly population with managed care delivery systems. Overall, about three-quarters of the Medicare population live in an area in which a managed care option is available.[19] Nevertheless, there is no significant Medicare enrollment by risk contractors in twenty-eight states.[20] These plans have no incentive to market aggressively in counties in which the AAPCC is low. The AAPCC's year-to-year volatility also represents a deterrent. The highest penetration of risk contracts is found in California and Arizona, where close to 30 percent of all Medicare participants get their care from such plans.[21] All of this implies that reforms that propose to move Medicare

beneficiaries into managed care plans will take time. Institutional capabilities will have to be developed, and participants will have to learn more about and become more comfortable with managed care delivery systems.

The "cherry-picking" potential in Medicare. Insurance carriers or managed care plans can increase their profits either by providing services more efficiently or by seeking to insure persons with lower-than-average health care costs. In the case of employer-sponsored plans, the potential of the latter approach is limited because the sponsor is generally seeking coverage for an entire employee group and its dependents. The opportunity to "cherry pick" is greater under Medicare because beneficiaries enroll as individuals, and the stakes are higher because variability of the costs of care among Medicare enrollees—the disabled and the elderly—is far greater than that among the general population.

Medicare risk contractors must accept any Medicare participant who wants to join their plan. Nevertheless, disproportionate numbers of participants who have lower-than-average costs have signed up for these plans under the current Medicare program. Estimates suggest that Medicare's current payments to risk contractors, which are set at 95 percent of the AAPCC, are roughly 6 percent more than the costs that these lower-than-average-risk participants would incur in the standard Medicare program.[22] In other words, risk contracting raises costs to the government, although the risk contractors may produce health care more efficiently than other providers do and therefore may save money for the nation.

The extent to which vendors consciously try to attract only better-than-average risks to their plans is not known. To date, these vendors have been able to maintain acceptable profit margins and even offer additional benefits because they generally can provide services more inexpensively than the fee-for-service sector can, competition among risk contractors is low, and Medicare payment is generous. But if profit margins narrow, competitive pressures to engage in marketing and other administrative practices that attract low-cost enrollees and repel high-cost enrollees could intensify.

The profit-boosting potential of such efforts could be substantial, given the skewed nature of health care costs. Roughly 5 percent of Medicare participants account for more than half of the program's total cost; one-quarter of the program's participants account for more than 90 percent of the costs.[23] Under the existing payment system, a provider can boost profits significantly by small reductions in high-risk enrollments. A plan might attract a disproportionate number of healthy or younger elderly enrollees by offering exercise classes or other services that such participants find attractive or by locating its facilities in certain geographic areas. Similarly, subtle differences in the availability of services might make a plan unattractive to people with certain chronic health problems or might encourage partici-

pants who become heavy users to leave a plan. The current policy of permitting Medicare participants to switch from managed care plans into the traditional Medicare delivery system with a month's notice facilitates such practices.

All of this suggests that if Medicare is going to move from a fee-for-service reimbursement system toward one that emphasizes capitation, payments made to the plans will have to be better calibrated to the health risks of persons covered by those plans. Care will have to be given to ensure that plans do not engage in subtle practices to ward off high-risk participants.

Cost variations. The Medicare benefit package is uniform nationwide, but its cost is not. In 1992 reimbursements nationally averaged $4,341 per person served but varied from a low of $3,048 in Nebraska to a high of $5,114 in Louisiana.[24] The variations across substate areas are even greater: Cost per enrollee in Miami, Florida, is 2.4 times that in Waco, Texas.[25] Such differences reflect interstate variations in DRG prices and RBRVS fees, salary levels, and medical practice patterns and the propensity to use services. Such variations survive without serious scrutiny in a system that simply pays for services rendered or that pays fixed fees to providers based on local costs. But such variations would be hard to justify or sustain if Medicare shifts from paying for services to paying for insurance. Pressure would arise to justify variations in payments per person. While variations associated with differences in input prices could be rationalized, it is doubtful that a persuasive case could be made for per person reimbursements that are 68 percent higher in Louisiana than in Nebraska.

Uncertainty about costs. Actuarial projections that Part A of Medicare will be insolvent in a few years add a sense of urgency to the need to "do something" to fix Medicare. The impossibility of balancing the budget in seven (or even ten) years without large reductions in Medicare raises this sense of urgency to almost frantic levels.

Two aspects of the actuarial projections are relevant to the process of reform. The first is that the actuarial projections are extremely volatile. The period until projected insolvency has changed by many years from one trustees' report to another (Exhibit 1). Some of these changes are attributable to legislation, but many are not, such as the change from 1992 to 1993. The estimated cost of Part A benefits, measured as a percentage of taxable payroll, also has oscillated widely. To illustrate, the trustees' reports of 1982, 1987, 1994, and 1995 placed the cost of Part A, as a share of taxable payroll, at 6.7 percent, 3.65 percent, 4.52 percent, and 4.17 percent, respectively. The change from 1994 to 1995 is particularly noteworthy, because no relevant legislation was enacted between the two projections. We know of no methodological breakthroughs to suggest that similar variations will not occur in the future. Thus, the magnitude of reductions in Medicare

Exhibit 1
Number Of Years From Medicare Hospital Insurance (Part A) Trustees' Projection Until Insolvency

Year of trustees' report	Years until insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20[a]
1976	About 15[a]
1977	About 10[a]
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966–1995.
[a] Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

costs or of increases in payroll taxes necessary to close projected deficits is not known with any certainty.

The second aspect of the projections that is relevant to reform is that the gap between current revenues and current benefits is so large that even the large fluctuations in projected costs shown in Exhibit 1 give no hope that the current system can be sustained. In 1995 actuaries projected that the Part A trust fund would be insolvent in 2002. The large cuts in Medicare Part A implied by the budget resolution for fiscal year 1996 would only delay insolvency by a few years. The twenty-five-year actuarial projections

indicate that Part A outlays would have to be cut 30 percent or revenues increased 43 percent to balance the program. Since any legislative changes would be small at first, the changes in the terminal years of the projection period would have to be considerably larger.

The growth of spending under Part B is considerably higher than under Part A, in large measure because many services that were once provided in hospitals can now be provided on an outpatient basis or in physicians' offices. As a share of gross domestic product (GDP), Part A is projected to increase from 1.62 percent in 1995 to 2.83 percent in 2020, a 75 percent increase. Part B is projected to increase from 0.93 percent of GDP to 3.18 percent over the same period, a 242 percent increase.

Medicaid and Medicare. State Medicaid programs, as has already been pointed out, have been called upon to supplement Medicare for low-income participants. Dually eligible participants have whatever benefits their state's Medicaid program provides and assistance to pay their Medicare Part B premiums, coinsurance, and deductibles. Medicaid programs also have been required to cover the Part B premiums, coinsurance, and deductibles of QMBs. State Medicaid programs pay the full actuarial cost of Part A for elderly and disabled persons who have incomes below the poverty line but do not have sufficient work histories to be eligible for Part A. As of January 1995 Medicaid also pays Part B premiums for those with incomes between 100 percent and 120 percent of the poverty threshold.

Congress has adopted these requirements over the past decade because Medicare's coverage, by itself, is not overly generous. Low-income participants in poor health who lack this supplemental protection could find most of their limited income absorbed by out-of-pocket spending for health care. But these requirements also have imposed a significant burden on states, which, on average, pay 43 percent of the costs of Medicaid.

As Medicare evolves or is changed, the logic of dividing the responsibility for health care for the low-income aged and disabled between these two programs will weaken. As more participants have the opportunity to join plans that offer benefit packages that include prescription drug coverage and catastrophic protection and that have low cost-sharing requirements, the need for the QMB protection will diminish. Furthermore, if premium subsidies must be provided, equity suggests that they should be uniform nationwide. Estimates suggest that fewer than half of persons eligible for QMB subsidies have received them. The take-up rate is thought to vary considerably because of differences in states' outreach efforts. The possibility that Medicaid payments per recipient might be capped or transformed into a block grant reinforces the logic of having Medicare assume full responsibility for covering the acute health care costs of low-income aged and disabled persons.

A Program For Medicare Reform

Goals and principles. Any fundamental social policy reform should be guided by clear principles and goals. The following four should direct the changes that Medicare will require. (1) Reforms should deal not just with "public" Medicare but with the full package of benefits most Medicare beneficiaries use. (2) Under a reformed Medicare program, the quality of health care provided to the elderly and disabled should not be materially different from that available to the general population. Nor should the delivery system for this population be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care). (3) Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide high-quality care at the lowest possible cost. This does not necessarily mean, as some advocates of managed care seem to suggest, that the least costly providers are the best, nor does it define the limits of care that public financing should support. (4) Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population.

Designing an entirely new program is usually easier than reforming an existing one. Program designers need to concern themselves with objectives and feasibility. Program reformers must attend not only to these concerns but also to current entitlements and people's sense of ownership in these entitlements. For Medicare, the political acceptability of proposed changes hinges not just on whether they are, in some sense, objectively fair, but also on how they affect the access of two very vulnerable groups, the elderly and the disabled, to choices and services they regard as rights. Furthermore, creating new administrative and institutional frameworks is typically easier than transforming existing ones. Established institutions and bureaucracies that feel threatened typically resist reform. The reforms described here, which we believe would have to be phased in over a considerable period of time, attempt to reflect these constraints.

A new Medicare system. We propose converting Medicare from a "service reimbursement" system into a "premium support" system. Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a PPO, or operate through an HMO. Plans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately would receive a predetermined amount to be ap-

plied to the purchase of a health plan providing defined services. Because health care costs differ by health care market area, support given to enrollees would have to vary across health market areas, but not within them. As indicated below, risk adjustments among insurers based on the characteristics of their clients also would be necessary.

Plans would be required to offer defined services. Insurers would be permitted to sell coverage for additional services not covered under the basic plan, but only if marketing and delivery of these services were divorced from those of the basic plan. To the extent that such supplemental coverage induced use of basic services (for example, cost-sharing supplements), a premium surcharge would be imposed and rebated to Medicare.

The marketing of insurance to Medicare beneficiaries would follow the principles developed for the operation of managed competition.[26] The first step would be to define health care market areas, whose boundaries would be based on the supply of medical care. They typically would be metropolitan areas or large portions of states where population density is low, and they could cover portions of more than one state.

Entities interested in bearing the risk of providing health care for the Medicare population would be invited to submit bids for providing the defined benefit package in a particular market area for the "average" Medicare enrollee. The federal Medicare payment in each market area would be the same regardless of which plan the enrollee chose. If the enrollee chose a plan that cost more than the federal Medicare payment for the area, the participant would pay the balance. This supplementary payment can be thought of as a replacement for the cost of retiree and Medigap insurance.

Local marketing organizations would be established to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private, not-for-profit agencies, would receive information from insurers, ensure that it was presented to Medicare enrollees in a comprehensible and even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail or querulous, to minimize sales abuses. Enrollees would select an insurance plan for the coming year and would be permitted to switch plans during an annual open enrollment period.

Because some participants have much higher than average expected health costs, plans would receive risk-adjusted payments from Medicare based on age, sex, disability status, and other health indicators. Good methods of making such risk-adjusted payments do not now exist.[27] It is uncertain whether today's imperfect methods would suffice to offset attempts by insurers to select favorable risks or if improved methods could be

developed.[28] For this reason, our approach should be introduced gradually and evaluated periodically. For the first few years a blend of cost-based and capitated reimbursement may be necessary. We advocate this approach not because we necessarily believe that managed care and managed competition will produce huge savings. Such savings are highly uncertain and depend on unpredictable developments. Rather, a framework that forces people to face the consequences of their choices in the delivery of medical care should encourage them to choose the plans whose style of care matches their preferences, and we believe that enrollees should bear the financial consequences of their choices. Trends in health care spending are dominated by advances in medical technology, some of which are overused. Further advances in technology are inevitable and welcome, although they will be expensive.[29] Which should be used and how extensively should be determined by the persons who use them. Furthermore, we believe that a market in which plans offering similar benefits compete along dimensions that consumers can understand will promote efficient service delivery.

This framework lends itself to budget control in ways that the current Medicare system does not. Medicare now establishes a variety of price limits—DRG prices for hospital admissions and RBRVS fees for physician services—but since it cannot (and should not) control the quantity of services, it cannot control the total cost of care or federal spending. Under this system, neither health care providers nor patients have any incentive to limit physician services or hospital admissions. The result is the possibility of overuse of medical services.[30] The small area variations in the use of various medical procedures and the cost advantages of some managed health care providers support this possibility.

Problems Of Design And Transition

Converting Medicare from a fee-based reimbursement system into a premium support system will be neither quick nor easy. A number of issues and problems must be addressed before such an alternative can be instituted nationally.

(1) What should be the benefit package in the new plan? It would be a grave mistake, in our view, to use the current Medicare benefit package for the new plan. Instead, the benefit package should combine the current Medicare package with some modest coverage of prescription drugs and catastrophic protection. Plans should be required to offer this new benefit package in one of two standard forms: a low-cost-sharing variant and a high-cost-sharing variant. The expanded benefit package offered in the low-cost-sharing version would provide coverage similar to what many Medicare participants enjoy and pay for in the current hybrid system. They

will not willingly accept less and, in our view, should not be expected to. They pay premiums for this package and should continue to do so.

A standard benefit package and standardized cost-sharing regimes are important, at least initially, because they will reduce risk segmentation among plans and help participants to compare the cost and quality of different plans. Numerous benefit packages and cost-sharing arrangements would make comparisons difficult. Furthermore, higher-income, younger, and healthier participants would be attracted to plans with limited benefits and high cost sharing, which would place a greater burden on the yet-to-be-developed mechanism for making risk adjustment payments to the different plans.

(2) How should the federal payment be set? This issue has several dimensions. First, should the federal payment be set at the cost of the least expensive plan capable of covering a substantial portion of the participants in a region, or above that minimum? We believe that, initially at least, payments should be based on a defined benefit package, adjusted for variations in actual costs and use among regions, not on the basis of actual bids or the lowest bid within a region. The low bid in a region might reflect a highly efficient plan. But it also could reflect an unusually spartan delivery system or a low-quality plan; such outliers should not affect the federal support available in a region. If the federal payment were set at the lowest bid, several problems could develop. First, more participants might seek to join the plan whose costs were covered completely by the federal payment than the plan could absorb while maintaining quality. Second, low-income participants might be denied choice and could be concentrated in the one or two plans that required no supplemental premiums.

The initial federal payment should be set at 95 percent of the cost of the current Medicare package in the market area, adjusted to remove indirect medical education, direct medical education, and disproportionate-share payments.[31] If providers charge the Medicare payment plus the premium for a Medigap plan, enrollees now covered by Medigap plans would face a premium that is 5 percent higher than the cost of their current hybrid coverage. But if competing plans are able to provide this level of service at lower cost, enrollees would face a smaller cost increase or might even achieve savings if the reduction in price were sufficient.

During a phase-in period of perhaps five to ten years, the federal payment should grow more slowly than projected baseline costs. If growth of plan expenses slows, costs to enrollees might not increase. In any event, this mechanism would produce some relief for the federal budget. An expert commission should recommend the exact size of this reduction; this recommendation could be reevaluated every two or three years.

In the long run, the federal Medicare payment should grow at the same

rate as per capita spending on health care for the nonelderly. This formula is mechanical and may require periodic adjustment, because the per capita cost of care depends on the average age of the population, the age-specific gradient in health care costs, and the age bias of new medical technology.[32] If Congress found it necessary to reduce federal support for Medicare, it could slow payment increases, thus shifting costs to Medicare enrollees.

The second issue in setting federal payments concerns regional variation in Medicare spending per enrollee. Current cost differences reflect variations in wage rates and other input prices, availability of services, demand, and—more generally—practice patterns. If current variation is larger than is acceptable, over what period should this variation be reduced? Our view is that payment levels initially would have to reflect historical spending patterns, but that differences should be gradually narrowed until payments varied only for differences in wage rates and other input prices. Such payment differences are necessary if Medicare is to avoid penalizing the elderly or disabled for residing in a high-cost area. The objective would be to have the federal payment cover the same services throughout the country. The adjustment should be complete within a decade.

Third, plans in some regions may submit bids below the federal payment. What if enrollees select such plans? Initially, when participants are unfamiliar with the service style, quality, and other dimensions of plans offered to them, it probably would be best to require that these dividends be devoted to such supplemental services as eyeglasses or routine dental care, or to other services.[33] This policy would reduce the possibility that cash rebates would tempt infirm, low-income participants into a low-cost plan that provided unexpectedly inferior care. Over time, as the competitive marketplace developed and as participants became familiar with their options and the consequences of choosing one plan over another, differences between the federal payment and plan cost could be rebated to participants as nontaxable income or split between government and participants.

(3) Will Medicare enrollees segregate themselves, or will plan administrators market plans in ways that result in economic segregation among plans? One of the strengths of the current Medicare program is that all participants—rich and poor alike—come under the same basic plan, and providers are relatively indifferent to the incomes of their Medicare patients. In a world of competing plans, economic segregation could occur in various ways. Plans with high deductibles and high cost sharing probably would attract not only the relatively healthy but also the relatively wealthy, who can self-insure against all but the most costly illnesses. The same is likely to be true of relatively costly plans that offer enrollees an expanded choice of providers or higher-quality amenities. Because health status and income are positively correlated, such segregation will aggravate the risk

adjustment problem.[34]

To have some choice of plans, low-income participants would have to be provided with some sort of premium supplement to replace the current Medicaid assistance. These supplements, which would be nonrefundable even in the long run, could be keyed to the distribution of bids in a region. For example, they might be sufficient to allow a person with an income below the poverty threshold to participate at no cost in any plan that charged a premium below the median in the region.

(4) How should a new system be phased in? This question is clearly the most important and the most difficult. Before the plan described here can operate, it is necessary to create an environment of competition among health plans, to construct the apparatus necessary to regulate the marketing of insurance and the risk adjustment procedures for allocating payments based on enrollment, and to overcome the practical difficulties of transferring costs to many current Medicare enrollees. Even in the most prepared regions, it will take years to establish the necessary institutional structure.

The plan also hinges on the availability of enough plans in each market area to create meaningful choice and competition. These plans need not include traditional HMOs, at least at the outset, but the plans must be independent and must compete with one another. HMOs would increase the range of choice available to Medicare enrollees but are not essential. To the extent that aggressively managed care is necessary to reduce the growth of health care spending, the full benefits of the reform approach we have described would be realized only when such plans existed in most places.

The most difficult transitional issues involve beneficiaries themselves. How should they be phased into the new system? This problem would be hard, but manageable, if enrollees could be enticed into the new system by more generous payments. However, the current budget climate renders that option infeasible. The simplest method would be to run the current Medicare system alongside the new system. The new system would be mandatory for everyone who turns sixty-five and becomes eligible for Medicare after a certain date. It would be optional for everyone enrolled in Medicare before that date. Presumably, many who were not required to join the new system would do so anyway because they would prefer one of the alternative plans.

This approach may not be practical everywhere because the number of new Medicare enrollees in some sparsely populated regions may be too small to support even one plan. In such areas it may be necessary to delay the transition and then shift a group—such as all persons under age seventy—into the new system at one time.

(5) What role would Medicare price controls play? Medicare now reimburses most providers according to administered prices. Most of these payments are well below reimbursements from other payers. In addition,

providers cannot bill Medicare participants for charges beyond certain specified and limited amounts.

In the new system, a plan that offered the choice of providers now available under Medicare without these price discounts would have to either charge much higher premiums or leave participants exposed to significant balance billing. This shift would represent a noticeable reduction in the opportunities available to many Medicare beneficiaries, who would find such a shift exceedingly burdensome. For this reason, we believe that the various Medicare fee schedules must be maintained for a transitional period. All plans could use these schedules for paying providers other than those in their own networks. Existing balance billing and assignment restrictions would continue. Because competitive forces would reduce the need for such limits in the new system, fee schedules could be relaxed.

(6) How much regulation will the new system require? Initially, at least, the new system will require a good deal of regulation, and much of it will have to emanate from Washington. The nation should not gamble with health care for the aged and disabled, many of whom are unlikely to be able to do well in an unregulated market. Moreover, if there is a failure, the federal government will be required to step in.

Plans will have to be certified with respect to their medical capabilities and the quality of care they provide, their administrative competence, and their financial soundness. It is reasonable to expect that the same minimum standards should be met by each plan throughout the country. While these standards may be set nationally, state agencies or specialized nonprofit organizations could enforce them.

We have already noted that state, local, or not-for-profit organizations would be responsible for organizing and ensuring the orderly functioning of the health plan market in each area. These organizations would specify, collect, and disseminate information provided by health plans to Medicare enrollees. To help enrollees make informed choices among plans, they would ensure that the information is presented clearly, simply, and uniformly. These organizations also would monitor plans to prevent them from engaging in measures designed to attract good risks.

(7) What of Medicare's other functions? Over the past thirty years Medicare has evolved into more than a system to help pay the medical bills of the aged and disabled. Through its payment system, it has come to play an important role in supporting graduate medical education. The payment system also has sustained institutions in remote locations and helped hospitals serving disproportionate numbers of uninsured persons to bear the costs of uncompensated care. The payments made under our proposed plan would not continue to support these objectives. To the extent that they remain important, they should be funded through separate grants.

Conclusion

The Medicare program, which has served the nation—particularly the elderly and disabled—extremely well during its first thirty years, faces profound changes before it reaches its golden anniversary. Budgetary and demographic developments mean that the program as it is now structured is unsustainable. As this paper goes to press, congressional action on Medicare and Medicaid is not yet complete. The outcome of the wrangling between the president and Congress that will follow is unclear. Nevertheless, if the effort to craft a compromise reconciliation bill does not fail completely, it seems likely that large cuts will be made in Medicare. How much fundamental structural change will emerge is still an open question. Most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will be made even more complex and inequitable. Medicare eligibles will be given more of an impetus to shift into one form or another of managed care. However, the legislation that is likely to emerge probably will not provide strong incentives for participants to reduce their use of low-benefit services or to seek care through efficient delivery systems.

The ultimate response to the budget and demographic pressures could take more extreme forms. The nation could establish a separate national health care system for the aged and the disabled, with its own network of providers and its own limits on use. At the other end of the spectrum, Medicare could be transformed into a pure voucher system, in which the elderly and disabled receive a voucher and are told to fend for themselves in an unregulated or lightly regulated marketplace. We believe that both of these approaches are politically unacceptable and programmatically flawed.

The approach we have presented represents a middle ground. It builds on the strengths of the current program while converting it into a system similar to the employer-sponsored insurance now available to most Americans. A major argument in its favor is that it would strengthen participants' incentives to seek services from cost-effective delivery systems and providers' incentives to operate efficiently. This plan would enable Congress to directly control the per capita budget cost of Medicare. This feature is critical in view of the certainty that the gap between Medicare costs and revenues will be narrowed as part of efforts to balance the budget. But it is important to acknowledge that our plan also facilitates significant savings by shifting costs to Medicare enrollees, a channel that will have to be used if large reductions in Medicare spending growth are to be achieved.

We close with an unfashionable warning. The history of reforms in U.S. social policy is replete with exaggerated claims of the benefits the reform will produce. To muster enthusiasm, supporters of reform paint rosy pictures

of the marvelous benefits that will ensue if only their recommendations are adopted. Reality, as it is wont to do, eventually emerges, disappointment sets in, and the perception of the competence of policymakers takes another dive. We see the makings of just such a cycle with the current enthusiasm about the benefits of managed care and of improved incentives for cost-consciousness by purchasers of health care services. They promise enormous savings if only their reforms are adopted. Careful cost accounting suggests that their claims are grossly exaggerated.[35] But even if the rosiest plausible projections of savings from managed care are realized, benefits approximating those now provided by Medicare cannot be sustained unless revenues flowing into the system are increased. In plain English, that spells "TAXES." To sustain Medicare, payroll or other taxes earmarked for Medicare must be raised, or general revenue subsidies will have to be increased. We believe that having to live within the revenues of an earmarked tax provides some discipline. We urge that this course rather than increased general revenue subsidies be used when, after heroically trying to cut costs, Congress recognizes that the American people want to keep Medicare benefits and that to do so, somebody is going to have to pay for them.

The views expressed in this paper are those of the authors and should not be attributed to The Brookings Institution, its staff, trustees, officers, or funders. The authors thank Linda T. Bilheimer, Sandra Christensen, and Joshua Wiener for their helpful comments and absolve them of the responsibility for any errors remaining in the paper.

NOTES

1. Some who generally agree with this approach to aid argue that in some circumstances the provision of benefits produces unintended side effects that outweigh direct benefits to recipients, through either work disincentive effects or demoralization. This view, which is as old as the English debates over the Poor Laws, has achieved fresh currency in U.S. politics in debates over welfare reform. Thus far, however, it has not been part of the debate on Medicare reform.
2. The disabled and persons with ESRD were not covered by the original legislation.
3. Bipartisan Commission on Entitlement and Tax Reform, *Final Report* (Washington: Bipartisan Commission, January 1995); Concord Coalition, *The Zero Deficit Plan* (Washington: Concord Coalition, 1993); Congressional Budget Office, *Reducing the Federal Deficit: Spending and Revenue Options* (Washington: CBO, February 1995); and D. Bandow and M. Tanner, *The Wrong and Right Ways to Reform Medicare*, Cato Institute Policy Analysis no. 230 (Washington: Cato Institute, 8 June 1995).
4. The annual subsidy provided through Medicare to a male worker who retired from an average wage job in 1992 was $3,874.
5. Robert Meyers has pointed out the several ways in which this comparison is inappropriate and how the original estimate has been misrepresented. See R.J. Meyers, "How Bad Were the Original Actuarial Estimates for Medicare's Hospital Insurance Program?" *The Actuary* (February 1994): 6–7.
6. Health Care Financing Administration, *Medicare: A Profile* (Washington: U.S. Government Printing Office, February 1995), 51; and Congressional Budget Office, *Trends*

in Health Spending: An Update (Washington: CBO, June 1993), 44–45. The growth of per capita Medicare spending was below that of private health care spending in every year from 1984 through 1991, except in 1989. M. Moon and S. Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, July 1995).

7. Coinsurance of $358 per day is required for the lifetime allowance of sixty additional days of inpatient care. The Part B deductible is $100 per year, and coinsurance is 20 percent. Coinsurance for days 20–100 of skilled nursing facility care is $89.50 per day.
8. American Association of Retired Persons, Public Policy Institute, and The Urban Institute, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington: AARP, April 1994).
9. Congressional Budget Office, unpublished estimates.
10. According to CBO estimates, approximately 39 percent of Medicare participants have Medigap policies, and 26 percent have retiree plans. For a breakdown of supplemental coverage among aged Medicare participants in 1992, see U.S. Congress, House Committee on Ways and Means, *1994 Green Book*, Committee Print WMPC 103-27 (15 July 1994), 886. The Health Care Financing Administration provides the following estimates of coverage for aged participants in 1993: 11.4 percent of elderly Medicare participants have no other coverage, 36.8 percent have Medigap policies, 33 percent have retiree policies, 11.9 percent are covered by Medicaid, and 2 percent have coverage from another source. Medigap policies are offered in ten standard forms, the most popular of which cover deductibles and coinsurance. See P.D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* (Spring 1995): 31–48.
11. CBO, unpublished estimates.
12. Karen Davis, testimony before the U.S. Senate Committee on the Budget, 3 May 1995.
13. This estimate is from CBO tabulations for the elderly and disabled. The *1994 Green Book* provides an estimate of 22 percent for the elderly in 1992, and HCFA provides an estimate of 11 percent for the elderly in 1995.
14. Persons over age sixty-four who are not eligible for Social Security can obtain Part A coverage by paying the full actuarial cost of the coverage. State Medicaid programs are required to pay this cost for persons with low incomes.
15. Most of those who are covered by Part A but choose not to join Part B are workers over age sixty-four who are covered by an employer policy and can join Part B later without penalty.
16. CBO, "The Potential Impact of Certain Forms of Managed Care on Health Expenditures" (CBO Staff Memorandum, August 1992).
17. Most are probably not aware that they have other options besides the traditional fee-for-service plan.
18. The AAPCC is calculated for county areas and is adjusted for the participant's age, sex, institutional status, reason for entitlement (age or disability), and Medicaid eligibility. Plans often provide additional services because they must not have higher margins on their Medicare business than on their non-Medicare business. The excess must be spent on additional services or returned to the government. Plans have an incentive to locate and market in county areas where the AAPCC is high. Plans can switch annually from being paid on the basis of the AAPCC or on the basis of costs.
19. HCFA, *Medicare: A Profile*, 109, Chart MC-1.
20. The Henry J. Kaiser Family Foundation, "Medicare and Managed Care" (May 1995).
21. In Riverside and San Bernardino, California, and Portland, Oregon, the figure is close to one-half.
22. R.S. Brown et al., "Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs" (Princeton, N.J.: Mathematica Policy Research,

December 1993). The results of this study have been questioned in T. MaCurdy, "Evaluating the Cost-Effectiveness of HMOs in Medicare" (Washington: American Enterprise Institute, July 1995).

23. HCFA, *Medicare: A Profile*, 55, Chart PS-11.
24. HCFA, *Medicare and Medicaid Statistical Supplement, 1995* (February 1995), 172–174, Table 14. The text refers to the fifty states. At $6,484 per person served, reimbursement is higher in the District of Columbia.
25. HCFA, "Standardized Per Capita Rates of Payment for 1995" (Mimeo, 1 September 1995).
26. CBO, *Managed Competition and Its Potential to Reduce Health Spending* (Washington: CBO, May 1993); and A.C. Enthoven and R. Kronick, "Universal Health Insurance through Incentives Reform," *Journal of the American Medical Association* (15 May 1991): 2533.
27. J.P. Newhouse, "Patients At Risk: Health Reform and Risk Adjustment," *Health Affairs* (Spring I 1994): 132–146.
28. Control over marketing will reduce but not eliminate opportunities for insurers to engage in risk selection. Thus, a health plan might find it attractive to sponsor an active event and offer information about its plan near the end, when only the most robust remain. A plan might understaff for the treatment of particularly costly illnesses, putting staff physicians in a position in which their medical ethics might force them to tell a patient newly diagnosed with a given illness: "We can care for you. But, in all honesty, Plan X across the street really can do a better job." The avenues through which imaginative risk selection can occur are myriad, and no amount of regulation can close them all. The practical question is whether reasonable regulation together with feasible risk adjustment in payments can take enough of the profit out of risk selection to render it unattractive. At this point, no one knows for sure.
29. W.B. Schwartz, "In the Pipeline: A Wave of Valuable Medical Technology," *Health Affairs* (Summer 1994): 70–79.
30. One long-time advocate of social insurance, whose allegiance to Medicare none would question, remarked to one of us informally that he found it quite easy to imagine that many elderly people who live in relative isolation may find attractive sympathetic conversation with a health care provider about any of the many discomforts that come with age or disability, even if a visit to the physician was not "medically indicated."
31. Some increase may be needed in rural areas where current spending patterns may not reflect the cost of providing an equal level of services.
32. Suppose that the average age of the non-Medicare population rises, while the average age of the Medicare population falls (expected just after the baby-boom generation begins to reach age sixty-five). This would cause the per capita cost of care for the non-Medicare population to fall and that of the Medicare population to increase. Such shifts should not be allowed to occur mechanically. Similarly, new medical technology could be of disproportionate use in caring for diseases that are more prevalent among the Medicare population or among the non-Medicare population. Some allowance for technology-based shifts in the relative cost of care should enter into congressional decisions about the size of the increase in the per capita Medicare payment. Congress would require the technical assistance of a group similar to the Prospective Payment Assessment Commission or the Physician Payment Review Commission.
33. This is the current practice under Medicare risk contracts. Plans are precluded from having higher margins on their Medicare caseload than on their non-Medicare caseload and cannot provide cash rebates to participants.
34. HCFA, *Medicare: A Profile*.
35. W.B. Schwartz and D.N. Mendelson, "Eliminating Waste and Inefficiency Can Do Little to Contain Costs," *Health Affairs* (Spring I 1994): 224–238.

PHOTOCOPY PRESERVATION


5

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

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

- **President's Commitment to Addressing Medicare's Long-Term Solvency**: The President has an unparalleled record of strengthening and improving Medicare. When he took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be bankrupt this year -- 1999. Today, the Trust Fund is projected to be solvent through 2015 and its growth rate per beneficiary is below that of private health spending. However, Medicare's Trust Fund will become insolvent about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries. As such, the President has proposed a framework for dedicating part of the surplus to Medicare. This will be combined with a plan to modernize the program, make it more efficient and competitive, and add a long-overdue prescription drug benefit.

- **A Time-Tested Use of Funds:** The President's framework would extend the solvency of the Medicare Trust Fund by another decade by adding new financial resources -- about $690 billion over the next 15 years. These bonds will guarantee that Medicare will get the benefits from the fiscal improvement that debt reduction and lower net interest costs will bring about.

- **Lower Interest Costs:** By reducing debt held by the public, the framework would dramatically reduce the amount of net interest that the government would have to pay to service debt in the future. This reduction in net interest costs will help free up the resources to allow the government to meet its existing Social Security and Medicare commitments.

- **A Stable Share of the Economy:** Social Security and Medicare costs are projected to rise in the future, but the reduction in net interest costs resulting from the President's framework for Social Security and Medicare will offset those rising program costs. As a result, under the President's framework, the sum of Social Security, Medicare, and net interest costs will remain the same (or smaller) share of the economy through 2020.

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

Year	Share of GDP
1999	9.4 %
2010	8.2 %
2020	9.1 %

- **Additional Benefits to the Economy:** These results flow from the simple benefits of carrying less debt. They do not depend on improvement in the economy, even though most economists project that a significant improvement will result from reduced federal government borrowing. As the government borrows less (that is, reduces its demand for credit), interest rates (the price of credit) should come down, making private sector investment more economical, and increasing economic growth, yielding a fiscal dividend of increased budget surpluses in addition to the effects of declining net interest costs.

HOW THE PRESIDENT'S FRAMEWORK FOR MEDICARE WOULD WORK

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

- **Step 1 -- Reduce the Debt:** The Treasury would use 15 percent of the budget surpluses we now project to pay down $686 billion in publicly held debt over the next 15 years, reducing the government's demands on the credit market.

- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).

- **Step 3 -- Lock-Box Protections:** Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

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

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

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

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

- **Using the surplus for tax cuts would have the following effects**:

  - **Effect # 1:** It would create permanent and growing federal government obligations.

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

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

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHOTOCOPY
PRESERVATION

PHOTOCOPY
PRESERVATION

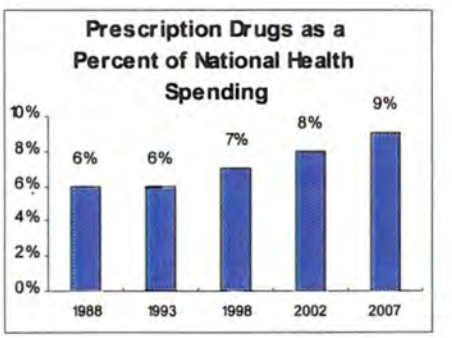
BACKGROUND ON PRESCRIPTION DRUGS

Medicare does not pay for outpatient prescription drugs. The number of Medicare beneficiaries with some other source of insurance for drugs is decreasing, primarily because private sources are becoming less accessible and more expensive. Fewer employers are offering retiree health coverage, and Medigap is increasingly scarce and expensive. Even those with coverage are finding that the extent of their coverage is declining (especially in Medicare HMOs). This occurs at a time when prescription drugs are becoming a central component of medical care.

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

- **Increasing reliance on drugs**. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Elderly and people with disabilities rely more on prescription drugs**. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.

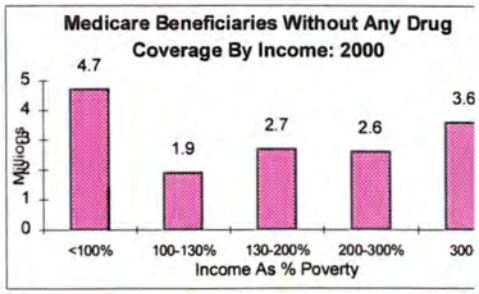


- **Rising share of national health spending**. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.

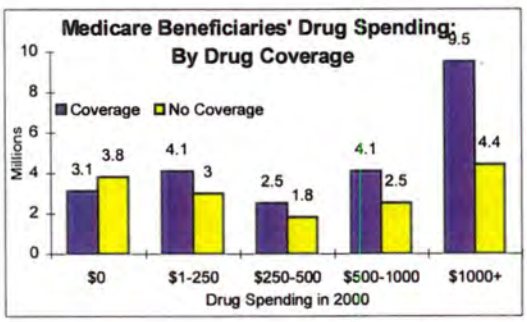
- **Drugs may reduce need for and cost of other services**. Some studies have found that elderly Medicare beneficiaries whose Medicaid drug coverage is limited are twice as likely to enter nursing homes, whose costs are 20 times higher than the savings from the limitation. Stroke patients treated promptly with drugs to thin clots have lower health care costs. And, all experts agree that drug management can reduce complications that lead to costly hospital care. At the same time, drug coverage could add potential new costs due to increases in utilization and possible extension of lives.

BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- **Beneficiaries across the income spectrum lack drug coverage.** About 16 million beneficiaries are projected to have no drug coverage in 2000. Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $17,000 for a single, $23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



- **Many beneficiaries need drugs but do not use them because they are uninsured.** Most research has found that lack of coverage reduces needed drug utilization. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. And while some do not receive the drugs they need, nearly half of all beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of $500 or more.



- **Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that can be 15 to 30 percent higher than large HMOs, employers and the Veterans' Administration. A recent General Accounting Office study found that pharmaceutical benefit managers in the Federal Employees' Health Benefits Plan reduced costs by 20 to 27 percent.

- **Larger financial burden**. Elderly with private insurance for drugs have about half the financial burden (out-of-pocket drug spending as a percent of income) as those without drug coverage. The financial burden of drug costs for rural elderly is on average 35 percent higher than urban elderly since they are less likely to have insurance covering drugs. Women have, on average, out-of-pocket costs as a percent of income that are 20 percent higher than men, primarily because many are widowed and have lower income. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed $3,000 - which more than 20 percent of income for at least half of these beneficiaries.

- **Difficult to help only beneficiaries without drug coverage**. The diversity of beneficiaries without drug coverage, along with the instability of coverage for those who have it, makes it difficult and inequitable to target a new drug option only those who are uninsured. Such a policy would either require people paying for expensive Medigap or who joined an HMO only for drug coverage to maintain that coverage or result in substitution.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES

- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private employer-based or Medigap insurance for drug coverage in 2000 according to the Medicare actuary -- down significantly from 1995. Both sources of coverage have been declining as the cost of coverage rises. Therefore, they cannot be relied upon to provide coverage in the future.

    - ***Retiree health insurance***: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage.

    - ***Medigap***: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. Beneficiaries can be denied coverage if they do not enroll immediately when they are age 65. The premium for a plan with drug coverage is about $1,100 more than a plan without drug coverage ($2,073 v $913 in 1998). Medigap premiums have been rising at double-digit inflation, and coverage has been declining. About 6 percent of beneficiaries are expected to have Medigap drug coverage in 2000.

- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that the potential for "crowding out" private spending are exaggerated.

    - ***Medicare managed care***: Over 90 percent of beneficiaries in Medicare HMOs have some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to $1,000 or less. Rising costs and lower Medicare payments could reduce benefits in the future.

    - ***Medicaid***: Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.

DESIGN PARAMETERS FOR A PRESCRIPTION DRUG BENEFIT

Designing a prescription drug benefit is one of the more complicated health policy challenges. Not only are there a large number of decisions involved, but each decision has a cost and/or political tradeoff. This memo describes a number of major design features that affect the costs and coverage of a Medicare prescription drug benefit: (1) eligibility; (2) optional versus mandatory; (3) premium subsidy; (4) cost sharing; and (5) management. It also briefly discusses costs. Specific options will be presented in forthcoming meetings.

Eligibility: One of the basic questions about a new drug benefit is who is eligible. Medicare benefits have never been limited to subsets of beneficiaries or means tested. Laura Tyson, Bob Reischauer, Henry Aaron, Uwe Reinhard, David Cutler and other economists argue that the only efficient – albeit expensive to the Federal government -- option is to extend drug coverage to all beneficiaries. Not only does this ensure that beneficiaries that need this coverage get it, but it limits the need for inefficient, expensive supplemental coverage.

However, most Republican members of the Medicare Commission opposed a Medicare benefit due to its cost, concerns about substituting for existing private coverage, and a philosophical aversion to expanding Medicare. In addition, although covering all beneficiaries was considered, Congressman Thomas did not want to respond to a Democratic priority without greater support for his version of premium support. Thus, the Breaux-Thomas proposal included a new Medicaid (not Medicare) subsidized benefit for those with income below 135 percent of poverty (about $11,000 for a single, $15,000 for a couple). It would also require Medicare plans and Medigap to offer an unsubsidized drug option (described later).

Providing low-income beneficiaries with a fully subsidized benefit is important -- and would, in fact, happen automatically if a new Medicare benefit were created. This is because, under current law, Medicaid pays for Medicare premiums for all beneficiaries with income below 135 percent of poverty. It also pays for cost sharing for beneficiaries up to 100 percent of poverty. Unless this provision is changed, Medicaid would also pay for the Medicare premium for prescription drugs for low-income beneficiaries (note: in our cost estimates).

However, a low-income drug benefit would leave most beneficiaries vulnerable. Nearly 3 out of 5 beneficiaries who lack drug coverage have income above 135 percent of poverty. About 30 percent of these beneficiaries have drug expenditures that exceed $1,000. This represents a considerable expense for beneficiaries with income between $15,000 and $20,000. Moreover, private coverage for drugs is unstable. The actuaries project that the proportion of beneficiaries with retiree coverage will decline to 17 percent by 2000, and with Medigap declining to 6 percent. This has mostly resulted from rising costs of drug coverage, and health coverage for the elderly in general. Similarly, managed care plans report that they are also facing higher costs for drugs and are increasingly limiting their benefit. Thus, the lack of drug coverage is not just a low-income problem.

There are also other problems associated with a Medicaid drug benefit. Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the

voluntary Part B program. The issues of Federal-state matching rates and "unfunded mandates" also emerge. States are reluctant to take on more Medicare-related obligations, even if adequately funded.

Optional versus mandatory: Today, the Part B premium for Medicare is voluntary but, since the government pays 75 percent of the premium, virtually all beneficiaries take this option. In contrast, in 1988, when a catastrophic drug benefit was added to Medicare, all beneficiaries were required to pay the new premium. This mandatory premium was unpopular, particularly with beneficiaries with other, less expensive, and typically more generous retiree coverage. This contributed to the subsequent repeal of this benefit.

Although proponents of a drug benefit would prefer that it be optional, there is one compelling reason to consider a mandatory benefit: costs. As with most insurance, a new optional drug benefit would create a "moral hazard", meaning that beneficiaries with high drug costs are more likely to purchase the option. This results in a high average cost of the insurance which translates into higher premiums. Over time, healthier beneficiaries will be less willing to pay the higher premiums, causing the risk pool to shrink and the premiums to rise even more.

There are ways to reduce risk selection in an optional drug benefit. The most important would be to subsidize the premium for the benefit. Since nearly all beneficiaries use drugs, a reduced-price premium would encourage healthy beneficiaries to participate. The actuaries assume that even those with employer-sponsored retiree coverage would participate (employers would pay for the beneficiaries' share of the premium, and wrap around the Medicare benefit if their current benefit is more generous). Another way to ensure that an optional benefit is viable is to limit when beneficiaries can enroll. If beneficiaries can wait until they are sick to enroll, even a subsidized option could be subject to risk selection (note: we are working on transition rules to help beneficiaries with legitimate reasons for postponing enrollment). Our actuaries assume that if there is at least a 50 percent premium subsidy and a one-time option to participate (when a beneficiary enrolls in Medicare), then all beneficiaries will participate in an optional benefit.

Premium subsidy: As described above, premium subsidies are important to participation in an optional drug benefit. At the same time, while they reduce the cost per beneficiary, they raise Federal spending in aggregate. The level of the premium subsidy was discussed extensively in the last days of the Medicare Commission. Laura Tyson and Stuart Altman, following logic of the actuaries, argued for at least a 50 percent subsidy. At one point, it appeared that the Commission would agree to a 25 percent subsidy for all beneficiaries, but in the end the Republicans rejected it -- both on philosophical grounds and because they could not get Democratic support for their version of premium support.

In addition to its low-income proposal, described earlier, the Breaux-Thomas proposal included the requirement that all Medigap and Medicare plans offer some type of prescription drug coverage – without rate restrictions or premium subsidies. However, without premium assistance, the costs would be high, so that only those who really need the coverage would enroll. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or inaccessible as few plans participate in Medicare.

One option that could address concerns about premium subsidies is an income-related premium for the optional drug benefit. It would have to be designed carefully, to avoid selection, but could both lessen the cost of the benefit and reduce government assistance for those who could afford it. It would make even more sense if there were an income-related Part B premium, simplifying the administration.

In general, your advisors are suggesting that the monthly premium for prescription drug coverage be in the $20 to $30 per month range. This is about half of the current Part B premium, and is low enough to encourage nearly full participation. To put this in context, the typical Medigap premium for drug coverage is about $90 per month. In all of Maine, New Hampshire and Vermont, only three managed care plans offer prescription drug coverage. In Maine, its plan pays up to $800 of drug costs for a $67 premium; in New Hampshire, beneficiaries pay $45 per month for up to $300 in plan payments for drugs, and in Vermont, a beneficiary can pay $36 per month for unlimited coverage with a 50 percent copayment.

Cost sharing: In additional to the premium subsidy, the cost of a Medicare drug benefit depends on its cost sharing structure. There are four major moving parts of a drug benefit: its (1) deductible, (2) coinsurance or copayments, (3) limits on out-of-pocket spending or stop-loss protection, and (4) cap on benefit payments. The cost sharing for Medicare beneficiaries with drug coverage varies dramatically. Employer-sponsored coverage is probably the most generous. Mirroring coverage for their under-65 workers, it typically has no separate deductible for drugs, low copayments, stop-loss protection, and no limit on benefit payments. Medigap, in contrast, has a separate, $250 deductible, 50 percent coinsurance, and a cap on how much the plan will pay. As the attached table illustrates, its premiums and cost sharing are so high that only beneficiaries with greater than $2,500 in spending benefit from this coverage. Medicare managed care usually has low to no deductible and copayments, controlling costs by limiting the amount that plans pay.

EXAMPLES OF DRUG BENEFIT COST SHARING

Option	Deductible	Copay	Stop-Loss	Benefits Cap
FEHBP*	$50	20%	($3,750)	None
Retiree **	($300)	$5/15	($1,750)	None
Medigap	$250	50%	None	$1250/3000
Kaiser DC:	$0	$5/20	None	$1,000

Limits in parentheses are for all services, not just drugs
* Blue Cross/Blue Shield standard option
** Typical retiree plan

These different design features affect who benefits the most from each policy. As with most health expenditures, most people have relatively low expenditures, while a few have very high expenditures. As the attached chart shows, 17 percent of beneficiaries account for over half of all drug spending for beneficiaries. At the same time, over half of beneficiaries have over $500 in drug spending in a year – suggesting that it is not only the sickest who face high costs. A comprehensive policy that covers both up-front and catastrophic drug spending is not affordable in the context of our reform plan. Thus, there are tradeoffs. Policies with high deductibles that protect against catastrophic costs will help fewer beneficiaries, but those with the greatest need. Policies with low deductibles and low limits on plan payments help a much larger proportion of beneficiaries, but could leave the sickest vulnerable.

Management of the benefit: The last major parameter of a drug benefit is its management. Administering a new benefit, especially one with as much use as prescription drugs, raises a number of questions. The major question is how it would be administered. Medicare could manage the drug benefit in the same way that states administer the Medicaid program. Under

such an approach, as a condition of participation in the Medicare program, pharmaceutical manufacturers would be required to either provide a statutorily set discount or the best price in the market place. As the largest single purchaser of prescription drugs in the world, Medicare could justify getting at least this level of discounts. A slight modification of this approach would allow Medicare to access the Federal supply schedule, which is what the Veterans' Administration, DoD and certain public health programs use. While this administrative structure would almost inevitably secure discounts of 20 to 30 percent of retail prices, it also is the approach that is most certain to attract the unqualified opposition of the pharmaceutical manufacturers. They would claim that such a design represents a straight-out price control approach that threatens the fiscal integrity of the drug industry, the stability of the market, and would lessen their investment in research and development.

Alternatively, Medicare could contract out the administration of the drug benefit to private pharmacy benefit managers (PBMs). PBMs use a variety of approaches to reduce costs, like negotiating price discounts from drug companies for putting their drugs in their formularies; using mail-order companies; and managing utilization through electronic card systems. Some studies suggest that the management tools used by PBMs can save up to 20 percent. However, the Medicare actuary is suggesting that purchasers will be unable to achieve more than a 15 percent discount on average. Relative to a Medicare rebate program, this would translate to billions of dollars of more prescription drug costs that the Medicare program would have to underwrite. Having said this, the Congress will inevitably choose the PBM route to avoid a confrontation with the pharmaceutical manufacturers and concerns about market distortions. In fact, even Senators Kennedy and Rockefeller chose the PBM approach over the rebate option in order to secure a more positive reception by they drug industry (although the industry did not embrace the bill, it acknowledged its administrative provision as a step in the right direction). This is the approach assumed in our cost estimates, although we continue to explore ways to reduce costs which may involve more aggressive management.

Costs of a new drug benefit. As can been seen, there are many choices in designing a prescription drug benefit for Medicare – all of which have cost implications. Although we would like to be considering drug benefits that are comparable to those of Federal employees or other privately insured people, such comprehensive benefits are not affordable. Assuming 2001 implementation and not taking into account Medicaid offsets, this type of benefit could cost the Federal government $185 billion over 5 years, $450 billion over 10 years.

The Kennedy-Rockefeller-Stark-Dingell-Waxman bill attempts to capture the advantages of a comprehensive benefit without the expense. It includes both front-end coverage (a $200 deductible, with 20% beneficiary copayments for the next $1500 in spending (a $1200 cap on government coverage)) and catastrophic coverage (it pays for all costs once a beneficiary has spent $3,000 out-of-pocket). Our actuaries estimate that that this will cost over $300 billion over 10 years.

Staff are currently examining options in the range of $150 to 200 billion over 10. Within this constraint, we will present to you options with different trade-offs – e.g., low premium v. more catastrophic coverage; low copay vs. higher cap.

ILLUSTRATION OF MEDIGAP COST SHARING

OPTION	SPENDING					
	$0	**$250**	**$500**	**$1,000**	**$2,500**	**$5,000**
Distribution 100% (38.8 million)	18% (6.8 m have $0 spending)	18% (7.1 m spend $1-250)	11% (4.4 m spend $250-500)	17% (6.6 m spend $500-1000)	24% (9.2 m spend $1000-2500)	12% (4.7 m spend > $2500)
MEDIGAP PLAN H						
Plan Payment:						
Copay Up to $1,250 Cap	**$0**	**$0**	**$0**	**$250**	**$1,000**	**$1,250**
Beneficiary Payment:						
$500 Deductible	$0	$250	$500	$500	$500	$500
50% Copay	$0	$0	$0	$250	$1,000	$2,250
Amount above $1,250 Cap	$0	$0	$0	$0	$0	$1,000
Total	**$0**	**$250**	**$500**	**$750**	**$1,500**	**$3,750**
Premium Payment:	**$1,000**	**$1,000**	**$1,000**	**$1,000**	**$1,000**	**$1,000**
Spending (+)/ Savings (-)	***+$1,000***	***+$1,000***	***+$1,000***	***+$750***	***+$0***	***-$250***

* According to one study, the Medigap premium for Plan H for an average 65-year old was $2,073 in 1998, compared to $913 in Plan D, which is virtually the same except for drug coverage. This premium reflects both adverse selection and high administrative costs typically associated with Medigap.

MEDICARE BENEFICIARIES: PRESCRIPTION DRUG USE & SPENDING, 2000

	No Spending	$1 - 500	$500 - 1,000	$1,000 - 2,000	$2,000 - 5,000	$5,000 +	TOTAL
TOTAL							
Beneficiaries (millions)	6.8	11.4	6.6	7.4	5.4	1.1	**38.8**
Percent	*18%*	*29%*	*17%*	*19%*	*14%*	*3%*	***100%***
Expenditures (billions)	$0.0	$2.4	$4.8	$10.6	$16.6	$8.6	**$43.0**
Percent	*0%*	*6%*	*11%*	*25%*	*38%*	*20%*	***100%***
COVERED							
Beneficiaries (millions)	3.1	6.6	4.1	4.8	3.8	0.8	**23.3**
Percent	*13%*	*29%*	*18%*	*21%*	*16%*	*4%*	***100%***
Expenditures (billions)	$0.0	$1.4	$3.0	$6.9	$11.6	$6.5	**$29.4**
Percent	*0%*	*5%*	*10%*	*24%*	*40%*	*22%*	*100%*
NO COVERAGE							
Beneficiaries (millions)	3.8	4.8	2.5	2.6	1.6	0.3	**15.5**
Percent	*24%*	*31%*	*16%*	*16%*	*11%*	*2%*	***100%***
Expenditures (billions)	$0.0	$1.0	$1.8	$3.7	$4.9	$2.2	**$13.6**
Percent	*0%*	*7%*	*13%*	*27%*	*36%*	*16%*	*100%*
< 100% of Poverty							
Beneficiaries (millions)	2.5	2.6	1.5	1.7	1.3	0.3	**9.9**
Percent	*25%*	*26%*	*15%*	*17%*	*13%*	*3%*	***100%***
Expenditures (billions)	$0.0	$0.5	$1.1	$2.4	$4.0	$2.1	**$10.2**
Percent	*0%*	*5%*	*11%*	*24%*	*39%*	*21%*	***100%***
100 - 200% of Poverty							
Beneficiaries (millions)	1.7	2.9	1.8	1.8	1.3	0.3	**9.8**
Percent	*17%*	*30%*	*18%*	*19%*	*13%*	*3%*	***100%***
Expenditures (billions)	$0.0	$0.6	$1.3	$2.6	$3.9	$2.0	**$10.4**
Percent	*0%*	*6%*	*12%*	*25%*	*38%*	*19%*	***100%***
200% + Poverty							
Beneficiaries (millions)	2.7	5.9	3.3	3.8	2.8	0.6	**19.1**
Percent	*14%*	*31%*	*17%*	*20%*	*15%*	*3%*	***100%***
Expenditures (billions)	$0.0	$1.2	$2.4	$5.5	$8.6	$4.5	**$22.3**
Percent	*0%*	*5%*	*11%*	*25%*	*39%*	*20%*	***100%***

Based on HHS, HCFA Office of the Actuary, estimated 2000 baseline

PHOTOCOPY PRESERVATION

PHOTOCOPY PRESERVATION

INCOME-RELATED PREMIUM

- **Currently, all beneficiaries pay the same Part B premium**. To enroll in Medicare Part B (which provides physician and other outpatient services), beneficiaries pay a premium that covers 25 percent of Part B costs – the government pays 75 percent. This premium subsidy assures that the three-fourths of beneficiaries with incomes below $25,000 can afford Medicare physician and outpatient services. However, higher income beneficiaries also receive the 75 percent government subsidy.

- **Income-related premium.** An income-related premium would reduce the premium subsidy for higher-income beneficiaries and increase their Part B premiums. The income-related premium is the most progressive way of increasing beneficiary contributions to Medicare since, unlike cost sharing or across-the-board premium increases, it does not affect the 75 percent of the elderly whose income is below $25,000 or high users of health care. Additionally, studies have found that higher-income beneficiaries tend to live longer and use more intense medical services.

- **Previous income-related premium proposals.** In 1992, 1993, and 1997, the President supported or indicated support for a well-designed income-related premium.

- **Democrats' concerns.** Many aging advocates (National Committee for the Protection of Medicare and Social Security; National Council of Senior Citizens) and base Democrats (Gephardt, Waxman, Kennedy) are concerned that this premium undermines the social insurance nature of Medicare, opening the door to means-testing. They argue it sets an irreversible precedent, could easily be lowered in the future, and if it only hits the highest income, it does not raise enough revenue to justify the policy. However, moderate Democrats, especially in the Senate, continue to support this policy. They argue that the highest income should not be subsidized this much – or at all – and believe that this is not a constituency that tends to support Democratic.

- **Republicans' concerns:** Conservative Republicans, like Phil Gramm, are increasingly becoming hostile to the income-related premium because it hits their constituency and, because it almost inevitably must be administered through Treasury, would be considered a tax. Moderate Republicans like Senators Chafee and Grassley continue to support this policy, however, because they think that beneficiaries should contribute more to Medicare and this is just one of a number of necessary steps to prepare Medicare for its financial challenges.

- **Medicare Commission proposal:** Under pressure from Senator Gramm, the final Breaux-Thomas proposal did not include an income-related premium but earlier versions did. Under the earlier plan, single beneficiaries with income of $24,000, couples with $30,000, would pay more. This would affect about 30 percent of beneficiaries (about 12 million) -- twice as many people as the most aggressive proposal in the past 5 years (Chafee-Breaux's 1997: $50,000 for a single, $75,000 for a couple). It would increase the Part B premium to $125 a month for a single beneficiary with $40,000 and a married beneficiary with $50,000 in income (it is now $45.50 per month) and raise nearly $100 billion over 10 years.

OPTIONS

- **Income-Related Premium: Parameters:** The Administration's past support for an income-related premium was conditional on several important parameters:

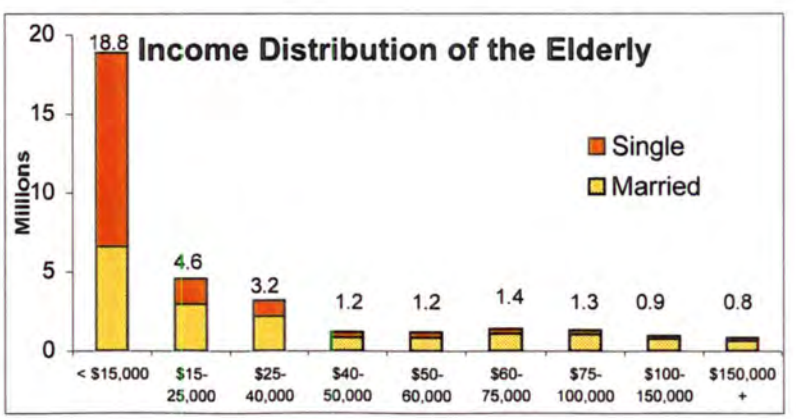
  - ***Does not fully phase out the subsidy: keeps 25 percent subsidy for the highest income:*** This prevents high-income beneficiaries -- who typically have good health -- from opting for less expensive, private alternatives. The result of healthy beneficiaries leaving Medicare would be an increase in the average Federal spending per beneficiary.

  - ***Targets truly high-income beneficiaries:*** Any income-related premium should begin at a high enough income level to that exclude middle-class beneficiaries, who may have difficulty affording the premium. Additionally, the income thresholds for beginning the income-related premium should be indexed to inflation to prevent an ever-increasing proportion of elderly from paying the higher premium.

  - ***Administered by Treasury.*** Only the Treasury Department already collects the income information needed to determine the amount of the income-related premium. HHS cannot do this without losing revenue.

Begins Subsidy Phase-Down	Full Subsidy Phase-Down	Number of Beneficiaries Affected	Savings 2000-04 2001-09
$90,000 for Singles $115,000 for Couples*	$100,000 $125,000	1 million	$8 billion / $22 billion
$80,000 for Singles $100,000 for Couples	$100,000 $125,000	2 million	$9 billion / $25 billion
$50,000 for Singles $75,000 for Couples**	$100,000 $150,000	4 million	$15 billion / $40 billion

* Health Security Act
** 1997 Chafee-Breaux Senate Option



COST SHARING: BACKGROUND

PREVENTIVE SERVICES:

- **Cost**: CBO estimated that the cost of adding these benefits was $8.5 billion from 1998-2007.
- **Users**: Not yet known.
- **Current Cost Sharing:** Varies (see table).
- **Proposal:** Eliminate deductible and copays for all preventive services. Estimated preliminary costs: $2-3 billion from 2000-2008.

COST SHARING FOR PREVENTIVE SERVICES

Preventive Service	Counts Toward Deductible?	Copay
Screening Mammography	No	20%
Pap Smear	No	None
Pelvic Exam	No	20%
Colorectal Cancer Screening*	Yes	20%
Prostate Cancer: Digital Rectal Exam	Yes	20%
Diabetes Self-Management	Yes	20%
Bone Mass Measurements	Yes	20%
Vaccinations: Flu, Pneumococcal	No	None
Hepatitis B	Yes	20%

*Fecal occult blood test has no deductible or copay

- **Facts:**
  - Studies show that cost sharing can discourage people from using preventive services.
  - The only reason why cost sharing was included with these new benefits in the BBA was cost.

LAB SERVICES

- **Cost**: $5 billion in 1997.
- **Users**: 24 million beneficiaries used diagnostic lab service in 1997.
- **Current Cost Sharing:** None.
- **Proposal:** 20% coinsurance. Preliminary estimates suggest that this saves about $4 billion over 10 years.
- **Facts:**
  - Recommended by Medicare Payment Advisory Commission, most experts.
  - About 14 services per person served in 1997, at an annual cost of $200 per user.

SKILLED NURSING FACILITIES (SNF)

- **Cost**: $13 billion in 1999 .
- **Users**: 1.4 million beneficiaries used SNF in 1997.
- **Current Cost Sharing:** No copay on days 1-20, $96/day for days 21-100, 100% for additional days.
- **Proposal:** Replace copays with 20% coinsurance on days 1-100; preliminary estimates suggest that this is either budget neutral or saves a small amount.
- **Facts:**
  - 30% annual average growth in Medicare spending per beneficiary between 1988-97.
  - Cost growth driven both by cost per day – which has doubled since 1988 – and the number of users. Studies suggest that rises in the cost per day have driven rapid growth.
  - The average SNF admission lasts for 24 days.
  - Over 60% of admissions last less than 20 days, but about half of all SNF days occur after 20 days and are thus subject to the high copay.
  - The average Medicare cost per SNF day was $230 in 1997. It is projected to be closer to $300 by 2001.
  - The average coinsurance per person in a SNF for over 20 days was well over $1,000.
- **Issues**:
  - Helps the sickest beneficiaries; rationalizes the copay.
  - New prospective payment system that pays providers a fixed amount per day should reduce growth in cost per day, but provides no incentives to limit admissions or the number of days.
  - SNFs are the most vocal provider group concerned about the BBA cuts. This could be perceived as an additional cut if they cannot collect the coinsurance.
  - May not reduce inappropriate use, since admission to a SNF is not usually optional and is covered by Medigap.

HOME HEALTH

- **Cost:** $15 billion in 1999
- **Users:** 3.6 million beneficiaries used home health in 1997
- **Current Cost Sharing:** None.
- **Proposal:** Unlimited 10% coinsurance or $5 per visit , limited to the first 60 visits. Preliminary estimates suggest that this saves about $5 billion over 10 years
- **Facts:**
  - 25% annual average growth in Medicare spending per beneficiary, 1987-97
  - Number of visits per user tripled in last decade (from 23 to 73 visits/user)
  - Used by older beneficiaries (those over age 85 are 4 times more likely to use services), women (65%)
  - Some beneficiaries have many home health visits:
    - Over 1 million beneficiaries have more than 60 home health visits/ year
    - Rural users average 81 vs 69 visits on average for urban beneficiaries
- **Issues:**
  - Recommended by Medicare Payment Advisory Commission, most experts. With cap, can be acceptable to some advocates (particularly if in a bill with prescription drug benefit).
  - Home health industry has strongly asserted that the BBA payment changes are having an adverse effect on viability of agencies and access to care.
  - In 1997, the Senate passed a $5 home health copay capped at the hospital deductible ($768).
  - Moving to prospective payment system, based on 60-day "episodes" so providers have strong incentive to limit use within an episode – but helps control use within an episode.
  - Controversial; Administration expressed concerns about the provision in 1997.

PHOTOCOPY PRESERVATION

PHOTOCOPY
PRESERVATION

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE

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

ISSUES:

- **The availability and affordability of health insurance for people in their early 60s has not improved -- and in fact has deteriorated.**

  - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups. One recent study projects that the number of uninsured ages 61-64 will increase by over 40 percent by 2005 (from 3 million to 4.25 million).

  - **Fewer have employer-based health insurance**. Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.

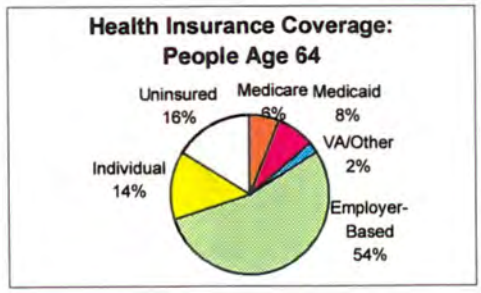
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.

- **Different than Social Security because it is more difficult to postpone health care needs than retirement**. Unlike preparation for income security in retirement, illness and disability are rarely foreseeable. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would affect people with the greatest risk of health problems and lowest probability of finding affordable private health insurance.

- **Breaux-Thomas proposal does not conform to Social Security**. Even under current law, Social Security provides the option for a partial benefit at age 62. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62. Thus, it does not accurately conform to Social Security policy.

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

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



  - **Cost shift to employers**. About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage if these older people continue to work. Costs would result not only from covering workers longer, but from higher premiums for all workers since this older group would raise the average costs of all employees. The few firms that offer retiree coverage would pay more as well, since their insurance would be the primary source of coverage, not a wrap-around to Medicare. This could accelerate the trend of dropping retiree coverage. Finally, the Federal government would lose revenue as employers deduct additional cost of premiums.

  - **Unfunded mandate to states**. State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.

- **No viable policy has been offered to prevent the elderly uninsured from increasing.**

  - **Medicare buy-in cannot replace Medicare**. Some proponents of raising the age eligibility of Medicare have suggested that the President's Medicare buy-in proposal as a health insurance alternative for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in.

  - **Costs of subsidies for buy-in would reduce savings**. The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about $27,000 for a single), the cost of subsidies would be high, lowering savings.

PHOTOCOPY PRESERVATION

PHOTOCOPY
PRESERVATION

RURAL BENEFICIARIES: ISSUES WITH THE BREAUX-THOMAS MEDICARE PROPOSAL

Challenges Facing Rural Beneficiaries Today. About 9 million, or one in four, Medicare beneficiaries live in rural America.

- **Fewer doctors**. Only slightly more than 10 percent of physicians practice in rural areas, and some rural beneficiaries have to travel great distances for health care.

- **Fewer health plan options and extra benefits**. This year, 85 percent of all rural counties with three-fourths of rural beneficiaries have no Medicare+Choice plans available to them. As such, these rural beneficiaries do not get the extra benefits (e.g., prescription drugs, lower cost sharing, preventive benefits) that managed care offers to beneficiaries in areas where Medicare payment rates are higher.

- **Greater health problems.** About 43 percent of rural beneficiaries 75 years old or older report fair to poor health, compared to 30 percent of beneficiaries in metropolitan areas.

- **Lower income**. Rural beneficiaries are more likely to be poor (13 percent versus 10 percent of urban elderly).

- **Less coverage for prescription drugs.** The proportion of rural Medicare beneficiaries with no insurance coverage for prescription drugs is about twice as high as that for urban residents. This is because rural beneficiaries have both less access to employer-based retiree coverage (since such coverage is typically associated with large firms) and Medicare managed care plans that typically offer drug coverage. As a result, the proportion of income spent on drugs is about 35 percent higher for rural than urban beneficiaries.

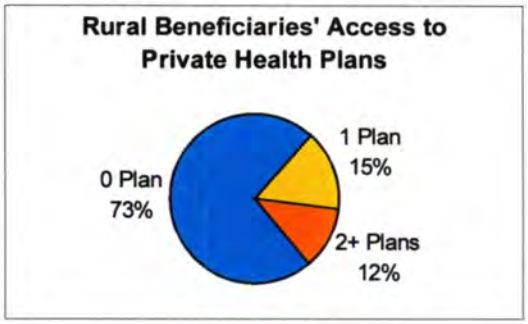
Effects of the Breaux-Thomas Proposal on Rural Beneficiaries. The Breaux-Thomas proposal would probably not help -- and could hurt -- rural beneficiaries.

- **Dilemma: Greater choice or higher premiums**. The Breaux-Thomas "premium support" proposal would limit the government contribution to all Medicare plans -- including the traditional Medicare fee-for-service program. Beneficiaries choosing low-cost plans would pay less and those choosing high-cost plans pay more. However, since the Medicare actuary estimates that traditional Medicare would be a high-cost plan, its premiums would be 18 to 30 percent more than current law (10 to 20 percent with increased efficiency) nationwide.

  To help rural beneficiaries, the proposal would charge beneficiaries with no access to private plans the current premium for traditional Medicare since they have no lower cost options. However, this proposal puts beneficiaries in a difficult situation.

  - **Different premiums depending on location**. Within a state -- and even from town to town -- rural beneficiaries would pay different premiums for the same, traditional Medicare, depending on whether they have access to a private health plan option.

- **Millions of rural beneficiaries would not be protected against higher premiums**. Over 25 percent of rural beneficiaries have access to a Medicare managed care plan, and thus would pay higher premiums for traditional Medicare. Over half of those beneficiaries with access to private plans have only one option. (see attached state table). Even if this single plan has limited capacity or does not include the beneficiary's physician or hospital, all beneficiaries in its area would either have to pay the higher premium for traditional Medicare or enroll in managed care.

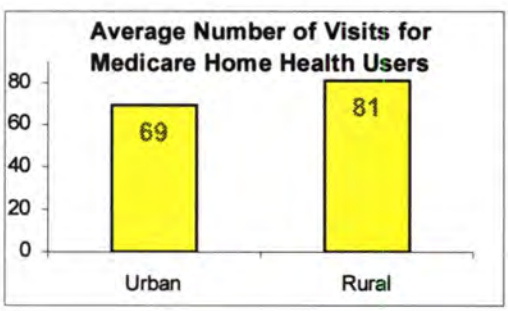


- **Premium protection ends if even one managed care plan enters a rural county**. The Breaux-Thomas plan would subsidize private plans that enter low-cost areas, increasing the likelihood that at least one plan option would be available. If one plan enters the area, the traditional Medicare premium would increase abruptly.

- **More likely to lose coverage as a result of raising Medicare's age eligibility**. Today, workers in rural America tend to have more physically demanding jobs and typically retire earlier: 36 percent of rural people ages 60 to 64 were retired, compared to 32 percent of urban people in the same age bracket. However, rural residents have less access to employer-based health insurance (60 v 68 percent of rural v urban 55 to 65 year olds have employer insurance) -- especially retiree health insurance. As such, rural beneficiaries are at greater risk of becoming uninsured if Medicare's age eligibility were raised.

- **Less able to purchase unsubsidized drug coverage**. The Breaux-Thomas plan would expand Medicaid coverage for beneficiaries with income up to 135 percent of poverty (about $11,000 for a single beneficiary, $15,000 for a couple). It would also provide access to -- but not premium assistance for -- Medigap and a new traditional Medicare drug option. However, since rural elderly disproportionately have lower income, it could be more difficult for them to afford premiums that could be as high as $1,000 annually.

- **More likely to have high home health care use -- and to suffer from an unlimited home health copay.** The Breaux-Thomas proposal would add an unlimited 10 percent home health copay. This is slightly higher than the $5 home health copay and does not contain the cap on beneficiary payments that were in the Senate 1997 proposal. Rural beneficiaries are more likely than urban home health users to have more home health visits. Rural beneficiaries who use home health services average 81 visits per year, relative to an average of 69 visits for urban beneficiaries. The proportion of rural beneficiaries whose home health visits are greater than 100 is about 20 percent higher than that of urban beneficiaries. Combined with their lower average income and access to supplemental insurance coverage, this copay could pose a significant financial burden for some rural beneficiaries.



MEDICARE BENEFICIARIES IN RURAL AMERICA: ACCESS TO PRIVATE HEALTH PLANS, 1999

State	Access to Private Medicare Plans						
	No Plans	One Plan	Two Plans	Total	No Plans	One Plan	Two Plans
Alabama	232,657	20,142	-	**252,799**	92%	8%	0%
Alaska	17,326	-	-	**17,326**	100%	0%	0%
Arizona	-	54,969	39,020	**93,989**	0%	58%	42%
Arkansas	219,305	24,272	22,909	**266,486**	82%	9%	9%
California	86,566	73,704	13,955	**174,225**	50%	42%	8%
Colorado	67,794	18,668		**86,462**	78%	22%	0%
Connecticut	-	-	16,028	**16,028**	0%	0%	100%
Delaware	30,595	-		**30,595**	100%	0%	0%
District of Columbia	-	-	-	**-**	0%	0%	0%
Florida	133,232	47,812	43,600	**224,644**	59%	21%	19%
Georgia	345,562	-	18,269	**363,831**	95%	0%	5%
Hawaii	-	8,284	36,201	**44,485**	0%	19%	81%
Idaho	98,557	9,899	-	**108,456**	91%	9%	0%
Illinois	291,938	56,313	6,121	**354,372**	82%	16%	2%
Indiana	253,315	13,569	-	**266,884**	95%	5%	0%
Iowa	307,031	-	-	**307,031**	100%	0%	0%
Kansas	207,977	-	-	**207,977**	100%	0%	0%
Kentucky	354,152	-	-	**354,152**	100%	0%	0%
Louisiana	46,885	76,984	44,618	**168,487**	28%	46%	26%
Maine	80,920	19,716	-	**100,636**	80%	20%	0%
Maryland	-	60,561	-	**60,561**	0%	100%	0%
Massachusetts	-	3,508	11,698	**15,206**	0%	23%	77%
Michigan	285,731	17,719	-	**303,450**	94%	6%	0%
Minnesota	253,719	6,983	4,595	**265,297**	96%	3%	2%
Mississippi	297,190	-	-	**297,190**	100%	0%	0%
Missouri	317,151	12,155	-	**329,306**	96%	4%	0%
Montana	106,015	-	-	**106,015**	100%	0%	0%
Nebraska	153,338	-	-	**153,338**	100%	0%	0%
Nevada	26,196	-	-	**26,196**	100%	0%	0%
New Hampshire	45,781	11,356	-	**57,137**	80%	20%	0%
New Jersey	-	-	-	**-**	0%	0%	0%
New Mexico	80,925	19,848	7,217	**107,990**	75%	18%	7%
New York	121,033	65,309	56,795	**243,137**	50%	27%	23%
North Carolina	370,305	21,270	59,943	**451,518**	82%	5%	13%
North Dakota	70,730	-	-	**70,730**	100%	0%	0%
Ohio	90,589	147,134	96,599	**334,322**	27%	44%	29%
Oklahoma	94,075	51,786	98,371	**244,232**	39%	21%	40%
Oregon	74,010	53,097	49,256	**176,363**	42%	30%	28%
Pennsylvania	-	80,726	269,423	**350,149**	0%	23%	77%
Rhode Island	-	-	-	**-**	0%	0%	0%
South Carolina	191,551	-	-	**191,551**	100%	0%	0%
South Dakota	88,022	-	-	**88,022**	100%	0%	0%
Tennessee	183,512	104,243	30,100	**317,855**	58%	33%	9%
Texas	267,882	170,517	87,904	**526,303**	51%	32%	17%
Utah	57,030	-	-	**57,030**	100%	0%	0%
Vermont	66,710	-	-	**66,710**	100%	0%	0%
Virginia	297,732	99,684	52,726	**450,142**	66%	22%	12%
Washington	59,214	37,012	69,339	**165,565**	36%	22%	42%
West Virginia	156,429	48,607	-	**205,036**	76%	24%	0%
Wisconsin	287,242	-	12,536	**299,778**	96%	0%	4%
Wyoming	45,082	-	-	**45,082**	100%	0%	0%
Puerto Rico	84,066	-	-	**84,066**	100%	0%	0%
TOTAL	**6,861,006**	**1,435,847**	**1,147,223**	**9,444,076**	**73%**	**15%**	**12%**

PHOTOCOPY
PRESERVATION

REMARKS BY THE PRESIDENT
ON RELEASE OF 1998
SOCIAL SECURITY TRUSTEES REPORT

March 30, 1999
Rose Garden

THE PRESIDENT: Thank you very much. Please be seated. (Applause.) I welcome all of our guests here, as well as the members of the administration. And I thank those who have joined me here on the platform for this important announcement.

Twice in the last six years, we have strengthened our nation's future in the 21st century by addressing serious, great fiscal challenges to America. In 1993, we met the threat of mounting deficits and a stagnant economy with an economic plan of fiscal discipline, expanded trade and investment in our people.

Thanks to that action, the red ink of the federal budget has turned to black, and we are enjoying the longest peacetime expansion in our nation's history.

In 1997, we reaffirmed our commitment to fiscal discipline with the bipartisan balanced budget agreement. It took important steps to improve Medicare, savings tens of billions of dollars in costs while expanding benefits for recipients and choices.

Today, we have new evidence that those determined actions were the right ones. I have just been briefed by our four Social Security and Medicare Trustees for the administration -- Secretaries Rubin, Shalala, Herman, Social Security Commissioner Apfel, who here with me today. The Trustees have issued their annual report on the future financial health of these vital programs. The Trustees Report shows that the strength of our economy has led to modest but real improvements in the outlook for Social Security. They project that economic growth today will extend the solvency of the Social Security trust fund to 2034 -- two years longer than was projected in last year's report.

After that date, however, the trust fund will be exhausted, and Social Security will not be able to pay the full benefits older Americans have been promised. Therefore, still I say we must move forward with my plan to set aside 62 percent of the surplus for Social Security, investing a small portion in the private sector for better return, just as any private or state government pension would do.

As I said in my State of the Union address, we then must go further, with difficult but achievable reforms that put Social Security on a sound footing for 75 years; that lift the earnings limitations on what seniors can earn; and that do something about the incredible problem of poverty among elderly women living alone.

The trustees have also told us that today the future for Medicare has improved even more.

The trustees project that the life of the Medicare trust fund has been extended until 2015. That's seven years longer than was projected in last year's report. These improvements are only partially due to the stronger economy. According to the trustees, they are also the result of the difficult but necessary decisions made in 1997; and to our successful efforts to fight waste, fraud, and abuse in the Medicare program.

Now, this Trustee Report is very good news. We should be pleased; Americans can be proud. But we should not be lulled into thinking that nothing more needs to be done, because the improvements we see today, themselves, did not happen by accident, but instead came as a result of determined action to make sure that the problems were not allowed to get out of hand.

When I became President six years ago, Medicare was actually projected to go bankrupt this year. We worked hard in 1993 and 1997 to make sure that didn't happen. Some of the actions we took at the time were not particularly popular, but we knew they had to be done. They helped to strengthen Medicare, and they laid the foundations from the difficult challenges we still must face.

Social Security and Medicare face long-term challenges, as all of you know, with the baby boom aging, with medical science extending the lives of millions, with the number of elderly Americans set to double by 2030. Even with today's good news, Social Security will run out of money in 35 years, Medicare in 16 years. We cannot -- we will not -- allow that to happen.

For three decades, Medicare has protected seniors and the disabled while expressing the values of care and mutual obligations that bind families and the generations of Americans together. Since my State of the Union address, I have called for devoting 15 percent of our surplus to strengthening Medicare, while modernizing the program with real reforms and helping seniors with prescription drugs.

When the Medicare Commission completed its work two weeks ago, I said we must build on their recommendations by adopting the best practices from the private sector while also maintaining high-quality services, continuing to provide every citizen with a guaranteed set of benefits, and making prescription drugs more accessible and affordable to Medicare beneficiaries.

Now we must build on the good news we have received today. We must extend the life of Medicare even further, modernize the program even more, and make prescription drugs even more accessible and affordable. Medicare cannot remain static in the face of the sweeping changes in our nation's health care system, a system today that relies increasingly on prescription drugs.

Today, 13 million seniors each spend more than $1,000 a year, out of pocket, for prescriptions. Let me say that again -- 13 million seniors today spend more than $1,000 a year out of pocket for prescription medication.

At the same time, seniors who have no drug coverage do not benefit from the lower

prices that insurance firms often can negotiate from pharmaceutical companies. The higher prices these seniors pay are in effect a hidden tax. We must find a way through Medicare to inject more competition into the health care system and to provide a prescription drug benefit.

Now, I know that some might say this good news means that we can simply delay reform. Nothing could be further from the truth. Strengthening and modernizing Medicare requires tough but achievable changes. And now is the time to make those changes -- now when our economy is strong; now when our people have renewed confidence; and now when we have time on our side so that modest changes today can have major impacts in the years ahead.

Nothing in this report lessens the need to devote 15 percent of the surplus to strengthening Medicare. But nothing in this report lessens the need to make tough but achievable reforms either. And nothing in this report lessens the need to help seniors with a prescription drug benefit. If we wait we will be condemning ourselves to future changes that will be much more costly and wrenching and much less satisfying in the end.

Today we face a choice that is a test of our wisdom as a self-governing people and a test of our vision of 21st century America. Will we seize this moment of prosperity? Will we devote these surpluses to strengthening Medicare, to strengthening our future? Or will we rush and do the most appealing prospect of the moment, a tax cut that will explode in later years and avoid our generation's responsibility and put the future of Medicare at risk?

The Trustees Report is welcome news, but it also contains a clear lesson -- tough, disciplined action is good economics. It's good for Social Security; it's good for Medicare; it's good for America. It's very good for our children's future and for the future of our families across the generations.

We can extend the life of Social Security and Medicare, and have an appropriate, affordable amount of tax relief specially targeted to the neediest working families and middle class families. But we have to apply the lessons we have learned in the last six years to the first years of the 21st century. I am determined to see that we do so this year. And the Trustees Report should make it easier for us to fulfill our responsibilities.

Thank you very much.

MEDICARE TRUSTEES' REPORT: 1999

March 30, 1999

*Today, the Medicare Trustees projected that the life of the Medicare Trust Fund has been extended until **2015** -- **7** years longer than projected in last year's report. This report affirms that the President's commitment to strengthening and improving Medicare is paying dividends, but it also underscores the need for additional action to strengthen and improve the program.*

- **The Trustees' Report on the Improved Financial Status of Medicare is Good News and Reflects that the Hard Choices the President Made in 1993 and 1997 Strengthened the Program and Were Justified.** When the President came into office, the Medicare program was projected by the Trustees to go bankrupt by 1999. The Trustees' Report validates the President's economic policies. It reports that: "income exceeded expectations as a result of robust economic growth and expenditures declined due to implementation of the Balanced Budget Act of 1997, low increases in health care costs generally, and continuing efforts to combat fraud and abuse." In the last few years, the life of the Trust Fund has been extended by a full 14 years and the actuarial deficit has been cut by two-thirds.

- **Good News Does Not Delay the Need for Decisive Action.** We are proud of our stewardship of the Medicare program. However, our success does not in any way diminish the challenges facing Medicare. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. As the Trustees' Report points out, "substantially greater changes in income and/or outlays are needed, in large part as a result of the impending retirement of the baby boom generation."

- **The President's Proposal to Modernize Medicare and to Dedicate 15 Percent of the Surplus to the Program is Clearly Necessary to Adequately Extend the Life of the Trust Fund and Add a Long Overdue Prescription Drug Benefit.** While the financial well-being of the Medicare program has improved, its reserves will become exhausted just as the baby boom population begins to retire and long before those of the Social Security program. Moreover, 15 million beneficiaries have absolutely no prescription drug coverage, millions more have totally inadequate coverage, and our nation's elderly are paying excessively high costs for their desperately needed medications. The President's Medicare reform proposal will address these unmet challenges.

- **We Now Face A Historic Fiscal Choice: Do we use the surplus to strengthen and modernize Medicare and keep the program solvent further into the future OR do we use it to provide for an exploding and irresponsible tax cut.** If we choose unwisely and use the surplus to finance tax cuts -- rather than Social Security and Medicare -- we will have made one of the most short-sighted fiscal decisions in our nation's history. Not only will we leave two programs unacceptably weakened, but we will have given up on an unprecedented opportunity to reduce our nation's debt from 44 percent of GDP to 7 percent by 2014 -- the lowest level since 1917. We must use this historic opportunity to strengthen Medicare by devoting 15 percent of the budget surplus to this program over the next 15 years and modernizing Medicare to help fund a prescription drug benefit.

REMARKS BY THE PRESIDENT
UPON DEPARTURE
ON MEDICARE REFORM

March 16, 1999
Outside Oval Office

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

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

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

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

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

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

As I said in January, we must act, and when we do our actions should be grounded in some firm principles. We must seize the opportunity created by our balanced budget and surplus to devote 15 percent of the surplus to strengthen the trust fund. We must modernize Medicare and make it more competitive, adopting the best practices from the private sector and maintaining high quality services. We must ensure that it continues to provide every citizen with a guaranteed set of benefits.

And we must make prescription drugs more accessible and affordable to Medicare beneficiaries.

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

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

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

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

Every independent expert agrees that Medicare cannot provide for the baby boom generation without substantial new revenues. Beyond that, it is clear the it will also require us to make difficult political and policy choices. Devoting 15 percent of the surplus to Medicare would stabilize the program -- and improve our ability to modernize and improve its services, and to make those hard choices.

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

Thank you very much.

BREAUX-THOMAS MEDICARE REFORM PLAN
March 19, 1999

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

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

- **Making Medicare's traditional plan more competitive**: It recommends that the program use the same effective, competitive management tools that are used in the private sector.

- **Simplifying Medicare's complicated, confusing and multiple deductible structure**: It recommends creating a single, simple deductible. It also eliminates cost sharing for preventive services, an Administration priority for years.

- **Recognizes need for expanded coverage of prescription drugs:** By expanding Medicaid prescription drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries. But we can and must do better than providing coverage for fewer than one in ten beneficiaries. The widespread use of drugs in modern medicine, their high cost, and the inaccessibility and unaffordability of drug coverage present problems for all Medicare beneficiaries, not just the poorest.

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

- **It does not address Medicare's financing**: Because it includes no additional commitment for financing, the proposal ducks the economic reality that every independent Medicare expert confirms -- the demographic explosion of the Medicare program will require more financing. No amount of structural reform or cost cutting can compensate for this. The lack of financing makes the problem much larger to solve in the future and shifts more of the burden to our nation's children. This is why the President proposed to dedicate 15 percent of the surplus over the next 15 years to Medicare, to save some of today's prosperity for tomorrow's needs. We cannot waste this historic opportunity.

- **Raises the age eligibility for Medicare**: We are extremely skeptical of any plan that would increase the numbers of uninsured. The most rapidly growing group of the uninsured are between the ages of 55-65; raising the eligibility age of Medicare without a policy that assures that there will not be even more uninsured elderly is simply the wrong thing to do.

- **Includes flawed "premium support" proposal**: The President is committed to adding competition to Medicare, but not at the risk of harming the existing program or its beneficiaries. The current construction of the Breaux-Thomas premium support plan would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to the independent Medicare actuary. Although the plan attempts to address this problem for beneficiaries with no private plan options, those with limited or unattractive private options would be forced to pay more to stay in the system. We believe that this is unacceptable.

PRESIDENT WILLIAM JEFFERSON CLINTON
STATE OF THE UNION ADDRESS
MEDICARE EXCERPTS

January 19, 1999
United States Capitol
Washington. D.C.

THE PRESIDENT: Second, once we have saved Social Security, we must fulfill our obligation to save and improve Medicare. Already, we have extended the life of the Medicare trust fund by 10 years -- but we should extend it for at least another decade. Tonight, I propose that we use one out of every $6 in the surplus for the next 15 years to guarantee the soundness of Medicare until the year 2020.

But, again, we should aim higher. We must be willing to work in a bipartisan way and look at new ideas, including the upcoming report of the bipartisan Medicare Commission. If we work together, we can secure Medicare for the next two decades and cover the greatest growing need of seniors -- affordable prescription drugs...

Therefore, in addition to saving Social Security and Medicare, I propose a new pension initiative for retirement security in the 21st century. I propose that we use a little over 11 percent of the surplus to establish universal savings accounts -- USA accounts -- to give all Americans the means to save. With these new accounts Americans can invest as they choose and receive funds to match a portion of their savings, with extra help for those least able to save. USA accounts will help all Americans to share in our nation's wealth and to enjoy a more secure retirement. I ask you to support them.

Fourth, we must invest in long-term care. I propose a tax credit of $1,000 for the aged, ailing or disabled, and the families who care for them. Long-term care will become a bigger and bigger challenge with the aging of America, and we must do more to help our families deal with it.

I was born in 1946, the first year of the baby boom. I can tell you that one of the greatest concerns of our generation is our absolute determination not to let our growing old place an intolerable burden on our children and their ability to raise our grandchildren. Our economic success and our fiscal discipline now give us an opportunity to lift that burden from their shoulders, and we should take it.

Saving Social Security, Medicare, creating USA accounts -- this is the right way to use the surplus. If we do so -- if we do so -- we will still have resources to meet critical needs in education and defense. And I want to point out that this proposal is fiscally sound. Listen to this: If we set aside 60 percent of the surplus for Social Security and 16 percent for Medicare, over the next 15 years, that saving will achieve the lowest level of publicly-held debt since right before World War I, in 1917.

So with these four measures -- saving Social Security, strengthening Medicare, establishing the USA accounts, supporting long-term care -- we can begin to meet our generation's historic responsibility to establish true security for 21st century seniors.

America's families deserve the world's best medical care. Thanks to bipartisan federal support for medical research, we are now on the verge of new treatments to prevent or delay diseases from Parkinson's to Alzheimer's, to arthritis to cancer. But as we continue our advances in medical science, we can't let our medical system lag behind. Managed care has literally transformed medicine in America -- driving down costs, but threatening to drive down quality as well.

I think we ought to say to every American: You should have the right to know all your medical options -- not just the cheapest. If you need a specialist, you should have the right to see one. You have a right to the nearest emergency care if you're in an accident. These are things that we ought to say. And I think we ought to say, you should have a right to keep your doctor during a period of treatment, whether it's a pregnancy or a chemotherapy treatment, or anything else. I believe this.

Now, I've ordered these rights to be extended to the 85 millon Americans served by Medicare, Medicaid, and other federal health programs. But only Congress can pass a patients' bill of rights for all Americans. Now, last year, Congress missed that opportunity and we must not miss that opportunity again. For the sake of our families, I ask us to join together across party lines and pass a strong, enforceable patients' bill of rights.

As more of our medical records are stored electronically, the threats to all our privacy increase. Because Congress has given me the authority to act if it does not do so by August, one way or another, we can all say to the American people, we will protect the privacy of medical records and we will do it this year.

Now, two years ago, the Congress extended health coverage to up to five million children. Now, we should go beyond that. We should make it easier for small businesses to offer health insurance. We should give people between the ages of 55 and 65 who lose their health insurance the chance to buy into Medicare. And we should continue to ensure access to family planning.

No one should have to choose between keeping health care and taking a job. And, therefore, I especially ask you tonight to join hands to pass the landmark bipartisan legislation -- proposed by Senators Kennedy and Jeffords, Roth and Moynihan -- to allow people with disabilities to keep their health insurance when they go to work.

We need to enable our public hospitals, our community, our university health centers to provide basic, affordable care for all the millions of working families who don't have any insurance. They do a lot of that today, but much more can be done. And my balanced budget makes a good down payment toward that goal. I hope you will think about them and support that provision...

Smoking has cost taxpayers hundreds of billions of dollars under Medicare and other programs. You know, the states have been right about this -- taxpayers shouldn't pay for the cost of lung cancer, emphysema and other smoking-related illnesses -- the tobacco companies should. So tonight I announce that the Justice Department is preparing a litigation plan to take the tobacco companies to court -- and with the funds we recover, to strengthen Medicare.

REMARKS BY THE PRESIDENT
TO AARP NATIONAL LEGISLATIVE COUNCIL

February 3, 1999
The Willard Hotel
Washington. D.C.

THE PRESIDENT: Thank you, and good morning. Thank you, Mr. Perkins -- or, good afternoon. Don't tell anybody. Don't tell anybody I didn't know what time it was.

Thank you, Mr. Perkins, for your memory of that -- I did say that, about counting. Mr. McManus, Tess Canja, Margaret Dixon, John Rother, Horace Deets -- thank you especially for representing the AARP so well in dealing with the White House over the last six years.

I was glad to be invited to come over here today. You know, it's rare that a President gets to speak to an organization of which he's a member. As I said repeatedly a couple years ago, I had mixed feelings about that, when you called my attention to the fact that I was aging. But I don't have mixed feelings about the record the AARP has established for 40 years, calling attention to the challenges of aging to all Americans.

Those challenges, today, are more profound than ever as we look forward to the baby boom becoming a senior boom -- the number of seniors doubling by 2030. We owe it to 21st century America, to the children and the grandchildren of the baby boom-- as well as to all the seniors -- to meet those challenges and to meet them together.

I remember, in 1992 when I was a candidate for President, I came to your convention in San Antonio, and talked about the kind of America I wanted to work with you to build -- an America in which we honor our obligations to older Americans without burdening younger Americans. An America with its fiscal house in order and its future shining brightly. When I took office, we charted a new course to achieve that kind of America-- with fiscal discipline, more investments in our people, more trade for our goods and services around the world.

In the past six years, the American people have worked hard and come far. We know now that we have the longest peacetime expansion in history; nearly 18 million new jobs; wages rising at twice the rate of inflation; the highest home ownership in history; the lowest welfare rolls in history; and now, the lowest peacetime unemployment rate since 1957. Last year, for the first time in three decades, the red ink turned to black with a $70 billion surplus. We project one slightly larger than that this year, and projecting them on out for about a generation, as we have ended the structural deficits that caused our national debt to quadruple between 1981 and 1992.

I want to thank you for your hard work over these past six years -- for standing strong for bipartisan progress on the issues of great concern to you. Now, I ask you to stand with me and to say, we must meet the great challenges of the next century. We must use this prosperity, we must use this confidence, we must use this projected surplus to save Social Security, to strengthen Medicare, to meet the challenges of the aging of America.

In my State of the Union address, I laid out a four-point plan to do that: saving Social Security; strengthening Medicare; providing tax relief to help Americans save for their own retirement; and a tax credit to help families with long-term care for aging, ailing and disabled relatives. These will help our country to honor our duties to people today, and to uphold our responsibility to future generations.

On Monday, I sent my new balanced budget to Congress -- the first budget of the 21st century -- to implement this plan.First, in the budget we dedicate the lion's share of the surplus to saving Social Security and to strengthening Medicare. Both are important, and I'd like to explain why.

I proposed that we invest 62 percent of the surplus to save Social Security, and the surplus -- excuse me, for the next 15 years. I am very pleased that members of Congress in both Houses and both parties have agreed that this is the right thing to do. As you know, I have proposed investing a small portion of the trust fund in the private sector, to do it in a way that any private or state government pension would do. I agree with AARP that we absolutely have to insulate any investment of the surplus from political influence. And I believe we can, just as other public pension funds do.

I was in New York last night, talking to several people there in the investment community who came up to me and said they thought I was right and they hoped that we wouldn't let initial criticism stop us from offering a plan which would demonstrate to the American people that you could run this investment just like any other public pension investment is run. And I am confident that we can do that.

If we do this, we can earn a higher return and keep Social Security sound for 55 years. Now, all of you know that from the beginning we have measured the financial health of Social Security by asking if it will be sound for 75 years into the future. I do believe we have to take steps to strengthen Social Security for 75 years. I have looked at the options, believe me -- it's a lot easier to go from 55 to 75 than it is to go from where we are now, 2032 to 75.

I also believe we have to improve the program by reducing poverty among elderly women who are twice as likely to be poor as married couples on Social Security. I believe we should eliminate the limits on what seniors on Social Security can earn. This costs the trust fund some money in the short run, but over the long-term it will actually strengthen the retirement systems of the country and, more importantly, it will strengthen the quality of life of people in their later years.

Now, doing these things will require some difficult choices, but they are clearly achievable. You know basically what the range of options is and I know what it is, as well. To make them, it is clear what we have to do. We have got to work together across party lines to make these decisions. We have to work together across generational lines to make these decisions. But think of how we'll feel if we have Social Security secure for 75 years, if we lift the earnings limit and if we do something to reduce the deeply troubling rate of poverty among single elderly women, who are growing in numbers at a very rapid rate.

I have told the American people and members of Congress in both Houses of both parties -- I've met with dozens of them, literally -- that I am ready to make these choices and to make them with them, and it is time to get on with the job. Now, I feel pretty good about where we are with that, because of the initial positive support for setting aside the surplus portion for Social Security. I wanted to come here today to tell you what I said in the State of the Union I was very serious about -- I do not think it is enough. We all know that Medicare is going to have financial trouble well before Social Security does, unless we do something about it.

Now, if you look at -- where is my chart -- there it is. What I propose is to take 62 percent of the surplus, which you see there for Social Security -- maybe I'll bring it up a little closer. You may be able to see it just fine, but I can see better from here. And then to take 15 percent, about a little less than $1 in every $6 of the surplus, and commit it to Medicare.

Now, some of those who agree with us on Social Security do not agree that we should do this. They would use the entire rest of the surplus for tax cuts. I believe we can only meet our responsibility to the future by saving Social Security and Medicare. Now, President Kennedy, who first proposed Medicare, once said, "To govern is to choose." And so we should have a great national debate about the choices involved in managing this surplus. After all, we haven't had one in 30 years, and it's a little unusual for us.

Yesterday, we learned of a proposal that would make a very different choice about what to do with the surplus. The plan would spend well over $1 trillion over the next 15 years on a tax proposal that would benefit clearly the wealthiest Americans -- who have, I might add, done quite well as the stock market has virtually tripled in the last six years. I'm happy about that; we should all be. But we ought to look at this proposal against that background. It would do this before Medicare has been secured, and in a way that would prevent us from spending 15 percent of this, or investing 15 percent, of this surplus in Medicare.

Now, to govern is to choose. I believe that's the wrong choice; I believe this is the right choice. You, the American people, and the United States Congress will have to decide. This is the latest in a rather long series of large and risky tax proposals that we have heard over the years. If we had adopted even one of the large ones, we wouldn't have the surplus we enjoy today.

We cannot return to the old policies of deficit and debt. Quite apart from our obligations to deal with the aging of America, the strength of our economy is premised on our demonstrated discipline and driving down profligate deficit spending, driving down interest rates, getting private investment up, generating opportunities for the American people.

I believe the American people should have tax relief; in a few moments I'll talk a little bit about what I think the best way to do that is. I believe there are things we can and we must do to help families. And I believe our targeted tax cut for the USA account is especially important. I'll say more about it in a moment.

But, first of all, anyone who hopes to invest the surplus or to spend it on other programs, or to spend it with a tax cut, must first tell America's families: What is your plan to preserve and strengthen Medicare in the 21st century? I was always taught from childhood, as most of you were, that you may want to do a lot of things, but you have to do first things first. To me, Social Security and Medicare, with their looming financial challenges, are the first things, and we have to take care of them first.

I want to work with you to strengthen Medicare. I want to work with the results of the Medicare Commission that Senator Breaux is chairing. In the bipartisan balanced budget we reached in 1997, we extended the life of the Medicare trust fund by 10 years. But no one seriously believes this is adequate, particularly with more and more people qualifying for Medicare.

To stabilize Medicare, we should extend its life until 2020. To truly strengthen Medicare for the long-term, we will have to take further steps. That means committing a percentage of the surplus to the trust fund. It also means committing ourselves to meaningful reforms that will meet the demands of the 21st century.

I am frank to tell you that some people have said, well, the President, by committing this amount of money from the surplus to Medicare to the trust fund, is trying to convince people that we can just go on forever without making any changes in Medicare. That is simply not true, and I don't want to pretend that that's true. But neither do I believe we should be in the position of making reforms or changes that we might later regret, simply because we haven't stabilized the trust fund when we have the funds to do it. These funds should support meaningful reform and prevent permanent damage to Medicare and to the people who depend upon it and are entitled to rely on it.

So here's what I think we should do, with regard to at least basic principles, as we look forward to the 21st century Medicare program. Did they change the chart? Good.

First, Americans should be able to count on Medicare and know it will be there when they need it. I have proposed to use, as I said, about one of every six dollars in the surplus for the next 15 years to just simply guarantee the soundness of the Medicare fund until the year 2020. Without these new resources, Medicare spending would have to plummet significantly below the private sector average. No one believes we can have that happen without seriously weakening a program that millions of older Americans need.

Second, Americans on Medicare should be able to count on a modern, competitive system that maintains high-quality care and top-notch service by drawing on the best private sector practices. Third, Americans on Medicare, especially Americans with lower incomes, should be able to count on a defined set of benefits and protections without having to worry about excessive new costs they can't begin to afford.

Fourth, Americans on Medicare should be able to count on a benefit that many have long waited for, and that will actually cut our cost over the long run, and lengthen life, and lengthen the quality of life: prescription drugs.

Now, I believe we ought to use the savings that reforms in Medicare can create to provide this prescription drug benefit. Yes, it will be more costly on the front end, but over the long run it is bound to save money. It will keep people out of the hospital. It will keep people away from more expensive medical procedures. It will lengthen life and it will lengthen the quality of life.

I want to thank especially Senators Kennedy and Rockefeller for their leadership on this issue. I look forward to working with members of both parties. But keep in mind -- within these principles, my view of Medicare is: take 15 percent of the surplus, make sensible reforms, add the prescription drug benefit. All three will be required to truly strengthen Medicare for the 21st century.

Now, as I said before, we know the American people have worked very hard to replace the era of budget deficits with an age of budget surpluses. They deserve to benefit from that, and they deserve some tax relief. The real question is: What kind of tax relief and how much should it be? What are the other competing demands for the country? Again, to govern will be to choose.

I think we should use a percentage of the surplus to give Americans tax relief -- that strengthens working families, that encourages savings and the sharing of our nation's wealth among a broader range of Americans. And that is why I have proposed that we set aside -- we're back to the chart now -- 12 percent of the surplus, or, over 15 years, $536 billion, to establish USA accounts, Universal Savings Accounts, that give working Americans a chance to save for the future. These accounts would basically involve the government giving a tax credit that would be a cash match for a certain amount of savings by Americans who save, with extra help for Americans who are lower-income working families who have less ability to save on their own.

Now, all of you know that when Social Security was set up, it was never viewed as the sole source of income, ideally, for retirees -- although, unfortunately, it still is the sole source of income for a large number of people. We need a country in which we have a sound Social Security system, a sound set of pension options -- and all of you know how the pension marketplace has been changing, from defined benefits to defined contributions -- and we need, thirdly, a vehicle which promotes more private savings.

The USA account is designed to give tax relief -- which, I might add, would be considerably greater tax relief for middle income families than most of the other proposals I've heard that cost a lot more money. But tax relief in the form that actually promotes personal savings, more secure retirement and gives people who otherwise would not have it a chance to have a savings account which would give them the opportunity to hook into the creation of wealth in America, and to own a part of America's wealth-creating enterprise. I think it's very, very important.

I have also proposed $1,000 tax credit to help pay for the long-term care needs of families who are caring for aged, ailing or disabled family members. We know that long-term care needs will increase. Frankly, I would like this tax credit to be even larger. But I believe if we start now, within our other obligations to fix Social Security and Medicare and other competing claims and responsibilities of the government, I believe that this will become an integral part of the way we manage long-term care, and will be a strong part of a bipartisan American consensus for how we should support long-term care over the long run. So I very much hope that will pass.

For middle-income families I have also supported tax relief for child care, for work related expenses for disabled Americans, for further tax relief from the interest payments on student loans and tax relief to businesses which help their employees start retirement programs. We've worked very hard for six years to stabilize the existing retirement systems and to facilitate the establishment of retirement programs by more small- and medium-sized businesses for whom the old laws were quite a hassle and a lot of trouble, and actually a lot of start-up costs, so we're working very hard on that.

Now, this is the kind of tax relief that I think is good for the country. I have proposed tax reliefs to individuals and corporations who will invest money in areas of high unemployment in America -- in inner cities and rural areas, to bring private enterprise to create jobs and to generate more national growth and more national wealth.

This is the first time, at least in 30 years, when we've had a level of prosperity and the resources necessary to actually get free enterprise into the inner-city and rural areas that still have been left behind by the economic expansion. And I hope you will all support that, because, keep in mind, that helps the whole economy. We have to keep finding new ways to growth this economy, even with a low unemployment rate, that doesn't spark inflation. And this is clearly the best way we can.

Now, I think this tax relief is good for America. We can afford it. It is all paid for -- all this tax relief I mention, except for the USA Account -- every other bit of this tax relief I mentioned is paid for in the balanced budget. It has nothing to do with this surplus. It will not have anything to do with undermining our fiscal strength.

I simply think we have to use the surplus in a way that honors our most profound responsibilities to our parents, to our children, to our grandchildren, and I think that we cannot waste a penny of it until we have saved Social Security and Medicare for the 21st century.

As I pointed out in the State of the Union address, there is another enormous benefit that will come from saving the surplus in this way. It will enable us to buy back a lot of the national debt held by the public. And that is very important. Why? In 1981, our total national debt amounted to about 26 percent of our annual income. In 1992 it had quadrupled in dollars, and it was about half our national income. When I got the budget charts, it was projected to go as high as 75 or 80 percent of our national income -- a very dangerous situation.

Now, the national debt has dropped from 50 percent down to 44 percent of our income, but if -- if -- we save the money I recommend for Social Security and for Medicare for 15 years, our national debt will drop to seven percent of our national income. That's the lowest level since 1917, before the United States entered World War I.

Now, what does that mean in practical terms, to an average family? It means that we will have lower interest rates; lower home mortgage rates; lower car payment rates; more investment; a dramatic increase in national savings; and more economic growth. It also means that if we have all the financial instability you see around the world -- and I want to make it clear that the financial instability that we saw, for example, in Asia, came primarily not out of irresponsible government spending policies -- a lot of those people had balanced budgets -- but there was just turmoil in the financial markets because of banking systems and investment patterns. That undermines our ability to grow, when our trading partners get in trouble.

We need to know that we have some insurance against that sort of trouble here at home, so we can keep plugging ahead, even as we try to help our friends around the world get back on their feet and start growing again. So this is an enormous insurance policy.

The last thing I want to tell you is this: You can be thinking about what your successors around this table will be debating 15 years from now. Today, when we draw up a budget, the first thing we have to do is take interest payments on the debt off the table. Right? Some of you may own that debt -- you may have government bonds. We've got to pay you before we can do anything.

Today, that takes over 13 cents of every single tax dollar. Fifteen years from now, if we do this, it will take 2 cents of every tax dollar. Once we secure Social Security and Medicare, think what you could do with that difference -- in tax cuts, or investments in education, or whatever you think it ought to be spent on. This is a very important issue.

So, seven years ago, I said to you that if we worked together we could leave our children a nation that is stronger, freer, and wealthier than the one we inherited. Today, we actually have the chance to do this. Today we have a chance to deal with the aging of America -- a challenge facing every advanced society on earth -- in a way that is dignified, that has genuine integrity; that will strengthen not only the lives of seniors but will strengthen the lives of their children and grandchildren. It is an enormous opportunity, and an enormous opportunity.

I ask you to join with me to make sure that our country meets that responsibility. Thank you, and God bless you.

PRESIDENT CLINTON UNVEILS PRINCIPLES FOR MEDICARE REFORM AND UNDERSCORES NEED TO DEDICATE THE SURPLUS TO MEDICARE

February 3, 1999

Today, in his speech to the American Association of Retired Persons (AARP), President Clinton underscored the need to dedicate 15 percent of the budget surplus to secure the Medicare Trust Fund until 2020. He stressed his preference for bipartisan Medicare reform that is necessary to modernize Medicare and achieve additional savings to strengthen the program, and outlined four main principles that he believes any such plan should meet. The President:

- **Highlighted the Need to Dedicate Budget Surplus to Strengthen Medicare.** The President highlighted the fact that, while we need reform to improve competition and efficiency in the Medicare program, these reforms will not produce savings that are sufficient to significantly extend the life of the Trust Fund. In fact, if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be limited to 2.8 percent per year -- in every year -- to get to 2020. This rate is over 60 percent below projected private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. These projections help explain why virtually every independent health analyst agrees that Medicare cannot be significantly strengthened without adding outside financial support such as the surplus.

- **Unveiled Principles to Guide Medicare reform.** The President outlined principles that he will use to evaluate any Medicare reform proposal. Any broad-based reforms should:

  - **Dedicate Surplus to Secure Medicare until 2020.** One of the fundamental goals of Medicare reform is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century. These challenges cannot be addressed solely through making the program more efficient, transferring current liabilities out of the Trust Fund, or increasing payments. The President is proposing to use 15 percent of the projected surpluses over the next 15 years to secure the Medicare Trust Fund until 2020 as part of broader reforms to further strengthen the program.

  - **Modernize Medicare and Make It More Competitive.** Medicare should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with the private spending. Moreover, strong and effective Federal administration of Medicare should be assured.

  - **Guarantee Defined Set of Benefits Without Excessive New Costs to Beneficiaries**. Beneficiaries should still be entitled to an adequate set of health benefits. A modernized, well-defined benefits package is needed to assure that health plans compete on cost and quality rather than price. Reforms should also maintain or strengthen protections for low-income beneficiaries, assure that any new cost burdens are not excessive, and assure that beneficiaries have access to a viable traditional Medicare program.

  - **Use Savings from Reform to Help Fund a Prescription Drug Benefit.** Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. In fact, over half of Medicare beneficiaries pay more than $500 per month for prescription drugs and one in ten pay more than $2,000. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. The President believes that additional savings from making Medicare more efficient should be used to help finance a long-overdue prescription drug benefit for all Medicare beneficiaries.