B. HEALTH PROGRAMS

7. Require a monthly Medicare Part A premium, indexed to program costs

CURRENT LAW

There are two parts to Medicare: Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Americans aged 65 or older are automatically entitled to Part A benefits under Medicare if they or their spouse are eligible for monthly Social Security or Railroad Retirement cash benefits. People under age 65 who are receiving Social Security disability benefits are also eligible for Medicare Part A after a two-year waiting period. All people age 65 and older and those under age 65 receiving Social Security disability benefits may elect to be covered under Part B.

Part A is financed through a 1.45 percent payroll tax on current wages. Both workers and their employers pay the tax at a combined rate of 2.9 percent. Self-employed individuals are taxed at the combined rate of 2.9 percent of their earnings. For workers earning average wages over their lifetime who enroll in Medicare Part A in 1994, the average insurance value of benefits is estimated to be 2.5 times the lifetime payroll taxes paid (including interest) by the employer and the employee. For future enrollees, the ratio of the average insurance value of benefits to payroll taxes paid is expected to decline because of increased lifetime contributions due to changes made in OBRA 93. The Medicare HI Trust Fund is projected to be insolvent by the year 2001. No premium is required for enrollment in Part A.

OPTIONS

(a) $25 per month. This option would establish a Medicare Part A premium of $25 per month starting in 2000. Thereafter, the premium would be indexed based on Part A program costs.
(b) $40 per month. This option is similar to Option (a) except that the monthly Part A premium would start at $40 in 2000.
(c) $60 per month. This option is similar to Options (a) and (b) except that the monthly Part A premium would start at $60 in 2000.

These options would require beneficiaries to bear a greater share of the costs of Part A benefits, reducing the Federal subsidy, but not eliminating it. As in Part B, Medicaid would be required to pay the premium for low-income individuals. Federal Medicaid payments to States could be raised to cover increases in State Medicaid spending resulting from this option. The premium could also be reduced for low-income Medicare enrollees who do not qualify for Medicaid under current law.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Outlay savings	0.12%	0.15%	0.20%	0.25%
b. Outlay savings	0.19%	0.24%	0.32%	0.41%
c. Outlay savings	0.28%	0.36%	0.48%	0.61%

8. Modify the $100 Medicare Part B deductible for increases in program costs

CURRENT LAW

Medicare Part B is a voluntary program for all persons over age 65 and all persons enrolled in Medicare Part A. Enrollees in Part B pay a monthly premium of $41.10. By statute, the premium will rise to $46.10 in 1995. Current law also imposes a deductible that requires enrollees to pay the first $100 of medical expenses that would otherwise be covered by Part B. The Federal government pays 80 percent of Medicare approved fees for most covered services above the deductible. The enrollee is responsible for the remaining costs.

When Medicare began in 1966, Congress set the Part B deductible at $50. Since that time, Congress has increased the deductible three times to the current level of $100. During the same period, consumer prices have increased by 350 percent and the cost of medical care for urban consumers has increased by 680 percent. The deductible has fallen from 45 percent of average charges for services covered by Medicare Part B (including amounts paid by enrollees for deductibles and copayments) in 1967 to about 5 percent in 1993.

OPTIONS

(a) Index the Part B deductible for increases in program costs starting in 2000. This option would index the deductible beginning on January 1, 2000, based upon the rate of growth in Part B charges per enrollee.

(b) Index the Part B deductible for increases in program costs immediately. This option would index the deductible beginning on January 1, 1996.

(c) Increase the Part B deductible to $150 on January 1, 2000, and index it thereafter. This option would raise the deductible to $150 starting in 2000 and index it to program costs thereafter. The $150 deductible is roughly equal to the current $100 deductible indexed for projected program costs from 1996 to the year 2000.

(d) Increase the Part B deductible to $300 on January 1, 2000, and index it thereafter. This option would raise the deductible to $300 starting in 2000. Raising the deductible to $300 would increase the deductible as a percentage of average charges for services covered by Part B from 5 percent in 1994 to 8 percent, still below the original 45 percent level enacted in 1967.

These options would reduce the government subsidy for Medicare Part B by requiring enrollees to pay for a higher share of their medical expenses. Medicaid would be required to pay the deductible for low-income individuals. Federal Medicaid payments to States could be raised to cover increases in State Medicaid spending resulting from this option. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid, or the Medicare Part B deductible could be reduced for low-income persons.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Outlay savings	*	0.04%	0.07%	0.10%
b. Outlay savings	0.02%	0.07%	0.12%	0.15%
c. Outlay savings	0.02%	0.06%	0.10%	0.14%
d. Outlay savings	0.05%	0.08%	0.12%	0.15%

9. Replace the Part B premium with a higher deductible

CURRENT LAW

Medicare Part B is a voluntary program for all persons over age 65 and all persons enrolled in Medicare Part A. Enrollees in Part B pay a monthly premium of $41.10. By statute, the premium will rise to $46.10 in 1995. Current law also imposes a deductible that requires enrollees to pay the first $100 of medical expenses that would otherwise be covered by Part B. The Federal government pays 80 percent of Medicare approved fees for most covered services above the deductible. The enrollee is responsible for the remaining costs.

When Medicare began in 1966, Congress set the Part B deductible at $50. Since that time, Congress has increased the deductible three times to the current level of $100. During the same period, consumer prices have increased by 350 percent and the cost of medical care for urban consumers has increased by 680 percent. The deductible has fallen from 45 percent of average charges for services covered by Medicare Part B (including amounts paid by enrollees for deductibles and copayments) in 1967 to about 5 percent in 1993.

OPTIONS

(a) Increase the deductible from $100 to $800 and repeal the monthly premium (projected to total about $680) in 2000, and index it thereafter. This option would increase the Part B deductible to $800 annually starting on January 1, 2000. For each succeeding year after 2000, the deductible amount would be indexed to the rate of growth in Part B program costs. In addition, the Part B monthly premium would be eliminated on January 1, 2000. Because the Part B premium is projected to be over $680 in 2000 and the current deductible is $100, the premium reduction roughly offsets the $800 deductible ($680 plus $100 is $780). As a result, out-of-pocket costs for enrollees with medical expenses exceeding the deductible would not be materially changed. Healthy seniors without Medigap policies would pay less in out-of-pocket expenses due to elimination of the premiums.

(b) Increase the deductible to $1,200 and repeal the monthly premium (projected to total about $680) in 2000, and index it thereafter. This option would increase the Part B deductible to $1,200 annually starting on January 1, 2000. For each succeeding year after 2000, the deductible amount would be indexed to the rate of growth in Part B program costs. In addition, the Part B monthly premium would be eliminated on January 1, 2000. This option would decrease out-of-pocket costs for seniors who use relatively few services. It would increase out–of-pocket costs by about $420 for seniors who have expenses more than the new deductible amount.

The shift to a higher deductible in lieu of existing premiums in these options could lead some enrollees to be more price conscious about acquiring routine medical care. However, it could be argued such effects might not be large because the increased deductible would be covered by employer-subsidized retiree health plans, Medigap policies, and Medicaid coverage for a significant share of enrollees.

Medicaid would be required to pay the increased deductibles and would benefit from the repeal of the premium for low-income Medicare enrollees under this option. Federal Medicaid payments to States could be raised to cover the increases in State Medicaid spending resulting from this option. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid, or the Medicare Part B deductible could be reduced for low-income persons.

EFFECT

Outlay reductions from these options are principally due to indexing the deductible. The budgetary effects from these options are projected to increase the deficit in the first few years of the projection period. Under option (a), the deficit is projected to increase by $66 billion over 2000 through 2009. Under option (b), the deficit is projected to increase by $11 billion over 2000 through 2003. The estimates do not include the effects of behavioral responses by enrollees.

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Outlay savings	– 0.11%	*	0.08%	0.13%
b. Outlay savings	– 0.05%	0.12%	0.24%	0.33%

10. Index the Medicare Part B premium to maintain the enrollees' share of program costs currently paid by enrollees

CURRENT LAW

Benefits under Medicare Part B are partially funded by monthly premiums paid by enrollees. The remainder of program funding is from general revenues, roughly a 70 percent average subsidy given to both high- and low-income enrollees in 1995.

Medicare Part B premiums initially covered 50 percent of program costs. Part B premiums for 1994 and 1995 cover about 30 percent of program costs ($41.10 and $46.10 per month, respectively). From 1996 to 1998, premium levels will be set by formula to offset 25 percent of program costs for aged enrollees. As a result, in 1996, premiums will drop from $46 per month to about $43 per month. After 1998, the Consumer Price Index (CPI) will be used to adjust the Part B premium. Because CPI indexing is not projected to keep pace with medical costs, enrollees are scheduled to pay a smaller share of the cost of Part B services over time. Premiums are deducted automatically from Social Security checks for most enrollees.

OPTION

This option would permanently index the Part B premium to maintain the 30 percent share of program costs currently paid by enrollees. To achieve this result, premiums after 1995 would be based upon the 1995 premium indexed for increases in program costs. Without this change, premiums would fall in absolute dollars and as a share of program costs.

Medicaid would be required to pay the premium for low-income Medicare enrollees. Federal Medicaid payments to States could be raised to cover the increases in State Medicaid spending resulting from this option. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid, or the Medicare Part B premium could be reduced for low-income persons not currently covered by Medicaid.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
Outlay savings	0.09%	0.36%	0.55%	0.72%

11. Reduce the subsidy of Medicare Part B premiums for high-income enrollees

CURRENT LAW

Benefits under Medicare Part B are partially funded by monthly premiums paid by enrollees. The remainder of program funding is from general revenues, roughly a 70 percent average subsidy given to all enrollees regardless of income level in 1995.

Medicare Part B premiums initially covered 50 percent of program costs. Part B premiums for 1994 and 1995 cover about 30 percent of program costs ($41.10 and $46.10 per month, respectively). From 1996 to 1998, premium levels will be set by formula to cover 25 percent of aged beneficiary costs. As a result, in 1996, premiums will drop from $46.10 to about $43.00 per month. After 1998, the Consumer Price Index (CPI) will be used to adjust the Part B premium. Because CPI indexing is not projected to keep pace with medical costs, enrollees will pay a smaller premium as a share of the cost of Part B services over time. Premiums are deducted automatically from Social Security checks for most enrollees.

OPTIONS

(a) Gradually phase in a reduction in the Part B premium subsidy for enrollees with incomes above $75,000 for couples ($50,000 for individuals). This option would adjust the Part B premium based on the enrollee's modified adjusted gross income (MAGI) which equals adjusted gross income (AGI) plus non-taxable interest income. Income-related adjustments to premiums would begin at $50,000 for individuals and $75,000 for couples. Adjustments would increase proportionally with income until they reached a maximum figure (designed to cover up to 56 percent of Part B per capita costs) at MAGI exceeding $75,000 for individuals and $112,000 for couples. This represents almost a doubling of Part B premiums for high-income persons. The income thresholds would be indexed for general price inflation. This option would be effective beginning January 1, 2000.

(b) Gradually phase in a reduction in the Part B premium subsidy for enrollees with incomes above $40,000 for couples ($30,000 for individuals). This option would adjust the Part B premium based on the enrollee's modified adjusted gross income (MAGI) which equals adjusted gross income (AGI) plus non-taxable interest income. Income-related adjustments to premiums would begin at $30,000 for individuals and $40,000 for couples. Adjustments would increase proportionally with income until they reached a maximum figure (designed to cover up to 80 percent of Part B per capita costs) at MAGI exceeding $60,000 for individuals and $100,000 for couples. This represents more than a doubling of Part B premiums for high-income persons. The income thresholds would be indexed for general price inflation. This option would be effective beginning January 1, 2000.

The top premium rate of 80 percent of program costs is designed so that the average enrollee does not pay premiums greater than the value of the Part B insurance coverage in any geographic region. The income-related adjustments to the Part B premium would be collected through the income tax system. Roughly 5 percent of Medicare enrollees would be subject to the income-related premiums under Option (a) and 15 percent of Medicare recipients under Option (b).

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Outlay savings	0.03%	0.05%	0.07%	0.09%
b. Outlay savings	0.07%	0.13%	0.18%	0.23%

12. Charge a 20 percent coinsurance payment for home health and clinical laboratory services

CURRENT LAW

Medicare Part A covers home health services furnished by a participating home health agency for homebound persons who need skilled nursing care, physical therapy, or speech therapy on an occasional basis. Medicare Part B covers an unlimited number of medically necessary home health visits for persons not covered under Part A. Neither Part A nor B requires enrollee coinsurance payments for home health care.

Enrollees are also not required to make coinsurance payments for clinical laboratory services under Part B. As a cost-containment measure, Medicare sets a fee schedule for these services, and providers must accept that fee as full payment for the service. Other services covered under Part B are subject to 20 percent coinsurance.

OPTION

This option would establish a uniform coinsurance rate of 20 percent on home health services paid by Part A and Part B. This option would also impose coinsurance payments of 20 percent on laboratory services in excess of $10. The coinsurance payments would be implemented in 2000.

This option would reduce the government subsidy of home health and clinical laboratory services by requiring enrollees to pay for a portion of these services. It could create incentives for individuals to curb excessive utilization of these services. Medicaid would be required to pay the coinsurance for low-income Medicare enrollees. Federal Medicaid payments to States could be raised to cover the increases in State Medicaid spending resulting from this option. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid, or Medicare coinsurance could be reduced for low-income persons.

EFFECT

The estimates include behavioral effects on utilization of services based on information from CBO.

Percentage of Gross Domestic Product

	2000	2010	2020	2030
Outlay savings	0.09%	0.14%	0.17%	0.21%

13. Modify Medicare to expand coverage for large financial costs resulting from serious medical conditions, while limiting coverage for costs of less serious health conditions

CURRENT LAW

There are two parts to Medicare: Part A (Hospital Insurance or HI) and Part B (Supplementary Medical Insurance or SMI). Americans aged 65 or older are automatically entitled to Part A benefits under Medicare if they or their spouse are eligible for monthly Social Security or Railroad Retirement cash benefits. People under age 65 who are receiving disability insurance benefits under Social Security are also eligible for Medicare Part A after a two-year waiting period. Part A beneficiaries may elect to be covered under Part B.

Currently, Medicare Part A pays for all covered services for the first 60 days of care, for all covered services except for a copayment of $174 a day for the next 30 days of care, and for all covered services except a copayment of $348 for 60 additional days (that are cumulative over the enrollee lifetime) and nothing thereafter. Copayments are indexed annually for general inflation. Current law also provides for a deductible amount that requires enrollees to pay the first $696 of costs that would otherwise be covered by Part A. All figures cited above are for 1994.

Part A is financed through a 1.45 percent payroll tax on current wages. Both workers and their employers pay the tax at a combined rate of 2.9 percent. Self-employed individuals are taxed at the combined rate of 2.9 percent of their earnings. The Medicare HI Trust Fund is projected to be insolvent by the year 2001. There is no premium required for enrollment in Part A.

Enrollees in Part B currently pay a monthly premium of $41.10. By statute, the premium will rise to $46.10 in 1995. Current law also imposes an annual deductible that requires enrollees to pay the first $100 of medical expenses that would otherwise be covered by Part B. The Federal government then pays 80 percent of the Medicare approved fee. The copayment requirement does not apply to home health care (under both Parts A and B) and laboratory services. The enrollee is responsible for the remaining costs.

There are no out-of-pocket limits on medical costs by Medicare enrollees. As a result, long-term hospitalization can erode all of an enrollee's resources before eligibility for Medicaid coverage begins.

OPTION

This option combines some of the previous health program options described above that limit Medicare subsidies and adds:

- An annual out-of-pocket limit on medical expenses covered by Medicare for enrollees unlike current law, annual expenses over the out-of-pocket limit would be covered by the Federal government for Medicare enrollees (the limit could be based on the enrollee's income);
- Require a 20 percent Part A coinsurance on the initial diagnosis related group reimbursement rates for all inpatient hospital expenses;
- Charge the Part A deductible from a "per illness" to an "annual" deductible;
- Add coverage for prescription drugs subject to the overall deductible amount for Part B; and
- Require a $25 per month Part A premium that will be indexed annually for increases in program costs.

Health program options identified above and included in this option are:

- Require a 20 percent coinsurance for all clinical laboratory services and home health care otherwise covered by the Federal government for Medicare enrollees; and
- Eliminate the Part B premium, increase the deductible on Part B to $1,200, and index the deductible to program costs.

This option moves Federal government policy for Medicare enrollees away from pre-paid health care and emphasizes protection against extraordinary financial burdens due to major or long-term illness. Coverage for routine or short-term illness would be diminished with the intent of having more of these costs paid for by enrollees or third-party coverage. This option would take effect beginning in 2000 and be phased in over several years. Medicaid would be required to pay the coinsurance for low-income Medicare enrollees. Federal Medicaid payments to States could be raised to cover the increases in State Medicaid spending resulting from this option. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid, or Medicare coinsurance could be reduced for low-income persons.

EFFECT

The outlay effects of this option have not been estimated because savings depend on the threshold for the out-of-pocket limit on expenses paid by enrollees and other specifications.

14. Tax Medicare Part A and Part B benefits as individual income

CURRENT LAW

Medicare Part A reimburses providers for inpatient hospital care, skilled nursing facility care, home health care, and hospice care furnished to enrollees. The program is financed through a 1.45 percent payroll tax on wages paid by workers and their employers, for a combined tax rate of 2.9 percent. Self-employed individuals are taxed at the combined rate of 2.9 percent of earnings.

Benefits under Medicare Part B are partially funded by monthly premiums paid by enrollees. The remainder of program funding is from general revenues, representing a subsidy paid without regard to need.

OPTIONS

(a) Include the insurance value of Part A in income. This option would increase an enrollee's adjusted gross income (AGI) by the value of Medicare Part A insurance coverage that exceeds average payroll tax contributions. For administrative ease, the amount included in AGI would be set at 85 percent of average annual Part A program costs for aged enrollees. For 1995, 85 percent of the value is approximately $2,600 per person.

(b) Include the insurance value of Part A in income for upper-income enrollees. This option is the same as the preceding option, except that it would not apply to individuals with income less than $25,000 ($32,000 for couples). In addition, the option would include only 50 percent of average Part A program costs for individuals with income between $25,000 and $34,000 (between $32,000 and $44,000 for couples), instead of 85 percent. This treatment parallels the taxation of Social Security benefits under current law.

(c) Include the average Part B subsidy in income. This option would include the average Federal subsidy received by Medicare Part B enrollees in their adjusted gross income (AGI). For administrative ease, the amount included in AGI would be set at the average annual Part B benefits paid on behalf of all aged enrollees, less average premiums paid. The average subsidy is projected to be about $1,900 in 1995.

(d) Include the average Part B subsidy in income for upper-income enrollees. This option is similar to the preceding option, except it would not apply to individuals with income less than $25,000 ($32,000 for couples). In addition, the option would include only 50 percent of the average Part B subsidy in income for individuals with income between $25,000 and $34,000 (between $32,000 and $44,000 for couples), instead of the entire subsidy. This treatment parallels the taxation of Social Security benefits under current law.

The addition to AGI under this option would be phased in over five years, starting in 2000.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Revenue increase	0.03%	0.21%	0.28%	0.35%
b. Revenue increase	0.02%	0.13%	0.16%	0.21%
c. Revenue increase	0.02%	0.20%	0.28%	0.35%
d. Revenue increase	*	0.12%	0.17%	0.21%

15. Include the value of employer-paid health insurance and health care expenses in income for income tax purposes

CURRENT LAW

Under current law, employer-paid health insurance premiums and health care expenses for employees are deducted from employers' taxable income as a cost of doing business. Furthermore, these expenditures on behalf of employees are not included in the income of the employees for purposes of the payroll tax or the individual income tax. Health insurance premiums and health care costs paid for on behalf of an employee through a "cafeteria plan" are also excluded from income and payroll taxes. In addition, retirees whose former employer provides health insurance coverage as a retirement benefit exclude the employer-paid premiums from adjusted gross income (AGI) under the income tax.

OPTIONS

(a) Include in income the value of employer-paid health benefits that exceeds the average health insurance premiums. This option limits the amount of employer-paid medical insurance and medical care that may be excluded from an employee's income for income tax purposes. Employer contributions for health insurance, health care costs paid through cafeteria plans, and employer-provided medical care that exceeds a cap would be included in the employee's taxable income. The cap would be based on projected average health insurance premiums for 1995, $375 a month for a family and $175 a month for an individual, indexed to reflect future increases in the general level of prices. When the change first takes effect in 2000, the cap would be about $440 a month for a family and about $210 a month for an individual, depending on inflation.

Because the option indexes the limits to the overall inflation rate while health care costs have been rising faster than inflation, it would gradually include an increasing portion of employer-paid health benefits. The caps could be adjusted for geographic variations in health care costs.

(b) Include in income the entire value of employer-paid health benefits. This option would include all employer-paid health insurance premiums, employer-paid medical expenses, and payments for health care costs through cafeteria plans in an employee's taxable income.

Both options would phase in the addition to employees' income over five years, starting in 2000. In 2000, 20 percent of the benefits received (or in the case of the cap, 20 percent of the benefits received in excess of the cap) would be included in AGI. This amount would be increased by 20 percent in each succeeding year so that 100 percent would be included in AGI in 2004.

Neither option would alter the treatment of employer-provided health care for purposes of the payroll tax. These options would limit or end tax-based subsidies for health care coverage. As a consequence, they could make employers and employees more cost conscious and curb excess use of health care services. Further extension of the phase-in period might be necessary to allow labor contracts to be adjusted.

The options could be structured to partially or completely deny the employer's deductions of expenses paid for employee health care, rather than including the payments in an employee's income.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Revenue increase	0.05%	0.44%	0.58%	0.64%
b. Revenue increase	0.19%	1.31%	1.45%	1.45%

16. Raise the eligibility age for Medicare

CURRENT LAW

Medicare provides hospital and physician services insurance for most people age 65 years and over, for certain disabled people, and for individuals with chronic renal disease. It consists of two parts — Part A, the Hospital Insurance program, and Part B, the voluntary Supplementary Medical Insurance program for physician and laboratory services, and outpatient hospital care.

As a result of the Social Security Amendments of 1983, the normal retirement age for Social Security will rise from age 65 to 67, starting with persons who are currently 56 (for whom the Normal Retirement Age will be 65 years and two months). It will reach age 67 for persons under age 35. This was done to account for longer lifespans and to strengthen the solvency of the Social Security Trust Funds. No similar changes were made to the Medicare eligibility age as part of the 1983 amendments.

OPTIONS

(a) Match the Medicare eligibility age with the scheduled change in Normal Retirement Age for Social Security. This option would gradually raise the Medicare eligibility age along with the scheduled increases in the Normal Retirement Age for Social Security. This would require raising the eligibility age by two months per year beginning with persons who are currently 56. The eligibility age will continue to rise in two-month increments until it reaches age 66 for persons who are now 51. The Medicare eligibility age would remain at age 66 for 12 years, then begin to rise again by two months per year until it reaches age 67 for persons who are under 35.

(b) Raise the eligibility age for Medicare to age 67 for persons under age 46. This option is the same as the preceding option, except it would eliminate the 12-year period during which the eligibility age would be 66. The eligibility age would gradually rise by two months per year beginning with persons who are now age 56, until it reaches age 67 for persons now age 45. This option would match the increase in the normal retirement age for Social Security provided in H.R. 4245, introduced by Congressman Rostenkowski.

(c) Raise eligibility age for Medicare to age 68 for persons under age 40. This option is the same as the preceding option, except it would continue to raise the Medicare eligibility age by two months per year until the eligibility age reaches 68 for persons under age 40 today.

(d) Raise eligibility age for Medicare to age 70 for persons under age 28. This option is the same as the preceding option, except it would continue to raise the eligibility age by two months per year until it reaches 70 for persons under age 28 today. This option would match the increase in the Normal Retirement Age for Social Security provided in H.R. 4275, introduced by Congressman Pickle.

The eligibility age increases, to varying degrees, would reflect increases in life expectancy that have occurred since the inception of the Medicare program and that are projected to occur in the future. These options would not affect any person now over the age of 56. Moreover, they would not increase the eligibility age by more than one year for anyone now over the age of 50.

The options could create hardship for older workers with chronic, but not disabling, health problems. Low-income persons, who would not be eligible for Medicare until later ages, would receive coverage under Medicaid. Additional changes could be made to Medicaid to assist low-income Medicare enrollees not currently covered by Medicaid. Federal Medicaid payments to States could be raised to cover the increases in State Medicaid spending resulting from these options.

To ensure continued access to health insurance for individuals age 65 and older, Medicare could be made available at rates that spread the market cost of the early coverage over the person's remaining life. Coverage at reduced rates could be made available to low-income persons who are not eligible for Medicaid.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
a. Outlay savings	—	0.09%	0.16%	0.39%
b. Outlay savings	—	0.14%	0.37%	0.39%
c. Outlay savings	—	0.14%	0.58%	0.62%
d. Outlay savings	—	0.14%	0.58%	1.03%

17. Modifications to Medicare provider payments

CURRENT LAW

Medicare provides insurance for hospitalization and physician services for most people age 65 years and over, certain disabled people, and individuals with chronic renal disease. It consists of two parts — Part A, the Hospital Insurance program, and Part B, the voluntary Supplementary Medical Insurance program for physician services, laboratory services, and outpatient hospital care.

OPTION

This option includes six illustrative reductions in Medicare provider payments to indicate the general impact that changes to provider payments can have on long-term Federal health care spending. These changes were included in the major health system reform bills introduced in the 103rd Congress.

- Part A — adjust inpatient capital payments to reflect better cost data.
- Part A — revise Disproportionate Share Hospital (DSH) adjustment.
- Part B — change the Medicare Volume Performance Standard (MVPS) to reflect real growth in Gross Domestic Product (GDP) per capita.
- Part B — establish cumulative growth targets for physician services.
- Part B — reduce the Medicare fee schedule conversion factor by 3 percent, except primary care services.
- Part B — eliminate formula-driven overpayment in hospital outpatient departments.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
Outlay savings	0.12%	0.47%	0.72%	0.92%

18. Cap Federal Medicaid acute care spending

CURRENT LAW

Medicaid is a Federal-State matching program providing medical assistance for (1) low-income persons who are aged, blind, or disabled; (2) members of families with dependent children; and (3) certain persons who are defined as medically needy. Within Federal guidelines, each State designs and administers its own program. For example, States are permitted to contract for coverage of Medicaid eligible persons with health maintenance organizations upon receipt of a waiver from the Department of Health and Human Services (HHS). Seven States have received waivers.

There are two broad categories of Medicaid benefits: (1) long-term care benefits and (2) acute care benefits. Long-term care benefits are about 40 percent of total spending. Acute care benefits are about 60 percent of total spending.

Federal Medicaid payments are based upon a matching formula that is adjusted annually. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent (though the highest current rate is 79 percent).

OPTION

This option would impose an annual cap upon Federal Medicaid spending to each State for acute care services. Federal Medicaid matching rates would not be changed (except to fix inequities for Alaska and Hawaii). The cap would take effect in 2000.

The cap would be determined by multiplying the "per capita amount" for each State by the number of Medicaid recipients in the State. The per capita amount for fiscal year 2000 would be 118 percent of per capita Federal Medicaid expenditures for acute care services in fiscal year 1998. The per capita amount for fiscal years 2001 through 2004 would be the per capita amount for the previous fiscal year increased by 6 percent. The increase would be 5 percent for fiscal years 2005 and beyond.

This option would not permit individual States to eliminate coverage of eligibility groups covered by the State as of 1998. In order to prevent an unfunded mandate on the States, States could be given more flexibility to determine what types of benefits are covered under the State Medicaid program. It would permit States to enter into agreements with health maintenance organizations that meet Federal standards for access, enrollment, and quality assurance.

19. Provide for Medicaid vouchers

CURRENT LAW

Medicaid is a Federal-State matching program providing medical assistance for (1) low-income persons who are aged, blind, or disabled; (2) members of families with dependent children; and (3) certain persons who are defined as medically needy. Within Federal guidelines, each State designs and administers its own program. For example, States are permitted to contract for coverage of Medicaid eligible persons with health maintenance organizations upon receipt of a waiver from the Department of Health and Human Services (HHS). Seven States have received waivers.

There are two broad categories of Medicaid benefits: (1) long-term care benefits and (2) acute care benefits. Long-term care benefits are about 40 percent of total spending. Acute care benefits are about 60 percent of total spending.

One of the major categories of Medicaid recipients often referred to are those with "mandatory" coverage. Mandatory coverage includes families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program, as well as additional AFDC-related groups who are not actually receiving cash payments. Examples of those not receiving payments include persons for whom the amount would be less than $10 and persons whose payments are reduced to zero because of the recovery of previous overpayments. Another example of mandatory coverage includes recipients for whom the States are required to continue Medicaid coverage for families losing AFDC benefits for a specified period of time.

Federal Medicaid payments are based upon a matching formula that is adjusted annually. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent (though the highest current rate is 79 percent).

OPTION

This option would replace Medicaid acute care with Federal vouchers for "mandatory" Medicaid recipients to purchase State-provided or private sector health insurance.

The option would replace the Medicaid matching formula with a "per capita" formula starting in the year 2000. The State voucher amount would be determined by multiplying the "per capita amount" for each State by the number of "mandatory" Medicaid recipients in the State. The per capita amount would be the total Federal budgetary resources appropriated annually, divided by the number of mandatory Medicaid recipients in all States. States would be required to provide a Federal-State health insurance voucher only for the mandatory Medicaid population. If States have remaining Federal funds after providing vouchers for the mandatory population, they must use these funds to expand access to health insurance for persons with income under 200 percent of the poverty line.

The Secretary of HHS would make recommendations regarding phasing out the disproportionate share hospital (DSH) program or integrating the DSH expenditures into the per capita amount as coverage increases.

EFFECT

Percentage of Gross Domestic Product

	2000	2010	2020	2030
Outlay savings	*	0.12%	0.15%	0.16%

States would have the option to eliminate coverage of "non-mandatory" eligibility groups now covered by the State. State Medicaid programs would continue to be required to pay Medicare premiums and cost sharing for qualified Medicare beneficiaries (QMBs). Individual States would receive a 75 percent match for QMB enrollees from the Federal government. The option would also permit States to enroll recipients into managed care arrangements without seeking Federal waivers. Although limited only to Medicaid, the voucher concept used in this option is based, in part, on H. R. Res. 508, introduced by Congressman McMillan.

This option could be structured to include an option for Medicare enrollees to choose a Federal voucher to purchase a private sector health plan (that could include prescription drugs and long-term care).

EFFECT

The outlay effects depend on the funds appropriated by Congress for the Medicaid program and other specifications.

20. Reduce the growth of Medicaid payments for disproportionate share hospitals (DSH)

CURRENT LAW

States are required to factor in extra costs incurred by hospitals that serve disproportionately large numbers of Medicaid or low-income patients when setting Medicaid hospital payment rates. Congress has established minimum criteria for States for defining "disproportionate share" hospitals (DSH) and the hospital reimbursement rates. Under current law, aggregate State payments for DSH cannot exceed 12 percent of Federal Medicaid expenditures. DSH payments have been subject to the critique that they have been expanded beyond the original purpose and that the funds have been used to finance State activities beyond uncompensated care.

OPTION

Under this option, aggregate DSH payments would not exceed 11 percent of aggregate Federal Medicaid expenditures in 2000, 10 percent in 2001, 9 percent in 2002, and 8 percent in 2003.

EFFECT

Because Federal Medicaid baseline spending is projected to grow faster than DSH payments, CBO's projected level of DSH payments declines from over 12 percent of Federal Medicaid spending today to almost 8 percent by the year 2002. The savings from this option are projected to equal zero by 2005 due to this relationship.

Percentage of Gross Domestic Product

	2000	2010	2020	2030
Outlay savings	0.03%	*	*	*

21. Increase Medicare Part A payroll tax rates

CURRENT LAW

Medicare Part A is financed through a 1.45 percent payroll tax paid by both workers and employers on all wages for a combined rate of 2.9 percent. Self-employed individuals are taxed at the combined rate of 2.9 percent on earnings. Prior to the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), only the first $135,000 of wages were subject to the Part A payroll tax. OBRA 1993 eliminated the $135,000 wage cap and now all wages are subject to the Part A payroll tax. Medicare Part A is also financed by a portion of the income tax levied upon Social Security benefits.

The revenues from Part A payroll taxes are credited to the Medicare Hospital Insurance (HI) Trust Fund. If projected benefit payments from the HI Trust Fund are equal to or less than the projected Trust Fund revenues and interest earnings, the Trust Fund is in long-term "actuarial balance." The Medicare Trustees have determined that the HI Trust Fund is not in long-term actuarial balance and will be insolvent by 2001.

OPTION

This option would raise Medicare Part A payroll tax rates to close the financing gap in Medicare Part A. The current actuarial estimate is that the Medicare Part A combined payroll tax rate paid by employers and employees would have to rise immediately and permanently by 4.22 percentage points (from 2.9 percent to 7.12 percent) to achieve actuarial balance without reducing benefits over a 75-year period. Alternatively, payroll tax rates could be raised gradually over time. Based upon current projections, that would require about a 5 percentage point increase by 2030 (to 7.9 percent) and greater increases thereafter. The rate increases could be allocated one-half to the employer and one-half to the employee as provided under current law. Another alternative would involve allocating the rate increases disproportionately between the employer and employee. Economists argue that the burden of payroll taxes falls largely on workers in the form of lower wages or fewer employment opportunities.

EFFECT

This revenue table shows the impact of a given combined employer and employee payroll tax increase for any given effective date. For example, a 2 percentage point payroll tax increase (raising the rate from 2.9 percent to 4.9 percent) effective in 2020 would raise revenues of 0.90 percent of GDP in that year.

Percentage of Gross Domestic Product

		2000	2010	2020	2030
Payroll	1%	0.45%	0.44%	0.44%	0.43%
Tax Rate	2%	0.90%	0.89%	0.87%	0.86%
Increase	3%	1.34%	1.33%	1.31%	1.29%
	4%	1.79%	1.77%	1.75%	1.72%

22. Limit growth in Federal health program spending

CURRENT LAW

Under current law, the Federal government provides significant health insurance subsidies for certain populations through the Medicare and Medicaid programs. Outlays for these Federal health programs totalled about $246 billion in fiscal year 1994.

The Budget Enforcement Act of 1990 (BEA) established procedures intended to increase control of most "mandatory" or "direct" spending legislation including Medicare, Medicaid, and the exclusion of employer-paid health insurance from employee income. The BEA, with some changes, was extended through 1998 in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93).

The BEA procedures depended on two separate disciplines: discretionary spending caps and Pay-As-You-Go (PAYGO) rules. With the exception of Social Security, most other entitlement programs and tax expenditures — including Medicare, Medicaid, and the exclusion of employer-paid health insurance from employee income — are included in PAYGO. The PAYGO rules of the BEA require that deficit-increasing PAYGO legislation must be offset by other PAYGO legislation. If the sum of all PAYGO legislation (direct spending and taxes) increases the deficit for a fiscal year, automatic across-the-board cuts are made to reduce spending in selected direct spending programs to erase the annual PAYGO deficit. These reductions are called sequesters. Non-legislative changes in "baseline" spending, such as unanticipated increases in Medicare spending and administrative (regulatory) decisions, are not covered by the PAYGO process and do not require offsets.

OPTION

This option would set a baseline for limiting growth rates Federal health care expenditures and establish procedures for "corrections" if the health expenditures grow faster than the limits. The growth rate limits can be linked to an inflation index, such as the Consumer Price Index (CPI), or an index of health care inflation like the Medicare Economic Index (MEI). The expenditures subject to the baseline would be Medicare and Medicaid.

If a limit has been exceeded, in the following fiscal year (or in the second year if a two-year spending limit is used), Congress and the President would have an opportunity to adopt other budgetary savings that offset the excess health expenditures. In the absence of these savings, sequesters would trigger automatic spending reductions.

Sequesters would be allocated proportionally to the two major Federal health programs (Medicare and Medicaid) based on dollar amounts by which they exceeded the separate spending targets. Medicare sequester amounts would be achieved by a combination of increasing the Part B monthly premium for enrollees and reducing reimbursement rates for both Part A and B services or by providing a

voucher for Medicare enrollees to select private insurance. Medicaid payments to States would be reduced based on the extent to which each State exceeded the target growth rate. Medicare would not be responsible for Medicaid cost overruns.

EFFECT

The outlay effects depend on the inflation index chosen and the ability to enact specific programmatic changes to comply with the caps and/or the willingness of Congress to adhere to the sequesters.

C. SOCIAL SECURITY

23. Raise the Normal Retirement Age and retain the Early Retirement Age at 62

CURRENT LAW

The Normal Retirement Age (NRA) refers to the age at which a worker may retire with full Social Security benefits. Currently, the NRA is set at age 65. Under the 1983 Social Security amendments, the NRA will gradually rise at a rate of two months per year beginning for people currently age 56 (*e.g.*, the NRA will be 65 and two months for persons age 56 and 65 and four months for those age 55). The NRA will reach age 66 for persons age 51 today and will remain at age 66 for 12 years. It will then begin to rise again by two-month increments starting with persons now age 39, until it reaches age 67 for persons under age 35.

Workers who retire and collect benefits before reaching the NRA take a permanent reduction in benefits. Workers retiring at age 62 today (the current early retirement age) receive 80 percent of the full benefit. Benefits for workers retiring at age 62 are scheduled to decrease gradually to 70 percent of full benefits as the NRA increases to age 67.

OPTIONS

(a) Accelerate the currently scheduled NRA increase so the NRA reaches age 67 for persons under age 46 instead of under age 35. This option would accelerate the date the NRA reaches age 67 by eliminating the 12-year plateau during which the NRA remains set at age 66. Instead of pausing at age 66, the NRA will continue rising by two-month increments until it reaches age 67 for persons under age 46. The Early Retirement Age would remain the same.

Elimination of the 12-year plateau will affect no one currently over the age of 50. This option applies higher retirement ages more equitably to members of the Baby Boom generation. This provision was included in H.R. 4245, introduced by Congressman Rostenkowski.

(b) Accelerate the currently scheduled NRA increase to age 67 and further increase the NRA to age 68 for persons under age 40. This option would accelerate the date the NRA reaches age 67 by eliminating the 12-year plateau during which the NRA remains at age 66. It would also extend the period over which the NRA rises by two-month increments, starting for persons currently age 44, until the NRA reaches age 68 for those persons under age 40. No one currently over the age of 50 would be affected. This option changes the retirement age to more fully reflect the improvements in U.S. life expectancy that have occurred during the period from the program's inception through 1990 (life expectancy at age 65 has grown by 2.6 years for men and 4.9 years for women). It does not reflect projected future lifespan increases.