Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Democratic Asian and Pacific American Meeting (5 pages)	5/18/93	P5
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Kassebaum/Glickman "BasicCare" Meeting (130 pages)	5/18/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Securitry Act)
OA/Box Number: 23754

FOLDER TITLE:
May 1993 HSA [4]

gf84

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Democratic Asian and Pacific American Meeting (5 pages)	5/18/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Securitry Act)
OA/Box Number: 23754

FOLDER TITLE:
May 1993 HSA [4]

gf84

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Kassebaum/Glickman "BasicCare" Meeting (130 pages)	5/18/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Securitry Act)
OA/Box Number: 23754

FOLDER TITLE:
May 1993 HSA [4]

gf84

RESTRICTION CODES

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

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

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

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

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

CLOSE
HOLD

May 19, 1995

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to: Alice Rivlin
Nancy-Ann Min
Barry Clendenin BC

Decision needed ____
Please sign ____
Per your request X
Please comment ____
For your information ____

With informational copies for:
HD Chron,HFB Chron

Subject: Medicare/Medicaid/Health Care Reform Package

From: HFB MM

Phone: 202/395-4930
Fax: 202/395-3910
Email: miller_me @gov.1
Room: #7001

Attached is the package requested on Medicare, Medicaid, and health care reform options.

TABLE OF CONTENTS

TAB

A

DRAFT

Possible Sources of Funds

Fiscal Years, Billions of Dollars

	5 Years 1996 - 2000	7 Years 1996 - 2002	10 Years 1996 - 2005
Medicare Savings			
-- Beneficiaries	33.3	60.1	123.5
-- Providers	54.4	106.0	223.0
-- Receipts	7.1	9.9	13.5
-- Medicare managed care	7.3	12.8	24.2
Total Medicare Savings	102.1	188.8	384.3
Medicaid Savings			
-- Disproportionate share hospital payment reform (1/3rd)	22.3	34.4	56.1
-- State flexibility			
-- Medicaid managed care	1.2	4.5	10.8
-- Boren Amendment reform			
Total Medicaid Savings	23.6	38.9	66.9
Tobacco Revenue ($1.00)	61.8	87.0	123.8
Total Sources of Funds	187.5	314.7	575.0

DRAFT

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	5 Years 1996 - 2000	7 Years 1996 - 2002	10 Years 1996 - 2005
Medicaid Investment Fund	84.1	121.4	179.9
Medicaid Investment Fund (alternative financing)	53.2	77.9	118.0
Improved Solvency of Medicare HI Trust Fund	30.9	43.5	61.9
Kids Subsidy (133% - 240%)	21.9	34.8	56.7
Long-term Care Program			
-- Capped entitlement to states	6.2	9.7	15.4
-- Long-term care tax changes	3.0	5.1	9.2
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction Phased to 100%	4.6	8.4	15.7
Insurance Market Reform	Effects indeterminate, but likely to be small.		
Access to FEHBP	Could increase federal costs depending upon design.		

DRAFT

For Illustrative Purposes Only

MEDICAID INVESTMENT FUND COVERING 12.9 MILLION PERSONS IN 2002
Medicare HI Trust Fund Insolvency Pushed to 2006

Initiatives

MEDICAID INVESTMENT FUND (100% Tobacco)

LONG-TERM CARE INITIATIVES

PUBLIC HEALTH SERVICE EXPANSION

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICARE SAVINGS AND IMPROVED SOLVENCY

MEDICAID DSH REFORM

MEDICAID MANAGED CARE REFORM

TOBACCO REVENUE

---

	5 Years	7 Years	10 Years
Medicaid Investment Fund	84.1	121.4	179.9
Long-term Care Initiatives	9.2	14.8	24.6
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction	4.6	8.4	15.7
TOTAL COSTS:	**$99.3**	**$146.6**	**$223.1**
Medicare Savings & Solvency	102.1	188.8	384.3
Medicaid DSH Reform	22.3	34.4	56.1
Medicaid Managed Care Reform	1.2	4.5	10.8
Tobacco Revenue	61.8	87.0	123.8
TOTAL FINANCING:	**$187.5**	**$314.7**	**$575.0**
SAVINGS/DEFICIT IMPACT:	**$88.2**	**$168.1**	**$351.8**

Dollars in billions.
Preliminary estimates. Totals may not add because of rounding.

DRAFT

MEDICAID INVESTMENT FUND COVERING 12.9 MILLION PERSONS IN 2002
Medicare HI Trust Fund Insolvency Pushed to 2006

Initiatives

Medicaid Investment Fund

- States would be allowed to use federal funds from this fund, in combination with state funds, to expand coverage. The fund would be financed at the federal level through revenues obtained by increasing the tobacco tax (estimates assume a $1.00 tobacco tax increase) and savings from reforming the current Medicaid DSH program.

Long-Term Care Initiatives

- Capped entitlement to the states. Beginning in 1997, states will be given a fixed allotment of money to provide home and community based services (HCBS) to individuals regardless of age or income. The allotments will reflect the number of severely disabled in a state, the costs of HCBS, and the proportion of low income persons in the state. Services may be limited by amount and type and may be targeted to specific groups or geographic areas.

- Long-term care tax changes. This proposal makes three changes to the tax treatment of long-term care services and expenses. First, long-term care expenses and insurance premiums will be treated as medical expenses for income tax purposes. Employers may also treat long-term care insurance premium contributions as business expenses. Second, accelerated death benefits paid from riders on life insurance policies will not be counted as taxable income. Third, disabled working persons will receive a tax credit for half of their work-related personal assistance expenses up to $15,000. At higher incomes-$50,000 and above-this credit is phased out.

Public Health Service Expansion

- This proposal would provide performance partnership grants to target funds to State health departments for distribution to county and city health departments and community health centers.

DRAFT

Self-employed Tax Deduction

- Allows the self-employed to deduct 100% of the cost of health insurance premiums. The 100% deduction is phased-in according to the following schedule: 30% in 1995; 50% in 1996; 75% in 1997; and 100% in 1998 and thereafter. The estimate assumes that deductions in excess of 30% of the premium are subject to discrimination rules (allows greater of 30% deduction or the percentage contributed to an equivalent plan for employees).

Sources of Funds

Medicare Savings and Improved Solvency

- In the context of health reform that increases coverage, Medicare savings in the range of $185 billion over seven years could be pursued. A savings package could be designed to improve the solvency of the Hospital Insurance (HI) Trust Fund by achieving approximately $100 billion in HI outlay savings over seven years. This amount of savings would move projected HI insolvency from the current estimated date of 2002 to approximately 2006.

- We would also propose a bipartisan commission to deal with the long-term solvency problem.

Medicaid Reform

- Allow states to mandatorily enroll some groups of Medicaid recipients into managed care without having to seek a waiver.

- Provide states greater flexibility to administer the Medicaid program (e.g., repeal of the Boren Amendment).

- Over a period of time, designate a standard benefit package for Medicaid recipients.

- Reform the system for Medicaid payments to states for disproportionate share hospitals (DSH) and use the savings to expand coverage along the lines of TennCare (or other mechanisms).

Tobacco Revenue

- As in many of the health reform bills discussed in Congress last year, the current $0.24 per pack cigarette tax would be increased. All three Packages show an increase of $01.00 per pack beginning January 1, 1996 (taxes on other tobacco items would also be increased proportionately). In the Ways and Means and Mitchell reform bills from the 103rd Congress, the tobacco tax was increased by $0.45 per pack (taxes on other tobacco items were also increased proportionately). The tax was phased-in according to the following schedule: On 8/1/95, the current rate of $0.24 per pack was increased by $0.15 per pack to $0.39 per pack; on 1/1/97 the tax was increased from $0.39 to $0.49 per pack; on 1/1/98 the tax was increased to $0.59 per pack; and on 1/1/99 the tax was increased to $0.69 per pack.

DRAFT

For Illustrative Purposes Only

MEDICAID INVESTMENT FUND COVERING 8.6 MILLION PERSONS IN 2002
Medicare HI Trust Fund Insolvency Pushed to 2010

Initiatives

IMPROVED SOLVENCY OF MEDICARE HI TRUST FUND (50% Tobacco)

MEDICAID INVESTMENT FUND (50% Tobacco)

LONG-TERM CARE INITIATIVES

PUBLIC HEALTH SERVICE EXPANSION

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICARE SAVINGS AND IMPROVED SOLVENCY

MEDICAID DSH REFORM

MEDICAID MANAGED CARE REFORM

TOBACCO REVENUE

	5 Years	7 Years	10 Years
Improve Solvency of HI Trust Fund	30.9	43.5	61.9
Medicaid Investment Fund	53.2	77.9	118.0
Long-term Care Initiatives	9.2	14.8	24.6
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction	4.6	8.4	15.7
TOTAL COSTS:	**$99.3**	**$146.6**	**$223.1**
Medicare Savings & Solvency	102.1	188.8	384.3
Medicaid DSH Reform	22.3	34.4	56.1
Medicaid Managed Care Reform	1.2	4.5	10.8
Tobacco Revenue	61.8	87.0	123.8
TOTAL FINANCING:	**$187.5**	**$314.7**	**$575.0**
SAVINGS/DEFICIT IMPACT:	$88.2	$168.1	$351.8

Dollars in billions.
Preliminary estimates. Totals may not add because of rounding.

DRAFT

MEDICAID INVESTMENT FUND COVERING 8.6 MILLION PERSONS IN 2002
Medicare HI Trust Fund Insolvency Pushed to 2010

Same as the first package except that 50 percent of the revenue from the tobacco tax would be dedicated to the Medicare HI Trust Fund. This would improve the solvency of the HI Trust Fund and move the projected insolvency date to approximately 2010 (when combined with the Medicare savings described in Package A).

Dedicating half of the tobacco tax revenue to the Medicare HI Trust Fund reduces the amount available for the Medicaid Investment Fund, meaning that fewer persons would be covered by the fund (8.6 million persons covered by 2002 as opposed to 12.9 million persons covered under Package A).

DRAFT

For Illustrative Purposes Only

KIDS FIRST

Medicare HI Trust Fund Insolvency Pushed to 2010

Initiatives

IMPROVED SOLVENCY OF MEDICARE HI TRUST FUND (50% Tobacco)

KIDS PROGRAM UP TO 240% (50% Tobacco)

LONG-TERM CARE INITIATIVES

PUBLIC HEALTH SERVICE EXPANSION

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICARE SAVINGS AND IMPROVED SOLVENCY

MEDICAID DSH REFORM

MEDICAID MANAGED CARE REFORM

TOBACCO REVENUE

	5 Years	7 Years	10 Years
Improve Solvency of HI Trust Fund	30.9	43.5	61.9
Kids' Program to 240% of Poverty	21.9	34.8	56.7
Long-term Care Initiatives	9.2	14.8	24.6
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction	4.6	8.4	15.7
TOTAL COSTS:	**$68.0**	**$103.5**	**$161.8**
Medicare Savings & Solvency	102.1	188.8	384.3
Medicaid DSH Reform	22.3	34.4	56.1
Medicaid Managed Care Reform	1.2	4.5	10.8
Tobacco Revenue	61.8	87.0	123.8
TOTAL FINANCING:	**$187.5**	**$314.7**	$575.0
SAVINGS/DEFICIT IMPACT:	$119.5	$211.2	$413.1

Dollars in billions.
Preliminary estimates. Totals may not add because of rounding.

DRAFT

KIDS FIRST
Medicare HI Trust Fund Insolvency Pushed to 2010

Same as the first package except:

- 50 percent of the revenue from the tobacco tax would be dedicated to the Medicare HI Trust Fund. This would improve the solvency of the HI Trust Fund and move the projected insolvency date to approximately 2010 (when combined with the Medicare savings described in Package A).

- Medicaid Investment Fund is replaced with Federal subsidies for uninsured children up to 240 percent of poverty:

  - Low and moderate income families with eligible children would receive subsidies to enable them to purchase health coverage for their children. Families with incomes of up to 133% of the federal poverty level would receive full subsidies; families with incomes from 133% to 240% would receive partial subsidies based on a sliding scale phasing down to zero at 240%. Families with incomes of more than 240% of poverty could purchase coverage for their children, but would not receive any subsidies. [Under current law, children up to 7 years of age in families with incomes to 133% are eligible for Medicaid. In 1995, the federal poverty level, for a family of four is $15,200; 133% of the poverty level was $20,216; 240% of the poverty level was $36,480.]

  - To be eligible, a child must be 18 years or younger and not have been covered by a private insurance plan in the previous six months and the parents must not have access to an employer contribution of at least 50% for dependent coverage. Eligibility for subsidies would be determined on a monthly basis using monthly cash income.

  - Children could be covered under a benefits package which has the same actuarial value as the current Blue Cross/Blue Shield standard option benefits package provided to federal employees through FEHBP.

  - The subsidy program would be 100% federally financed but administered by states. States would be responsible for eligibility determinations and assuring that eligible individuals receive covered services. States could provide coverage by contracting with appropriate providers (or HMOs, PPOs, or other managed care providers), purchasing private health insurance plans, from HMOs and other managed care providers), or covering the children through their Medicaid programs.

DRAFT

For Illustrative Purposes Only

KIDS FIRST, NO TOBACCO REVENUE
Medicare HI Trust Fund Insolvency Pushed to 2006

Initiatives

KIDS PROGRAM UP TO 240%

LONG-TERM CARE INITIATIVES

PUBLIC HEALTH SERVICE EXPANSION

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICARE SAVINGS AND IMPROVED SOLVENCY

MEDICAID DSH REFORM

MEDICAID MANAGED CARE REFORM

	5 Years	7 Years	10 Years
Kids' Program to 240% of Poverty	21.9	34.8	56.7
Long-term Care Initiatives	9.2	14.8	24.6
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction	4.6	8.4	15.7
TOTAL COSTS:	**$37.1**	**$60.0**	**$99.9**
Medicare Savings & Solvency	102.1	188.8	384.3
Medicaid DSH Reform	22.3	34.4	56.1
Medicaid Managed Care Reform	1.2	4.5	10.8
TOTAL FINANCING:	**$125.7**	**$227.7**	**$451.2**
SAVINGS/DEFICIT IMPACT:	**$88.6**	**$167.7**	**$351.2**

Dollars in billions.
Preliminary estimates. Totals may not add because of rounding.

DRAFT

KIDS FIRST, NO TOBACCO REVENUE
Medicare HI Trust Fund Insolvency Pushed to 2006

Same as the first package except:

- Medicaid Investment Fund is replaced with Federal subsidies for uninsured children up to 240 percent of poverty.
- No tobacco tax.

TAB

B

Expanding Coverage Through A Medicaid Investment Fund

DRAFT

Summary

- Federal savings gained from reducing DSH payments by one-third would be pooled with the revenue from a tobacco tax to create a "Medicaid Investment Fund" that would help states expand coverage to the previously uninsured.

- States would have the flexibility to use the new federal money to cover more people in a number of ways: through Medicaid, through the private market, or by building a managed care delivery system similar to Tennessee's. In moving to TennCare, Tennessee achieved the following:

    - shifted the current Medicaid and newly-eligible population into managed care networks,
    - aggressively negotiated rates with providers, and
    - expanded coverage to approximately 440,000 previously uninsured.

- Assuming that the states would contribute funding for coverage of new eligibles, and that the program would cover a basic benefit package like that proposed in the Health Security Act, the Medicaid Investment Fund could cover (assuming that 50% of the revenue generated from a $1.00 a pack tobacco tax was available) an average of 4.25 million beneficiaries over the ten year period.

- This represents an increase of approximately 10% above current average Medicaid enrollment projections for the seven year period, and on average, a 10 percent reduction in the number of uninsured.

Sources of Funding

- Coverage expansions through the Investment Fund would be financed by federal savings realized by reducing DSH payments by one-third and the revenue generated from a tobacco tax. All or half of the revenue generated from a $1.00 a pack tobacco tax would be available. The other half of the tax revenue could be redirected as a source of revenue for the HI trust fund.

- An alternative to these funding sources is the savings generated by limiting the growth in Medicaid per capita expenditures to the growth in nominal GDP per capita, i.e., retaining the entitlement nature of the program but limiting federal payments to

states. This option could be pursued as an alternative, or in combination with the options discussed above.

- **The DSH savings proposal** seeks to enhance the financial integrity of the Medicaid program by targeting the inappropriate use of DSH funds. This savings proposal should be pursued even in the absence of any expansion of coverage.

  Current rules regarding federal DSH payments to hospitals that were part of OBRA 93 could be further tightened to produce savings. DSH funding could be directed only to those currently designated DSH hospitals that meet certain criteria (e.g. with respect to the volume or proportion of low income patients). For example, DSH payments could be limited to the highest volume DSH providers such as those with a low income utilization rate in excess of five or ten percent (the current rate is one percent). This DSH proposal could be tailored to produce the savings necessary to finance the Investment Fund

  In addition, the amount of hospital costs eligible for reimbursement under the DSH rules could be reduced by the amount of State and local subsidies paid to the hospital for some previous cost-reporting period. This option was considered by the Energy and Commerce Health Subcommittee during OBRA 93, but was taken out of the final mark.

Financing

- The Medicaid Investment Fund would be a capped entitlement to the states.

- Investment funds could be apportioned to the states through a formula grant process. The formula could take into account the number of uninsured in each state and/or other indicators of need (i.e., poverty rates, total taxable resources). Each state would be allotted an amount equal to the total investment fund pool multiplied by their formula percentage.

  For example, according the March 1994 CPS, uninsured residents in Florida account for 6.8% of the national uninsured population. Therefore, Florida would be eligible to receive approximately 6.8% of the Medicaid Investment funds each year.

- States would be required to contribute an amount equal to their current state matching requirement for coverage of new populations under the fund. That is, if the state contributes 43 percent of its Medicaid costs, it would continue to contribute 43 percent of the costs of the new population. Those states who could not afford to expand coverage would not be able to apply for the new federal funds. All of the current rules regarding what constitutes the state share of Medicaid would apply to the state share of the investment fund (although current rules could be modified to prevent cost-shifting).

- The amount of funds available each year is tied directly to the estimates of DSH savings and tobacco tax revenue. The amount of funds available in future years would be recalculated each year, and changes in available funds would be made based on the latest estimate of available resources. By recalculating the amount of funds available each year, the program would be truly "deficit neutral."

- Treasury projections of tobacco tax revenue indicate a gradual decline in revenue. In the event that actual resources fall below the estimated levels, states would take responsibility to cap future enrollment levels to account for reduced resources. Since coverage under the new program is not an individual entitlement, individuals could lose coverage or benefits if the funding for the program runs out. If states do not want to cap enrollment, they could choose to absorb the full costs of coverage above the federal limit.

  Any downward adjustments could be allocated among the states using the distribution formula.

- Alternatively, the unused funds reserved for states who do not choose to participate could be set aside for use as a funding reserve. In the event of declining federal resources, the reserve could be allocated among states based on the formula discussed above to make up for reductions in federal funds. The balance of unused funds could roll over each fiscal year, like the regular Medicaid appropriation or, alternatively, be returned to the Treasury.

Eligibility

- States would be free to determine eligibility for programs under the investment fund. Federal guidelines would indicate a preference that states use the funds to cover pregnant women and children. The purpose of the fund is to increase the number of people who have insurance coverage, not to supplement the benefits of the currently-insured, nor to supplant other forms of insurance.

- States would be required to offer insurance coverage only to people who have been uninsured and ineligible for Medicaid for some period of time (e.g., uninsured for six months prior to coverage).

- States could also be required to adopt some mechanisms to prevent employer dropping (e.g., non-discrimination clauses).

Benefits

- States would be required to offer a standard benefit package to the newly-insured. This benefit package would include coverage for basic acute care services and prescription drugs. Coverage estimates were developed using Medicaid per capita expenditures for services that would be included in an acute care benefit package similar to the one that was introduced in the Health Security Act.

- Over time, the current Medicaid program could be reformed to include a standard benefit package.

- States would have the option to impose cost-sharing for the new program for beneficiaries whose incomes are above 100 percent of the federal poverty level. States could not require copayments for preventive care services.

Service Delivery

- States would be encouraged, but not required, to serve these new recipients through managed care.

- States could choose to serve this population through the same mechanisms/delivery system as their Medicaid program, or they could choose to provide subsidies for the purchase of private insurance.

Duration of the State Programs

- There would be no federally-mandated duration of the investment fund programs. The programs could either be indefinite, or the duration could be left up to the state. Regardless of the duration, investment fund programs would be subject to the standard Medicaid quality and access requirements.

- If additional investment funds become available, states could apply for new programs, or to expand their current investment fund programs, or to renew programs that they had chosen to terminate.

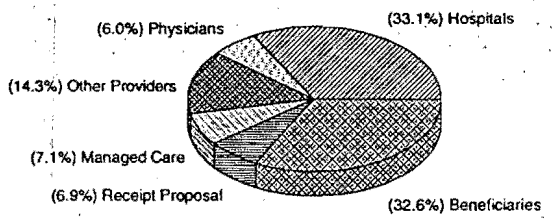
- Federal approval of state programs financed by the Medicaid Investment Fund would be administered through the current Medicaid state plan amendment process.

TAB

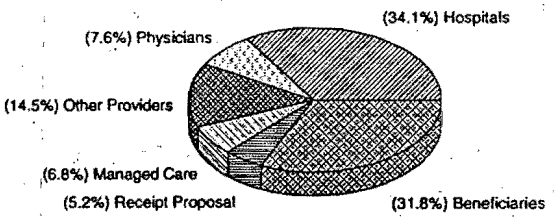
C

DRAFT

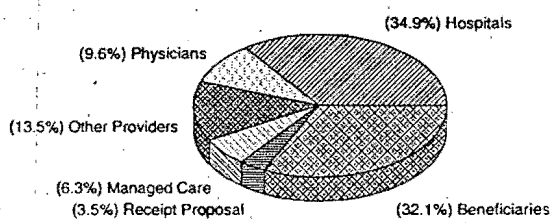
Impacts of Proposed Medicare Package
(5-yr. Total = $102.1 billion)



Impacts of Proposed Medicare Package
(7-yr. Total = $188.8 billion)



Impacts of Proposed Medicare Package
(10-yr. Total = $384.3 billion)



DRAFT

Medicare Savings Proposals -- $100 Billion in HI Savings, 1996-2002

(Billions of Dollars, by Fiscal Year)

		5-yr. Total 1996-2000	7-yr. Total 1996-2002	10-yr. Total 1996-2005
Part A Proposals				
Hospitals				
Reduce Hospital PPS Update (MB-1%, FY 1997-2000)	HSA	-6.4	-13.3	-25.7
Extend PPS Capital Reduction from OBRA 90	HSA	-6.1	-9.3	-14.8
Reduce PPS-Exempt Update (MB-1%, 1998-2000)		-0.3	-0.7	-1.6
Reduce PPS-Exempt Capital Payments	HSA	-1.0	-1.6	-2.6
Moratorium on Long-Term Care Hospitals	HSA	-0.4	-0.8	-1.8
Expand Centers of Excellence	HSA	-0.2	-0.4	-0.5
Lower IME to 5.3% in FY 2000	HSA	-2.0	-7.1	-16.9
GME Reform		-3.1	-6.0	-12.6
Reduce Medicare DSH Payments by 25%	HSA	-5.3	-8.6	-14.4
Eliminate Add-Ons for Outliers		-0.5	-0.9	-1.5
PPS Redefined Discharges		-1.1	-1.7	-2.9
Eliminate Bad Debt Payments		-1.7	-2.7	-4.5
Eliminate Add'l Payment to Sole Community Hosp.		-1.4	-2.2	-3.6
Subtotal, Hospitals		*-29.6*	*-55.3*	*-103.5*
Home Health and SNF				
SNF Cost Limits Freeze: Preserve OBRA 93 Savings	HSA	-1.3	-2.0	-3.2
HHA Cost Limits Freeze: Preserve OBRA 93 Savings	HSA	-1.6	-2.5	-4.2
Home Health Prospective Payment		-1.9	-4.2	-8.2
SNF Prospective Payment		-0.7	-1.5	-2.8
Eliminate HH PIP		-1.2	-1.4	-1.7
Home Health Pay on Location of Service		-1.4	-2.0	-3.2
Subtotal, Home Health & SNF		*-8.1*	*-13.6*	*-23.3*
HMOs				
Remove GME, IME and DSH from AAPCC		-7.3	-12.8	-24.2
Beneficiaries				
Home Health Coinsurance at 10% (30 day window)	HSA	-5.5	-8.8	-14.5
HI Receipt Proposal				
Extend HI Tax to All State & Local Employees	HSA	-7.1	-9.9	-13.5
Medicare Secondary Payer (Part A)				
Extend OBRA 93 Provisions	HSA	-2.1	-5.2	-11.7
Insurer Reporting and Court Case Fix		-1.1	-1.8	-3.0
Part A Interactions	1/	2.8	5.1	9.9
Total Part A Savings		***-58.0***	***-102.3***	***-183.8***
Part B Proposals				
Physicians				
Freeze Physician Fees in 1996-1997 (not primary care)		-1.8	-2.9	-5.0
Eliminate MVPS Upward Bias		-1.5	-6.2	-21.9
Single Fee for Surgery		-0.4	-0.7	-1.1
High-Cost Medical Staffs	HSA	-2.4	-4.6	-8.9
Subtotal, Physicians		*-6.1*	*-14.3*	*-36.9*
Hospital Outpatient Departments				
OPDs: Eliminate Formula-Driven Overpayment	HSA	-5.9	-12.4	-37.4
OPDs: Payment Reductions for Cost-based Svcs.	1/	-1.1	-1.8	-3.2
Medicare Secondary Payer (Part B)				
Extend OBRA 93 Provisions	HSA	-0.9	-2.5	-6.2
Insurer Reporting and Court Case Fix		-0.9	-1.4	-2.7
Other Providers				
Competitive Bidding for Labs	HSA	-1.0	-1.8	-3.3
Competitive Bidding for Part B Services	HSA	-0.6	-1.0	-1.8
Subtotal, Other Providers		*-1.5*	*-2.8*	*-5.1*
Beneficiaries				
Extend Part B Premium at 31.5%	1/	-32.9	-62.4	-137.8
Interactions with Part B savings proposals	1/	5.2	11.1	28.8
Subtotal, Beneficiaries		*-27.8*	*-51.3*	*-109.0*
Total Part B Savings		***-44.1***	***-86.5***	***-200.5***
TOTAL MEDICARE SAVINGS		**-102.1**	**-188.8**	**-384.3**
Memo: Medicaid Interactions (Federal share)	1/	1.5	2.4	4.6

NOTE: All estimates are PRELIMINARY. Interactions between proposals may change estimates.

1/ Denotes a preliminary staff estimate. Other estimates are actuary pricing from FY 1996 President's Budget baseline.

HSA: Proposal (or similar one) was in the Administration's Health Security Act.

DRAFT

Description of Illustrative Medicare Savings and Solvency Proposals

Part A Proposals

Hospital Proposals

- Reduce PPS Market Basket Update (MB -1.0%, FY 1997-2000). This proposal would reduce the hospital market basket index update by 2.0 percent. This is consistent with the current reduction and would eliminate a sudden increase in the baseline that exists under current law. OBRA 1993 reduced the market basket index update by 2.5 percentage points in FY 1994 and 1995, 2 percentage points in 1996, and 0.5 percentage points in 1997. An extension of these reductions would affect hospitals relatively evenly.

  While some have argued that the reduction in casemix "creep" undermines the justification for a reduction of 2 percentage points, it should be noted that hospitals have experienced a declining casemix increase for the last two years and have simultaneously withstood update reductions of 2 and 2.5 percent. Additionally, OACT cannot confirm that the slowdown in casemix is due to the elimination of creep.

  In addition, the contention that a lower market basket projection in the FY 1996 President's Budget has adversely affected hospitals is unfounded. The final market basket amount is determined separately from the Budget (DRI, an econometric consulting firm, determines the final update) under the same methodology as in the past. The Prospective Payment Assessment Commission (ProPAC) recommends a reduction to the market basket of 1.8 percentage points.

- Extend PPS Capital Reduction from OBRA 1990. This proposal would permanently capture the savings from the OBRA 1990 provision which reduced hospital capital payments by 10 percent through FY 1995. Without this extension, payments to hospitals will increase approximately 16 percent in FY 1996, over four times more than expected general inflation. This proposal could be considered an efficiency adjustment to recoup excessive Medicare capital reimbursement of the late 1980s. In addition, the current base payment amount reflects overestimated capital costs, and should be modified to reflect more accurate data. Hospitals would oppose this provision.

- Reduce Payment Update for PPS-Exempt Hospitals. This proposal would reduce the update for PPS-exempt hospitals by 1.0 percentage points each year between FY 1998 and FY 2000. This proposal is an extension of an OBRA 1993 provision. Maintaining an update less than the full market basket rate of increase provides incentives for hospitals to increase efficiency

and reflects anticipated productivity gains. Few costs continue to be reimbursed on a reasonable cost basis. This proposal is consistent with update reductions for PPS hospitals. While this policy would be a continuation of current law, it would likely trigger opposition from specialty hospitals.

- Reduce Payments for PPS-Exempt Capital. This proposals would pay 85 percent of capital costs for PPS-excluded hospitals and units for FY 1996 through 2005. PPS-exempt hospitals and units are specialty hospitals (e.g., childrens', rehabilitation and psychiatric) and would object to this proposal on the grounds that they serve distinct and needy populations. However, this cut is consistent with policies in place for PPS facilities.

- Place Moratorium on New Long-Term Care Hospital Exclusions. This proposal would prohibit new long-term care hospitals from being excluded from PPS, effective on 10/1/95. Designation as a long-term care hospital has few requirements. Beneficiaries served by these hospitals could also be served by rehabilitation hospitals, psychiatric hospitals and skilled nursing facilities (SNFs), which have more rigorous requirements. A more comprehensive policy would be to eliminate the category and require that all current long-term care hospitals convert to other types of hospitals within a certain time frame. Long-term care hospitals would oppose this proposal.

- Expand Centers of Excellence Demonstration. This proposal would expand Medicare's current "centers of excellence" demonstration to all urban areas. Medicare would contract with individual centers using a flat payment rate for all services associated with cataract or CABG surgery. Beneficiaries would not be required to have these procedures performed only at the centers. This proposal would stipulate that beneficiaries choosing to seek care at a center of excellence would receive a rebate of 10 percent of the government's savings from the center. The proposal could be modified to eliminate the beneficiary rebate. Designated "Centers of Excellence" could instead promote their seal of approval to achieve increased volume.

  This proposal would engender opposition from certain provider groups (especially opthamologists) concerned that they be forced to accept lower payment rates or be at a competitive disadvantage. Beneficiary groups could also raise concerns about freedom of choice among providers, but the proposal would not force beneficiaries to give up choice of provider. Scoring note: In contrast to OACT, CBO scored this provision as having diminishing savings.

- Lower Indirect Medical Education Payment to 5.3 percent in FY 2000. Currently, Medicare reimburses hospitals for expenses associated with teaching residents and interns. Most evidence indicates that payments overcompensate hospitals. This proposal would reduce payments to teaching hospitals to better reflect the costs incurred. Academic medical centers would vigorously oppose this provision.

- Implement Graduate Medical Education (GME) Reform. This proposal actually contains six individual proposals, including two program expansions.[1] There is general agreement that the GME and Indirect Medical Education (IME) payment methodology is flawed. Evidence suggests that hospitals are overcompensated (especially in terms of the IME adjustment), and that GME/IME payments encourage hospital-based specialty training at the expense of primary care training. This set of proposals should help address these problems.

  While reform is needed in GME and IME payment policy, staff have a number of concerns regarding these particular proposals. Taken together, the overall package saves money. HHS, however, has not provided staff with pricing of each individual proposal. To have a full range of options for a package of GME reforms, we would request full pricing for each proposal as well as an "interactions" line. Without this information, we cannot fully evaluate these proposals. The details of these individual proposals would require further refinement and explanation before they could be discussed more publicly.

  Reductions in graduate medical education funding will face strong opposition from a variety of sources, including medical schools academic health centers, and teaching hospitals. Hospitals will also argue that, when combined with the proposed reductions in DSH, this proposal unfairly targets hospitals in large urban areas. These hospitals often have low total margins and provide more uncompensated care.

- Reduce Medicare Disproportionate Share Hospital (DSH) Payments by 25 percent. This proposals would reduce the current Medicare DSH adjustment for PPS hospitals by 25 percent effective in FY 1997. This proposal assumes that all DSH hospitals would have their payments reduced by 25 percent. While this flat reduction may the easiest approach politically, it fails to better target payments to hospitals that demonstrate higher costs per case as a result of a large SSI and Medicaid population. If payment were determined according to the empirical evidence, the payments could be trimmed by approximately 65 percent and targeted only to large urban hospitals.

  Hospitals would oppose this provision and argue that when combined with IME and GME savings provisions, unfairly targets large urban hospitals. These hospitals often have low total margins and provide more uncompensated care.

These six proposals are: (1) freeze the total number and the number of non-primary care residency positions reimbursed under Medicare; (2) extend OBRA 1993 freeze on updates for non-primary care residents for an additional 5 years; (3) count residents beyond their initial residency period as 0.5 FTE for IME; (4) count work in non-hospital settings for IME; (5) allow GME payments to non-hospitals for residents receiving primary care training when hospital is not paying the resident's salary; and (6) cap hospital-specific GME payments at 140% of the national average per resident amount.

- Eliminate Add-Ons for Outliers. This proposal would eliminate IME and DSH payments for outlier cases, effective with discharges beginning with FY 1996. IME and DSH would be counted as part of hospitals' costs that trigger outlier payments, but IME and DSH payments would not be paid in addition to outlier payments. This proposal would result in IME and DSH hospitals receiving a greater portion of outlier payments, rather than IME and DSH payments for each outlier case. A distributional analysis has not been performed, but certain urban and rural hospitals would likely oppose this proposal.

- Redefine PPS Discharges. Under this proposal, hospitals that move patients to PPS-exempt facilities and SNFs, would "transfer" rather than "discharge" patients, limiting their reimbursement to a per diem, rather than the full DRG payment. There is concern that gaming now occurs because hospitals currently receive a full DRG for a case they transfer to a PPS-exempt facility or SNF. This payment may create an incentive for hospitals to discharge cases more quickly. As a result, rehabilitation facilities or SNFs may incur more costs in caring for the patient. Because they have minimal constraints on their cost growth, expenditures for the SNF and PPS-exempt facilities have grown rapidly.

  While it is technically possible to expand the definition of "transfer", there is concern about the newly created incentives. Hospitals would only be paid a full DRG if the patient were returned to home. This may lead to higher home health costs and/or inappropriate care. This proposal would be opposed by both hospitals and SNFs.

- Elimination of Bad Debt Payments to Hospitals. Currently, Medicare reimburses hospitals for any copayments or deductibles owed by beneficiaries but not paid, provided that the hospital makes a reasonable effort to collect them. This proposal would eliminate Medicare payments to hospitals that have failed to collect enrollees' bad debts. This option would give hospitals a financial incentive to expand their collection efforts, which would probably increase their recovery of enrollees' deductible and coinsurance amounts. Hospitals, especially those serving low-income people, would object to this proposal.

- Eliminate Medicare's Additional Payments to Sole Community Hospitals. Hospitals designated as Sole Community Hospitals receive payments about 10 percent higher than they would be otherwise. While the objective of the SCH payment rules is to assist hospitals in locations where closings would threaten access to hospital care, the support is not aimed at essential providers. Some rural hospitals may experience financial distress as a result and all currently eligible SCH would object to this provision.

Home Health and SNF

- SNF Cost Limits Freeze: Preserve OBRA 93 Savings. OBRA 93 established a two-year freeze on updates to the cost limits for SNFs. A "catch-up," however, is allowed after the SNF freeze expires in FY 1996; new cost limits would be established that do not reflect the effects of the freeze. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

- HHA Cost Limits Freeze: Preserve OBRA 93 Savings. OBRA 93 eliminated the inflation adjustment to the home health limits for two years, FY 1994-1995. This proposal would eliminate the inflation "catch-up" -- currently allowed after the freeze expires on July 1, 1996 -- by recalculating the percent of the mean that would produce the same amount of savings as if the freeze continued.

- Implement Home Health Prospective Payment System. This proposal would implement a per-episode prospective payment system (PPS) for home health beginning in FY 1999. HCFA is currently running a demonstration (the operational period of the demonstration is scheduled to conclude by the end of CY 1998) testing this type of home health PPS. Under this proposal, HCFA would use the technical components (e.g., case-mix index, geographic adjustors, update factors) developed for the demonstration to implement the system nationally. This proposal is designed to reduce Medicare home health expenditures by 5 percent off of the FY 1999 level. A number of technical concerns would need to be addressed before implementation. Home health agencies will likely support this proposal (although they may not want to wait until FY 1999 for PPS to start) because they strongly oppose beneficiary copayments.

- SNF PPS. This proposal would implement PPS for SNFs beginning in FY 1996. PPS rates for routine costs would be set on a facility-specific basis, subject to regional limits based on the costs for free-standing SNFs. This allows the proposal to generate savings. This proposal would bring the routine operating costs under PPS, but not necessarily the capital-related or ancillary services costs. If these costs are not included in the prospective rate, the proposal does allow for a ceiling to be imposed, thereby limiting Medicare payments for capital and ancillaries.

  The SNF program is one of the fastest growing Medicare benefits, with both increased volume and costs driving the overall increase in SNF expenditures. A prospective payment system, if carefully designed, could address both of these factors. As with home health PPS, a number of technical concerns would need to be worked out before implementation.
  Most SNFs tend to support PPS as a payment approach, as an alternative to large payment reductions.

- Eliminate Periodic Interim Payments for Home Health Agencies. This proposal would eliminate periodic interim payments (PIP) for home health agencies (HHAs) beginning in FY 1996. PIPs are intended to help smooth out cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, the PIPs are reconciled with actual expenditures. According to HHS, Medicare tends to overpay providers who receive PIPs and has had a difficult time recovering these overpayments. In addition, with new HHAs joining the Medicare program at a rate of approximately 100 per month, beneficiary access to home health care is no longer a problem. Thus, new providers no longer need this kind of help to encourage them to participate in the Medicare program.

  PIPs, however, are popular on the Hill and within the home health industry and may face opposition from these two sources.

- Pay Home Health Based on Location of Services. Under this proposal, home health services would be paid based on the zip code of the location of where the services are *rendered* rather than where the service is *billed*, starting in FY 1996. Home health agencies are often established with a home office located in an urban area and the branches located in rural areas. When the HHA bills Medicare, payment is based on the wage rate for the urban area, even though the actual service delivery occurred in a rural area. This proposal would bring Medicare payments more in line with the costs HHAs actually incur. HHAs will likely oppose this proposal.

HMOs

- Remove GME, IME and DSH from AAPCC. A proposal to gain savings from Medicare managed care would ideally lower payment levels relative to fee-for-service, while also increasing enrollment. Payment could be lowered in several ways: no longer allowing payment to reflect wide geographic fluctuations in service volume, reducing the percentage of fee-for-service costs HMOs receive, competitive bidding, or eliminating GME, IME and DSH payments from their payment. The pricing associated with this provision reflects the proposal to eliminate GME, IME and DSH payments for HMOs, however, it is considered a placeholder. It should be noted that reductions in payment levels may thwart increased enrollment. HMOs would likely oppose efforts to constrain payments.

Beneficiaries

- 10% home health copayment (with a 30-day window). This proposal would establish a 10 percent copayment for home health visits, effective 10/1/96, for all visits except those occurring within a 30 day period following an inpatient hospital discharge. Home health is one of the fastest growing benefits in the Medicare program, and beneficiaries currently are not required to pay

a copayment. Imposing a beneficiary copayment should cause beneficiaries to use less services. Exempting visits during the first 30 days following an inpatient discharge protects beneficiaries from losing access to home health services which tend to be less discretionary because of rehabilitative needs.

This proposal will not be popular with beneficiaries who will view it as a reduction in benefits and will increase their out-of-pocket costs. HHAs will also oppose this change. The industry will argue that it will decrease beneficiary access, create an administrative burden on HHAs, and create bad debt which HHAs will never be able to collect.

HI Receipt Proposal

- End HI Subsidy by Extending HI Tax to All State & Local Government Employees. Extend the HI tax to state and local workers hired before 4/1/86 and currently exempt from the HI tax (same as HSA). Imposition of the HI tax on these individuals will have an effect on the out year savings estimates for the non-contributing retiree MSP proposals, although HHS has not done this analysis. State and local governments and their employees would object to this proposal. From the state's perspective, this proposal may be considered an unfunded mandate.

Medicare as a Secondary Payer (Part A and Part B)

- Extend Expiring OBRA 1993 MSP Provisions. This proposal was included in the FY 1996 President's Budget. It would make permanent three MSP provisions from OBRA 1993 currently scheduled to expire after 1998. The three policies include Medicare as a secondary payer for the working disabled; an 18-month period for Medicare as a secondary payer for individuals with end-stage renal disease; and the IRS/SSA/HCFA data match.

- MSP Insurer Reporting. This proposal would replace the Medicare/Medicaid Data Bank with insurer (rather than employer) reporting requirements to prospectively identify MSP situations. Although far less burdensome than the Data Bank, this proposal carries some of the same baggage. Specifically, employers will likely be upset at having to provide, through their insurers, information on employers (such as dependent's SSNs) that they do not now collect. Also, insurers will resist passage of something that will likely increase their benefit payouts.

- MSP Court Case Fix. The Supreme Court recently upheld a lower court's ruling invalidating certain HCFA MSP regulations. The lower court's ruling limited HCFA's ability to make collections on older claims, make recoveries from third party administrators, and determine appropriate recovery amounts. This proposal would clarify HCFA's authority in these areas.

Part B Proposals

Physician Proposals

- Freeze Physician Fees in 1996 and 1997 (except primary care). This provision would reduce the 1996 and 1997 physician fee updates for services other than primary care, such that fees for most services would effectively be frozen at their 1995 levels. This proposal would be a means to recoup the excessive fee increases (23 percent cumulative increase) for surgical services in 1994 and 1995. Physician groups will oppose this proposal, but they may split along specialty lines as primary care services are exempt from the reduction. Physicians may argue that fee reductions will harm beneficiaries' access to care. There is no evidence of widespread access problems currently, even though Medicare payment rates tend to be less than private payers' rates. Finally, preliminary Physician Payment Review Commission data indicate that private payers are putting downward pressure on physician fees, indicating a reduction in the gap between private insurers' and Medicare's payments.

- Elimination of the Medicare Volume Performance Standard (MVPS) Upward Bias. This provision would eliminate the inconsistency in the way that performance adjustments to fee updates are passed through to the MVPS for the relevant fiscal year. The MVPS (a target rate of expenditure growth) is inflated by this inconsistency in the current formula.

  Physicians -- particularly surgeons -- will oppose this proposal but will not have a strong case on policy grounds. The current MVPS system is broken and resulted in a 15 percent physician update for 1994 and 1995 combined (23 percent for surgical services). Projected negative fee updates in the next few years would result from the partially self-correcting nature of the MVPS. However, even after this self-correction, the MVPS would remain inflated by this formulaic upward bias. This proposal would correct that problem. The Physician Payment Review Commission supports this improvement.

- Single Fee for Surgery. The Administration proposed this provision in the FY 1994 President's Budget. This proposal would make the same payment to a primary surgeon regardless of whether they chose to use an assistant-at-surgery. There is substantial geographic variation in the use of assistants for the same surgical procedure, suggesting that there is a lack of medical consensus on the use of assistants. The Medicare payment for the primary surgeon would be reduced by the amount of

the payment for the assistant-at-surgery used by the surgeon. Exceptions would be created for specific procedures or situations specified by the Secretary; separate payments could be made in these special cases. Surgical groups will likely oppose.

- High-Cost Medical Staffs: The HSA contained this provision to require the Secretary to identify hospital medical staffs with excessive in-patient physician service volume compared to national norms. Medicare payments for inpatient physician services would be re-designed to create an economic incentive for these designated "high-cost" medical staffs to review and modify their high-volume practice patterns. The Secretary would reduce payments to medical staffs of such hospitals. Physicians would be opposed to this proposal, and hospitals may also perceive it as adding an administrative burden.

Outpatient Departments

- Eliminate Medicare Outpatient Formula Driven Overpayment (FDO). This provision can be enacted as a stand-alone proposal or as part of the implementation of a hospital PPS system. The provision would correct the anomaly in Medicare's "blended" payment method for hospital outpatient radiology, other diagnostic services and ambulatory service center (ASC) approved surgical procedures. Generally, every dollar beneficiaries pay in coinsurance results in a direct dollar decrease in Medicare payment. However, because of the way payment is determined under the blend, Medicare does not get the full benefit of the actual coinsurance that beneficiaries pay.

  A related problem concerns beneficiary coinsurance for these specific services, which equals 49 percent rather than 20 percent of total payments, as enumerated by statute. If this is adopted as a stand-alone proposal, beneficiaries will resist it because of coinsurance remains unaddressed. Hospitals will also oppose this provision.

- Reduce Cost-Based Hospital Outpatient Department (OPD) Payments. This provision would make a five percent reduction in Medicare payments for certain hospital outpatient services that are currently reimbursed (in whole or in part) on a cost basis. This proposal could be viewed as an extension of an OBRA 1990 provision that reduced payments for OPD operating costs by 5.8 percent. Services affected by this proposal would include outpatient surgery, radiology and diagnostic procedures, physical therapy services, and other services paid on a cost basis. Services currently paid on the basis of a fee schedule (e.g., clinical lab, DME) or with a composite rate (e.g., dialysis services) would not be affected. This provision likely would be opposed by hospitals and well-organized provider groups affected by the reductions, such as physical therapists.

Other Providers

- Competitive Bidding of Lab Services. The Health Security Act (HSA) included the same provision to establish a competitive acquisition system for Medicare clinical diagnostic laboratory services as for other selected Part B items and services, effective 1/1/97. If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services that would occur in CY 1997, then the Secretary would reduce Medicare fees for lab services by the difference needed to result in a 10 percent price discount from CY 1997 level.

  As a policy, this provision makes Medicare payment practices more consistent with those in the private market. Moreover, it provides a good strategy to reduce fees for lab services because the guaranteed 10 percent reduction forces laboratories to cut prices in exchange for not enacting this policy. However, the independent lab industry will probably oppose this proposal as a fee cut. Physician groups may also oppose it because competitive bidding would tend to favor large, high-volume and highly efficient laboratories.

- Competitive Bidding of Other Part B Services. The HSA included the same provision to establish a competitive acquisition system for Medicare services and supplies in a geographic area. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient amount of the item or service. Initial items for competitive procurement are: oxygen and oxygen equipment; enteral and parenteral nutrients, supplies and equipment; and MRI and CT scans, effective 1/1/97. If the competitive system does not result in a reduction of at least **10 percent** in the price of all items and services that would occur in CY 1997, then the Secretary would reduce Medicare fees for lab services by the difference needed to result in a 10 percent price discount from CY 1997 level.

  As a policy, this provision makes Medicare payment practices more consistent with those in the private market. Moreover, it provides a good strategy to reduce fees for lab services because the guaranteed 10 percent reduction forces laboratories to cut prices in exchange for not enacting this policy. This proposals was strongly opposed by the oxygen supply industry during the health care reform debate in the 103rd Congress.

Beneficiaries

- Extend Part B Premium at 31.5 Percent. The Part B premium -- paid monthly by all beneficiaries enrolled in Part B -- currently is equal to approximately 31.5 percent of program costs. Under current law, the premium will drop to 25 percent of program costs in 1996. This proposal would set the Part B premium such that it covered its current portion of costs.

The Part B premium was originally designed to cover 50 percent of program costs. As costs grew more rapidly than Social Security COLAs, this fraction was scaled back, settling at around 25 percent in 1982. A 25 percent premium has been extended several times since then. However, beneficiaries have paid more than 25 percent of program costs since 1992. Benefit outlays grew more slowly than anticipated at the time of OBRA 1990 premium projections, such that the current law premium covers 31.5 percent of program costs. OBRA 1993 set the monthly premium at 25 percent of program costs for CY 1996-1998. The general fund will make up the difference in lost income when the monthly premium again reverts to 25 percent of program costs.

This proposal achieves significant savings but would not increase the beneficiary share of Part B insurance costs beyond what beneficiaries are now paying. In that sense, the proposal can be thought of as an "extender."

TAB

D

DRAFT

Insurance Reform Options[1]

The following are possible elements of an insurance reform proposal that would build upon the Thomas bill (H.R. 1610):

- Broadening of the portability provisions in the Thomas bill. The Thomas bill would require health plans to reduce their pre-existing condition exclusion period by the amount of previous coverage for someone who is changing plans when changing jobs. The bill would also prohibit discrimination in eligibility or contribution levels based on health status for someone changing from one employer plan to another. These provisions could be broadened in several ways:

  - Pre-existing condition exclusion periods under employer plans would be reduced for anyone with prior coverage (e.g., individual coverage, Medicaid, or Medicare), not just for people who previously had employer-sponsored coverage. This is similar to the standard in the National Association of Insurance Commissioners' (NAIC) model law that has been adopted in a majority of states.

  - Discriminate based on health status would be prohibited for anyone newly eligible for coverage under an employer plan (e.g., someone who was not covered in a previous job), not jut for people moving from one employer plan to another. This is similar to provisions in the NAIC model law.

  - The length of a pre-existing condition exclusion period would be limited (e.g., to 6 or 12 months). Exclusions could not be applied to pregnancy or coverage of newborns (this provision was in Senator Bentsen's bill in 1992). A bill introduced by Representative Nancy Johnson (R-CT) uses a 6-month period. Also, waiting periods for coverage under group plans could be limited to 60 days.

---

[1]Provided by HHS.

- Helping people maintain coverage. Insurers would be required to renew coverage for small businesses and individuals except for certain limited circumstances (e.g., fraud or non-payment of premium). To prevent insurers from effectively forcing people with poor health status to drop coverage by raising their premiums significantly, premium increase due to health status would be limited.

  - For individual insurance, where experience rating is inappropriate, premiums could not be adjusted at renewal for changes in health status.

- For small group coverage, experience adjustments must be actuarially sound and would be limited to no more than 5% above trend (this provision was in Senator Bentsen's bill in 1992).

Portability protections (e.g., nondiscrimination in eligibility, enrollment, and premiums) also could be provided to people applying for individual coverage if (1) they were previously insured and (2) they lost coverage due to a change in employment, a change in residence, or lost eligibility for dependent coverage under a family member's plan.

TAB

E

Access to Federal Employees' Health Benefits Program

Along with insurance market reforms, one policy option could also provide access to the Federal Employees' Health Benefits Program for certain businesses and families. Below is the general framework and a discussion of policy questions that might arise.

Small firms would be allowed to offer to their employees, through FEHBP, plans available to federal employees.

Such an approach would require a decision relative to one key issue: what would be the premiums faced by small firms and their employees if they purchased coverage through FEHBP?

- One option would be to mix the rating pools (e.g., federal workers and workers with small firms) and charge the same premiums to both types of workers. Under this approach, if there is adverse selection on the part of small firms (e.g., only less healthier firms decide to purchase through FEHBP), premiums for federal workers would be higher than they would be otherwise. This would have an impact on federal government costs.

- A second option would be to keep the risk pools separate, but allow small firms and their workers to purchase coverage at the same prices as available to federal workers. Under this approach, if there is adverse selection on the part of small firms, premiums for federal workers would not increase. On the other hand, insurers would lose money on small firms. Depending upon a number of other factors, such losses could cause some insurers to stop participating in FEHBP.

- A third option would be to separate the risk pools and charge small firms the same premiums they would face in the community-rated market.[2] Premiums for federal workers would continue to be determined as under current law. Under this approach, FEHBP would serve as a purchasing cooperative for small businesses, as it does for federal workers.

Adverse selection effects could be limited by restricting the number of firms and individuals that are allowed to enter into FEHBP.

---

[2]This approach requires the presence of a community-rated market. Small firms would still be able to purchase coverage directly from insurers, through brokers, through purchasing groups, or through MEWAs.

May 20, 1993
Publication: SR-15-Health

dpc special report

Believe It or Not: Incredible Facts About America's Health Care Crisis

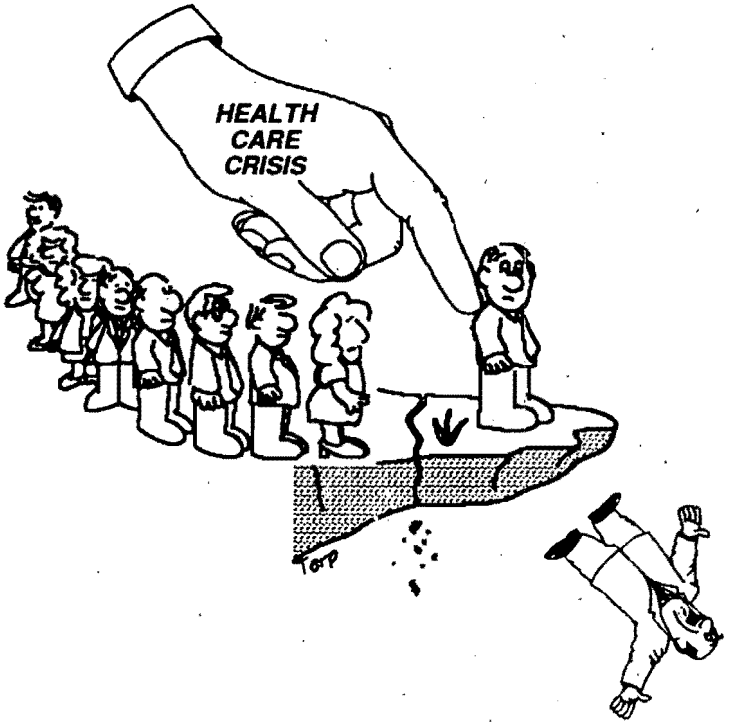
DPC Staff Contact: Dave Corbin (202-224-3232)
DPC Media Contact: Debra Silimeo (202-224-3232); Diane Dewhirst (202-224-2939)

dpc
Democratic Policy Committee
United States Senate
Washington, D.C. 20510

George J. Mitchell, Chairman
Thomas A. Daschle, Co–Chairman

democratic policy committee

Believe It or Not: Incredible Facts About America's Health Care Crisis



- ✔ *Every 30 seconds another American loses health care insurance.*
- ✔ *General Motors spends more on health care than for steel to build all its cars.*
- ✔ *American businesses spend $26 million per hour on health care.*

These and other alarming facts about America's health care system are cited and documented in this report. These facts reveal that America's health care system has broken down. It is hard to believe that the same system that provides some of the world's best health care also is devastating American families, straining our national economy and threatening the future of the American dream.

The system is failing the American people. The facts are startling and true. Read the report and believe it.

Many Americans Are Afraid

Many Americans are afraid that they could be the next victims of the health care crisis.

Believe It or Not

✔ Every 30 seconds, another American loses health insurance.

More than 100,000 Americans lose their insurance every month. That's one American every 30 seconds.[1]

✔ Most of those who do not have health insurance are working Americans.

Americans who work year round and their dependents make up almost 3 out of every 5 Americans without health insurance.[2] Government studies report that 70 percent of the uninsured are above the poverty level.[3]

✔ Almost half of all American families have at least one family member without adequate health insurance.

This year, 1993, 46 percent of American families have at least one family member without adequate health coverage.[4]

Believe It or Not

✔ The number of Americans without health insurance is more than the entire population of many States.

More than 35 million Americans have no health insurance.[5] This is equal to the combined populations of the following 23 States and the District of Columbia:

1.	Alaska	550,000
2.	Arkansas	2,350,000
3.	Delaware	666,000
4.	D.C.	606,000
5.	Hawaii	1,108,000
6.	Idaho	1,007,000
7.	Iowa	2,777,000
8.	Kansas	2,477,000
9.	Maine	1,277,000
10.	Mississippi	2,573,000
11.	Montana	799,000
12.	Nebraska	1,578,385
13.	Nevada	1,201,000
14.	New Hampshire	1,109,000
15.	New Mexico	1,515,000
16.	North Dakota	638,900
17.	Oklahoma	3,145,000
18.	Oregon	2,842,000
19.	Rhode Island	1,003,000
20.	South Dakota	696,000
21.	Utah	1,723,000
22.	Vermont	563,000
23.	West Virginia	1,793,000
24.	Wyoming	454,000
Total		**34,450,000**

Believe It or Not

✔ Only two western industrial countries do not guarantee affordable health care for their citizens, and the United States is one of them.

The only other industrialized nation that does not guarantee affordable health care is South Africa.[6]

✔ American citizens are less satisfied than citizens of any other major nation with their national health care system.

A Louis Harris poll of citizens of 10 nations found Americans to be the least satisfied of all with their system of health care.[7] We are spending more than others, and we're most dissatisfied with the system we have.

Believe It or Not

✔ Even Americans who have jobs that provide health insurance can be victims of the health care crisis.

The fear of losing health insurance coverage, or having family members or certain conditions excluded from coverage, keeps millions of Americans frozen in their jobs.

In some cases, workers are afraid to change jobs because they have a family member in poor health who would be excluded from a new policy.

A Consumers Union/Gallup Survey found that one-fifth of the American people are so afraid of losing their health insurance that it has blocked them from looking for or accepting another job.[8]

The *New York Times* found that one of every three Americans earning between $30,000 and $50,000 reports that they or someone in their household stayed in jobs they wanted to leave but can't leave because they are afraid of losing their health care coverage.[9]

Health care job lock brings with it a loss of economic liberty, opportunity, and choice.

A Few Americans Are Profiting

While the high cost of health care leaves millions of citizens without adequate health care protection, some Americans are making large profits.

Believe It or Not

✔ The head of a pharmaceutical company earns more by lunch time on each workday than the average American worker earns in a year.

> The head of Bristol-Myers Squibb makes $12.9 million a year, or $6,200 an hour, based on an eight-hour day.[10]

✔ The chief executives of America's largest health insurance companies are paid 5 times more than the President.

> The incomes of the CEOs at Aetna, Travelers, and Cigna insurance companies exceeded $1 million each in 1991.[11] The President of the United States makes $200,000 a year.

Believe It or Not

✔ Someone living in the USA pays *twice* what someone living in Europe pays for the same prescription drug.

Americans pay on the average 54 percent more than Europeans for 25 commonly prescribed drugs. Some essential drugs are especially costly in the USA. A month's supply of Eldepryl (a Parkinson's disease medication) costs about $28 in Italy, $48 in Austria, and $240 in the USA. Aerosolized pentamidine (used by AIDS patients to prevent pneumonia) costs $150 in the USA. In France, Germany, and Great Britain, the price for an identical vial is $26.[12]

✔ The drug industry is the most profitable industry in the United States.

Pharmaceuticals top the Fortune 500 list in percent of profit on return on sales, return on assets, and return on common equity.

Stockholder profits were higher in 1992 for investors in drug companies than investors in any other corporate manufacturing group, and so were profits per dollar of sales.

One of the reasons pharmaceutical companies are so profitable is that drug companies' prices consistently rise at triple the rate of inflation.[13]

The Health Care Crisis Threatens America's Businesses

Health care not only has become America's biggest business, but also is overwhelming most other American businesses.

Believe It or Not

✔ General Motors spends more for health care than it does on steel to build cars.

So does Ford Motor Co.[14]

✔ American employers spend $26 million per hour on health care.

American employers spend a total of $225 billion per year (1993 estimate) on health care. That comes to $616 million a day, or $26 million per hour.[15]

American Telephone and Telegraph pays out $3 million every day for its employees' health care benefits.[16]

Believe It or Not

✔ The number of employers paying their employees' medical coverage in full dropped by fully 1/3 in just the past 4 years.

Between 1988 and 1992, the number dropped from 57 percent to 39 percent .[17]

✔ Although small businesses are the backbone of the American economy, insurance companies discriminate against them by charging them higher premiums than large businesses.

A survey by the National Association of Manufacturers found that employers with fewer than 25 employees pay about 30 percent higher premiums than large employers.[18]

✔ Health care is a major source of current labor-management conflict.

Health care cutbacks were a major issue in 78 percent of all strike activity in 1989.[19]

✔ More than 8 of every 10 new companies created each year do not offer health insurance to their employees.

In 1992, 85 percent of new companies did not offer health benefits to their employees.[20]

The Incredible Health Care Bureaucracy

The cost of administering our failing health care system is outrageous.

Believe It or Not

✔ For smaller businesses, administrative costs consume 40 cents of every health dollar.

According to the Congressional Budget Office, administrative costs consume 40 percent of the total health costs for businesses with fewer than 5 employees.[21]

✔ Massachusetts Blue Cross alone employs more administrators than does the entire Canadian health care system.

According to *Consumer Reports*, to run a health plan covering 25 million people, Canada employs fewer administrators than Massachusetts Blue Cross, which covers 2.7 million people.[22]

✔ Each day, our Nation spends nearly a half billion dollars on the American health care administrative bureaucracy.

According to *Consumer Reports*, Americans pay out $163 billion a year (1992) for health care administrative costs. That comes to $447 million a day, or $19 million per hour.[23]

Spending More But Getting Less

Although the American health care system is failing our people and our country, we spend more on our system than any other country.

Believe It or Not

✔ Although one of every three Americans lacks adequate health care protection, the USA spends more money on health care than other industrial nations which provide health care to all of their citizens.

In 1991 (the last year for which comparable data is available), West Germany spent 8.5 percent of its GDP on health care and covered everyone. Japan spent 6.6 percent of its GDP on health care and covered everyone. The USA spent 13.2 percent of GDP on health care and still, 35 million Americans were without health insurance and 60 million Americans were underinsured.[24]

✔ America spends only a few pennies of every health care dollar on preventive care.

According to the Centers for Disease Control and Prevention, only 3.4 percent of total health expenditures are used for disease prevention and health promotion. Yet, preventive health care could effectively reduce deaths from cancer and heart disease, and could significantly lower the overall cost of health care in the long run.[25]

Believe It or Not

✔ Most American families have no idea what they really spend on health care.

In addition to what families pay directly out of pocket on health care, they are charged far more for what are called the "hidden costs" of health care spending.

As much as 40 cents of every dollar Americans spend on goods and services — at grocers, department stores, and car dealers — is a "hidden cost." It goes to pay business health care expenses.

Roughly 10 percent of all sales, property, income and social security taxes paid by individuals is spent on health care.[26]

America Without Health Care Reform

Things could be worse — and they will be — unless there is health care reform.

Believe It or Not

✔ Within 7 years, health care costs will consume almost 1 of every 5 American dollars, unless current trends are changed.

> It is estimated that national health care spending will reach 18 percent of GDP ($1.7 trillion) by the year 2000.[27]

✔ Within 7 years, almost a quarter of every tax dollar will go to Medicare and Medicaid, unless current trends are changed.

> CBO projects that Medicare and Medicaid spending will constitute 23 percent of the Federal budget by the year 2000. By contrast, all discretionary spending (defense, international and domestic programs taken together), is expected to fall from 40 percent to 31 percent of the Federal budget by the turn of the century.[28]

✔ Within 7 years, more than a quarter (one-fourth) of State and local budgets will be spent on health care, unless current trends are changed.

> CBO projects that by the year 2000, health spending could rise to more than 27 percent of State and local expenditures.[29]

Believe It or Not

✔ No matter how much we cut domestic programs or defense spending, the deficit will still go up, unless we change our health care system. If the USA does nothing about its health care crisis, nearly half of every dollar of real economic growth between now and the year 2000 will go to feed the ever-increasing cost of health care.

> The growth of Federal health care programs is the main reason that the Federal deficit is expected to swell to more than $500 billion by the year 2002.[30]

End Notes

1. White House, Health Care Talking Points, Spring 1993.

2. Families USA Report, *Half of Us: Families Priced Out of Health Protection*, April 1993.

3. Testimony to House Committee on Ways and Means, October 10, 1991.

4. Families USA Report, *Half of Us: Families Priced Out of Health Protection*, April 1993.

5. Current Population Survey data cited in CBO's *Projections on National Health Expenditures*, October 1992.

6. Senate Labor and Human Resources Committee.

7. "Blueprints of National Health Insurance," *Washington Post Health*, December 4, 1990.

8. Consumer Union News, April 20, 1993.

9. CBS News/*New York Times* Survey, "Health Care: The Big Worry," March 28-31.

10. Families USA, *They Make That Much?*, March 1993, p. 1.

11. Families USA, *They Make That Much?*, March 1993, p. 2.

12. "Why Drugs Cost More in the U.S.," *New York Times*, May 24, 1991; General Accounting Office, *Prescription Drugs: Companies Typically Charge More in the United States than in Canada*, September 1992.

13. U.S. General Accounting Office, *Pharmaceutical Industry: Tax Benefits of Operating in Puerto Rico*, (Briefing Report to the Chairman of the Senate Aging Committee), May 1992; Senate Aging Committee, Majority Staff Analysis of General Accounting Office Report, *Pharmaceutical Industry: Tax Benefits of Operating in Puerto Rico*, May 1992; U.S. Department of Commerce, Quarterly Financial Report, December 1992; "Industry Overviews," Fortune, April 20, 1992, p. 288.

14. "Condition Critical," *Time*, November 25, 1991: "Clinton Seeks a Health Care Plan," *Washington Post*, February 3, 1993.

15. CBO data, provided by CRS, 1993.

16. "From Business, Urgent Cries for Reform," *Christian Science Monitor*, November 21, 1991.

17. A/Huggins Benefits Report, 1992.

18. National Small Business United, cited in White House Talking Points, "Small Business and Health Care: The Current System," May 10, 1993.

19. Service Employees International Union (SEIU) data, cited in *Christian Science Monitor*, November 21, 1991.

20. "The Impact of Health Care Costs and Cost Containment Proposals on the American Economy," Kenneth E. Thorpe, University of North Carolina, August 1992.

21. Congressional Budget Office, October 1992, cited in White House Talking Points, "Small Businesses and Health Care: The Current System," May 10, 1993.

22. "Wasted Health Care Dollars," *Consumer Reports Magazine*, July 1992.

23. "The $200 Billion Bottom Line," *Consumer Reports Magazine*, July 1992.

24. OECD data provided by CRS; OMB; White House, Health Care Talking Points, Spring 1993; Department of Health and Human Services.

25. Cited in Partnership for Prevention, "Prevention is Basic to Health Reform," Recommendations from a Conference, November 30-December 1, 1992, p. 9.

26. *USA Today* calculations based on HFCA and CBO data. "How You Pay Your Share of Health Care," *USA Today*, May 6, 1991.

27. CBO, *Projections on National Health Expenditures*, October 1992, p. ix.

28. CBO, *Projections on National Health Expenditures*, October 1992, p. 6.

29. CBO, *Projections on National Health Expenditures*, October 1992, p. 8;
CBO, *Economic Implications of Rising Health Care Costs*, October 1992, pg. 7.

30. CBO, *Economic Implications of Rising Health Care Costs*, October 1992, p. 49.