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Medicare Reform: Issues and Options

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ABSTRACT

Medicare is facing a number of problems. The first and most pressing concern is that Medicare's financing mechanism will be unable to sustain it in the long run. Many are also concerned that the program's structure has failed to keep pace with changes in the health care system as a whole. A number of observers have stated that the program is now at a critical juncture. Previous efforts to shore up the Part A (Hospital Insurance) trust fund have delayed the insolvency date but have not addressed completely the underlying problems. A number of recommendations have been offered. Some proposals would involve modifications to Medicare's current structure. These include introducing means-testing, raising the program's initial eligibility age, and increasing beneficiary cost-sharing. Other proposals would involve major restructuring. These include modernizing the benefit structure; combining the Part A and Part B programs; replacing the program's current guarantee of a defined package of benefits with a defined per beneficiary contribution; or privatizing the program. This report reviews the issues and options currently under consideration. This report will be updated as circumstances warrant.

Medicare Reform: Issues and Options

Summary

Medicare is the nation's health insurance program for the elderly and certain disabled persons. Over its 32-year history, it has provided important protections for millions of Americans. However, the program is facing a number of problems. The first and most pressing concern is that Medicare's financing mechanism will be unable to sustain it in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with changes in the health care system as a whole.

For a number of years, the Congress has passed legislation which has attempted to address Medicare's short-term financing problems by restraining the growth in program spending. The lower growth rates have been achieved largely through reductions in payments to providers, primarily hospitals and physicians. Generally, Medicare provisions have been part of larger budget reconciliation measures. Most recently, the Balanced Budget Act of 1997 (BBA 97) was enacted. This legislation again provided for reductions in payments to providers; it also provided for a significant expansion in the choices available to beneficiaries for obtaining covered services. BBA 97 guarantees Medicare's solvency for several additional years. However, the current financing mechanism will be unable to sustain the program in the long run. The problems facing Medicare are expected to be magnified in 2011 when the baby boom generation begins to reach 65 — the eligibility age for Medicare.

A number of observers have stated that the program is now at a critical juncture. Previous efforts to shore up the Part A (Hospital Insurance) trust fund have delayed the insolvency date but have not addressed completely the underlying problems. It is argued that the whole structure of the program needs to be reexamined. This is not an easy task in view of the many, sometimes competing, concerns underlying the current debate. BBA 97 provided for the establishment of a commission, the National Bipartisan Commission on the Future of Medicare, to develop recommendations. It is required to make recommendations concerning a number of specific program issues. The Commission is required to submit a report by March 1, 1999.

During its review, the Commission is expected to examine a number of recommendations which have been offered for addressing some of Medicare's problems. Some proposals would involve modifications to Medicare's current structure. These include introducing means-testing, raising the program's initial eligibility age, and increasing beneficiary cost-sharing. Other proposals would involve major restructuring. Proposals which have been suggested include modernizing the benefit structure; combining the Part A and Part B programs; replacing the program's current guarantee of a defined package of benefits with a defined per beneficiary contribution utilizing the current Federal Employees Health Benefits Program (FEHBP) model; or privatizing the program. These approaches are not mutually exclusive. For example, a restructuring proposal could also include an

increase in the eligibility age. This report reviews the issues and options currently under consideration. This report will be revised as circumstances warrant.

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Medicare Reform: Issues and Options

Introduction

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Over its 32-year history, it has provided important protections for millions of Americans. However, the program is facing a number of problems. The first and most pressing concern is that Medicare's financing mechanism will be unable to sustain it in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with the changes in the health care system as a whole. A related concern is whether the program's benefit structure adequately responds to the health care needs of today's aged and disabled populations.

A number of observers have stated that the program is now at a critical juncture. Previous efforts to shore up the Part A (Hospital Insurance (HI)) trust fund have delayed the insolvency date but have not addressed completely the underlying problems. It is argued that the whole structure of the program needs to be reexamined. This is not an easy task in view of the many, sometimes competing, concerns underlying the current debate.

Medicare and the Federal Budget

Medicare is the nation's second largest social welfare program, exceeded only by social security. It is an *open-ended entitlement program* that provides coverage for a *defined package of services*. Medicare is a *mandatory spending program*; it pays for as many covered medical services as the eligible population needs. As a result, it is difficult to control overall program spending.

Medicare is a key concern for policymakers, not only because of its role in financing health care for the elderly, but also because it represents a major spending item in the federal budget. The Congressional Budget Office (CBO) estimates total Medicare outlays for FY1998 at $220.5 billion; net outlays (after deduction of beneficiary premiums) are estimated at $199.6 billion. Net outlays represent an estimated *11.8% of total federal outlays* in FY1998. CBO estimates the percentage will rise to 16.6% of total federal outlays by 2008.

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by the Congress since 1980. These efforts intensified as Congress considered legislation to bring the entire federal budget into balance and culminated in the passage of the Balanced Budget Act of 1997 (BBA 97). This legislation

achieved significant savings in Medicare and extended the solvency of the Part A trust fund. BBA 97 also included a number of program reforms, the most significant of which was to expand the types of managed care options available to program beneficiaries under the new Medicare+Choice program. However, the law did not resolve the program's long-term financing problems.

Medicare Financing

Medicare Part A is primarily financed by *current workers and their employers* through a payroll tax. Medicare Part B (Supplementary Medical Insurance (SMI)) is financed by a combination of monthly premiums levied on *current beneficiaries* and federal general revenues (tax dollars). Almost from its beginning, the Part A program has faced a shortfall. The insolvency date has been postponed a number of times, primarily due to legislative changes which had the effect of restraining the growth in program spending. The program is currently slated to become insolvent in 2008. At that time, income coming into the program will be insufficient to pay benefits. Part B does not face exhaustion because of the way it is financed. However, observers continue to voice concern about the rapid growth in program costs.

The trustees of the Medicare Part A trust fund have stated that to bring Part A into financial solvency over 25 years (CY1998-2022), either outlays would have to be reduced by 18% or total income increased by 22% (or some combination thereof) throughout the 25-year period. As noted, the primary income source for Part A is payroll taxes. Many observers oppose any increase in taxes to support the program. They feel that current taxes already represent a considerable drain on the incomes of many middle class workers. They also suggest that merely increasing taxes would not address the program's inherent inefficiencies.

Demographic Considerations

The financing problems facing Medicare are expected to be magnified in 2011 when the program will begin to experience the impact of major demographic changes. First, baby boomers (those born between 1946 and 1964) begin turning age 65. Second, there is a shift in the number of workers paying the Medicare payroll tax and supporting persons receiving benefits under Part A. In 1997, there were 3.9 workers per beneficiary; in 2010 there will be 3.6. In 2030 the ratio will have declined to 2.3.

Who Pays for Benefits

A related series of issues relates to who is, or should be, paying for covered benefits. Many beneficiaries feel that the combination of the payroll tax they paid during their working careers coupled with their Part B premiums means that they have paid in full for the benefits they receive. Various studies have shown that this is not the case. Persons on Medicare today receive considerably more in Medicare benefits over their lifetimes than they pay in; this trend is expected to continue into future years for low and average wage earners; however, over time, high wage earners are expected to pay more into the system than they get back.

Under the current system, current workers pay a payroll tax to cover benefits for current Part A beneficiaries. Current workers also pick up the majority of Part B costs since the federal government (i.e., current taxpayers) pick up 75% of the costs of that program. These financing mechanisms have raised intergenerational equity issues. Many younger persons recognize that the program provides significant help to their parents and grandparents and has relieved them of some potential healthcare expenses for family members. However, some younger individuals contend that they should not be required to assume a major portion of the costs for older populations. Many of these same individuals question whether Medicare will be there when they retire.

Some persons have argued that the current system should be replaced by a system which gives individuals more responsibility for planning for their own futures. This would be done by requiring current workers to save for their own retirement health care expenses. Others suggest that this may be difficult to do and suggest that the consequences of inadequate planning or inappropriate decisions could be severe.

Benefit Design

Many persons view this time as an opportunity to reexamine the structure as well as the financing of the program. Several key components of the current system are expected to be reexamined. One series of issues relates to the program's current benefit structure. While Medicare provides broad protection against the costs of many, primarily acute care, services, it only covers about one-half of beneficiaries' total health care expenses. The program includes significant cost-sharing charges for most covered services, provides only limited protection for some other services (such as outpatient prescription drugs) and includes no protection against the costs of some other services (such as hearing aids). While many observers would like to expand program coverage, the potential costs of such expansions could be considerable.

Most individuals have some coverage in addition to basic Medicare benefits. Some have additional benefits (such as physicals and prescription drugs) through a managed care plan; this number is expected to grow with implementation of the Medicare+Choice program. Most other persons have some form of private or public supplementary coverage. Many observers have suggested that when reviewing Medicare's coverage, it is important to understand the interaction of these plans with Medicare. This is not an easy task, since there is wide variation among plans in the services covered and total costs to beneficiaries.

Some observers have suggested that the concept of a defined package of Medicare benefits should be reexamined. They suggest that the program should use a defined contribution model under which the federal government would guarantee a defined payment per beneficiary. Proponents argue that beneficiaries would be able to purchase coverage tailored to their health care needs. At the same time, the federal government's financial exposure would be more predictable.

Beneficiary Perceptions and Concerns

Medicare provides millions of senior citizens with significant protection against the costs of their health care. Beneficiaries value the program and register strong opposition when policymakers suggest reducing the benefits or increasing the program's premiums or cost sharing charges. The ability of seniors to shoulder additional costs is of concern, particularly in light of the fact that most beneficiaries have relatively modest incomes.

Current Reform Discussion

The problems facing Medicare are not new. However, there has been no general consensus on how to address the long range problems. BBA 97 provided for the establishment of a National Bipartisan Commission on the Future of Medicare. This Commission is to develop recommendations concerning a number of program issues; it is required to submit a report to Congress by March 1, 1999. The Commission has begun its work and is examining a wide range of options.[1] This report provides background on Medicare and outlines some reform options under consideration.

Background on the Medicare Program

Medicare is a nationwide health insurance program for the aged and disabled. Total program outlays in FY1998 are estimated at $220.5 billion; net Medicare outlays (after deduction of beneficiary premiums) are estimated at $199.6 billion. Medicare actually consists of two distinct parts — Part A (HI) and Part B (SMI).

Coverage

Medicare is a non-means tested program; that is, there are no income or assets tests for coverage. Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 receiving social security cash benefits on the basis of disability. Most persons who need a kidney transplant or renal dialysis are also covered, regardless of age. In FY1998, Part A will cover an estimated 38.6 million persons.

Medicare Part B is voluntary. All persons over 65 and all those enrolled in Part A may enroll in Part B by paying a monthly premium. Most persons eligible to enroll in Part B do so. In FY1998, Part B will cover an estimated 36.8 million persons.

Benefits

The Part A program covers inpatient hospital services, skilled nursing facility (SNF) services, home health care, and hospice care (home care services for the terminally ill). Part B covers physicians services, laboratory services, durable medical equipment, other medical services, as well as a portion of home health expenses.

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[1] See Appendix A, for a discussion of the membership and responsibilities of the National Bipartisan Commission on the Future of Medicare.

Medicare benefits are generally provided under the "traditional Medicare" program (sometimes known as "fee-for-service Medicare"). Under this program, beneficiaries obtain covered services through providers of their choice and Medicare makes payments for each service rendered (i.e., fee-for-service). The amount of payment per service is generally subject to certain limits. In recent years, the traditional program has been modified several times to expand the types of services paid for on a prospective, rather than fee-for-service, basis. Under a prospective payment methodology, a predetermined payment is made for each episode of care, regardless of the scope and mix of resources used in the individual case.

Benefits may be provided through a managed care arrangement instead of through the traditional program. As of 1998, about 15% of beneficiaries have elected to enroll in a Medicare risk-based health maintenance organization (HMO) which has agreed to assume the risk for paying for all of Medicare's covered services for each enrolled beneficiary. In return, Medicare makes a predetermined monthly payment to the plan; this capitated payment is fixed and does not vary by the amount of resources used. Another 2% of beneficiaries are enrolled in other private plan options.

BBA 97 significantly expanded the types of private plan options which will be available to beneficiaries beginning in 1999. Under the new Medicare+Choice program beneficiaries will be able to select from preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans as well as traditional risk-based HMOs. Further, under a demonstration program, a limited number of beneficiaries will be able to establish medical savings accounts (MSAs) in conjunction with a high deductible plan.[2]

Administration

Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS). Much of the day-to-day work of reviewing claims and making payments is done by intermediaries (for Part A and some Part B services) and carriers (for Part B). These are commercial insurers or Blue Cross and Blue Shield plans.

Medicare Financing

Financing Part A and Part B

The financing mechanisms for Part A and Part B are completely different. Part A is primarily financed by *current workers and their employers* through a payroll tax. Each pays a payroll tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike social security (which currently has a taxable earnings base of $68,400), there is no upper limit on the amount of earnings subject to the tax. Part B is financed by a combination of monthly premiums levied on *current program beneficiaries* and

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[2] For additional information see CRS Report 98-80, *Medicare: Risk-Contract HMO and Medicare+Choice Private Plan Options*, by Beth Fuchs and Jack Hoadley.

federal general revenues. In 1998, the premium is $43.80. Beneficiary premiums have generally represented 25% of Part B costs; federal general revenues (i.e., tax dollars) account for the remaining 75%.

Financial operations for Part A are accounted for through the HI trust fund while those for Part B are accounted for through the SMI trust fund. Both funds are maintained by the Department of the Treasury.[3] Each fund is overseen by a Board of Trustees who make annual reports to Congress concerning their financial status.

Financial Status of Part A and Part B

Almost from its inception, the HI trust fund has faced a projected shortfall. When observers refer to the impending insolvency of Medicare they are actually referring to the pending insolvency of the HI trust fund. The SMI trust fund does not face exhaustion because of the way it is financed. However, the SMI trustees continue to voice concern about the rapid growth in program costs.

The Board of Trustees projected insolvency for the HI fund beginning with the 1970 report (which was less than 4 years after the program went into effect). The insolvency date was postponed a number of times, primarily due to legislative changes which had the effect of restraining the growth in program spending. The lower growth rates were achieved largely through reductions in payments to providers, primarily hospitals and physicians. Generally, these measures were part of larger budget reconciliation laws which attempted to restrain overall federal spending.

BBA 97

Despite the enactment of a series of budget reconciliation bills, the Board of Trustees predicted in April 1997, that the HI trust fund would become insolvent in 2001. In that year, revenues coming into the trust fund (primarily payroll taxes), together with any balance left over from prior years, would have been insufficient to cover the payment for Part A benefits in that year. In response to the impending insolvency (as well as the larger goal of bringing the overall federal budget into balance), the BBA 97 was enacted.[4] This legislation provided for $116 billion in Medicare savings over the FY1998-FY2002 period. The legislation achieved these savings by again slowing the rate of growth in payments to providers and by establishing new payment methodologies for certain service categories. As noted above, it also provided for a significant expansion in the choices available to beneficiaries for obtaining covered services.

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[3] The trust funds are an accounting mechanism; there is no actual transfer of money into and out of the fund.

[4] For a history and summary of BBA 97 see CRS Report 97-802, *Medicare Provisions of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*, by Jennifer O'Sullivan.

BBA 97 also provided for the transfer of some home health spending from Part A to Part B. While this action does not reduce overall program spending, it does reduce Part A spending and thus delay the Part A projected insolvency date.

Current Estimates

Both the Congressional Budget Office (CBO) and the 1998 Board of Trustees report estimate that the enactment of BBA 97 delayed the HI insolvency date.[5] In January 1998, CBO (using its January 1998 baseline) estimated that the fund would become insolvent early in FY2010. In April 1998, the Board of Trustees estimated that it would become insolvent in 2008. Both estimates show that while BBA 97 addressed the immediate short-term financing concerns, it did not resolve the longer-term financial problems.

Both the short-range and long-range projections reflect the fact that HI costs (reflecting largely increases in medical costs) are rising faster than HI income. Beginning in 2011, the program will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946-1964) begin turning age 65. Second, there is a shift in the number of covered workers supporting each HI enrollee. In 1997, there were 3.9; in 2010 there will be 3.6; while in 2030 there will only be an estimated 2.3.

The combination of expenditure and demographic factors is also reflected in the increasing size of the HI program relative to other sectors of the economy. According to the 1998 report, the program's cost is expected to rise from 1.7% of gross domestic product (GDP) in 1997 to about 3.4% of GDP in 2070.

The 1998 trustees' report stated that *to bring the HI fund into financial solvency over 25 years (CY1998-2022), either outlays would have to be reduced by 18% or total income increased by 22% (or some combination thereof)* throughout the 25-year period. If changes were *just made to the payroll tax*, the rate would have to be immediately increased from the current level of 1.45% to 1.81% for employees and employers, each; the rate for the self-employed rate would go from 2.9 % to 3.62%.

Larger changes would be required to maintain financial soundness over the 75-year projection period. To achieve long-term financial solvency, the payroll tax for both employees and employers would have to be immediately increased by 1.05 percentage points; the rate would thus go from 1.45% to 2.5%.

While BBA 97 extended the solvency of the HI program for several additional years, additional changes are required. The trustees, as well as a number of other observers, have recommended that reforms be developed and enacted as rapidly as

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[5] For further discussion of the trustees report see CRS Report 98-457, *Medicare: Financing the Part A Hospital Insurance Program*, by Jennifer O'Sullivan.

possible. They note that the sooner solutions are enacted, the more flexible and gradual they can be.

Other Major Issues

While the pending insolvency of the Part A trust fund is of major concern to policymakers, it is only one of the issues facing Medicare. Many observers contend that a number of other issues need to be addressed. One question is whether the program's current structure reflects the changes that have occurred in the health care delivery system in recent years. A related concern is whether the program's benefit structure adequately responds to the health care needs of today's aged and disabled populations. Many observers contend that a Medicare reform package must take into account the entire scope of health care benefits available to beneficiaries including that provided by other public and private sources. This is difficult, since there is a wide variation among plans, both in terms of services covered and total costs to beneficiaries.

Response to Changes in the Health Care Delivery System

Many observers argue that the program's current structure, relying primarily on traditional fee-for-service mechanisms, has failed to adequately reflect changes that have occurred in the health care delivery system as a whole. While over 85% of the workforce and their dependants are currently enrolled in some form of managed care, only about 15% of the Medicare population is enrolled in such arrangements. CBO projects that as a result of BBA 97, 38% of the Medicare population will be enrolled in group plans by 2008. While this represents a significant shift, fee-for-service would still remain the program's predominant delivery system.

Medicare Benefits Package

Medicare provides broad protection against the costs of many, primarily acute care, services. However, beneficiaries are still faced with significant additional health care expenses. The program requires cost-sharing for most covered services, provides only limited protection for some services (such as outpatient prescription drugs and long-term care) and includes no protection against the costs of other services (such as hearing aids and dentures). Further, unlike most large group health insurance plans, Medicare contains no upper ("catastrophic") limit on out-of-pocket expenses. As a result, the program covers only about half of beneficiaries total health expenses.[6]

A number of observers have noted that Medicare's benefit package is somewhat less generous than typical employment-based coverage. While Medicare contains more generous coverage of mental illness and substance abuse than typical employment-based plans for the non-elderly, it lacks coverage for most outpatient

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[6] In 1993, Medicare covered 51.4% of the personal health care expenditures for all beneficiaries, (53.3% for the aged, and 40.2% for the disabled). Laschober, Mary A. (November 1997) Health and Health Care of the Medicare Population: Data from the 1993 Medicare Current Beneficiary Survey. Rockville, MD: Westat.

prescription drugs, dental care, and a catastrophic limit on the amount of out-of-pocket expenses. These items are generally found in employment-based plans.[7]

Many observers have recommended expansions in coverage. However, the potential costs of various proposals have restricted the number of new or expanded benefits.[8] One service category that has received considerable attention is that of preventive care. Initially, Medicare coverage was restricted to the diagnosis and treatment of illness. Over time, coverage was added for some routine screening services. The most significant expansion in preventive services was included in BBA 97. Some persons have recommended additional expansions arguing that the provision of preventive care services actually results in savings over the long term.

Supplementary Coverage

Most beneficiaries depend on some form of private or public coverage to supplement their Medicare coverage. In 1996, only about 11.3% of beneficiaries relied solely on the traditional fee-for-service Medicare program for protection against the costs of care; an additional 8.0% were enrolled in managed care organizations.

The majority of the Medicare population (62.5% in 1996) have private supplemental coverage. This private insurance protection may be obtained through a current or former employer (29.9% had such coverage in 1996). It may also be obtained through an individually-purchased policy, commonly referred to as a "Medigap" policy (28.4% had these plans in 1996). Some persons have both (4.2% in 1996). In addition, a smaller percentage (about 16.5% in 1996) have Medicaid coverage; a small group (1.7% in 1996) have supplemental coverage from one of a variety of public sources (such as the military).[9]

Managed Care. Managed care organizations have often provided coverage for services in addition to those covered under the traditional fee-for-service program. Additional benefits most frequently offered include routine physicals, eye and hearing exams, and outpatient prescription drugs. In many instances, these benefits are offered to beneficiaries at little or no additional cost. The method Medicare used to pay HMOs (which resulted in significant variation in risk payment rates across the country) was the chief reason some HMOs were able to offer these additional benefits. BBA 97 significantly modified the payment methodology beginning January 1, 1998. The changes are designed to reduce the wide variation in payments

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[7] For additional information see CRS Report 97-95, *Medicare: Comparison to Typical Employment-Based Health Insurance Plans*, by Madeleine Smith.

[8] In 1988, the Medicare Catastrophic Coverage Act (P.L. 100-360) was enacted. This legislation expanded benefits, added a "catastrophic cap" and included catastrophic prescription drug coverage. The legislation was repealed the following year (P.L. 101-234), both because beneficiaries objected to paying an income-related premium for additional coverage and because of the rapid increase in the estimated costs of the program.

[9] Eppig, Franklin J. and George S. Chulis. Trends in Medicare Supplementary Insurance: 1992-1996. *Health Care Financing Review*. v. 19, no. 1, fall 1997. (Hereafter cited as Eppig and Chulis, Trends in Medicare Supplementary Insurance: 1992-1996)

and the year-to-year volatility that resulted from the old rules, especially in less populated counties.[10] One consequence of the revised rating methodology is that some managed care organizations may reduce or eliminate the amount or scope of additional benefits offered. This could potentially affect the attractiveness of some plans to current or potential enrollees. It is too early to gauge the full impact of the recent changes.

Private Supplementary Coverage.

Employer-Based Coverage. Several concerns have been raised regarding private supplementary coverage. There are indications that the percentage of employers offering retiree health coverage for their Medicare retirees is dropping. In addition, many other employers are pursuing strategies to lower their liabilities for retiree health costs. Some employers are moving toward a defined dollar contribution model for retiree health benefits; this means that the employer offers coverage up to a specified dollar amount, rather than offering coverage for a specific package of benefits. Others are using Medicare risk plans and other managed care organizations to deliver services to their retirees. These employer choices have a significant impact on the health insurance available to program beneficiaries.

Medigap. Beneficiaries with Medigap insurance have coverage for Medicare's deductibles and coinsurance and for some services not covered by Medicare. In 1997, the typical premium for a community-rated Medigap policy was $1,300.[11] Many observers contend that the premiums are difficult for many elderly individuals to afford. Further, they note the significant year-to-year increases in the premium costs.

Beneficiaries select a Medigap policy from one of 10 standardized plans. These are known as Plans A through Plan J. The Plan A package covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive.

The intention of standardized policies is to enable consumers to better understand policy choices and to prevent marketing abuses. However, some observers suggest that the current policy options overemphasize first dollar coverage (namely coverage of Medicare's cost-sharing charges) which many beneficiaries could potentially budget for. At the same time the plans provide less generous coverage for other services not covered by the program. (For example, only three standardized plans - Plans H, I and J- cover some drug costs and even the most generous requires significant out-of-pocket payments by beneficiaries.)

Some observers have suggested that policy options should be redesigned to place greater emphasis on catastrophic coverage. A recent change authorized by BBA 97 adds two high deductible plans to the current list of 10 standard plans. With the exception of the high deductible feature, the benefit package under the high

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[10] For additional information see CRS Report 98-80, *Medicare: Risk-Contract HMO and Medicare+Choice Private Plan Options*, by Beth Fuchs and Jack Hoadley.

[11] PPRC, *Annual Report to Congress, 1997*. Washington 1997.

deductible plans will be the same as under Plan F or Plan J. This approach will remove first dollar coverage (which should presumably result in a significant reduction in premiums).

Impact on Medicare Spending. Medicare spending for beneficiaries with supplemental coverage is estimated to be significantly higher than expenditures for those without such coverage. A review of 1995 data by the Physician Payment Review Commission (PPRC) showed that Medicare expenditures for beneficiaries having Medicare coverage *only* were less than 75% of those for beneficiaries with Medigap. Medicare spending for beneficiaries with employer-provided benefits averaged 10% less than those for persons with Medigap. Higher Medicare spending reflects higher overall use of services. High service use among beneficiaries with secondary insurance appears to be a direct consequence of having such insurance.

Beneficiaries (particularly those with Medigap) may face little or no out-of-pocket costs at the time they use the additional services. They thus perceive the service to be free. Comparison of service use between those with and without private supplementary coverage suggests that there may be some overutilization of services. However, some of the increased services may represent appropriate service use.

Medicaid.

Covered Populations. Some low-income aged and disabled persons receive full or partial coverage under Medicaid. Such persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles" Medicare pays first. Medicaid picks up Medicare cost-sharing charges and provides protection against the cost of services generally not covered by Medicare, such as outpatient prescription drugs and long-term care.

Several population groups are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low-income beneficiaries (SLIMBs), and certain qualified individuals. QMBs are individuals with incomes below 100% of the poverty line and resources below 200% of the resource limit established for the Supplemental Security Income (SSI) program. The specific QMB income limits are $8,050 for a single and $10,850 for a couple in 1998. The resource limits are $4,000 for a single and $6,000 for a couple; certain items such as an individual's home are excluded from the calculation.

Medicaid pays Medicare's cost-sharing and premium charges for the QMB population. Medicaid coverage is limited to payment of these charges unless the individual is otherwise eligible for full Medicaid benefits. Thus, the QMB-only population does not have prescription drug coverage.

SLIMBs are persons meeting the QMB criteria except that their income is slightly over the QMB limit. The SLIMB limit is 120% of poverty. Medicaid pays Part B premiums only for the SLIMB population. Medicaid coverage is limited to payment of the Part B premium unless the individual is otherwise eligible for full Medicaid benefits. The SLIMB-only population is still liable for Medicare's cost-sharing charges as well as for the costs of uncovered services.

BBA 97 added coverage for qualified individuals. These are persons whose income is between 120% and 135% of poverty. These persons are eligible to have their Part B premiums paid through a block grant program. Potentially eligible persons will be served on a first-come, first served basis up to the state's allocation limit under the block grant.[12]

To date, a small percentage of persons actually eligible for the QMB or SLIMB program actually obtain the assistance. Only 63% of those potentially eligible for QMB benefits and 10% potentially eligible for SLIMB benefits participated in the programs in 1996.[13]

Program Spending. Medicaid costs are shared by the federal government and the states. The level of state spending is of concern to many observers. Many states have specifically objected to "unfunded federal mandates"; in the case of Medicaid this occurs when the federal government requires coverage of specific population groups without providing full federal funding. As a result of this concern, expanded coverage in BBA 97 is primarily paid for by the federal government.

A number of Medicare reforms would involve some modification to Medicare's benefit package. Any such change would have specific budgetary implications for Medicaid and thus for both federal and state spending. If Medicare's coverage were reduced (either through a reduction in services or the introduction of significant up-front cost-sharing), Medicaid costs could go up accordingly. Alternatively, states could choose to limit their cost increases by reducing the scope of Medicaid benefits. In this instance, beneficiaries would be entitled to a more limited package of benefits.

Beneficiary Incomes and Out-of Pocket Spending

Beneficiary Incomes. Most beneficiaries have relatively low incomes. In 1995, 46% of seniors had incomes below $15,000, 72% had incomes below $25,000, while only 6% had incomes over $50,000. Even fewer disabled beneficiaries had more than a modest income; 84% had incomes of $25,000 or less, while only 3% had incomes over $50,000. These relatively low income levels have generally made policymakers reluctant to increase Medicare's cost-sharing charges or reduce program benefits.

Despite the relatively low average income levels, there has been a significant improvement in the poverty rate for the elderly. In 1970, 24.6% of the elderly population had incomes below poverty, while in 1995 the figure had declined to 10.5%. Conversely the rate for children in 1995 (20.5%) was considerably above that

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[12] BBA 97 gradually transfers some home health spending from Medicare Part A to Medicare Part B. State Medicaid programs must cover that portion of the Medicare Part B premium attributable to this transfer for persons with incomes between 135% and 175% of poverty.

[13] Moon, Marilyn, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries*. Urban Institute. Washington. December 1996.

for the general population and substantially larger than that for the elderly.[14] These findings have raised questions regarding the appropriate use of limited resources.

Beneficiary Spending. Most beneficiaries pay out-of-pocket for a portion of their health care expenses. These payments vary not only by the total level of an individual's health care expenses but also by whether or not the individual has supplementary coverage and what type of supplementary coverage the individual has.

Several studies examined the level of out-of-pocket expenses and the relationship of these expenses to income. One study estimated that the non-institutionalized elderly spent *on average* $2,605 per person out-of-pocket in 1996. Of this amount, nearly 42% was spent for Medicare cost-sharing and Part B premiums, 31% on private insurance premiums, and 27% for noncovered services such as prescription drugs. Overall, the $2,605 figure represented 21% of household income for elderly persons. The percentage of spending was higher for poor persons — 30% for persons below poverty and 31% for those between 100% and 125% of poverty.[15]

Another study examined *median* out-of-pocket spending by non-institutionalized elderly. This study showed that half of this group spent at least 14.4% of their income on out-of-pocket health care costs in 1995. The highest spending was concentrated among the "near poor" elderly, that is those persons with incomes between 100% and 200% of poverty. Median spending for this group was between 45% and 61% of income. In contrast, the top one-quarter of elderly (those with incomes at least 400% of poverty) spent only 6.5% of their income on health costs.[16]

While the data differ somewhat between these two studies, it is clear that many low-income persons face significant health care costs not met by Medicare or supplementary coverage. These findings reflect a number of factors. While Medicaid provides good protection, it fails to cover all low-income persons. The findings also reflect the fact that not all persons eligible for the QMB and SLIMB programs participate. Further, persons entitled to QMB or SLIMB protection, but not full Medicaid coverage, do not have protection against all of their medical expenses.

Policymakers are concerned about the potential impact of any Medicare changes on low-income populations. Some have suggested that special provision may need to be made for these individuals.

Impact of Demographic and Other Changes

Medicare will begin to face the impact of the baby boom population in 2011. This will result in a rapid increase in the sheer number of aged Medicare beneficiaries over the ensuing 20 years. The baby boom population is likely to live longer than previous generations. This will mean an increase in the number of "old

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[14] U.S. Social Security Administration. *Annual Statistical Supplement*, 1997.

[15] Moon, et. al. *Protecting Low-Income Medicare Beneficiaries.*

[16] See CRS Report 98-534, *Medicare: Out-of-Pocket Health Spending*, by Jason Lee.

old" beneficiaries (i.e., those 85 and over). The combination of these factors is estimated to increase the size of the aged Medicare population from 34.3 million in 1995 to 39.8 million in 2010 and 61.5 million in 2025.[17] By 2030, the aged will account for about one-fifth of the population adding nearly 20% to the level of health spending.[18]

The number and health status of the aged population will also be affected by future advances in medical technology. Some changes will not only improve the health status of the aged but also prolong lives. The net impact on per capita health spending and by extension on Medicare health spending is difficult to predict.

Reform Options

As noted, the problems facing Medicare are not new. To date, the primary focus has been on enacting short-term measures designed to achieve budget savings and to postpone the Part A insolvency date. Generally this has involved enacting legislation limiting increases in payments to providers, primarily hospitals and physicians. Most observers agree that this approach alone will not address the long-term financing problem. Further, there is the concern that continued reductions in provider payments may result in fewer providers participating in the program and, by extension, limiting beneficiary access to care.

A number of different proposals have been offered to achieve program savings, modify the benefit package, or otherwise revise the current system. It is expected that the Bipartisan Commission will be looking at a number of these options. The proposals that the Commission is likely to look at can be classified into two broad categories. One set of proposals would involve program modifications, but would essentially retain Medicare's current structure. These include increasing the program's eligibility age, introducing means testing, and increasing beneficiary cost-sharing. Other proposals involve major restructuring. Proposals which have been suggested include modernizing the benefit structure, combining the Part A and Part B programs, replacing the program's current guarantee of a defined package of benefits with a defined per beneficiary contribution utilizing the current FEHBP model; or privatizing the program. The approaches are not mutually exclusive. For example, a restructuring proposal could also include an increase in the eligibility age.

The following sections outline the major proposals which have been offered to date. This report does not review proposals which could be categorized as a continuation or modification of previous efforts to limit year-to-year increases in provider payments. Also not reviewed are proposals targeted toward curtailing program fraud and abuse. These could stem cost increases. However, a reduction in fraud will not by itself resolve Medicare's long-term financial problems.

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[17] These are actually the Board of Trustees 1998 intermediate projections for the 65 and over social security population (which is almost identical to the Medicare population).

[18] Statement of Alan Greenspan, Chairman, Board Of Governors, Federal Reserve System before the National Bipartisan Commission on the Future of Medicare, April 20, 1998.

Program Modifications

Increasing the Program's Eligibility Age From 65 to 67.

Proposal. The Social Security Act Amendments of 1983 (P.L. 98-21) was designed to address long-range financing problems in the social security *cash* benefits program. One provision in that law raised the full retirement age (the age at which one receives unreduced cash benefits) from age 65 to 67 over the 2003-2027 period. The Medicare eligibility age remained at 65.

Some persons suggested that the Medicare eligibility age should be increased according to the same phase-in schedule established for social security benefits. The Senate-passed version of BBA 97 included this provision. (**Table 1** shows what the phase-in schedule would have been under the bill.) The provision proved very controversial and was dropped in conference.

Table 1. Eligibility Age by Year of Birth under Senate-Passed BBA

Year of birth	Eligibility age	Year of birth	Eligibility age
Before 1938	65 years, 0 months	1955	66 years, 2 months
1938	65 years, 2 months	1956	66 years, 4 months
1939	65 years, 4 months	1957	66 years, 6 months
1940	65 years, 6 months	1958	66 years, 8 months
1941	65 years, 8 months	1959	66 years, 10 months
1942	65 years, 10 months	1960 and after	67 years, 0 months
1943-1954	66 years, 0 months	--	--

Source: Table prepared by CRS, Education and Public Welfare Division .

Issues. Proponents of raising Medicare's eligibility age argue that is reasonable given the increases in life expectancy and general improvements in health status that have occurred since the program was enacted in 1965. They cite the fact that average life expectancy for a 65 year old increased from 14.3 years in 1960 to 17.5 years in 1996. They also note that people in their 60s are in generally better health and perhaps could work a few more years.

Proponents further argue that raising the age would result in needed program savings. The Senate-passed provision would have phased-in beginning in CY 2003.

CBO estimated that the provision would save $10.2 billion over the FY2003-FY2007 period.[19] (Estimates were not made for savings over the full phase-in period.)

Opponents of increasing the eligibility age argue that it would place a number of seniors at risk. They cite the circumstances of the uninsured population aged 62-64 and suggest that the problems could be magnified for the population aged 65-66. Among the younger group, 16% (900,000) were uninsured in 1996. Of these, 25% were poor and 51% were neither employed nor the dependent spouse of an employed person — characteristics that would make it unlikely for these persons to be able to afford insurance. Employment-based group coverage generally spreads costs across *all* workers in the same health insurance plan. However, private non-group insurance premiums for persons 62-64 generally reflect the higher risk attributable to the *individual* policyholder's age and health status. It is not unusual for persons in this age group to face annual premiums for non-group coverage of $4,000 to $6,000. [20]

Some observers state that raising the eligibility age would have the effect of lengthening the period when some persons were uninsured or faced very high premiums for coverage. It is likely that those most affected would be lower-paid workers. This suggests that higher paid workers could keep their employment-based coverage for the additional 2 years. However, recent trends in retiree health coverage suggest that this might not be the case. A Hewitt Associates[21] report (based on a constant sample of 600 large employers) shows that a declining share of large employers offered health benefits to retirees in 1996 compared to 1991. Further, the number of such employers charging premiums, tightening eligibility requirements, encouraging the use of managed care, and placing caps on coverage increased.

Some observers argue that the tendency of employers to restrict or drop coverage might be exacerbated if the proposal to increase the eligibility age were enacted. Many employers might decide that the provision of health insurance coverage for retirees was just too expensive. The Hewitt study estimated that gradually raising the eligibility age to 67 (using the same schedule applicable for social security) would increase the actuarial costs for lifetime retiree benefits by 12% for large employers with a younger workforce and 8% for employers with an older workforce. Once the phase-in to age 67 were complete (or if there were no phase-in) the increase would be 16% for employers with a younger workforce and 18% for those with an older workforce. These figures reflect the fact that the employer's average per capita cost for a retiree before Medicare eligibility is about three times that of a retiree with Medicare coverage ($4,000 vs. $1,350 in 1997).

Raising the eligibility age would also have implications for Medicaid. Under current law, some Medicare beneficiaries are also entitled to Medicaid on the basis

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[19] Congressional Budget Office Cost Estimate. *S. 947/H.R. 2015, Balanced Budget Act of 1997, as passed by the Senate on June 25, 1997.* July 2, 1997.

[20] See CRS Report 98-73, *Medicare Expansion: President Clinton's Proposals to Allow Coverage Before Age 65*, by Bob Lyke, et. al.

[21] Hewitt Associates LLC, *Retiree Health Trends and Implications of Possible Medicare Reforms*. Report prepared for Kaiser Medicare Policy Project (Henry J. Kaiser Foundation Grant Number 96-1710B), Washington, September 1997.

of income (These are the "dual eligibles.") Medicaid supplements Medicare coverage for this group. If the eligibility age were raised, Medicaid would (under current law) assume some expenses previously assumed by Medicare. As a result, a portion of the anticipated Medicare savings would translate into increased federal and state Medicaid costs. Alternatively, the eligibility age for Medicaid could also be increased; however, this would leave some low income individuals without any insurance coverage.

Buy-In Proposals. Some observers suggest that if Medicare's eligibility age is raised, the 65-66 year-old population should be able to buy into the program. One approach would require these persons to pay a supplemental early sign-up premium for the rest of their lives.[22] The buy-in approach has also been recommended for the under-65 population. The Administration has proposed allowing persons 62-64 to buy-in if they do not have access to employer-sponsored or federal health insurance. While they would pay most of their premium while enrolled in the early coverage program, a portion of their premium liability would be deferred until after they reached age 65.[23] [24]

The CBO estimated the costs of buying-in at $300 to $400 per month for the under-65 population under the Administration's plan. Similar estimates were included in a recent report prepared for the American Association of Retired Persons (AARP).[25] The AARP report estimated monthly premiums at $381 a month ($4,570 a year in 1997) assuming that 20% of the eligible population participated in the program. If the age were raised to 67, AARP estimated that the costs for ages 65 and 66 would be $420 a month ($5,041 a year) at a 20% participation rate. Higher participation rates could mean less adverse selection and lower premiums.

Observers are concerned about the implications of adverse selection (i.e., only those anticipating higher than average costs enroll, thus driving up the per capita costs). It is assumed that the buy-in proposals would result in some adverse selection. However, some are concerned about an "adverse selection spiral." If the buy-in were attractive mostly to higher cost people, premiums would rise. Over time, healthier individuals would find other insurance to be less expensive or would forgo coverage entirely. Unless the premiums were subsidized, costs would increase to the point that either few people would enroll or the early-buy-in would not pay for itself.

Means Testing.

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[22] See Reischauer, Robert D. *Two Years That Make a Big Difference*. Letter to the Editor. *New York Times*, July 13, 1997.

[23] The Administration plan would allow displaced workers aged 55-61 to buy-in if they lost employer-sponsored coverage; they would pay the full premium while enrolled in the early coverage program.

[24] The proposal was introduced as H.R. 3470 (Representative Stark) and S. 1789 (Senator Moynihan). For further information see CRS Report 98-73, *Medicare Expansion: President Clinton's Proposals to Allow Coverage Before Age 65*, by Bob Lyke, et. al.

[25] McDevitt, Roland D. (Watson Wyatt Wordwide). *A Medicare Buy-In: Examining Costs for Two Populations*. Paper prepared for American Association of Retired Persons (AARP). Public Policy Institute, AARP, Report #9804, April 1998.

Proposal. Medicare is not a means tested program. There are no income or assets tests for coverage. Further, the benefits and cost-sharing requirements are the same for all persons, regardless of income. Some observers have suggested that means testing should be incorporated into the program. The most common proposal is that of means testing the Part B premium.

Under current law, all persons enrolled in Part B pay a monthly premium equal to 25% of program costs. Federal general revenues account for the remaining 75%; (sometimes referred to as the federal subsidy). Many persons argue that it is inappropriate for taxpayers to pay three-quarters of Part B costs for high income Medicare beneficiaries. They point out that low and middle income working persons may be subsidizing higher income elderly persons. In response to these concerns, proposals to income relate the Part B premium have been offered for several years.

The Senate-passed version of BBA 97 would have provided for an income-related Part B premium for individuals with incomes over $50,000 and couples with incomes over $75,000. Individuals with incomes at or above $100,000 and couples with incomes at or above $125,000 would have paid 100% of program costs. The federal subsidy would have been phased-out on a straight-line sliding scale. For individuals, the phase-out would have occurred over the $50,000 to $100,000 income range and for couples over the $75,000 to $125,000 income range.[26]

At the time the BBA 97 proposal was considered, the Congressional Research Service estimated that 1.6 million persons age 65 or older (5% of the noninstitutionalized aged population) would have experienced higher Part B premiums under the Senate bill. This number included approximately 323,000 single filers with adjusted gross income (AGI) in excess of the $50,000 threshold and 1.3 million joint filers, with AGI in excess of the $75,000 threshold.[27]

The Senate-passed BBA provision was controversial and was dropped in conference. Many observers are reluctant to introduce means testing into the current program. They note that once means testing is approved, it would be easier to lower the income threshold at some future date as part of a budget savings measure. Means testing could thus affect persons with more modest incomes. Another concern is that if some beneficiaries are required to pay 100% of Part B costs, they might drop Medicare and seek alternative coverage. At this point, insurers do not market Part B coverage (except for supplementary coverage) to the over-65 population. However, this might change if insurers felt there was a market for this type of product. If too

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[26] For example, the 1998 Part B premium is $43.80 per month ($525.60 per year) which represents 25% of costs; the federal subsidy is $131.40 per month (which represents 75% of costs). Over the year, the federal subsidy is $1,576.80. If the Senate provision were in effect, individuals with incomes over $100,000, would be subject to a Part B premium of $175.20 ($2,102.40 a year, 100% of costs). Those with incomes between $50,000 and $100,000 would have monthly premium amounts between $43.80 (the current amount) and $175.20.

[27] CRS Memorandum, *Estimates of Number of Persons Age 65 and Older Subject to Proposed Medicare Part B Premium Increases under the Balanced Budget Act of 1997 (H.R. 2015) as Passed by the Senate*, by Thomas Gabe. July 7, 1997.

many healthier people dropped Part B, this could potentially result in adverse selection, with sicker people staying in Part B and driving up the per capita costs.

Administration. The major issue during the most recent debate was how means testing would be administered. Many claim that income-relating the Part B premium would be costly to administer because of the need to obtain and verify income information. While currently available through Internal Revenue Service (IRS) records, there is no other currently operational system of identifying income. The Senate-passed version of BBA 97 had proposed that a parallel system to the IRS be created through HCFA to identify income level. Some argued that this proposal would have required a large resource commitment. Many argue that given that the IRS already accesses income data, it should be the entity to administer an income-related premium. However, others are concerned that if the IRS administers the income-related premium it will be viewed as a tax.

Increased Beneficiary Cost-Sharing. Some observers have suggested that beneficiary cost-sharing should be increased. Proposals which have been offered include increasing the Part B coinsurance from 20% to 25%, increasing the Part B deductible from the current $100 to a level more comparable to that in private insurance plans (such as $200-$250), and imposing coinsurance on services not currently subject to such charges (such as home health care and lab services).

Increased cost-sharing would presumably make beneficiaries more cost conscious in their use of services. However, some observers are concerned that increasing cost-sharing charges could impede access for some beneficiaries. They cite data showing that over 70% of the aged and close to 85% of the disabled Medicare beneficiaries had incomes below $25,000 in 1995.[28]

Most beneficiaries have supplementary coverage and therefore would not directly feel the impact. Persons likely to be most immediately affected by changes in cost-sharing requirements are persons in fee-for-service Medicare without any supplementary health insurance coverage (approximately 11.3% of the 1996 Medicare population.)[29] Many of these individuals have incomes above the levels necessary to qualify for full Medicaid or QMB coverage but not high enough for them to obtain other supplementary coverage.

Beneficiaries with employer-based coverage might or might not see increased out-of-pocket expenses if cost-sharing charges were raised. As noted previously, a number of employers are rethinking the amount of supplementary coverage they are offering their retirees.

Beneficiaries with Medigap insurance would see increased premium charges. A number of observers have suggested that as Medigap premiums keep rising, more beneficiaries may be encouraged to join HMOs or other managed care arrangements under the Medicare+Choice program.

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[28] HCFA, *A Profile of Medicare Chart Book, 1998*.

[29] Eppig and Chulis, Trends in Medicare Supplementary Insurance: 1992-1996.

Medigap Modifications. Some have suggested that incentives in current Medigap policies should be revised. As noted in the introductory chapter, beneficiaries with Medigap coverage tend to perceive services as free at the point when they are actually using them; thus they use more services and cost Medicare more money than those without supplementary coverage. Another concern is that while current Medigap policies offer good protection against some Medicare-related costs, they offer less adequate protection against other potential expenses of the elderly. For example, even the most generous Medigap policy (Plan J) limits coverage for prescription drugs to 50% of the cost of prescriptions after the policyholder meets a $250 per year drug deductible; the maximum annual drug benefit is $3,000.

The BBA 97 permits beneficiaries to purchase policies which have high deductibles in exchange for lower premium charges. Specifically, the law provided for 2 additional Medigap plans. These plans would be identical to the current Plan F and Plan J, except that they would have a high deductible — $1,500 in 1998 and 1999 and indexed to inflation thereafter.[30] This will enable beneficiaries to obtain *catastrophic* Medigap protection at a lower premium charge.

Some analysts have suggested taking this approach a step further by *prohibiting* some or all of the 10 standard Medigap packages from offering first dollar coverage. This presumably would make beneficiaries more cost conscious in their use of services and by extension lower Medicare costs. It should also have the advantage of lowering Medigap premiums. However, the elderly are generally risk adverse and tend to want full coverage. Some of this concern might be allayed if provision were made for full coverage after an individual had incurred a certain level of catastrophic expenses.

Innovations in the Current Medicare Program.

Managed Care Initiatives. Prior to enactment of BBA 97, persons enrolled in Medicare had two basic coverage options. They could obtain services through the traditional fee-for-service program. Alternatively, they could enroll with a managed care plan (generally a risk-based HMO) which had entered into an agreement to provide covered services to beneficiaries. BBA 97 significantly expands the private plan options available to beneficiaries. Under the new Medicare+Choice program beneficiaries will be able to obtain services through HMOs, preferred provider organizations, provider-sponsored organizations, private fee-for-service plans, and, on a limited demonstration basis, high deductible plans offered in conjunction with medical savings accounts. The law established a new method for paying for participating plans. It also established new rules for enrollment and disenrollment; required plan comparisons be made available to beneficiaries; specified financial and organizational requirements; and included a number of provisions designed to protect

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[30] As noted in the discussion on Medigap coverage, beneficiaries select a Medigap policy from one of 10 standardized plans. These are known as Plans A through Plan J. The Plan A package covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive (and includes some drug coverage).

beneficiaries. Within these parameters, plans will be able to experiment with alternative ways of delivering services. It is expected that over the next several years, plans will experiment with a variety of approaches.

Fee-for-Service Initiatives. Some observers have suggested that some of the innovative cost-savings approaches being tested in the managed care environment could also be applied to the fee-for-service system. Some approaches are currently being tested. For example, HCFA is conducting a Medicare Participating Heart Bypass Center Demonstration under which hospitals and physicians are paid a single negotiated global price for all inpatient care for heart bypass patients. Also, as a result of BBA 97, HCFA will shortly be entering into competitive bidding demonstrations for the furnishing of Part B services (excluding physicians services). Under competitive bidding, the Secretary would conduct a competition among individuals and entities supplying items and services in the demonstration area. The Secretary could limit the number of contractors in an area to the number projected to meet demand at a given price; noncontracting entities could not receive Medicare payment except in cases of urgent need.

Many observers have suggested that additional alternatives should be examined. The Study Panel on Fee-For-Service Medicare convened by the National Academy of Social Insurance has recommended that Medicare's fee-for-service program should move beyond its function as a bill payer to one more accountable for health care quality and costs. It urged management reforms based on the best practices of private health plans. The Panel recommended that Congress should mandate that Medicare experiment with methods developed in the private sector for providing and managing services. In particular HCFA should look at disease and case management for persons with chronic conditions and other special health care needs. HCFA should also look at providing beneficiaries with incentives to use selected providers and implementing a competitive procurement process. The Panel further recommended that HCFA target the innovations toward geographic areas and populations where they had the most potential to improve quality and cost outcomes. The Panel further recommended that HCFA be given authority to waive statutory requirements so that it could conduct these experiments in a more timely manner and make successful experiments part of the regular Medicare program.[31]

Another approach, offered by Theodore Marmor and Jonathan Oberlander, is that of budgetary caps coupled with centralized regulation of provider payments. Under the proposal, the federal government would set an annual budget for all Medicare expenditures for the coming year. Separate caps would be set for various service categories such as hospital care and physicians services. The authors argue that commitment to a global budget would impose stronger fiscal discipline than has occurred to date.[32] The Balanced Budget Act of 1995 (which was vetoed by the President) included a similar "failsafe" proposal. Under failsafe, aggregate spending

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[31] National Academy of Social Insurance. *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare*. Final Report of the Study Panel on Fee-For-Service Medicare. Washington., January 1998.

[32] Marmor, Theodore, and Jonathan Oberlander. Rethinking Medicare Reform. *Health Affairs*, v. 17, no. 1, January/February 1998.

limits were established for the fee-for-service program. If it were anticipated that spending would exceed specified budget targets, reductions would be made in payments to providers, with cuts applied proportionately to excess spending sectors.

As noted earlier, the primary means of achieving savings in Medicare has been through reductions in payments to providers. The Marmor/Oberlander proposal would continue this approach and add an additional element, namely an overall budget. This approach raises several issues chief of which is how a sufficiently stringent budget could be imposed without affecting beneficiary access to care.

Restructuring

A number of observers have suggested that the problems facing Medicare require more than modifications to the existing system but rather a fundamental program restructuring. They suggest that the current program reflects in large measure both the health care delivery system as well as political considerations that were in place at the time of enactment in 1965. They argue that Medicare has failed to keep pace with changes in the health care delivery system as a whole. These observers have suggested that the whole program including benefit design, program structure, and financing mechanisms should be reexamined. While a consensus has not been reached on a restructuring proposal, a number of recommendations have been offered. These include modifying the current benefit package; combining the current Part A and Part B programs; replacing the program's current guarantee of a defined package of benefits with a defined per beneficiary contribution such as that under the current FEHBP model, or privatizing the program.

Redesign the Medicare Benefit Package. Many observers state that Medicare's benefit structure does not reflect the current health care delivery system. As noted in the introductory chapter, Medicare's benefit package is somewhat less generous than typical employment-based coverage. Some persons have suggested that a redesign is appropriate. They recommend inclusion of such additional items as prescription drugs or a catastrophic limit on out-of-pocket expenses. However, such expansions have the potential for significantly increasing Medicare's costs.

Modifications could be considered in the context of other reforms. For example, a Part B catastrophic limit could be coupled with a significant increase in the part B deductible. Another approach would be to allow beneficiaries more freedom in selecting a benefit package tailored to their individual needs. Still another approach would expand the package of covered services but place an overall per capita cap on expenditures. Regardless of the approach taken, revisions would need to be considered in the context of the entire package of benefits available to the Medicare population, including their supplementary coverage. For instance, a program change which might increase beneficiary out-of-pocket Medicare costs might at the same time lessen the need to purchase Medigap policies.

Combine Part A and Part B. Frequently, proposals to redefine Medicare's benefit structure include a recommendation to combine the current Part A and B programs. A number of observers have suggested that Medicare's current two part structure is no longer appropriate. They note that the vast majority of beneficiaries are enrolled in both programs. They also cite the program's increasing emphasis on

managed care approaches and the fact that the new Medicare+Choice program requires enrollment in both Parts A and B.

While many observers agree that the current structure may not be the most appropriate in face of today's realities, they question how the two vastly different systems should be combined. Of particular concern are the two different financing structures. Part A is funded by current workers through a payroll tax, while Part B is funded by current beneficiaries and federal general revenues. Under the current design, Part A becomes insolvent when payroll taxes are not sufficient to meet current obligations. Under current law, no general revenue financing is available for Part A. A combination of the two programs could potentially alter this situation. Many are concerned that if the two programs were combined, there would be less incentive to control costs since "general revenues would be available." However, such a plan would likely include some overall limit on general revenue expenditures.

The combination of Parts A and B would likely be part of any major reform plan such as a defined contribution system or privatization; it could also be part of a more modest reform package.

Defined Contribution.

Background. Medicare guarantees that each beneficiary is entitled to a defined package of services. There is no upper limit on the number of covered services an individual can receive, provided the services are medically necessary. Under the traditional fee-for-service system, Medicare itself assumes the financial risk associated with the provision of benefits. Under the Medicare HMO program (and soon other Medicare+Choice plans) individual plans assume the risk; however, they are required to offer beneficiaries coverage for at least the same services as are provided under the fee-for-service program. Many such plans also offer coverage for services not reimbursed under the traditional Medicare program, such as annual physicals and prescription drugs. Individual plans establish payment rates for providers serving the plan's enrollees. Payments to plans are based on a formula established in law; they are risk adjusted according to beneficiary demographic characteristics.

Some observers have recommended moving to a defined contribution plan. This approach is similar to that used for managed care plans in that a specific per-capita dollar amount would be paid on behalf of each Medicare recipient. However, unlike the current system, plans would not be required to offer a specified package of benefits. Under one defined contribution scenario, the beneficiary could take the per capita payment amount in the form of a voucher and purchase insurance coverage on the open market. However, the approach most frequently suggested is that used under the current FEHBP.

Under FEHBP, eligible individuals select from competing plans which have contracted with the Office of Personnel Management (OPM). Participants can choose from a relatively wide variety of health insurance and prepaid plans offering differing combination of benefits, cost-sharing, and premiums. The federal government establishes standards for carrier and plan participation in the program, but it does not regulate the payments made by such carriers and plans to providers.

OPM negotiates with FEHBP plans the premiums they intend to charge. The fee-for-service plans (such as the Blue Cross standard option) charge a single national premium. HMOs in an area are allowed to charge a single premium that approximates for an enrolled group of a similar size their local commercial rates. FEHBP pays each plan a fixed dollar amount equal to 72% of the average premium of all participating plans (but not exceeding 75% of the individual plan premium). The enrollee pays the remainder (which averages about 28%). Enrollees that want coverage under more generous plans pay higher premiums. OPM *does not risk adjust* plan payments based on participants' demographic characteristics or expected utilization of services.

Proposal.[33] If the FEHBP model were applied to Medicare, the government would set minimum standards for plans to participate, provide a process for qualifying plans, and provide information on plan choices to the beneficiary population. Available plan choices would be similar to the types of options available under Medicare+Choice. A key difference would be that plans would not be required to offer beneficiaries the current Medicare benefit package. Beneficiaries would select from a variety of plans with different benefits, cost-sharing requirements and premium levels. Presumably, beneficiaries would no longer purchase separate Medigap coverage, but would purchase a single package for all their health insurance needs.

Under a FEHBP model, the federal government would make a specified payment ("premium contribution") per beneficiary. The beneficiary would pay the individual insurance or prepaid plan the difference between the federal contribution and the plan's premium. There are a number of key design issues that would need to be addressed. These include how the initial federal contribution amount would be set and how the annual updates would be determined. Broadly speaking, there are two options. The first would set the amount based on some annual recalculation based on the plans' competitively bid premiums (for example a weighted average). The second option would set a base level with updates linked to some inflation indicator (for example the consumer price index). A related issue is how any geographic adjustments should be incorporated into the premium calculation.

The potential for adverse selection would also need to be addressed. Plans could potentially design benefit packages to appeal to healthier beneficiaries. Even if the plans themselves did not actively market to healthier individuals, beneficiary self-selection could achieve similar results. Over time the sicker and low-income beneficiaries might be forced into a relatively limited number of plans. One way to address this concern would be to adjust the federal contribution amount to reflect variations among beneficiaries in health status. Key issues are how any such risk adjustments would be calculated and administered.

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[33] For further discussion on defined contribution model approaches, see: (1) Physician Payment Review Commission. *Annual Report to Congress, 1997*. Washington, 1997; and (2) Fronstein, Paul and Craig Copeland, *Medicare on Life Support: Will it Survive?* Employee Benefit Research Institute, EBRI Issue Brief Number 189, Washington, September 1997.

Proponents of a defined contribution system argue that it would enable the federal government to control aggregate federal outlays. They also suggest that it would enable beneficiaries to purchase coverage more tailored to their individual health care needs. For example, a given beneficiary might elect to purchase a policy which emphasizes prescription drug benefits or preventive care. Proponents also note that Medicare would no longer be charged with setting prices paid to providers. It is argued that private insurers and health plans participating under the program would take the necessary steps to control their costs in order to remain competitive.

Critics of a defined contribution model suggest that the system may place individual beneficiaries at undue risk if the per capita payment fails to keep pace with the rising cost of plans. Low-income beneficiaries would be particularly hard hit and might be forced to choose low cost or low quality plans. Questions have also been raised regarding the number and mix of plans that would compete in the market if the value of the federal contribution eroded over time. Further, any clout that the government might have as a large purchaser could also be eroded.

As previously noted, Medicare currently pays about half of an aged beneficiary's total health care costs. The remainder is paid for through a combination of Medigap plans, private employer coverage, other programs (such as the military) and out-of-pocket payments by the beneficiaries themselves. Under a defined contribution model, Medigap would no longer play an important role. However, consideration would need to be given to the impact of restructuring on coverage offered through other third party sources and on total out-of-pocket payments made by beneficiaries.

A recent analysis of the impact of possible Medicare reforms on retiree health coverage suggests that if the Medicare program moved to a defined contribution approach, employers would almost be forced to adopt a similar model. The report noted that if employers continued with a defined benefit approach, they would expose themselves to a greater risk of cost shifting. This is because future increases in Medicare's payment amount would not be expected to keep pace with the increases in health care costs. The report further suggested that if Medicare went to a defined contribution system, employers could be expected to accelerate recent efforts to limit their financial liability. Large employers could also rethink the extent to which they wished to offer retiree coverage.[34]

The analysis further noted that employers who decided to continue retiree coverage would have to decide how to provide a viable supplement to a program under which the retiree chooses from a variety of health plans. Some of these coordination issues are already being raised by the new Medicare+Choice program.

Consideration must also be given to the impact of a defined contribution system on low-income beneficiaries. One question is the type of financial support that would be provided through Medicaid or another mechanism to assist these persons in meeting their premium and cost-sharing obligations. Another question is how the

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[34] Hewitt Associates LLC, *Retiree Health Trends and Implications of Possible Medicare Reforms*. Report prepared for Kaiser Medicare Policy Project (Henry J. Kaiser Foundation Grant Number 96-1710B), Washington, September 1997.

program would be designed to assure that beneficiaries had access to a reasonable selection of plans at an affordable cost.

Demonstration Proposal. The BBA 97 provided for competitive pricing demonstration projects under which payments to different Medicare+Choice organizations in defined payment areas would be determined under a system of competitive pricing. The Secretary is required to designate, in conjunction with the newly established Competitive Pricing Advisory Committee (CPAC), up to seven areas in which the project would be conducted. For each area, the Secretary, in accordance with CPAC recommendations, would establish the benefit design among plans, structure the method for selecting plans, and establish methods for setting the price to be paid to plans.

The Study Panel on Capitation and Choice, convened by the National Academy of Social Insurance, has recommended implementation of defined contribution demonstrations in conjunction with the competitive pricing demonstrations.[35] The defined contribution demonstrations, based on a premium support model (discussed below), would offer traditional fee-for-service as one of the options. The basic Medicare benefit package would be expanded to include a modest prescription drug benefit. A limited number of supplemental packages could be purchased in addition to, or in conjunction with, other plans. The demonstration would not include persons with employer-based retiree coverage.

Under the study panel recommendation, total payments to plans would be established by local entities contracting with HCFA, in consultation with the CPAC established by BBA 97. The process would take into account bids submitted by plans as well as general economic conditions. All bids would be based on the assumption of providing services to all beneficiaries in the demonstration area. The bids would show costs of providing basic Medicare benefits, enhanced benefits provided under the demonstration, and additional benefits offered by each plan. Medicare would determine a fixed contribution toward the cost of premiums for all participating plans. Actual Medicare payments to plans would be risk-adjusted based on the individual's expected use of services. However, individual premium payments within each plan would not vary by health status. Beneficiary costs (increased premiums and copayments) or savings (reduced premiums or added benefits) would be based on the difference between the plan's premium price and the Medicare contribution. The Panel concluded that planning the demonstration would take 3 years with the actual demonstration running 5 years.

Private Investment Approaches. Some persons have recommended that the current Medicare program be replaced by an investment-based system under which people build up assets during their working years to fund their medical costs in retirement. This is referred to as "privatization." Privatization proposals would move away from the current system under which current *workers* pay for the Part A expenses of current *retirees*. Instead, workers would be saving for their own future health care needs. Proponents argue that these approaches would allow individuals

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[35] National Academy of Social Insurance, *Structuring Medicare Choices*. Final Report of the Study Panel on Capitation and Choice, Washington, April 1998.

to take advantage of the gains that can be made through investment earnings. Individuals would also be able to exercise more control over their health care.

The idea of privatizing entitlement programs is not new. In recent years, a number of proposals have been offered to privatize the social security cash benefits program. These recommendations have taken a variety of forms. One reform option would replace the current system with a system of personal investment accounts. Other approaches would combine the current system with a new personal savings account system; depending on the plan, personal savings accounts would be funded by a portion of existing payroll taxes or by additional funds. Another variant would retain the current social security program structure but create a social security investment board with authority to invest in the stock market.[36]

Proponents of privatization argue that investment of monies in stocks or mutual funds would allow the holdings to grow at rates that significantly exceed those currently earned when monies are only invested in government securities. Other observers caution that the recent upsurge in the stock market may not continue over the long term. Further, a drop in asset value just before retirement or investment in low earning accounts could have a serious impact on the affected individuals.

Another concern is how the transition from the old system to the new system would be structured and financed. Current workers pay for current retirees through payroll taxes. If workers shifted some or all of their funds to saving for their own retirement, these monies would stop entering the system for current retirees.

To date, the privatization discussion has primarily focused on the social security cash benefits program though some aspects of a number of the plans could be adopted in modified form for Medicare. One proposal for Medicare has been outlined by Senator Phil Gramm, Thomas R. Saving and Andrew J. Rettenmaier.[37] Under this plan, the current Medicare program would be converted into an investment-based system. Each age cohort (defined as persons born in a given calendar year) would insure itself against future retirement medical expenses. Each *worker* in the cohort would be required to make a contribution, equal to a specified percentage of wages, which would be used to fund medical expenses arising during retirement. As the cohort aged, the amount of the wage-based payment would be periodically adjusted as more information about the cohort's future medical needs became available. The annual cumulative funds collected from each age cohort would be divided equally and deposited in each persons's account to grow until retirement.

Worker participation in the program would be mandatory. Workers in a particular age cohort would subsidize nonworkers in that cohort and high wage

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[36] See CRS Report 96-504, *Ideas for Privatizing Social Security*, by David Koitz.

[37] Gramm, Phil, Andrew J Rettenmaier, and Thomas Saving. *Medicare Policy for Future Generations — A Search for a Permanent Solution*. Sounding Board. *New England Journal of Medicine*, v. 338, no. 18, April 30, 1998.

earners would subsidize low wage earners. If a person died before retirement, their contributions would be redistributed to other members of their respective age group.

The Gramm-Savings-Rettenmaier proposal anticipates that beneficiaries would have a range of health care choices when they retire. Their estimates are, however, based on a plan with a $2,500 deductible and 100% coverage thereafter. (The $2,500 figure is slightly less than current out-of-pocket expenditures for the aged.) Necessary contributions are compared with the current payroll tax contribution of 4.39 % of wages (2.9 % Part A tax plus an implied 1.49 % Part B tax in 1996). The authors estimate that a new 22-year old worker could fully fund anticipated future costs with a contribution of 1.58% of payroll over the individual's working career; a 43-year old could just fund their costs with the 4.39% rate. The current 4.39% tax would be retained for a 50-year transition period. Age cohorts 43 and younger could be moved into the new plan with this contribution rate. Older workers would remain in the current Medicare program. Their expenditures would be paid for through the excess of contributions from the switched population (i.e., payroll taxes contributed by those under 44), the contributions of the yet to retire population, and general revenue contributions (estimated at $49 billion annually). These estimates are based on an estimate of 3.5% real rate of return on investment and an assumption that over time market forces will drive medical care prices back in line with the general price index. The authors anticipate total transition costs of $2.7 trillion.

Proponents of privatization plans argue that investment in private markets would allow the program to benefit from the effect of compound interest. However, there are a number of issues that would need to be considered in the design of an investment-based plan. These include whether the system could accommodate unanticipated long-term downturns in the private market or a sharp increase in inflation. Another concern is the ability of private investment approaches to respond to future changes in the health care market which cannot be predicted at this time. For example, new technologies could have a major impact (either positive or negative) on the overall costs of medical services. New developments could also potentially result in a significant increase in life expectancy and by extension a significant increase in total health care costs over an individual's lifetime.

It is difficult to predict the scope and adequacy of health care policies that will be available for purchase at some point in the future. It is also difficult to predict whether funds in individuals' accounts will be sufficient to purchase policies over their entire post-retirement lifetimes. Periodic adjustments to the tax would minimize these problems during workers' employment; however, this would no longer be true as the majority of the population in the cohort retired.

Additional questions arise with respect to low-income individuals. For example, would the $2,500 deductible policy that a low-income individual purchased with investment-based funds really meet that individual's health care needs? What provision would be made if such policies fell short? Another question relates to whether assistance would be provided to assist low-income persons to meet the out-of-pocket costs associated with a high-deductible catastrophic policy.

Current Prospects

The National Bipartisan Commission on the Future of Medicare is reviewing a range of options for reforming Medicare. The Commission's required reporting date is March 1, 1999. Some observers have noted that this date is too early to allow a thorough review of the impact of the Medicare+Choice program added by BBA 97.

By law, the Commission's report can contain only those recommendations that have received the support of 11 of the 17 members. Many persons have suggested that the Commission, faced with almost 10 years of projected solvency in the Part A program, may be unable to come to agreement on major reform recommendations. These concerns have been countered by various Commission members who state that they intend to come to agreement on recommendations.

Any reform recommendations will need the support of a broad constituency representative of beneficiaries, providers, and future beneficiaries. Each will need to perceive some benefit to them in the reforms; they will also need to feel that any new burdens are shared relatively equally.

At his point it is difficult to predict precisely what a revised Medicare program will look like or when Congress might actually enact changes. However, it is likely that it will contain some elements of the reform options currently under consideration.

Appendix A. National Bipartisan Commission on the Future of Medicare[38]

BBA 97 Provision

The BBA 97 provided for the establishment of a 17-member Bipartisan Commission on the Future of Medicare. The Commission is required to review the program's financial condition, identify problems that threaten its financial security and analyze potential solutions. It is also required to make recommendations concerning concerning the following issues: (1) restoring financial solvency and integrity; (2) establishing an appropriate financial structure for the program as a whole; (3) establishing the appropriate balance of benefits and beneficiary contributions; (4) financing graduate medical education (GME); (5) whether the eligibility age should be modified to conform to that applicable to social security; (6) the feasibility of allowing those between age 62 and the Medicare eligibility age to buy into the program; (7) impact of chronic disease and disability trends on the future costs and quality of services under the current system; and (8) time periods during which recommendations in (1) - (3) should be implemented. It is further required to make recommendations concerning a comprehensive approach to preserve the program.

The Commission must submit a report by March 1, 1999. By law, the report is to include only those detailed recommendations, findings, and conclusions of the Commission that receive approval of at least 11 members of the Commission.

Membership

BBA 97 provided that the members of the Commission would be appointed by December 1, 1997. It specified that four members were to be appointed by the President; six members by the Speaker of the House in consultation with the Minority Leader (of whom no more than four were of the same party); six members by the Majority Leader of the Senate in consultation with the Minority Leader (of whom no more than four were of the same party). The Chairman would be jointly appointed by the President, Speaker, and Majority Leader.

While BBA 97 required that members be appointed by December 1, 1997, not all members were appointed until January 16, 1998. Senator John Breaux was appointed Chairman and Congressman Bill Thomas was appointed Administrative Chairman. **Table 2** lists all Commission members.

Commission Activities

The Commission membership has been divided into three task forces — modeling, reform, and fundamental restructuring. The Commission has defined the role of each task force as follows. The modeling task force will define the problem

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[38] For additional information, see the Commission's Web site at: http://thomas.loc.gov/medicare/.

and then help the Commission members educate the public about issues confronting the Medicare program. The reform task force will review options to strengthen the current program and prepare it for future changes. The fundamental restructuring task force will approach the Medicare program from a "blank sheet of paper" perspective. Both the reform and fundamental restructuring task forces will organize their work around the following four topics: (1) eligibility, (2) benefits, (3) structure, and (4) financing and cost.

Table 2. Medicare Commission

Honorable John Breaux, Chairman , Senator (appointed by President Bill Clinton, Honorable Trent Lott, Honorable Thomas Daschle, Honorable Newt Gingrich, & Honorable Richard Gephardt)
Honorable Bill Thomas, Administrative Chairman, Congressman (appointed by Gingrich)
Mr. Stuart H. Altman, Ph. D., Sol C. Chaikin Professor of National Health Policy, Brandeis University, Waltham, MA (appointed by Clinton)
Honorable Michael Bilirakis Congressman (appointed by Gingrich)
Ms. Colleen Conway-Welch, Ph.D., Dean of the School of Nursing, Vanderbilt University (appointed by Gingrich)[39]
Honorable John Dingell, Congressman (appointed by Gephardt)
Honorable Bill Frist, Senator (appointed by Lott)
Ms. Ilene Gordon, State Office Staffer, Honorable Trent Lott (appointed by Lott)
Honorable Phil Gramm, Senator (appointed by Lott)
Mr. Samuel Howard, Chairman, Phoenix Healthcare Corporation, Nashville, TN. (appointed by Gingrich)
Honorable J. Robert Kerrey, Senator (appointed by Daschle)
Honorable James A. McDermott, Congressman (appointed by Gephardt)
Honorable John D. Rockefeller, IV, Senator (appointed by Daschle)
Ms. Deborah Steelman, Attorney (appointed by Lott)
Ms. Laura D'Andrea Tyson, Ph.D., Professor of Economics, University of California at Berkeley (appointed by Clinton)
Bruce Vladeck, PhD., Professor of Health Policy, Mt. Sinai School of Medicine, New York, NY (appointed by Clinton)
Mr. Anthony L. Watson, Chairman and CEO, Health Insurance Plan, New York, NY (appointed by Clinton)

[39] Replaced **Honorable Greg Ganske**, Congressman, who resigned July 15, 1998.