REVISIONS TO REPUBLICAN MEDICAID PLAN

The House Commerce Committee's approved changes to the Republican Medicaid proposal may appear to improve the plan, but actually are minor or cosmetic in nature and, at the core, do not change the basic facts. This bill is still a block grant. It would do nothing to provide a guarantee to coverage and a meaningful benefit package. The financing structure still puts states at risk for increases in costs associated with enrollment changes.

Eligibility

Methodology

State discretion to determine eligibility is restricted compared to the original bill. For example, certain methodologies and standards that are used in certain parts of the eligibility determination process are required under certain circumstances (e.g., income and assets for determining eligibility for disability are specified, if states elect the SSI definition of disability).

- **However, the states still have enough choices to eliminate coverage for many.**

Medicaid Coverage for Welfare Transition

Retains and modifies transitional Medicaid coverage for employed former welfare beneficiaries for twelve months. Eliminates the current 1998 sunset provision for this coverage, thus creating a permanent mandatory Medicaid eligibility category.

- **This superficial improvement does not provide real guarantees of coverage -- such as a Federal right of action or any requirement for adequate benefits -- for former welfare beneficiaries.**

Eligibility Phase-In

Reinstates the eligibility phase-in of children aged 13 to 18 with incomes below poverty as mandatory eligibles.

- **Children aged 13 to 18 appear to be "guaranteed" coverage. However, these children have no real guarantee of coverage as long as amount, duration and scope requirements and Federal right of action are repealed.**

Services

FQHC and RHC Services

Retains FQHC and RHC services as mandatory Medicaid services and requires States to

guarantee that FQHCs and RHCs receive 85 percent of FY 1995 spending on FQHC/RHC services through FY 2000. States could request lower set-aside amounts for later years. Allows States to establish separate solvency standards for FQHC/RHC-controlled health plans.

- **These changes establish a temporary funding guarantee for one type of safety-net provider, but, because the set-aside is based on 1995 spending, the real value of this guarantee would erode with time.**

- **In addition, FQHC/RHC services are "guaranteed" only to the extent that other services are "guaranteed" -- and without amount, duration and scope requirements and a Federal right of action, no services are truly "guaranteed".**

Physician Assistants

Adds physician assistant services as a guaranteed Medicaid service.

- **This amendment enhances the list of "guaranteed" services but does not provide any assurance that enrollees will be able to access this or any other service, as long as amount, duration and scope requirements and Federal right of action are repealed.**

Financing

Block Grant Formula

Lowers (by comparison to the original bill) the growth of state base allotments for 1997, and adds an additional layer of complexity to the already complex (40 pages of legislative language), block grant formula. The bill now conforms with GAO's state-by-state estimates.

- **No changes have been made to the basic structure of the program--it's still about 97 percent block grant and 3 percent limited umbrella fund that is available for only one year.**

Donations and Taxes

Retains current restrictions on States' use of voluntary donations and provider taxes to generate State share. Permits HHS to waive these restrictions, at State request, after the first two years. Requires GAO to study States' use of tax and donation schemes under the revised Medicaid program.

- **The extension of current law restrictions would ensure that, for at least the first two years before the waiver authority begins, States must use "real" dollars to match block-grant funding. Exactly what GAO would study while these practices continue to be prohibited under the revised financing structure is unclear.**

- **The current restrictions on taxes and donations could be undermined after the first two years because HHS would have no basis for denying waiver requests. There would be no evidence or analysis of abusive practices in the first two years of the program and therefore no new information for developing criteria to use when evaluating waiver requests.**

Cost Sharing

The changes to the cost sharing provisions are extensive. They do in fact, limit the liability of Medicaid patients for cost sharing in many instances.

- **However, as with other changes, they are cosmetic, not real. For every protection that would be provided, there are conflicting provisions that would counteract the effect of the proposed change.**

Although the revised proposal would prohibit premiums for the guaranteed population, it would, at the same time, allow States to impose premiums, up to 2 percent of individual gross income, on all other Medicaid beneficiaries.

- **Imposition of a 2 percent premium may not sound like much, but to a low income person, it is potentially a huge barrier to care.**

- **The bill also permits cost sharing (nominal cost sharing for guaranteed populations, and comparable to HMO cost sharing for other groups) for Medicaid beneficiaries. It is possible that a pregnant woman with a hospital episode of $5000, for example, could still be at risk for a cost sharing payment of $300.**

The bill prohibits balance billing by providers.

- **It would nonetheless permit providers to charge cost sharing, and would remove the prohibition on denial of service to a beneficiary unable to pay the cost sharing.**

Indian Health

As amended, the bill requires States to include payment provisions for health services provided to Indians in their State plans and requires States to consult with Indian tribes while developing the State plan.

- **This change provides some minor procedural assurances but does not address the inadequacy of the supplemental pool that appears to be the sole source of Medicaid financing for Indian health care.**

New language clarifies that States that receive an allotment for Indians may use it for tribes and

urban Indian organizations as well as for IHS.

- **This change heightens the inadequacy of the special grants funding, since the funds will be stretched across multiple types of providers.**

The bill still limits special grant funds to states with at least one IHS facility.

- **The bill still limits special grant funds to States with at least one IHS facility, thus excluding California which has significant Indian populations and no IHS facilities.**

Nurse-Aide Training

Allows nurse-aide training programs to continue in certain rural nursing homes, including those that are subject to an extended survey for quality deficiencies. A similar provision was included in the Medicaid portion of the President's balanced budget proposal.

- **This amendment largely conforms with the President's proposal and provides States with additional administrative flexibility. (Note: the amendment does not appear to apply to Medicare and thus poses problems for dually-certified facilities.)**

PROPOSAL
DNCC MEDICARE EVENT

"Why Does The Democratic Party Care About Medicare?"
Because That's What Families Do!"

CONCEPT

To construct a 20 minute message segment at the Convention with a goal of reinforcing the Democratic Party's historic commitment to Medicare, and to highlight the intergenerational significance the program has to America's families.

EVENT SEQUENCE

00:00 Backdrop: An intergenerational array of real people on stage.

00:00 Intro: Senator Pryor, Rockefeller, a regular American introduces Medicare.

02:00 Video: Sequence captures the Democratic Party's commitment to Medicare:

- o The Democratic Party's struggle to create Medicare in the early 1960s. (Black & White Footage of JFK's early efforts and of LBJ presenting the first Medicare card to Harry Truman.)
- o Highlights of the success Medicare has had in improving the lives of seniors. (Contrast pre-Medicare poverty rates.)
- o The President's fight to save Medicare during the budget battle of 1995.
- o Display the intergenerational significance of Medicare to America's families, and the importance of preserving Medicare for future generations.

06:00 Al Gore, Sr.: Recalls the pride of voting for Medicare in 1965. Remind voters that Bob Dole voted against video.

09:00 Video of Bob Dole: "I was there, fighting the fight, 1 of 12, voting against Medicare in 1965...because we knew it wouldn't work." Speech to American Conservative Union, 10/24/95.

12:00 Testimonial: Real stories of why Medicare does work, Bob. People who are apart of the backdrop come forward to tell their stories.

Single Senior Woman: From California who speaks about the impact Medicare has on her life.

Chorus: Moderator asks the convention, "And why do the people of California and the Democratic Party care about Medicare?" The Convention responds, "Because that's what families do!"

Baby Boomer: Moderator introduces a middle-age couple from Pennsylvania who deliver the message: "Without Medicare, we'd have to choose between paying for the costs of caring for our parents or saving for our children's education."

Chorus: Moderator asks the convention, "And why do the people of Pennsylvania and the Democratic Party care about Medicare?" The Convention responds, "Because that's what families do!"

Person with a Disability: Moderator introduces a person with a disability from Ohio who speak for 2 minutes about how Medicaid enables them to live in a community and not in an institution.

Chorus: Moderator asks the convention, "And why do the people of Ohio and the Democratic Party care about Medicaid?" The Convention responds, "Because that's what families do!"

Senior Couple: Moderator introduces senior couple from Florida who speak for 2 minutes about the impact Medicare.

Chorus: Moderator asks the convention, "And why do the people of Florida and the Democratic Party care about Medicare?" The Convention responds, "Because that's what families do!"

17:00 Closing Video: The event closes with footage of the President from the 1995 budget battle speaking passionately about his commitment to the future security of Medicare.

18:00 Closing Chorus: Moderator asks the convention, "And does President Clinton care about Medicare?" The Convention responds, "Because that's what families do!"

18:00 Floor Demonstration: Homemade Medicare theme/message signs waved by delegates.

Expansion of Coverage to Kids

- **Who Is Eligible?** Children under a specified age (e.g., 19) who were not covered by a private insurance plan during the 6 months prior to their enrollment. Children are not eligible if their parents have access to employer-sponsored insurance where the employer pays at least 80% of dependent coverage are not eligible.

- **What Benefits Would They Receive?** We have examined two options.

  Option 1. Eligible children would receive the Medicaid package available in their state.

  Option 2. Blue Cross/Blue Shield Standard Option (FEHBP)

- **How Much Would Eligible Children Pay?** Eligible children in families with incomes below a designated income level (e.g., 185% of poverty) would be fully subsidized. Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 300% of poverty).

- **How Much Would the Federal Government Pay?**

  Option 1. Under the Medicaid option, the federal government would share the costs with states and local governments using the existing federal Medicaid matching formula.

  Option 2. The federal government would provide all of the premium subsidies.

- **Other Program Features**. To discourage employers from dropping dependent coverage for lower income workers, a limited nondiscrimination provision may be needed. For example, employers could be prohibited from limiting dependent coverage to only a portion of full-time employees.

Range of Program Options	
Lower Cost Option: $30 Billion	Cover children under age 6; Full subsidies up to 185% of poverty; subsidies phase out at 300% of poverty; BC/BS benefits.
Higher Cost Option: $140 Billion	Cover children under age 19; Full subsidies up to 185% of poverty; subsidies phase out at 300% of poverty; Medicaid benefits.

Voucher Program for Working Families

- **Who Is Eligible?** All working families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

  Eligibility would be based on a family's work history; families that average at least 15 hours of work per week, or 390 hours in the previous 6 months would be eligible for the program.

  For the self-employed, eligibility is based on earning a specific level of self-employed earnings in a quarter (or in the previous two quarters). Families eligible for medical assistance under a State's Medicaid program would not be eligible for subsidies under this program.

- **What Benefits Would They Receive?** Two options were considered:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government would provide all of the premium subsidies.

Range of Program Options	
Lower Cost Option: $290 Billion	Full subsidies to working families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $470 Billion	Full subsidies to working families below 100% of poverty; Subsidies phase out at 200% of poverty; BCBS standard benefits

Broad-Based Low-Income Voucher Program

- **Who Is Eligible?** All families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

- **What Benefits Would They Receive?** Two options were considered:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government generally would provide all of the premium subsidies. If Medicaid is integrated into the voucher program, state and local governments would make maintenance of effort payments toward the cost of premium subsidies.

Range of Program Options	
Lower Cost Option: $450 Billion	Full subsidies to families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $720 Billion	Full subsidies to families below 100% of poverty: Subsidies phase out at 200% of poverty; BCBS standard benefits.

Note: Options assume that Medicaid population remains covered by the Medicaid program.

Extension of Medicaid Benefits For Welfare Recipients That Go To Work

- **Who Is Eligible?** Families that lose AFDC benefits when working (increased earnings place them over the AFDC eligibility thresholds). Today such families can receive up to 1 year of transitional Medicaid coverage after leaving AFDC. The proposal extends this to two years of Medicaid coverage.

- **What Benefits Would They Receive?** Those eligible would receive an additional year of Medicaid benefits.

- **How Much Would Eligible Families Pay?** Like today's Medicaid program, eligible families would not pay toward the cost of coverage.

- **How Much Would The Federal Government Pay?** The program would use the existing Medicaid matching formula. On average, the federal government pays approximately 57% of program costs, with states and local governments paying 43%

Coverage for the Unemployed Uninsured

- **Who Is Eligible?** All families with incomes below a specified poverty level that have a head of household or spouse who is unemployed and receiving unemployment compensation at least one month during the year. The family is not eligible if the spouse of an unemployed person is receiving employer-sponsored insurance and the employer is contributing at least 80% toward the premium.

- **What Benefits Would They Receive?** A benefit package similar to the Blue Cross/Blue Shield standard option for up to 6 months.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 250% of poverty). Families between poverty and 250% of poverty will pay according to a sliding fee scale. For purposes of the program, income is computed on a monthly basis and excludes unemployment compensation and other transfers (e.g., AFDC payments).

- **How Much Would The Federal Government Pay?** The federal government would provide all of the premium subsidies.

State Flexibility Option

- **Who Is Eligible?** States that develop programs to extend coverage to currently uninsured populations would be eligible for federal financial assistance. States would have flexibility, within broad federal guidelines, in determining how to expand coverage and which segments of the population to cover.

  The federal government would provide matching funds to state programs for expenditures made on behalf of families that have incomes below a specified income level (e.g., 150% - 200% of poverty). Families eligible for Medicaid would not be eligible for matching payments under this program.

- **What Benefits Would They Receive?** Two options under consideration:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

  States could be given flexibility be determining the level of benefits under the program. Federal matching payments would be capped at a designated benefit level.

- **How Much Would Eligible Families Pay?** States would be permitted to determine the premium payments and subsidy schedule for program participants, within broad federal parameters.

- **How Much Would the Federal Government Pay?**

  The federal government would match expenditures made by state programs to cover eligible populations. To encourage states to extend coverage as broadly as possible, federal matching payments might be provided on a progressive basis -- states that cover a higher percentage of their currently uninsured population would receive a higher matching rate.

  To assure that the costs of the program remain reasonable, the program would be established as a capped entitlement to states. Additional limitations would also be necessary to prevent gaming by states (e.g., tax and donation schemes; shifting people from Medicaid to the new program to get a higher matching rate).

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....

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 Midsession Estimates)	–167.1	–179.2	–190.0	–191.8	–207.4	N/A	N/A	N/A	N/A	N/A		
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

Possible Options and their Costs

~~Subsidy~~ Coverage Options	Billions of Net Subsidy Dollars, 1996-2005						
	30-60	120	150	200	310	410	550-815
Welfare to Work	X						
Unemployed	X						
Kids Only	X	X	X				
Working Families					X	X	X
Broad, Low Income Voucher						X	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 extending the current 25% deduction from 1/1/94 to one that also increases the deduction to 100% on 1/1/95.

The high end of the long term care options is ~~range from~~ the capped entitlement in the Mitchell bill, and the range includes ~~to something smaller,~~ ~~and also include~~ 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. Twenty-five percent of this program is ~~25%~~ financed by an increase in the Part B premium.

Previously Proposed Sources of Funding

	1996-2000		1996-2005	
	Medicare	Total	Medicare	Total
(Ways and 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 Bipartisan Medicare Savings	34	58	139	195
(W/M) Tobacco + OBRAs + Additional Bipartisan Medicare Savings + Mainstream Medicare Savings	73	97	256	312
Tobacco + OBRAs + Additional Bipartisan Medicare + Net Mainstream Medicare + Previously Bipartisan Supported ~~Other~~ 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

Previously Proposed

TABLE 2.
ESTIMATED CBO SCORING of MEDICARE SAVINGS PROPOSALS
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).

BUDGET DEFICITS AND ESTIMATED CBO SCORING OF MEDICARE SAVINGS PROPOSALS

Fiscal Years, Dollars in Billions
1995-2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2004
DEFICIT	-167.1	-179.2	-190.0	-191.8	-207.4							
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 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	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 (not cleared by OMB)	2.5	8.1	13.9	17.5	25.1	33.6	42.2	53.2	66.2	80.1	67.1	342.3

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Potential Sources of Funding

	1996-2000		1996-2005	
	Medicare	Total	Medicare	Total
Tobacco Tax ($0.45 per pack)	0		0	
Tobacco + OBRA '93 - I	10		66	
Tobacco + OBRA '93-I + OBRA '93-II	20		96	
Tobacco + OBRAs + Additional Medicare Savings:	34		139	
Tobacco + OBRAs + Additional Medicare Savings + Mainstream Medicare Savings	73		256	
Tobacco + OBRAs + Additional Medicare + Net Mainstream Medicare + Change in Cafeteria Plans + Tax Cap	73		256	

AGENDA

I. Opening Remarks

II. Discussion of Strategic Political Policy Questions

III. General Presentation of Deficit Coverage and Financing Ranges

IV. Communications Strategy

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 Midsession 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:

- o 10 year estimates will include an additional year, 2005
- o Medicare and Medicaid baselines will be reestimated by both CBO and OMB
- o 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.

Expansion of Coverage to Kids

- **Who Is Eligible?** Children under a specified age (e.g., 19) who were not covered by a private insurance plan during the 6 months prior to their enrollment. Children are not eligible if their parents have access to employer-sponsored insurance where the employer pays at least 80% of dependent coverage are not eligible.

- **What Benefits Would They Receive?** We have examined two options.

  Option 1. Eligible children would receive the Medicaid package available in their state.

  Option 2. Blue Cross/Blue Shield Standard Option (FEHBP)

- **How Much Would Eligible Children Pay?** Eligible children in families with incomes below a designated income level (e.g., 185% of poverty) would be fully subsidized. Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 300% of poverty).

- **How Much Would the Federal Government Pay?**

  Option 1. Under the Medicaid option, the federal government would share the costs with states and local governments using the existing federal Medicaid matching formula.

  Option 2. The federal government would provide all of the premium subsidies.

- **Other Program Features**. To discourage employers from dropping dependent coverage for lower income workers, a limited nondiscrimination provision may be needed. For example, employers could be prohibited from limiting dependent coverage to only a portion of full-time employees.

Range of Program Options	
Lower Cost Option: $30 Billion	Cover children under age 6; Full subsidies up to 185% of poverty; subsidies phase out at 300% of poverty; BC/BS benefits.
Higher Cost Option: $140 Billion	Cover children under age 19; Full subsidies up to 185% of poverty; subsidies phase out at 300% of poverty; Medicaid benefits.

Voucher Program for Working Families

- **Who Is Eligible?** All working families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

  Eligibility would be based on a family's work history; families that average at least 15 hours of work per week, or 390 hours in the previous 6 months would be eligible for the program.

  For the self-employed, eligibility is based on earning a specific level of self-employed earnings in a quarter (or in the previous two quarters). Families eligible for medical assistance under a State's Medicaid program would not be eligible for subsidies under this program.

- **What Benefits Would They Receive?** Two options were considered:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government would provide all of the premium subsidies.

Range of Program Options	
Lower Cost Option: $290 Billion	Full subsidies to working families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $470 Billion	Full subsidies to working families below 100% of poverty: Subsidies phase out at 200% of poverty; BCBS standard benefits

Broad-Based Low-Income Voucher Program

- **Who Is Eligible?** All families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

- **What Benefits Would They Receive?** Two options were considered:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government generally would provide all of the premium subsidies. If Medicaid is integrated into the voucher program, state and local governments would make maintenance of effort payments toward the cost of premium subsidies.

Range of Program Options	
Lower Cost Option: $450 Billion	Full subsidies to families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $720 Billion	Full subsidies to families below 100% of poverty: Subsidies phase out at 200% of poverty; BCBS standard benefits

Note: Options assume that Medicaid population remains covered by the Medicaid program.

Extension of Medicaid Benefits For Welfare Recipients That Go To Work

- **Who Is Eligible?** Families that lose AFDC benefits when working (increased earnings place them over the AFDC eligibility thresholds). Today such families can receive up to 1 year of transitional Medicaid coverage after leaving AFDC. The proposal extends this to two years of Medicaid coverage.

- **What Benefits Would They Receive?** Those eligible would receive an additional year of Medicaid benefits.

- **How Much Would Eligible Families Pay?** Like today's Medicaid program, eligible families would not pay toward the cost of coverage.

- **How Much Would The Federal Government Pay?** The program would use the existing Medicaid matching formula. On average, the federal government pays approximately 57% of program costs, with states and local governments paying 43%

Coverage for the Unemployed Uninsured

- **Who Is Eligible?** All families with incomes below a specified poverty level that have a head of household or spouse who is unemployed and receiving unemployment compensation at least one month during the year. The family is not eligible if the spouse of an unemployed person is receiving employer-sponsored insurance and the employer is contributing at least 80% toward the premium.

- **What Benefits Would They Receive?** A benefit package similar to the Blue Cross/Blue Shield standard option for up to 6 months.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 250% of poverty). Families between poverty and 250% of poverty will pay according to a sliding fee scale. For purposes of the program, income is computed on a monthly basis and excludes unemployment compensation and other transfers (e.g., AFDC payments).

- **How Much Would The Federal Government Pay?** The federal government would provide all of the premium subsidies.

State Flexibility Option

- **Who Is Eligible?** States that develop programs to extend coverage to currently uninsured populations would be eligible for federal financial assistance. States would have flexibility, within broad federal guidelines, in determining how to expand coverage and which segments of the population to cover.

  The federal government would provide matching funds to state programs for expenditures made on behalf of families that have incomes below a specified income level (e.g., 150% - 200% of poverty). Families eligible for Medicaid would not be eligible for matching payments under this program.

- **What Benefits Would They Receive?** Two options under consideration:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

  States could be given flexibility be determining the level of benefits under the program. Federal matching payments would be capped at a designated benefit level.

- **How Much Would Eligible Families Pay?** States would be permitted to determine the premium payments and subsidy schedule for program participants, within broad federal parameters.

- **How Much Would the Federal Government Pay?**

  The federal government would match expenditures made by state programs to cover eligible populations. To encourage states to extend coverage as broadly as possible, federal matching payments might be provided on a progressive basis -- states that cover a higher percentage of their currently uninsured population would receive a higher matching rate.

  To assure that the costs of the program remain reasonable, the program would be established as a capped entitlement to states. Additional limitations would also be necessary to prevent gaming by states (e.g., tax and donation schemes; shifting people from Medicaid to the new program to get a higher matching rate).

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

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- **Who Is Eligible?** Children under a specified age (e.g., 19) who were not covered by a private insurance plan during the 6 months prior to their enrollment. Children are not eligible if their parents have access to employer-sponsored insurance where the employer pays at least 80% of dependent coverage are not eligible.

- **What Benefits Would They Receive?** We have examined two options.

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  Option 2. Blue Cross/Blue Shield Standard Option (FEHBP)

- **How Much Would Eligible Children Pay?** Eligible children in families with incomes below a designated income level (e.g., 185% of poverty) would be fully subsidized. Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 300% of poverty).

- **How Much Would the Federal Government Pay?**

  Option 1. Under the Medicaid option, the federal government would share the costs with states and local governments using the existing federal Medicaid matching formula.

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- **Other Program Features.** To discourage employers from dropping dependent coverage for lower income workers, a limited nondiscrimination provision may be needed. For example, employers could be prohibited from limiting dependent coverage to only a portion of full-time employees.

Range of Program Options	
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Higher Cost Option: $140 Billion	Cover children under age 19; Full subsidies up to 185% of poverty; subsidies phase out at 300% of poverty; Medicaid benefits.

Voucher Program for Working Families

- **Who Is Eligible?** All working families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

  Eligibility would be based on a family's work history; families that average at least 15 hours of work per week, or 390 hours in the previous 6 months would be eligible for the program.

  For the self-employed, eligibility is based on earning a specific level of self-employed earnings in a quarter (or in the previous two quarters). Families eligible for medical assistance under a State's Medicaid program would not be eligible for subsidies under this program.

- **What Benefits Would They Receive?** Two options were considered:

  <u>Option 1</u>. The Blue Cross/Blue Shield standard option.

  <u>Option 2</u>. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government would provide all of the premium subsidies.

Range of Program Options	
Lower Cost Option: $290 Billion	Full subsidies to working families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $470 Billion	Full subsidies to working families below 100% of poverty: Subsidies phase out at 200% of poverty; BCBS standard benefits

Broad-Based Low-Income Voucher Program

- **Who Is Eligible?** All families with incomes below a specified poverty level would be eligible for federal assistance. For example, the poverty cut-off for subsidy eligibility could be 150% or 200% of poverty.

- **What Benefits Would They Receive?** Two options were considered:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 75% - 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 150% - 200% of poverty).

- **How Much Would the Federal Government Pay?** The federal government generally would provide all of the premium subsidies. If Medicaid is integrated into the voucher program, state and local governments would make maintenance of effort payments toward the cost of premium subsidies.

Range of Program Options	
Lower Cost Option: $450 Billion	Full subsidies to families below 100% of poverty; Subsidies phase out at 200% of poverty; Catastrophic (or ambulatory) benefit.
Higher Cost Option: $720 Billion	Full subsidies to families below 100% of poverty: Subsidies phase out at 200% of poverty; BCBS standard benefits.

Note: Options assume that Medicaid population remains covered by the Medicaid program.

Extension of Medicaid Benefits For Welfare Recipients That Go To Work

- **Who Is Eligible?** Families that lose AFDC benefits when working (increased earnings place them over the AFDC eligibility thresholds). Today such families can receive up to 1 year of transitional Medicaid coverage after leaving AFDC. The proposal extends this to two years of Medicaid coverage.

- **What Benefits Would They Receive?** Those eligible would receive an additional year of Medicaid benefits.

- **How Much Would Eligible Families Pay?** Like today's Medicaid program, eligible families would not pay toward the cost of coverage.

- **How Much Would The Federal Government Pay?** The program would use the existing Medicaid matching formula. On average, the federal government pays approximately 57% of program costs, with states and local governments paying 43%

Coverage for the Unemployed Uninsured

- **Who Is Eligible?** All families with incomes below a specified poverty level that have a head of household or spouse who is unemployed and receiving unemployment compensation at least one month during the year. The family is not eligible if the spouse of an unemployed person is receiving employer-sponsored insurance and the employer is contributing at least 80% toward the premium.

- **What Benefits Would They Receive?** A benefit package similar to the Blue Cross/Blue Shield standard option for up to 6 months.

- **How Much Would Eligible Families Pay?** The premium would be fully subsidized for eligible families with incomes below a designated income level (e.g., 100% of poverty). Subsidies would phase-out on a sliding scale for families with higher incomes (e.g., up to 250% of poverty). Families between poverty and 250% of poverty will pay according to a sliding fee scale. For purposes of the program, income is computed on a monthly basis and excludes unemployment compensation and other transfers (e.g., AFDC payments).

- **How Much Would The Federal Government Pay?** The federal government would provide all of the premium subsidies.

State Flexibility Option

- **Who Is Eligible?** States that develop programs to extend coverage to currently uninsured populations would be eligible for federal financial assistance. States would have flexibility, within broad federal guidelines, in determining how to expand coverage and which segments of the population to cover.

  The federal government would provide matching funds to state programs for expenditures made on behalf of families that have incomes below a specified income level (e.g., 150% - 200% of poverty). Families eligible for Medicaid would not be eligible for matching payments under this program.

- **What Benefits Would They Receive?** Two options under consideration:

  Option 1. The Blue Cross/Blue Shield standard option.

  Option 2. A catastrophic (high deductible) plan, or alternatively coverage for ambulatory care services with 5 days of inpatient hospital care.

  States could be given flexibility be determining the level of benefits under the program. Federal matching payments would be capped at a designated benefit level.

- **How Much Would Eligible Families Pay?** States would be permitted to determine the premium payments and subsidy schedule for program participants, within broad federal parameters.

- **How Much Would the Federal Government Pay?**

  The federal government would match expenditures made by state programs to cover eligible populations. To encourage states to extend coverage as broadly as possible, federal matching payments might be provided on a progressive basis -- states that cover a higher percentage of their currently uninsured population would receive a higher matching rate.

  To assure that the costs of the program remain reasonable, the program would be established as a capped entitlement to states. Additional limitations would also be necessary to prevent gaming by states (e.g., tax and donation schemes; shifting people from Medicaid to the new program to get a higher matching rate).

DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
1500 PENNSYLVANIA AVENUE, NW
WASHINGTON, DC 20220

Number of pages to follow: 5 Date: November 8, 1994

To: Chris Jennings

Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5585

From: Eric J. Toder
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-0646

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

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DEPARTMENT OF THE TREASURY
WASHINGTON

November 8, 1994

MEMORANDUM FOR NANCY-ANN MIN
ASSOCIATE DIRECTOR FOR HEALTH
OFFICE OF MANAGEMENT AND BUDGET

FROM: **ERIC TODER**
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: **Revenue Estimates of Health Reform Proposals for NEC-DPC Meetings**

Chris Jennings (White House) requested revenue estimates of several health reform proposals to be presented at the upcoming NEC and DPC meetings on health reform. The Office of Tax Analysis was asked to prepare estimates of the following proposals:

- The change in individual income and payroll taxes as a consequence of providing subsidies for health insurance to low-income families.
- Extending and expanding the self-employed health insurance deduction.
- An increase in the cigarette tax by 45 cents-per-pack to 69 cents, phased-in over a five-year period (the Ways and Means proposal).
- Restricting employer contributions for health insurance through cafeteria plans and capping the exclusion for health insurance contributions.

Subsidies: At the meetings, the NEC will be shown several alternative approaches to providing subsidies to low-income families. At this time, two alternative models for providing subsidies to cover a large number of uninsured families have emerged:

- Broad, income-based subsidies for families with incomes of up to 200 percent of poverty.
- A "kids-first" policy, which would provide vouchers for children in families with incomes of up to 300 percent of poverty.

Options for providing additional assistance for welfare recipients entering the workforce and for the unemployed have also been prepared by HHS and OMB, but do not have significant implications for revenues.

There are subtle differences in the design and estimation of the two subsidy models which affect their costing. Although the "kids-first" subsidies would extend to families with higher incomes than the broad, income-based subsidies, other restrictions on eligibility restrain the costs of child vouchers. For example, eligibility for the "kids-first" subsidy would be limited to children who have not been covered by a private insurance plan in the past six months. Moreover, parents would not be eligible if their employer contributed at least 80 percent of the cost of dependent coverage. Neither of these restrictions were specified for the broad, income-based subsidy options. When estimating the "kids-first" subsidy options, the modelers were instructed to assume that, at most, one-third of employers would drop coverage of their workers' children in order to entitle their workers to subsidies. In contrast, the specifications for the broad, income-based subsidy programs do not include such restrictions on eligibility, and the subsidies were assumed to displace most employer contributions for workers eligible for the subsidies.

Both subsidy designs would also have implications for revenues. Under the broad-based income subsidy, employers would be able to reduce their contributions for health insurance, without penalty, for their low-income workers. As employer contributions are reduced, workers would receive increases in their taxable money wages, causing individual income and payroll taxes to increase. According to OTA estimates, individual income and payroll taxes would increase by $32 to $44 billion over the next ten years, depending on the specification of the proposal. With fewer employers reducing coverage under the kids-first subsidy options, revenues would increase by only about $6 billion over the next ten years.

<u>Self-employed health insurance deduction:</u> OTA was also asked to provide a range of estimates to expand and extend the health insurance deduction for self-employed workers. Under the less aggressive option, the deduction for 25 percent of the costs of health insurance for self-employed workers would be permanently extended, beginning with 1994 liabilities, at a cost of $8.8 billion between FY 1995 and 2005 ($3.8 billion between FY 1995 and 2000). Alternatively, the 25 percent deduction could be extended for 1994, and then increased to 100 percent for 1995 and thereafter. This option would cost $35.1 billion between FY 1995 and 2005 ($14.3 billion between FY 1995 and 2000).

<u>Tobacco taxes:</u> The NEC may also be shown a table which provides some lower- and upper-bounds on the amount of funding available to finance new subsidies for low-income families. The first revenue item on the list will be the tobacco tax increase, as specified in the Ways and Means bill. Under the Ways and Means bill, the cigarette tax would be increased by 45 cents-per-pack to 69 cents per pack, phased-in over a five-year period. The option also includes comparable proportional increases in taxes on other tobacco products. According to OTA, the proposal would raise $23.7 billion between FY 1996 and 2000 and $55.6 billion between FY 1996 and 2005. These estimates are based on mid-session economic assumptions and thus are slightly lower from previous estimates of similar proposals. In addition, we have assumed that the effective date for the excise tax increase would be October 1, 1995 (instead of August 1, 1995), with full implementation of the 45 cent increase occurring by January 1, 1999. Note that CBO's estimates of a comparable increase in the tobacco tax are likely to be about $6

billion higher.

<u>Restricting employer contributions for cafeteria plans and capping the exclusion for employer provided health insurance:</u> Estimates of changes in either the tax treatment of cafeteria plans or employer contributions for health insurance will depend greatly on other aspects of the health reform package. For example, an option which would restrict the tax preference to employer contributions for the standard benefit package could raise either negligible or significant revenues, depending on the generosity of the standard benefit package. As a consequence, we are providing a broad, but reasonable, range of estimates which will give a lower and upper boundary on the amounts of revenues to be expected from these proposals. Further, we note that the estimates of the proposals are also highly dependent on design aspects of the tax cap proposals and the treatment of existing collective bargaining agreements. At this time, we would suggest that a reasonable range, for estimates of cafeteria plan and tax cap proposals, would be from $35 to $55 billion over the next ten years.

Attachments

cc: Nichols

Indirect Effect on Receipts
of Several Proposals to Provide Subsidies to Lower Income Families
For the Purchase of Health Insurance

Effective: 01/01/97

(Fiscal Years, $ Billions)
Changes From Current Law

Estimates For Broad Subsidies Based on Urban Subsidy Path, OMB shares to obtain Private ESI 1/
Estimates for Children Subsidies Based on OMB Estimates of Total Subsidies for "Kids First" and OTA Allocation 2/

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1995-2000	Total 1995-2005
Proposal:													
Broad Based Subsidies													
Standard Benefit with Medicaid in Community Rate	-	-	2.7	3.9	4.1	4.4	4.7	5.0	5.4	5.7	6.1	15.1	42.1
Standard Benefit with Medicaid out of Community Rate	-	-	2.2	3.0	3.2	3.5	3.7	4.0	4.3	4.6	4.8	11.9	33.4
Ambulatory Benefit with Medicaid in ...	-	-	2.8	4.0	4.3	4.6	4.9	5.2	5.6	6.0	6.4	15.8	43.9
Ambulatory Benefit with Medicaid out ...	-	-	2.1	3.0	3.2	3.4	3.6	3.8	4.1	4.4	4.7	11.6	32.2
Children Only Subsidy													
Standard Benefit with Medicaid out of Community Rate	-	-	0.4	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8	2.2	5.8
Welfare to Work	-	-	*	*	*	*	*	*	*	*	*	*	*
Subsidies for the Unemployed	-	-	*	*	*	*	*	*	*	*	*	*	*

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Note: An * denotes negligible effect on receipts under standard assumptions.
A – denotes that no estimate is provided because the provision isn't applicable to that year or that proposal.

1/ Family subsidies estimated by Urban (via OMB), OMB shares for persons who currently have ESI, form base to which OTA marginal rates are applied.
2/ Total subsidies from OMB allocated to persons who currently have employer contribution using OMB assumption of 33% erosion and OTA potential share of subsidies going to families with current contribution.

Estimates of Selected Health Reform Options
(FY; $ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1995-2000	1995-2005
Deduction for Health Insurance Costs for Self-employed													
Extend 25% Deduction for Tax Years 1/1/94 and beyond	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2	-3.8	-8.8
Extend 25% Deduction for Tax Year 1/1/94 and Increase Deduction to 100% 1/1/95	-0.9	-2.2	-2.4	-2.7	-2.9	-3.2	-3.5	-3.8	-4.1	-4.5	-4.8	-14.3	-35.1
Tobacco Tax													
Phase-in $.45 increase in Cigarette Tax: $.15 10/1/95; $.25 1/1/97; $.35 1/1/98; $.45 1/1/99	--	2.5	3.5	4.9	6.2	6.6	6.5	6.4	6.4	6.3	6.3	23.7	55.6

Department of the Treasury
Office of Tax Analysis

November 8, 1994

HEALTH CARE WORKPLAN

1. Expanding Access to Health Care

Employment Transition Insurance: We are updating cost estimates and distributional analysis of the insurance program for workers who are between jobs that is in the President's balanced budget proposal. We will have new estimates by the end of next week.

Kids Coverage: We are providing technical assistance on the Democratic "Kids Only" initiative. We are also reviewing our own proposal to increase coverage for children and will have more detail and initial estimates by the end of next week.

Purchasing Cooperatives: In any new health care announcement, we can highlight the proposal in the President's budget to provide technical and financial assistance to states to set up purchasing cooperatives and to empower states to require FEHBP plans to participate in these cooperatives. We are also planning to set up a meeting with OPM next week to pursue other options.

2. Focusing on Prevention and Investment in Research and Development

New Preventive Benefits in Medicare: In any new health care announcement, we can highlight the preventive benefits (e.g., mammography, colorectal screening, diabetes management) in the President's balanced budget.

Tobacco: In any new health care announcement, we can highlight the President's anti-smoking initiatives.

Biomedical Research: We can highlight our continuing commitment to investment in research which has great potential to prevent disease, save lives and decrease health care costs.

3. Protecting Health Care Consumers

Appropriate Regulation of Managed Care: We can highlight upcoming regulations that will be implemented on January 1, 1997 to monitor and improve the quality of managed care plans in Medicare and Medicaid. We can also develop proposals to increase quality regulation in the private sector (building on our support for 48 hour discharge legislation.) We are looking at models in California.

Fraud and Abuse: We will begin developing a proposal to combat fraud and abuse through use of the internet. We can also highlight the anti-fraud and abuse provisions in the Kassebaum-Kennedy bill.

4. Simplifying the Health Care System

We can highlight what the Administration has done already to reduce paperwork and other regulatory burdens in Federal programs and to make Federal programs more understandable for beneficiaries. We also believe we can support the provisions in Kassebaum-Kennedy to simplify the private health care sector.

5. Reforming Medicare and Medicaid

We should continue to emphasize the progress we have already made to reform Medicare and Medicaid without legislation as well as the provisions in the President's balanced budget proposal.