MEMORANDUM

TO: **Health Care "Map Room" Participants and Other Health VIPs**
FR: **Lorrie McHugh, Chris Jennings and Jennifer Klein**
RE: **Health Care Talking Points/Qs and As/Daschle Bill**
DT: **January 4, 1995**
cc: **Carol Rasco, Bob Rubin**

Attached you will find talking points/Qs and As to help Administration officials respond to questions regarding health care reform, in particular, Senator Daschle's bill that he will be introducing today. It is for internal use only. Please do not distribute.

Also enclosed is the latest two-page summary of the Daschle bill that his office just prepared. Although I have Monday night's copy of his bill language (and have given some of you copies), the bill was still being modified late into last evening and, I think, today. I hope to have a final version later today for those of you who are interested.

We hope that you will find these documents helpful. If you have any questions, please do not hesitate to contact either Chris Jennings (456-5560) or Jennifer Klein (456-2599).

For Internal Use

Health Care Questions and Answers - January 3, 1995

Q. How is the Administration going to proceed on health care reform?

A. * The President remains firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses and Federal, State and local governments.

* As he stated in his December 27 letter to Congressional leadership and during end-of-the-year interviews last week, he believes that we should work in a step-by-step manner to achieve these goals.

* The President wants this Congress to work with him in taking the first steps by passing measures to address the unfairness in the insurance market, making coverage available and affordable for children and unemployed temporarily, assuring that the populations served by Medicare and Medicaid are protected and reducing the long-term federal deficit.

Q. What is the Administration's reaction to Senator Daschle's health care proposal?

* Senator Daschle's proposal is consistent with the vision laid out by the President in his December 27 letter to the Congressional leadership. Both the President and Senator Daschle want to work in a bipartisan fashion on health care reform. The nation's health care problems have not gone away and it is imperative that we move forward.

Q. Is the Daschle bill effectively the Administration's bill?

* No, but it shares the vision that the President outlined in his letter to the Congressional leadership last week.

* By including health care in his leadership package, Democrats are sending an important signal that health care reform remains a high priority for the nation. We hope to work with the Republicans in a bipartisan manner to enact health care reform this year.

Q. Did Senator Daschle consult with the President?

* Senator Daschle and his staff informed the Administration of the proposal and outlined the direction that it would take.

Q. Senator Daschle is challenging Senate Republicans to pass his bill within the first 100 days of the 104th Congress. Does the Administration support this challenge?

* Every day, American families are losing health care coverage. This Administration has been working hard to ensure that families have quality, affordable health care. Every day that we wait, more families live in jeopardy of being one job loss or one illness away from losing their coverage. We want to work with Congress to move health care reform forward as quickly as possible.

Q. What specifically does the Administration feel about Senator Daschle's insurance reform proposals (or any other specifics in the bill)?

* We haven't yet analyzed line-by-line every provision proposed. Senator Daschle's bill appears to be consistent with the vision outlined by the President last week. What the Administration feels is important is that both Democrats and Republicans work together to move forward on health care.

* As the President said last week, we can and should work together to take the first steps necessary to put us on the road to achieving health security and containing health care costs.

Q. Last year the Administration said that insurance reform could not really be achieved in the absence of universal coverage. Has the Administration backed away from this claim?

A. * This Administration has not backed away from its commitment to provide Americans with real health security. We believe, however, that this now should be done in a step-by-step approach. We can put America on the road to universal coverage by addressing the unfairness in the insurance market and beginning by expanding coverage to children and working families. But all of this must be done in the broader context of eventually reaching universal coverage.

Q. Last year the Administration said that everyone must be covered by 1997. Now you are saying eventually. What does eventually mean?

A. * We need to focus our energies now on putting America on the road to health security. Let's move forward in a step-by-step fashion to ensure that Americans have quality and affordable health care.

Q. Will health care be in the budget?

A. * There have not been any announcements made on the budget.

Q. Will the President introduce health care legislation?

A. * Everyone knows where the President stands on health care. His goals have not changed. He believes that we must now act in a step-by-step manner to achieve these goals.

* The President is committed to work in a bipartisan fashion to begin putting America on the road to health security. He will work with Congress as Democrats and Republicans develop proposals. If he feels that adequate steps are not being taken, legislation may be introduced. The President has made it very clear that he will NOT give up the fight to for health security and affordable health care. We need to work with Congress and see what develops.

Q. The President says that he believes that we can make a start on expanding coverage. How will he pay for it?

* The Administration wants to work with Congress to expand coverage and ensure that any action taken is paid for and achieved without increasing the deficit.

THE WHITE HOUSE

WASHINGTON

December 27, 1994

Dear Newt:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

Bill Clinton

The Honorable Newt Gingrich
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

December 21, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: CAROL RASCO *J.K. for C.R.*
ROBERT RUBIN *Not for RR*

SUBJECT: Health Care/Budget Briefing

As you know, the health NEC/DPC health reform working group has been reviewing a wide range of policy options. The purpose of this memorandum is to provide background on the health care policy options that we will discuss at our meeting at 8:30 tomorrow morning and that must be considered and resolved within the budget process. We will present: (1) the new deficit line that reflects changes to the Medicare/Medicaid baseline; (2) potential sources of financing for coverage expansions and/or deficit reduction; (3) possible options for coverage expansions; and (4) illustrative packages that pair financing sources with options for coverage expansion and deficit reduction.

THE NEW DEFICIT LINE

While OMB and HHS are currently discussing the magnitude of the reduction in the Medicare and Medicaid baseline that will be presented to you tomorrow, the changes will reduce the deficit by tens of billions of dollars over the five year budget period.

LIKELY SOURCES OF FINANCING

Background

Many health reform initiatives that were introduced in the last Congress by the Administration as well as by Members of Congress (e.g. Health Security Act, Mitchell's bill, Gephardt's bill, Dole's bill and Chafee's bill) were financed primarily by savings in Medicare and Medicaid.

In this Congress, the Republicans will be under pressure to use Medicare and Medicaid savings to pay for their commitments in the Contract with America. (This is why

many in our base group and Hill health reform coalition are nervous that any cuts we put on the table will be used not for health investments, but to pay instead for the Republican Contract.)

The political and policy question is how best to achieve public sector cost containment through more efficient management of federal health programs while: (1) avoiding the charge that we are backing away from promises to preserve Medicare, (2) protecting the Medicare and Medicaid programs and their recipients from overly harsh cuts, and (3) preserving some of the savings for coverage expansion or program improvement.

Specific Sources of Funding on Options List

After long discussions about likely financing sources for health care, the NEC/DPC health policy working group has concluded that the current political environment limits the consideration of financing options to three (if unoriginal) sources: (1) Medicare, (2) Medicaid, and (3) tobacco taxes. Specific options include:

(1) Medicare

Medicare savings were, by far, the primary source of funding for all health care proposals in the last Congress. Even the Dole bill had $42 billion in Medicare savings over 5 years. Medicare savings will likely remain a targeted source of funds for either deficit reduction or health care reform in the new political environment.

The two major categories of Medicare savings proposals are "extenders" and "other savings proposals." Because of the extreme sensitivity to Medicare cuts and the potential for Hill Democrats to dispute our characterization of our Medicare savings, it is essential to define these categories as well as the areas of disagreement.

(a) **Medicare Extenders ($19 billion over 5 years).** In the current political context there is likely to be a discussion about the distinction between what is a "new" policy and what is simply an extension of past policy. In our budget discussions we have used $19 billion to represent the pool of policies that could be defended as merely an extension of existing policies. However, as you know, both from recent budget discussions and from Alice Rivlin's memo, there may be some dispute as to whether $5.6 billion of the $19 billion that we list as extenders are perceived as resulting from new policies.

We list $19 billion of Medicare savings as "extenders" in our budget tables. "Extenders" have been categorized in two ways in our budget discussions : (1) proposals that simply extending existing savings that would disappear from the Medicare spending baseline as a provision of current law sunsets; and (2) proposals that continue a trend of Medicare payment reductions, and in so

doing achieve additional savings during the five-year budget window as well as in all future years.

You should consider two political realities. First, it is possible that some people will consider any new Medicare savings -- even pure extenders -- as Medicare cuts. Second, if provider groups or the Hill take issue with the definition of extenders, the protective label of "extenders" quickly wears off.

(b) **Other Medicare Savings Proposals. ($39.3 Billion over 5 years).** HHS and OMB produced a list of additional Medicare savings proposals that they believe are defensible, particularly in the context of health care reform reinvestment. Of the $39.3 billion, HHS believes that about one-third of the changes ($12.5 billion) could be categorized as "desirable programmatic changes" -- changes that would lead to a more efficient Medicare program without cost-shifting or benefit cuts. In other words, if you are trying to run an efficient Medicare program, these cuts (such as competitively bidding out for lab services) should be implemented and would require statutory changes. OMB believes that there are a greater number of desirable programmatic changes.

The $39.3 billion in cuts come from providers, beneficiaries and state and local workers and their employers. The provider cuts account for over 50% (about $20 billion) of the total savings, the beneficiary cuts produce 31% (about $12 billion) of the savings, and the state and local workers/employers contribute the additional 19% (about $7 billion). Of particular note, the hospitals are targeted for almost 80% of the total provider cuts (about $16 billion) and, if history is any judge, they will be certain to raise very loud objections. The beneficiaries are targeted with cuts that target the high income elderly and people who are recipients of home health services through a 10% copayment on services.

(2) Medicaid

A major source of possible funds for health care investments or deficit reduction would be reducing the growth in Medicaid. It is almost a certainty that even with the "dynamic scoring", the extremism of the Republican Contract will require a serious assault on Medicaid. The benefits of our affirmatively calling for savings from Medicaid are: 1) it is a serious source of savings that the Republicans will be calling for anyway; 2) the growth and perceived generosity of Medicaid may seem indefensible when raised to a high national profile, and if we do not propose savings, we may be seen as the defenders of the "status quo". This could actually make it harder for us to draw the line against draconian cuts.

The downside of taking savings from Medicaid are: (1) there is a chance that we would actually make it easier for Republicans to cut Medicaid in a way that hurts poor children and (2) on political grounds, if we propose Medicaid cuts, we may take away political heat that the Republicans would have to take. If our cuts were major, we could

alienate our base or be accused of taking steps that would reduce coverage -- working against our goal of expanding coverage.

Clearly, the negatives would be blunted if the savings were moderate or if they were done in combination with some plan to expand coverage.

(a) **Freeze federal DSH payments at FY 1995 level ($17.4 billion over 5).** The savings policy that would appear least connected to benefit cuts and could be solidly justified on policy grounds is freezing current DSH payments. This proposal would save $17.4 billion. It would be more easily justified if we could argue that we were expanding coverage -- and thus uncompensated care. The main issue is going to be the reaction of Governors -- who will object. This $17.4 billion cut, however, will likely be far less than what Republicans will eventually be forced to propose.

(b) **Mandatory Managed Care for AFDC Populations (Current scoring: Costs $1 billion over 5 years; saves $4.7 over 10 years).** The concept of finding savings through managed care is an attractive one, because the claim can be made that savings are coming through the benefits of managed care and not a reduction in benefits. Furthermore, advocates of this proposal claim that beneficiaries would be better off if they came from a consistent provider, as they would in a managed plan. House Republicans (Kasich) make precisely this case when they advocate this proposal and claim $10 billion in savings over five years. Our preliminary analysis, however, shows that this proposal may actually cost $1 billion over five years (although it would save $4.7 billion over 10 years). Nonetheless, this proposal, together with a proposal under review to eliminate all waiver approval processes for states wanting to move ahead on managed care, could prove an attractive option to states.

One of the reasons why OMB has scored less savings for the mandatory managed care option is that they already assume in the baseline that 50% of recipients will eventually be in some form of managed care. In viewing Tennessee as a model for reform, two caveats should be noted. First, the federal government let Tennessee lock-in its projected baseline growth at a maintenance of effort level -- and, given the recent significant reductions in the Medicaid baseline, they will be getting more federal aid than they otherwise would have. Furthermore, Tennessee was better able than most states to transition to managed care because they had a strong managed care system already in place, and were in a position to reduce provider payments -- a situation that several states are not in.

(c) **Mandatory Managed Care - A Small Percentage 0.5%.** One option would be to require states to place all Medicaid beneficiaries in managed care, with a slight reduction ($10 billion) in Medicaid over five years

as an incentive for states to move quickly to more efficient care. If this is accomplished as a capped entitlement it would be scorable and could be seen as accepting Kasich's proposal -- while drawing the line on further cuts. As with any cap proposal, states with higher growth rates might argue that they are disproportionately harmed by the cap; this would be particularly troublesome to those states that did not have the capacity to establish managed care systems. Lastly, some would argue that this approach opens the door on capped entitlement for the gain of only a small amount of savings.

(d) **Total block grant-like cap on total program growth -- Medicaid population plus CPI; in other words, Medicaid current funding plus 8 percent ($43.6 billion over 5 years).** Under this proposal, states would assume full control of Medicaid. One idea would be to give states a capped entitlement that would grow at perhaps 8%. By doing so, we could save $43 billion if the cap started in FY 1997 -- or $70 billion if the 8% cap was in place by 1996.

The advantages of this strategy are the following: First, it is a significant source of funds. Second, from a purely message point of view, it may be difficult for Governors to communicate a public message that they cannot manage an 8% to 9% increase per year -- though, from a policy perspective, this growth rate is not as high as it may appear. Indeed, it is close to the sum of beneficiary growth and CPI. Third, by giving this offer to the Governors, we give them "ownership" of the Medicaid baseline -- they either accept it or they are the defenders of the status quo baseline.

The downsides of this approach, however, are considerable from a policy standpoint. The Governors will ask for considerable flexibility, which could lead to reductions in benefits or coverage. In addition, we could contribute to a false perception that Federal health care aid to the poor is more out of control than we believe to be true. The real policy question, however, is whether this proposal will blunt the Republicans' Medicaid assault (by calling their bluff) or whether it will make things worse. We must consider whether we end up taking the blame for a Medicaid cut that would have been proposed by the Republicans anyway and legitimizing the block grant approach.

COVERAGE OPTIONS

For the purpose of selecting options for coverage expansions, the NEC/DPC working group assumed that all options should be:

(1) **A Serious, but Modest Step Toward Universal Coverage.** While we must stay committed to move towards universal coverage, the goal of achieving

universal coverage would best be reached by seeking passage of a more modest first step.

(2) **Middle-Class Oriented.** We focused on investments that either directly benefit the middle class or at least appeal to them politically.

(3) **Privately Administered.** To extent possible, the policies are administered privately to avoid the big government label.

The options for coverage expansions that best met these requirements were:

(a) **Kids Coverage. ($20-$25 billion over 5 years).** Children who have been uninsured for at least six months would be eligible for subsidies to purchase an insurance package similar to the Blue Cross/Blue Shield package offered to Federal employees. Since low-income children are already covered by Medicaid, the subsidies are targeted to higher income families: one option would reach children whose families have income up to 300% of poverty ($44,400 for a family of four) and the other would reach children up to 240% of poverty ($35,520 for a family of four).

(b) **Temporary Unemployed Coverage. ($16.6 billion over 5 years).** Individuals who are eligible for unemployment compensation and who are uninsured would be eligible to receive an insurance package similar to the Blue Cross package. The subsidy would be phased out at 250% of poverty ($37,000 for a family of four), but -- since eligibility would be determined on a monthly basis -- it is likely that Americans with annual incomes that are higher than $37,000 would be eligible.

(c) **Welfare to Work. ($6.2 billion over 5 years).** Consistent with the Administration's welfare reform initiative, people leaving welfare for work would be eligible to continue receiving Medicaid for two years. (Under current law, only one year of continued Medicaid is available.)

(d) **Self-Employed Tax Deduction -- 25%/100%. ($3.8-$7.5 billion over 5 years).** It is likely that any Republican or Democratic health reform bill will include an extension or expansion of the self-employed tax deduction. Treasury estimated a number of versions. We chose two to illustrate the policy. The first permanently extends the 25% deduction. The second phases-in the 100% deduction by 1998.

(e) **Long-Term Care Program. ($6.2 -$8.3 billion over 5 years).** If we consider significant Medicare cuts, you may want to reinvest some of the savings for the elderly. (The drug benefit is cost prohibitive.) This policy option is a moderate investment in state-administered home- and community-

based long-term care program. (This investment is much less than what was contemplated in the Health Security Act).

(f) **Long-Term Care Tax Incentives. ($2.8 billion over 5 years).** These proposals include: (1) tax clarifications for long-term care private insurance policies and (2) a tax credit for personal assistance services for the disabled. If the Republicans do any significant Medicare cuts, they are likely to propose these incentives to illustrate their commitment to long-term care. (These policies were included in the Contract with America.)

(g) **Public Health Investment. ($1 billion over 5 years).** Since all Republican sponsored health reform initiatives that have invested in public health -- generally by expanding funding for community health centers -- we may want to propose a small investment in order to get credit for this type of proposal.

ILLUSTRATIVE EXAMPLES

During the presentation, you will have before you the attached tables on sources of financing and uses of funds to enable you and the other participants the opportunity to mix and match packages. However, to help focus the discussion, we also have prepared several package examples (e.g. one package includes rewarding workers through subsidies for the temporarily unemployed, extending Medicaid for individuals leaving welfare, and increasing and permanently extending the self-employed tax deduction). They are attached for your review.

CONCLUSION

We have limited this discussion to issues that must be resolved as part of the budget process. Subsequent memoranda will describe insurance reform and other issues that have been discussed by the working group.

Attachments

POSSIBLE SOURCES OF FUNDING

Fiscal Years, Billions of Dollars

MEDICARE/MEDICAID SOURCES WILL BE REDUCED WITH NEW BASELINE CHANGES

		1996	1997	1998	1999	2000	1996–2000
Medicare Savings Options							
Extensions of OBRA 1993 Baseline Savings	1/	-0.1	-0.4	-0.6	-3.1	-6.0	-10.2
Extensions of OBRA 1993 Savings Policies	1/	-1.0	-1.1	-1.5	-2.2	-2.8	-8.7
Additional Medicare Savings and Receipt Proposals	2/	-2.5	-6.4	-7.7	-10.3	-12.5	-39.4
Medicaid Savings Options							
Managed Care AFDC/NC Kids, 5% One-time Reduction	2/	0.0	0.8	0.4	0.5	-0.7	1.0
Potential Republican Caps							
Total Program Growth (Medicaid Population + CPI)	3/		-3.3	-8.1	-13.1	-19.1	-43.6
Target DSH Offsets for Coverage Expansions							
Freeze Federal DSH Payments at FY 1995 Level	4/	-1.1	-2.2	-3.4	-4.6	-6.0	-17.4
Tobacco Tax							
$0.45 Phased Increase	5/	-1.9	-3.5	-4.9	-6.2	-6.6	-23.1
$0.75 Increase		-8.2	-10.4	-10.3	-10.3	-10.2	-49.4
$1.00 Increase		-10.2	-13.0	-12.9	-12.9	-12.8	-61.8
Medicare Savings from Health Care Reform Bills							
Dole	6/	-1.8	-3.5	-7.4	-12.2	-17.0	-41.9
Mainstream		-4.0	-8.2	-14.1	-21.1	-28.3	-75.7

NOTES

All estimates are preliminary. Totals may not add due to rounding. Baseline re-estimates for FY 1996 President's Budget will affect all savings estimates.

1/ Estimates from HCFA and OMB/HFB. Unclear of availability for health care uses.

2/ Estimates from HCFA and OMB/HFB.

3/ Estimates from OMB/HFB.

4/ Estimates from OMB/HFB. A large downward re-estimation of the FY 1996 President's Budget baseline may significantly reduce estimates of DSH expenditures relative to the rest of the program.

5/ Estimates from Department of the Treasury.

6/ Estimates from HCFA.

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	Total 1996-2000
OUTLAYS							
Kids' Program (1,2)							
Free to 133%, Phase-Out to 240%	0.0	0.0	3.8	5.2	5.4	5.6	20.0
Free to 133%, Phase-Out to 300%	0.0	0.0	4.7	6.5	6.8	7.1	25.1
Temporarily Unemployed (3)	0.0	0.0	3.0	4.2	4.5	4.9	16.6
Welfare to Work	0.0	0.0	1.4	1.5	1.6	1.7	6.2
Kids + Temporarily Unemployed (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	6.2	8.6	8.9	9.4	33.1
Free to 133%, Phase-Out to 300%	0.0	0.0	7.2	9.9	10.4	10.9	38.3
Kids + Temporarily Unemployed + Welfare to Work (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	7.2	9.7	10.1	10.7	37.7
Free to 133%, Phase-Out to 300%	0.0	0.0	8.2	11.0	11.6	12.2	42.9
Public Health/ FQHC	0.1	0.2	0.2	0.2	0.2	0.2	0.9
Long Term Care Program							
Expand Home & Community Based Services							
Low Option	0.0	0.0	1.5	1.5	1.6	1.6	6.2
High Option	0.0	0.0	0.0	1.8	2.9	3.6	8.3
REVENUES (4)							
Self-Employed Deduction (5)							
Extend 25% deduction	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-3.8
100% deduction In 1995	-0.9	-2.2	-2.4	-2.7	-2.9	-3.2	-14.3
100% Deduction Phased In (6)	-0.5	-0.5	-0.9	-1.4	-2.0	-2.2	-7.5
Long Term Care							
Long-Term Care Insurance Tax Incentives	0.0	-0.2	-0.4	-0.5	-0.6	-0.7	-2.4
Personal Assistance Services Tax Credit	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.4

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume employer or employee dropping of insurance, which would result in increased tax revenues of approximately $2.2 billion between FY 1997 and FY 2000 and $5.8 billion between FY 1997 and FY 2005

(3) Assumes that unemployment compensation is included in income determinations.

(4) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue.

(5) These totals include FY 1995 losses in revenue.

(6) Phase in: 25% in 1994, 25% in 1995, 50% in 1996, and 75% in 1997 and 100% in 1998.

FOR ILLUSTRATIVE PURPOSES ONLY

"KIDS FIRST"

Initiatives

KIDS (UP TO 300% OF POVERTY)

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.75 TOBACCO TAX

	1996-2000
Kids, up to 300% of poverty	28.1
Self-Employed phased-in to 100%	7.5
TOTAL COSTS:	$35.6 billion
$0.75 Tobacco Tax	49.4
TOTAL FINANCING:	$49.4 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKERS"

Initiatives

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.45 TOBACCO TAX

MEDICAID DSH

	1996-2000
Temporarily Unemployed	16.6
Self-Employed, phased-in to 100%	7.5
Welfare to Work	6.2
TOTAL COSTS:	$30.3 billion
$0.45 Tobacco Tax	23.1
Medicaid DSH	17.4
TOTAL FINANCING:	$30.5 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury.
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKING FAMILIES"

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996-2000
Kids up to 300% of Poverty	25.1
Temporarily Unemployed	16.6
Self-Employed, phased to 100%	7.5
TOTAL COSTS:	$49.2 billion
Medicaid DSH	17.4
Provider Medicare Savings	43.5
TOTAL FINANCING:	$60.9 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"BUILDING THE FOUNDATION FOR UNIVERSAL COVERAGE"

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

LONG TERM CARE

PUBLIC HEALTH SERVICES

Sources of Funds

$0.75 TOBACCO TAX

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996-2000	
Kids up to 300% + Temporarily Unemployed + Welfare to Work (Combined)	42.9	
Self-Employed, phased-in to 100%	7.5	
Long Term Care	9.0	
Public Health Services	0.9	
TOTAL COSTS:		$60.3 billion
$0.75 Tobacco Tax	49.4	
Medicaid DSH	17.4	
Provider Medicare Savings	43.5	
TOTAL FINANCING:		$110.3 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-Jan-1995 03:41pm

TO: (See Below)

FROM: Stacey L. Rubin
Domestic Policy Council

SUBJECT: Friday's Health Care Meeting (NEW TIME)

The Health Care Map Group Meeting scheduled for Friday, January 13 will now take place from 10:00am to 12:00pm (it was previously scheduled for 9:00am). The meeting will take place in the Map Room. PLEASE NOTE THAT THE MEETING IS PRINCIPALS PLUS ONE. The Principals attending include:

Mrs. Clinton
Mrs. Gore
Secretary Reich
Secretary Shalala
Secretary Rubin
Frank Newman
Alice Rivlin
Laura Tyson
Leon Panetta
Carol Rasco
Pat Griffin
George Stephanopoulos
Mike McCurry
Mark Gearan
Ira Magaziner
Don Baer

If you have any questions, please call Stacey Rubin 6-5585.

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TO: FAX (9456-6298,Cynthia Gire)
TO: FAX (9622-0073,Marne Levine)
TO: FAX (9690-6166,Secretary Shalala)
TO: FAX (9395-6958,Laura Tyson)
TO: FAX (9456-2317,Patti Solis)
TO: Valerie M. Owens
TO: Matthew L. Miller
TO: Jennifer N. Palmieri
TO: Denise Ricketson
TO: Rosalyn A. Miller
TO: Paul A. Deegan
TO: Christopher C. Jennings
TO: FAX (9456-2878,Bill Galston)
TO: Erin A. O'Connor
TO: Steven A. Cohen
TO: Heather Beckel
TO: Elisabeth L. Lindemuth
TO: Linda J. McLaughlin
TO: Sylvia M. Mathews
TO: Kimberly J. O'Neill
TO: Diane G. Limo
TO: Sara Grote
TO: FAX (9219-7659,Katherine Jayne)

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

10-Jan-1995 05:34pm

TO: (See Below)

FROM: Margaret P. Smith
Economic and Domestic Policy

SUBJECT: Health Care Meeting - Map Room

A HEALTH CARE meeting to discuss political and communication strategy will be held on Friday, January 13 from 9:00am to 11:00am in the Map Room. This is a principals only meeting. Participants will be:

Mrs. Clinton
Mrs. Gore
Secretary Reich
Secretary Shalala
Frank Newman
Alice Rivlin
Laura Tyson
Leon Panetta
Pat Griffin
George Stephanopoulos
Ira Magaziner
Carol Rasco

If you have questions, I can be reached on 456-5373.

Distribution:

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POSSIBLE ALTERNATIVE TO MEDICAID CAP

- **Agree to NGA request to eliminate waiver approval process for states implementing managed care programs.**

- **Eliminate waiver approval process for states implementing home and community-based care programs.**

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA proposal to establish safe harbors under the Boren amendment for state hospital payments.**

- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA proposal for substantial modifications to the PASARR provisions under nursing home reform.** For example, we agree that the annual resident review should be repealed.

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Governor Dean sending signals he might be open to a cap,** although most Democratic Governors appear to be extremely nervous about it. Governor Chiles, for example, very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of them appears to be the size of potential reductions in Federal support.

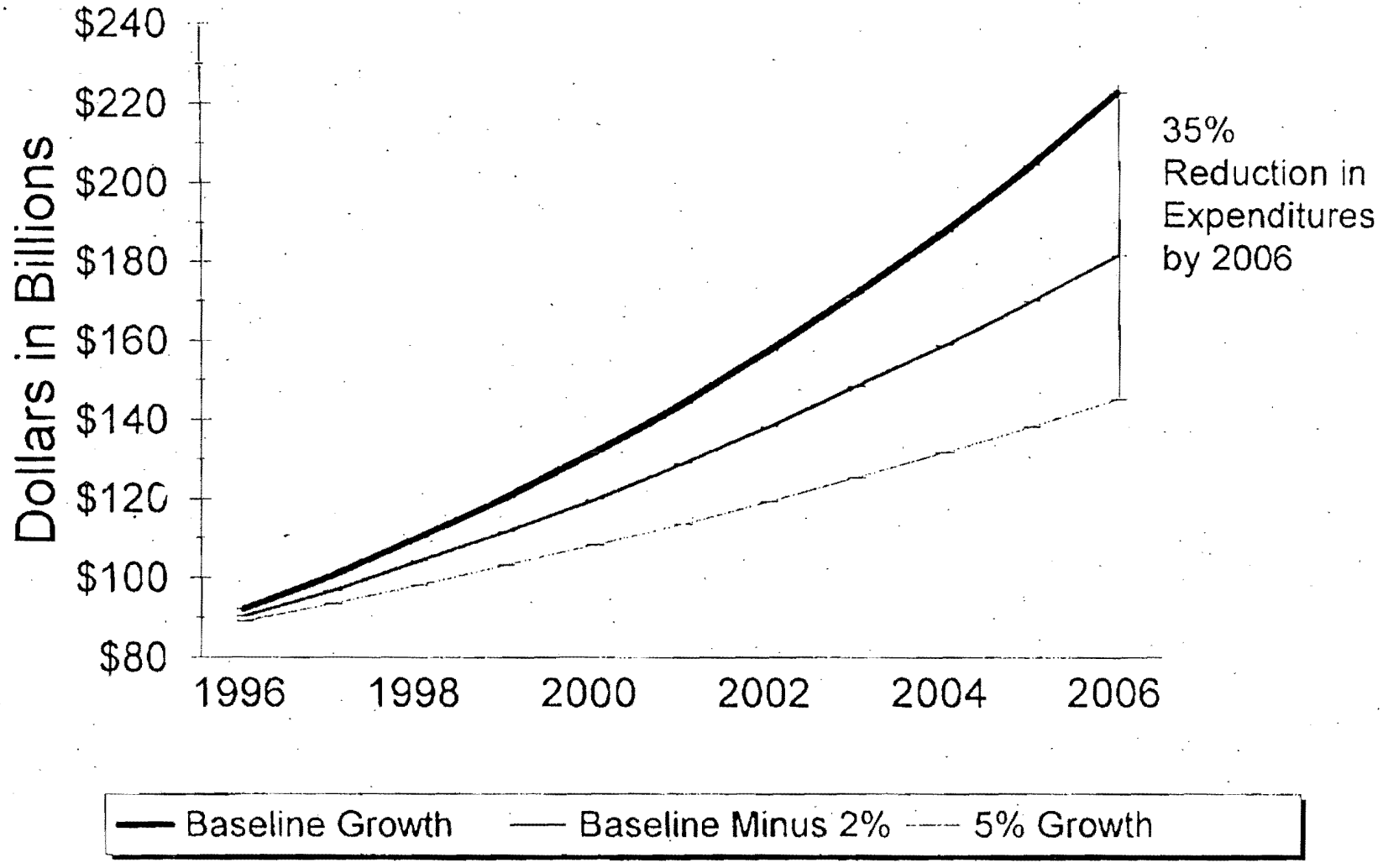
- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but loud advocates are very nervous:** many of these are considered our traditional Democratic base.

Medicaid Expenditure Growth 1996-2002

Capped Expenditures to States



HOW WOULD STATES RESPOND TO MEDICAID CAP?

(Recall states would need to realize savings to replace $130 billion Federal spending by 2002/$375 over 10 years -- using OMB numbers)

- **Increase State Medicaid Spending**

  -- A few states might, but seems much more unlikely in this environment.

- **Reduce Provider Payments**

  -- Medicaid baseline program growth is at 9 percent, but 4 percent of that number is population growth; the additional 5 percent is at or very near private sector growth rate.

  -- New baseline has assumed much of managed care/other delivery savings. There is some savings, OMB says at most 5 percent, but nowhere near what is necessary to cover the 35–40% reduction in Federal payments that would result from 5 percent cap.

  -- Rural states still having hard time getting new managed care delivery systems established.

- **Reduce Benefits**

- **Reduce Program Eligibility**

ROUGH EXAMPLE:

If a state were to reduce provider payments, benefits, and eligibility, it could achieve the necessary savings by (1) reducing provider payments by about 11 percent, (2) eliminating coverage for prescription drug and EPSDT, and (3) eliminating coverage for non-cash children and Medicare QMBs. And, because Federal payments would continue to decline, further reductions would be needed each future year. (No interactive effects assumed.)

Medicaid Services and Recipient Expenditures
(Dollars in billions)

	1997	2005
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	-1.9	-3.9
Drugs	-9.3	-17.6
EPSDT	-1.1	-4.0
Home Health & Hospice	-2.5	-5.8
Medicare Premiums & Cost Sharing	-4.7	-10.8
Personal Care Services	-3.8	-7.1
Cost of Services for Recipients		
AFDC Adults	-12.0	-24.4
NonCash Kids (OBRA Expansion)	-4.3	-9.5
QMBs/SLMBs (1)	-4.7	-10.8
Medically Needy	-22.1	-38.8

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

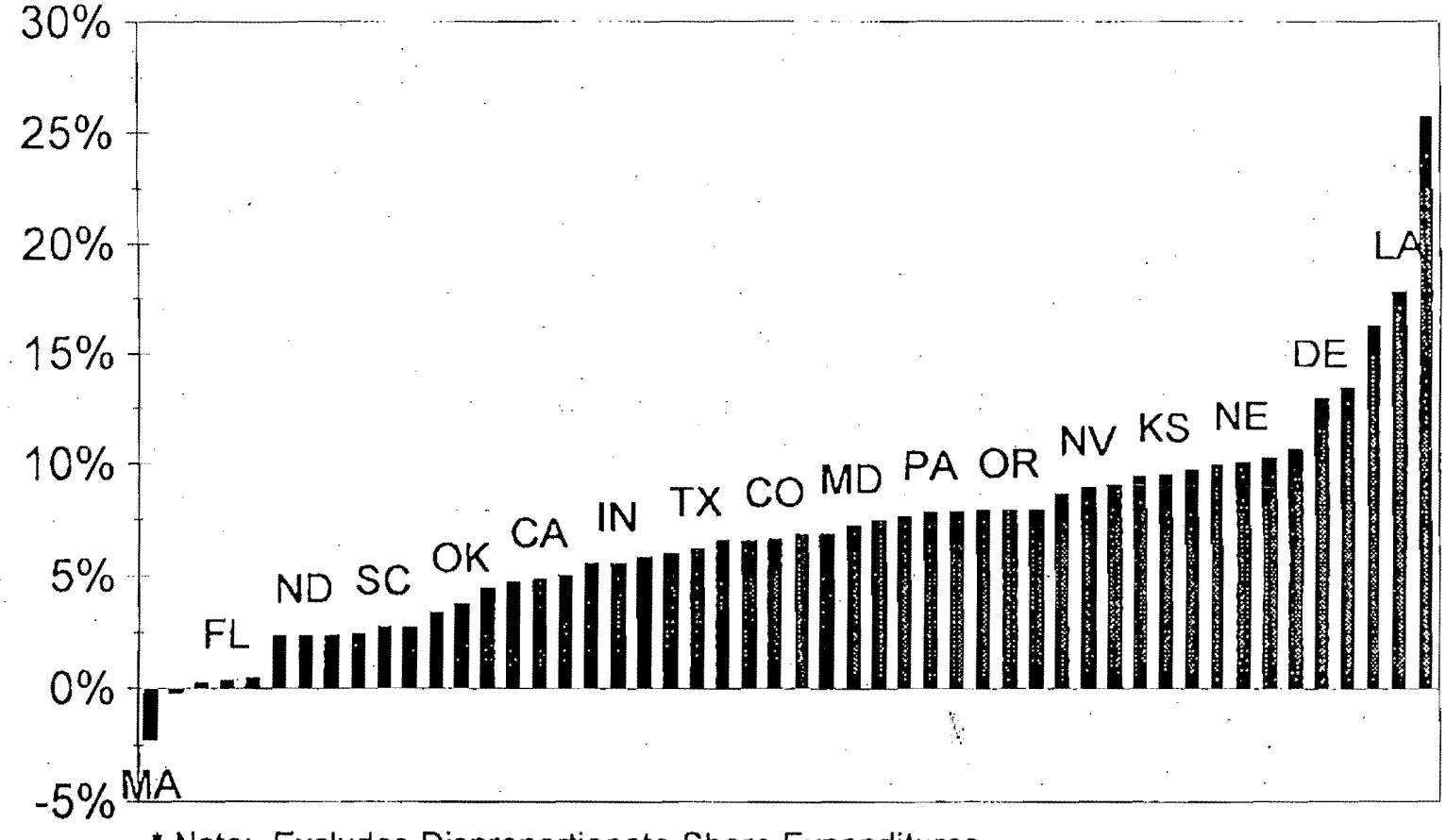
- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
  - Leaves States at risk during recessions.
  - Places States at risk for cost of aging population.
  - Makes States less able to expand coverage.
  - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
  - Increases number of uninsured.
  - Exacerbates cost shifting.

Medicaid Per Capita Expenditure Growth

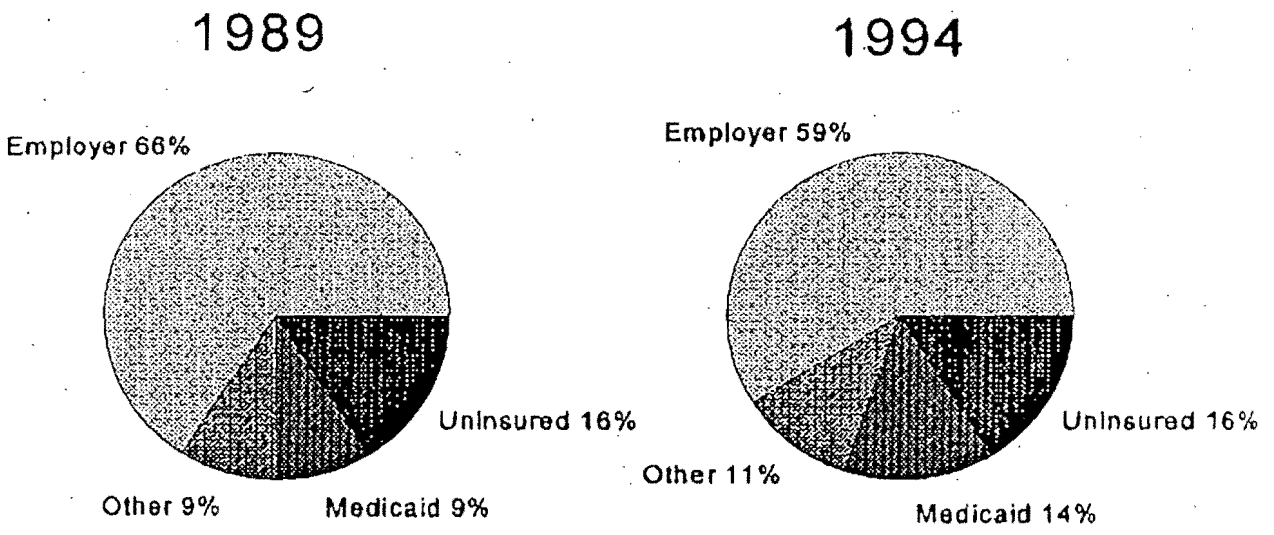
Average Annual Growth Rates, 1990-1993



* Note: Excludes Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

POSSIBLE ALTERNATIVE TO MEDICAID CAP

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- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA proposal for substantial modifications to the PASARR provisions under nursing home reform.** For example, we agree that the annual resident review should be repealed.

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax (phased-in)	1/	0.0	0.0	4.3	6.0	6.0	5.9	5.9	8.3	9.1	9.0	8.9	22.2	63.4
Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	12.1	15.7	18.3	21.7	25.5	31.2	35.8	39.8	44.1	70.3	246.7
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.7	3.9	4.2	4.6	5.1	5.6	6.1	6.5	7.1	15.4	45.7
Net Effect on Unemployment Insurance Program	10/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	11/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	14/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	15/	0.5	-1.6	-1.6	-1.7	-3.1	-5.7	-8.5	-13.1	-16.4	-19.2	-21.9	-13.2	-92.3

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Increases from $0.24 to $0.64 1/1/97 and to $0.90 1/1/2002. Estimate from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy cost).

2/ Estimates from HCFA/OACT.

3/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

4/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

5/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

11/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

14/ Estimate from HHS/PHS.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Medicare Savings	1/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	2/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	3/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	4/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	5/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	7.8	9.7	12.3	15.7	19.6	23.0	26.7	30.8	35.1	48.1	183.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	6,7,8,/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
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Net Effect on Unemployment Insurance Program	9/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	10/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
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Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
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15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Kids Program (133% - 240%)	1,2,3/	0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Temporarily Unemployed (100% - 240%) Only	3,4,5/	0.0	0.0	3.8	5.4	5.7	6.0	6.4	7.0	7.6	8.2	8.9	21.0	59.2
Subsidy Cost		0.0	0.0	3.3	4.7	5.2	5.7	6.2	6.8	7.4	8.0	8.7	18.9	56.0
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	1 - 5/	0.0	0.0	7.4	10.2	10.7	11.1	11.7	12.4	13.2	14.0	15.0	39.4	105.6
Subsidy Cost		0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	6/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	7/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	8/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	9/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0

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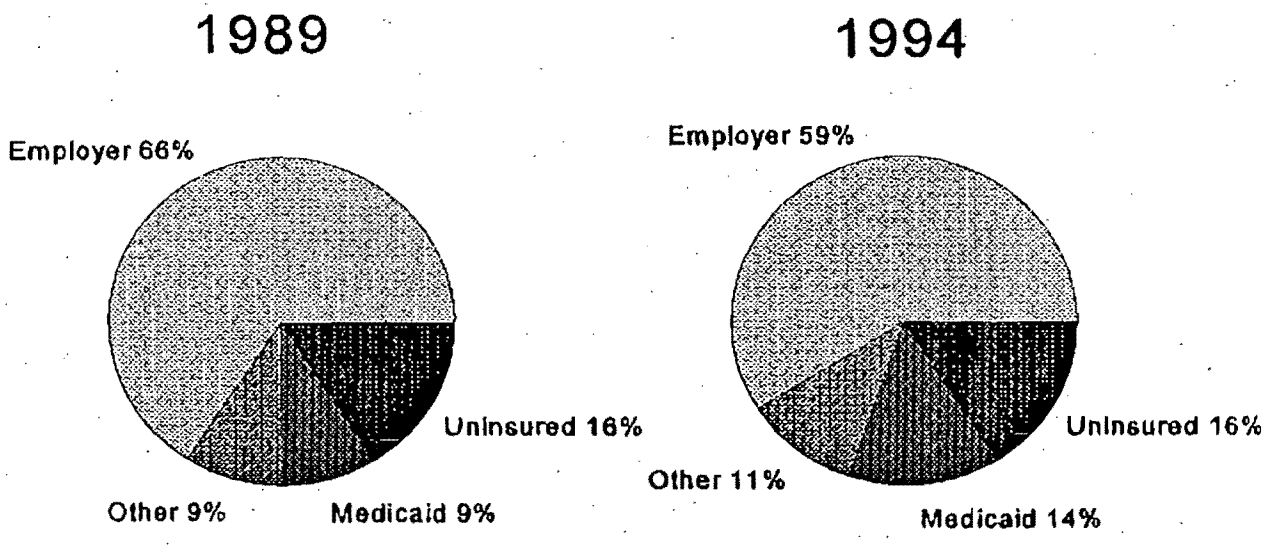
STIMATED IMPACTS OF MEDICARE AND MEDICAID PROPOSALS
iscal years, $ in billions, FY 1996 President's Budget baseline)

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1996-2000	1996-2005
EDICARE													
Hospital Proposals													
Moratorium on Long-Term Care Hospitals		-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-1.8
Expand Centers of Excellence		0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5
Reduce PPS-Exempt Capital Payments		-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-1.0	-2.6
Lower Indirect Medical Education		0.0	0.0	0.0	-0.5	-1.5	-2.4	-2.7	-3.0	-3.3	-3.6	-2.0	-17.0
GME Reform	1/	-0.2	-0.4	-0.6	-0.8	-1.1	-1.3	-1.6	-1.9	-2.2	-2.5	-3.1	-12.6
Reduce Medicare DSH Payments by 25%		0.0	-1.1	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.9	-2.1	-5.2	-14.2
Reduce Hospital PPS Update		0.0	-0.3	-0.7	-1.2	-1.7	-2.3	-3.0	-3.7	-4.5	-5.4	-4.0	-22.8
Physician Proposals													
Eliminate MVPS Upward Bias		0.0	0.0	0.0	-0.1	-0.4	-0.9	-1.6	-2.5	-3.5	-4.5	-0.4	-13.5
Other Provider Proposals													
Competitive Bidding for Labs		0.0	-0.1	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-3.3
Competitive Bidding for Part B Services		0.0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-1.8
HMO Payment: Part B Floor/Ceiling		-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.5	-1.8
Home Health Prospective Payment		0.0	0.0	0.0	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-1.7
Home Health Coinsurance (10%; exempt 30-day post-discharge)	2/	0.0	-1.2	-1.5	-1.6	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2	-5.9	-15.8
Receipt Proposals													
Income-Related Part B Premium		-0.3	-1.3	-1.1	-1.3	-1.6	-1.9	-2.3	-2.7	-3.1	-3.7	-5.5	-19.2
Extend HI Tax to All State & Local Employees	3/	-1.1	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.3	-1.2	-1.1	-7.1	-13.5
TOTAL, Medicare		-1.9	-6.3	-7.5	-9.4	-12.1	-15.1	-17.7	-20.6	-23.9	-27.4	-37.3	-142.0
MEDICAID													
Freeze DSH at 1995 Level	4/	-0.6	-1.1	-1.7	-2.4	-3.1	-3.8	-4.6	-5.4	-6.2	-7.0	-8.9	-35.9
TOTAL, Medicare + Medicaid		-2.5	-7.4	-9.2	-11.8	-15.2	-18.9	-22.3	-26.0	-30.1	-34.4	-46.2	-177.9
Memo: Medicaid Offset		0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5

NOTES:
All savings estimates are net of beneficiary premium offsets.
Current estimates assume that the 25% Part B premium is extended beyond 1998.
Numbers may not add due to rounding.
1/ Pricing assumes 7/1/95 implementation date for most GME proposals. Pricing does not include proposal to remove GME and IME from the AAPCC formula.
2/ An alternative proposal with no 30-day post-discharge exemption would have savings of $8.8 billion over FY 1996-2000 and $23.5 billion over FY 1996-2005.
3/ Treasury estimate (1/12/95).
4/ Estimate assumes 25% behavioral offset.
Sources: HCFA/OACT, Treasury, and OMB/HFB.

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

Medicaid Services and Recipient Expenditures
(Dollars in billions)

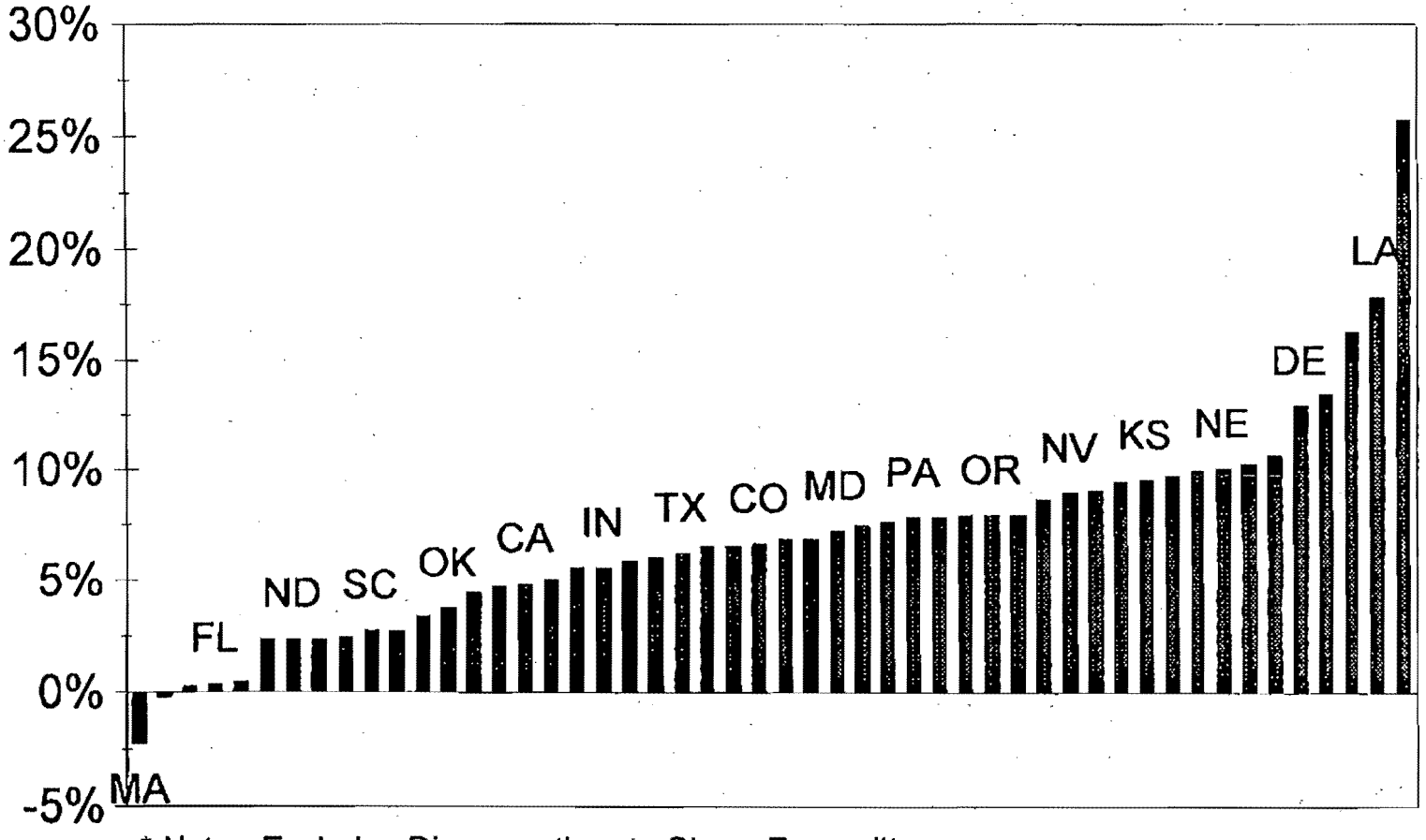
	1997	2005
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	-1.9	-3.9
Drugs	-9.3	-17.6
EPSDT	-1.1	-4.0
Home Health & Hospice	-2.5	-5.8
Medicare Premiums & Cost Sharing	-4.7	-10.8
Personal Care Services	-3.8	-7.1
Cost of Services for Recipients		
AFDC Adults	-12.0	-24.4
NonCash Kids (OBRA Expansion)	-4.3	-9.5
QMBs/SLMBs (1)	-4.7	-10.8
Medically Needy	-22.1	-36.8

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states.

Medicaid Per Capita Expenditure Growth

Average Annual Growth Rates, 1990-1993



* Note: Excludes Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

PURPOSE:

To discuss the implications for states and for coverage under the Medicaid program of NGA and Republican proposals to cap Medicaid spending through a block grant.

DISCUSSION:

The topic of capping the Medicaid program is likely to be raised at the upcoming meeting with the Governors. NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. In addition, the Governors have been discussing a Medicaid block grant with the Republicans in Congress, and both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate. The projected baseline rate of growth is about 9.3%.

The Governors are interested in block grants because they free states from federal requirements and oversight. They appear to be willing to consider very large reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. You should know that the type of reductions that they are discussing are large initially and grow dramatically over time (about $375 billion over ten years). Under this type of block grant, states could realize savings in their own budgets only after they reduced total program costs in response to the $375 billion reduction federal payments. Otherwise, all of the savings that can be achieved from the program will go to the federal government.

The desire of states for additional flexibility can be accommodated without changing the entitlement nature of the program. For example, states could be permitted to implement managed care and home and community-based care programs without applying for a waiver. Boren amendment restrictions on hospital payments also could be eliminated. The key difference is that providing increased flexibility under the current structure, in contrast to a block grant, assures that coverage will not be reduced.

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. These concerns will be discussed below.

<u>Converting Medicaid From an Individual Entitlement to a Block Grant</u>

Although some Governors appear to favor block grants in order to get greater flexibility, converting Medicaid from an individual entitlement to a block grant would be a radical change to the structure of the program that would shift a substantial economic risk to the states.

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work

that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rise to 35% to 40%. This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from the Governors that managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the levels of reductions being discussed with the block grant proposals. Given the rapid expansion that already is occurring in states, significant savings are already being realized. Preliminary estimates show that if all nondisabled, nonelderaly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. Some additional savings might be achieved in states that can use managed

care as a vehicle to further reduce provider payment levels below costs (as opposed to achieving true program efficiencies).

Under the baseline, Medicaid per capita spending is growing at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline assumes either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program are acceptable.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. States are assumed not to reduce their projected levels of spending.

- **Increase State Medicaid Spending**

  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on **average by 13.7%**. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;
  - In 2005, a 32.8% reduction in hospital payments would be needed.

  These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

  States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

  These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

  States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. For example, under the 5% growth proposal, federal payments to states in 2005 would be $66.3 billion below baseline projections. If a state were to allocate this reduction equally across the four responses discussed above, it could achieve the necessary savings by (as compared to baseline projections):

- Increasing spending by about 11%;
- Reducing provider payments by about 8%.
- Eliminating coverage for prescription drugs, and
- Eliminating coverage for most noncash children and qualified and special Medicare beneficiaries.

And, because federal payments would continue to decline, further reductions would be needed each future year.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSIONS

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put families at risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting.** One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

The Administration can offer states flexibility without shifting costs to states or reducing coverage. For example, regulations could be relaxed so that states could use managed care to achieve savings without current restrictions. And, the 1115 waiver process could continue to be used to provide states with the flexibility to change categorical eligibility rules. While these changes would retain the individual entitlement under Medicaid, they would provide states with much of the flexibility they are seeking.

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ESTIMATED IMPACTS OF MEDICARE AND MEDICAID PROPOSALS
(Fiscal years, $ in billions, FY 1996 President's Budget baseline)

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1996-2000	1996-2005
MEDICARE													
Hospital Proposals													
Moratorium on Long-Term Care Hospitals		-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-1.8
Expand Centers of Excellence		0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5
Reduce PPS-Exempt Capital Payments		-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-1.0	-2.6
Lower Indirect Medical Education		0.0	0.0	0.0	-0.5	-1.5	-2.4	-2.7	-3.0	-3.3	-3.6	-2.0	-17.0
GME Reform	1/	-0.2	-0.4	-0.6	-0.8	-1.1	-1.3	-1.6	-1.9	-2.2	-2.5	-3.1	-12.6
Reduce Medicare DSH Payments by 25%		0.0	-1.1	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.9	-2.1	-5.2	-14.2
Reduce Hospital PPS Update		0.0	-0.3	-0.7	-1.2	-1.7	-2.3	-3.0	-3.7	-4.5	-5.4	-4.0	-22.8
Physician Proposals													
Eliminate MVPS Upward Bias		0.0	0.0	0.0	-0.1	-0.4	-0.9	-1.6	-2.5	-3.5	-4.5	-0.4	-13.5
Other Provider Proposals													
Competitive Bidding for Labs		0.0	-0.1	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-3.3
Competitive Bidding for Part B Services		0.0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-1.8
HMO Payment: Part B Floor/Ceiling		-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.5	-1.8
Home Health Prospective Payment		0.0	0.0	0.0	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-1.7
Home Health Coinsurance (10%; exempt 30-day post-discharge)	2/	0.0	-1.2	-1.5	-1.6	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2	-5.9	-15.8
Receipt Proposals													
Income-Related Part B Premium		-0.3	-1.3	-1.1	-1.3	-1.6	-1.9	-2.3	-2.7	-3.1	-3.7	-5.5	-19.2
Extend HI Tax to All State & Local Employees	3/	-1.1	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.3	-1.2	-1.1	-7.1	-13.5
TOTAL, Medicare		-1.9	-6.3	-7.5	-9.4	-12.1	-15.1	-17.7	-20.6	-23.9	-27.4	-37.3	-142.0
MEDICAID													
Freeze DSH at 1995 Level	4/	-0.6	-1.1	-1.7	-2.4	-3.1	-3.8	-4.6	-5.4	-6.2	-7.0	-8.9	-35.9
TOTAL, Medicare + Medicaid		-2.5	-7.4	-9.2	-11.8	-15.2	-18.9	-22.3	-26.0	-30.1	-34.4	-46.2	-177.9
Memo: Medicaid Offset		0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5

NOTES:
All savings estimates are net of beneficiary premium offsets.
Current estimates assume that the 25% Part B premium is extended beyond 1998.
Numbers may not add due to rounding.
1/ Pricing assumes 7/1/95 implementation date for most GME proposals. Pricing does not include proposal to remove GME and IME from the AAPCC formula.
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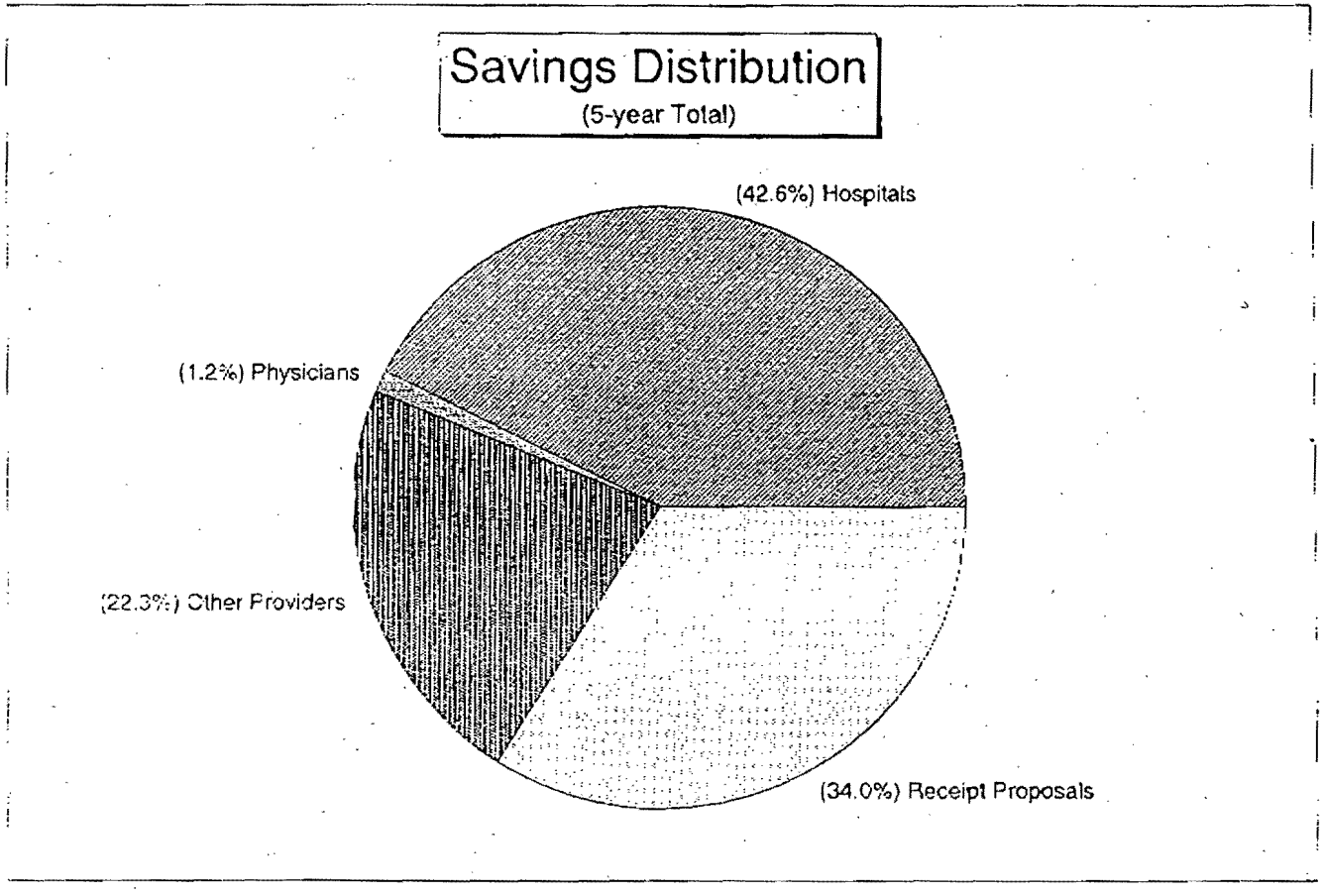
4/ Estimate assumes 25% behavioral offset.
Sources: HCFA/OACT, Treasury, and OMB/HFB.

01/20/95



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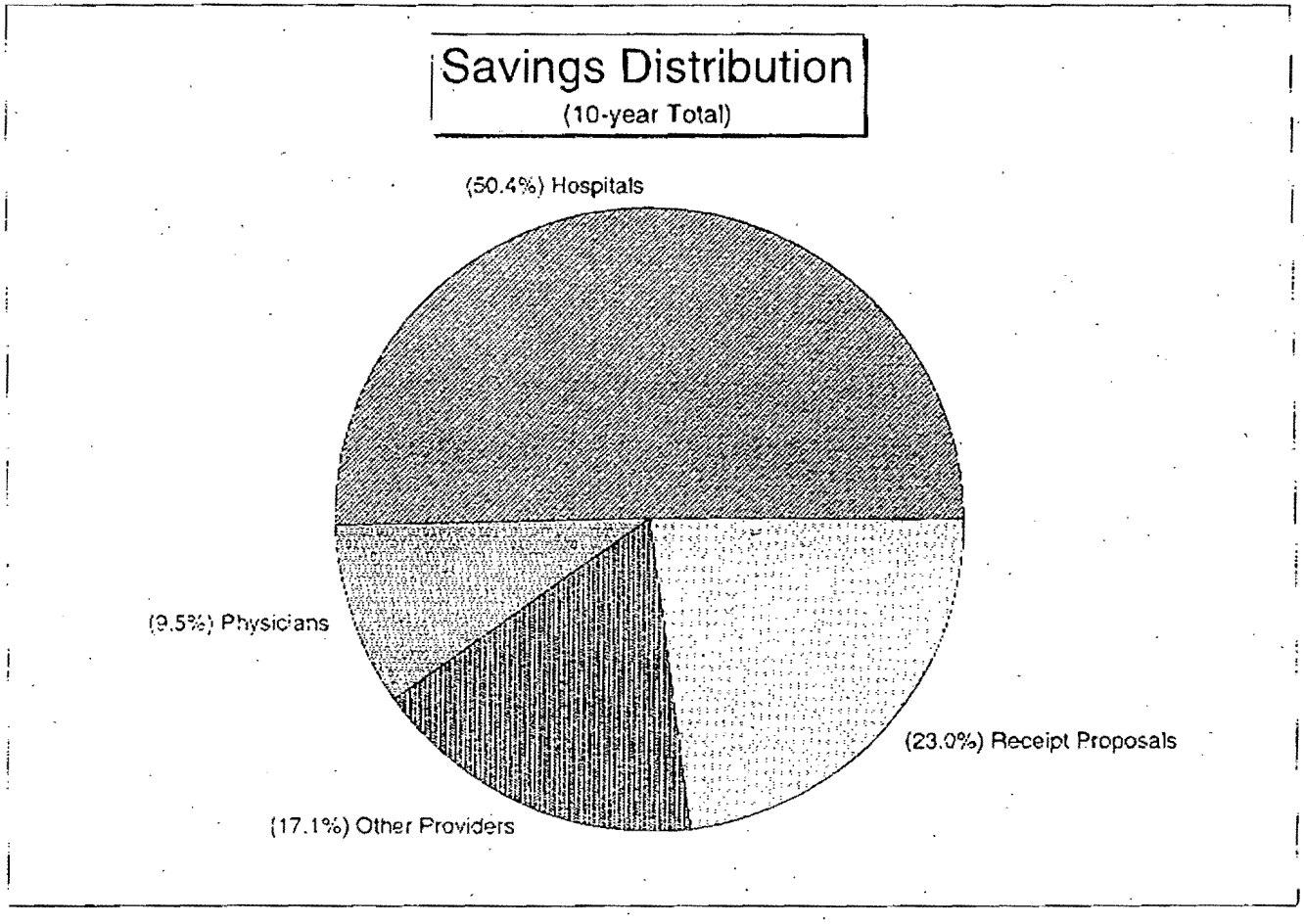

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Comments and Concerns re: Medicare and Medicaid Proposals Table

- Centers of Excellence. The pricing for this proposal essentially remains constant from FY 1996-2000. The reason for this, according to OLIGA, is that the actuaries held all of their assumptions constant over time, and thus, the scoring remains steady at $60 million per year. Is the assumption of zero growth over 10 years realistic?

- GME Reform. This proposal actually contains 6 individual proposals, including 2 program expansions. OACT has not provided HD with pricing of all of these individual proposals. Taken together, the package of proposals save money. However, to have a full range of options for a package 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. An alternative to this package of GME proposals would be a package that contains only proposals which save money.

- Home health prospective payment proposal. 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 end by the end of CY 1998) testing this type of home health PPS. Under this proposal, HCFA would use the technical pieces (e.g., case-mix) developed for the demonstration to implement the system nationally. This proposal would be budget neutral with respect to 99 percent of FY 1999 Medicare home health expenditures. This proposal raises a number of issues, including:

  1. Can a per-episode PPS be ready for implementation nationally by FY 1999? It is unclear whether the technical components (e.g., case-mix index, geographic adjustors, update factors) will be in place;

  2. PPS would start in October 1998 which is before the demonstration is supposed to end. Is it reasonable to proceed with national implementation before the demonstration and its evaluation are completed?

  3. Typically, PPS is designed to be budget neutral. It is unclear why this proposal is designed to save 1 percent of FY 1999 Medicare home health expenditures. If the proposal is supposed to generate savings, why not save more than 1 percent? The savings from this proposal are small ($0.4 billion over 5 years and $1.7 billion over 10 years), and home health is one of the fastest growing Medicare programs.

- 25 percent reduction in Medicare DSH. Without a substantial decrease in the number of uninsured, the rationale for a 25 percent reduction in DSH payments is tenuous.

- Medicaid DSH freeze proposal. The Medicaid estimates for freezing DSH payments at the FY 1995 level assume a 25 percent behavioral offset. It is assumed that States will find a way to recover approximately 25 percent of the lost Federal revenue through other creative financing mechanisms, i.e., intergovernmental transfers. Freezing DSH payments at the FY 1995 level without enacting any substantive policy changes in the DSH program locks in the current inequitable distribution of DSH

funds among States.

- Hospitals bear significant burden of the Medicare package. The five- and ten-year distributions are disproportionately skewed towards hospitals (43 percent over 5 years and 50 percent over 10), while physicians bear significantly less of the burden (1 percent from FY 1996-2000, and 10 percent from FY 1996-2005). To address these problems, other Medicare savings proposal that target physicians could be used, including:

  1. A high cost medical staffs proposal which would save $1.5 billion over 5 years and $5 billion over 10 years; and

  2. A 3 percent reduction in the 1996 physician update for all but primary care services. This proposal would save $3.5 billion over 5 years and $9.2 billion over 10 years.

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Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax	1/	0.0	0.0	3.8	5.3	5.3	5.5	5.6	5.5	6.7	7.1	7.0	20.0	51.8
Additional Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds	11/	0.0	2.5	11.6	15.0	17.6	21.4	25.2	28.5	33.4	37.9	42.1	68.0	232.0
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.1	8.4	8.9	9.4	10.0	10.5	11.1	11.8	12.5	32.9	88.8
Subsidies for Kids		0.0	0.0	3.8	5.2	5.4	5.6	5.8	6.0	6.2	6.5	6.8	19.9	51.3
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.3	3.2	3.5	3.8	4.2	4.5	4.9	5.3	5.7	12.9	37.5
Self-employed Tax Deduction Phased to 100%	10/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	11/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	12/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	13/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Indirect Effect on Unemployment Insurance Program														
Total Uses of Funds	14/	0.5	0.9	9.2	12.2	13.5	14.1	15.2	16.3	17.4	18.5	19.7	50.5	137.6
								15.2	16.3	17.4	18.5	19.7	50.5	137.6
Impact on Deficit	15/	0.5	1.6	2.4	2.8	4.1	7.0	9.9	12.2	16.0	19.4	22.4	17.5	94.4
								9.9	12.2	16.0	9.4	22.4	58.5	94.4

ES:
timates are preliminary. Totals may not add due to rounding.
: both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays.
Clarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.
creases from $0.24 to $0.59 1/1/97; to $0.62 1/1/00; to $0.75 1/1/03. Estimate from Treasury.
timates from HCFA/OACT.
cludes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.
cludes 25% behavioral offset. Estimate from HCFA/OACT.
direct effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only.
Estimates from Treasury
ledicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.
hese estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.
ssumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program.
ligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.
Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.
Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.
Estimate from HHS/PHS.
Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

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Comments and Concerns re: Sources and Uses of Funds Table

- Two new lines on Sources & Uses Table:

  1. *Indirect Effect on Receipts.* This line shows the effect of low-income subsidies on federal taxes. Federal tax receipts increase because subsidies cause some employers to drop health insurance coverage for children and others to reduce their contribution below 50% so that their employees could receive a federal subsidy. The lower employer contributions for health insurance would be offset in part by higher taxable wages, thereby increasing the tax base of income and payroll taxes.

     This line displays the effect on income tax receipts only (on-budget receipts). Payroll tax receipts (off-budget) cannot be used for PAYGO and thus, are not included. Treasury estimates payroll receipts increasing by $0.4 billion between FY 1995 and FY 2000 and by $1.0 billion between FY 1995 and FY 2005. Note that in theory these indirect effects derive from both the kids and the temporarily unemployed subsidy, but the indirect effects from the unemployed subsidy is negligible.

  2. *Indirect Effect on Unemployment Insurance.* This line displays the effect of the temporarily unemployed subsidy on the unemployment insurance (UP) program. The presence of a subsidy for health insurance would cause two behavioral responses. First, some individuals on UP will stay on UP longer to continue receiving health insurance subsidies. Second, employers and individuals will game the subsidy in order for these individuals to receive federal subsidies (e.g., uninsured individual gets laid off, receives federal subsidy for health insurance that will cover a needed operation, and then gets rehired by former employer). As a result, the costs for the UP program will be higher than they would be otherwise.

     The line displays only the estimated effects of increased lengths of stay on the UI program. It is virtually impossible to estimate the impact of gaming. Note: Subsidies for the temporarily unemployed will increase as a result of increased length-of-stay. Urban is in the process of completing estimates of the effect on UI and subsidy programs.

- Subsidy estimates on the Sources & Uses table. These estimates assume CPI growth at 3.0%. Recently released CBO economic assumptions assume 3.4% while OMB assumptions assume 3.1 to 3.2%. Should we revise subsidy estimates to incorporate new OMB assumptions about CPI? Using revised CPI assumptions will also affect the estimates of the Indirect Effects on Receipts and UI. Should Urban also, at some point, be asked to use new OMB economic assumptions?

- Long-term care proposal. This proposal represents a shift in strategy for long-term care (LTC) reform. Most notable is the emphasis on private insurance in long-term care reform relative to public insurance. Two important public policy goals of LTC were (1) to reduce dependence on Medicaid and (2) to bring more balance (between

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nursing home and home care) to the delivery system by increasing funding to home care. Private insurance is less effective at both. A large portion of private LTC insurance purchasers do not run the risk of becoming Medicaid recipients because they tend to be somewhat better off financially (e.g., 70 percent of purchasers in Treasury's tax loss estimate had incomes greater than $50,000). And, while generally better than the "first generation" policies, many private LTC insurance policies still limit coverage of services in the home.

New home and community-based services program: Better targeting needed. Earlier iterations of the President's LTC reform were more targeted towards persons with greater needs i.e. the severely disabled and the lower and middle income. This proposal has no requirements on what population should be targeted for receiving services.

The tax treatment of private LTC insurance and services in this proposal also raises the following issues:

1. *Variations in tax loss estimates.* There are considerable differences in the estimates of the tax loss from favorable tax treatment of private long-term care insurance and related expenses developed by CBO (Joint Tax Committee) and Treasury. Treasury numbers are uniformly higher than those developed by CBO except for the tax loss associated with accelerated death benefits. In this case, Joint Tax's estimates are significantly higher;

2. *Assumptions drive the estimates.* Calculations of the tax loss associated with private insurance purchase and benefit receipt are driven by assumptions about private insurance premiums, probability of purchase, induced demand, and lapse rates. A couple of these assumptions could be questioned. Treasury's assumptions tend to be more conservative than Joint Tax's and, therefore, produce larger tax loss estimates;

3. *Need for sensitivity analysis.* Because of the differences between Treasury and Joint Tax Committee estimations, and because any estimates are highly dependent on the kinds of assumptions that are used, it is extremely important that sensitivity analyses be conducted. In this way parameters can be put around what expenditures are likely to be; and

4. *Behavioral response.* Tax clarification may not actually change potential purchasers' behavior and induce them to buy coverage, rather it may simply provide tax relief to people who would have purchased policies regardless.

- PHS FQHC proposal. The HHS HCR tables contain a proposal to add $2 billion over 10 years in new Federal grants for FQHCs. A portion of these funds is to assist FQHCs in "network development" with Medicaid managed-care providers. This proposal raises several questions, including:

1. FQHCs are reimbursed by Medicaid and Medicare at 100 percent of the

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FQHC's definition of reasonable costs. Should the Administration expand Federally-subsidized organizations with these arrangements or should it seek new ways for the low-income population to access the private mainstream health care system?

2. According to HHS, these funds will provide care to an additional 2.2 million people, of which only 880,000 (40 percent) are uninsured. Assuming that the rationale of this proposal is to increase access for the uninsured, is this the most cost-effective use of $2 billion?

3. It is unclear how this proposal relates to the other elements of the Administration's HCR proposal (i.e. subsidies for kids, the unemployed, and expanded insurance deductibility for the self-employed);

4. If the Administration pursues this policy, is this a good time also to propose ending the practice of reimbursing FQHCs at 100% of reimbursable costs?

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Possible Sources and Uses of Funds - Package One (Phased-in Tobacco Tax)

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax (phased-in)	1/	0.0	0.0	3.9	5.4	5.4	5.4	5.3	5.3	6.4	6.8	6.7	20.2	50.8
Medicare Receipt Proposals	2/	0.0	1.4	2.7	2.6	2.6	2.9	3.2	3.5	3.8	4.2	4.6	12.3	31.4
Indirect Effects on Receipts	3/	0.0	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.9
Medicare Savings	4/	0.0	0.8	4.0	5.4	7.3	9.7	12.5	14.8	17.5	20.3	23.5	27.1	115.9
Medicaid DSH Freeze	5/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.8	11.9	15.3	17.9	21.3	25.1	28.5	33.4	37.9	42.2	69.2	236.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.8	9.4	10.0	10.6	11.3	12.0	12.8	13.6	14.5	36.7	100.8
Subsidies for Kids (net of kids in TU Program)		0.0	0.0	3.8	5.2	5.3	5.5	5.7	5.9	6.1	6.5	6.8	19.8	50.7
Subsidies for Temporarily Unemployed Families	10/	0.0	0.0	3.0	4.2	4.6	5.1	5.6	6.1	6.6	7.1	7.7	16.9	50.1
Public Health Service/FQHC Expansion	11/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
FQHC Expansion Effect on Medicare/Medicaid	12/	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.5	1.5
Long-term Care Program	13/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	14/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Self-employed Tax Deduction Phased to 100%	15/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Total Uses of Funds:	16/	0.5	0.9	10.0	13.2	14.6	15.6	16.7	17.9	19.2	20.5	22.0	54.9	151.2
Impact on Deficit:	16/	0.5	-1.9	-1.9	-2.1	-3.3	-5.7	-8.4	-10.5	-14.3	-17.3	-20.2	-14.3	-85.1

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Footnotes for Package One - Phased-in Tobacco Tax

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays.

Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

Administrative costs have not been estimated.

1/ Increases by $0.49 per pack from today's $0.24 level. Specifically, on 1/1/97 increased to $0.60 and to $0.73 on 1/1/2003. Estimate from Treasury.

2/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Includes effects on Part B takeup and utilization of services. Estimates from HCFA/OACT and Treasury.

3/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury.

4/ Estimates from HCFA/OACT.

5/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Also assumes that kids and families with access to employer contributions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Assumes that unemployed compensation is included in income determinations for unemployed program. Eligibility for kids' subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Subsidies to unemployed individuals will have an indirect effect on the unemployment insurance (UI) program. Such an indirect effect is estimated to increase the cost of the UI program by approximately $2 billion over five years and $3 billion over ten years (net of offsetting UI receipts).

11/ Estimate from HHS/PHS.

12/ Estimate from HCFA/OACT.

13/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

14/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%. Phase-in: 25% in 1994/95; 50% in 1996; 75% in 1997; and 100% in 1998 and thereafter.

16/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.