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Health - Medicare Commission

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Medicare Commission Working Group to the President re: Medicare Commission Special Notes [partial] [page 3 withdrawn in whole] (4 pages)	10/20/1997	P6/b(6)

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2009-1006-F
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RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Health-Medicare Commission

To: Steve, Gene, Larry, Bruce
Fr: Chris J.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To express the sense of the Senate regarding the modernization and improvement of the medicare program.

IN THE SENATE OF THE UNITED STATES—106th Cong., 1st Sess.

S. CON. RES. 20

Setting forth the congressional budget for the United States Government for fiscal years 2000 through 2009.

Referred to the Committee on ____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. ROTH (for himself, Mr. BREAUX, Mr. FRIST, Mr. KERREY, Mr. GRAMM, Mr. DOMENICI, and Mr. NICKLES)

Viz:

At the end of title III, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE MODERNIZATION AND IMPROVEMENT OF THE MEDICARE PROGRAM.

(a) FINDINGS.—The Senate finds the following:

(1) The health insurance coverage provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is an integral part of the financial security for retired and

disabled individuals, as such coverage protects those individuals against the financially ruinous costs of a major illness.

(2) Expenditures under the medicare program for hospital, physician, and other essential health care services that are provided to nearly 39,000,000 retired and disabled individuals will be $282,000,000,000 in fiscal year 2000.

(3) During the nearly 35 years since the medicare program was established, the Nation's health care delivery and financing system has undergone major transformations. However, the medicare program has not kept pace with such transformations.

(4) Former Congressional Budget Office Director Robert Reischauer has described the medicare program as it exists today as failing on the following 4 key dimensions (known as the "Four P's"):

(A) The program is inefficient.

(B) The program is inequitable.

(C) The program is inadequate.

(D) The program is insolvent.

(5) The President's budget framework does not devote 15 percent of the budget surpluses to the medicare program. The federal budget process does not provide a mechanism for setting aside current

surpluses for future obligations. As a result, the notion of saving 15 percent of the surplus for the medicare program cannot practically be carried out.

(6). The President's budget framework would transfer to the Federal Hospital Insurance Trust Fund more than $900,000,000,000 over 15 years in new IOUs that must be redeemed later by raising taxes on American workers, cutting benefits, or borrowing more from the public, and these new IOUs would increase the gross debt of the Federal Government by the amounts transferred.

(7) The Congressional Budget Office has stated that the transfers described in paragraph (6), which are strictly intragovernmental, 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.

(8) The President's budget framework does not provide access to, or financing for, prescription drugs.

(9) The Comptroller General of the United States has stated that the President's medicare proposal does not constitute reform of the program and "is likely to create a public misperception that some-

O:\GOE\GOE99.162 S.L.C.

thing meaningful is being done to reform the Medicare program".

(10) The Balanced Budget Act of 1997 enacted changes to the medicare program which strengthen and extend the solvency of that program.

(11) The Congressional Budget Office has stated that without the changes made to the medicare program by the Balanced Budget Act of 1997, the depletion of the Federal Hospital Insurance Trust Fund would now be imminent.

(12) The President's budget proposes to cut medicare program spending by $19,400,000,000 over 10 years, primarily through reductions in payments to providers under that program.

(13) While the recommendations by Senator John Breaux and Representative William Thomas received the bipartisan support of a majority of members on the National Bipartisan Commission on the Future of Medicare, all of the President's appointees to that commission opposed the bipartisan reform plan.

(14) The Breaux-Thomas recommendations provide for new prescription drug coverage for the neediest beneficiaries within a plan that substantially improves the solvency of the medicare program

without transferring new IOUs to the Federal Hospital Insurance Trust Fund that must be redeemed later by raising taxes, cutting benefits, or borrowing more from the public.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the provisions contained in this budget resolution assume the following:

(1) This resolution does not adopt the President's proposals to reduce medicare program spending by $19,400,000,000 over 10 years, nor does this resolution adopt the President's proposal to spend $10,000,000,000 of medicare program funds on unrelated programs.

(2) Congress will not transfer to the Federal Hospital Insurance Trust Fund new IOUs that must be redeemed later by raising taxes on American workers, cutting benefits, or borrowing more from the public.

(3) Congress should work in a bipartisan fashion to extend the solvency of the medicare program and to ensure that benefits under that program will be available to beneficiaries in the future.

(4) The American public will be well and fairly served in this undertaking if the medicare program reform proposals are considered within a framework

surpluses for future obligations. As a result, the notion of saving 15 percent of the surplus for the medicare program cannot practically be carried out.

(6) The President's budget framework would transfer to the Federal Hospital Insurance Trust Fund more than $900,000,000,000 over 15 years in new IOUs that must be redeemed later by raising taxes on American workers, cutting benefits, or borrowing more from the public, and these new IOUs would increase the gross debt of the Federal Government by the amounts transferred.

(7) The Congressional Budget Office has stated that the transfers described in paragraph (6), which are strictly intragovernmental, 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.

(8) The President's budget framework does not provide access to, or financing for, prescription drugs.

(9) The Comptroller General of the United States has stated that the President's medicare proposal does not constitute reform of the program and "is likely to create a public misperception that some-

that is based on the following 5 key principles offered in testimony to the Senate Committee on Finance by the Comptroller General of the United States:

(A) Affordability.

(B) Equity.

(C) Adequacy.

(D) Feasibility.

(E) Public acceptance.

(5) The recommendations by Senator Breaux and Congressman Thomas provide for new prescription drug coverage for the neediest beneficiaries within a plan that substantially improves the solvency of the medicare program without transferring to the Federal Hospital Insurance Trust Fund new IOUs that must be redeemed later by raising taxes, cutting benefits, or borrowing more from the public.

(6) Congress should move expeditiously to consider the bipartisan recommendations of the Chairmen of the National Bipartisan Commission on the Future of Medicare.

(7) Congress should continue to work with the President as he develops and presents his plan to fix the problems of the medicare program.

Decide to call B.

If we call, what charge?

D. Thinks we should call B.

D: call in or sign -

What do we want to do?

Count a check

Health - Medicare Commission

RESPONSE TO
ROTH-NICKLES-GRAMM-DOMENICI-BREAUX-KERREY AMENDMENT

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

Response: Not true. The President's framework would dedicate $686 billion to debt reduction and the Medicare trust fund. The independent Medicare actuary -- repeatedly cited by Republicans in 1995 -- confirmed that this proposal would significantly extend the life of the Trust Fund: "This budget proposal would postpone the year of exhaustion by an estimated 12 years." (Rick Foster, 1/27/99).

Charge: **Transferring IOUs will require raising taxes, benefits cut, and/or increased gross debt to pay for Medicare in the future.**

Response: Not true. OMB projects that there will be a surplus well into the middle of the next century even after we dedicate part of the surplus to Medicare and Social Security. This is because, by paying down the publicly held debt, the President's plan reduces net interest costs to the Federal government and increase economic growth. Thus, even after we start using the surplus to pay for Medicare and Social Security, there will be a budget surplus.

Charge: **"No effect on the unified budget surpluses or the on-budget surpluses and therefore have no effect on the debt held by the public."**

Response: Not true. The President is locking in $686 billion from the surplus which, 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).

Charge: **"The President's budget framework does not provide access to, or financing for, prescription drugs."**

Response: The President stated that prescription drug coverage should be included in any plan to reform the Medicare program. He called on the Congress to work in a bipartisan fashion to develop there reforms and indicated that he would wait until after the Medicare Commission made its final recommendations before outlining his specific preferences. The President is committed to including a prescription drug benefit in the plan that he submits to the Congress.

Charge: **The Comptroller General states that the President's Medicare proposal "is likely to create a public misperception that something meaningful is being done to reform the Medicare program."**

Response: The Comptroller General himself put out a statement saying that "the President's proposed transfer of new securities to the Hospital Insurance trust fund constitutes a significant financing change...." and praised the President for his remarks on the need for program reforms as well as financing. On March 18, the Comptroller General acknowledged that the President had "suggested that, although substantial new general fund revenues may be needed for the program over the long-term, substantive program reforms requiring 'difficult political and policy choices' will also be required."

Charge: **Breaux-Thomas plan received majority vote, but "all of the President's appointees to that commission opposed the bipartisan reform plan."**

Response: All of the Democratic appointees, except for Senators Breaux and Kerrey, opposed the Breaux-Thomas plan. The President appointees voted their conscience. The President felt he should not instruct his Commission members to vote for something that they felt represented flawed policy. He believes that it would have been inappropriate for him to do otherwise.

Charge: **The Breaux-Thomas recommendations "substantially improve the solvency of the Medicare program" that will not require "raising taxes, cutting benefits, or borrowing more from the public."**

Response: The Breaux-Thomas plan does not substantially extend the solvency of Medicare. At most, it adds 4 or 5 years to the program's life -- which by any definition is not a "long-term" solution. In contrast, the President's plan, that includes the dedication of the surplus and a much more meaningful prescription drug benefit, will extend the life of Medicare by a significantly greater period of time.

Charge: **No transfer from surplus.**

Response: Senators Breaux and Kerrey voted for this transfer yesterday. Earlier this year, Senator Breaux indicated interest in the surplus proposal, but argued that he could not endorse it because of his role as Commission chair.

Charge: **Work in bipartisan fashion on reform; examine recommendation in the Breaux-Thomas plan; work with the President on his plan.**

Response: We couldn't agree more and his proposal will be designed to reach bipartisan consensus on the type of reforms we need to strengthen and improve the program.

Health - Medicare commission

THE WHITE HOUSE

WASHINGTON

March 15, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K., Jack L., Dan M.
David B., Melanne V., Sarah B., Neera T., Janet M.

FROM: Chris J. and Jeanne L.

RE: BREAUX-THOMAS MEDICARE PLAN

Attached is the final Breaux-Thomas Medicare plan. They released it at a 5pm press conference. Highlights of the plan include:

- **No specific plan for Medicare financing**: The plan contains no options for raising new revenue for Medicare -- specifically it does not include the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding.

- **No meaningful prescription drug benefit**: The plan would require private managed care plans, Medigap, and possibly Medicare fee-for-service to offer a drug benefit, but only provides a subsidy for that coverage for people below 135 percent of poverty. This is troubling because it moves Medicare towards a means-tested, Medicaid-like program, and would probably result in large adverse selection in the unsubsidized Medicare fee-for-service option.

- **Age eligibility increase without a viable insurance alternative**: Although there is a suggestion that vulnerable sick people ages 65 to 67 would get Medicare, the proposal explicitly states that the Medicare buy-in would be unsubsidized and would not begin at 62 (which is truly conforming to Social Security). This plan would likely lead to an increase in the uninsured.

- **No income-related premium:** This was dropped since the last draft -- reportedly because some Republicans considered it too similar to a tax (since it is administered through Treasury).

There are probably other issues that we have not yet noticed; we will be working on a more complete memo of the issues for the morning.

Please call or page with questions.

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:
The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries premiums. Board would approve plan service areas and benefit package designs.

Benefits Package:
The standard benefits package is specified in law and would consist of all services covered under the existing Medicare statute. Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:
Private Plans
All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income
The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Medigap
All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:
Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:
The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. 10 percent coinsurance would be charged for home health, laboratory services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Special Payments:
Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. The proposal would also recommend exploring funding Indirect Medical Education (IME) and other non-insurance subsidies outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program. Any special payments remaining in Medicare would not be included in the calculation of premiums for the government-run fee-for-service plan or private plans.

Retirement Age:
The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. A non-subsidized buy-in would be available at age 65. Congress should develop a special category of eligibility based on specific needs-based criteria (i.e. ADLs) for individuals between 65 and the then-current eligibility age.

Long-Term Care:
Long-term care issues should be separated from Medicare (an acute care program), and long-term care improvements should be made through pension, Social Security, and investment reforms. The proposal would require a study of various long-term care issues.

Financing:
Part A and Part B trust funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare outlays, Congress would be required to authorize any additional contributions to the Medicare Trust Fund. This new test (40% of outlays) would probably not be reached until after 2005. Even if general revenue contributions were limited to 40% of program outlays, this proposal would extend solvency to 2013 (2017 under CBO's new baseline.)

Budgetary Impact:
Between 2000 and 2009, this proposal would save approximately $100 billion. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

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All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income
The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

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All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

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Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW

I. INTRODUCTION

This recommendation is in three parts:

- the design of a premium support system,
- improvements to the current Medicare program, and
- financing and solvency of the Medicare program.

We believe it is important to address the current program now because of the transition time necessary to implement this premium support system. We assume the enactment of this proposal in 1999 and that the premium support system would be fully operational in 2003.

We believe a premium support system is necessary to enable Medicare beneficiaries to obtain secure, dependable, comprehensive high quality health care coverage comparable to what most workers have today. We believe modeling a system on the one Members of Congress use to obtain health care coverage for themselves and their families is appropriate. This proposal, while based on that system, is different in several important ways in order to better meet the unique health care needs of seniors and individuals with disabilities. Our proposal would allow beneficiaries to choose from among competing comprehensive health plans in a system based on a blend of existing government protections and market-based competition. Unlike today's Medicare program, our proposal ensures that low income seniors would have comprehensive health care coverage.

Because the implementation of a premium support system will take a number of years, we recommend immediate improvements to the current Medicare program. In Section II we outline the incremental improvements to enhance the beneficiaries' security and quality of care now. We recommend immediate federal funding of pharmaceutical coverage through Medicaid for seniors up to 135% of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing.

In reviewing the three parts of this proposal, it is important to keep in mind the different government roles in the premium support system and in current law. We believe the guarantee our society makes to every senior is to ensure that they can obtain the highest quality health care, and that their health care coverage not be allowed to fall behind that available to people in their working years. We believe that our society's commitment to seniors, the Medicare entitlement, can be made ***more secure*** only by focusing the government's powers on ensuring comprehensive coverage at an affordable price rather than continuing the inefficiency, inequity, and inadequacy of the current Medicare program.

I. PREMIUM SUPPORT SYSTEM TO PROVIDE COMPREHENSIVE COVERAGE

The Medicare Board

A Medicare Board should be established to oversee and negotiate with private plans and the government-run fee-for-service plan. Some examples of the Board's role are: direct and oversee periodic open enrollment periods; provide comparative information to beneficiaries regarding the plans in their areas; transmit information about beneficiaries' plan selections and corresponding premium obligations to the Social Security Administration to permit premium collection as occurs today with Medicare Part B premiums; enforce financial and quality standards; review and approve benefit packages and service areas to ensure against the adverse selection that could be created through benefit design, delineation of service areas or other techniques; negotiate premiums with all health plans; and compute payments to plans (including risk and geographic adjustment).

This Board would operate under a government charter that would describe its responsibilities and operating standards including the ability to hire without regard to civil service requirements and salary restrictions.

Ensuring Plan Performance and Dependability

All plans (private plans and the government-run FFS plan) would compete in the premium support system; all plans would have Board-approved benefit designs and premiums. The Board would ensure that the benefits provided under all plans are self-funded and self-sustaining, determining whether plan premium submissions meet strict tests for actuarial soundness, assessing the adequacy of reserves, and monitoring their performance capacity.

Management of Government-run Fee-for-service in Premium Support

The government plan would have to be self-funded and self-sustaining and meet the same requirements applied to all private plans, including whether its premium submissions meet strict tests for actuarial soundness, the adequacy of reserves, and performance capacity.

Cost containment measures would be necessary. The provisions of the Balanced Budget Act of 1997 should be extended, or comparable savings achieved. In any region where the price control structure of the government run plan is not competitive, the government-run fee-for-service plan could operate on the basis of contracts negotiated with local providers on price and performance, just as is the case with private plans. The government plan would be run through contractors as it is today; contractors in one region would be able to bid in other regions; the Board should have powers to assure that the government-run plan would not distort local markets.

Benefits Package

A standard benefits package would be specified in law. This benefits package would consist of all services covered under the existing Medicare statute. Plans would be able to offer additional benefits beyond the core package and plans would be able to vary cost sharing, including copay and deductible levels, subject to Board approval. Benefits would be updated through the annual negotiations process between plans and the Board, although the Board would not have the power to expand the standard benefit package without Congressional approval. Health plans would establish rules and procedures to assure delivery of benefits in a manner consistent with prevailing private standards and procedures offered to employer groups and other major purchasers.

The Medicare Board would approve benefit offerings and could allow variation within a limited range, for example not more than 10% of the actuarial value of the standard package, provided the Board was satisfied that the overall valuation of the package would be consistent with statutory objectives and would not lead to adverse or unfavorable risk selection problems in the Medicare market.

New benefit to be instituted in the premium support system: Outpatient prescription drug coverage and stop-loss protection

In Private Plans:

Private plans would be required to offer a high option that includes at least Medicare covered services plus coverage for outpatient prescription drugs and stop-loss protection. Plans would be able to vary copay and deductible structures. Minimum drug benefits for high option plans would be based on an actuarial valuation. High option and standard option plans each would be required to be self-funded and self-sustaining.

In Government-run Fee-For-Service Plan:

The government-run fee-for-service plan would be required to offer high option (including outpatient prescription drugs and stop-loss) in addition to standard option plans. The Medicare Board approval process would be the same as for private plans. High option and standard option plans would be required to be separately self-funded and self-sustaining. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Comprehensive coverage for low-income beneficiaries:

Coverage would be provided through high option plans. The federal government would pay 100% of the premiums of the high option plans at or below 85% of the national weighted average premium of all high option plans for all eligible individuals up to 135% of poverty ($10,568 for an individual and $13,334 for a couple) on a fully federally funded basis. This financial support does not limit

these beneficiaries' choice of plans nor restrict plans' design with regard to cost-sharing or other flexibility authorized by the Board. State would maintain their current level of effort, but the federal government would pay 100% of additional costs for these individuals. In this context, Congress should review DSH payments to ensure that double payments do not occur.

Premium Formula Basics

On average, beneficiaries would be expected to pay 12 percent of the total cost of standard option plans. For plans that cost at or less than 85 percent of the national weighted average plan price, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries' premiums would include all costs above the national weighted average.

Only the cost of the standard package would count toward the computation of the national weighted average premium. Plans with a high option, whether private plans or government-run, would separately identify the incremental costs of benefits beyond the standard package in their submissions to the Board, and the government contribution would be calculated without regard to the costs of these additional benefits.

Premium for government-run fee-for-service plans

The government-run fee-for-service plan would be treated the same as private plans.

Government-run plan premium excludes costs of special subsidies in premium calculation

All non-insurance functions and special payments now in Medicare would not be included in calculation of premiums for the government-run FFS plan or private plans.

Guaranteed premium levels where competition develops more slowly

In areas where no competition to the government-run fee-for-service plan exists, beneficiaries' obligations would be no greater than 12 percent of the FFS premium or the national weighted average, whichever is lower. The Medicare Board should periodically review those areas with a fixed percentage premium to ensure that the fixed percentage premium is not anti-competitive.

Medicare's Special Payments in a Premium Support System

Congress should examine all non-insurance functions, special payments and subsidies to determine whether they should be funded through the Trust fund or from another source. For example, payments for Direct Medical Education (DME) would be financed and distributed independent of a Medicare premium support system. Since the Part A and Part B trust funds would be combined and the traditionally separate funding sources of payroll taxes and general revenues would be blurred, Congress should provide a separate mechanism for continued funding through either a mandatory entitlement or multi-year discretionary appropriation program. On the other hand, Indirect Medical Education (IME) presents a unique problem since it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals.

Therefore, for now Congress should continue to fund IME from the Trust Fund as an adjustment to hospital payments.

II. IMMEDIATE IMPROVEMENTS TO THE CURRENT MEDICARE PROGRAM AND OTHER ASPECTS OF SENIORS HEALTH CARE SPENDING

Provide Outpatient Prescription Drug Coverage for 3 million more low-income beneficiaries

Immediately provide federal funding for coverage of prescription drugs under Medicaid for beneficiaries up to 135 percent of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing. All funding obligations related to the coverage under this provision would be federal.

Improve access to outpatient prescription drug coverage for seniors

Revise federal directives to National Association of Insurance Commissioners (NAIC) to develop new Medigap state model legislation immediately. All private supplemental plans would include basic coverage for prescription drugs. One plan would be a prescription drug-only plan.

Combine Parts A and B

Health care delivery changes have blurred the distinctions originally contemplated when Parts A and B of Medicare were enacted. Parts A and B should be combined in a single Medicare Trust Fund. (See Section III on Financing and Solvency.)

Lower deductible for 8 million beneficiaries

The current Medicare program subjects beneficiaries entering the hospital to extremely high costs just at a time when they face the many other expenses associated with serious illness. Virtually no private health plan imposes such costs. We propose to combine the current Part A ($768) deductible and B ($100) deductible, and replace it with a single deductible of $400, which should be indexed to growth in Medicare costs.

Improve utilization of health care services

A fee-for-service plan is best maintained by financial incentives, without which costs spiral out of control or freedom of choice must be restricted. To protect against unnecessary rises in beneficiary Part B premiums, 10% coinsurance would be established for all services except inpatient hospital stay and preventive care, and except where higher copays exist under current law.

Revise federal directives to NAIC to develop new state model legislation to conform to the changes proposed for Medicare cost-sharing. These directives should also be

designed to achieve more affordable and more efficient supplemental insurance and to minimize Medicare outlays. The new single Medicare deductible and coinsurance schedule would be insurable in part or in whole.

Eligibility Age

Medicare eligibility age should be conformed to that of Social Security. A non-subsidized buy-in should be available at age 65. In addition, Congress should develop a special category of eligibility based on specific needs-based criteria, for example selected activities of daily living, for individuals between age 65 and then-current eligibility age.

III. FINANCING AND SOLVENCY

The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms would result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and would enhance our ability to meet our commitment to today's and future beneficiaries. Without these changes, quality of care could suffer, and significantly greater revenues and/or beneficiary sacrifices would be required. Beneficiaries and the taxpayers would not receive the greatest value for the total health dollars spent on seniors' behalf.

Medicare's financing needs would be dictated by the Medicare growth rate achieved under the premium support system. By moving to a premium support system, Medicare's growth rate would be reduced by 1 to 1.5 percentage points per year from the current long-term annual growth rate of 7.6 percent (Trustees Intermediate) or 8.6 (Commission's No Slowdown Baseline.) If this reduction in growth rate can be achieved, the fiscal integrity and Medicare would be significantly improved.

Even if the estimated reduction in growth rate is achieved, Medicare will require additional resources as the percent of population that is eligible for Medicare increases. As revenue is needed, how much should be funded through the payroll tax, through general revenue, and through beneficiary premiums?

The answer to this question is difficult because it would require knowing today the health care system of the future. We do not know what the future holds in terms of the evolution of the health care delivery system, or the impact that technology will have on health care costs.

At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs" Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future "technology cuts both ways with respect to both saving medical expenditures and

potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology--and I could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity."

Notwithstanding the magnitude of uncertainty contained in the task, the statute establishing the Commission directed us to recommend measures to attain the long-term "solvency" of the Medicare program. Because of recent history the meaning of "solvency" has come under question. We believe a new measure of solvency must be developed that couples the uncertainty inherent in the task with the real need for the public to evaluate the cost of Medicare and how we should choose to fund this program over time.

The solvency test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

In addition, the payroll tax supporting the OASDI Trust Funds is limited both by its rate and the wage base on which that rate is applied. No portion of Medicare's funding contains these limitations. In Medicare, there is no cap on the wage base; the Part A Trust Fund is funded by a payroll tax of 2.9% on all earnings, and pays only for the Part A benefits of Medicare. Medicare's Part B benefits are paid 75% by general revenues and 25% by beneficiaries.

Consequently, the historic concept of Medicare's solvency is one that has been partially and inappropriately borrowed from Social Security and has never fully reflected the fiscal integrity, or lack thereof, of the Medicare program. In Medicare, "solvency" has meant only whether the Part A Trust Fund outlays were poised to exceed Part A reserves and collections. That is all.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A "solvency" or rather "insolvency" has been used to shift more program costs to the general fund. An act of Congress shifted major home health expenditures from Part A to Part B in 1997, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A "solvency".

The ever increasing estimates of general fund exposure should be part of any definition of solvency. Absent reform, general fund exposure jumps from 37% of program funding in FY2000 to 43% in FY2005 and 49% in FY2010. General fund demand will increase from $92 billion in FY2000 to $156 billion in FY2005 to $261 billion in FY2010.

Consequently, the "solvency" of the Part A Trust Fund is not useful as a guide to policy making or even as a tool to educate the public on the security and financial condition of the Medicare program.

Therefore, Part A and Part B Trust Funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. This concept should more accurately reflect the implications of the program's financing structure, i.e., the ratio of relative financing burdens on the general fund, the Hospital Insurance payroll tax, and the premiums beneficiaries pay. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. This could be referred to as a programmatic solvency test.

Congress should enact this revised definition of Medicare solvency so that decisions can be made in the context of competing demands for general revenue. Congress should require the Trustees to publish annual projections regarding the ratio in program financing. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent. The Trustees Report should provide for necessary and important public debate leading to potential adjustments to the payroll tax and/or the beneficiary premium as well as any adjustment of the general fund devoted to Medicare. Congressional approval would be required to authorize any additional contributions to the Medicare Trust Fund.

With the reforms contemplated under this proposal, that new test would probably not activated until after 2005. Even if we limit general revenue contributions to 40% of program outlays, however, this proposal would extend the solvency of Medicare to 2013. This calculation, based on the most recent CBO baseline, would indicate that solvency under this test would extend to 2017 or beyond.

Long-term care

The Commission recognizes that its proposal is focused on acute care, and does not address the issue of long-term care. In 1995, Americans spent an estimated $91 billion on long-term care, with 60 percent coming from public sources. Despite these large public expenditures, the elderly face significant uncovered liabilities. The Commission recommends that the Institute of Medicine conduct a study to 1) estimate future demands for long-term care; and 2) analyze the long-term care financing options available to seniors, including long-term care insurance, tax policy and community-based, state and federal government programs.

To: Medicare Commission 3/14/99

From: Jeff Lemieux

Subject: Cost estimate of March 14 proposal

The attached estimate is based on the proposal specified below. The estimate is displayed in annual figures for the 10-year budget window used in the Senate (and slightly beyond). Long-term tables developed by the Modeling Task Force, which display the impact of the proposal using several different measures, are also included. In addition, a simulation of a combined trust fund is attached. The explanation of the basis of the estimate is limited to new items in the proposal. The February 17 estimate of the original Breaux proposal contains a general explanation of the premium support plan. Since the current proposal is similar to the nontraditional estimate on February 17, simulations of the impact on beneficiary premiums from that estimate continue to apply.

DESCRIPTION OF THE PROPOSAL

Medicare Board:

The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries' premiums (collected via Social Security system as with Part B premiums now). Board approval would be required for plan service areas and benefit package designs.

Benefits:

The standard benefits package specified in law would consist of all services covered under the existing Medicare statute (Medicare covered services). Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:

Private Plans

All private plans would be required to offer a high option that included at least the standard benefits package plus coverage for prescription drugs. The minimum drug benefit for high option plans would be based on an actuarial valuation, with standards and examples set by the Board.

Low-Income

The proposal would immediately extend coverage of prescription drugs to qualifying beneficiaries under 135 percent of poverty under Medicaid with full federal funding of the additional cost. That coverage

could be provided through high option plans when the premium support system was implemented. (A special premium support schedule could be used to combine premium and drug subsidies for low-income beneficiaries.)

Fee-For-Service
The Health Care Financing Administration (HCFA) would be allowed to contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would allow a public/private high option plan or plans, with HCFA providing coverage for Medicare covered services and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, HCFA would be allowed to transition the government-run fee-for-service plan to a more private-managed basis overall, possibly with different alternatives available regionally.

Medigap
The National Association of Insurance Commissioners would develop new model plans immediately under a federal directive. All plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:

Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. (An example of this type of premium schedule was included in the estimate from February 17.)

Although all plans would be available on the national premium schedule, only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board for that purpose.

If early versions of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:

The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. Ten percent coinsurance would be charged for home health, laboratory

services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Management of the Government-Run Fee-for-Service Plan:

All plans, private plans and the government-run fee-for-service plan, would compete in the premium support system; all plans would have premiums and would be available on the national schedule. The fee-for-service plan would have a premium like any other plan–it would adjust its premium in subsequent years based on its cost experience.

The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate. The estimate assumes that the growth of fee-for-service spending would be moderated somewhat by a combination of HCFA and Congressional efforts. Without some such ongoing savings, the fee-for-service plan could gradually lose its competitive position with private plans.

Special Payments (Education, Disproportionate Share, Rural Subsidies):

Under the proposal, federal support for Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. Depending on the nature of the replacement program for DME, the federal budget as a whole might not be affected by the carve-out. The proposal would also recommend exploring funding disproportionate share hospitals (DSH) and Indirect Medical Education (IME) outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program.

Any special payments remaining in Medicare would not be included in premiums for the government-run fee-for-service plan or private plans.

Retirement Age:

The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. Congress would develop an exemption process for affected beneficiaries with special needs, such as those unable to work and otherwise get health coverage. Eligibility requirements under that exemption process would not necessarily be the same as the requirements for eligibility based on disability for those under 65, although the waiting period for eligibility based on disability could also be waived or shortened for those affected by the change.

Long-Term Care:

The proposal indicates that long-term care issues should be separated from Medicare (an acute care program). The proposal would require a study of various long-term care issues. The cost estimate

does not include any impact on the budget from long-term care items.

Financing:

The proposal would implement a combined trust fund, with guaranteed general revenue funding to grow at the same rate as overall program costs if it otherwise would exceed 40 percent of the program's cost (without further Congressional approval). The initial balance in the combined fund would equal the balance in the Part A and Part B funds at the time of enactment.

BUDGETARY IMPACT

Table 1 lays out the estimate in the style of an annual Congressional cost estimate. The savings attributed to the individual policies result from a top-down ordering of the estimate. Premium support was estimated first, in the absence of any other policies. Then the subsequent policies were added one by one–the savings represent the incremental impact of that policy on Medicare spending. Because Medicare spending would be reduced compared with current law, premium collections from beneficiaries would be reduced as well. That is why the impact of the proposal on premiums is displayed as a cost item in the table–lower government premium collections reduce the budget surplus (or increase the deficit).

Excluding the optional items, the proposal would be approximately budget neutral in the 5-year budget window between 2000 and 2004. That is because the new assistance for low-income beneficiaries would begin immediately, while the savings provisions would not be implemented until 2003. Over the 10 years between 2000 and 2009, the proposal would save approximately $100 billion.

Tables 2-6 show the detailed cost estimate of the March 14 plan in the format developed by the Modeling Task Force. That format was designed to gauge the impact of proposals using many different measures. Because the Part A trust fund would be replaced by a combined fund, tables 2-6 do not show results for the Part A fund under the proposal. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

Table 7 shows the projected impact of a combined trust fund under the proposal, with general revenue funding growing at the same rate as program costs overall. As noted in the February 17 estimate, the growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30-year baselines

used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short-run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in Table 7 should be extended by 3 or 4 years as well, to 2016 or 2017.

BASIS OF THE ESTIMATE AND DISCUSSION

Premium Support

The basic estimate of the premium support plan is largely unchanged from the February 17 estimate. Tying the national average to the cost of Medicare covered services reduces transition costs by a small amount, increasing slightly the savings attributed to premium support. The provision protecting beneficiaries in areas with only one plan from paying more than 12 percent of the cost of that plan or the national weighted average would add slightly to the cost of the proposal.

Requiring all plans to offer a high option plan and allowing the Board to maintain an appropriate price difference between plans' high and standard options until the risk adjuster was proven over time greatly reduces concerns about adverse selection in high option plans.

Low-Income Subsidies

Currently, state Medicaid programs cover drugs for only so-called dually-eligible Medicare beneficiaries, often limiting such coverage to those well under the poverty line. Medicaid covers Medicare premiums and cost sharing for those between the limit of Medicaid dual eligibility and the poverty line. Between 100 and 135 percent of poverty, Medicaid covers Medicare premiums only. The cost of such Medicaid coverage under current law is split between the states and the federal government. About 50 percent of beneficiaries between the limit of dual eligibility and the poverty line participate in premium and cost sharing subsidies; about 20 percent of beneficiaries between 100 and 135 percent of poverty participate.

This estimate assumes that the federal government would pay 100 percent of the cost of extending drug coverage to qualifying beneficiaries under 135 percent of poverty via the Medicaid program. (States would continue to be responsible for their share of the cost of drug coverage for dually-eligible beneficiaries.) In addition, the federal government would make grants to the states in amounts set to cover 100 percent of the cost of the extra participation in the current assistance programs (for premiums and cost sharing) that the new drug coverage would cause. The estimate assumes that the participation rate for those under 135 percent of poverty, but not dually eligible, would be 60 percent. Thus the federal government would effectively cover the cost of expanding participation for those not dually eligible but under poverty from 50 to 60 percent, and from 20 to 60 percent for those between 100 and 135 percent of poverty.

Management of the Fee-for-Service Plan

In the short run, the proposal would allow the government-run fee-for-service plan to partner with private plans to offer drug benefits under one high option premium. The estimate assumes that such partnerships would not involve HCFA regulation of that industry.

The estimate assumes that a combination of HCFA and Congressional initiatives would slow the growth of spending in the fee-for-service program somewhat. That slowdown was explained in the description of the nontraditional estimate of February 17. The estimated impact of the specified cost sharing changes in the fee-for-service plan is shown separately.

Financing

The Part A fund covers only part of Medicare spending, and an act of Congress recently aided the fund simply by transferring a portion of its spending out of Part A into Part B (which is funded mostly by general revenues). Current budget proposals would transfer additional funds from the general Treasury to the Part A fund in order to postpone its insolvency date. Because the Part A fund never covered all of Medicare, and because of the recent and proposed transfers of obligations and funds, the Part A fund no longer adequately summarizes the financial condition of the Medicare program. A combined fund could make it more clear who pays for Medicare and would allow a more transparent discussion of how to aid Medicare's finances.

Table 1. March 14 Proposal

(by calendar year)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	00-04	00-09
	Cost (+) or Savings (-) in Billions of Dollars															
Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 135 Percent of Poverty \1	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs \2	2	2	2	3	3	3	3	4	4	4	4	5	5	5	12	30
Cost sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-8	-8	-4	-24
Removal of DME \3	0	0	0	-4	-5	-5	-5	-5	-6	-6	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-5	-1	-11
Slowdown of Growth in Gov't FFS plan \4	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
Total	4	4	5	-6	-9	-11	-16	-20	-24	-29	-34	-41	-48	-55	-1	-102
Average Monthly Premium:																
Government-run FFS plan				$76	$80	$84	$89	$93	$98	$103	$108	$114	$119	$125		
Government-run plan in no alternative areas				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Private plans				$75	$79	$82	$86	$90	$93	$97	$102	$106	$110	$114		
Average of all plans				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Monthly Part B Premium under Current Law				$71	$77	$84	$91	$98	$106	$115	$123	$132	$141	$151		

Source: Medicare Commission Staff.

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items.
Estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003.
The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003.
Over time, that percentage would gradually fall; if national private plans developed, it would fall to zero.
In this time period, the results are approximately the same using either of the Commission's baselines.
The premium support schedule is calibrated to Medicare spending after the home health transfer is fully phased in (2006).

\1 Assumes 100% federal funding with a state maintenance of effort for dually-eligible beneficiaries. Participation rate assumed to be about 60 percent.
\2 Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).
\3 Savings to Medicare, but not necessarily to the overall budget.
\4 Follows the method of the nontraditional estimate of Feb. 17, which assumed that the fee-for-service plan would compete to some extent.

Table 2. **March 14 Proposal** **DRAFT**

14-Mar-99

	Medicare Spending Growth Rate, 2000-		Medicare Spending as a Percent of GDP /1/2		Medicare as a Percent of Federal Revenues		Medicare Spending (in billions of dollars) /3		Part A or Combined Fund Insolvency /4	Premiums as a Percent of Beneficiaries' Income		Budgetary Costs (+) or Savings (-) (in billions) /5	
	2015	2030	2015	2030	2015	2030	2015	2030		2015	2030	2015	2030
Baselines													
Trustees Intermediate	8.2%	7.6%	4.4%	6.3%	19%	28%	801	2,212	2008	7%	7%	0	0
No Slowdown	8.3%	8.6%	4.5%	8.5%	19%	38%	817	2,972	2008	7%	10%	0	0
Viability Standard Based on Spending													
Slow Growth of Per Beneficiary Spending to that of Per Capita GDP													
Trustees Intermediate	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-182	-615
No Slowdown	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-195	-1272
Preliminary Estimate													
March 14 Proposal													
Trustees Intermediate	6.9%	6.4%	3.7%	4.5%	16%	20%	676	1,596	~2013	5%	5%	-99	-514
No Slowdown	7.1%	7.4%	3.8%	5.9%	17%	27%	688	2,087	~2013	5%	6%	-101	-740

Policy: The Part B premium and the Medicare+Choice system for private plans would be replaced by a premium support with standard and high options under formula that allowed zero-premium plans. Normal age of eligibility would be gradually increased, but waiting period for eligibility for disabled would be waived or reduced for those affected. Low-income subsidies expanded with drug coverage for qualifying beneficiaries under 135 percent of poverty Benefits package change would include coinsurance for home health and lab services with combined deductible (indexed to program costs). Direct education carved out. HCFA can organize public/private fee-for-service plan, with standard and high option. Premium formula anchored to standard option/Medicare covered services.

SOURCE: Medicare Commission Staff.

1. In 2000, Medicare spending will be 3 percent of GDP and 12 percent of the federal budget (revenues). Total projected Medicare spending will be $247 billion in 2000.
2. Payroll is approximately half of GDP. For example, in 2015 under the Trustees Intermediate baseline, Medicare spending would be 9.0 percent of payroll.
3. All spending estimates after Part A fund insolvency are hypothetical.
4. Updated estimates from HCFA and CBO will probably extend insolvency date by 3 or 4 years under current law. This cost estimate does not include that update.
5. Medicare cost or savings in the year shown.

Table 3.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
Trustees Intermediate Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.4	5.0	5.7	6.3
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.7	4.0	4.3	4.5
Medicare Spending as a Percent of Payroll \1													
Trustees Intermediate Baseline	1	2	3	4	4	5	6	6	8	9	10	12	13
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	8	9	9
Medicare Spending as a Percent of the Federal Budget \2													
Trustees Intermediate Baseline	3	5	6	8	9	11	12	14	16	19	22	25	28
March 14 Proposal	3	5	6	8	9	11	12	13	14	16	18	19	20
Medicare Spending in Billions of Dollars													
Trustees Intermediate Baseline	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
Average Annual Growth in Spending from Previous Year Shown													
Trustees Intermediate Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.1	8.4	7.5	7.0	6.6
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.2	6.4	5.7	5.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
Trustees Intermediate Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.3	6.0	4.9	4.3	4.2
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	4.9	3.8	3.0	3.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
Trustees Intermediate Baseline						3	4	5	6	7	7	7	7
March 14 Proposal						3	4	5	5	5	5	5	5

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP .

Table 4.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
No Slowdown Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.5	5.5	6.9	8.5
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.8	4.4	5.1	5.9
Medicare Spending as a Percent of Payroll \1													
No Slowdown Baseline	1	2	3	4	4	5	6	6	8	9	11	14	17
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	9	10	12
Medicare Spending as a Percent of the Federal Budget \2													
No Slowdown Baseline	3	5	6	8	9	11	12	14	16	19	24	30	38
March 14 Proposal	3	5	6	8	9	11	12	13	14	17	19	23	27
Medicare Spending in Billions of Dollars													
No Slowdown Baseline	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
Average Annual Growth in Spending from Previous Year Shown													
No Slowdown Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.2	8.7	9.0	9.2	8.8
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.6	7.8	7.6	7.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
No Slowdown Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.4	6.4	6.4	6.4	6.4
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	5.3	5.2	4.9	5.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
No Slowdown Baseline						3	4	5	6	7	8	9	10
March 14 Proposal						3	4	5	5	5	6	6	6

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP.

Table 5.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
						Billions of Dollars							
Trustees Intermediate Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	110	156	217	299
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	432	668	992	1,416
Total, Medicare Spending	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	84	114	150	196
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	333	484	666	902
Total, Medicare Spending	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
						Percent Distribution							
Trustees Intermediate Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	13
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	28	25	22
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	54	58	62	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	35	33	31
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	49	53	55	57
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
Trustees Intermediate Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	262	388	607	949	1,450
Net	1	1	1	5	13	-3	1	-10	-40	-109	-258	-517	-914
Balance	3	11	14	21	99	130	110	87	(49)	(438)	(1,388)	(3,411)	(7,090)

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

Part A estimates here computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical.
Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 6.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
							Billions of Dollars						
No Slowdown Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	112	171	263	401
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	445	763	1,285	2,073
Total, Medicare Spending	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	85	124	179	257
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	344	555	868	1,333
Total, Medicare Spending	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
							Percent Distribution						
No Slowdown Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	14
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	26	21	17
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	55	61	66	70
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	32	28	24
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	50	55	60	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
No Slowdown Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	263	397	669	1,159	1,969
Net	1	1	1	5	13	-3	1	-10	-41	-117	-320	-727	-1434
Balance	3	11	14	21	99	130	110	87	(49)	(457)	(1,581)	(4,308)	(9,872)

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

Part A estimates computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical. Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 7. A Combined Trust Fund Under the March 14 Proposal

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
					Billions of Dollars						
Inflows											
Premiums	32	36	39	42	46	50	55	60	65	70	77
Payroll Taxes	149	156	164	171	180	188	197	206	216	226	237
General Revenues	117	128	140	150	161	172	184	198	212	228	245
Interest	9	9	9	9	9	8	7	5	3	0	0
Total, Inflows	307	329	352	373	395	418	443	469	496	525	559
Outflows											
Medicare Spending	307	329	352	376	402	431	461	494	530	570	613
Interest	0	0	0	0	0	0	0	0	0	0	3
Total, Outflows	307	329	352	376	402	431	461	494	530	570	617
Net	0	0	0	(3)	(7)	(13)	(18)	(25)	(34)	(45)	(57)
Balance	150	150	150	147	140	127	109	84	49	4	(53)
Memorandum:											
General Revenue Share of Medicare Financing	38%	39%	40%	40%	40%	40%	40%	40%	40%	40%	40%

Source: Medicare Commission Staff.

Note: The growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30 year baselines used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in this table should be extended by 3 or 4 years as well, to 2016 or 2017.

Health-Medicare discussion

MEDICARE COMMISSION PRINCIPALS' MEETING
Agenda: March 15, 1999

I. UPDATE ON THE MEDICARE COMMISSION

II. BASE MEDICARE POLICIES

III. ADDITIONAL MEDICARE POLICIES

- Drug Benefit
- Income-Related Premium
- Premium Support

IV. ILLUSTRATIVE OPTIONS

BASE MEDICARE POLICIES

(Calendar Years, Dollars in Billions)

POLICIES:	**2000-04**	**2000-09**
Modernizing Medicare Fee-for-Service	-9	-22
Balanced Budget Act Extenders	-7	-57
Cost Sharing Changes - Combined deductible of $350 - Adds hospital catastrophic coverage - Removing preventive services coinsurance - Adding 20% lab copay, limited 10% home heath copay	-1	+1
Medigap: Prohibiting Deductible Coverage	-5	-11
Interactions	+1	+4
TOTAL	**-21**	**-85**

* These savings exclude the President's budget proposals whose savings are used for other purposes

PRESCRIPTION DRUG BENEFIT

OPTIONS:	**2000-04**	**2000-09**
Back-End Coverage (No Cap on Benefit)		
High Option No cap on benefits, $3,000 stop-loss $300 deductible, 10% coinsurance Premium in 2002: $41.50	+84	+253
Low Option No cap on benefits, no stop-loss $500 deductible, 25% coinsurance Premium in 2002: $28.10	+58	+176
Front-End Coverage (Cap on Benefit)		
High Option $2,000 cap on benefits, no stop-loss $250 deductible, 20% coinsurance Premium in 2002: $28.40	+51	+141
Low Option $1,000 cap on benefits, no stop-loss $250 deductible, 10% coinsurance Premium in 2002: $20.30	+37	+101

For all: Voluntary, 50% premium subsidy, implemented in 2001; for all beneficiaries

INCOME-RELATED PREMIUM

OPTIONS:	2000-04	2000-09
• Health Security Act Singles: $90,000 with full payment at $100,000 Couples: $110,000 with full payment at $125,000 Beneficiaries affected: About 2 million (5%)	-16	-42
• Chafee-Breaux / Senate 1997 Singles: $50,000 with full payment at $100,000 Couples: $75,000 with full payment at $150,000 Beneficiaries affected: About 4 million (11%)	-23	-58
• Breaux / Commission Draft 1999* Single: $24,000 with full payment at $40,000 Couples: $30,000 with full payment at $50,000 Beneficiaries affected: About 13 million (33%)	-38	-95

For all: Index income thresholds to inflation; No full phase-out of subsidy; Treasury run

* Phases out at a higher subsidy level than the other options

PREMIUM SUPPORT

OPTIONS:	2000-04	2000-09
• Breaux Plan Assuming 2000 implementation Fee-for-service premium higher than current law Partial geographic adjustment; limited benefits flexibility	-26	-75
Assuming 2002 implementation	-13	-62
• Competitive Defined Benefit Assuming 2002 implementation Fee-for-service premium no higher than current law Full geographic adjustment; limited benefits flexibility	-8	-30
• Phased-In Competitive Defined Benefit Assuming 2004 implementation Fee-for-service premium no higher than current law Full geographic adjustment; limited benefits flexibility	-1	-20

SUMMARY OF COMMISSION PROPOSALS

OPTIONS:	2000-04	2000-09
Base*	**-21**	**-85**
Income-Related Premium		
Health Security Act ($90 / 110,000)	-16	-42
Chafee-Breaux ($50 / 75,000)	-23	-58
Premium Support		
Competitive Defined Benefit	-8	-30
Phased-In Competitive Defined Benefit	-1	-20
DRUG OPTIONS		
High Uncapped Option ($250 deductible)	+84	+253
Low Uncapped Option ($500 deductible)	+58	+176
High Capped Option ($2,000 cap)	+51	+141
Low Capped Option ($1,000 cap)	+37	+101

*** Could go higher if willing to forego President's Budget proposal, or could add other policies**

ILLUSTRATIVE OPTIONS

OPTIONS:	2000-04	2000-09
Option 1: No Competitive Defined Benefit		
Base Plan	-21	-85
Income-Related Premium ($90/110,000)	-16	-42
Subtotal	-37	-127
Drug Benefit: Front-End, $1,000 Cap	+37	+101
Net Savings:	***0***	***-26***
Option 2: Phased-In Competitive Benefit / Aggressive Income-Related Premium		
Base Plan	-21	-85
Income-Related Premium ($50/75,000)	-23	-58
Phased-In Competitive Defined Benefit	-1	-20
Subtotal	-45	-163
Drug Benefit: Front-End, $1,000 Cap	+37	+101
Net Savings:	***-8***	***-62***
Option 3: Competitive Defined Benefit / Aggressive Income-Related Premium		
Base Plan	-21	-85
Income-Related Premium ($50/75,000)	-23	-58
Competitive Defined Benefit	-8	-30
Subtotal	-52	-173
Drug Benefit: Front-End, $2,000 Cap	+51	+141
Net Savings:	***-1***	***-32***

Health - Medicare commission

DRAFT

TALKING POINTS ON MEDICARE PREMIUM SUPPORT

March 23, 1999

The President does not support the Breaux-Thomas premium support plan.

- **Raise premiums for traditional Medicare.** According to the Medicare actuary, premiums for most beneficiaries would be raised by 10 to 20 percent. Although the latest proposal exempts beneficiaries with no other plan options from this premium increase, millions of beneficiaries with limited or unattractive options would be forced to pay more to stay in the traditional system. Such a "Hobson's choice," particularly for frail elderly who need access to physicians that a Medicare HMO might not provide, is unacceptable.

- **Uncertain guarantee to defined benefits.** It is not clear that this proposal guarantees Medicare's defined benefits. While there appears to be general language that provides for a defined benefits package, the plans are apparently given sufficient leeway to vary benefits and cost sharing, which could lead to segmenting healthy populations away from the sick.

The Administration is committed to making Medicare more competitive and efficient. The President has been -- and will continue to be -- supportive of policies that add competitive, effective tools to the ways that Medicare reimburses under both the traditional and private plans.

However, the President will insist on clear, defined benefits. This guarantee of benefits is one of Medicare's defining characteristics and strengths and should not be altered.

The President's plan will also maintain a strong, viable, affordable traditional program. For many beneficiaries, the traditional program is not just the only choice, but the preferred choice. Premiums for traditional Medicare should be protected so that it remains an affordable option.

Draft: MEDICARE QS AND AS
March 22, 1999

Q. When is your plan going to be introduced?

A. You all know how dangerous it is putting a specific time frame on releasing a specific proposal. First, the new Trustees' report is coming out next week, which is likely to change cost estimates associated with Medicare reform options. Second, we want to review all viable options. Third, we need to consult with you. And, fourth, we need to strategically consider the best time frame for releasing the plan after the first three steps have been completed. Suffice it to say, it will be early enough to credibly argue that the Congress will have enough time to respond to it this year.

Q. What is the process you are going to use to develop this plan, and will we be consulted?

A. As this meeting indicates, we fully intend on consulting with you as the President develops his plan. We will also be reviewing the options put on the table by the Commission, to see which ones have merit. Also, we want to make sure that our proposals get assessed by the independent Medicare actuaries so we have a good idea of how these policies will affect Medicare.

Q. Secretary Shalala specifically said that raising the age eligibility is off the table. Is this true?

A. Raising the eligibility age will not be in the President's package. The President believes that raising the eligibility age for Medicare without policies to prevent the uninsured from increasing is going in the wrong direction.

Q. What is your prescription drug benefit?

A. We are reviewing options. As you know, the cost of the benefit is directly linked to its design. Clearly, we want to provide the package that benefits the most people possible while still being affordable.

Q. **How much will it cost and how will you finance it?**

A. We believe that there have to be Medicare offsets that help pay for the Medicare drug benefit. It is not clear that, by themselves, these offsets will be enough to achieve this goal. We need to work with you closely on this issue.

Q. Will you use the surplus to help offset the cost of the prescription drug benefit?

A. As we've said, we believe that other offsets must contribute to the cost of this benefit. But before we even contemplate using the 15 percent of the surplus for anything other than extending the life of the program, we need to finalize the design of drug benefit, determine its costs, and assess whether the offsets are sufficient. We believe, however, that no one should rush into using the surplus for this or any other purpose.

Q. Will your plan include an income-related premium?

A. The President supported this policy in the past, including in his 1992 campaign, the 1993 Health Security Act, and again during the Balanced Budget Act discussions in 1997. It is certainly being discussed, but, again, we have made no final decisions whether it is necessary or advisable to include in the President's package.

Health - Medicare commission

Draft

ADDRESSING MEDICARE'S CHALLENGES

MARCH, 1999

ADDRESSING MEDICARE'S CHALLENGES

I. Overview

- Importance of Medicare
- Challenges Facing Medicare
- Options for Addressing Medicare's Financial Crisis

II. Medicare Commission

III. President's Plan for Medicare Reform

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare 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 reduce poverty**: Since 1965:

    - Life expectancy of the elderly 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%)

FINANCIAL CHALLENGES FACING MEDICARE

- **More beneficiaries**: Enrollment in Medicare will climb when the baby boom generation retires: from 39 million to 47 million in 2010, to 80 million by 2035.

- **Fewer workers**: At the same time, the ratio of workers (who support Medicare) to beneficiaries is expected to decline by over 40 percent by 2030. (3.6 workers per beneficiary in 2010, declining to 2.3 in 2030)

- **Cost growth will rise**: Medicare has recently reigned in cost growth. However, it is expected to rise again as the effects of recent policy changes wear off (from 3 percent per beneficiary for 98-02 to 6 percent for 2003-10).

- **Trust Fund crisis:** Medicare's Trust Fund (for institutional services) will become insolvent in 2008 according to the 1998 Trustees' Report. Even though the 1999 Report will likely show a better prognosis, Medicare will still run out of funds about 20 years before Social Security does. With no changes, Medicare's spending will outstrip its financing and produce a $1 trillion shortfall by 2020.

ADDITIONAL CHALLENGES FACING MEDICARE

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

  - No prescription drug coverage: Even though drugs 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.

  - 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 buy expensive and inefficient Medigap coverage.

- **Fewer private tools for reducing costs**: Current laws prohibit Medicare from adopting some of the most effective private sector tools to save Medicare money.

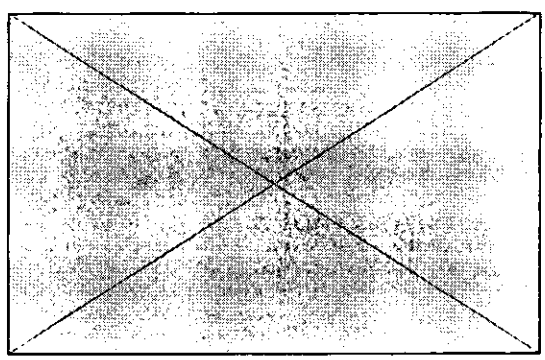
OPTIONS FOR ADDRESSING MEDICARE'S FINANCING CRISIS

- **Options to address Medicare's long-term solvency**: A wide range of ideas have been considered to help solve Medicare's fiscal imbalance. These can be categorized as:

  - Reducing provider payments and increasing efficiency
  - Restricting or reducing benefits
  - Increasing beneficiary contributions to Medicare, and/or
  - Adding new revenue to Medicare

1. REDUCING PROVIDER PAYMENTS AND INCREASING EFFICIENCY

- **Strong, fiscal discipline is always a goal for Medicare**: Since 1992, overpayments to health care providers have been reduced and payment systems have been modernized. In addition, there has been great successes in reducing fraud, waste and abuse. As a result, Medicare is now growing at a rate that is below the private sector health spending.



- **However, impossibly low Medicare growth rates would be needed to extend Medicare's life through provider payment reductions and efficiency alone**: Spending growth per beneficiary would have to be constrained 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) and about 1 percentage point below inflation

- **Unsustainable provider cuts**: To ensure solvency through 2020, Part A provider payments would have to be cut by 18 percent --almost $150 billion over 5 years.

2. RESTRICTING OR REDUCING BENEFITS

- **Restricting the benefits that Medicare covers is a second option**: However:
  - Medicare's benefits are already less generous than 4 out of 5 employers' health insurance plans.
  - All experts agree -- Medicare's benefits should be expanded to include prescription drugs and improved cost sharing, not reduced.
- **Only removing major, critical services could keep Medicare solvent in the long-run**: Because Medicare already has a limited benefits package, limiting it even more would probably not solve its long-term problems. Even removing the following services would not be sufficient to get to 2020:
  - All skilled nursing facility plus hospice spending
  - All Part A home health spending
  - Graduate medical education and disproportionate share hospital spending.

3. INCREASING BENEFICIARY PAYMENTS

- **Making beneficiaries pay more**: A third option for addressing Medicare's long-term financing crisis is to have beneficiaries pay for more of the cost of care.

  - Beneficiaries already pay for almost half of their health care costs: Because of its less generous benefits and higher cost sharing, Medicare only pays 52 percent of the total health care costs of its beneficiaries.

  - Although there are an increasing number of beneficiaries with higher income, nearly two-thirds of elderly households have income below $20,000.

4. ADDING NEW FINANCING TO MEDICARE

- **Adding new financing to Medicare**: The fourth and final option is adding revenues to the program. In the past, this option has rarely been used by Congress and the Administration to bolster the program's financial status.

- **Different -- and larger-- financing crisis**: However, as virtually every independent analyst has concluded (e.g., Reischauer, Aaron, Tyson, Altman), the retirement of the baby boom generation makes this crisis different. The demographics make it impossible to address the financing challenge solely through provider payment cuts and efficiency gains.

- **Two choices: Raise taxes or dedicate part of the surplus to Medicare**: The amount of financing needed to pay for Medicare's shortfall -- even after significant restructuring -- can only come from the surplus or a new tax increase.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal**: Its centerpiece is its "premium support" proposal. This would allow private plans to compete for Medicare beneficiaries on price and extra benefits. The plan also includes a number of other policies such as modernizing traditional Medicare, adding an unlimited 10 percent home health copay, and raising Medicare's eligibility age.

- **Savings from the Proposal**: According to Commission staff, the proposal would increase Federal spending by $8 billion over the next 5 years, and decrease it by $66 billion over 10.

- **Final Vote on the Breaux-Thomas Proposal**: The proposal received 10 rather than the required 11 votes to report it out as a Commission recommendation.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare**: The year-long deliberations of the Medicare Commission has helped highlight the problems 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 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.

- 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 THE BREAUX-THOMAS MEDICARE PROPOSAL

- **Does not address Medicare's long-term solvency**: Because it includes no financing options, the Breaux-Thomas proposal does not address long-term solvency. 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.

- **Raises the age eligibility for Medicare**: 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 Breaux-Thomas proposal would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to the independent Medicare actuary. Although the proposal 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.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare**:
  Neither the President nor his 4 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 conform to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;
  - Maintaining and improving Medicare's guaranteed benefits; 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;

  - Selectively contracting with lower-cost, high-quality providers; and

  - Paying one price for a specific conditions (e.g., diabetes or heart attacks) rather than on a service-by-service basis.

- **Examining other policies to reduce overpayment and increase competition**: The Administration will also examine specific options to reduce fraud and overpayment, extend effective payment policies, and make managed care payments more competitive.

MAINTAINING AND IMPROVING 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. Proposal to strengthen Medicare must not do so at the expense of this guarantee.

- **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.

  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable, regardless of where they live or whether they are in a managed care plan.

- **Simplifying and improving Medicare's cost sharing**

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.

- Investing now prevents larger problem later. Even though the Medicare shortfall is projected to accumulate to over $1 trillion by 2020, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing with interest later.

- One-time, fixed contribution: The plan does not create an unlimited tap on general revenue for Medicare. Instead, it invests a fixed proportion of the surplus -- in large part created by the baby boom generation -- in Medicare to pay for services for the temporary but overwhelming influx of retirees in the future.

- Better option than raising taxes: Medicare's 2.9 percent payroll tax would have to be raised by 20 percent to get Medicare through 2020. It would be borne by all workers -- including younger and low-income workers.

Health - Medicare commission

Jeanne Lambrew
03/23/99 07:34:11 AM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP

cc:
Subject: medicare qs and as for leadership meetings

MCRQS.22

Attached are draft qs and as that Larry Stein was interested in for upcoming meetings with Gephardt, Daschle and other key Democrats. How we position ourselves re. our Medicare plan may come up at the morning meeting. Page Chris or call me with questions.

Thanks, Jeanne

MEDICARE QS AND AS
March 22, 1999

Q. When is your plan going to be introduced?

A. You all know how dangerous it is putting a specific time frame on releasing a specific proposal. First, the new Trustees' report is coming out next week, which is likely to change cost estimates associated with Medicare reform options. Second, we want to review all viable options. Third, we need to consult with you. And, fourth, we need to strategically consider the best time frame for releasing the plan after the first three steps have been completed. Suffice it to say, it will be early enough to credibly argue that the Congress will have enough time to respond to it this year.

Q. What is the process you are going to use to develop this plan, and will we be consulted?

A. As this meeting indicates, we fully intend on consulting with you as the President develops his plan. We will also be reviewing the options put on the table by the Commission, to see which ones have merit. Also, we want to make sure that our proposals get assessed by the independent Medicare actuaries so we have a good idea of how these policies will affect Medicare.

Q. Are you going to include premium support in your package?

A. The President has always been interested in policies to make Medicare more competitive and efficient. Clearly, we do not pay managed care plans in Medicare in a rational way. HMOs continue to pick and choose locations to serve beneficiaries depending on the local payment rate. This should be addressed.

However, the President will not support a voucher proposal or any proposal that undermines Medicare's defined benefits. He has serious concerns about the premium support model proposed by Senator Breaux and Congressman Thomas. It is not entirely clear that this proposal guarantees Medicare's defined benefits. It also would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to our actuaries. 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.

Q. Secretary Shalala specifically said that raising the age eligibility is off the table. Is this true?

A. Raising the eligibility age will not be in the President's package. The President believes that raising the eligibility age for Medicare without policies to prevent the uninsured from increasing is going in the wrong direction.

Q. What is your prescription drug benefit?

A. We are reviewing options. As you know, the cost of the benefit is directly linked to its design. Clearly, we want to provide the package that benefits the most people possible while still being affordable.

Q. **How much will it cost and how will you finance it?**

A. We believe that there have to be Medicare offsets that help pay for the Medicare drug benefit. It is not clear that, by themselves, these offsets will be enough to achieve this goal. We need to work with you closely on this issue.

Q. Will you use the surplus to help offset the cost of the prescription drug benefit?

A. As we've said, we believe that other offsets must contribute to the cost of this benefit. But before we even contemplate using the 15 percent of the surplus for anything other than extending the life of the program, we need to finalize the design of drug benefit, determine its costs, and assess whether the offsets are sufficient. We believe, however, that no one should rush into using the surplus for this or any other purpose.

Q. Will your plan include an income-related premium?

A. The President supported this policy in the past, including in his 1992 campaign, the 1993 Health Security Act, and again during the Balanced Budget Act discussions in 1997. It is certainly being discussed, but, again, we have made no final decisions whether it is necessary or advisable to

include in the President's package.

Health- Medicare Committee

THE WHITE HOUSE

WASHINGTON

NEC MEDICARE PRINCIPALS' MEETING

Room 248, March 18, 1999

AGENDA

I. BREAUX-THOMAS PLAN

- Summary and issues

II. PROCESS AND TIMING

- Baseline issues (Medicare Trustees 1999; CBO)
- Timing relative to Breaux-Thomas plan introduction and mark-up
- Congressional Democrats interaction / input
- Legislative language

III. UPDATE ON ONGOING WORK / FUTURE DISCUSSIONS

- Drug coverage: Additional options, distributional information, background
- Cost sharing package
- Premium support issues
- New Medicare Board issues
- Merging Medicare's Trust Funds issues

BREAUX-THOMAS MEDICARE REFORM PLAN

March 18, 1999

CONTRIBUTIONS TO MEDICARE DEBATE

- **Appears to Maintain Guarantee of Defined Benefits**: Appears to ensure that beneficiaries receive the current Medicare benefits in both traditional Medicare and in private plans.

- **Modernizes Traditional Medicare**: Allows the Health Care Financing Administration to use the effective, competitive management tools that are used in the private sector.

- **Puts Balanced Budget Act Extenders on the Table:** Extends policies to assure efficient payments to health care providers.

- **Rationalizes Medicare Cost Sharing**: Although we are still reviewing the details, the plan acknowledges that some of Medicare's cost sharing provisions should be restructured.

MAJOR CONCERNS

- **Does Not Address Medicare's Financing**: Although the Medicare Trust Funds are merged, there is no additional funding recommended for Medicare. It recommends waiting to act until Medicare's solvency is at risk.

    - As the baby boom generation retires, enrollment in Medicare will double -- no amount of reducing Medicare spending can compensate for this. Waiting to find new revenues will make the problem harder to solve and shift more of the burden to our children. This is why the President proposed to dedicate part of the surplus to Medicare immediately, to save some of today's prosperity for tomorrow's needs.

- **Raises the Age Eligibility for Medicare**: Gradually, Medicare eligibility age will be increased from 65 to 67. People losing Medicare eligibility could buy into Medicare.

    - Without a policy to provide assistance to low-income people no longer eligible for Medicare, there could be large increases in the numbers of the uninsured.

- **Includes Flawed "Premium Support" Plan**: Limits the amount that the government pays per beneficiary -- so that beneficiaries choosing low-cost plans pay less, and those choosing high-cost plans pay more. Private plans also can offer extra benefits and vary cost sharing.

    - The President is committed to adding competition and private sector approaches to Medicare, but not at the risk of harming the existing program or its beneficiaries. The Breaux-Thomas premium support model has the potential to increase the costs of the traditional Medicare program, even for beneficiaries with limited alternatives.

- **Adds limited drug benefit:** Provides Medicaid funding to cover prescription drugs for beneficiaries with income below 135 percent of poverty ($11,000 for a single, $15,000 for a couple). Also requires all Medicare and Medigap plans to offer a drug benefit.

- Without insurance reforms or government assistance to ensure that the premiums are affordable, the expanded access will help few beneficiaries. Moreover, most health economists agree that the current system's patchwork drug coverage is highly inefficient and expensive. Only by making a drug benefit affordable for all beneficiaries can the

OTHER ISSUES

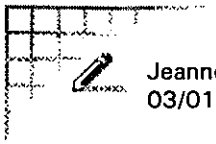
- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. Provides no details of how this would be funded. The amount transferred ($40 billion over 10 years) is counted towards the Commission staff estimates of $100 billion in savings from the proposal -- savings to the Federal budget would actually be $60 billion over 10 years.

- **Adds an unlimited home health copay**: Charges beneficiaries 10 percent coinsurance for home health visits, without any limit on the cost sharing. For the over 1 million beneficiaries who have more than 60 visits in a year, this cost sharing could represent a large financial burden.

- **Creates New, Powerful Medicare Board**: A new Board, exempt from executive branch rules, would be given a broad range of powers including enforcing financial and quality standards, approving benefits packages and rates, deciding on service areas, and computing payments to plans. It appears that it has some authority over Medicare fee-for-service as well as private plans.

- **Merges Medicare's Parts A and B**: Recommends merging these two trust funds, and capping the general revenue contribution at 40 percent of Medicare spending. This general revenue contribution will be less than current law over time, creating a bigger financing problem than the one that we already have.

Health - Medicare Commission



Jeanne Lambrew
03/01/99 07:46:30 PM

Record Type: Record

To: Elena Kagan/OPD/EOP, Laura Emmett/WHO/EOP

cc: Christopher C. Jennings/OPD/EOP
Subject: daily for the POTUS

Medicare Commission Update. Today, Stuart Altman and Laura Tyson sent a list of suggested changes to Chairmen Breaux and Thomas on their reform plan. They have informed us that it is their belief that these changes are not negotiable but, rather, are what would be minimally acceptable for them to even consider voting to report out a Commission plan. Their recommendations are generally consistent with the principles for reform that you outlined. For example, they suggest including the surplus or an analogous proposal, adding an optional prescription drug benefit accessible and affordable to all beneficiaries, ensuring guaranteed benefits, and allowing 62 to 64 year olds to buy into Medicare.

However, the list also includes controversial elements such as raising the age eligibility from 65 to 67 so long as there is a subsidized Medicare buy-in and adding an income-related premium beginning at $50,000 (which is twice as high as recommended by the Commission but much lower than most of the Democratic base would contemplate). Although consistent with their past statements, the document reiterates their openness to premium support that meets the goals that they outline (e.g., adequate government payment, defined benefits).

This paper was sent confidentially, but we would be surprised if it doesn't soon become public. If it does, Senator Daschle, Congressman Gephardt and others can be expected to be critical on both substantive and political grounds. They will be particularly upset that your appointees continue to negotiate with Senator Breaux and Congressman Thomas at a time when they feel they have disregarded Democratic concerns. Having said this, it is unlikely that Senator Breaux will be able to obtain Republican support for all of Stuart and Laura's recommendations. If this is the case, then the Commission will likely report out with 9 or 10 votes, not the supermajority (11 votes) needed. We will keep you posted on any news.

Health-Medicare Commission

THE WHITE HOUSE

WASHINGTON

NEC MEDICARE COMMISSION PRINCIPALS' MEETING

Room 180; 3:15pm
February 22, 1999

AGENDA

I. PREMIUM SUPPORT (15 minutes)

- Policy
- Politics

II. OPTIONS (45 minutes)

- Guidance for Upcoming Commission Meetings

POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- Would likely reduce Medicare costs through competition.
- Better aligns Medicare with private health insurance.
- Gives beneficiaries more choices.

CONS

- Puts beneficiaries at risk for higher fee-for-service premiums and less stable private plan premiums.
- Could reduce extra benefits that current Medicare managed care enrollees receive.
- Significant regulation would be required to avoid two-tiered Medicare.

OPTIONS

IF COMMITMENT THAT THE PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

- **Work to improve details**

IF NO COMMITMENT THAT PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

1. **Rest on principles**

2. **Develop an alternative that includes premium support**

3. **Develop an alternative that includes the common denominator provisions, states an openness to premium support that is consistent with principles.**

Health - Medicare Commission

NEC MEDICARE COMMISSION PRINCIPALS' MEETING

Roosevelt Room; 3:15pm
February 22, 1999

AGENDA

I. PREMIUM SUPPORT (15 minutes)

- **Policy**
- **Politics**

II. OPTIONS (45 minutes)

- **Guidance for Upcoming Commission Meetings**
- **Response to Commission Vote**

POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- **Would likely reduce Medicare costs through competition.** Premium support encourages beneficiaries to choose lower cost health plans by giving them a financial incentive to do so. Depending on how premium support is structured, efficient plans can attract beneficiaries by offering lower premiums or additional benefits. As beneficiaries move to lower-cost plans, the national average Medicare spending is reduced (or doesn't grow as fast as it would have), thus reducing Federal Medicare costs over time.

- **Better aligns Medicare with private health insurance.** Today, Congress and the President must make explicit changes to Medicare reimbursement levels to control program costs. While over time the growth in Medicare has roughly matched private health insurance growth, cost control is cumbersome and subject to significant political constraints. Under premium support, Medicare spending is more dependent on the ability of private plans to achieve efficiency, which should more closely align the growth of future government Medicare spending with the overall level of efficiency achieved by private health insurers.

- **Gives beneficiaries more choices.** Today, beneficiaries enroll in managed care plans because, in some areas, those plans can offer extra, free benefits. Under this proposal, beneficiaries can lower their Medicare premiums by enrolling in low-cost plans and, under some proposals, also get some extra benefits. Premium support also has the potential to attract more private plans to participate in Medicare or extend their market area, since they would have new flexibility to use financial incentives to attract beneficiaries.

CONS

- **Puts beneficiaries at risk for higher fee-for-service premiums and less stable private plan premiums.** Under premium support, the Medicare fee-for-service premium would likely be higher than that of private plans -- especially if traditional Medicare is not allowed to use the same management tools as private plans. This could be exacerbated if sicker people stay in fee-for-service, driving up costs. Also, beneficiaries choosing private plans could face premiums that vary considerably from year to year, similar to what happens in the private sector. This instability could cause anxiety for beneficiaries.

- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under premium support, a greater share of the efficiency savings accrue to the government, reducing the amount that can be provided as additional benefits.

- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- rather enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, premium support could have the unintended effects of creating higher premiums for people who are sick and low-income.

POLITICAL PROS AND CONS OF SUPPORTING PREMIUM SUPPORT

PROS

- **Increases the likelihood of bipartisan agreement on Medicare -- and Social Security.** Without premium support, it is unlikely that Republicans will consider any type of Medicare legislation -- including a bill that includes the surplus or a prescription drug benefit.

- **Enhances credibility as real reformers, increases elite validation.** Most economist and elite media consider premium support "real" reform. An openness to it would end Republican criticism that we only want an election issue or only more revenues and benefits for Medicare.

- **Although still challenging, would increase the likelihood of a drug benefit for all beneficiaries and new purchasing tools for the traditional program.** Republicans will clearly not consider either a drug benefit or the modernization proposals for Medicare fee-for-service without premium support. Thus, an openness to premium support could open the door to these desired changes.

- **Winning a drug benefit and the dedication of the surplus in return for premium support may be a good trade.** The complexity and controversy surrounding premium support will necessitate it being phased in and otherwise altered. Therefore, it is likely the surplus transfer would begin in 2000, the drug benefit in 2001, but premium support on a more phased-in basis. Thus, we could get credit for being supportive without having to address its immediate effects.

- **Defining acceptable premium support at the beginning of the debate could give us more credibility in opposing it if, at the end, Congress passes a flawed version.** An early openness to premium support may prevent criticism that we only signed onto this idea because we want to get prescription drugs. It could also offer us the opportunity to define what a good premium support plan would be -- laying the groundwork for a veto if necessary.

CONS

- **Lose the opportunity to end the momentum toward a Commission recommendation that will likely produce a flawed premium support and inadequate prescription drug benefit.**

- **Will alienate Democratic base, particularly in the House, which is concerned that premium support undermines Medicare's guarantees.** Base Democrats generally think that the risk of something bad coming out of any negotiation far exceeds any potential for a positive outcome -- even if that means a prescription drug benefit. Moreover, they believe that a Medicare compromise will help the Republican party far more than the Democratic party in 2000.

- **Even if accompanied by a drug benefit and the surplus, the fear of higher premiums and elderly dissatisfaction may outweigh benefits.** High costs and less certainty will always be much more threatening and politically volatile to the elderly than the promise of a new benefit. This is particularly the case given the low odds that a good drug benefit and premium support proposal could emerge from a Republican Congress.

- **Weakens our leverage during the legislative process and could make it difficult to oppose premium support at the end of the process -- particularly if included in a broader reconciliation.** The only message that the public will hear will be our support for premium support. Once that message is solidified, it will be extremely difficult to justify any opposition to premium support, no matter how flawed the particular proposal. Such opposition would be considered political rather than substantive.

- **Opposition to premium support could unify beneficiary and provider groups.** Political weapon.

OPTIONS FOR FEBRUARY 23, 24 MEETINGS

IF COMMITMENT THAT THE PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

- **Work to improve details**

IF NO COMMITMENT THAT PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

1. **Rest on principles**

   PROS
   - Slows down momentum for flawed Breaux plan.
   - Probably the most acceptable to Congressional Democrats who want neither a plan nor an extension of the Commission.
   - Sets the stage for a specific plan by the President.

   CONS
   - Would be criticized by Breaux, Republicans and elite media as evidence of our interest in the status quo rather than reform.
   - Undermines chances for a reasonable compromise with Republicans on Medicare reform.

2. **Develop an alternative that includes premium support**

   PROS
   - Extricates ourselves from the Commission process while maintaining support for premium support, which will be validated by elites as "true" reform.
   - Increases the likelihood that the elite media will critique and undermine the work product of the Commission.
   - Could serve as a trial balloon for an Administration proposal.

   CONS
   - Probably impossible to get base Congressional Democrats to agree on a plan with premium support.
   - Onus of developing a viable Medicare reform package falls completely on us; there would therefore be no bipartisan political cover for controversial provisions. Also, may not be feasible given its complexity in a short time frame.
   - Preempts the option of a proposal by the President. ??

Plan w/out premium support!? e.g. why —

3. **Develop an alternative that includes the common denominator provisions, states an openness to premium support that is consistent with principles.**

PROS

- Extricates ourselves from the Commission process without having to lay out all the details of a controversial and difficult to design premium support plan.
- We might be able to maintain elite support if Laura and Stuart suggest that we are seriously open to a premium support option.
- Gives us the time to find common ground between base Democrats and moderate Republicans and Democrats on premium support.

CONS

- Just as serious likelihood that elites will critique us as not being serious.
- Democrats will still be nervous that we are validating premium support as a credible reform proposal.

Health - Medicare commission

Medicare Comm.

MEDICARE COMMISSION, JANUARY 22, 1999

DRAFT REFORM PLAN. Senator Breaux released a "draft working document" on Medicare on January 21. It includes:

- **Premium support**: A combination of a defined contribution / defined benefit approach.
  - ***FEHBP-like model***: Medicare would pay a percent of whatever the plan's premium is up to a cap (the national average premium) for benefits at least actuarially equivalent to those in current Medicare. – won't save $
  - ***Alternative: Competitive pricing / Reischauer-like model***: Medicare and private plans would bid on an identical set of benefits. The government contribution would be set at the median premium. People pay more for plans above the median premium, nothing for plans below.

Poderton:

– some competitive savings
– Gramm, others oppose

- **Reforms similar to Senate Finance Committee's 1997 BBA:**
  - ***Raises Medicare's age eligibility***: Conforms to Social Security, suggests a Medicare buy-in proposal could be included.
  - ***Income-related premium***
  - ***Home health co-payment***

D's want
– drugs (HMO + fee for service)
– low income protection
– modernize

$40-120 B/5 yrs.

- **Replaces most of HCFA with a separate "Medicare Board", reforms graduate medical education**

IMPLICATIONS

- **Democratic principles**: Does not conform with Democrats' principles that include:
  - Equal, defined benefits for fee-for-service and managed care
  - Prescription drug benefit -- in a section called "areas that need resolution"
- **May not save much money:** FEHBP model probably does not save much money,
  - Alternative approach would probably save money, but not fully developed
  - Provider payment reductions -- in a section called "areas that need resolution"
- **Timing:** Next public meeting: January 26; Final report is due on March 1

guaranteed core benefit pkg.

a weakening of Medicare core pkg

QUESTIONS

- What is an acceptable outcome for the Commission
    - What should our role be in achieving that outcome (both with respect to Senator Breaux and Democratic appointees)

- If a compromise looks unlikely, how do we want to position the Administration

Chris
45[illegible]5557

DRAFT WORKING DOCUMENT
Medicare Commission

January 21, 1999 (6:03pm) c://breaux/wpwin/mark_2

This document is guided by the statute creating the National Bipartisan Commission on the Future of Medicare and is a product of what we learned through the process of the Commission's meetings and work over the past year.

As directed by statute, the Commission must address Medicare's financial instability and make recommendations addressing the solvency crisis facing the program. Once Medicare is on firmer fiscal footing, our first priority should be to modernize and rationalize Medicare's benefit package. Using a portion of any budget surplus that materializes to shore up Medicare can help, but it won't solve the problem. Premium or tax increases should not be considered until the Commission addresses the government's ability to meet its commitment to fund Medicare's current benefit package.

One of our early witnesses, Robert Reischauer, expressed the problems facing the Medicare program in terms of the four "i's": insolvency, inadequacy, inefficiency and inequity. In terms of its solvency, there are many indicators of Medicare spending and its projected impact on the budget. For example, Medicare will grow from 12 percent of the federal budget to 28 percent in 2030 under our most optimistic baseline. Medicare's Hospital Insurance (HI) trust fund, which is funded primarily with payroll taxes, will take in less revenue than it pays out in Part A benefits beginning in 2008. The program is inadequate insofar as its benefits package does not reflect modern notions of comprehensive health care coverage and isn't comparable in scope, quality and structure to the health benefits generally available to employed persons and their dependents. The system of government-administered pricing causes inefficiencies in the way health care services are delivered to seniors and providers have little incentive to provide the most cost-effective care. Lastly, the current program is inequitable in that there is no geographically uniform or constant set of benefits. If a beneficiary lives in southern California or Florida, Medicare will pay for prescription drugs or dental benefits if the person joins an HMO. If a beneficiary lives in rural Nebraska, he or she gets nothing approaching such benefits. Additionally, beneficiaries who don't qualify for low-income subsidies or can't afford supplemental insurance must depend on a program that only covers an estimated 53 percent of their health care costs.

The proposal outlined below, which is based on a premium support model, aims to modernize Medicare's benefit design and correct the four "i's". It will allow beneficiaries to combine in an integrated and comprehensive form all sources of support for their health care coverage while ensuring that Medicare is more efficient and more responsive to beneficiaries needs. It also guarantees low-income protections so that all beneficiaries have meaningful access to quality health care including the

traditional Medicare fee-for-service plan.

The Commission's recommendations should be a blueprint for Congress to enact comprehensive legislation to fundamentally restructure Medicare over the next several years. Our nation's health care delivery system is constantly evolving and given the uncertainty of long-term health care spending projections and the advances in medical technology, Medicare will have to be revisited at regular intervals.

SUMMARY

- This proposal would model Medicare on a system patterned after the Federal Employees Health Benefits Program (FEHBP). This premium support system would allow for a blend of existing government protections and market-based competition. It would also guarantee financial protection for low-income beneficiaries.
- Medicare's fee-for-service program will operate as part of this new system and HCFA will be given the tools it needs to modernize and compete accordingly.
- This proposal will reform the Medigap program to make it more efficient and to try to minimize the adverse effects of first dollar coverage.
- The eligibility age for Medicare will increase to conform with the eligibility age increase scheduled for Social Security. A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.

I. PREMIUM SUPPORT

A. Administrative Structure

- A Medicare Board will be established to oversee and negotiate with private plans and the government run fee-for-service plan and to approve plan service areas. The board will have authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries.

B. Benefits Package

- Plans participating in Medicare would be required to offer a standardized core benefit package defined in statute (e.g., hospital, surgical, inpatient, etc.). Participating plans would have some flexibility on design details (i.e. cost-sharing, copays) but the Medicare Board would have final approval. Private plans participating in premium support will be required to offer benefits at least equivalent to the package offered in the government-run fee-for-service plan.
- Plans can offer additional benefits beyond the core package. Much like the negotiations process between plans and OPM in FEHBP, benefits will be

updated through the annual negotiations process between plans and the board. The board will be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.

- The benefits package in the government-run fee-for-service plan will be revamped by modernizing cost-sharing and by combining the Parts A and B deductibles. One example of a modernized cost-sharing structure would be to have a combined deductible of $350, charging 20% coinsurance for everything except hospital and preventive care and charging 10% coinsurance for home health.

C. CALCULATING MEDICARE'S PREMIUM

- The government-run fee-for-service plan will bid nationally based on its actual and projected claims costs. Other plans can choose to bid nationally, regionally or in local areas. The Board would oversee the designation of service areas to ensure access in areas that would otherwise have limited plan availability.
- Under an FEHBP system, total Medicare premiums for plans in a given area will be based on a national schedule similar to that used in the FEHBP system. The overall cost of plans will be based directly on their bids and the negotiations process with the Medicare Board.

a) *Government's Contribution*:

- The government's contribution will be based on a percentage of the national weighted average premium. Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental costs of choosing more expensive plans.
- The government's contribution as it is made to the plan that the beneficiary chooses will be adjusted for health risk and other factors.

b) *Beneficiary's Contribution*

- The beneficiary's contribution will be based on the cost of the plan chosen with beneficiaries paying a minimum percentage of the premiums based on their income. The government contribution will stop increasing and beneficiaries will pay the full incremental costs for plans above a certain threshold (e.g., 100% of the cost of average plan). Both the beneficiary and government contribution toward the cost of the average plan will rise and fall in the same proportion as the cost of that plan changes from year to year.
- Higher-income Medicare beneficiaries should be required to pay a larger share of their Medicare premiums than moderate and low-income beneficiaries. Income-related premiums will apply to both private plans and the government-run fee-for-service option. For example, low-income beneficiaries could contribute 10 percent of the premium with higher-income beneficiaries contributing up to 25 percent of the premium.
- Premium support subsidies should be sufficient to ensure that low-income

beneficiaries have access to necessary health services and have a meaningful choice of plan options. The revenue generated by income-relating the premium for upper-income beneficiaries will be primarily dedicated to subsidizing premiums for low-income beneficiaries. The first focus should be to enroll beneficiaries who are currently eligible for QMB and SLMB but who are not enrolled.

II. MODERNIZING MEDICARE FEE-FOR-SERVICE

The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries. In accordance with Congressional and Board oversight and approval, the government-run plan will have flexibility to modify its payments rates and its arrangements with contractors as well as offering benefit enhancements if they are financially feasible in a competitive environment.

- The government-run fee-for-service plan will have a premium just like the private plans participating in a premium support system. To enable the government-run fee-for-service plan to compete with private plans in a premium support system, HCFA would be given management tools adopted by the private sector. These reforms include things such as enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

III. MEDIGAP REFORM

- In order to keep fee-for-service costs affordable, Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost.

IV. MISCELLANEOUS

- Medicare's eligibility age will be gradually increased to match the Social Security retirement age. It is also recommended that Social Security and Medicare be reformed in conjunction with each other because of the interrelated effects of these programs on the retirement security of older Americans.
- A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.
- Graduate Medical Education: Payments for Direct Medical Education (DME) would be carved out of the Medicare program--financed and distributed independent of a premium support system. The Commission assumes that

federal support for DME would continue through either a mandatory or discretionary appropriations program. Since the funding source would shift from the HI payroll tax to general revenue, the Commission believes that it is appropriate to include institutions not currently eligible for Medicare GME support that conduct approved residency programs, such as free-standing children's hospitals. Similarly, the long-term solution for indirect medical education (IME) may involve a carve-out from Medicare. For now, however, the Commission believes that the Medicare program should continue to pay for differences in costs between teaching and non-teaching hospitals through the indirect medical education (IME) adjustment. However, the Commission recognizes that the level of the Medicare IME adjustment may need to be aligned gradually over several years with what analyses show is the actual statistical difference between teaching and non-teaching hospital costs. The Commission believes that Disproportionate-Share Hospital (DSH) payments and other subsidies within the Medicare program should be revisited to ensure that Medicare's support is reasonable and appropriate. The Commission notes that these subsidies could be carved out of the Medicare program and financed through a mandatory or discretionary appropriation program. However, the Commission recognizes that any changes in federal support should continue to recognize the additional costs to hospitals of treating large numbers of low-income individuals.

V. REVENUE AND FINANCING

- The primary source of income to the Hospital Insurance (HI) trust fund is the payroll tax. The 2.9 percent tax on all earned income accounts for 88.3 percent of the total $121.1 billion in income in 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.
- The Supplementary Medical Insurance (SMI) trust fund is financed from premiums paid by the users of Part B and from general revenues. When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Premiums over time dropped to 25% of program costs because Part B costs increased much faster than the inflation computation that was used to compute the upward premium adjustment.
- Under current law, the proportion of financing sources are expected to change over time, with the portion represented by payroll taxes decreasing and the portion represented by general revenue increasing. By 2030, premiums and payroll taxes are expected to fund only 31-35 percent of Medicare's expenditures compared to 63 percent in 1997. In 2030, 64-70 percent of

Medicare will be funded through general revenue (or other funding) as compared to approximately 28 percent in 1997.

- The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms will result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and will enhance our ability to stand by our commitment to today's and future beneficiaries. Even if projected budget surpluses materialize, without these changes, significantly greater revenues and/or beneficiary sacrifices will be required in the future and beneficiaries will not receive the greatest value for the total health dollars spent on their behalf.

VI. AREAS THAT NEED RESOLUTION

- DRUGS—open issue-Democrats are exploring ways to include an affordable drug benefit in Medicare's fee-for-service program.

- Changes to provider payments

ALTERNATIVE DESIGN OPTIONS

Following are examples of elements of a premium support system that could be changed to arrive at a different model than the one described above.

National vs. Regional Bidding: Under a national bidding structure, a geographic adjuster is necessary to create a fair and equitable system. A geographic adjuster would also address the fact that Medicare spending varies by a factor of more than three across regions with seemingly similar populations and with no demonstrable differences in health outcomes. Under a national schedule, national plans such as the government-run fee-for-service could compete in a straightforward and fair way. Beneficiaries in national plans would pay the same amount regardless of where they lived. Under a regional bidding system, a geographic adjuster would not be required but some provision would have to be made to allow fair competition between local and national plans such as fee-for-service and to prevent regional inequities in beneficiary premiums.

- Benefits Package: Plans would be required to offer and compete on a core benefits package. Unlike the model described above, additional benefits could be offered in a supplemental plan that would have to be sold and marketed separately from the core package. This would ensure that plans compete on the basis of cost and quality, not on the basis of the benefits offered.

is intended to

Health-Medicare Commission | Could do administratively or legislatively.

HMO's want to unwind risk adj mech in current law, to be implemented in 2000. Cost – 800 m - 1.5b in 1st year. Extraordinary pressure to reform this. Low-low. Any: otherwise HMOs will drop out.

Medicare Commission / Budget / Social Security Issues
November 19, 1998

BUDGET

- Adopting private sector, competitive purchasing practices
- Program integrity (fraud and abuse)

Tops - 1-5b, over 5

- Medicare HMO withdrawals
  - Risk adjustment
  - Rate reform
  - Medigap reform

Package - but not a lot of steps - worried about plans withdrawing some whole programs if no exit option.

- Medicare buy-in for 55 to 65 year olds
- Fixing premium assistance program for low-income beneficiaries / outreach

OVERLAPS WITH SOCIAL SECURITY REFORM

- Funding issues:
  - Use of the surplus
  - Effects of change in payroll tax
  - Implications of privatization of Trust Fund on Medicare debate
- Eligibility changes:
  - Age eligibility for Medicare, Social Security / effects on retirement age
- Benefit / payment changes:
  - Implications of Social Security defined contribution on Medicare debate
  - Interaction between Medicare premiums, Medicaid and Social Security
  - Allocation of responsibility between government & beneficiaries (long-term care)
- Population groups:
  - Disability
  - Women and minorities

LARGE ISSUES IN THE MEDICARE COMMISSION

rationalize benefit structure - deductibles/co-payments etc. probably impossible to do budget-neutrally

- Prescription drug coverage and modernizing Medicare cost sharing
- FEHBP model of "premium support"
- Graduate medical education

DRAFT

PRINCIPALS TO GUIDE THE MEDICARE COMMISSION RECOMMENDATIONS

Any Medicare proposal should:

- **Adopt private sector, competitive practices**: Historical, statutory, and regulatory barriers prevent Medicare from adopting some of the successful payment policies used by private health plans to control health costs. Any proposal should allow and encourage the Health Care Financing Administration to adopt such practices to better contain costs.

- **Allign Medicare per capita cost growth with the private sector rate**: The rate of growth of private sector health care costs takes into account both the unique effects of technology on health costs and the cost control achieved through innovative practices. Even though Medicare beneficiaries are sicker and more difficult to manage than privately insured people, private health spending growth should be a goal of any Medicare reform proposal.

- **Guarantee a minimum, modernized benefits package**: Today's Medicare benefits are more similar to private plans in the 1960s rather than the 1990s. For example, while most private plans today offer prescription drug coverage, Medicare does not. Additionally, Medicare has high cost sharing for certain benefits and does not offer protection against catastrophic health care costs. As a result, the majority of beneficiaries rely on other types of coverage (e.g., Medigap, employer plans, Medicaid), resulting in inefficiency and high out-of-pocket costs. Any reform proposal should both guarantee a basic set of health benefits and modernize those benefits to lessen the need for secondary health coverage.

- **Assure access to Medicare fee-for-service coverage**: While over 80 percent of privately insured people are enrolled in managed care, only 16 percent of Medicare beneficiaries are so enrolled. In part, this is because Medicare beneficiaries are older and more likely to be sick -- thus less likely to benefit from managed care. It may also reflect the lack of plan choices for beneficiaries; one in four beneficiaries today lives in a place with no private managed care option, and only about half have more than one plan to choose from. This year, Medicare is allowing a greater variety of plans to offer coverage, but to date, it has not resulted in a greater number of beneficiaries with choices. Thus, to ensure that Medicare beneficiaries have access to needed health care services, strong, modernized, more efficient Medicare fee-for-service coverage is essential to any reform proposal.

- **Protect low-income beneficiaries**: Nearly two-thirds of elderly households have income under $20,000. Already, these elderly pay about one-third of their incomes on out-of-pocket health care costs. Thus, any proposal should assure that such beneficiaries pay no more -- and possibly less -- than they do under current law.

Health - Medicare commission

THE WHITE HOUSE

WASHINGTON

March 4, 1998

DROP-BY MEETING WITH ADMINISTRATION APPOINTEES TO THE MEDICARE COMMISSION

DATE:	March 5, 1998
LOCATION:	Map Room
BRIEFING TIME:	10:00 am - 10:10 am
EVENT TIME:	10:15 am - 10:30 am
FROM:	Bruce Reed/Gene Sperling

I. PURPOSE

To meet privately with your appointees to the Medicare Commission, before your meeting with the full Commission later in the day. (*See separate briefing memo.*)

II. BACKGROUND

This will be the first opportunity for you to meet with your appointees to the Medicare Commission as a group and to offer them the full support and assistance of the Administration. You can take this time to introduce them to the members of your staff and assure them they will have access to the Administration. This is also an opportunity to thank them for their willingness to take on this important responsibility and for the thoughtful comments they have already been making publicly.

III. PARTICIPANTS

Briefing Participants:
Gene Sperling
Bruce Reed
Chris Jennings

Event Participants:
Secretary Shalala
Secretary Herman
Bruce Reed
Chris Jennings
Gene Sperling
Frank Raines
Janet Yellen

Presidential Appointees to the Medicare Commission:
Dr. Stuart Altman, Professor of Health Policy at Brandeis University, Waltham, MA
Dr. Laura D'Andrea Tyson, Former Economic Advisor now serving at the University of California-Berkeley
Dr. Bruce Vladeck, Former Head of the Health Care Financing Administration
Mr. Anthony L. Watson, President and CEO of HIP Health Care Corporation

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will enter the Map Room, greet the guests, and take your seat.
- **YOU** will briefly make informal remarks and then depart.

VI. REMARKS

Remarks Provided by Jordan Tamagni in Speechwriting.

THE WHITE HOUSE

WASHINGTON

March 4, 1998

MEDICARE COMMISSION MEETING

DATE:	March 5, 1998
LOCATION:	Cabinet Room
BRIEFING TIME:	11:50 - 12:15 pm
EVENT TIME:	12:15 pm - 1:15 pm
FROM:	Bruce Reed/Gene Sperling

I. PURPOSE

To demonstrate your commitment to the work of the Medicare Commission.

II. BACKGROUND

You will be meeting with the 17 members of the National Bipartisan Commission on the Future of Medicare Commission, the Staff Director Bobby Jindal, and members of the Administration. The Commission is having their first meeting on Friday, and you have invited them to the White House to call attention to their important work and offer the support and assistance of the Administration to help them succeed in their efforts.

In the Balanced Budget Act, you preserved Medicare in the short term by providing for the extension of the Medicare Trust Fund for at least a decade with new structural reforms. You also made a commitment to secure the financial integrity of Medicare well into the 21th century by the formation of this bipartisan commission.

In the last 30 years, Medicare has provided essential high-quality health care to millions of Americans. Since its introduction the rate of uninsured elderly has dropped from 46% to 1%. Without Medicare, half of the elderly -- 15 million people -- could lack health insurance.

But as you know, Medicare faces great challenges. As the baby boom generation retires, the number of elderly will increase by 45% in the next 20 years, and by 2030 one in five Americans will be elderly. In addition, seniors will be living longer lives, and the higher costs of this larger Medicare population will be borne by a smaller workforce.

The goal of the Medicare Commission must be to meet the new challenges facing Medicare while preserving the basic tenets of the program: providing basic health care protections for older and disabled Americans.

III. PARTICIPANTS

Briefing Participants:
The Vice President
Gene Sperling
Bruce Reed
Chris Jennings
Larry Stein

Event Participants:
The Vice President
Secretary Shalala
Secretary Herman
Bruce Reed
Chris Jennings
Gene Sperling
Larry Stein
Frank Raines

Medicare Commission Members and Staff:
Dr. Stuart Altman
Dr. Laura D'Andrea Tyson
Dr. Bruce Vladeck
Mr. Anthony L. Watson
Senator John Breaux
Congressman Bill Thomas
Congressman Michael Bilirakis
Congressman John Dingell
Congressman Greg Ganske
Congressman James McDermott
Senator Bill Frist
Ms. Ilene Gordon, Assistant to Trent Lott
Senator Phil Gramm
Samuel Howard, President and CEO of Phoenix Health Care Corporation, Tennessee
Senator Robert Kerrey
Senator John Rockefeller
Ms. Deborah Steellman, Esq., Washington Lawyer who is a health policy specialist.
Bobby Jindal, Staff Director for the Commission

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- You and the Vice President will enter the Cabinet Room, greet guests, and take your

seats.
- The Press Pool will enter.
- **YOU** will make opening remarks.
- The Vice President will make brief remarks.
- Senator Breaux will make brief remarks.
- Congressman Thomas will make brief remarks.
- The Press Pool will depart.
- The meeting will proceed at your direction. You could begin by calling on Senator Breaux, and then select members.

VI. REMARKS

Remarks Provided by Jordan Tamagni in Speechwriting.

DRAFT Q&AS FOR MEDICARE COMMISSION EVENT

Q: IF YOU THINK MEDICARE IS SUCH A PRIORITY, WHY DIDN'T YOUR BUDGET DEDICATE REVENUES FROM THE ASSUMED TOBACCO LEGISLATION TO STRENGTHEN THE TRUST FUND -- LIKE SENATOR DOMENICI IS PROPOSING?

A: **First, I welcome Senator Domenici's comments because they, of course, assume a shared goal -- the passage of national, bipartisan tobacco legislation.** There is no doubt that the Congress, the states and many others will have a spirited debate over how exactly to use any revenue associated with tobacco legislation. Many thoughtful ideas, such as Senator Domenici's Medicare option, will no doubt emerge and we look forward to that discussion.

Our investment priorities for the tobacco legislation are aimed at helping children and the victims or potential victims of smoking. The budget dedicates almost all of any tobacco revenues towards initiatives designed to reduce smoking, help find treatments and cures for diseases associated with tobacco, and invest in our children through health care coverage, needed child care, and education. *We believe that these investments have a natural link to tobacco revenue and will make a major contribution toward preparing the nation for the 21st century.*

I certainly share the Senator's concern about the Medicare program. Two of the provisions of last year's Balanced Budget Act that I am most proud of relate to the Medicare program. The first was the package of reforms and savings that extended the life of the Medicare Trust Fund for over a decade. The second was the establishment of the Medicare Commission to begin addressing the long-term financing challenges facing the program.

But before we get in a big debate about how we invest dollars from a tobacco bill, we should work to do the heavy lifting of developing legislation that will help stop our nation's children from taking up smoking in the first place. After it is clear that we will succeed in accomplishing this long overdue goal, we can and we should have a thorough debate about the best way to invest tobacco revenues.

Q: ISN'T IT DISAPPOINTING THAT YOUR OWN CHAIRMAN OF THE MEDICARE COMMISSION HAS DECLARED THAT YOUR MEDICARE BUY-IN PROPOSAL IS DEAD FOR THIS YEAR?

A: **I do not believe that is what Senator Breaux has said, but I am not going to speak for him.** I will say that Senator Breaux has accurately stated that the Medicare Commission will look into this issue as well as a wide range of other issues.

I do not believe he or most other Members of Congress would needlessly delay providing a targeted expansion of health coverage for a vulnerable population if we are successful at achieving a consensus to move forward this year. It is my job to work with the Congress to achieve that consensus and I intend to just that. With Senator Moynihan's help, I think we will succeed.

As CBO confirmed yesterday, the Medicare buy-in proposal is a financially responsible and targeted policy that addresses a vulnerable population that the private insurance market has failed to serve. CBO concluded that the policy is paid for and would not harm the Medicare Trust Fund in any way.

Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. We cannot continue to come up with excuses to not address this problem.

While the work of the Medicare Commission is extremely important, I do not believe that the American public would sanction holding up a targeted, important proposal that would help hundreds of thousands of Americans with access to health insurance. I am confident that as Congress examines the needs of this population and the proposal to address it, the necessary consensus to move this legislation forward will be achieved.

Q: ISN'T THIS EXACTLY THE WRONG TIME TO PROPOSE EXPANDING MEDICARE -- JUST WHEN THE COMMISSION IS GOING TO MAKE RECOMMENDATIONS ABOUT THE OVERALL FINANCING OF THE PROGRAM?

A: Once again, this is a targeted proposal that is paid for within the Medicare program and therefore does not add any new burdens to the program. As such, it does not conflict with the Commission's work in this area.

Q: YOU HAVE INDICATED YOUR SUPPORT FOR MEANS-TESTING BY INCOME. SHOULDN'T THERE BE AN INCOME-RELATED PREMIUM FOR MEDICARE?

A: Ever since I took office, I have supported the concept of an income-related premium for Medicare as long it was done in a thoughtful workable manner and that it was done in the context of broader reforms that make the program stronger. I included in my first health care reform proposal in 1993 and I indicated my support for it last year during the Balance Budget discussions. I am certain the Commission will review options in this area and I look forward to its recommendations.

Q: WHAT DO YOU THINK OF GINGRICH'S "NO TAX PLEDGE" THAT HE HAS ASKED ALL HIS APPOINTEES TO THE COMMISSION TO TAKE?

A: I don't know that any additional revenues will be necessary. That is the Commission's job to tell us. Having said this, I of course do not believe that any preconditions should be placed on anyone to participate on any Commission. I hope this Commission will look at a range of options before making any final determinations. It is certainly worth noting that Senator Domenici has proposed using tobacco taxes to fund the Medicare program. But again, I do not think we should preclude anything at this point.

PRESIDENT WELCOMES MEDICARE COMMISSION AND MAKES STRONG COMMITMENT TO PREPARE MEDICARE FOR THE RETIREMENT OF THE BABY BOOMERS
March 4, 1998

Today, meeting with the newly appointed Medicare Commission, the President stated his strong commitment to work with Chairman Breaux, Congressman Thomas, and the rest of the Commission to develop a bipartisan consensus for future reforms to the Medicare program that prepare it for the retirement of the baby boom population. In so doing, he highlighted the great achievements of Medicare and the important contributions that the Balanced Budget Act (BBA) made to strengthening and improving the program. The President indicated that he is confident the Commission can build on the successes of last year's Medicare reforms and take the next steps to prepare the program for the unprecedented demographic challenges it faces. He also urged the Commission to never forget that Medicare is more than just a program of policies and numbers; it is a national commitment that serves almost 40 million of our most vulnerable Americans.

MEDICARE HAS BEEN ONE OF THIS CENTURY'S GREATEST ACHIEVEMENTS -- IMPROVING THE HEALTH OF MILLIONS OF AMERICANS. In the last 30 years, the Medicare program has provided high-quality health care to millions of older Americans and people with disabilities. Since the program was signed into law:

- **The rate of uninsured elderly has dropped from 46 percent to 1 percent.** Today, about 15 million Americans could go uninsured without Medicare's guarantee of coverage.

- **Older Americans are living 20 percent longer.** A 65 year old today can expect to live until the age of 82; whereas in 1960, a 65 year old lived on average until the age of 79. This is partly attributable to Medicare's expansion of needed health care coverage to older American.

- **The poverty rate has dropped by over half.** Medicare has contributed to decreasing poverty among older Americans. Today, about 11% of people ages 65 and older are poor, compared to 29% in 1966.

THE BIPARTISAN BALANCED BUDGET ACT INCLUDED UNPRECEDENTED MEDICARE REFORMS. One of the most important achievements of the Balanced Budget Act the President signed into law last summer was its unprecedented reforms to the Medicare program. This bipartisan effort strengthened the life of the Medicare Trust Fund for at least a decade from now, included new health plan choices, and added coverage of preventive benefits. It:

- **Extended the life of the Medicare Trust Fund for at least a decade.** Through a series of payment and structural reforms, the BBA extended the life of the Medicare Trust Fund for at least a decade from today. This achievement built on the President's 1993 budget which extended the Trust Fund for three years.

- **Contained important new preventive benefits.** The Balanced Budget Act included new preventive benefits including annual mammograms for all Medicare beneficiaries over forty; regular pap smears and pelvic exams; diabetes management benefits, and regular colorectal cancer screening.

- **Enacted important new structural reforms.** The BBA also included new market-oriented reforms, such as adding new plan choices including Provider Sponsored Organizations, Preferred Provider Organizations, prospective payment system reforms, and a number of prudent purchasing provisions that allow Medicare to buy services in the same way private health plans do.

- **Growth in line with private spending.** Because of the important BBA reforms, Medicare growth per beneficiary will actually be slightly less than projected private insurance spending growth: 4 percent versus 5 percent between 1997 and 2002.

STRENGTHENING MEDICARE FOR THE RETIREMENT OF THE BABY BOOMERS. While the Balanced Budget Act strengthened Medicare in the short term, the program will face new challenges as the baby boomers retire. The President highlighted some of these challenges and made a strong commitment to work with the Commission to develop consensus for long-term Medicare reforms. The challenges include:

- **An unprecedented number of Americans will enter Medicare as the baby boom generation retires.** The number of elderly will increase by 45 percent in the next 20 years. By 2030, one in five Americans will be elderly.

- **The ratio of workers to Medicare beneficiaries will drop significantly by 2030.** The number of workers per Medicare beneficiaries will decline from 3.9 to 2.3 during this period, straining the financing of the Medicare program, which is partly financed through a payroll tax.

The President reiterated his confidence that the Commission, working with Congress and the Administration, will successfully meet the new challenges facing the Medicare program. He pointed out that the American people have always been able to reach consensus to address this extremely important program, which provides needed services to tens of millions of Americans.

DRAFT Q&AS ON MEDICARE COMMISSION

Q: IF YOU THINK MEDICARE IS SUCH A PRIORITY, WHY DIDN'T YOUR BUDGET DEDICATE REVENUES FROM THE ASSUMED TOBACCO LEGISLATION TO STRENGTHEN THE TRUST FUND -- LIKE SENATOR DOMENICI IS PROPOSING?

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But before we get in a big debate about how we invest dollars from a tobacco bill, we should work to do the heavy lifting of developing legislation that will help stop our nation's children from taking up smoking in the first place. After it is clear that we will succeed in accomplishing this long overdue goal, we can and we should have a thorough debate about the best way to invest tobacco revenues.

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While the work of the Medicare Commission is extremely important, I do not believe that the American public would sanction holding up a targeted, important proposal that would help hundreds of thousands of Americans gain access to health insurance. I am confident that as Congress examines the needs of this population and the proposal to address it, the necessary consensus to move this legislation forward will be achieved.

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A: Ever since I took office, I have supported the concept of an income-related premium for Medicare as long it was done in a thoughtful, workable manner and that as long as it was done in the context of broader reforms that make the program stronger. I included this proposal in my first health care reform proposal in 1993 and I indicated my support for it last year during the Balanced Budget discussions. I am certain the Commission will review options in this area and I look forward to its recommendations.

Q: WHAT DO YOU THINK OF SPEAKER GINGRICH'S "NO TAX PLEDGE" WHICH HE HAS ASKED ALL HIS APPOINTEES TO THE COMMISSION TO TAKE?

A: I don't know that any additional revenues will be necessary to address the challenges that the Medicare program faces. That is the Commission's job to tell us. Having said this, I do not believe that any limitations should be placed on the work of the Commission. I hope this Commission will look at a range of options before making any final determinations. It is certainly worth noting that Senator Domenici has proposed using tobacco taxes to fund the Medicare program. But again, I do not think we should preclude anything at this point.

Health - medicare commission

SCHEDULING REQUEST FEBRUARY 17, 1998

___ACCEPT ___DECLINE ___PENDING

TO: Stephanie Street, Director of Scheduling

FROM: Bruce Reed, Assistant to the President for Domestic Policy
Gene Sperling, Assistant to the President for Economic Policy

REQUEST: To drop-by a meeting with the President's appointees to the Medicare Commission.

PURPOSE: To privately meet with the President's appointees to discuss their objectives for the Medicare Commission.

BACKGROUND: The evening before the President's meeting with the full Medicare Commission, Chris Jennings, Gene Sperling, and Larry Stein will brief the four presidential appointees. The President may want to drop by this meeting as well. The Presidential appointees include: Stuart Altman, Laura D'Andrea Tyson, Bruce Vladek, and Anthony L. Watson.

DATE: March 5, 1998

LOCATION: The White House

PARTICIPANTS: The President
Bruce Reed
Gene Sperling
Larry Stein
Chris Jennings
Stuart Altman
Laura D'Andrea Tyson
Bruce Vladek
Anthony Watson

REMARKS REQUESTED: Yes

MEDIA: Closed press.

CONTACT: Bruce Reed (6-6515)
Christa Robinson (6-5165)

SCHEDULING REQUEST FEBRUARY 17, 1998

___ACCEPT ___DECLINE ___PENDING

TO: Stephanie Street, Director of Scheduling

FROM: Bruce Reed, Assistant to the President for Domestic Policy
Gene Sperling, Assistant to the President for Economic Policy

REQUEST: To meet with the Medicare Commission Members.

PURPOSE: To speak to the new Medicare Commission Members before they begin their review of the Medicare system. This is an opportunity for the President to personally communicate his ideas and goals for the commission.

BACKGROUND: The Commission was appointed in December, 1997 to look at the long-term financial condition of the Medicare Program. The Commission includes 17 members, four of whom are Presidential appointees. Senator Breaux was recently named the Chairman of the Commission.

DATE: March 5, 1998

LOCATION: The White House

PARTICIPANTS: The President
Senator Breaux
Staff Director
17 Commission Members

REMARKS REQUESTED: Yes

MEDIA: Closed press, with possible photo-op or pool spray.

CONTACT: Bruce Reed (6-6515)
Christa Robinson (6-5165)

OMB Estimates of the FY 1998 President's Budget Medicaid Proposals
(dollars in billions)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Total 1998 - 2002	Total 1998 - 2007
FY 1998 President's Budget Baseline	104.4	111.2	119.6	129.1	139.2	150.8	163.4	177.4	192.2	208.4	603.4	1,495.5
Savings												
Per Capita Cap	0.0	0.0	-0.8	-2.4	-4.0	-6.6	-9.9	-13.6	-17.7	-22.3	-7.2	-77.2
DSH (net of pools)	0.2	-1.6	-3.3	-4.9	-5.6	-7.0	-7.6	-8.2	-8.9	-9.6	-15.2	-56.4
Subtotal Savings	0.2	-1.6	-4.1	-7.3	-9.7	-13.6	-17.5	-21.8	-26.6	-31.8	-22.4	-133.6
Welfare												
Legal Immigrant Provisions	0.6	0.8	1.0	1.2	1.3	1.5	1.6	1.7	1.9	2.0	4.9	13.5
Keep Medicaid for Disabled Kids	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.3	0.6
Refugee/Asylee Exemption	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Kids Initiatives												
12 Month Eligibility	0.3	0.5	0.7	1.0	1.2	1.3	1.4	1.5	1.6	1.8	3.6	11.2
Indirect Impact of Kids Health Demos	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.5	1.1	3.4
Other												
Puerto Rico	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Extension of VA Sunset	0.0	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	1.2	3.2
Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Raise DC FMAP to 70%	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.9	2.3
Interactions												
Part B Premium Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.9	1.2	1.5	1.8	0.8	6.8
Total Net Savings	1.4	0.4	-1.4	-3.9	-5.8	-9.0	-12.4	-16.1	-20.3	-24.9	-9.3	-91.9
New Outlays	105.8	111.6	118.2	125.2	133.4	141.8	151.0	161.3	171.9	183.5	594.2	1,403.6

Health - Medicaid Proposals

CBO Estimates of the Final FY 1998 President's Budget Medicaid Proposals
(dollars in billions)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Total 1998 - 2002	Total 1998 - 2007
CBO 1/97 Baseline	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4	1,541.2
Savings												
Per Capita Cap 1/	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-6.8	-8.7	-11.1	-13.8	-8.5	-54.3
DSH	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-7.7	-8.9	-10.2	-11.6	-16.6	-61.5
Pool Amounts												
FQHC/RHC	0.0	0.5	0.4	0.3	0.2	0.1	0.0	0.0	0.0	0.0	1.4	1.5
Transition Pool 1/	0.0	0.4	0.3	0.2	0.1	0.1	0.0	0.0	0.0	0.0	1.0	1.1
Subtotal Savings	-0.3	-1.7	-4.6	-6.8	-9.2	-11.8	-14.5	-17.6	-21.3	-25.4	-22.7	-113.2
Welfare												
Legal Immigrant Provisions	0.9	0.9	1.1	1.3	1.6	1.9	2.3	2.8	3.3	3.8	5.8	19.9
Keep Medicaid for Disabled Kids	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	1.0	2.5
Refugee/Asylee Exemption	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kids Initiatives												
12 Month Eligibility	0.9	0.9	1.0	1.0	1.1	1.2	1.2	1.3	1.4	1.4	4.9	11.4
Outreach - Kids Health Demos	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	1.8
Other												
Puerto Rico	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
Extension of VA Sunset	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	1.1	3.1
Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Raise DC FMAP to 70%	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9	2.3
Eliminate Vaccine Excise Tax	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1
Interactions												
Part B Premium Interactions	0.0	0.1	0.2	0.2	0.4	0.6	0.8	1.1	1.3	1.6	0.9	6.3
Total Net Savings	1.8	1.1	-1.6	-3.3	-5.1	-7.0	-8.9	-11.2	-14.0	-17.1	-7.0	-65.3
New Outlays	107.1	114.7	121.3	129.5	138.7	148.9	159.8	171.9	185.0	199.1	611.3	1,476.0

1/ **Memorandum:** The per capita cap and transition pool policies assumed in the initial CBO estimates do not reflect final policy decisions. The per capita cap growth rate in the final policy is equal to the growth in nominal GDP per capita plus 2% in 1997 and 1998 and 1% thereafter. Additionally, the transition pool in the final policy totals $1.0 billion over five years. CBO provided unofficial estimates of the final policy. CBO unofficially estimated gross savings of $22.7 billion over five years and net savings of $7.0 billion over five years from the final policy.

Medicaid Per Capita Cap and DSH Policies
CBO January 1997 Baseline
(Dollars in Billions)

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Total 1998 - 2002	Growth 1997 - 2002
CBO January 1997 Baseline									
Total Outlays	98.6	105.3	113.6	122.9	132.8	143.8	155.9	618.4	
Growth		6.8%	7.9%	8.1%	8.1%	8.3%	8.4%		7.8%
Per Capita Spending	2,876	3,031	3,219	3,429	3,653	3,900	4,179		
Growth		5.4%	6.2%	6.5%	6.5%	6.8%	7.1%		6.3%
CBO Scoring of Final FY 1998 President's Budget									
Per Capita Cap Savings	0.0	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-8.5	
DSH Savings	0.0	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-16.6	
Pools	0.0	0.0	0.9	0.7	0.5	0.3	0.2	2.4	
Total Cap/DSH Savings	0.0	-0.3	-1.7	-4.6	-6.8	-9.2	-11.8	-22.7	
Resulting Baseline	98.6	105.0	111.9	118.3	126.0	134.6	144.1	595.7	
Growth		6.5%	6.6%	5.7%	6.5%	6.8%	7.0%		6.4%
Resulting Per Capita	2,876	3,023	3,171	3,300	3,466	3,651	3,862		
Growth		5.1%	4.9%	4.1%	5.0%	5.3%	5.8%		4.9%
Per Capita Cap Assumptions:									
Growth in Nominal GDP Per Capita	3.90%	3.80%	3.70%	3.70%	3.80%	3.90%	4.00%		
Additive Factors	2.00%	2.00%	1.00%	1.00%	1.00%	1.00%	1.00%		
Index Growth	5.90%	5.80%	4.70%	4.70%	4.80%	4.90%	5.00%		5.0%
Estimates of CBO's Private Spending Growth Per Privately Covered Person									
Growth		3.8%	4.9%	4.8%	4.8%	4.6%			4.6%

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

- **Repeal Boren Amendment**

  Repeal the Boren amendment for hospitals and nursing homes, while establishing a clear and simple public notice process for rate setting for both hospitals and nursing homes.

  Modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to add a public notification process that provides an opportunity for review and comment, which should result in more mutually agreeable rates.

- **Eliminate cost-based reimbursement for health clinics**

  Federal requirements that most Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) be paid based on costs would be removed beginning in 1999; and a capped, temporary funding pool would be established to help these facilities during the transition.

Increase Flexibility in Program Eligibility

- **Allow Budget Neutral eligibility simplification and enrollment expansion**

  Enable States to expand or simplify eligibility to cover individuals up to 150 percent of the Federal poverty level through a simplified and expedited procedure. Current rules would be retained to the extent they are needed to ensure coverage for those who do not meet the eligibility criteria of the new option. Federal spending would be restrained by the per capita cap for current eligibles and such expansions would be approved only if they were demonstrated to be cost neutral (i.e. no credit for persons who were not otherwise Medicaid eligible in the determination of cap number).

  This proposal enables States to expand to new groups that are not eligible under current law without a Federal waiver. Administration would be streamlined and simplified in that States would be able to use the same eligibility rules for everyone eligible under the new percent-of-poverty option in place of the current plethora of different rules for different groups. Integrity of Federal spending limits would be maintained by the cost neutrality requirement.

- **Guarantee eligibility for 12 months for children**

  This proposal would permit States to provide 12-month continuous Medicaid eligibility for children ages 1 and older. (Continuous coverage was enacted for infants by OBRA 90.)

  This proposal would provide stable health care coverage for children -- particularly children in families with incomes close to the eligibility income limits, who often lose eligibility for a month due to an extra pay period within a month. This proposal would also reduce State administrative burden by requiring fewer eligibility determinations.

Eliminate Unnecessary Administrative Requirements

- **Eliminate OB/Peds physician qualification requirements**

  Federal requirements related to payment for obstetrical and pediatric services would be repealed. States would only have to certify providers serving pregnant women and children based on their State licensure requirements

  The minimum provider qualification requirements under current law do not effectively address quality of care. In addition, current law fails to recognize all bodies of specialty certification, so certain providers are precluded from participation in Medicaid (e.g., foreign medical graduates). Congress amended the law in 1996 to include providers certified by the American Osteopathic Association and emergency room physicians.

- **Eliminate annual State reporting requirements for certain providers**

  States would no longer have to submit reports regarding payment rates and beneficiary access to obstetricians and pediatricians.

  Current law assumes that access is linked to payment rates. However, the State-reported data do not reveal much regarding the link between payment rates and access.

- **Eliminate Federal requirements on private health insurance purchasing**

  Eliminate requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective.

  The current law provision is not necessary. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. The proposed per capita spending limits increase this incentive. The current, detailed, one-size-fits-all Federal rules hinder States from designing programs that most effectively suit local circumstances.

- **Simplify computer systems requirements**

  Eliminate detailed Federal standards for computer systems design. State systems would be held to general performance parameters for electronic claims processing and information retrieval systems.

  Current detailed requirements for system design were developed for an earlier time in which technology was primitive and detailed Federal rules were necessary to move States closer to what was then state-of-the-art. This is no longer the case. It is now sufficient to require States merely to show that their State-designed system meets performance standards established under an outcome-oriented measurement process.

- **Reduce unnecessary personnel requirements**

  We would work with States and State employees to replace the current, excessively detailed, and ineffective Federal rules regarding administrative issues that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.

<u>Increase Flexibility Regarding Managed Care</u>

- **Modify upper payment limit for capitation rates**

  Modify upper payment limit and actuarial soundness standards for capitation rates to better reflect historical managed care costs by requiring actuarial review of the rates.

  The current Medicaid upper payment limit for managed care contracts (i.e., 100% of fee-for-service) is not an accurate payment measurement for Medicaid managed care plans. It does not reflect historical managed care costs and States claim it is inadequate to attract plans to participate. This proposal would modify the definition of the UPL to more accurately reflect Medicaid spending. It would also modify actuarial soundness standards.

- **Convert managed care waivers [1915(b)(1)] to State Plan Amendments**

  Permit mandatory enrollment in managed care without federal waivers. States would be able to require enrollment in managed care without applying for a freedom of choice waiver [1915(b)(1)]. States would be allowed to establish mandate enrollment managed care programs through a State plan amendment. Qualified IHS, tribal, and urban Indian organization providers would be guaranteed the right to participate in State managed care networks.

  This proposal would provide States greater flexibility in administering their State Medicaid programs by eliminating the freedom-of-choice waiver application process. States would not have to submit applications for implementation or renewal. The Administration is pursuing strategies to assure quality in Medicaid managed care that are more effective and less burdensome than the assurances added through the waiver process. Guaranteeing urban Indian organization providers the right to participate in State Medicaid managed

care networks integrates ITUs into managed care delivery systems and recognizes their unique health delivery role.

- **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule**

  Replace the current enrollment composition rule with a new quality data monitoring system under a beneficiary purchasing strategy with new data collection authority.

  As part of the continuous effort to ensure Medicaid managed care beneficiaries receive quality care, HCFA proposes to implement a "beneficiary-centered purchasing" (BCP) strategy. BCP will replace certain current federal managed care contract requirements. The current enrollment composition rule (i.e., 75/25 rule) requires that no more than 75 percent of the enrollment can be Medicare and Medicaid beneficiaries. The current requirement is a process-related, ineffective proxy for quality. This requirement would be replaced with a quality monitoring system based on standardized performance measures.

  HCFA, in collaboration with States, would define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures would be used to quantify and compare plans' quality of care, provide purchasers and beneficiaries with the means to hold plans accountable, and provide HCFA with comparable data to compare the performance of State programs to effectively hold States accountable as well.

  This proposal would enhance the Secretary's ability to ensure that beneficiaries' interests are being protected as enrollment in managed care increases, and to detect and correct possible abuses by managed care plans. A more outcome oriented quality review process is vital to the Federal and State oversight of managed care plans to ensure that Medicaid beneficiaries are receiving the highest quality care possible. Data would be vital to the success of such an effort.

- **Change threshold for federal review of contracts**

  Raise the threshold for the federal review of managed care contracts from the current $100,000 threshold to $1 million contract amount (or base threshold for federal review on lives covered by plan).

  This proposal would provide greater State flexibility in management and oversight of Medicaid managed care programs. It would also reduce the number the of managed care plan contracts requiring HCFA review and approval.

- **Nominal copayments for HMO enrollees**

  Permit States to impose nominal copayments on HMO enrollees.

  This proposal would bring policy on Medicaid copayments for HMO enrollees more in line with Medicaid copayments that a State may elect to impose in fee-for service settings. It would also allow HMOs to treat Medicaid enrollees in a manner similar to how they treat non-Medicaid enrollees. However, impact on beneficiaries would not be harmful since copayments, if imposed, would still have to be nominal.

Increase Flexibility Regarding Long-Term Care

- **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments**

  Give States the option to create a home and community-based services program without a Federal waiver, through a State plan amendment. This proposal would benefit States and beneficiaries by eliminating the constant and costly necessity of renewing the waivers, while ensuring a high level of care.

- **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities**

  Raise the Medicaid Federal financial participation (FFP) rate to 85 percent.

  Federal funding is important to maintain both quality standards established by OBRA 87 and resulting enforcement activities. Increasing the Medicaid federal financial participation percentage to 85 percent would encourage States to increase total spending on nursing home survey and certification activities.

- **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities. Clarify that the trigger for disapproval of nurse aide or home health aide training and competency evaluation programs is substandard quality of care (Medicare and Medicaid).**

  This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program.

  The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a

result of losing a training program's approval. This proposal is also a part of the Vice-President's Reinventing Government initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

- **Eliminate repayment requirement for alternative remedies for nursing home sanctions**

  Eliminate the requirement for repayment of federal funds received if a State chooses to use alternative remedies to correct deficiencies rather than termination of program participation.

  This proposal would allow States to promote compliance by employing alternative remedies on nursing facilities. This provision for alternative remedies gives States the flexibility for more creative implementation of the enforcement regulations.

- **Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Eliminate the duplicative requirement for Inspection of Care (IOC) reviews in mental hospitals and ICFs/MR. The survey and certification reviews that currently take place in mental hospitals and ICFs/MR would remain in place.

  Inspection of Care (IOC) reviews were originally designed to ensure that Medicaid recipients were not being forgotten in long term care facilities. The current survey process has been improved through a new outcome-oriented process that protects recipients in mental hospitals and ICFs/MR from improper treatment. Consequently, IOC reviews are no longer needed and are, in fact, in direct conflict with the revised ICF/MR survey protocol. The current requirement for two reviews (IOC and the ICF/MR survey) has become duplicative. If the IOC were eliminated, the ICF/MR survey and certification process would remain in place.

- **Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Provide for alternative sanctions in ICFs/MR that already are available for nursing homes. Alternative sanctions that currently are available in nursing homes include: directed in-service training, directed plan of correction, denial of payment for new admissions, civil monetary penalties and temporary management.

  Sanctions other than immediate termination were established for nursing homes under the OBRA-87 legislation, but not for ICFs/MR. This proposal would extend the alternative sanction option to ICFs/MR.

THE PRESIDENT'S FY 1998 BUDGET:
MEDICAID PROPOSAL

- OVERVIEW
- DISPROPORTIONATE SHARE HOSPITAL POLICY
- PER CAPITA CAP POLICY
- MEDICAID FLEXIBILITY PROVISIONS

THE PRESIDENT'S BUDGET'S MEDICAID PROPOSAL

The President's budget produces **$9 billion in net savings** between FY 1998 and 2002.

- **It saves $22 billion in gross savings from two policies:**
  - About two-thirds of the savings (**$15 billion**) come from reductions in payments to disproportionate share hospitals (DSH), and
  - About one-third of the savings (**$7 billion**) from a per capita cap.
- **It invests about $13 billion in policies such as:**
  - Allowing States to extend 12 months of continuous coverage to children, and
  - Restoring coverage for some groups who lost it as a result of last year's welfare reform law.

The President's budget also offers unprecedented flexibility so that States, not the Federal government, can determine how best to improve Medicaid's efficiency.

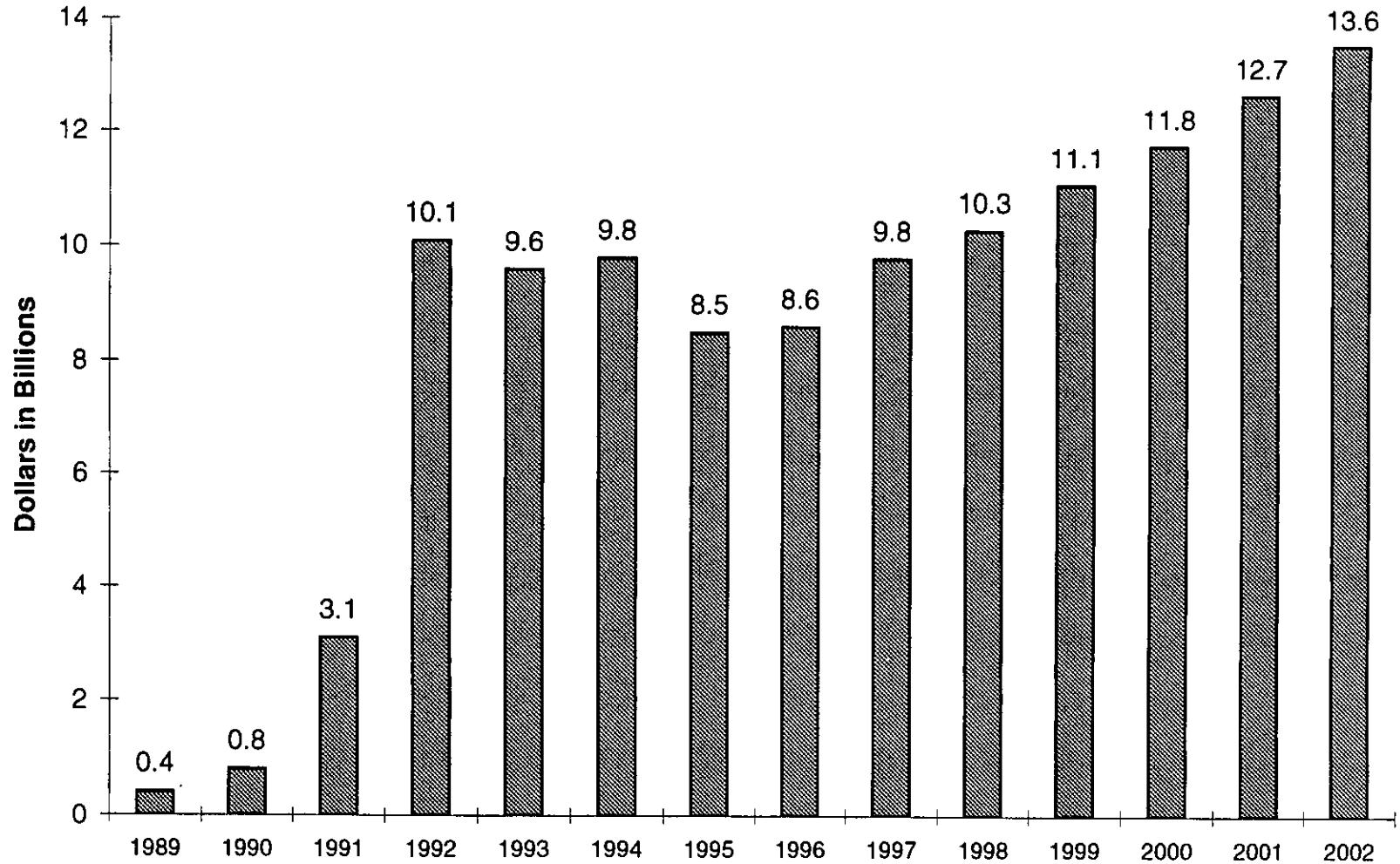
WHY REDUCE DSH SPENDING

- **DSH spending skyrocketed in the early 1990s.** Between 1989 and 1992, Federal payments for Medicaid DSH rose by over 250 percent.

- **Today, the Federal government spends nearly $10 billion on DSH**.
  - Its growth has moderated due to laws passed in 1991 and 1993.
  - However, about one-third of DSH funds still may not be received by the hospitals it is intended to help, according to an Urban Institute study.

- **Both CBO and OMB predict that DSH grow rates will rise.**
  - By 2002, the Federal government will spend an estimated $13 to 14 billion on DSH. Its growth rate in 2002 alone will be 7.4 percent according to CBO.

Federal Disproportionate Share Hospital Payments



Projections based on CBO January 1997 baseline

DSH REDUCTIONS IN THE PRESIDENT'S BUDGET

- **The President's budget reduces Federal Medicaid spending in DSH.** Specifically, it saves $15 billion, or about 25 percent, relative to the 1998 to 2002 CBO baseline. It:
  - Freezes Federal DSH spending at 1995 levels for 1998,
  - Reduces it to $9 billion in 1999, and
  - Funds DSH at $8 billion per year for 2000 and subsequent years.
- **Equal reductions, with an upper limit.** Savings are achieved by taking an equal reduction from each States' 1995 DSH spending, up to an "upper limit". These percentage reductions are:
  - 0 percent in 1998,
  - 15 percent in 1999, and
  - 25 percent in 2000 and equal subsequent year.

  If a State's DSH spending in 1995 is greater than 12 percent of its total Medicaid spending, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount.
  - The upper limit recognizes, like the laws enacted in 1991 and 1993, that some States' Medicaid programs are particularly dependent on DSH funding. The upper limit also ensures that the few States with high DSH spending are not bearing the entire impact of the policy.

BETTER TARGETING OF DSH FUNDS

- **Currently, almost all hospitals qualify as "disproportionate share hospitals."** Under current law, any hospital with more than 1 percent of its patients covered by Medicaid is eligible for disproportionate share funding.

- **As DSH funding is tightened, directing the funds within States' allotments to safety net providers becomes more important.** Limited Federal funding should be better targeted to providers that need it most: hospitals that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income patients.

- **Collaboration on exact formula.** Because targeting funds is technically complex and could have potentially disruptive effects in some States and for some providers, we want to work with Congress, States, providers, policy experts and advocates to develop an appropriate targeting mechanism.

FUNDS FOR CERTAIN HEALTH CLINICS

- **Helping FQHCs and RHCs make the transition.**
  - Federally qualified health centers (FQHCs) and rural health clinics (RHCs), like disproportionate share hospitals, play an important role in the safety net.
  - They may be disproportionately affected by the proposal to repeal the requirement of cost-based reimbursement for these facilities.

- **Temporary FQHC / RHC fund.** The President's plan includes a temporary fund of $1.4 billion over five years (from the DSH savings). It would sunset at the end of 2003.
  - Funds from this pool would be paid directly to facilities.

WHY INTRODUCE A PER CAPITA CAP

- **Medicaid spending growth has been volatile.**
  - In the early 1990s, Medicaid spending per beneficiary rose rapidly.

- **While Medicaid growth is low today, it may well rise again in the future.**
  - In fact, CBO projects that Medicaid spending growth per beneficiary will rise to nearly 7 percent by 2002.

Growth in Medicaid Spending per Beneficiary

Projections based on CBO's projections of Medicaid spending per beneficiary (including DSH) January 1997

THE PRESIDENT'S PER CAPITA CAP PROPOSAL

- **The President's budget constrains spending growth responsibly.** The President's per capita cap proposal savings $7 billion over five years. The per capita cap:

  - **Creates an incentive to reduce cost growth without reducing coverage.**

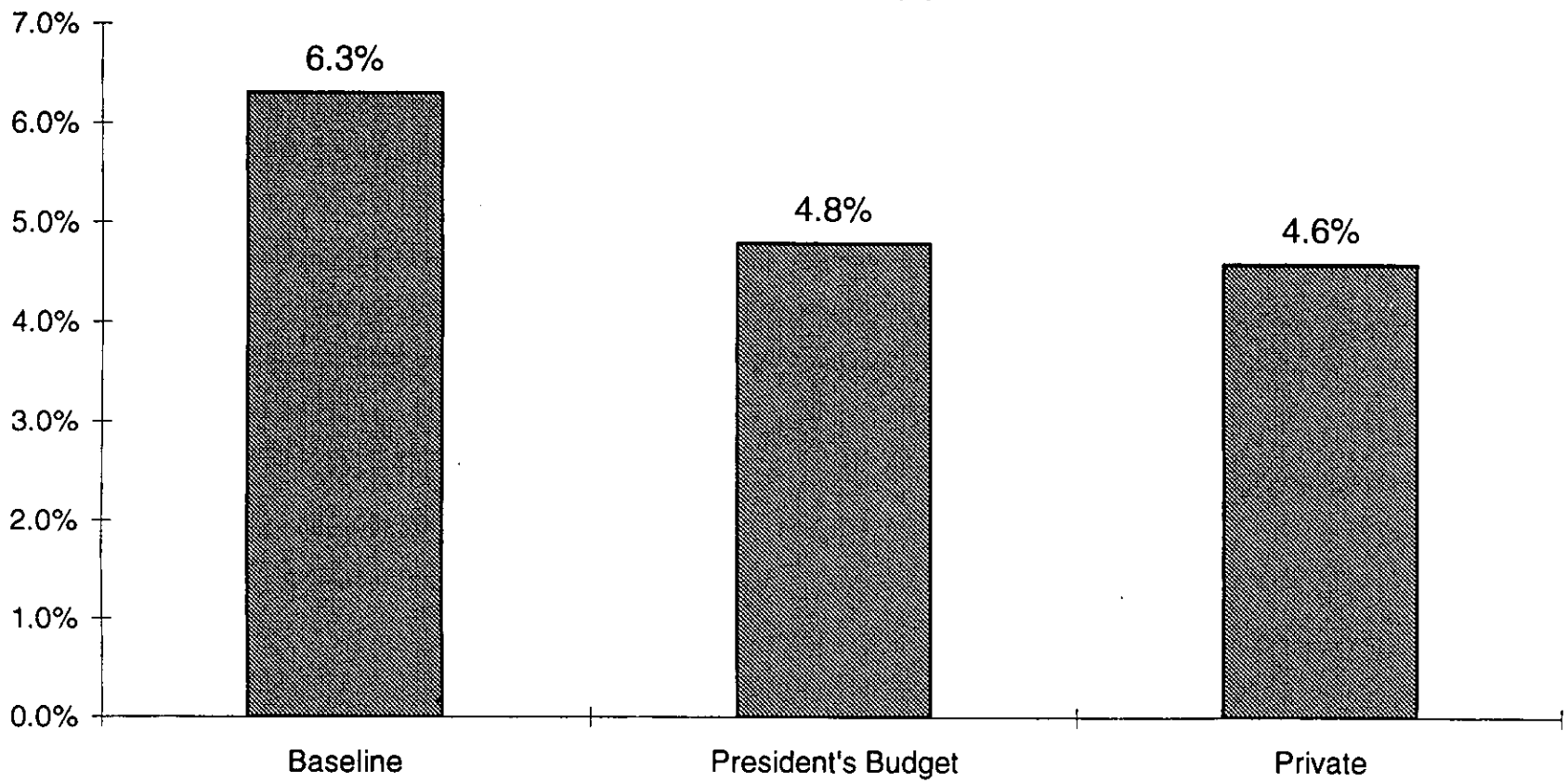
  - **Preserves the Federal - State partnership.** The Federal government will continue to share in the States' costs when they face unexpected recessions or changes in demographics.

  - **Lets States decide how to improve efficiency.** States will decide how best to reduce their costs through a flexible spending limit and increased program flexibility offered in the President's budget.

  - **Keeps spending growth in line with the private sector.** Medicaid spending will only be constrained if today's growth rates rise excessively. The growth limit, which parallels the rate of private spending growth, will not be breached unless Medicaid inflation rises.

  - **Increases taxpayer confidence in the program.** By requiring a much greater level of budgetary accountability, the per capita cap enhances the public support for Medicaid.

Comparison of Medicaid and Private Growth Rates Per Beneficiary 1997 to 2002



"Baseline" is CBO's January 1997 Medicaid baseline growth per beneficiary (including DSH); "President's Budget" reflects CBO's estimated Medicaid outlays under the Budget; "Private" is CBO's projected private spending growth divided by its projected growth in privately insured people. Fiscal Years.

HOW THE PER CAPITA CAP WORKS

- **Setting the Federal limit.** Each State will have one spending limit for its Medicaid benefits spending. This limit is calculated by multiplying:
  - 1996 Medicaid spending per beneficiary (separately for aged, disabled, adults & children) by
  - An inflation adjuster, set in legislation, by
  - The actual number of beneficiaries covered by the States (by type of beneficiary).

  The Federal government will match State expenditures as under current law up to this limit.

- **Excluded expenditures.** Spending not counted toward this limit includes all DSH, Medicaid spending on Medicare cost sharing, and other miscellaneous expenditures unrelated to benefits.

- **Setting the inflation adjuster.** The President's budget limits Medicaid spending growth to the average growth in nominal GDP per capita plus 2 percentage points in 1998, and plus 1 percentage point for all subsequent years. This averages about 5 percent between 1997 and 2002.

  Recognizing that there is a debate about what is the most appropriate index, we intend to work with Congress, States, researchers and others to develop the best inflation adjuster.

FLEXIBILITY OF THE PER CAPITA CAP

- **Adjusts for changes in a State's population.**
  - Each State has a unique and changing mix of people it covers through Medicaid.
  - Consequently, the per capita cap explicitly adjusts for changes in both the number and mix of beneficiaries.
  - For instance, a State that experiences a rapid rise in its elderly population will receive a greater increase in their limit than a State with an equal rise in Medicaid children, given the higher cost of care for the elderly.
- **Allows savings from one area to offset overspending in another.** There is only one limit per State. This means that if a State is able to produce extra savings from its elderly program but overspends on its children, it may use those savings to offset the extra spending, thus receiving full matching payments.

ADDRESSING DIFFERENCES ACROSS STATES

- **Helping in the transition.** The budget includes about $1 billion (from the per capita cap savings) in a capped, temporary pool to assist States and other entities who may be disproportionately affected by the new Medicaid policies.

- **Medicaid Commission.** The per capita cap represents a major change in Medicaid financing. The President's budget will establish an independent, impartial commission to examine:

    - **Differences in base year spending.** The commission will examine States' Medicaid spending patterns to better understand why there are differences.

    - **Alternative Medicaid matching rates.** The commission will also assess whether the current Medicaid matching rate, created in the 1960s, is still a fair and accurate formula.

  At the end of two years, the commission will recommend any changes to the Medicaid matching rate, per capita cap growth rates or base year spending that ensure equitable treatment across states.

MEDICAID FLEXIBILITY PROVISIONS

- **Unprecedented flexibility.** The President's proposes unprecedented flexibility in Medicaid so that States, not the Federal government, can determine how best to achieve the savings targets in the budget. Under the plan, States can:
  - Reform their programs without the need for a waiver,
  - Set provider payment and managed care rates with less Federal micromanagement, and
  - Administer their programs with fewer and simpler Federal requirements.

FREEDOM FROM WAIVERS

- Managed care without a waiver (1915(b)) with new quality standards
- Home and community-based care programs without a waiver (1915(c))
- Expansion to people with incomes up to 150 percent of poverty without a waiver (1115)

FLEXIBILITY IN PROVIDER PAYMENTS AND MANAGED CARE

- Repeal Boren amendment
- Eliminate cost-based reimbursement requirement for Federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Replace "75 / 25" enrollment composition rule with reasonable quality standards
- Reduce the number of managed care contracts subject to Federal review
- Revise outdated upper payment limits for managed care
- Allow States to let managed care plans use nominal copayments

SIMPLIFICATION OF ADMINISTRATIVE REQUIREMENTS

- Eliminate a series of unnecessary Federal requirements, including:
  - Requirement for private health insurance purchasing when cost effective
  - Computer systems requirements
  - Increase matching payment for nursing home survey and certification requirements

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Health- Medicaid proposals

THE PRESIDENT HAS SEEN
10-10-97

THE WHITE HOUSE

WASHINGTON

October 9, 1997

MEMORANDUM TO THE PRESIDENT

cc: Vice President, Erskine Bowles, Bruce Reed, Gene Sperling

FROM: Chris Jennings

RE: **NEW YORK AND THE PROVIDER TAX ISSUE**

Today, DHHS announced the results of its policy review of Medicaid provider taxes and its policy changes regarding New York. In brief, they announced (1) policy clarifications that clarify that certain provider taxes previously in question, including New York's regional tax, are permissible; and (2) support for legislation that expedites identifying impermissible taxes and ending their use. This is the culmination of an intensive process that involved HHS, OMB, DPC/NEC, Legislative and Intergovernmental Affairs, the Office of the Vice President and other senior staff.

BACKGROUND

Financing scheme and the law limiting it. During the late 1980s, many States established financing schemes that had the effect of increasing their Federal Medicaid funds without using additional State resources. Typically, States would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the State was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

Because provider taxes and donations were effectively siphoning off potentially billions of dollars from the Federal Treasury, the Congress limited states' use of these schemes in a bill enacted by President Bush in 1991. The subsequent regulatory interpretation of these limits was, as you know, negotiated with the states and the National Governors' Association in 1993.

States' continued reliance on impermissible provider taxes and our enforcement record. Despite the new law and the regulations, many states continued to use provider taxes that at least appeared to be out of compliance. To date, these possibly impermissible taxes total an estimated $2 to 4 billion and, in the future, could cost billions more. In response, HCFA issued letters and discussed its concerns about certain taxes with states, but -- for a variety of reasons -- never took any final action. Unfortunately, this has meant that a number of states continue using these taxes, believing that HCFA might never enforce the law, or that if they did, they could seek recourse through the White House or the Congress.

The New York provision in the balanced budget. To ensure that New York would never be vulnerable to Medicaid provider tax enforcement actions, Senator Moynihan and Senator D'Amato successfully added a provision to the Balanced Budget Act to exempt all of its provider taxes (it has dozens), both retrospectively and prospectively, from disallowances. Both in writing and orally we repeatedly objected to this provision. Moreover, we provided alternative statutory language that would have forgiven about $1 billion. As you know, however, the Senators (through their staff) rejected our offer and insisted on their original provisions.

Line-item veto and New York's reaction. In announcing the line-time veto on August 11, we raised concerns about the cost and ramifications of singling out as permissible one state's provider taxes. Although our actions were generally viewed as responsible and defensible by those who know the program and/or who are budget experts, the same clearly cannot be said of New York's political establishment. The Governor's office, the New York Congressional delegation, the Mayor, providers and unions reacted strongly and negatively to the veto. Among a host of complaints, they charged that they were singled out and were never made aware that this provision could be subject to the line-tem veto. Most recently they have criticized us for our delay in getting back to them and our willingness to support fixes for the other two vetoed provisions without addressing their problem.

TODAY'S ACTIONS. The line-item veto of New York's special provider tax waiver provision accelerated a review process of these tax policies that was already underway at DHHS. This process has yielded two results. First, HCFA is issuing a set of policy clarifications in a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid; this letter will be viewed as good news for at least nine states. HCFA also released a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent; this will make New York's regional tax permissible.

The State Medicaid Director's letter also includes an announcement of our support for legislation that (a) lays out in statute how to identify impermissible taxes; and (b) would provide enhanced authority to the Secretary **to forgive up to the entire amount of individual states' current liabilities if they come into full compliance with the law for future financing**. If, however, by a date certain -- August 1998 -- no legislation is passed, HCFA will aggressively enforce its current policies. (Attached is a one-page summary of our actions today.)

Need for legislation. The Administration's goal in these actions is to work with the states to end the impermissible use of provider taxes. Given the staggering size of the liabilities for some states, we agree that this is best accomplished through negotiation. Specifically, we are interested in trading reductions in some or all of states' retrospective liabilities for discontinued use of such taxes in the future. However, the administrative process that HCFA has at its disposal offers many opportunities for states to continue to stall (as they have done in the past). More importantly, final settlements must be approved by the Department of Justice which may take a hard line in terms of recouping retrospective liabilities. This could force states to look for a legislative "rifle shots" to fix their particular problem, or to go to court.

Consequently, we think that the best way to bring states to the negotiations is through reliance on a legislative strategy. By strengthening the Secretary's ability to negotiate, we avoid the uncertainty inherent in an ordinary administrative process. By stating what type of legislation we would support, we get ahead of the rifle shots and possibly prevent them, as well as to get the Congress invested (albeit reluctantly) in developing a mutual solution to the provider tax mess. And by offering to clarify our ways of identifying impermissible taxes, we may engage states that have concerns about our interpretation, thus possibly preventing suits. These incentives are reinforced by threat of a deadline for passage of such legislation (August 1998) that triggers an aggressive enforcement action by HCFA.

Reaction from New York. Today's briefing of both Governor Pataki's staff and the New York Congressional delegation seemed to go quite well. They appreciated the resolution on the states' regional tax and seemed to accept that our legislation approach was much preferable to an immediate administrative enforcement action. We explained to them that the law and our current regulations would have forced us to publicly state that some of their provider taxes appear to be impermissible. Having said this, they certainly would have preferred an action that retrospectively and prospectively forgiven any potential liability; in other words, they want the provisions we line-item vetoed. As such, as of this writing, it is unclear what public posture either the Governor or the Congressional delegation will take.

Reaction from other states. Although nine other states benefit from the new policy clarifications, it is news of our support for legislation that caught the states' attention at our NGA briefing. The dozen or so states that have widely used provider taxes appeared to view this positively. It is these states that we want to engage in discussion and eventually negotiations. However, it was unclear whether the remaining states that either ended their provider tax use or who never used them to begin with viewed our action as too conciliatory. We communicated to all the states that we have not -- and will not -- change our opposition to the use of provider taxes. We simply stated that we are looking for the most effective way to end all states' reliance on impermissible taxes.

Next steps. HCFA plans on immediately reaching out to the states to obtain updated information about the status of state provider taxes. There will probably be Congressional interest in knowing how we plan on pursuing our legislative strategy. John Hilley believes that we should have an Administration bill, but that we should not introduce it until we have had sufficient time to achieve more investment in the details of the bill from the Congress and the states. We will keep you apprised of developments.

SUMMARY: MEDICAID PROVIDER TAXES

- **What is being released.** Today, the Department of Health and Human Services (DHHS) has sent a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent.

  The State Medicaid Director letter also includes an announcement of our support for legislation that (a) codifies current regulations that contain the tests to determine that a tax is permissible; and (b) would concentrate authority in the Department to resolve impermissible tax liabilities if a state comes into full compliance by ending the use of impermissible taxes. This legislative approach may more expeditiously end the use of impermissible taxes. If, however, by August 1998 no legislation is passed, the Secretary will move forward to complete the process already begun to apply with full force the current law.

- **Why action is needed**? States' use of impermissible provider taxes poses a major threat to Medicaid's fiscal integrity. During the late 1980s, health care provider tax programs were used to increase Federal Medicaid funding without using additional state resources. These schemes contributed to the doubling of Federal Medicaid spending between 1988 and 1992.

  Today, a number of states continue to use potentially impermissible provider taxes. To maintain the integrity of the Medicaid program, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibilities of the states. To not do so would be unfair to those states (and their taxpayers) which are in compliance.

- **Why now?** This review, which has been on-going at DHHS for many months, has drawn increased attention recently due to the line-item veto of a Medicaid provider tax provision in the Balanced Budget Act. Under this provision, all of New York's over 30 provider taxes would be deemed approved. The President vetoed this provision because it was too broad and singled out a single state for special treatment. However, he promised that DHHS would intensify its review of its interpretation of the law for New York and all states. Today's action is a result of this review.

- **Impact on New York**. One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration will publish a correcting amendment to the regulation in the Oct.15 *Federal Register*. This action relieves New York of over $1 billion of provider tax liability.

  No final resolution on New York's other provider taxes has been reached. However, HCFA will be contacting New York and other states to gather further information on taxes.

- **Impact on other states**. 10 States will benefit from the clarification that the Department is providing today. States will be contacted with requests for additional information. It is our hope that all states and their representatives will work toward legislation that protects the Federal Treasury as well as treats States fairly as we move to ensure that all states are in compliance with the law (D.C., Alabama, Lousiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Medicare Commission Working Group to the President re: Medicare Commission Special Notes [partial] [page 3 withdrawn in whole] (4 pages)	10/20/1997	P6/b(6)

COLLECTION:
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Health - Medicare Commission

2009-1006-F
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RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Elena: FYI. You don't have to do this ... Health-Medicare Commission

CJ

DRAFT

BL. review

October 20, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: THE MEDICARE COMMISSION WORKING GROUP

SUBJECT: MEDICARE COMMISSION SPECIAL NOTES

Following your feedback to our last Medicare Commission memorandum, Erskine called a meeting to try to reach closure on a final staff recommendation for your four Commission slots. He also asked us to produce a list of possible Chairman candidates that you could propose and feel comfortable with if the Republican Leadership accepted. The following provides a quick update of likely Hill appointments and a summary of the status of our recommendations.

Status of Congressional Choices

Democrats: As you know, Senator Daschle wishes to trade one of his appointments to the Commission with you so he can accommodate Senator Rockefeller's desire to serve on the Commission without having to appoint him. Senator Daschle's other selection is Senator Kerrey. Congressman Gephardt does not seem to have concerns about only picking members and seems likely to choose P6/(b)(6) and John Dingell, P6/(b)(6) [001] P6/(b)(6)

Republicans: For their eight slots, Senator Lott and Speaker Gingrich are reportedly likely to appoint two members and two health policy experts each. The two front-runner Senate candidates are Senator Gramm and either Senator Frist P6/(b)(6) P6/(b)(6) P6/(b)(6) The two health care experts are likely to be Debbie Steelman (Bush Administration Chair of the Steelman Health Care Commission) and someone from Mississippi who has a health care background.

Speaker Gingrich is likely to appoint Bill Thomas and Michael Bilirakis (the two health subcommittee Chairs on the committees of jurisdiction over Medicare). His two other slots still appear open, P6/(b)(6) P6/(b)(6)

Republican Chair Selections: The latest "quiet" rumors we are hearing about possible Chair selections by the Republicans are all focused on retired Republican Members. The most likely

P6/(b)(6)

First Two Presidential Slots: Stuart Altman and Laura D'Andrea Tyson.

Within the White House, there appears to be consensus on two Medicare Commission slots -- Stuart Altman and Laura Tyson. Both are strong policy-based, economists who would be validated externally as appropriately placed on the Commission. They both are articulate spokespersons who can be counted on to be extremely loyal to the Administration.

P6/(b)(6)

P6/(b)(6) However, we are recommending Stuart because his years of experience with the Congress and the Nixon Administration makes him much more likely to be influential with Members of Congress on both sides of the aisle.

P6/(b)(6)

Rockefeller Slot.

P6/(b)(6)

Chair Options: Bob Ray, Lawton Chiles, Tom Jones, other CEO types.

Since the chair must be mutually agreed to, Erskine has asked us to provide you with options for the Chair that you could offer without reservation. It is dubious that Speaker Gingrich and Senator Lott will accept anyone that we have in mind without a good deal of discussion. It seems likely that Democratic or Republican Members, Governors, or ex-Members that we suggest will immediately become suspect. This is why Erskine has asked us to do a search of possible CEO-types that we could generally trust to do a reasonably fair job and who would not be do mistrusted from the beginning.

P6/(b)(6)

CEO INSERTS: BOB AND GENE -- YOU CAN FILL IN.

There are a number of CEOs we are now reviewing as possible chair candidates. We will keep you updated with promising names, as well as new news about individuals the Republicans are considering.

One last point: It is important to recognize that the Executive or Staff Director of this Commission has great potential to be as influential or more influential than any member. It is for this reason that we should consider insisting that, as with the Chair, there must be mutual agreement on the Executive Director and that there will be no agreement on the Chair until we know and are comfortable with who his or her lead staff person is.