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Comments/Special Instructions: Here are Eric Toder's outlines for Wednesday's NEC meetings. He has approved these outlines.

UNCLASSIFIED

TAX CAP AND HIGH COST PLAN ASSESSMENTS

I. Background.

A. Current law for employer-provided health insurance.

B. Other tax preferences for medical expenditures.

1. 25% deduction for self-employed.
2. Itemized deduction for medical expenses above 7.5% of adjusted gross income.

II. Reasons to tighten current law treatment of employer contributions for health insurance.

A. Cost containment.
B. Revenue.

III. Tax cap options.

A. Supplementals.

B. Co-payments and deductibles.

C. Dollar caps.

1. Equity issues.
2. Administrative issues.

D. Additional issues.

1. Need for basic benefit package.
2. Employer vs. employee cap.

IV. High cost plan assessment.

A. 1994 Senate proposals.
B. Similar problems in designing base.
C. Additional concerns.

V. Conclusions.

MEDICAL SAVINGS ACCOUNTS

I. Overview of why we are considering Medical Savings Accounts (MSAs).

- A. On the surface they sound good even though they may have undesirable effects that outweigh their desirable effects.
- B. Support in Congress for MSAs.
- C. Need for cost-containment.

II. What is an MSA?

- A. Description of how it works in general.
- B. Variety of proposals.
- C. Different designs lead to different magnitudes of effects.

III. What is the problem that supporters claim MSAs will solve?

- A. Bias against catastrophic plans.
  1. Tax-exclusion of employer-provided health insurance.
  2. Limited deductibility of out-of-pocket health costs.
- B. Do catastrophic plans reduce costs?
  1. Empirical evidence.
  2. Catastrophic plans vs. HMO type managed care.
  3. Total spending vs. out-of-pocket costs.

IV. Effects of MSAs.

- A. Expansion of coverage.
- B. Cost containment.
- C. Impact on health insurance market and distributional effects.
  1. Healthy and upper income benefit.
  2. Less healthy and lower income lose.
- D. Tradeoff between cost containment and distributional effects.
  1. Outcomes depend on participation rates.
  2. Examples.

V. Ways to minimize adverse effects.

A. Risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

B. Tax instead of, or in conjunction with, risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

C. Other design features.

1. Contribution limits.
2. Tax treatment of earnings in MSAs.
3. Availability of funds for nonmedical purposes and tax treatment.
4. Definition of medical withdrawals.

VI. Alternatives to MSAs.

A. Tax caps.
B. Small market and other health insurance reforms.
C. Subsidies, tax credits and deductions for purchase of catastrophic plans.

AGENDA
November 16, 1994

I. Follow-Up to Last Meeting: Coverage and Baseline Issues

II. Insurance Reform Discussion

A. Insurance Reform in the Absence of Universal Coverage

B. Defining the Problem

C. Insurance Reform Objectives and Options

III. Presentation of Polling Data?

Program for Children, 1997

Federal Costs Between 1997-2005: $60-112 Billion

Income Quintiles	Percent of Federal Subsidies	Federal Subsidy Per Enrolled Child Per Year (1997 $)
Lowest Income (1st Quintile)	15%	$1293
Low Income (2nd Quintile)	33%	$1312
Middle Income (3rd Quintile)	40%	$1180
High Income (4th Quintile)	12%	$ 465
Highest Income (5th Quintile)	0%	$ ----
Total	**100%**	**$ 817**

TOTAL COVERAGE: 4 - 6 MILLION

Program for the Temporarily Unemployed

Federal Costs Between 1997-2005: $66 Billion

Income Quintiles	Percent of Federal Subsidies	Federal Subsidy Per Family Per Year (1997 $)
Lowest Income (1st Quintile)	23%	$1256
Low Income (2nd Quintile)	35%	$1034
Middle Income (3rd Quintile)	28%	$1025
High Income (4th Quintile)	12%	$ 895
Highest Income (5th Quintile)	2%	$ 695
Total	**100%**	**$1040**

"Income" is defined as the adjusted gross income for families. In 1994 dollars, the breaks are:

1st Quintile:	Less than $6,517
2nd Quintile:	$6,518 - 17,826
3rd Quintile:	$17,827 - 31,675
4th Quintile:	$31,676 - 53,630
5th Quintile:	Greater than $53,631

These breaks are lower than convential definitions of income because they exclude transfer payments.

THE PROBLEM

PORTABILITY

Even people with insurance can't be sure that they can keep it over any extended period of time.

- People can't be sure that they can get insurance if they have to move or change jobs.
- The terms of insurance can change -- an employer can limit coverage for serious illnesses or treatments.

ACCESS AND AFFORDABILITY

People with health problems can be denied coverage or charged very high premiums.

- Individuals with health problems who want to buy coverage may not be able to find an insurer that is willing to sell to them at all, or at an affordable rate.
- Insurers and employers can impose long waiting periods for coverage.
- People who have insurance may face unaffordable increases in their premiums when they get sick.
- Without coverage, people often do not get medical care when they need it.

COMPETITION

Too much energy is spent on avoiding sick people instead of managing health care delivery.

- Insurers use benefit design and marketing strategies to target healthier risks and avoid poorer risks.
- As long as the focus remains on risk selection, the market will not adequately encourage organizations to efficiently manage care.

INSURANCE AND MARKET REFORMS

Preliminary Review
November 16, 1994

OUTLINE OF POSSIBLE OBJECTIVES

OBJECTIVE 1: PORTABILITY: To improve the ability of the currently insured to maintain coverage.

POSSIBLE INITIATIVES:

1. Limit the use of pre-existing condition exclusions.

2. Require insurers to renew coverage regardless of health status.

3. Guarantee access to insurance for new employees in businesses that offer coverage.

4. Prohibit insurers (and self-insured employer plans) from imposing caps on benefits for specific diseases.

- Similar provisions were contained in most Democratic and Republican proposals in the last Congress.

OBJECTIVE 2: ACCESS AND AFFORDABILITY: To guarantee access to coverage for everyone and to limit variations in premiums across individuals and businesses (which can make coverage unaffordable for high risks).

POSSIBLE INITIATIVES:

1. Guaranteed issue: Require insurers to make coverage accessible to everyone, regardless of health status.

2. Limit premium variations across individuals and small businesses.

   Possible Options:

   1. Limit Rate Variations. The extent to which insurers could vary their premiums due to health status could be limited.

   2. Permit Premium Variations only for age for each benefits package.

   3. Pure Community Rating.

3. Integrate individual purchasers and small businesses into a single community risk pool.

- Most Democratic, and a number of Republican proposals in the last Congress contained provisions that would assure access and limit premium variation. Many proposals permitted age variation.

- Most Republican proposals and Democratic proposals contained provisions to integrate the individual and small group markets. However, some proposals permitted small businesses and small business associations to opt-out of the insured market through self-insurance.

OBJECTIVE 3: ENCOURAGE COMPETITION: To restructure the market to promote competition among insurers based on efficiency and service and to reduce opportunities for risk selection by insurers.

POSSIBLE INITIATIVES:

1. Standardize benefit packages.

   Benefits could be standardized to a single package, or to several packages (with some more comprehensive than others). Standardization of a defined set of benefits makes it easier for applicants to compare premiums across insurers, which increases competition. It also limits the ability of insurance companies to avoid sick people through the design of their benefits packages.

- Most Democratic proposals in the last Congress provided for a standard benefit package. Most Republican proposals required that a standard benefit package be offered, but permitted insurers to offer other benefit packages as well.

2. Promote establishment of purchasing cooperatives for individual purchasers and small businesses.

   Possible Options: The Federal government could:

   1. Provide administrative funding and technical assistance.
   2. Require the establishment (e.g., by states) of cooperatives.
   3. Enact uniform standards for cooperatives.
   4. Make FEHBP -- the health program for Federal employees -- available to other businesses and individuals.

- Most Democratic and Republican proposals in the last Congress authorized or encouraged formation of purchasing cooperatives. A variety of proposals to provide coverage through FEHBP were offered by both parties.

TOP 10 RESPONSES FROM KAISER POLL

1. Priority issue for Congress? (Open-ended question) --
   Number one answer -- 40% health care (table 2a)

2. Who should take the lead -- President or Congress?
   56% Congress vs. 18% President (table 3)

3. Incremental or Major?
   41% incremental vs. 25% major -- (Democrats still at 45% for major) (table 5)

4. States or Federal Government take lead?
   54% states vs. 32% Federal (table 8)
   (Pollsters say completely switched in last 2 years)

5. If incremental, who should be covered first?
   40% kids, 24% workers who are uninsured, 9% low income (table 10)

6. What is the largest Federal expense today?
   Top three choices: Defense, Foreign Aid, Welfare (table 18-1)

7. After being told how many Federal dollars go to Social Security, Medicare, and Medicaid, support for cuts in these programs to reduce the deficit?
   10% say yes vs. 65% look elsewhere (table 16)

8. Support for reducing spending on Social Security to reduce the deficit?
   17% say yes (table 15b)

9. Support for reducing "Medicare for the elderly" to reduce the deficit?
   8% say yes (table 15b)

10. **Support for reducing "Medicaid for the poor" to reduce the deficit?**
    17% say yes (table 15b)

SMALL GROUP INSURANCE REFORM

State-by-State Analysis

- 40 states require **Portability**
- 34 states have set **General Rating Limits**
- 18 states have set **Tight Rating Limits**
- 42 states require **Guaranteed Renewal**
- 34 states require **Guaranteed Issue**
- 20 states have established **Reinsurance Programs**

Map Group
11/16

INDIVIDUAL INSURANCE MARKET REFORM

State-by-State Analysis

- 12 states require **Portability**
- 11 states have set **Rating Limits**
- 9 states require **Guaranteed Renewal**
- 8 states require **Guaranteed Issue**
- 4 states have established **Reinsurance Programs**

SMALL GROUP INSURANCE REFORM

State	Portability	General Rating Limits	Tight Rating Limits	Guaranteed Renewal	Guaranteed Issue	Reinsurance
AL						
AK	X	X		X	X	X
AZ	X	X		X	X	X
AR		X		X		
CA	X		X	X	X	X
CO	X	X	X	X	X	X
CT	X	X	X	X	X	
DE	X	X		X	X	X
FL	X	X	X	X	X	X
GA						
HI						
ID	X	X		X	X	
IL	X	X		X		
IN		X		X		
IA	X	X	X	X	X	X
KS	X	X		X	X	X
KY	X		X	X	X	
LA	X	X	X			
ME	X		X	X	X	X
MD	X		X	X	X	X
MA	X		X	X	X	
MI						
MN	X	X		X	X	X
MS	X	X		X		
MO	X	X		X	X	
MT	X	X		X	X	
NE	X	X		X	X	
NV						
NH	X	X	X	X	X	

State	Portability	General Rating Limits	Tight Rating Limits	Guaranteed Renewal	Guaranteed Issue	Reinsurance
NJ	X		X	X	X	X
NM	X	X	X	X		
NY	X		X	X	X	
NC	X	X	X	X	X	X
ND	X	X		X	X	
OH	X	X		X		
OK	X	X		X	X	X
OR	X		X	X	X	X
PA						
RI	X	X		X	X	X
SC	X	X		X	X	X
SD		X		X		
TN	X	X		X	X	X
TX	X	X		X	X	X
UT	X	X		X		
VT	X		X		X	
VA	X	X		X	X	
WA	X		X	X	X	
WV		X		X		
WI	X	X		X	X	
WY	X	X		X	X	X
TOTALS	40	34	18	42	34	20

Source: Blue Cross and Blue Shield Association 7/94

INDIVIDUAL INSURANCE MARKET REFORM

State	Portability	General Rating Limits	Guaranteed Renewal	Guaranteed Issue	Reinsurance
CA	X				
ID	X	X	X	X	X
KY	X	X	X	X	
LA		X	X		
ME	X	X	X	X	
MN	X	X	X		
NH	X	X	X	X	
NJ	X	X	X	X	X
NY	X	X	X	X	X
ND					
SC	X	X			
VT	X	X		X	X
WA	X	X	X	X	
TOTALS	12	11	9	8	4

Source: Blue Cross and Blue Shield Association 7/94

11/10/94

AGENDA

I. Opening Remarks

II. Discussion of Strategic Political Policy Questions

III. General Presentation of Deficit Coverage and Financing Ranges

IV. Communications Strategy

NEC/DPC MEETING

- The purpose of today's meeting is to begin to discuss and focus our attention on what health reform options we believe we should present to the President for his consideration. This is the first of a series of meetings with principals who will be playing the primary role in determining these options.

- We obviously must conduct our evaluation within the context of what we believe to be the realistic political, economic, and policy environment that we face following Tuesday's election results.

- Having said this, if we have any desire for any health investment or cost containment option to be included **in the budget** (or, for that matter, if we simply want to keep our options open), it is clear that our work must proceed in a timely manner in order to have a full and complete review of the options available. Today we will hopefully start the process of narrowing the infinite number of options that are possible, so that our respective staffs can better serve us and the President.

- Once again, before we start in earnest, we want to thank you for the assistance you and your staff have provided to this effort. To date, we have been quite successful in completing some preliminary staff groundwork and the information discussed and circulated has been carefully and professionally handled.

- As we proceed forward, there will be an intensified interest in our work by the media, the Congress, the outside interest groups and others. As a result, we are going to have to bend over backwards to guard against leaks. (In this regard, sometime during this meeting, we'd like to discuss and seek advice on how we -- as a group -- want to characterize our work and progress outside this room).

- Failure to protect ourselves against leaks and/or characterize meetings inappropriately or inconsistently is likely to severely hamper if not eliminate the possibility of providing the President with the best and most broadly-based policy options.

- We cannot afford to have the Congress or the outside interest groups reach the false conclusion that anything other than preliminary discussions are taking place. A belief to the contrary has every potential to be devastating to our relationships with them and our ability to produce a politically and policy-sound health reform strategy and package.

- We have asked Chris to develop a brief, first-cut health policy options presentation that we hope will help focus and give context to today's discussion.

- Prior to turning to him, however, we believe it is important that you evaluate these options within the context of the following questions regarding our health care goals, policy philosophies, and overall strategy:

1) **Legislative Strategy.** Should our health policy recommendations be driven by a "positioning" or an "enactment" strategy? How can we best integrate our political/budget/policy priorities with the new Republican Congressional Leadership? (Pat, et al)

2) **Budget Strategy.** Should we integrate our health policy inside or outside the President's budget proposal?

3) **Deficit Reduction.** Do we have a desire/need to dedicate any of the savings or revenues associated with health reform for deficit reduction as opposed to coverage expansions? If so, can we begin to think about parameters of the amounts and budget year timeframe (i.e., short term and/or long term deficit reduction goals) that we would like to be considered?

4) **Coverage Expansion.** To what extent -- if any -- do we desire or need to advocate for coverage expansions?

5) **Revenue Options.** In the new political environment, what -- if any -- revenues can be even contemplated for consideration for coverage expansion?

6) **Medicare Savings.** Within the context of deficit reduction, how many -- if any -- Medicare dollars should be on the table? Are there some categories of cuts that can/should be put on or off the table or prioritized in any way (e.g., extenders, hospitals, physicians, beneficiaries)? If we are talking about anything significant in terms of Medicare cuts, do we have to consider expansions of benefits for the Medicare population?

7) **Cost Containment.** Do we have public or private cost containment objections beyond medicare?

8) **Government Role.** Should there be a driving philosophy about the role of Government relative to any of these options? For example, can we consider public (i.e., medicaid) coverage expansions understanding, if we do not, significant Federal insurance reform will be necessary if we opt for private subsidy approaches?

9) **Federal/State Strategy.** Should any health care reform strategy be a substantially Federal driven/administered initiative OR should we give more latitude to the states?

10) **Linkage to other Administration Priority Issues.** Should we link our health policy options to other Administration policy priorities, such as welfare reform?

Obviously, the politics and numbers will significantly drive our policy decisions. As such, it is extremely helpful to us (and to Chris, as well as all principals' staff) to get a sense of where we are headed on the above mentioned issues. Please keep them in mind as you evaluate the policy options that Chris will now present.

Start Presentation by Chris....

HEALTH CARE STRATEGIC QUESTIONS

1) Legislative Strategy

2) Budget Strategy

3) Deficit Reduction

4) Coverage Expansion

5) Revenue Options

6) Medicare Savings

7) Cost Containment

8) Government Role

9) Federal/State Considerations

10) Linkage to other Administration Priority Issues

BUDGET DEFICITS AND ESTIMATED CBO SCORING OF PREVIOUSLY PROPOSED MEDICARE SAVINGS

Fiscal Years, Dollars in Billions
1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995–1999	1995–2004
DEFICIT (Adminstration Estimates)	-168	-184	-194	-192	-219	-235	-251	-264	-274	-285		
DEFICIT (CBO Midsession Estimates)	-162	-176	-193	-197	-231	-257	-287	-319	-355	-397		
Medicare Savings Options:												
Extensions of OBRA 1993 Baseline Savings	0.0	0.1	0.4	0.6	3.1	6.0	8.7	11.9	15.9	19.4	10.2	66.1
Extensions of OBRA 1993 Savings Policies	0.2	1.0	1.2	1.6	2.3	2.9	3.7	4.7	5.7	6.9	9.0	30.2
Extensions Subtotal	0.2	1.1	1.6	2.2	5.4	8.9	12.4	16.6	21.6	26.3	19.2	96.3
Additional Bipartisan Medicare Savings and Receipt Proposals	0.0	1.6	3.3	2.7	3.2	3.7	5.0	6.3	7.8	9.7	14.4	43.2
TOTAL OBRA + ADDITIONAL BIPARTISAN MEDICARE SAVINGS	0.2	2.7	4.9	4.9	8.6	12.6	17.3	22.8	29.5	36.0	33.6	139.5
MITCHELL III MEDICARE SAVINGS	2.5	8.1	13.9	17.5	25.1	33.6	42.2	53.2	66.2	80.1	67.1	342.3

Coverage Options and their Costs

Coverage Options	Billions of Net Subsidy Dollars, 1996-2005						
	30-60	120	150	200	310	410	450-815
Welfare to Work	X						
Unemployed	X						
Kids Only	X	X	X				
Working Families					X	X	X
Broad, Low Income Voucher							X
State FMAP Flexibility	??	??	??	??	??	??	??

All options assume a 1/1/97 start date. The options have been estimated as if they are independent, stand alone options. For example, if Welfare to Work, Unemployed, and Kids Only programs were to be implemented simultaneously, the total cost would substantially exceed $60 billion but would not reach $180 billion because the programs are somewhat overlapping.

Net Subsidy Dollars represents gross subsidy cost minus any Medicaid savings and state maintenance of effort requirements.

Each column shows the amount of funding required for different coverage proposals, and does NOT include the cost of any Other Options (detailed below).

Other Options

	Total Cost		
	1996-2000		1996-2005
Self-Employed Deduction	4-15		9-36
Long Term Care	10-12		20-75
Medicare Drug	21		100

The self-employed deduction options range from permanently extending the current 25% deduction from 1/1/94 to one that also permanently increases the deduction to 100% on 1/1/95.

The high end of the long term care options is the capped entitlement in the Mitchell bill, and the range includes other related policies.

The Medicare drug benefit is the one in the Mitchell bill. Beginning 1/1/99, beneficiaries pay a deductible and 20% copayment up to a $1275 yearly out-of-pocket limit. 25% of this program is financed by an increase in the Part B premium.

Previously Proposed Sources of Funding

	1996-2000		1996-2005	
	Medicare	**Total**	**Medicare**	**Total**
Ways & Means Tobacco Tax ($0.45 per pack)	0	24	0	56
W&M Tobacco + OBRA '93-I	10	34	66	122
W&M Tobacco + OBRA '93-I + OBRA '93-II	20	44	96	152
W&M Tobacco + OBRAs + Additional Medicare Savings	34	58	139	195
W&M Tobacco + OBRAs + Additional Medicare Savings + Net Mainstream Medicare Savings	73	97	256	312
W&M Tobacco + OBRAs + Additional Medicare Savings + Net Mainstream Medicare + Previously Bipartisan Supported Revenue Options	73	104-128	256	353-411

Medicare Savings in Previous Proposals	**1995-2000**	**1995-2004**
House Ways & Means	120	490
Health Security Act	118	376
Mitchell	103	348
Dole	43	160

TABLE 2.
ESTIMATED CBO SCORING of SELECTED, PREVIOUSLY PROPOSED MEDICARE SAVINGS
Fiscal years, dollars in billions

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1996-2000	10-yr Total 1995-2004
Extensions of OBRA 1993 Baseline Savings													
Extend OBRA93 Medicare Secondary Payer		0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-3.0	-11.4
Part B Offset		0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Reduce Routine Cost Limits for HHAs		0.0	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.6	-0.7	-1.7	-4.2
Extend OBRA93 SNF Update Freeze		0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.8	-1.8
Permanent 25% Part B Premium - Gross savings		0.0	0.0	0.0	0.0	-1.3	-3.6	-6.1	-9.2	-12.9	-16.2	-4.9	-49.3
Subtotal		0.0	-0.1	-0.4	-0.6	-3.1	-6.0	-8.7	-11.9	-15.9	-19.4	-10.2	-66.1
Extensions of OBRA 1993 Savings Policies													
Hospital PPS Update (MB-0.5%, 1997-2004)		0.0	0.0	0.0	-0.3	-0.8	-1.3	-1.9	-2.7	-3.6	-4.6	-2.4	-15.2
1995 Physician Update -3% (-0% primary care)	1/	-0.3	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-2.5	-5.6
Part B Offset		0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.6	1.4
ASC Payment Update Freeze (1996-1999)	2/	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Clinical Lab Payment Update Freeze (1996-99)	3/	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.9	-2.9
Reduce Hospital Capital (-7.31%/-10.41%)		0.0	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.1	-3.7	-7.8
HI Interactions		0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7
Subtotal		-0.2	-1.0	-1.2	-1.6	-2.3	-2.9	-3.7	-4.7	-5.7	-6.9	-9.0	-30.2
Additional Medicare Savings and Receipt Proposals													
Extend HI Tax to All State & Local Employees		0.0	-1.6	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.1	-7.6	-12.6
Income-Related Part B Premium ($90K/$115K)	4/	0.0	0.0	-1.7	-1.2	-1.5	-1.8	-2.5	-3.0	-3.7	-4.5	-6.2	-19.9
Eliminate MVPS Upward Bias	1/	0.0	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-0.8	-14.2
Part B Offset		0.0	0.0	0.0	0.0	0.1	0.2	0.4	0.7	1.0	1.4	0.2	3.6
Subtotal		0.0	-1.6	-3.3	-2.7	-3.2	-3.7	-5.0	-6.3	-7.8	-9.7	-14.4	-43.2
TOTAL		-0.2	-2.7	-4.9	-4.9	-8.6	-12.6	-17.3	-22.8	-29.5	-36.0	-33.6	-139.5

NOTES:

1/ Savings assume implementation of proposals in 1995. Savings would need to be recalculated for 1996 effective dates. FY 1995-2004 savings would be decreased.

2/ OBRA 1993 eliminated the update for ASC payment rates in 1994 and 1995. Proposal shown would extend freeze through 1999. OACT (9/14/94).

3/ OBRA 1993 eliminated the update for clinical lab payment rates in 1994 and 1995. Proposal shown would extend freeze through 1999. OACT (9/14/94).

4/ Proposal would establish income thresholds at $90,000 for single filers and $115,000 for joint filers (HSA and Senate Finance proposal).

General Caveats for Savings Proposals

Estimates are derived from earlier proposals, new estimates will differ for several reasons:

- 10 year estimates will include an additional year, 2005
- Medicare and Medicaid baselines will be reestimated by both CBO and OMB
- CBO will score cost-shifting impacts from Medicare price reductions, this will have the effect of raising subsidy estimates and lowering federal tax revenues

Revenue Caveats

The range of revenue estimates is dependent upon the scope and nature of the subsidy program, as well as the design features of the revenue provisions involved.

DPC/NEC HHS/ Shelale File
Regulation options

- **Making Medicare User Friendly For Beneficiaries**

  - A single, easy-to-read monthly statement of all Medicare claims will replace our current claim by claim communications with beneficiaries.

  - Recognizing the diversity of Medicare beneficiaries, we will be testing a Spanish Medicare claims information to improve our outreach to Medicare's Hispanic population.

- **Simplifying Medicare for Providers**

  - Before billing Medicare for major inpatient hospital services, physicians are required to sign a document certifying that have indeed provided the services for which the hospital is submitting a bill. We plan to eliminate this requirement in order to lessen the administrative burden on physicians.

  - We are revising the conditions of participation for hospitals, end stage renal disease facilities, and home health agencies to make them more easily understandable, outcomes-based, and less process-oriented.

  - Providing organizations which operate HMOs with greater flexibility in operating other health benefit plans.

  - We have begun to revise the clinical laboratory survey criteria to eliminate excessive surveying and to lessen the burden on laboratories and States.

- **Improving the Quality of Health Care**

  - Our new quality improvement program focuses on bringing typical care up to the standards of best practices rather than searching for abberations and punishing providers.

  - We are developing "quality indicators" for nursing homes and home health services to change the way we monitor quality of care from a series of process standards to a focus on outcomes of patient care.

- **Eliminating Fraud and Abuse**

  - Working with carriers and intermediaries, we are developing advanced computer systems to detect fraudulent patterns of billing in all types of claims. We are undertaking an education program to inform employees and beneficiaries of their responsibility to report suspicious practices.

- We have initiated stricter standards for suppliers under Medicare and Medicaid and are working with States to trace repeat offendors. We are actively coordinating the enforcement activities of carrier fraud units, HCFA staff, the Inspector General's Office and the Department of Justice in areas where high rates of fraud are suspected.

o **Promoting Efficiency in Contracting**

- We have developed a streamlined contract renewal process in our quality improvement program and our kidney disease networks. These new procedures will permit expedited renewal of contracts for those contractors who consistently perform well.

o **Simplifying Medicare Billing**

- The Medicare Transaction System (MTS), a uniform, national system for processing Medicare claims will replace the diverse existing systems and significantly simplify administrative operations for beneficiaries, providers, and Medicare.

Eliminate Fraud and Abuse

Detection

We have consolidated payment of durable medical equipment into four carriers in order to enable us to focus claims review on this problem area. One of the four has responsibility for analyzing patterns within all DME claims to highlight problem areas.

Working with carriers and intermediaries, we are developing advanced computer systems to detect fraudulent patterns of billing in all types of claims. This will enable us to intervene early when problems are suspected.

It problem areas such as South Florida, we are combining Medicare claims with those from Medicaid to provide a more robust data base on which to detect unusual patterns. We plan to expand to include private claims with the cooperation of several existing carriers.

We are undertaking an education program to inform employees and beneficiaries of their responsibility to report suspicious practices.

State surveyors who visit home health agencies and nursing homes will be trained in detecting and reporting evidence of fraud. They will also be provided with information from claims analysis which indicates quality problems.

Prevention and Enforcement

We have initiated stricter standards for suppliers under Medicare and Medicaid and are working with States to trace repeat offendors who create new organizations in order to continue in the program.

We are developing methods to ensure that both suppliers and providers who have engaged in fraudulent activities will not be able to move to another state and resume practice.

We are actively coordinating the enforcement activities of carrier fraud units, HCFA staff, the Inspector General's Office and the Department of Justice in areas where high rates of fraud are suspected.

SIMPLIFYING MEDICARE FOR BENEFICIARIES[1]

Integrated Discharge Planning

This proposal would establish linked discharge planning/preparation and continuity of care requirements for hospitals (possibly modifying the existing hospital requirements), SNFs/NFs, and HHAs. The purpose is to smooth a beneficiary's transition from one setting to another. This effort is consistent with the ongoing effort to field test a uniform needs assessment instrument.

Coordinated Open Enrollment for Medicare Managed Care and Medigap

With certain exceptions, beneficiaries would be able to enroll in HMOs and CMPs with Medicare contracts and in Medigap plans only during an annual coordinated open enrollment period. Enrollment would be through a third party designated by the Secretary. Beneficiaries enrolling in HMOs and CMPs would be "locked in" until the next open enrollment period, with some flexibility possible for the first lock in period. Newly entitled individuals and individuals who move into an area would be entitled to a special enrollment period. The Secretary would develop materials comparing all managed care and Medigap plans. Medigap plans would be prohibited from underwriting enrollments, and the current six-month pre-existing condition exclusion period would be eliminated.

Lifetime Reserve Days

Under current law, Medicare beneficiaries have 60 lifetime reserve days for hospitalization which they can use after they have exhausted the 90 day benefit period for inpatient hospitalization. This proposal would replace these reserve days with an increase in the number of days in the regular benefit period. The details of this proposal are being studied by the HCFA's Office of the Actuary.

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[1] Minor statutory modification would be required for these initiatives.

SIMPLIFYING MEDICARE FOR PROVIDERS

Facility Conditions

We are revising the conditions of participation for hospitals, end stage renal disease facilities, and home health agencies to make them more easily understandable, outcomes-based, and less process-oriented.

HMO Organizational Structure and Services

This regulation will provide organizations which operate HMOs that are federally qualified under Title XIII of the Public Health Service Act with greater flexibility in operating other health benefit plans. It would also authorize, with certain limitations, federally qualified HMOs to offer out-of-plan physician services and require a reasonable deductible for those services. Further, this regulation would permit the HMO to use assets of the parent organization to meet fiscal soundness and insolvency protection requirements.

STREAMLINING BILLING AND PAYMENT

The Medicare Transaction System

Problem: At present, Medicare and its providers must cope with 14 different claims processing systems, operated by 79 insurance companies at 62 sites. Information flow from Medicare to providers, and vice versa, is unnecessarily slow and complex.

Solution: HCFA has awarded a contract for the development, testing, and implementation of a new Medicare Transaction System (MTS). This uniform, national system for processing Medicare claims will replace the diverse existing systems and significantly simplify administrative operations for beneficiaries, providers, and Medicare. Implementation of the MTS will begin in 1996 and will be complete in 1998. Benefits that will flow from the new system include:

- Improved service for beneficiaries
- Improved service for providers
- Improved management of program expenditures
- Greater uniformity in coverage and payment decisions
- Enhanced capability to identify fraud
- Improved coordination of benefits

The capabilities of MTS could go beyond claims submission. An on-line bulletin board function could provide instant access to Medicare bulletins and alerts, fee schedules, directories, Medicare Manuals and other useful information.

MTS is being developed for the Medicare program; we are committed to timely implementation. At the same time, we acknowledge that MTS will have implications well beyond Medicare. By virtue of Medicare's size and scope, MTS may shape the environment for information transaction in Medicaid, public health, other government programs, and private industry. In the development of MTS, we must be sensitive to the needs of all industry participants, and must ensure that providers and payers are not caught between incompatible systems.

Therefore, it is our intention to establish an advisory committee to HCFA, pursuant to the Federal Advisory Committee Act, to advise HCFA on data standards issues necessary to implement MTS. To assure that the evolution of MTS is compatible with broader DHHS information activities, oversight of this committee will be vested in the DHHS information system steering

committee, jointly chaired by ASPE and OGC. This steering committee was created to coordinate information system issues department-wide. The HCFA MTS advisory committee will be jointly chaired by a HCFA representative and by one of the cochairs of the Steering Committee, ex officio.

Additional Regulatory Initiatives

- Eliminating Pre-Billing Attestation Requirement: HCFA is eliminating pre-billing requirements for attestation by physicians of diagnoses and major procedures performed in the hospital.

- Providing Uniform Identification Numbers to all Providers: HCFA is leading an effort involving other Federal payers of health services, including the Departments of Veterans' Affairs and Defense, to provide unique provider identification numbers to all providers of Medicare services. Having uniform provider numbers for all government health programs will make it easier for physicians to complete billing forms.

- Simplifying the "Important Message from Medicare": HCFA plans to simplify the content of this message and to simplify the way hospitals distribute it.

- Utilize Title XIII for Medicare Contract Termination: Create a process for expedited termination of contracts with HMOs or CMPs for serious quality problems. Some legislative action would be required.

STREAMLINING FOR STATES AND LABORATORIES: MODIFYING REQUIREMENTS UNDER THE CLINICAL LABORATORIES IMPROVEMENT ACT (CLIA)

Problem: Current CLIA requirements are burdensome on laboratories and State survey agencies and the current survey guidelines create additional difficulties for the State survey agencies.

Solution: Reduce the burden on States to survey clinical laboratories and develop a more flexible approach to surveying small laboratories.

- CLIA Program: Categorization of Tests and Personnel Modification: In this final rule with comment period, we are revising our regulations to allow midlevel practitioners and dentists to perform tests in the "physician-performed" microscopy subcategory of moderate complexity procedures. Laboratories with this certificate would be exempt from routine inspection, reducing the burden on approximately 10,000 laboratories. HCFA will expand the exemption of microscopy tests from inspection, potentially doubling the number of laboratories exempt under this provision. This rule will also grandfather individuals currently employed as testing personnel and general supervisors performing high complexity testing reducing the burden to rural and underserved areas.

- CLIA deeming notices that will reduce the number of surveys that will have to be performed by States: CLIA approval of the College of American Pathologists, the Joint Commission on Accreditation of Health Care Organizations, and the American Society for Histocompatibility and Immunogenetics.

- Categorization and Certification Regulations for "Accurate and Precise Technology" Tests: This controversial proposal would create a new subcategory of moderate complexity procedures called "accurate and precise technology" tests. This provision would reduce the burden of having to comply with all of the "moderate complexity" testing requirements and require only 5% routine surveys. These tests would only have a minimum amount of error which is controlled by the laboratory. The NPRM is now being prepared for clearance in the Department.

- Flexible Surveys for Small Laboratories: HCFA has devised a flexible survey which takes into account the fact that laboratories vary tremendously in test volume and the degree of difficulty of the tests they perform. It will reduce administrative costs by $20 million in the first two years of the program. About 1,000 laboratories that are low volume or perform only simple screen tests will only be surveyed once every four years.

STREAMLINING THE PRO AND ESRD NETWORK PROCUREMENT PROCESS

Problem: In the past, the procurement process in contracting with Peer Review Organizations and End Stage Renal Disease Networks (hereafter referred to as Quality Improvement Programs (QIPs) has been both time and labor intensive for both government and contractor personnel.

Solution: HCFA has developed a streamlined procurement process for noncompetitive renewal of QIP contracts. HCFA has also worked with the QIPs to develop pricing principles and contract provisions based on a common understanding of the Statement of Work.

Contractors certify that they will perform the work as stated in the Statement of Work. This approach allows HCFA and the QIPs to forego the development and evaluation of technical proposals for noncompetitively renewed contracts. The government and the QIPs can then focus their energies on the negotiation of the business agreements. Benefits derived from this approach include:

- reduced acquisition processing time;

- significant cost savings realized by both the QIPs and the government in the procurement process;

- improved understanding of contract expectations;

- greater uniformity in QIPs' contact execution;

- elimination of technical proposal review for contractors who have met the renewal criteria; and

- improved administrations and management of program expenditures.

Although this approach has been implemented for the QIPs, it has implications for any contract that can be noncompetitively awarded. This collaborative planning model can be used in developing and extending our partnerships with other contractors and agents.

QUALITY IMPROVEMENT INITIATIVES

Transforming Medicare Peer Review

Problem: Until recently, HCFA through its contractors (Peer Review Organizations and ESRD Networks, hereafter referred to as Quality Improvement Programs (QIPs)), monitored quality mainly through a detection program. This was accomplished primarily through the intensive review of individual case records (physician or provider records) that had been selected as part of random samples and outlier focused samples. This created a focus on "bad actors" rather than quality improvement.

Solution: HCFA is reinventing Medicare's quality assurance programs. This changed approach is called the Health Care Quality Improvement Program (HCQIP). The change in name reflects both the profound changes that have taken place and will continue and emphasizes the mission rather than the organizations that carry out the mission. Over the next five years we expect HCQIP to become a broader term for the integrated quality management system that is emerging as part of the Health Care Financing Administration's strategic planning.

As part of HCQIP local cooperative projects, QIPs work with the local health care community to identify and interpret scientifically sound parameters of practice to measure the quality of care. These parameters of care are often based on practice guidelines developed by the Agency for Health Care Policy and Research as well as other authoritative clinical bodies. QIPs use statistical quality surveillance to examine variations in both the processes and outcomes of care. QIPs share these data with providers and physicians and work cooperatively with them to interpret and apply findings. HCQIP gives QIPs and HCFA a chance to demonstrate that health care provided to Medicare beneficiaries can be measurably improved. HCQIP is based on the principle that QIPs can do more to improve the quality and cost effectiveness of care by bringing typical care into line with best practices than by inspecting to identify erred treatment in individual cases.

Key HCQIP Objectives:

- Build a community of those committed to improving quality.
- Monitor and improve quality of and access to care.
- Communicate with beneficiaries and providers of care so as to promote informed health choices.
- Protect beneficiaries from poor care.
- Create supporting infrastructure to make these achievements possible.

Using Quality Indicators (QI) in the Medicare/Medicaid Survey and Certification Program

Problem: At present, the only way in which the Secretary can determine whether or not providers meet Federal health care and safety requirements is through labor-intensive, expensive, onsite "snapshot" views of performance at one point in time.

Solution: HCFA has published a notice of proposed rule making to develop QIs for use in the nursing home survey and certification process and is preparing a notice of proposed rulemaking on QIs for home health agencies. QIs are tested, validated and reliable data-driven "markers" of outcomes of care or processes of care that have been shown to be predictors of outcomes of care. QIs include standards of performance that give performance meaning to the indicator. For example, the rate of use of physical restraints in nursing homes is a quality indicator. QI data is collected, analyzed and shared with providers, the State survey agencies, HCFA, and beneficiaries.

The ability of HCFA and the States to use QI data in the survey and certification process and the provider to use QI data for internal quality improvements depends at the outset on our ability to require standard assessment and reporting of the critical QI data, the implementation and maintenance of a State and national data system and the development of a reliable complete data base of information reported by the facilities on individual clients.

The benefits of developing and implementing a quality indicator system include:

- use in the survey and certification process by State and Federal regulators
- use in internal quality improvement activities by the provider
- use by beneficiaries to inform themselves as they make critical choices for health care
- use by professional, researchers, social and health policy experts to inform care practices and policy
- use by payment policy experts to help inform payment policy in the future.

The QIs currently developed cover all domains of care, and the data will routinely be collected as a regular part of providing care to people rather than as a separate data collection burden.

Department of Health and Human Services (DHHS) Regulatory Initiatives Options

The attached package is in response to your request for initiatives the Department of Health and Human Services (DHHS) could pursue to advance needed changes in health care delivery, apart from any major legislative effort. These initiatives focus on administrative streamlining and improved consumer services. In a meeting next Tuesday, Secretary Shalala will make a formal and more complete presentation of DHHS options. Example of the initiative to be discussed include:

- Consumer Protection in Managed Care. One distortion of the debate on health care reform was the perception that the Administration's plan would have forced people into HMOs, where their patient-doctor interaction would be replaced by impersonal decisionmaking. People felt that while the Administration was concerned about guaranteeing coverage, there was less concern about the quality of that coverage. One important goal of the Administration should be repositioning itself to make clear its intent to protect American health care consumers from shoddy business practices. The Administration can do this by developing a Consumer Bill of Rights, implemented in federal regulation of Medicare and Medicaid HMOs and the HMO Act, which would include provisions requiring HMO to:

  -- maintain an internal grievance system, including expedited appeals in specified situations;

  -- provide consumers with information about the HMO's utilization review procedures and practice guidelines;

  -- meet utilization review guidelines, such as time limits.

- Integrated Discharge Planning. DHHS would establish linked hospital, home health agency, and nursing facility discharge and continuity of care requirements, to smooth the beneficiary's transition between settings.

- Simplify the "Important Message from Medicare," to make the information more accessible to beneficiaries.

- Reinvent the Medicare Peer Review Program. Historically, the Medicare Peer Review program has monitored quality primarily through a detection program, involving intensive review of individual case records. DHHS is now transforming this program to promote quality, rather than merely identify problems. Under the Health Care Quality Improvement Program, DHHS will work with local health care communities to identify sound practice parameters to improve the quality of care. DHHS will rely on analysis of large number of

cases, and will share data with providers and work with them to apply findings.

- The Medicare Transaction System. At present, Medicare and its provider must cope with 14 different claims processing systems, operated by 79 insurance companies at 62 sites. The Medicare Transaction System will allow for a uniform, national system for processing Medicare claims, and will simplify administrative operations for beneficiaries and providers.

- Clinical Laboratory Improvement Act Flexibility. Current CLIA regulatory requirements are burdensome on laboratories and State survey agencies. DHHS would modify these regulations to reduce the burden on states and implement a more flexible approach to surveying small laboratories.

Most of these initiatives can be accomplished through regulatory actions; in a few cases, some statutory modification would be required. Materials for next Tuesday's meeting will include a more detailed description of these proposals, and the status of their development in DHHS.

Beyond this package, DHHS is exploring additional options including regulatory revision of Medicare's home health payment policy. Some of these options are well underway. For example, DHHS recently published a regulation strengthening and simplifying nursing home quality standards, to clarify DHHS policy and promote consumer protection (see attached press release).

Finally, these regulatory initiatives are in addition to the legislative proposals DHHS is preparing as part of the annual budget cycle. This year, the DHHS legislative proposals will include a major program integrity initiative (modifying administration of the "fraud and abuse" program), as well as additional streamlining and administrative simplification proposals.

- **Making Medicare User Friendly For Beneficiaries**

  - A single, easy-to-read monthly statement of all Medicare claims will replace our current claim by claim communications with beneficiaries.

  - Recognizing the diversity of Medicare beneficiaries, we will be testing a Spanish Medicare claims information to improve our outreach to Medicare's Hispanic population.

- **Simplifying Medicare for Providers**

  - Before billing Medicare for major inpatient hospital services, physicians are required to sign a document certifying that have indeed provided the services for which the hospital is submitting a bill. We plan to eliminate this requirement in order to lessen the administrative burden on physicians.

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- **Eliminating Fraud and Abuse**

  - Working with carriers and intermediaries, we are developing advanced computer systems to detect fraudulent patterns of billing in all types of claims. We are undertaking an education program to inform employees and beneficiaries of their responsibility to report suspicious practices.

- We have initiated stricter standards for suppliers under Medicare and Medicaid and are working with States to trace repeat offendors. We are actively coordinating the enforcement activities of carrier fraud units, HCFA staff, the Inspector General's Office and the Department of Justice in areas where high rates of fraud are suspected.

o **Promoting Efficiency in Contracting**

- We have developed a streamlined contract renewal process in our quality improvement program and our kidney disease networks. These new procedures will permit expedited renewal of contracts for those contractors who consistently perform well.

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Detection

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We have initiated stricter standards for suppliers under Medicare and Medicaid and are working with States to trace repeat offenders who create new organizations in order to continue in the program.

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File 1994 Insurance Reform.

Health Care Qs and As - November 8, 1994

Q. Congress failed to enact your health care plan last year and expectations are that with a more conservative Congress next year, it will even be more difficult to pass health care reform legislation. Will you produce a modified approach, perhaps something that will garner more Republican support - or will you introduce something that can be used as a campaign issue in 1996?

A. There have not been any decisions made on how we will approach health care next year. The only decision made is that we are not going to give up the battle. Another million Americans lost their health insurance last year and costs continue to escalate. We cannot walk away just because the road to reform is difficult.

We obviously want health care to be handled in a bipartisan fashion. We always have. We tried repeatedly during the last session to work with Republicans. They threatened to filibuster in September and it put health care reform on the shelf for now. But I think there is a good opportunity to provide people with the health security that they want - with quality, affordable health care and private insurance coverage. And it is an opportunity that can be a reality if we work together.

Q. The Republicans, with massive special interest help, successfully labeled your plan as government-run and stated it would lead to rationing and massive job losses. Will the Administration do something to help change this public perception? Will it abandon alliances, move at a slower pace, back away from universal coverage?

A. Again, no decisions have been made. We will obviously try to better explain to the American people that we are talking about preserving what is good in our system and fixing what isn't working. And when we talk about preserving what is good, we mean preserving the private insurance system. Providing Americans with private health insurance that can't be taken away if a loved one gets sick or a job is lost.

Special interests spent hundreds of millions of dollars to scare and mislead the public. Yet, in spite of their success in creating confusion, the American people still overwhelmingly believe that we must act to provide health security to American families and make health care more affordable.

Q. Reports from senior White House officials last week stated that you were removing the First Lady and Ira Magaziner as the leaders in developing health care legislation and replacing them with Carol Rasco and Bob Rubin. Is this move a recognition that last year's process was a failure?

A. First, let me state that reports that the First Lady will not be involved in health care are ridiculous. The First Lady will play an active role in policy strategy and development and

she will remain the Administration's public advocate on health care. At my request, Ira will also remain involved in health care.

We are entering a different phase in the health care debate. The last two years were spent doing an enormous amount of research and policy development. We are now entering a phase that will allow us to move health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts.

Q. You have repeatedly stated that any Medicare savings would be used for health care reform. Are you saying that if you decide to put forward a scaled-back plan, you will not consider using Medicare savings for deficit reduction?

A. I do believe that Medicare savings should not be used outside the context of health reform.

As everyone knows, we have worked hard to successfully control the deficit. But we will watch the deficit balloon out of control if we do not take steps to control escalating health care costs. That's why controlling costs has been and will continue to be one of the primary goals of health care reform.

Q. Given the difficulty in enacting a bill with universal coverage last year, will you pledge once again, in a more conservative Congressional environment, to veto a bill that does not achieve universal coverage?

A. We still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. We must continue to work toward achieving what the American people want and deserve.

Q. There is speculation that the Administration will be presenting recommendations to Congress on health care reform and that these recommendations will be part of the budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?

A. We have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible they won't be part of the budget.

~~Informati~~ File 1994- Insurance Reform

Draft November 8, 1994

OPTIONS FOR DELIVERING EXPANDED COVERAGE

Providing financial assistance alone does not assure that a target population have access to coverage. Health plans in many states are able to deny coverage or charge higher premiums to people with poor health status. Therefore, initiatives to expand coverage must address how the subsidized population would receive benefits.

Delivery Options:

Expanded coverage can be delivered to targeted populations through:

- Reformed private insurance market
- Private health plans that bid to provide coverage
- Existing public plans

The delivery option can be set nationally or states could be given flexibility.

Private Insurance Market

Because of barriers to access and price discrimination in the health insurance market marketplace, significant reforms are needed before the private insurance market can be used to deliver subsidized coverage. In addition, the market for children-only coverage is extremely limited or nonexistent in most places, so a functioning market for childrens' policies would need to be encouraged.

Family Coverage

To deliver subsidized coverage to ***families*** through the private insurance market, comprehensive insurance reforms would be needed, including policies that at least:

- Guarantee access to coverage (e.g., assure acceptance of all applicants);
- Limit premium discrimination based on health status (e.g., move toward community rating);
- Define a risk pool (e.g., individual purchasers and firms with less than 100 workers);
- Establish a standard benefit package;
- Eliminate pre-existing condition and other coverage limitations.

Children-Only Coverage

To deliver subsidized coverage for a ***children-only*** program through private health insurance (in states without comprehensive reform), a different set of problems must be addressed, because the current market for this type of coverage is extremely limited. Standards would be needed to:

- Assure that a sufficient number of plans offer children-only coverage;
- Assure that coverage is provided to all applicants without price discrimination based on health status;
- Define benefits and the way premiums are set;
- Assure that premiums charged are reasonably related to the costs of providing benefits. (Without a current market, and assuming that most purchasers would be subsidized, health plan premiums may not, at least initially, be set at competitive levels).

Contracts with Private Health Plans

The federal government or states could contract with private health plans to deliver subsidized coverage to targeted populations. For example, the federal government could use **FEHBP** to contract with private health plans to cover targe populations..

- Terms of contracting would define benefits and how coverage is made available.
- Coverage could be offered through a single contracting health plan or through multiple plans that meet conditions or participation. In an **FEHBP** option, health plans that provide services to federal employees could also offer coverage to target populations.
- Without insurance reforms, movement between the subsidized program and the private insurance market may not be possible for participants with health problems. Some continuation provisions or special portability protection may be needed.

Expand Existing Public Programs

Subsidized coverage could be provided to targeted populations by expanding Medicaid or Medicare.

- Eligible populations could be offered a separate benefit package or existing program benefits.
- Without insurance reforms, movement between the subsidized program and the private insurance market may not be possible for participants with health problems. Some continuation provisions or special portability protection may be needed.

POSSIBLE SOURCES OF FUNDS IN REPUBLICAN PROPOSALS

Fiscal Years, Dollars in Billions
1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995–1999	1995–2004
Medicare Savings Options:												
Extensions of OBRA 1993 Baseline Savings	0.0	0.1	0.4	0.6	3.1	6.0	8.7	11.9	15.9	19.4	10.2	66.1
Extensions of OBRA 1993 Savings Policies	0.2	1.0	1.2	1.6	2.3	2.9	3.7	4.7	5.7	6.9	9.0	30.2
Extensions Subtotal	0.2	1.1	1.6	2.2	5.4	8.9	12.4	16.6	21.6	26.3	19.2	96.3
Additional Bipartisan Medicare Savings and Receipt Proposals	0.0	1.6	3.3	2.7	3.2	3.7	5.0	6.3	7.8	9.7	14.4	43.2
Total OBRA + Additional Bipartisan Medicare Savings	0.2	2.7	4.9	4.9	8.6	12.6	17.3	22.8	29.5	36.0	33.6	139.5
Managed Care Medicaid Savings												
Tobacco Tax												
Other Revenue Sources												
Dole Medicare Savings (not additive)												

MEDICARE SAVINGS IN OTHER PROPOSALS:

Mitchell FY95–99:

Mainstream FY95–99:

Gephardt FY95–99:

Mitchell FY95–2004:

Mainstream FY95–2004:

Gephardt FY95–2004:

POSSIBLE USES OF FUNDS

Fiscal Years, Dollars in Billions
1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995–1999	1995–2004
DEFICIT REDUCTION	NA	NA	NA	NA	etc							
KIDS Private Insurance Through age 5 Full to 185% of poverty Phased to 300% of poverty	0	0	NA	NA	etc							
KIDS Private Insurance Through age 18 Full to 185% of poverty Phased to 300% of poverty	0	0	NA	NA	etc							
UNEMPLOYED Private Insurance Six months only Full to 100% of poverty Phased to 250% of poverty Unemployement comp. included	0	0	NA	NA	etc							
UNEMPLOYED AND KIDS Private Insurance Kids: Through age 18 Full to 185% of poverty Phased to 300% of poverty Unemployed [Same as above]	0	0	NA	NA	etc							
WELFARE TO WORK	0	0	NA	NA	etc							
UNEMPLOYED AND KIDS AND WELFARE TO WORK	0	0	NA	NA	etc							
SELF-EMPLOYED DEDUCTION Quick phase-in to 100%												
SELF-EMPLOYED DEDUCTION Slower phase-in to 100%												
LONG TERM CARE?												
STATE FLEXIBILITY?												