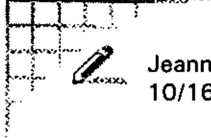
NLWJC - Kagan

DPC - Box 029 - Folder 002

Health - Home Health Care

health - home health



Jeanne Lambrew
10/16/98 09:12:07 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Melissa G. Green/OPD/EOP, Charles R. Marr/OPD/EOP
Subject: Status of Medicare Home Health

From Chris Jennings & Jeanne

As you all know, the Republicans have been pushing us to accept their proposal to fix the Medicare home health payment system problem with a set of offsets that includes increasing the income limits on Roth IRA rollovers. Per the senior staff discussion this morning, we were told that the Roth IRA provision is totally unacceptable. We subsequently worked with Treasury to develop several alternative financing packages to offer the Republicans as a substitute for the Roth IRA financing. We developed three packages, in consultation with Hill Democratic leadership and authorizing committtee staff:

1. **"Cats and Dogs"**: This includes 7 relatively non-controversial tax offsets that have appeared in other bills and have not yet been used.

2. **Limiting enrollment in the Medicare MSA demonstration:** This is basically free money, since no one is signing up for this demonstration that the Republicans insisted on including in the BBA.

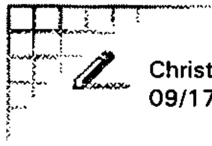
3. **Limiting MSA plus some cats and dogs:** This option increases the amount of savings that can be spent on helping home health agencies a little more. (While the home health fixes are generally accepted, some members from rural state (e.g., Grassley) are unhappy with the proposal -- extra funds can help solve this problem).

Chris and John Tallisman from Treasury briefed Bill Thomas and key Republican staff on these alternatives, and expressed our opposition to their offset. The conversations went well, but as predicted, Mr. Thomas said that the MSA provision was to him what the Roth IRA provision is to us. However, he was open to considering the cats and dogs. He did push us on whether we could support their other tax offset: a provision that changes the tax treatment of winnings from gambling and the lottery. This is a short term saver, but, depending on how it is structured, can cost in the out years. Treasury has not yet developed a position on this policy, but it looks like a compromise may involve this particular offset.

Thus, the ball is back in the Republicans' court. Mr. Thomas was going to canvas the House Ways & Means committee, and the Senate Finance tax people were going to closely look at the offsets. Meanwhile, our Democrats appear pleased with the way this process has unfolded to date and have been supportive of our objection to the Roth IRA. As a note, the major home health agency organization wrote a letter today objecting to the offset as well.

We will let you know if we have any news over the weekend.

health - home health care



Christopher C. Jennings
09/17/98 08:03:01 PM

Record Type: Record

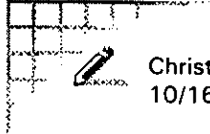
To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP, Laura Emmett/WHO/EOP

cc:
Subject: home health

Tomorrow morning, the Ways and Means Committee is scheduled to mark-up its home health proposal. HCFA will be in attendance to represent the Administration.
If all goes according to rumor, Congressman Thomas will pay for his $1.4 billion proposal from the surplus. Although we will say nice things about the policy, we will oppose the financing source. Moreover, we will not commit to any specific Medicare savings offset to pay for this, or any other, home health care proposal.

cj

Health - home health care



Christopher C. Jennings
10/16/98 01:51:46 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: See the distribution list at the bottom of this message
Subject: home health care fix

Last night (Thursday), the Congressional Republicans, on a bicameral basis, agreed on a compromise proposal designed to address concerns about the impact of BBA home health reimbursement reforms on the industry. They are asking that we agree to expedite review of their proposal, support it, and agree to place it on the omnibus spending bill. We need to develop our response to their proposal as soon as possible (sometime early today), so that we cannot be blamed for holding up or killing an extremely popular health policy initiative.

Background. Responding to the home health care industry has been the number one health care priority of numerous Members of Congress. Without question, the White House, OMB and HHS has received more direct inquiries from Members of Congress on this issue than any other health care issue -- including the Patients' Bill of Rights. Democrats have been even more agressive about addressing this problem than have Republicans. In addition, besides a massive campaign by the home health care industry, the aging advocates are starting to raise concerns about potential access problems to beneficiaries. In short, the Congress feels great pressure to act and members of both parties want it "fixed" before they leave town.

Last week, over 400 House Members voted out a Ways and Means Committee proposal that, by any definition, was severely flawed policy and included severely problematic financing. It used as its sole offset for the $2 billion policy fix to raise the BBA-set income limits on Roth IRA rollovers. Although this proposal paid for the 5-year, $2 billion cost, it lost over $10 billion in the second 5 years (as more higher income individuals were assumed to benefit from the tax-free treatment of future withdrawals.)

The Senate Finance Committee -- on a bipartisan basis -- agreed on an alternative home health package that was better policy, dropped the Roth IRA financing mechanism, and used more palatable savings proposals. (It did have a $300 million paygo problem, however.) At any rate, despite trying to bring this bill up to try to initiate a joint House/Senate conference, Senator Gramm (and perhaps others) objected to bringing the bill up under a U.C. agreement. As a result, the Senate Republican Leadership grew increasingly frustrated that they were going to be blamed for letting this die on their footsteps.

In response, Lott ordered his Republican Finance Committee Members yesterday to work out an agreement with the House Republicans (Thomas and Bilirakis). It was (and apparently still is) his hope to work with the White House to place their work product on the omnibus spending bill. At worst, he wants to be able to blame the White House for opposing a viable option that has every potential to gain large support from the home health agencies and advocates, as well as many Democratic Members of Congress.

The Republican Alternative. The alternative the Republicans produced last night is administratively

workable and generally defensible home health policy. It delays by one year the implementation of the new prospective payment system and its 15 percent payment cut, and it helps address geographic disparities that have been viewed as unfair. The proposal's major problem relates to its reliance on a three-part financing mechanism, particularly those two dealing with revenue raisers. The first and most acceptable financing source is a 5-year, $900 million cut in the out-year payments for home health care. Second, the Republicans propose to include a version of the McCreary gambling provision, which reportedly raises$250 million by modifying the tax treatment of prizes and awards. (Although this proposal has some notable bipartisan support, it is flawed because it is a revenue loser in the second 5 years.) And finally, and most controversial, is their proposal to reinstate a modified (and more modest) Roth IRA 5-year $500 million proposal.

On a policy basis, theTreasury Department, OMB, NEC, DPC and others continue to strongly oppose the Roth IRA provision. Not only does it violate last year's carefully constructed BBA compromise, it loses revenue in the out-years, it benefits only the wealthy, and sets a likely and unstopable precedence for future modifications to the BBA Roth IRA agreement.

It is important to point out, however, that unlike the original House proposal, the newest Republican Roth IRA alternative does not lose any revenue until the 7th year and over 10 years appears to lose about only 10 percent of the original proposal -- about $1.7 billion. This revenue loss is offset by the outyear savings associated with the home health payment cut, leaving the proposal budget neutral over 10 years. (After 10 years, the proposal almost inevitably will not be budget neutral.)

Democrats Reaction to Republican Proposal. Not surprisingly, the Democratic Leadership and Committees, who were completely excluded from the development of the Republican alternative, do not support the Republican alternative. They -- like us -- have particular problems with the Roth IRA provision. The do believe, however, that we must produce an viable alternative if we explicitly oppose the Republican proposal. As such, we developed one last evening that retains the Republicans' home health policy. However, it also drops the two Republican revenue raisers and substitutes a 100,000 participant cap on the Medicare Medical Savings Account (MSA) demonstration. (This raises about $800 million over 5 years.) We talked about other options, but the offsets were either politically unrealistic or too small to deal with the problem.

Potential Political Problem with Democratic Alternative. Although the Democratic Leadership supports the alternative we developed last night, they cannot and would not give any commitment that even a majority of Democrats would be supportive of this effort. (This is a particular problem in the House.) Many of their rank and file members truly do not want to leave town without a home health care fix and they might well support the Republican alternative for two reasons. First, they may well not particularly mind the downsized Roth IRA provision; it will look to them that it is much more modest than what they previously supported and it raises money for home health care by "lowering" taxes. Second, they and their home health care validators may conclude that our alternative -- although more fiscally responsible -- is not viable politically and is simply political cover for a policy that can never pass. As a consequence, the President -- (who has said he would like to address the home health care concerns) -- could be blamed by members of our own party and certainly the home health care community for not responding to an "urgent health care crisis."

Options/Dilemas. Because of the Democratic interest in being proactive on home health care (and the Republicans' desire to blame us for not producing), we need to move quickly to develop our strategy to respond to the Republican proposal. It appears likely that we will not want to immediately accept the Republican alternative. We certainly could counter with the Democratic "MSA" proposal we developed last night. However, we should recognize it will likely be rejected as unrealistic and partisan. Any subsequent discussion (that is viewed as credible and sincere) might well lead to something close to what the Republicans want. (This is because the potential Democratic and home health care support they may attract may well give them more leverage than

us to advocate for a final agreement.) Conversely, if we do not engage with them on this issue at all, it may be all the more easy for them to label us as the "terminators" of the "desperately needed" home health care fix.

As always, however, time may be on our side. One option could be to offer our alternative and start a negotiating process that we commit to staying at until we can work out an acceptable agreement. The downsides of this approach are that omnibus spending bill would probably not be viable and virtually anyone could kill it on almost any other conceivable legislative vehicle.

Sorry I offer no easy solutions. Hope this background is helpful. We await your guidance. Thank you.

Message Sent To:

Erskine B. Bowles/WHO/EOP
John Podesta/WHO/EOP
Maria Echaveste/WHO/EOP
Jacob J. Lew/OMB/EOP
Gene B. Sperling/OPD/EOP
Bruce N. Reed/OPD/EOP
Lawrence J. Stein/WHO/EOP
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Janet Murguia/WHO/EOP
Charles M. Brain/WHO/EOP
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Message Copied To:

Kevin S. Moran/WHO/EOP
Dawn L. Smalls/WHO/EOP
/WHO/EOP
Jessica L. Gibson/WHO/EOP
Mindy E. Myers/WHO/EOP
Sandra L. Via/OMB/EOP
Laura Emmett/WHO/EOP

health-home health care (and) health-assisted suicide

HealthMATTERS

Fighting Medicare Fraud: Easier Said Than Done

By Julie Rovner

■ IT SOUNDS SO EASY. Just get rid of the fraud in Medicare and we could save as much as 10 percent of the massive program's annual spending, auditors say. But in practice, it always seems to get messy.

A case in point is the fix Congress now finds itself in over Medicare's home health benefit. Long near the top of the Medicare fraud and abuse rogues' gallery, Congress took tough steps in the 1997 Balanced Budget Act to bring home health spending back in line.

But cracking down on the bad guys always seems to hurt good guys, too. For example, Congress originally required home health agencies to post "surety bonds" to prevent fly-by-night agencies from setting up shop, collecting a lot of money and skipping town. But almost immediately agencies began complaining that the bonds were too expensive or too difficult to obtain. Congress and the Health Care Financing Administration quickly backed down on the surety bond requirement.

Now the problem is the new payment system the 1997 act imposed. What was supposed to be a temporary system, to be replaced with a "prospective payment" system similar to how Medicare pays hospitals, now may have to stay in place longer — thanks to HCFA's year 2000 computer problems. But the "Interim Payment System," which bases payment on 1994 spending, penalizes those who acted efficiently back then, particularly if they are now serving sicker patients.

There is significant dispute over just how bad the situation is — whether only a few hundred agencies have closed their doors, or 1,200 as the industry's trade group, the National Association for Home Care contends. But home care has indisputably become a political problem. Most members of both the House and Senate have cosponsored at least one of more than a dozen bills to alter the payment system, and last week a demonstration on the Capitol's West Front featured a 2 1/2-mile long petition urging the payment system be fixed.

The bipartisan members who wrote the health section of the BBA have tried — unsuccessfully — to head off changes that would again encourage open-ended spending on home health care. The same day as the demonstration, they issued a CBO estimate that going back to the old payment system would cost more than $20 billion over five years. But on Tuesday, those same members of the Ways and Means Health Subcommittee unanimously approved a bill that would add back at least $1.4 billion in home health payments. And given that it is an election year with a key element of a popular program in peril, that may just represent an opening offer.

■ THE RIFT BETWEEN THE American Medical Association and the congressional GOP leadership continues to widen. Formerly among Republicans' most loyal and generous backers, the AMA has of late been in an ugly war of words with the joint Republican leadership over physicians' endorsement of the Democratic- backed "Patients' Bill of Rights."

Now, organized medicine for the second time this year is opposing a bill being pushed by Republicans at the behest of social conservatives. Back in February, medical groups, the AMA among them, helped block legislation to ban the cloning of humans. The problem with that bill was not its intent — virtually the entire medical community opposes the idea of cloning a human, at least at this point — but rather its potential for "collateral" damage; i.e., inadvertently banning more than cloning.

That is the situation with the Lethal Drug Abuse Prevention Act. The bill, which could reach the House floor as early as today, would make it illegal for physicians to prescribe drugs on the federal government's list of controlled substances for the purpose of assisting in a suicide. Intended at the moment to override Oregon's landmark "Death With Dignity Act," the measure is also an effort by groups opposing assisted suicide to nip the legalization movement in the bud.

But physician groups — led by the AMA — that oppose assisted suicide also oppose the bill. One problem, they say, is that legal controlled substances, including barbiturates and opiate painkillers, are not the only way to assist in a suicide. Assisted suicide physician Jack Kevorkian, for example, has used carbon monoxide — not even a drug, much less a controlled one.

But the heart of the medical community's opposition is survey after survey has shown that many terminal patients die in needless pain because doctors are loathe to prescribe adequate medication. They say the specter of an investigation by the Drug Enforcement Administration is not going to make physicians more likely to use appropriate means to control pain — and could, ironically, make assisted suicide more attractive to the terminally ill.

"We fear the 'real world' consequences of the bill would be to discourage the kind of appropriate aggressive palliative care that can dissuade patients in pain from seeking just such an early death," AMA President-elect Thomas Reardon told the House Judiciary Committee this summer. If the bill is passed, he said, "Recent promising advancements in the care of people at the end of life could be set back dramatically, to the detriment of patient care."

— HEALTHMATTERS CAN BE REACHED BY E-MAIL AT: JROVNER@NJDC.COM

Health

Continued from page 1

brought back a measure he hopes to pass — but also effectively blocked Democratic efforts to bring up the managed care bill. The Senate can spend up to 30 hours on the unamendable motion to proceed. But no debate on the measure took place Wednesday, as Senate leaders tried to regroup.

Just before voting to adjourn, Lott said he intended to put aside the child custody bill Thursday, spend the first part of the day debating and voting on a minimum wage amendment to the bankruptcy bill, and move to a previously scheduled debate on the override of the so-called partial-birth abortion ban.

But **Senate Labor and Human Resources ranking member Edward Kennedy**, D-Mass., sponsor of the minimum wage amendment and a lead backer of the managed care bill, announced he would object, leaving the Senate schedule uncertain.

Still, Democrats were livid that they had been thwarted in their bid to resume the managed care debate.

"The Republicans are afraid of this issue," Daschle told reporters while the Senate GOP leaders were trying to decide how to proceed. "They don't want to have to vote on it."

Kennedy said that despite the nation's preoccupation with President Clinton's problems, the managed care issue is still politically potent.

"There's no diminution of interest on this," Kennedy said. "This is an issue that has enormous resonance all across the country."

Senators also welcomed the president back to the managed care debate.

Clinton is scheduled to highlight the issue for the first time since the release of the Starr report in a speech this morning before the National Brotherhood of Electrical Workers.

Senate Democratic leaders said Wednesday they do not think Clinton has lost his focus on what has been his top domestic priority amidst his troubles.

"There's no question he's very much engaged in this issue, as we are," said Daschle.

Meanwhile, despite some predictions that it is too late for a managed care bill to become law before the end of the session, opponents of the measure are not slowing down.

On Wednesday morning, the American Association of Health Plans brought health researcher John Wennberg to the Capitol to help make their case against provisions in the Democrats' bill that would allow the treating doctor, rather than managed care plans, determine whether a treatment is "medically necessary."

Wennberg, known for his documentation of wide variations in the way doctors practice medicine in different parts of the country, said one way not to improve the quality of care is to let doctors practice as they always have.

"Generally accepted principles of professional medical practice," said Wennberg, "cannot serve effectively as the policy basis for defining medical necessity or appropriateness."

— *By Julie Rovner*

Study Shows HMO Executives' Salaries Rose In 1997

HEALTH

Even as managed care profits declined in 1997, most of the top companies gave their executives raises, according to a study released Wednesday by the consumer group Families USA.

Four of the five highest paid HMO industry executives made more money in 1997 than in 1996, exclusive of unexercised stock options, according to the study of the 15 for-profit publicly traded companies that owned HMOs with more than 100,000 members.

For the second consecutive year, the top earner was Stephen Wiggins of Oxford Health Plans, who earned nearly $31 million in 1997, not including stock options — up from $29 million in 1996.

Wiggins resigned his position in early 1998 after Oxford announced multi-million dollar losses.

According to the study, compiled from records filed with the SEC, the average compensation for the top for-profit managed care companies in 1997 was $2 million.

Average compensation for the 25 highest paid executives was $5.1 million, excluding unexercised stock options.

"The hypocrisy of the industry on the issue of healthcare costs is startling," said Families USA Executive Director Ron Pollack. "They lose money in 1997 but spend millions to compensate their top executives, spend millions on advertising and lobbying to kill patient protections, and then they go around scaring the American public saying they will need to raise premiums to cover the very minor costs of comprehensive patient protections."

A spokesman for the American Association of Health Plans, the managed care industry's trade group, dismissed the report as an effort "to divert attention from the real issues of how to improve the quality of health care in the United States."

— *By Julie Rovner*

Appropriations

Continued from page 1

that ensures the House will not approve the full $18 billion for the International Monetary Fund.

Supporters of the IMF would have needed a waiver to offer the amendments to add more than $13 billion in IMF funding to the bill; the Rules Committee did not approve that waiver.

The full IMF funding will go to a House-Senate conference, however, because the Senate version of the bill calls for the full Clinton administration request.

The rule also sets up a floor fight over federal funding for international family planning groups.

— *By David Baumann*

Elena - FYI - Please call.

DRAFT

Summary of Home Health Reallocation

Policy: Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. The highest growth in home health services has been for visits in excess of 100, with the 10 percent of beneficiaries who use more than 200 home health visits per year accounting for over 40 percent of home health spending. While this spending often goes for chronic care, nearly all home health services are currently paid for by Part A, which covers acute care services. The President's budget would restore spending on non-hospital-based chronic care (home visits in excess of 100 and services prescribed by a doctor) to Part B, the non-acute side of Medicare. This proposal protects Medicare beneficiaries from additional out-of-pocket costs because Part B home care services would not be subject to the 20-percent Part B coinsurance and would not be included in the Part B premium.

This policy is one of many home health care reforms in the President's budget. Other proposed reforms include implementing a prospective payment system and taking steps to reduce fraud and abuse on home health services. This home health reallocation does not count towards any of the $100 billion savings in the President's Medicare proposal.

Status of Policy: Our home health policy is complete unless principals decide to consider any additional beneficiary cost-sharing options that some Democrats and Republicans on the Hill believe is warranted.

Criticism of the Policy: Opponents argue that our home health reallocation is a financing "gimmick" which avoids the real reforms that are needed to save the Medicare program. As a result of recent education efforts on our policy, opponents are now less likely to label our policy a gimmick (particularly because we do not count the dollars shifted from Part A to Part B towards our $100 billion in Medicare savings). However, they believe that it is highly objectionable that we are exempting the home health reallocation from the calculation of the Part B premium.

Response:

Protects Medicare, Without Excessive Program Cuts. Our policy avoids the need for excessive reductions in Medicare payments to hospitals, physicians, and other health care providers, and protects beneficiaries from unjustifiable increases in premiums and other out-of-pockets expenses. Without this policy, Medicare's total growth for Part A would have to be constrained to 3.4 percent, according to CBO -- below the rate of inflation, if we want to extend the life of the Trust Fund to 2007.

Restores Original Intent of the Program to Keep Part A Expenditures for Post-Acute Care. The President's proposal restores the original home health policy so that payments for more than 100 visits are no longer in Part A of the program, the part of Medicare that is intended to pay for acute care -- not long-term care services. This

file

proposal was law until 1980 when Congress eliminated the 100-visit and the 3-day hospital stay requirement. Since then, home health care has increasingly become a chronic care benefit. Under the President's proposal, payments for services beyond 100 visits and not linked to hospitalization would be paid for by the Part B side of the program.

Status in Congress

Summary:

Base Democrats: Democrats are supportive of our position on this issue. They recognize that without the home health reallocation there would have to be additional, much deeper cuts in the program.

Blue Dogs/Bipartisan Coalition: Blue Dogs are generally supportive of our home health reallocation. However, some believe that we should include these funds in our calculation of the Part B premium.

Republicans: Some Republicans have been extremely critical of our position, arguing that this is a financing gimmick which avoids the much-needed tough choices on Medicare. They are particularly critical of the fact that the reallocation is not included in our Part B premium. However, the Republicans do not want to be the first ones to put Part B premium increases on the table. They also do not want to propose the deep Part A cuts that would be necessary to extend the life of the Trust Fund to 2007.

If the Blue Dogs decide they will be the first to include the home health reallocation in the premium, the Republicans may follow their lead. However, Republicans may also decide to argue that there is nothing magical about extending the life of the Trust Fund to the year 2007 and offer a proposal that does not achieve this goal.

Strategy: Keep the policy alive as a contributor to extending the life of the Trust Fund, without the need for excessive Part A cuts. Maintain strong policy defense and continue to get validators and providers to advocate for it. Review alternatives to the policy that may be needed to attract additional support, but do so with an eye to protecting low-income beneficiaries.

Interest Groups

Summary: Hospitals, physicians, nursing homes, and other providers are all extremely supportive of our home health policy. They, more than anyone, understand the implications of the cuts to providers that would be necessary without it. Aging advocates are also supportive of our policy, since it ensures that we can strengthen the Trust Fund without undermining the quality of health care services to beneficiaries. Home health care groups, however, do not like the policy since it puts their services in the more Part B side of the program, putting home health services at for risk for a potential copayment.

Strategy: We should work with various provider and consumer groups and continue to highlight their interest in this policy.

Communications

Summary: Chris Jennings, Bruce Vladeck, and Nancy-Ann Min met with a number of health care economists the day before the budget came out to explain our policy rationale and to attempt to attract support, or at least a better understanding of it. Marilyn Moon from the Urban Institute wrote an op ed in *The Washington Post* supporting our policy and Physician Payment Review Chair Gail Wilensky (a Republican health advisor) said at an Alliance for Health Reform briefing that the home health reallocation is not a gimmick.

Strategy: We should continue to work with health care experts, consumers, providers, and others to underscore that this is a reasonable policy which will help the Trust Fund without hurting providers or undermining the quality of health care to Medicare beneficiaries.

THE PRESIDENT'S FY 1998 BUDGET: HOME HEALTH CARE REFORM

The President's budget proposes a number of initiatives to control spending in home health expenditures. It implements a prospective payment system and also takes steps to reduce fraud and abuse on home health services. Both of these proposals achieve significant savings. Finally, the budget proposes to reallocate all home health expenditures to the Part B side of program, with the exception of the post-acute portion of the benefit.

- **Expenditures for Home Health Services are Increasing Faster than for Any Other Medicare Service.**
  - **Home health care utilization has risen.** The average number of home health visits per user has grown from 26 visits in 1984 to 69 visits in 1994.
  - **Highest growth in home health services in excess of 100 visits.** The 10 percent of beneficiaries who use more than 200 home health visits per year account for over 40 percent of home health spending.
- **Implements a Prospective Payment System.** The President's budget implements payment reforms, which would modify costs and lead to separate prospective payment system for home health services. Prospective payments would reduce incentives for overutilization, save billions of dollars, and begin to bring the current double-digit rise in spending on these services under control. **This proposal would save $14 billion over five years.**
- **Combats Fraud and Abuse in Home Health Services.** A March, 1996 GAO report on Medicare home health growth recommended that the Congress provide additional resources to HCFA to enhance enforcement controls against fraud and abuse. **The President's Fraud and Abuse initiatives would achieve approximately $1.4 billion over five years.**
  - **Home Health Payments on Location of Service.** This proposal would require that payment be determined by the location of the service, rather then the location of the billing office. (Billing offices tend to be in urban areas where rates are higher).
  - **Eliminate Periodic Interim Payments (PIP) for Home Health.** This proposal would eliminate PIP and simultaneously phase-in a prospective payment system. PIP was initially established to help simplify cash flow for new home health providers by paying them a set amount, and reconciling PIP with actual expenditures at the end of the year.

- o However, with 100 new HHAs joining Medicare each month, access to home health is no longer a problem.

- o Further, the Office of Inspector General has found that Medicare continually overpays PIP and has a hard time recovering the money. This proposal achieves $1 billion over five years.

- **Home Health Expenditure Reallocation.** Under the President's budget, the post-acute part of the budget would remain in Medicare Part A and all other home care services would be transferred from Medicare Part A to Medicare Part B. This proposal would protect Medicare beneficiaries from additional out-of-pocket costs because Part B home care services would not be subject to the 20 percent Part B coinsurance and would not be included in the Part B premium. This shift does not count towards any of the $100 billion savings in the President's Medicare proposal.

  - **Restores original intent of the policy.** Prior to 1980, the home health benefit was originally designed as a post-acute care service under Part A for beneficiaries who had been hospitalized. Home health care benefits were limited to 100 visits per year and could only be provided after a hospital stay of three or more days.

    In 1980, Congress altered the home care benefit by eliminating the 100-visit and the 3-day hospital stay requirement. As a result of these changes, home health care has increasing become a chronic care not linked to hospitalization. Part A now absorbs about 99 percent of the rapidly growing home health costs.

    The President's proposal restores the original intent of the policy so that payments for more than 100 visits are not be in Part A of the program, the part of Medicare that pays for acute -- not long-term care services. Under the proposal, the post-acute care portion of the home health benefit would remain in Part A and all other home care services would be transferred from Part A to Part B.

  - **Protects Medicare, Without Excessive Program Cuts**

    - This policy avoids the need for excessive reductions in Medicare payments to hospitals, physicians, and other health care providers, and protects beneficiaries from unjustifiable increases in premiums and other out-of-pockets expenses.

    - Without this policy, Medicare's total growth for Part A would have to be constrained to 3.4 percent per year (2.2 percent per capita), according to CBO -- below the rate of inflation.

    - This proposal is an integral part of the President's Medicare plan which extends the life of the Medicare Trust Fund to 2007 without imposing any new costs on beneficiaries or undermining the high quality services.

Marilyn Moon

No Medicare 'Gimmick'

In anticipating likely proposals for the Medicare program from the Clinton administration, it has become fashionable for budget experts, lawmakers and The Post to refer to the idea of shifting Medicare's home-health-care benefit from one part of the program to another as merely a "gimmick" because it does not help to balance the federal budget [editorial, Jan. 12]. But that misses the point.

Shifting home health from Part A of Medicare to Part B does not reduce overall spending. It is nonetheless needed to help delay the exhaustion of Medicare's Part A trust fund, buying enough

Taking Exception

time to consider what long-term changes make sense for the Medicare program. No combination of reasonable options for slowing the growth in spending on the program will achieve the full amount of short-run savings needed to extend the life of the Part A trust fund for more than a year or two. The home-health shift—or some equivalent policy change—is necessary to supplement other changes.

Medicare's Part A trust fund pays for hospital and related care for persons age 65 and over and those with disabilities. It is financed mainly by payroll taxes. In 1996 spending on Part A grew faster than the revenues coming into the trust fund. Like a family that spends more than it earns, Medicare is dipping into its savings in order to keep paying the hospital and other bills of its beneficiaries.

If left unchecked, the trust fund for Medicare will be exhausted by 2001. And by the end of 2003, the gap is projected to be more than $200 billion.

Efforts to address this gap need to begin immediately, but aggressive attempts to solve the problem *only* through cutting payments to hospitals and other providers of care or reducing benefits would do real harm to the Medicare program. These changes would have to go well beyond slowing the rate of growth of spending. To close the gap in fiscal year 1998, Medicare Part A spending would have to *fall* by about 13 percent from its projected 1998 level—a feat that none of the usual set of cost savings proposals could achieve.

In addition, a major restructuring of Medicare may not be the answer if it merely shifts the problem onto beneficiaries. Changes are underway in the overall delivery of health services and private insurance arrangements for younger families, much to the discomfort of many. Even healthy people are having difficulty in adjusting to the world of managed care, and the rules seem to be changing constantly. More time is needed to assess the changing marketplace before locking in changes for Medicare. Further, if incremental reforms begin to slow Medicare growth to more reasonable levels, less restructuring might be needed over time.

What, then, does make sense? First, efforts should begin immediately to make sensible changes in the Medicare program under both Parts A and B. Examples of changes in the traditional program—proposed by both Republicans and Democrats—include moving the system used to pay home-health benefits away from paying for reported costs to establishing fixed prices, and reducing the level of payments for hospital care to levels in line with the discounts being negotiated by private insurers. Improving the managed-care option by reforming how Medicare establishes premiums while encouraging further enrollment also makes sense. These reforms will help extend the life of the trust fund *and* balance the federal budget. But these changes take time to become fully effective.

Thus, it is also necessary to look for other adjustments *in addition to* cost-savings options to close the gap between spending and revenues and to extend the life of the Part A trust fund. Shifting home-health from Part A to Part B would have an immediate impact on narrowing the gap.

In addition, since Part A largely covers institutional care, home-health fits in more appropriately with physician and other services provided in the community that are associated with Part B. Originally, home-health services were offered under both parts of the Medicare program, so moving some or all of this service to Part B would not be unprecedented.

Why has such a seemingly minor issue become a sticking point about proposals to change Medicare? It is because such a proposal belies the claim that "saving" Medicare can be done only by cutting spending on the program. Opponents to the shift point out that it does not help balance the federal budget. But that is not why it is being proposed. Indeed, if the only allowable solutions to the trust-fund problem that Medicare faces are cuts in spending, then we are in danger of having the cure of "saving" the trust fund kill the patient. But it is equally important not to oversell the issue; the shift does not contribute to overall savings for Medicare. Rather, shifting the home-health benefit—in conjunction with other changes designed to achieve a reasonable level of savings—can buy time for an orderly consideration of longer-range solutions to Medicare's problems.

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