TALKING POINTS ON COST CONTAINMENT

Overview of the Current System

- We wanted to present to you today some of the primary options for achieving cost containment in the health sector, as well as the politics associated with those options.

- As you know, health care costs currently consume 14 percent of GDP -- and, by all measures, are expected to grow significantly faster than inflation into the next century.

Baseline

- Our ability to forecast health cost growth over the next 10 years is highly dependent on HCFA's release sometime in early December of the new health expenditure baseline and CBO's release of its baseline in January. There exists the possibility that the baseline -- especially for Medicaid -- could be revised downward significantly. This is particularly the case with CBO's projections, since they have not revised their baseline since January of this year.

- It is also dependenton whether some believe that current trends will continue or the recent slowdown represents just another blip.

Managed Care and Innovation by Large Firms

- Regardless of forecasts, one known fact is that health cost inflation had moderated in recent years. There are various hypothesis for why health cost growth has slowed, including the increased predominance of managed care and the fact that large firms are finding innovative ways to control their costs.

- Business purchasers may be squeezing out the fat that we've always said was there, which makes it unclear whether cuts in growth can be sustained. Some success may be at the expense of other societal desieres, such as choice, immediate access, quality, and reduced benefits. No one has yet been able to pin this down.

Political Pressure on the System

- Another possible explanation for some fraction of the reduction in health cost growth is that costs have slowed as a reaction to the political pressure placed on the health sector by this Administration. As the first chart in your packet illustrates, health cost inflation often falls at the same time that major health reform initiatives are debated. While no direct correlation has been proven, historical evidence does not necessarily disprove this theory either. In other words, it is an interesting phenomenon.

Let me move on to the substance of this morning's discussion:

- What you will hear about today are different policy options that are often discussed in the context of generating cost containment in the health care system. At a pure policy level, the staff working group favors some of these options more than others. When we bring in the politics, however, the most successful policies are generally not the most politically sustainable.

Expenditure Caps, Premium Caps, and Traditional Medicare Savings

- Given the new political environment, three options that the policy staff did not look into in more detail than the analysis that we did over the past year were expenditure caps (such as those proposed in the House Leadership bill), premium caps (as in the HSA), and traditional Medicare savings.

- While we did not prepare a presentation on these topics, let me point out that CBO scored premium caps, expenditure caps, as well as traditional Medicare cuts, as having the potential to generate significant savings.

- Assuming CBO maintains consistent modelling assumptions in the new world, expenditure caps and premium caps are more likely to generate significant scorable savings when they are phased in early and are not considered to be too tight. If one were to propose caps that were extremely tight, or were to propose the caps too far into the future, CBO would assume that cost-shifting and gaming the system would result in lower savings.

- Furthermore, we probably would not get the same scoring of the traditional Medicare savings that CBO scored for the HSA. One change that has taken place since the HSA and the original Mitchell bill were scored is that CBO is now scoring Medicare cost-shifting. This means that any cuts that one might make in Medicare will be partially reflected in higher private premiums and lower revenues.

Cost Containment Commissions: Scorable and Information-Collecting

- Another option that we can look into in some detail -- if there is an interest among those in this room -- is the idea of having a cost containment commission.

- Cost containment commissions can monitor the growth of health care costs, and, if desired, make fast-track recommendations to Congress on methods to control costs or trigger automatic cost control mechanisms (such as premium caps) if spending growth exceeds preset targets. Cost containment commissions can only generate scorable savings when they have a back-up

authority, such as a trigger.

- Cost containment commissions are not a recent innovation. In fact, the Bentsen bill proposed a commission to study the growth of health care costs and to make recommendations on how to limit them as well as to study administrative costs and other aspects of the health care system.

- Let me note that one important non-scorable function of a cost containment commission is that it can provide us with new data that could be used to make future reform decisions as we continue to work toward universal coverage. For example, data that would be extremely helpful in future reform efforts include better information about premiums, regional variations in costs, and where, how, and why competition is and is not working. To the extent that you are interested in some of the design implications of this option, I would be happy to get back to you with more information.

Introduction of the Presentations

- Let me now move on to the rest of the presentations:

- First, Nancy-Ann Min from OMB will give you an overview of what we currently see happening in the health sector and what we might see in the future in the absence of reform. After that, Eric Toder from Treasury will discuss Treasury's analysis and serious concerns about tax caps, high cost plan assessments and medical savings accounts. Finally, Bruce Vladeck will close with some innovative ideas to could encourage some competitive savings in Medicare and Medicaid.

TO ADD BEFORE ERIC TODER'S PRESENTATION:

In the new-world order, future CBO estimates may give weight to market-based reforms, such as purchasing cooperatives and a basic benefit package....

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + 3

DATE: 11/22/94

TO: Chris Jennings
Kim O'Neill
Mark Miller
Fax: 456-7431
395-4930
Phone:

FROM: Debbie Chang
Fax: (202) 690 - 8168
Phone:

REMARKS:

Attached are

1) Per capita table for Principals Meeting
2) raw #s
3) Growth rate table which is helpful but may not be for Principals meeting because it's a little erratic but the trend is definately downward.

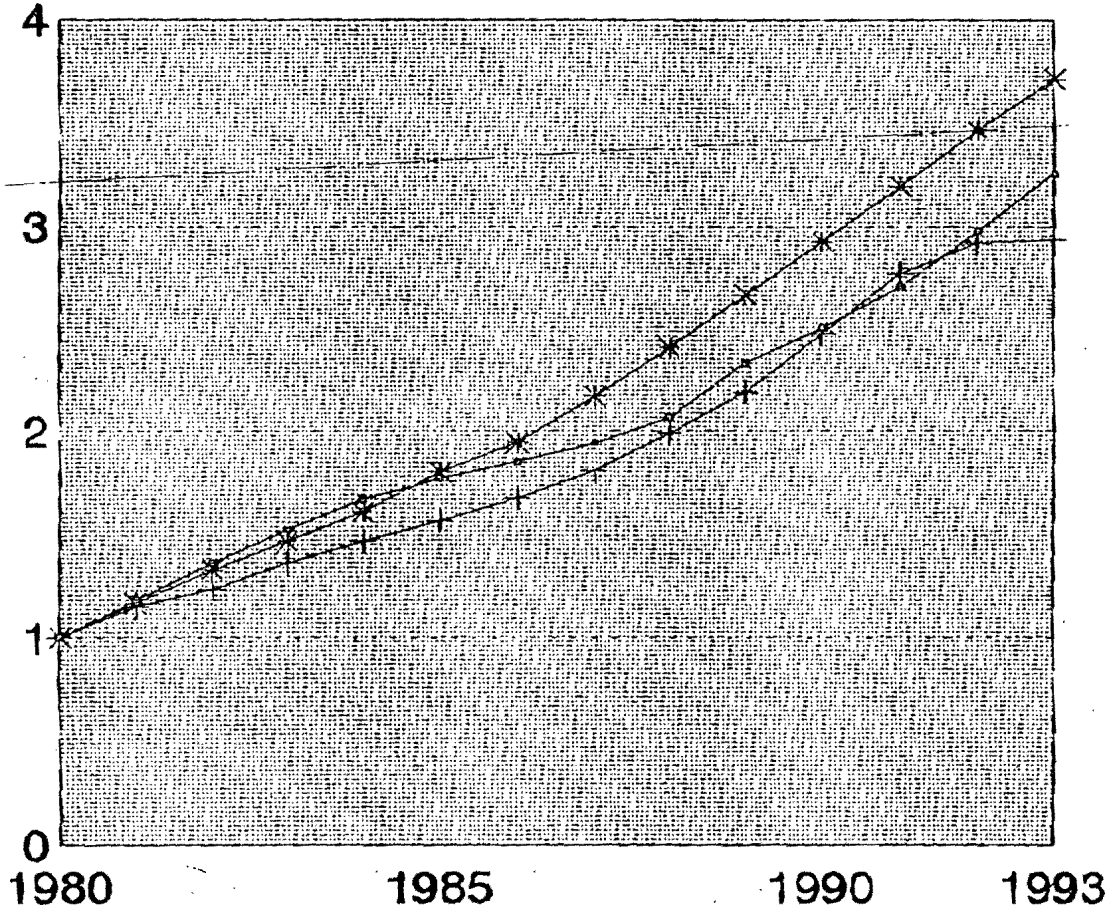
Debbie

HEALTH CARE FINANCING ADMINISTRATION
Washington, D.C.

11-22-94 05:04 PM FROM OLIA

Personal Health Care Expenditures

Expenditure Rates Per Population (Enrollee/Recipient)



In 1980 Dollars Relative to that Program

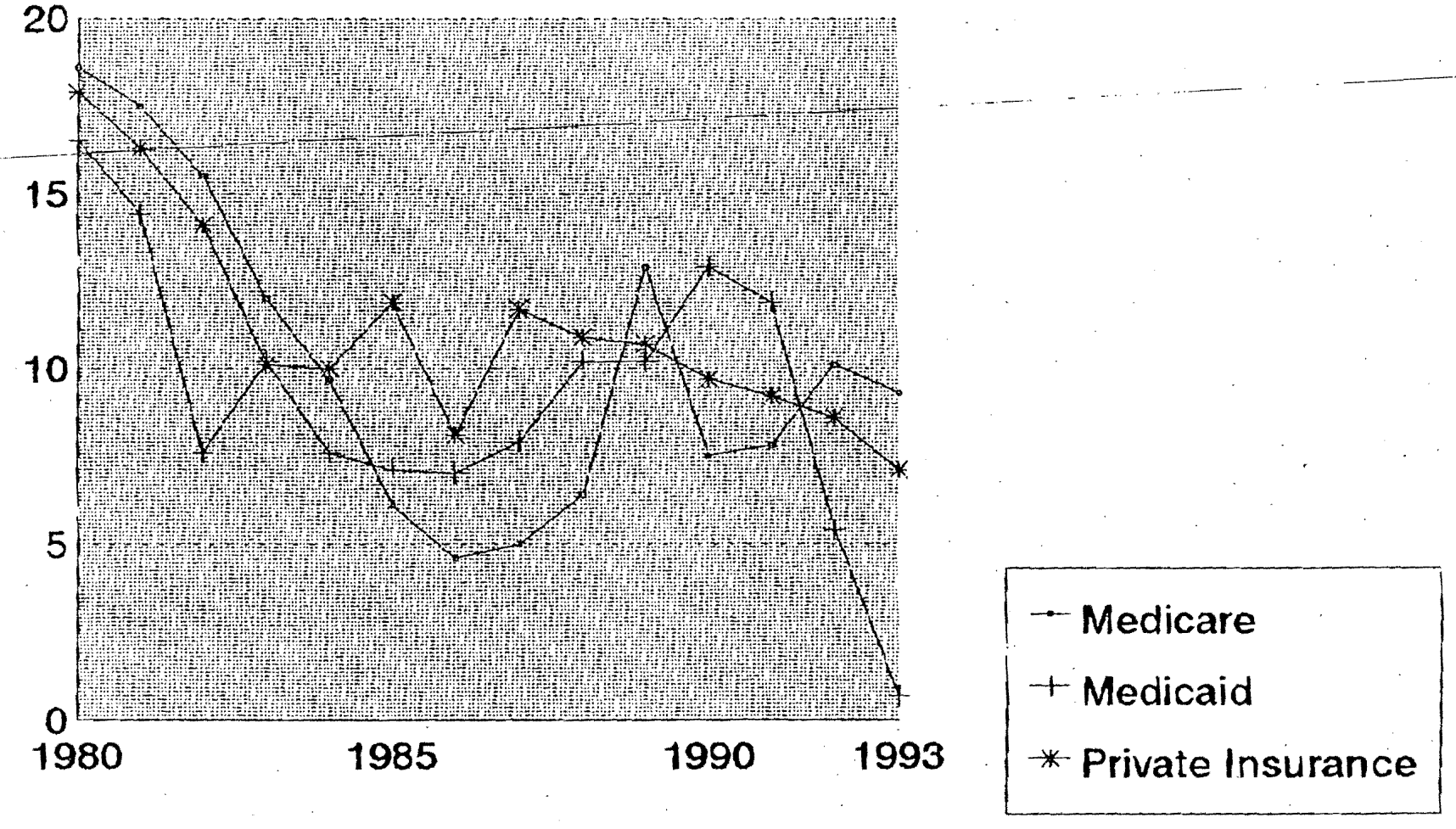
Expenditures Per Population in Dollars for Personal Hlth Care Expenditures

Year	Medicare Per Enrollee	Medicaid Per Recipient	Priv Hlth Ins Per Enrollee
1979	1077	985	321
1980	1278	1148	378
1981	1502	1314	440
1982	1735	1414	501
1983	1943	1559	552
1984	2131	1677	607
1985	2261	1796	680
1986	2364	1921	736
1987	2482	2073	821
1988	2641	2284	911
1989	2982	2516	1008
1990	3204	2841	1108
1991	3456	3180	1207
1992	3806	3351	1311
1993	4162	3374	1404
Per population value relative to 1980 spending			
1980	100.0%	100.0%	100.0%
1981	117.5%	114.5%	116.3%
1982	135.8%	123.2%	132.7%
1983	152.1%	135.8%	146.1%
1984	166.8%	146.1%	160.8%
1985	176.9%	156.4%	180.0%
1986	185.0%	167.3%	194.5%
1987	194.2%	180.6%	217.3%
1988	206.7%	199.0%	241.0%
1989	233.3%	219.2%	266.8%
1990	250.6%	247.5%	292.6%
1991	270.4%	277.0%	319.5%
1992	297.9%	291.9%	347.0%
1993	325.7%	293.9%	371.7%

SOURCE: HCFA, OACT

Personal Health Care Expenditures

Expenditures Per Population (Enrollee/Recipient)



Percent Annual Growth

AGENDA

November 22, 1994

State-Flexibility (Non-ERISA) and HHS Initiatives

I. Introduction

II. HHS Health Reform Initiatives
- Consumer Information
- PHS
- HCFA

III. State-Flexibility/Medicaid Options
- Expanding Coverage

IV. Republican Health Reform Menu List

V. Conclusion/Announcements for Next Meeting

HHS HEALTH REFORM INITIATIVES

I. CONSUMER INFORMATION

II. PHS

- Improving Quality of Health Care
- Improving the Health of the Nation
- Improving Access to Health Care
- Streamlining and Administrative Simplification

III. HCFA

- Making Medicare User Friendly for Beneficiaries
- Simplifying Medicare for Providers
- Improving the Quality of Health Care
- Eliminating Fraud and Abuse
- Promoting Efficiency in Contracting
- Simplifying Medicare Billing

SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

STATE	INITIATIVE
APPROVED	
OREGON	Expand access to uninsured; cost containment through managed care; benefit package defined by priority list. Oregon will be implementing Phase 2 which involves including the aged, blind, and disabled, and the addition of chemical dependency services to the demonstration. A January 1, 1995 start date is planned.
TENNESSEE	Expand access to uninsured through expansion of Medicaid. TENNCARE establishes a system of managed care similar to the current plan for State employees. There are no income or asset limits, but Tennessee will cap the program at 1.5 million enrollees.
HAWAII	Hawaii's HealthQuest provides seamless coverage of those on public programs, as well as the current uninsured. Through Medicaid expansions (300% FPL, elimination of categorical and asset tests) and a managed care delivery system, the State expects to expand access and control costs.
KENTUCKY	The Kentucky Health Care Reform Plan calls for universal access through: Medicaid eligibility to 100 percent FPL, elimination of certain categorical requirements, through managed care, primary care case management.
RHODE ISLAND	Rhode Island was given Medicaid waivers allowing for the extension of Medicaid eligibility to pregnant women and children up to 250% FPL and enrollment of all recipients in a capitated managed care delivery system.
FLORIDA	Florida's Agency for Health Care Administration (AHCA) has been granted section 1115 waivers to permit Federal financial participation for the Florida Health Security Program (FHS). FHS will utilize a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250% of the FPL. Health plans will be offered by Accountable Health Partnerships (AHPs) and sold by Community Health Purchasing Alliances (CHPAs).

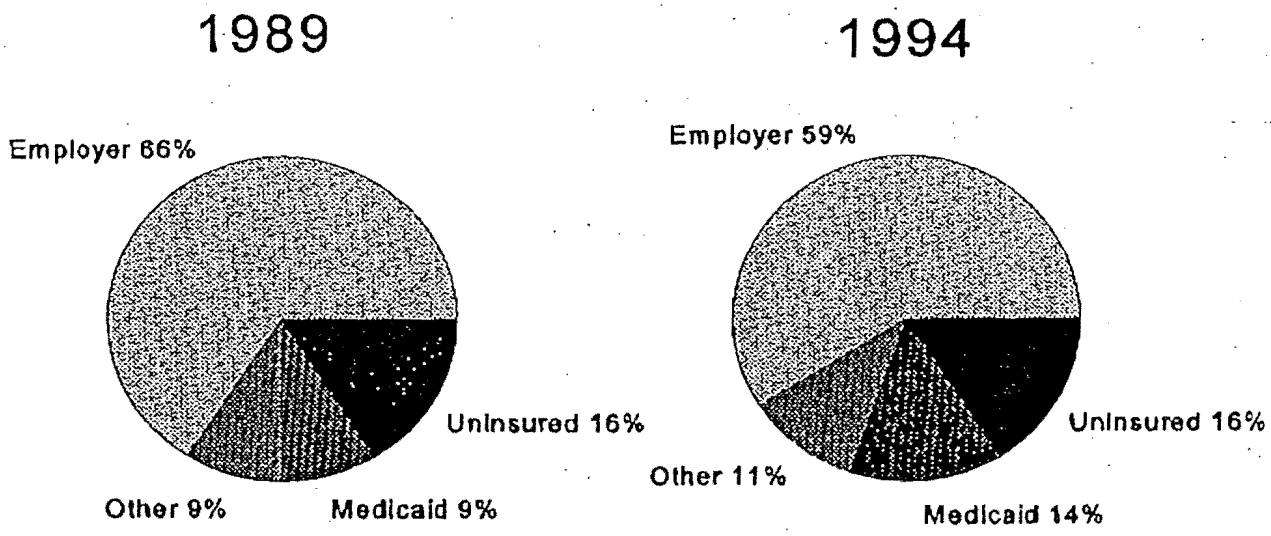
SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

STATE	INITIATIVE
	RECEIVED
OHIO	Ohio has submitted an 1115 waiver application which would allow them to implement OhioCare. Under OhioCare, Medicaid eligibility would be expanded to include the uninsured population with incomes up to 100% of FPL. Ohio expects to enroll approximately 500,000 additional recipients. The State will enroll all new eligibles and current Medicaid recipients into managed care programs throughout the State.
SOUTH CAROLINA	South Carolina has submitted an 1115 waiver application which would allow them to implement the South Carolina Palmetto Health Initiative. The program will extend Medicaid eligibility to include residents with incomes up to 100 % FPL. South Carolina expects to cover approximately 280,000 additional recipients. All Medicaid recipients will be enrolled in managed care programs.
MASSACHUSETTS	Massachusetts has submitted an 1115 waiver application, entitled MassHealth. The demonstration has nine component strategies which are intended to cover the 524,000 uninsured in Massachusetts. The proposed strategies address needs specific to the mixture of social economic groups that are uninsured in Massachusetts, which include the employed, the short-term unemployed, and the long-term employed. The proposal includes direct strategies that provide public health care and indirect strategies that seek to promote market forces and responsible decision making by providing financial incentives in the form of tax credits to employers, tax deferred medical saving accounts for insured individuals, and subsidies in the form of insurance vouchers for employees with incomes up to 200% of the FPL.
NEW HAMPSHIRE	New Hampshire submitted a proposal entitled, "The Granite State Partnership for Access and Affordability in Health Care". The State proposes the expansion of Medicaid eligibility to adults with incomes below the AFDC cash standard, along with the introduction of a public insurance product for low-income workers. Also, the State proposes to implement a number of pilot initiatives to help to ultimately redesign the State's health care delivery system.
MISSOURI	Missouri's Department of Social Services has submitted an 1115 waiver proposal that will provide managed care medical services to the State's Medicaid population and to the uninsured.

STATE	INITIATIVE
	RECEIVED
MINNESOTA	Minnesota has submitted a waiver proposal which has three major components: (1) integration of low-income and uninsured programs; (2) expansion of the managed care delivery system; and (3) linkage of Medicare to overall State health care reform efforts. The proposal presented a two phase implementation plan for each of the components. Phase 1 will be implemented in 1995, while Phase 2 is the conceptual framework for the development of elements of reforms to be implemented in subsequent years.
DELAWARE	Delaware has submitted a 1115 waiver proposal which will increase access to health care services through managed care plans by expanding Medicaid coverage to the State's uninsured adult population up to 100 percent of the Federal poverty level. This statewide proposal will include a comprehensive benefit package emphasizing primary and preventive care.
ILLINOIS	Illinois has submitted an section 1115 waiver to develop MediPlan Plus. Under this program the State will develop a series of networks either local or statewide, and tailor the health care systems to the needs of local urban neighborhoods or large rural areas. This program will allow the State to work with established or new HMO's, provider-based managed care community networks, FQHCs and RHCs to develop health networks.

Changes in Insurance Coverage

1989 to 1994



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

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

EXPANDING COVERAGE THROUGH STATE FLEXIBILITY: MEDICAID OPTIONS

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

1. Providing greater flexibility to states in administering health care programs (e.g., Medicaid).

2. Providing additional funding to states to help pay for new coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;
- Permitting benefit reductions; and
- Reducing administrative complexity (which can reduce administrative costs).

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.
- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.

- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.

- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Key Considerations:

- Budget neutrality is difficult to achieve.

- Retains some of the federal guarantees and consumer protections.

- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Key Considerations:

- If funds are provided on a matching basis, the States most likely to participate are these that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

Key Considerations:

- A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.

- Uncertainy for future program growth would be borne by the states and program recipients.

- States may reduce eligibility or benefits for groups now covered under the program.

REPUBLICAN HEALTH INITIATIVE LIKELY MENU

1. Insurance Reform --Including Self-insured Expansions for Associations (ERISA changes)
2. Self-employed Tax Deduction
3. Tax Clarification for Long Term Care Private Insurance
4. State-based Reforms, Focusing on Medicaid Flexibility and/or Federalization
5. Tax Caps
6. MSAs
7. **Medical Malpractice**
8. **Anti-trust Reforms**
9. **Fraud & Abuse**
10. **Simplification (Electronic Claims Processing/etc.)**
11. Medicare Restructuring of HMOs/Medicare Select Policies
12. **Product Liability**

Not distributed

HCFA

The following are non-legislative initiatives that are under consideration or in various stages of progress.

o **Making Medicare User Friendly For Beneficiaries**

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

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

o **Simplifying Medicare for Providers**

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

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

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

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

o **Improving the Quality of Health Care**

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

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

o **Eliminating Fraud and Abuse**

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

their responsibility to report suspicious practices.

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

o **Promoting Efficiency in Contracting**

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

o **Simplifying Medicare Billing**

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

① Consumer info ② PHS (readings) ③ HCFA (readings)

PHS

The following are non-legislative initiatives that are under consideration or in various stages of progress.

o Improving Quality of Health Care

- Expand technical assistance programs to grantees to move toward integrated systems of care and building public-private partnerships.

- Expand capacity to evaluate and compare quality of care across plans. HRSA is investigating use of HEDIS and other initiatives on quality indicators for its program beneficiaries.

- AHCPR will develop materials to improve consumer information to assist in the choice of health plans. They are also exploring health systems which encourage continuous quality improvement and cost efficiency.

- AHCPR improving consumer and provider clinical decisionmaking (eg. practice guidelines)

o Improving the Health of the Nation

- The PHS is advancing prevention activities in both research and practice. The CDC and HCFA have been working cooperatively on the Immunization Initiative.

- The PHS will advance an agenda to restore investments in public health which include focus on population-based prevention, infrastructure development in State and local health departments, and collaboration among the private and public sector.

- Provide technical assistance to States in developing reforms which refocus on improving health of all populations

- Assistance in the development of health plan performance measures focusing on access, prevention and health outcomes.

o Improving Access to Health Care

- HRSA provides funds to its grantees (eg. Community Health Centers) to develop networks to ensure access to community based providers

- Expand programs in PHS, States, and federal grantees for technical assistance and contract arrangements with managed care

- o **Streamlining and Administrative Simplification**

  - The PHS established a Reinvention Team to lead an effort to improve program performance and customer services.

  - PHS will provide technical assistance to States considering waivers with requests to strengthen public health components of the experiments

  - PHS has convened an interagency work group to coordinate and simplify administration of programs

- o Consumer Protection

MEMO TO: MARK MILLER

FROM: KEN THORPE

CC: CHRIS JENNINGS

Mark:

Here is a graph showing total compensation and wage growth with and without cost containment. We used the following assumptions. Total compensation (from the Economic Report through 1993) is assumed to grow at GDP..This is historically about correct. Wages grow at the rates outlined in the Midsession review. Health care costs (private) grow at 7.5%--this is mixed CBO/HHS projection.

Under reform, we assume (starting in 1994) that health care costs grow at GDP. We then , per Treasury and Joint Tax convention, assume that 85% of the savings go to higher wages. These higher wages would accrue to insured workers. Urban estimates 69.6 million insured workers in 1994, growing to 73.1 in 2000. We show the value of the cost containment savings in the aggregate as well as per insured worker.

Please feel free to page me if you have questions--490-0323. Hope the move went well.

(1)

INSURED WORKER'S ANNUAL WAGES WITH AND WITHOUT COST CONTAINMENT

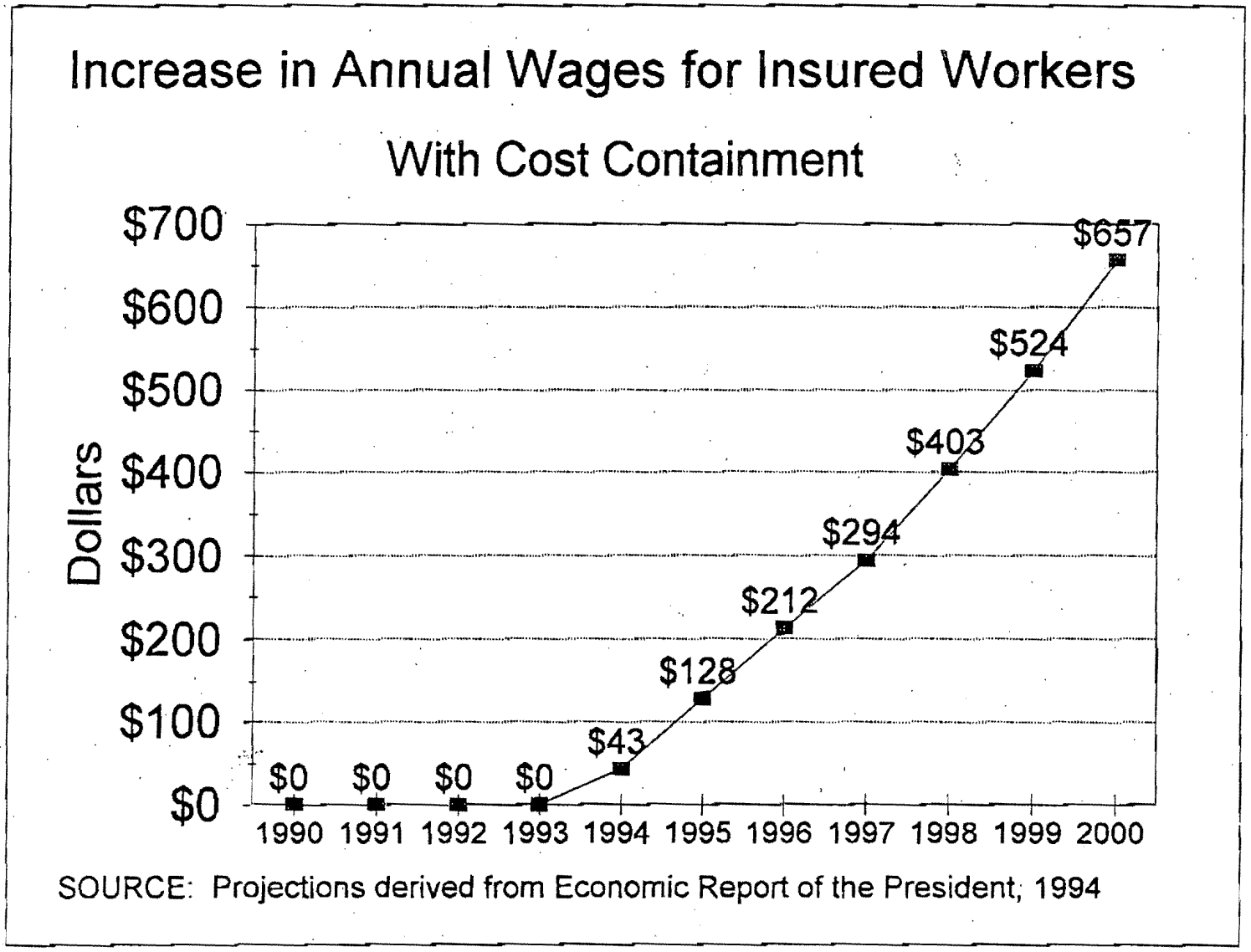
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Compensation	3298	3402	3582	3772	3998	4225	4460	4708	4969	5244	5538
Baseline Wages	2745	2815	2953	3100	3289	3437	3666	3873	4086	4310	4547
W/cost containment	2745	2815	2953	3100	3292	3446	3681	3894	4115	4348	4595

Source: ~~Trustees~~ Projections Based on Economic Report, 1994.

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Compensation	3298	3402	3582	3772	3998	4225	4460	4708	4969	5244	5538
Insured Workers	65.6	66.6	67.6	68.6	69.6	70.2	70.7	71.3	71.9	72.5	73,100
Wages per Insured	41.9	42.3	43.7	45.2	47.3	49.0	51.8	54.3	56.8	59.4	62,200
W/cost containment	41.9	42.3	43.7	45.2	47.3	49.1	52.0	54.6	57.2	60.0	62.9

62,200

fns


Increase in Annual Wages for Insured Workers
With Cost Containment
Dollars
$700
$600
$500
$400
$300
$200
$100
$0
$0
$0
$0
$0
$43
$128
$212
$294
$403
$524
$657
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
SOURCE: Projections derived from Economic Report of the President, 1994

Medicare and Medicaid
Cost Containment Legislative Proposals

A range of Medicare reforms could help to control costs in the short term and in the future. Some would have significant scorable budget savings. Others would reform various aspects of the program that would improve our ability to control costs in the future, even though they might not be scored as having significant savings within the budget window. Medicare managed care options are addressed in a separate paper. Major proposals could include:

1. Reform payment procedures

Over a period of years, we have moved large portions of the Medicare program onto payment methods that are designed to control Federal costs: prospective payment (for inpatient hospital services) and fee schedules (for physicians and most other Part B services). Since the implementation of the Prospective Payment System for hospitals, Medicare hospital spending per enrollee increased 6.1 percent per year while private insurance hospital spending increased 7.7 percent per year. Since implementation of the physician fee schedule, Medicare physician spending per enrollee increased 3.2 percent per year while private insurance physician spending increased 8.2 percent per year.

- Payment methods for two additional areas are now ready for reform: hospital outpatient services and skilled nursing facilities. Prospective payment systems in these areas will reform incentives that now tend to increase costs and put the Federal budget at risk.

Graduate Medical Education payment reform can achieve budgetary savings while changing a number of payment parameters to

- Increase emphasis on training of primary care practitioners

- Permit payments to recognize the major shift of medical training to ambulatory care.

Savings in the physician area have been a significant source of savings in the past and may be again, although lower baselines will lead to lower savings from particular proposals as well. Insofar as savings are required, it would be desirable to achieve them in ways that contribute to containing costs in the future.

- Remove the upward bias now inherent in the statutory formula for setting the annual physician growth target (the Medicare Volume Performance Standard).

Medicare payment for durable medical equipment (DME) can be reformed to reflect market rates, thus lowering Medicare costs.

- HCFA could take advantage of market rates in local areas by simplifying the current inherent reasonableness authority.

2. Promote Competition

Relying more heavily on market forces to establish how much Medicare pays is attractive in general and responds to the current climate.

- Competitive bidding for Part B services would allow Medicare to take advantage of market-based rates, as other large purchasers do.

- Several other changes would "level the playing field" between Medicare managed care plans and Medigap plans, leading to sharpened competition and improved performance.

3. Combat Fraud and Abuse in Medicare and Medicaid

- A major funding reform, the Benefit Quality Assurance Program, will permit adequate funding for payment integrity activities of Medicare carriers and intermediaries. We expect a 8-to-one return for these activities.

- Medicare secondary payer reforms will emphasize paying the claim right in the first place through improved coordination of benefits, rather than costly pay-and-chase approaches.

- Medicare can follow the lead of the private sector in adopting certain "good business" practices governing overpayments and other aspects of our business relations with providers.

- Several Medicaid proposals could improve States' ability to ensure payments from third parties liable to pay medical bills for beneficiaries.

- Medicaid statutory improvements could increase the effectiveness of existing provisions assuring medical support from absent parents.

4. Simplify and Streamline Program Management

Various program reforms can tighten up administration, reduce vulnerabilities, improve information flows, and eliminate certain unnecessary practices.

- "One-stop Billing" will use electronic transmittal of claims information from Medicare to secondary payers.

- Changes relating to the Medicare Transaction System now under development would increase the flexibility of our contracting authority and simplify claims processing.

- To remove requirements now largely redundant as a result of nursing home reform, mandated annual mental health screenings of nursing home residents could be replaced with reviews on an as-needed basis.

Medicare Managed Care

[redacted] Growth in Managed Care

Medicare has experienced significant growth in managed care enrollment as well as managed care contracts for the past four years.

Enrollment: In 1994, Medicare enrollment grew by 12 percent. As of September of this year, 9 percent of all Medicare beneficiaries were enrolled in managed care plans under three different contracting arrangements. (6 percent in risk plans, 2 percent in Health Care Prepayment Plans (HCPPs), with the remainder in cost plans and Medicare SELECT).

Contracts: As of September of this year, Medicare had 235 total prepaid contracts (145 risk contracts, 29 cost contracts, 57 HCPP contracts, and 4 Demo contracts). This is an increase from 188 in 1993 and from 165 in 1990.

II. Issues in Medicare Managed Care

Historically, the following issues have been raised as problematic in Medicare managed care:

Medicare Payment. Managed care organizations with Medicare risk contracts receive a per capita payment of 95 percent of Medicare's projected fee-for-service cost for each enrollee (referred to as adjusted average per capita costs (AAPCC)). Rates are adjusted by demographic factors such as age and sex and by a geographic factor based on county of enrollee residence.

The managed care industry has traditionally been critical of Medicare's payment methodology for risk contracts. Among the concerns are that payment levels are too low, county rates are unstable and that plans in areas with relatively low payment are disadvantaged compared to plans in areas with relatively high payment (for example, the monthly rate in Hennepin, Minnesota is $362, while in Dade, Florida it is $615).

Favorable Selection Results in Higher Medicare Costs. According to Mathematica Policy Research (MPR), even though Medicare's payment is 95 percent rather than 100 percent of the AAPCC, the program is still not achieving savings because of favorable selection (i.e., HMOs have enrolled beneficiaries that are healthier than average). Although Medicare enrollees benefit through reduced out-of-pocket costs and extra benefits, MPR found that Medicare was actually paying 5.7 percent more than the costs of covering the same beneficiaries in fee-for-service. It is assumed that an adequate health status adjustor could significantly reduce the current overpayment. HCFA has several

research projects in this area but implementation of a health status adjustor is at least several years away.

Marketing. There have been periodic problems and complaints in the way managed care plans market to Medicare beneficiaries, particularly in some regions of the country. Deceptive practices such as enrolling beneficiaries without their consent and agents not fully explaining critical managed care provisions, for example, the lock-in, have resulted in expensive mistakes and bureaucratic hassles for beneficiaries.

Beneficiary Confusion. Currently, Medicare beneficiaries do not have the information they would need to make an informed choice in regard to available managed care and Medigap options. Lack of a standard benefit package for managed care plans and of a coordinated open enrollment period makes comparison shopping almost impossible.

Uneven Playing Field With Medigap. While Medicare managed care plan are prohibited from health screening, imposing pre-existing condition exclusion periods or charging differential premiums based on health status or age, the same requirements do not apply to Medigap policies. As a result, the competition between Medicare managed care and Medigap does not take place on a level playing field.

Limited Beneficiary Choice. Only 39 percent of Federally Qualified HMOs participate in Medicare's managed care program. Only a handful of these plans offer a self-referral option to enrollees. Medicare SELECT, currently a 15-State demonstration, holds the promise of expanding choice through the creation of managed care/Medigap hybrid products (Medicare SELECT policies are similar to Medigap policies except that they may pay reduced or no Medigap benefits if care is received outside of the plan's network of providers). However, under the current demonstration, plans are not required to manage care. As a result, the majority of SELECT enrollees are in plans that achieve Medigap savings only through discount arrangements and selection. SELECT enrollees also do not have the same assurances as to access and quality as do enrollees in Medicare risk plans.

Quality Assurance. HCFA currently has certain process requirements for HMOs which are meant to assure quality of care. Work with the industry is in process on a new generation of quality measurement systems that will focus on outcomes, but full implementation is still several years away. Thus, while there is evidence from research studies that quality of care in HMOs is comparable to that in Medicare's fee-for-service sector, HCFA does not yet have systems to adequately measure, monitor and assure quality on an ongoing basis. Such systems are especially important when dealing with capitated systems because capitation provides financial incentives to minimize care.

III. Options

Option 1) Reduce benefits in fee-for-service Medicare as an incentive for beneficiaries to enter HMOs

In addition to the current Part B premium, require beneficiaries who do not enroll in a managed care plan to pay the difference between the average per capita fee-for-service costs in their area and the lowest premium for a managed care plan with a Medicare contract.

- All managed care plans in an area that wish to participate in the Medicare program would submit bids.
- Medicare's contribution for all beneficiaries in that area would be based on the lowest bid.
- The "bid" for regular fee-for-service Medicare (91 percent of all Medicare Beneficiaries) would be based on average per capita Medicare costs in the area.
- If the "bid" for regular Medicare was not the lowest, beneficiaries choosing fee-for-service would have to pay the difference between Medicare's contribution and the "bid".

Option 2) Strengthen Current Risk and Cost Contract Program and Create Additional Incentives for Participation

Under this option a variety of measures would be taken to strengthen Medicare's risk and cost contract program.

- HMO payment
  - + Conduct multi-state demonstrations on the use of market-based payment mechanisms to establish HMO payment.
  - + Impose upper limits and floors to reduce regional payment variation and create outlier pools for high cost cases.
- Simplify Beneficiary Choice
  - + Create a standard benefit package that all Medicare managed care plans would have to offer.
  - + Establish a coordinated open enrollment process for Medicare managed care plans and for Medigap with enrollment through a third party.
  - + Prohibit Medigap plans from health screening, imposing pre-existing condition exclusion periods or charging

differential premiums based on health status or age.

- o Increase Availability of Managed Care Options

  + Authorize the Secretary to contract with purchasing coalitions for the provision of Medicare benefits on a capitated basis.

  + Increase payment to managed care plans operating in rural areas and modify the requirement that commercial enrollment equal or exceed Medicare and Medicaid enrollment (50/50 quality of care requirement) to encourage participation.

Option 31 Create More Flexible Managed Care Options

Under this option, Medicare would move to create more flexible managed care options for beneficiaries.

- o Medicare SELECT - Make a restructured Medicare SELECT available to all beneficiaries. The SELECT program would become a federal contracting option subject to similar quality safeguards as now apply to risk and cost contractors. In addition, entities wishing to obtain a Medicare SELECT contract would have to be actively involved in managing care.

- o Expand Availability of Self-Referral Options - Encourage Medicare risk plans to offer self-referral options as an additional benefit to enrollees so that beneficiaries can have increased choice of providers.

- o Medicare Point-of-Service - Authorize Medicare to contract with entities to create comprehensive preferred provider networks in areas where this option would not be otherwise available.

MEDICAID MANAGED CARE

I. Current Law and Growth in Managed Care

Current law: States may implement Medicaid managed care through voluntary enrollment programs or mandatory programs under Freedom of Choice waivers (under 1915(b) waiver authority) and section 1115 demonstration waivers. Managed care arrangements under waiver programs include capitated, HMO-like programs and primary care case management (PCCM) programs.

Enrollment: Enrollment in Medicaid managed care has been dramatically increasing in both actual numbers and as a proportion of Medicaid beneficiaries over the last several years. Managed care enrollment grew by 63 percent between 1993 and 1994. Because States generally leave elderly and disabled Medicaid beneficiaries -- particularly nursing home residents -- in fee-for-service, current managed care enrollment represents approximately one-third of the non-SSI population (elderly and disabled). We anticipate that this proportion will continue to grow, and approach full enrollment in managed care over the next 10 years or so, without changes to current law. However, managed care has not been applied in a significant way to the SSI population, and we expect these individuals to remain outside of scope of most managed care programs.

II. Issues in Medicaid Managed Care

- Managed care expansions should represent an effort to develop more efficient health care delivery systems.

- Managed care arrangements should ensure accountability across all elements of the system. In particular, financial accountability, public oversight and quality of care should be emphasized, and the necessary data must be collected and furnished to permit such accountability.

- In the absence of a Federal mandate, proposed options must appeal enough to States to induce their participation. Providing program design flexibility and additional Federal dollars would appeal to States.

State Impact: Changes should provide flexibility for States to develop their own time-frame for managed care and target managed care programs to the populations and provider markets most appropriate for their State. While current law incentives have provided an effective avenue for managed care expansions, States have expressed interest in having more flexibility.

Managed care systems require considerable administrative "infra-structure" to be successfully implemented. Many States or portions of States may not be ready from a management perspective for managed care.

Budget Impact: The fiscal benefits of managed care will continue to hold down the rate of growth in Medicaid spending. Effective proposals would provide additional incentives or new methods for States to develop cost-effective managed care programs.

Reduced Pressure for 1115 Waivers: The Federal government has allowed States to implement comprehensive managed care systems through 1115 demonstration waivers, but budget neutrality continues to be problematic. Legislative proposals to ease managed care implementation without an 1115 waiver would both reduce administrative complexity and allow the demonstration program to focus on innovative approaches rather than only managed care expansions.

Beneficiary Impact: Proposals to give States broad latitude to mandate managed care and establish enrollment lock-ins have been very controversial in the past, because of their anticipated impact on Medicaid beneficiaries. Quality of care measures are still developing, yet the incentives to "underserve" patients in managed care need to be closely monitored.

III. Options

The following options emphasize flexibility rather than providing new Federal funds to the States.

Option 1) Increase State Flexibility

Targeted legislation would be proposed to reform the current Medicaid managed care program to provide States with additional flexibility within their regular Medicaid programs. These proposals would encourage the use of managed care and simplify Medicaid administration.

Legislative changes that would provide States with new latitude to establish managed care programs include:

- Permitting waivers of enrollment composition rules when States follow Federally-defined quality assurance standards.
- Permitting States to develop primary care case management programs without a waiver.
- Permitting six-month enrollment lock-ins for all managed care plans.
- Permitting States to contract with a single HMO in rural areas.

HCFA could also establish Federal 1115 waiver policies that would give greater priority to programs that would increase the use of managed care.

Option 2) Remove Current Prior Approval Barriers

Permit States to develop mandatory Medicaid managed care programs as state plan options. States would not need Federal waivers to continue operating primary care case management programs or develop mandatory capitated programs. Current statutory requirements that serve as barriers to Medicaid managed care would be eliminated.

In order to take advantage of this enhanced flexibility, States would be required to play an active role in quality oversight and require health plans to meet new, more stringent Federally-defined quality assurance requirements. Quality protections would also be reinforced by Federal monitoring and oversight. (This approach is similar to the 1992 Moynihan managed care bill.)

Option 3) Mandate Managed Care

Require that States develop Medicaid managed care programs for all beneficiaries. Quality assurance monitoring would be particularly critical if all States are required to implement managed care, regardless of previous experience with capitation and beneficiary protections. Therefore, States could be required to implement Federally-defined quality assurance programs; in return, current statutory quality proxies could be eased.

Proponents of this proposal assert that States can save approximately five percent from fee-for-service spending by utilizing managed care programs. Using this assumption, total additional Medicaid savings from an AFDC-related managed care mandate may be between $1 and $2 billion a year -- or $10 to $20 billion over ten years.

States would be able to apply for waivers to continue fee-for-service (FFS) service delivery in geographic areas that cannot sustain a managed care system. The State would have to stay within a FFS payment limit based on managed care rates. These waivers would last for three years; to renew the waiver, States would have to demonstrate again why managed care would not be successful.

Confidential

Medicare Proposals

11/22

	FY 96-00	FY 96-05
Reform Payment Policies		
OPD Reform	$savings	$small savings
SNF Reform	0.7 - 0.9	2.0 - 2.5
GME Reform	3.0 - 4.0	7.0 - 8.0
MVPS Upward Bias	0.5* - 0.7*	10.0* - 13.0*
DME Market Rates	0.0 - 0.1*	0.2* - 0.4*
Subtotal	$4.2+ -$5.7+	$19.2 -$23.9
Promote Competition		
Competitive Bid	1.0* - 1.4*	3.5* - 4.0*
Managed Care	unscorable	unscorable
Subtotal	$1.0+ -$1.4+	$3.5 - $4.0
Total	$5.2*- 7.1*	$22.7* - 27.9*

* Net of Part B premium offset. Assumes extension of Part B premium for 1999 and thereafter.

AGENDA

November 22, 1994

I. Timeline Issues

II. Agenda for Next Two Map Group Meetings

III. Health Care Budget (Jennifer)

IV. Medicaid: Federal/State Switch

DECISIONS FOR HEALTH POLICY DEVELOPMENT

1. Do we want any Federal health spending to go towards deficit reduction?

   1a. If yes, how much?

   1b. If yes, where should the spending reductions come from?

2. Do we want any Federal health spending to go towards health care reform?

   2a. If yes, how much?

   2b. If yes, where should the spending reductions come from?

3. Are there any policy options for which we are willing to raise money from other sources?

   3a. If yes, how much?

   3b. If yes, where will the additional revenues come from (tax cap, cigarette tax, other)?

4. Do we want to extend the self-employed tax deduction?

   4a. If yes, what percent of spending should be deductible (i.e., how much can we spend)?

   4b. If yes, how fast should the deduction be phased-in?

5. If we are willing to allocate revenues toward coverage expansions, which ones to we want to propose (welfare to work, kids, unemployed, low-income workers, broad-based low income)?

   5a. For each coverage expansion, how much can we spend?

5b. If kids option:

1. Up to what age group will be covered?

2. Up to what percent of poverty will be covered?

3. Will the expansion be through public insurance or private insurance?

4. How will the subsidy be administered (voucher, tax credit, etc.)?

5c. If unemployed option:

1. Up to what percent of poverty will be covered?

2. How should income be measured?

5d. If broad-based low-income option:

1. Up to what percent of poverty will be covered?

2. Will the expansion be through public insurance or private insurance?

3. How will the subsidy be administered (voucher, tax credit, etc.)?

5e. If low-income worker option:

1. Up to what percent of poverty will be covered?

2. Will the expansion be through public insurance or private insurance?

3. How will the subsidy be administered (voucher, tax credit, etc.)?

4. How will "working" be defined?

5. If we do not want to increase spending, are there other policies that we would like to consider?

6. If we do not want to propose legislation, do we need to develop a set of principles for reform?

AGENDA

November 22, 1994

State-Flexibility (Non-ERISA) and HHS Initiatives

I. Introduction

II. State-Flexibility/Medicaid Options
- Expanding Coverage

III. HHS Health Reform Initiatives

IV. Republican Health Reform Menu List

V. Conclusion/Announcements for Next Meeting

REPUBLICAN HEALTH INITIATIVE LIKELY MENU

1. Insurance Reform --Including Self-insured Expansions for Associations (ERISA changes)
2. Self-employed Tax Deduction
3. Tax Clarification for Long Term Care Private Insurance
4. State-based Reforms, Focusing on Medicaid Flexibility and/or Federalization
5. Tax Caps
6. MSAs
7. Medical Malpractice
8. Anti-trust Reforms
9. Fraud & Abuse
10. Simplification (Electronic Claims Processing/etc.)
11. Medicare Restructuring of HMOs/Medicare Select Policies
12. Product Liability

UNRESOLVED ISSUES

1. Budget -- is the deadline mid-December or early January?

2. Status of policy options update -- Do we need to have other issue discussions prior to lever-pulling political discussions? Review Republican menu and discuss status of decision tree document.

3. If we schedule 2-3 Map Group meetings during the week after Thanksgiving -- questions of agenda arise. Should these meetings be review of outstanding issues, political (where groups and Congress stand on issues) or are used for preparation for POTUS meetings?

4. If the budget baseline is not released until early December, what work can be generated in the absence of this information?

5. How should we structure the meetings with the President?

6. Who will attend the meetings with the President?

7. What policy issues need to be narrowed prior to meeting with the President?

8. Are consecutive scheduled meetings with the President unrealistic based on our experience with his desires for unforeseen answers to unforeseen questions?

9. The upcoming holidays and ongoing budget questions raise a significant policy resource issue (OMB staff will be difficult to access).

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NOVEMBER 1994

		Tue. Nov. 1, 1994	Wed. Nov. 2, 1994	Thu. Nov. 3, 1994	Fri. Nov. 4, 1994	Sat. Nov. 5, 1994
					11:30a Meeting re: Coverage Options 3:00p Health Care Policy Options Meeting	
Sun. Nov. 6, 1994	**Mon. Nov. 7, 1994**	**Tue. Nov. 8, 1994**	**Wed. Nov. 9, 1994**	**Thu. Nov. 10, 1994**	**Fri. Nov. 11, 1994**	**Sat. Nov. 12, 1994**
	9:30a Meeting re: Coverage Options 4:00p Health Care Policy Options Meeting			3:00p Map Group Meeting		
Sun. Nov. 13, 1994	**Mon. Nov. 14, 1994**	**Tue. Nov. 15, 1994**	**Wed. Nov. 16, 1994**	**Thu. Nov. 17, 1994**	**Fri. Nov. 18, 1994**	**Sat. Nov. 19, 1994**
	1:00p Insurance Market Reform Presentation Meeting	10:00a Presentation of Polling Data 1:30p ERISA Meeting at Labor 2:30p Proposed Agenda Meeting with Rasco & Rubin	4:00p Map Group Meeting	2:00p Meeting re: ERISA	11:00a Meeting re: Cost Containment Presentation	
Sun. Nov. 20, 1994	**Mon. Nov. 21, 1994**	**Tue. Nov. 22, 1994**	**Wed. Nov. 23, 1994**	**Thu. Nov. 24, 1994**	**Fri. Nov. 25, 1994**	**Sat. Nov. 26, 1994**
	7:30a Meeting at HHS re: State Flexibility and Administrative Issues 11:00a Map Group Meeting re: ERISA 4:00p Meeting re: Cost Containment Presentation	8:15a Meeting with Rasco & Rubin re: scheduling 12:00p Map Group Meeting re: State Flexibility and Administrative Issues	9:00a Map Group Meeting re: Cost Containment	—— HOLIDAY - THANKSGIVING	HOLIDAY	
Sun. Nov. 27, 1994	**Mon. Nov. 28, 1994**	**Tue. Nov. 29, 1994**	**Wed. Nov. 30, 1994**			
	Staff Meeting/Prep for future Map Group Meetings		Map Group Meetings Continue			

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DECEMBER 1994

				Thu. Dec. 1, 1994	Fri. Dec. 2, 1994	Sat. Dec. 3, 1994
				Map Group Meetings Continue	Map Group Meetings Continue	
Sun. Dec. 4, 1994	**Mon. Dec. 5, 1994**	**Tue. Dec. 6, 1994**	**Wed. Dec. 7, 1994**	**Thu. Dec. 8, 1994**	**Fri. Dec. 9, 1994**	**Sat. Dec. 10, 1994**
		Medicare/Medicaid Baseline Changes Due?	Medicare/Medicaid Baseline Changes Due?	Medicare/Medicaid Baseline Changes Due?	Meeting with POTUS?	
Sun. Dec. 11, 1994	**Mon. Dec. 12, 1994**	**Tue. Dec. 13, 1994**	**Wed. Dec. 14, 1994**	**Thu. Dec. 15, 1994**	**Fri. Dec. 16, 1994**	**Sat. Dec. 17, 1994**
	4:45p Meeting with POTUS	4:00p Meeting with POTUS				
Sun. Dec. 18, 1994	**Mon. Dec. 19, 1994**	**Tue. Dec. 20, 1994**	**Wed. Dec. 21, 1994**	**Thu. Dec. 22, 1994**	**Fri. Dec. 23, 1994**	**Sat. Dec. 24, 1994**
				Potential OMB Early Budget Deadline	Potential OMB Early Budget Deadline	OMB HOLIDAY
Sun. Dec. 25, 1994	**Mon. Dec. 26, 1994**	**Tue. Dec. 27, 1994**	**Wed. Dec. 28, 1994**	**Thu. Dec. 29, 1994**	**Fri. Dec. 30, 1994**	**Sat. Dec. 31, 1994**
HOLIDAY - CHRISTMAS	OMB HOLIDAY					OMB HOLIDAY

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JANUARY 1995

Sun. Jan. 1, 1995	Mon. Jan. 2, 1995	Tue. Jan. 3, 1995	Wed. Jan. 4, 1995	Thu. Jan. 5, 1995	Fri. Jan. 6, 1995	Sat. Jan. 7, 1995
—— HOLIDAY - NEW YEAR'S DAY		OMB OFFICIAL BUDGET DEADLINE				
Sun. Jan. 8, 1995	**Mon. Jan. 9, 1995**	**Tue. Jan. 10, 1995**	**Wed. Jan. 11, 1995**	**Thu. Jan. 12, 1995**	**Fri. Jan. 13, 1995**	**Sat. Jan. 14, 1995**
Sun. Jan. 15, 1995	**Mon. Jan. 16, 1995**	**Tue. Jan. 17, 1995**	**Wed. Jan. 18, 1995**	**Thu. Jan. 19, 1995**	**Fri. Jan. 20, 1995**	**Sat. Jan. 21, 1995**
Sun. Jan. 22, 1995	**Mon. Jan. 23, 1995**	**Tue. Jan. 24, 1995**	**Wed. Jan. 25, 1995**	**Thu. Jan. 26, 1995**	**Fri. Jan. 27, 1995**	**Sat. Jan. 28, 1995**
Sun. Jan. 29, 1995	**Mon. Jan. 30, 1995**	**Tue. Jan. 31, 1995**				