AGENDA
April 11, 1995

I. **Internal Policy Development Discussion**

- Medicare Trust Fund
  a. Hearing update
  b. White House Conference on Aging correlation

- Deficit Reduction
  a. Administration's Position on size and scope

- Medicare
  a. Savings options being reviewed
  b. Managed care
  c. Prescription drug/longterm care issues

- Medicaid
  a. Tennessee update
  b. Block grants vs. alternatives

- Administration Response to Republican Cuts
  a. Review of updated talking points on Medicare/Medicaid

- Administration Views on Reform
  a. Misdirected and confusing signals
  b. "Pols" vs. Policy Wonks
  c. Recent POTUS comments
  d. New policy options: tobacco tax increase/tax credits

II. **Update on Governors**

- Dean Requesting Briefing on Block Grants and Alternatives

- Entitlement with Flexibility Options that Achieve and Don't Achieve Savings

III. **White House Conference on Aging**

- POTUS Speech: Should it Include any New Initiatives such as Managed Care?

- Mammography event update

IV. **Regulatory Reform Update**

HEALTH CARE QUESTIONS

- How/Do we define what "in the context of reform" means?

- Assuming we have a broad definition, should we have a proposal ready to go?

- Should a goal of significant deficit reduction be included in our definition and, if so, what number should we be shooting for?

- We have said that we think the Medicare Trust Fund insolvency issue should be dealt with in the context of reform. Should we come to an internal agreement about what is our goal vis a vis strengthening trust fund (e.g., is it extending insolvency date several years or long-term)? NOTE: Not even the most significant Medicare cuts currently under consideration by some Republicans ($300 billion plus over 7 years with a 5% cap on growth) extend the insolvency date beyond 2010.

- What position should the President stake out on Medicare in his May 3rd White House Conference on Aging speech? Should he have an agenda beyond simply opposing deep and arbitrary cuts outside context of reform? How should he talk about the Trust Fund issue? NOTE: It will coincide with two major Congressional hearings on the Trust Fund issue: Finance/April 26th; Ways and Means/May 3rd.

- Should the President respond to desires by AARP, GHAA, the business community and others and announce his own Medicare managed care proposal? Note: We have a proposal almost ready, which provides for broadened managed care choices, but does not produce short-term savings. (This would illustrate that we want to expand in this area and show we think there is potential for long-term savings, but would smoke out Republicans on how they achieve savings in their managed care proposal.)

- How do we position ourselves on the Medicaid issue? There are many options:

  -- Develop a proposal that provides for state flexibility, but for little/no savings and uses Medicaid as program for possible expansions.
  -- Develop a proposal that provides for state flexiblility, but produces some savings -- perhaps through DSH savings or per capita cap.
  -- Oppose changes that reduce coverage.
  -- Oppose changes that eliminate the entitlement nature of program.
  -- Oppose block grant approaches.
  -- Oppose cuts on basis of magnitude.

AGENDA: April 12, 1995

I. Precipitating Events Requiring Administration Attention

- Senate and House Budget Resolution Mark-Ups (Late April/Early May)
- Senate and House Hearings on Medicare Trust Fund (Same timeframe)
- White House Conference on Aging (May 2-5)

II. Fundamental Questions

- We have said that we think the Medicare Trust Fund insolvency and deficit reduction issues should be dealt with in the context of reform. We will be under increasingly intense pressure, particularly from the media elite and the Republicans, to be able to respond to the following questions:
  - -- Do we define what "in the context of reform" means? If so, how?
  - -- What is our position vis a vis strengthening trust fund (e.g., is it extending insolvency date several years or long-term)? NOTE: Not even the most significant Medicare cuts currently under consideration by some Republicans ($300 billion plus over 7 years with a 5% cap on growth) extend the insolvency date beyond 2010.
  - -- Should a goal of significant deficit reduction be included in our definition and, if so, what number should we be shooting for?
  - -- Should we have a proposal ready to go in response to the Republican-passed budget resolution?

III. Questions Relating to Budget Resolution, Hearings, and Conference on Aging

- Whether we have the answers to the above questions or not, we need to be prepared for these upcoming high profile events. To do so, we need to answer the following questions:
  - -- Do we need to send signals to the Hill that Administration is serious on the deficit reduction issue and sincerely believes it can be achieved in context of reform? (To address concerns of potential of large numbers of Democratic defections.)

-- Do Trustees (Rubin, Shalala, Reich, Vladeck) testify? If so, which ones and what do they say?

-- What position should the President stake out on Medicare in his May 3rd White House Conference on Aging speech? Should he have an agenda beyond simply opposing deep and arbitrary cuts outside context of reform?

-- Should the President respond to desires by AARP, GHAA, the business community and others and announce his own Medicare managed care proposal?

IV. Medicaid

- How do we position ourselves on the Medicaid issue? We do not believe it is possible to obtain the magnitude of cuts the Republicans are now discussing without an accompanying loss in coverage. There are many options:

  -- Develop a proposal that provides for state flexibility, but for little/no savings and uses Medicaid as program for possible expansions.
  -- Develop a proposal that provides for state flexibility, but produces some savings -- perhaps through DSH savings or per capita cap.
  -- Oppose changes that reduce coverage.
  -- Oppose changes that eliminate the entitlement nature of program.
  -- Oppose block grant approaches.
  -- Oppose cuts on basis of magnitude.

V. Distribute Draft Talking Points for Review/Comment

RNC TALKING POINTS
SAVING MEDICARE: BILL CLINTON TAKES A HIKE

April 7, 1995

Medicare provides an important source of health security for 32 million of our nation's senior citizens and four million disabled persons. But Medicare spending has been rising 10-11% a year, and if costs continue to soar, everyone will have to pay more: beneficiaries, taxpayers and businesses. If we don't act by the year 2002, the Medicare portion of FICA taxes for everyone will have to be raised 125% from their current level--that's $725 more on a $40,000 salary, and senior citizens will face a 300% increase in annual premiums (Source: 1994 Social Security Trustees Report).

Last year, in their annual report, the Social Security and Medicare Board of Trustees projected that the Part A Trust Fund will be broke by the year 2001. The Trustees, who included Secretary Reich, Secretary Shalala and then-Secretary Bentsen, concluded:

> "The Federal Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about seven years and is severely out of financial balance in the long range."

Today, the trustees told Congress that the Medicare trust fund will go bankrupt by the year 2002. Despite the fact they added another year to the forecast, the trustees called the long-term outlook for Medicare "extremely unfavorable" and recommended "prompt, effective and decisive action" to save the fund from insolvency. A similar call to action was issued last year by the Bipartisan Commission on Entitlement and Tax Reform headed up by Sen. Bob Kerrey (D-Neb.) and former Sen. John Danforth (R-Mo.).

Unfortunately, despite the recommendation of this presidential commission and his own cabinet officials, Bill Clinton has failed to act on Medicare. His FY 96 budget proposed no

solution to the problem, saying it would have to wait for health care reform. But short of admitting in his State of the Union Address that his government-run health care proposal had been a mistake ("I know that last year, as the evidence indicates, we bit off more than we could chew"), Clinton has not advanced a health care proposal this year.

Bill Clinton has basically decided to take a hike on Medicare and the whole issue of balancing the federal budget. Clinton's FY 96 budget contains $200 billion deficits every year as far as the eye can see, adding $1 trillion of new debt to the trillions we already owe. Apparently he's content to stick his head in the sand and leave these problems up to our children, who will be forced to pay enormous taxes as a result of his procrastination.

Republicans believe we owe it to our senior citizens to save Medicare from bankruptcy, and we owe it to our children not to saddle their futures with our debt. In the coming months we will address the problems of Medicare and present our plan to give the country a balanced budget by the year 2002. If Bill Clinton is not going to lead, Republicans will.

o **Simpson and Kerrey to approach health care issue through Medicare and Medicaid reform.** During work on the budget reconciliation bill -- scheduled to begin when Congress returns from the Easter recess -- Republican Sen. Al Simpson and Democratic Sen. Bob Kerrey intend to work together on four separate bills aimed at reforming Medicare and Medicaid. Simpson and Kerrey plan to collaborate with Sen. Pete Domenici on one of the proposals, which would create block grants for state governments to administer their own Medicare and Medicaid systems, according to an aide close to the issue. "Basically, you would have a capitated grant going to each of the states based on their Medicaid-eligible population and the Medicare-eligible population that elect for it. And then people would get a voucher they would use to buy that amount of health insurance," the source said, adding, "The belief is that if you transform the dynamics of the health care market, you slow some of the excess health care cost inflation. And the grants would be capitated, so they wouldn't grow as quickly as Medicare and Medicaid have grown in recent years under their automatic pilot systems." Pointing out that health care costs rise faster than most other costs, the source said, "We would take that excess health care cost inflation and give the growth of the voucher credit for about two-thirds of that. In other words, what you're saying is the value of the vouchers will grow over time in such a way that if these reforms eliminated, say, one-third of the extra cost inflation in health care, the vouchers would be equally valuable in the year 2030 as they are today." Added the source: "In the worst case scenario, if you did nothing to slow down health care inflation by moving to a voucher system, then they'd still be worth about 88% what they are today, in terms of how far the health care dollar would go in the year 2030. But of course, we expect the voucher would even become more valuable over time because we expect the dynamics would be changed in such a way that a significant portion of health care hyperinflation would be eliminated."

Before the voucher legislation is introduced, however, Simpson and Kerrey plan to put forward three other reform proposals. "One would be hiking up Medicare's eligibility age to comport with that of Social Security. We'll gradually shift it up to 70 over the course of 20 years in the next century," a Simpson aide said, adding: "Another one would index the premiums so they stay at a constant percentage of program costs, which they don't now. The new costs are always thrust on the taxpayer and never on the recipient. This would just keep it constant."

Simpson and Kerrey will propose the change in eligibility age first, and then follow that legislation with a bill to "means-test" Medicare recipients. Under Part B, the Federal Government currently pays for 75% of the premium for Medicare. Simpson and Kerrey would require individuals with incomes of $30,000 and couples making $40,000 to pay for 30% of their premiums, while individuals making $60,000 and couples bringing in $100,000 would be required to pay 80%.

The indexing measure will likely be introduced along with the means-testing bill. According to a staffer working on the legislation: "The voucher is the most complicated and it's furthest down the line, but we plan to move all of this in budget reconciliation."

THE WHITE HOUSE

Office of the Press Secretary
(Dallas, Texas)

For Immediate Release April 7, 1995

EXCERPTS FROM

REMARKS BY THE PRESIDENT
TO THE AMERICAN SOCIETY OF NEWSPAPER EDITORS

Loews Anatole Hotel
Dallas, Texas

Health care: In the State of the Union I said I had learned that I bit off more than I could chew last year and we have to reform health care a step at a time. But I haven't forgotten the need to reform health care. Everybody knows we still have problems. It costs too much; there are a lot of people who have inadequate coverage; there are a lot of people who have no coverage at all; and there are millions of Americans who could lose their coverage at any time.

So I call on Republicans to join me in taking this one step at a time, beginning with things the majority of them have long endorsed: First, making benefits portable so you don't lose your health care when you change jobs. Second, requiring coverage for families with a preexisting condition so the whole family doesn't lose health care just because there's been one sick child.

I saw a couple from Delaware on the street in Washington a couple of months ago when I was taking my jog -- the best-looking family you ever saw. The young man and woman looked to be in their late '30s; they had five children. Their fourth child had a birth defect and he was a small businessman -- none of them had any health insurance. That's an intolerable situation in this country, and we shouldn't' put up with it.

The third thing we ought to do is to establish voluntary pools, such as those established in Florida and many other states, which allow small businesses and self-employed people to buy health care on the same terms as those of us who work for government or big corporations can buy it, to put some competitive power behind their need.

The fourth thing we should do is to expand home care for the elderly, so that families who are struggling to keep their elderly parents and grandparents at home in a more independent living setting have some alternative before putting them into a nursing home when it will almost certainly cost the government much, much more money.

And, finally, we ought to do our best in the way of coverage to help families keep their coverage when they're unemployed for an extended period of time. And we should do all this within the context of a determination to hold down the costs of health care -- still the biggest problem for most Americans. We can do this without a tax increase and while working to bring the deficit down. We have been working very hard on this. The numbers clearly make that apparent.

THE WHITE HOUSE

Office of the Press Secretary
(Sacramento, California)

For Immediate Release April 8, 1995

EXCERPTS FROM

REMARKS BY THE PRESIDENT
TO CALIFORNIA DEMOCRATIC PARTY

Convention Center
Sacramento, California

Now, I also ask for your support for three other things. They are unfinished agenda from the New Covenant that I ran on. One is, we've got to do something about health care. (Applause.) Now, I am well aware that by the time the interest groups and our political adversaries get through spending $300 billion to tell the American people how lousy my ideas were, reverse plastic surgery had been performed on them. (Laughter.) And I am well aware of the fact that the American people believe that I bit off more than I could chew in the bill I sent to Congress last year.

But I also have not forgotten the fact that we got over 1 million letters, Hillary and I did, from people who had heartbreaking problems, that there are people every year who have to give up more and more coverage because of the cost of health care, that there are millions of people who don't have any health insurance, that we are the only wealthy country in the entire world where there's a smaller percentage of people today with health insurance than people who had it 10 years ago. Nobody else has this problem; only us, because we refuse to deal with it.

So let's take it one step at a time. Let's say, you cannot lose your health insurance when you change jobs. Let's make the benefits portable. (Applause.) Let's say that a family ought to be able to get health insurance even if somebody in the family has been sick. Preexisting conditions preventing people from getting health insurance is wrong. Let's say that every state ought to have a huge pool where all small business people and farmers and self-employed people can buy health insurance from the same price as those of us who work for government or big corporations can buy it. (Applause.)

And let's expand home care for the elderly and the disabled, so that they don't have to spend themselves into poverty and go into a nursing home to get any decent care. We can afford to do this. (Applause.)

My fellow Americans, we can afford to do this without raising taxes and without expanding the deficit, while lowering the deficit. We can do these things. So let's ask them to do it. And let's do two more things. Let's ask the Republicans to start acting like Republicans used to act and join with us as Democrats and raise the minimum wage. (Applause.)

EFFECTS OF CAPPING MEDICAID **DRAFT**

IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
  - About 60% of Medicaid spending is for elderly and disabled people. (This includes both long-term care and acute care spending .)
- Republicans have proposed (through the use of a block grant with a 5% cap on growth) to cut federal Medicaid funding by more than $190 billion between now and 2002 a 30% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting $190 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. Even under optimistic assumptions, managed care could produce only about $10 billion in savings between now and 2002. The remaining $180 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.
- Finding the remaining $180 billion in Medicaid cuts without cutting provider fees which are already much lower than in the private sector would require massive reductions in health coverage and services. The number of uninsured Americans, currently about 40 million, would increase substantially.

To illustrate the types of cuts that states would have to make, cutting $180 billion through a combination of benefit and coverage reductions would require:

  - Elimination of coverage for prescription drugs, dental care, and personal care services by 2002, and
  - Elimination of Medicaid coverage for more than 13 million kids or for more than 2 million elderly or disabled people.

- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, the states could save money only if they cut more than $190 billion out of Medicaid.

VARIATION ACROSS STATES

- An across-the-board 5% cap on Medicaid spending does not recognize significant differences across states, leaving some states even harder hit than these numbers suggest.

  - Growth rates vary significantly across states and over time in a given state. Across states, variation results from differences in population, regional medical costs, enrollment patterns, and service mix. Over time, a state's growth rate can change because of recession or other economic factors.

  - When a recession occurs in a state, the number of people without work who qualify for Medicaid can rise dramatically, increasing program costs. With a cap on federal Medicaid payments, states would bear this burden.

  - Ironically, states with the most efficient programs are most penalized by a 5% cap -because it is hardest for them to find additional savings.

  - Retirement states with large numbers of elderly residents would bear a disproportionate burden as the population ages.

- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission on the Future of Medicaid finds that a 5% cap on the growth of federal Medicaid payments would cost states over $167 billion between 1996 and 2002. [Note: This estimate is about $25 billion less than the CBO baseline estimate].

  - New York, California, Texas, Florida and Ohio would lose the largest amounts. New York would lose $18.5 billion, California over $14 billion, Texas almost $11 billion, Florida $9.5 billion, and Ohio over $7 billion.

  - States in the South and Mountain regions would have the biggest percentage reductions in federal payments. Reductions during the period would average over 20% in states such as Florida, Georgia, Arkansas, Colorado, Montana, West Virginia and North Carolina.

NO EVIDENCE THAT THIS LEVEL OF GROWTH IS ACHIEVABLE WITHOUT SEVERE CUTS

- Republicans claim that managed care can generate enormous savings.

  - But, there is no evidence that managed care alone can achieve the level of cuts they are proposing.

- States already are aggressively pursuing managed care, but the populations for whom care can readily be managed children and AFDC adults account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

- Applying managed care techniques to the services typically used by the elderly and disabled (such as long-term care) is largely untried, making the potential for savings hard to predict.

- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care is not a real option.

- Some may point to low Medicaid growth rates in certain states as evidence that a 5% cap on growth is achievable.

  - While a few states may be able to hold growth down to 5% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.

  - Since 1992, 19 states have applied for state-wide health reform demonstration waivers from the Department of Health and Human Services. Under these waivers, states are able to change their Medicaid programs to increase efficiency and expand coverage. No state has projected an annual growth rate over the period at or below 5%.

- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.

DRAFT

EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans have proposed to cut Medicare funding by $300 billion between now and 2002 -- a 24% cut in 2002 alone.

- Medicare managed care cannot produce the magnitude of savings being proposed by the Republicans. For example, Senator Gregg predicts that managed care could save $35 - $45 billion between 1996 and 2000, although there is no evidence that managed care can produce Medicare savings of this magnitude. But even this overly optimistic projection produces less than one-third of the cuts being proposed by Republicans.

  - Claims that substantial savings can be achieved through Medicare managed actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.

  - CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the necessary changes to the existing payment system would be "difficult to specify."

  - Even with an improved payment methodology, the savings to Medicare would be only small percentage of cuts being proposed by Republicans.

- Even if the level of savings suggested by Senator Gregg (extended through 2002) for Medicare managed care could be realized, the proposed cuts would have serious impacts on beneficiaries and providers. If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:

  - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about $2,980 more for Medicare. In 2002 alone, they would be required to pay about $775 more.

  - In 2002 alone, a $32 billion cut in Medicare payments to hospitals, physicians and other health care providers would be needed.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.

  - There are now 40 million uninsured Americans, and this number will continue to grow.

- These unprecedented Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

  - Republicans are talking about combined Medicare and Medicaid cuts of almost $500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts by raising their rates for private patients. Even if only one-quarter of these cuts are passed on to private payers, businesses and families will be forced to pay $125 billion more for health care between now and 2002.

- Reducing Medicare payments would disproportionately harm rural hospitals.

  - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to primarily serve Medicare patients.

  - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

  - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.

  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

- In the last Congress, bills sponsored by both Republicans and Democrats contained large Medicare cuts. However, unlike current Republican proposals, the bills last year reinvested their savings into the health care system through subsidies to expand insurance coverage. Reinvesting the savings would have reduced the uncompensated care burden on providers and businesses and mitigated many of the adverse effects of Medicare cuts.

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.

  - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about 1% faster than private health insurance.

  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

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

21-Apr-1995 04:35pm

TO: (See Below)

FROM: Stacey L. Rubin
Domestic Policy Council

SUBJECT: HEALTH CARE MEETING WITH POTUS

There will be a health care strategy meeting with the President on Thursday, April 27 from 5:00 pm to 6:00 pm in the Cabinet Room. This is a principals plus one meeting. Participants include:

Vice President
Mrs. Clinton
Mrs. Gore
Secretary Rubin
Secretary Reich
Secretary Shalala
Leon Panetta
Erskine Bowles
Harold Ickes
Carol Rasco
Laura Tyson
Pat Griffin
George Stephanopoulos
Mark Gearan
Mike McCurry
Alice Rivlin
Ira Magaziner
Jack Quinn
Joe Stiglitz

If you have any questions, please contact Stacey Rubin at 456-5585.

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STATUS REPORT

Update on Policy Options Development:

Medicare:

-- Impact Analysis of Medicare Cuts Finalized
-- Reviewing Acceptable Medicare Savings Proposals
-- Medicare Managed Care Proposal Now Available

Medicaid:

-- Impact Analysis of Medicaid Cuts Finalized
-- Developing Medicaid Coverage Expansion Options
-- Finalizing Medicaid Flexibility Options (in or out of reform)

Context for POTUS Briefing

-- Health care coverage and costs still a problem
-- Stress that neither Medicare savings nor deficit reduction can be achieved outside the context of health reform.
-- Defining Administration's vision of health care in new environment

Need Direction on the Following for POTUS Meeting:

Medicare:

-- Role of Managed Care in Public Statements
-- Trust Fund Positioning Debate
-- Acceptable Level of Savings

Medicaid:

-- Specific vs. General Discussion

Budget Interaction:

-- Presentation of Impact of Savings on Deficit

Other Health Reform Initiatives: Where/If Placed in Presentation

APR 13 1995

DRAFT

PROPOSED MEDICARE MANAGED CARE INITIATIVE

HHS's approach to expanding and improving Medicare managed care options involves four elements that are interrelated:

- Expanding the types of managed care options available to Medicare beneficiaries and the types of organizations offering managed care products;
- Improving the Average Adjusted Per Capita Costs (AAPCC) payment methodology and developing alternatives;
- Fostering continuous improvement in health plan quality; and
- Making Medicare beneficiaries more informed about managed care.

Our strategy is aimed at improving current options and offering new options through high-quality, private managed care plans that meet beneficiaries' needs and which are paid fairly.

EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS

Background - Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option (entities with risk or cost contracts and Medicare SELECT plans). This 9 percent figure does not include beneficiaries who have supplemental coverage through a managed care plan as retirees.

1994 was a year of impressive growth in Medicare managed care with double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

Although managed care in Medicare is strong and growing, we need to do more to expand options so that Medicare beneficiaries will have the same range of choices as are available to commercial enrollees.

Initiatives

- Preferred Provider Organizations. Legislation will be proposed to allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under this new authority include commercial PPOs that:

  - Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);

  - Share risk with an employer or other entity (other than its providers); and/or

  - Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

  Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

- Self-Referral Option. HHS is currently developing guidelines, under existing statutory authority, for current risk contractor to offer SRO with implementation anticipated by 1996. The SRO would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace. In contrast to the PPO option, the HMO-based SRO would be optional for both plans and enrollees. Plans would not have to offer such a benefit but if they did it would be as an optional benefit. Plans would have flexibility on the design of the SRO; however, all Medicare-covered services would have to continue to be available and accessible in-network for all enrollees.

- Integrated Delivery Systems. HHS is also planning to use its demonstration authority to explore the possibilities of contracting on a risk or partial risk basis with integrated delivery systems (e.g., hospital-physician organizations) that are not already HMOs or that could not meet the PPO requirements. Preliminary discussions are already underway with a number of such systems.

IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES

Background - The current payment methodology for risk contractors, the adjusted average per capita cost (AAPCC) methodology, is often viewed as a flawed methodology. There is no adjustment for health status, and payments vary from area to area in ways that do not reflect variation in HMO costs across areas. The rates are derived through a complex computation method that has been controversial in and of itself, but the methodology is not necessarily inaccurate in what it is intended to accomplish (which is to predict fee-for-service costs on a county-by-county basis).

For Medicare to benefit from an expansion of managed care, significant improvements are needed in the way that Medicare pays plans. Managed care currently costs the Medicare program rather than achieving savings. HHS evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that plans attract the healthier members of the Medicare population whose health care costs are lower and a workable health status adjustor is currently not available.

Initiatives

- Risk Adjusters. For the past decade, HHS has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should produce health status adjusters that can be used on a pilot or demonstration basis as early as 1996. HHS has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

- Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate using competitive pricing for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/61)

- Alternative Payment Demonstrations. HHS has entered into discussions with Kaiser to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be

adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees. In addition to this potential demonstration with Kaiser, HHS will soon issue a broad solicitation for demonstrations of alternative payment methodologies and risk sharing arrangements.

- o Partial Risk. Under another legislative proposal, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC.
  - + If total payments were less than the target, the plan would receive half of the difference.
  - + If total payments exceeded the target, the plan would receive half of that amount. However, Medicare payments could not exceed 100 percent of the AAPCC. (See HCFA-96/72)
- o AAPCC Technical Changes. Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology, e.g., MSA, rather than county-based, rates.

FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

Background - Monitoring quality of care for risk plans is especially important since capitation provides financial incentives to limit medical care. HHS monitors the quality of care provided by Medicare managed care plans through a variety of methods -- complaint monitoring, appeals monitoring, site visits, disenrollment data and external review by Peer Review Organizations (PROs).

PROs monitor quality by conducting medical record reviews for a sample of Medicare beneficiaries enrolled in the managed care plan. This approach can be confrontational and does not give plans insights into systemic problems in the delivery of care. It also does little to help guide them to make fundamental improvements in care.

Initiatives

- o Cooperative Improvement Projects. HHS is moving away from medical record review and towards the development of performance indicators and cooperative improvement projects between the PROs and risk plans.
- o Performance Indicators. For example, HHS plans to pilot

test a set of performance indicators developed by the Delmarva Foundation in several risk plans. Based on the performance indicators, the PRO and the risk plans will work cooperatively to develop an appropriate quality improvement plans. In a complimentary project, HHS also plans to begin collaborating with the National Committee on Quality Assurance (NCQA) to expand HEDIS to include performance indicators relevant to the Medicare population.

- o Encounter Data. Quality assurance systems utilizing performance indicators requires that managed care plans collect comparable, encounter data. However, due to the nature of capitation, most managed care plans do not collect this data. HHS plans to convene public and private purchasers of health care services and managed care plans to discuss issues regarding the collection of encounter data.

INFORMATION\ENROLLMENT

Currently, Medicare beneficiaries do not have the information needed to make an informed choice about available managed care and Medigap options. Even if information were available, comparisons are complicated by varying benefit packages in managed care plans and the use of different premium rating methodologies by Medigap insurers. Limited open enrollment for Medigap further complicates choices.

While Medigap insurers are only required to offer a one-time open enrollment period, Medicare managed care plans are required to offer an annual open enrollment period of at least 30 days to all Medicare beneficiaries living in the service area. As a result, beneficiaries who enroll in managed care plans (and stay enrolled through their Medigap open enrollment period) lose their opportunity to purchase the Medigap plan of their choice.

Initiatives

- o Consumer Information. As part of the competitive pricing demonstration described above HHS will be exploring how best to communicate to beneficiaries their available managed care and Medigap choices.

- o Level Playing Field. Under a legislative proposal, the current limited open enrollment for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)

AGENDA FOR HEALTH CARE MEETING WITH THE PRESIDENT

April 27, 1995

I. Where Republicans Now Stand On Health Policy: Medicare and Medicaid Cuts

- Deficit and tax reduction targets require unprecedented Medicare and Medicaid cuts
- Republicans extremely nervous about public perception of cuts -- particularly Medicare
- Republicans seeking cover from us
- Republicans taking actions to pressure us

II. Where Administration Stands on Health Policy: Medicare and Medicaid

- Did not include new Medicare/Medicaid in budget
- Have taken position that we oppose health care cuts outside context of broader reform

III. Where Administration May Be Vulnerable

- Critique that we fall far short on need for deficit reduction and for strengthening the Medicare Trust Fund
- Omission of health care makes significant inroads on these problems impossible
- Conversely, because the Administration's language on what we are for and against has been fairly general to date (i.e., insurance reform, purchasing cooperatives, and some long-term care), we may have set the bar too low and have inadvertently made it too easy for Republicans to claim a deal is at hand.

IV. How Could We Respond and What Do We Want To Do?

- Presentation of revised sources and uses table, which includes the deficit line and the likely Republican health cuts
- Discussion about desired levels of health care re-investment and deficit reduction
- Discussion of strategic positioning with regard to savings/reform proposals
- Presentation of illustrative examples

V. Define Health Care Message for Senate Retreat, Upcoming Hearings, and White House Conference on Aging

- Discuss message options
- Specific message recommendations will be provided to help focus discussion

Chart 1

Fiscal Years, Billions of Dollars

		5 Years 1996-2000	7 Years 1996-2002	10 Years 1996-2005
Frozen CBO Baseline (Assuming Domenici Discretionary Freeze)		619.0	1,078.0	Not Available
Republican Medicare/Medicaid Savings ($250 bil./$160 bil.)		**207.6**	**414.8**	**925.1**
As percent of Frozen CBO Baseline		33.5%	38.5%	
-- Medicare savings		**128.3**	**250.1**	**550.4**
-- Medicaid savings		**79.3**	**164.7**	**374.8**
Moderated Republican Medicare Savings Proposals				
-- Beneficiaries	2/	15.2	25.1	45.0
-- Providers		39.1 - 54.5	70.9 - 102.3	136.1 - 209.2
-- Receipts		7.1	9.9	13.5
-- Medicare managed care	3/	7.7	13.6	25.9
Total Medicare Savings		**69.1 - 84.5**	**119.5 - 150.9**	**220.5 - 293.6**
Mediciaid				
-- Disproportionate Share Hospital Payment Reform		16.0 - 22.3	24.0 - 34.4	38.0 - 56.1
-- State Flexibility				
-- Medicaid managed care	4/	1.2	4.5	10.8
-- Boren Amendment reform		Possible savings, but not scoreable.		
Possible Republican Revenue Proposals				
-- I		22.2	33.9	50.9
-- II		49.4	69.5	98.9
-- III		61.8	87.0	123.8
Total Sources of Funds with:				
-- No Revenue Proposals		**86.3 - 108.0**	**148.0 - 189.8**	**269.3 - 360.5**
-- Revenue Proposals		**108.5 - 169.8**	**181.9 - 276.8**	**320.2 - 484.3**

Footnotes for Possible Sources of Funds Table

1/ **Current services deficit. Deficit projections beyond 2000 are not public.**

2/ Includes income-related Part B premium which can also be considered a receipt proposal.

3/ Any proposal that increases enrollment without altering the current Medicare managed care payment system would be scored by CBO as an additional cost to the Medicare program (because Medicare risk HMOs experience favorable selection). The Administration is developing a proposal modifying the current Medicare managed care program. If no changes are made to current payment method, the proposal could be scored as a cost. Alternatively, the proposal could be crafted to be budget neutral or to produce savings. The savings estimate on this chart should be considered a placeholder. The pricing associated with this provision reflects the proposals to impose floors and ceilings for Part B HMO payments and to eliminate IME, GME, and DSH payments from the AAPCC.

4/ Most optimistic assumption for estimating Medicaid managed care savings.

Chart 2

Fiscal Years, Billions of Dollars

	5 Years 1996-2000	7 Years 1996-2002	10 Years 1996-2005
Total Sources of Funds with:			
-- No Revenue Proposals	86.3 - 108.0	148.0 - 189.8	269.3 - 360.5
-- Revenue Proposals	108.5 - 169.8	181.9 - 276.8	320.2 - 484.3
Subsidy Programs			
-- Kids only (133% - 240%)	21.9	34.8	56.6
-- Temporarily unemployed only (100% - 240%)	16.9	28.6	50.1
Tax Credits	?	?	?
Medicaid Investment Fund 2/	44.5	68.2	107.0
Long-term Care Program			
-- Capped entitlement to states	6.2	9.7	15.4
-- Long-term Care Tax Changes	3.0	5.1	9.2
Public Health Service Expansion	1.4	2.0	3.0
Self-employed Tax Deduction Phased to 100%	4.6	8.4	15.7

Note that coverage expansions are not mutually exclusive and can be combined. For example, subsidy program can include subsidies for kids and temporarily unemployed.

1/ Current services deficit. Deficit projections beyond 2000 are not public.

2/ Funding for Medicaid Investment Fund dependent upon Revenue I and savings from Medicaid DSH payment reform. Scope of coverage expansion can be broad or limited, for example, to kids only.

OPTION I

FOR ILLUSTRATIVE PURPOSES ONLY

Initiatives

MEDICAID INVESTMENT FUND

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

LONG TERM CARE INITIATIVES

Sources of Funds

REPUBLICAN REVENUE I OPTION

MEDICAID MANAGED CARE

MEDICAID DSH (HIGH OPTION)

MODERATED REPUBLICAN MEDICARE & MANAGED CARE SAVINGS (HIGH OPTION)

	1996–2000	1996–2002	1996 –2005
Medicaid Investment Fund	44.5	68.2	107.0
Self-Employed Tax Deduction	4.6	8.4	15.7
Long Term Care Initiatives	9.2	14.8	24.6
TOTAL COSTS:*	$ 58.3	91.4	147.3
Republican Revenue I Option	22.2	33.9	50.9
Medicaid Managed Care	1.2	4.5	10.8
Medicaid DSH (High Option)	22.3	34.4	56.1
Republican Medicare & Managed Care Savings (High Option)	84.5	150.9	293.6
TOTAL FINANCING:*	$130.2	223.7	411.4
NET SAVINGS/DEFICIT IMPACT:	**$71.9**	**132.3**	**264.1**
PERCENTAGE OF CBO DEFICIT:	12%	12%	N/A

*FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by HHS and Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included
Dollars in billions

OPTION II

FOR ILLUSTRATIVE PURPOSES ONLY

Initiatives

KIDS' PROGRAM (UP TO 240% OF POVERTY)

TEMPORARILY UNEMPLOYED PROGRAM (UP TO 240% OF POVERTY)

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

LONG TERM CARE INITIATIVES

PUBLIC HEALTH INVESTMENT

Sources of Funds

REPUBLICAN REVENUE II OPTION

MEDICAID MANAGED CARE

MEDICAID DSH (HIGH OPTION)

MODERATED REPUBLICAN MEDICARE & MANAGED CARE SAVINGS (HIGH OPTION)

	1996-2000	1996-2002	1996 -2005
Kids' + Temporarily Unemployed Programs	36.7	60.0	101.1
Self-Employed Tax Deduction	4.6	8.4	15.7
Long Term Care Initiatives	9.2	14.8	24.6
Public Health Investment	1.4	2.0	3.0
TOTAL COSTS:*	$ 51.9	85.2	144.4
Republican Revenue II Option	49.4	69.5	98.9
Medicaid Managed Care	1.2	4.5	10.8
Medicaid DSH (High Option)	22.3	34.4	56.1
Republican Medicare & Managed Care Savings (High Option)	84.5	150.9	293.6
TOTAL FINANCING:*	$157.4	259.3	459.4
NET SAVINGS/DEFICIT IMPACT:	**$105.5**	**174.1**	**315.0**
PERCENTAGE OF CBO DEFICIT:	17%	16%	N/A

*FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by HHS and Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included
Dollars in billions

OPTION III

FOR ILLUSTRATIVE PURPOSES ONLY

Initiatives

TEMPORARILY UNEMPLOYED PROGRAM (UP TO 240% OF POVERTY)

SELF-EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICAID MANAGED CARE

MEDICAID DSH (HIGH OPTION)

MODERATED REPUBLICAN MEDICARE SAVINGS (LOW OPTION)

	1996–2000	1996–2002	1996 –2005
Temporarily Unemployed	16.9	28.6	50.1
Self–Employed Tax Deduction	4.6	8.4	15.7
TOTAL COSTS:*	$ 21.5	37.0	65.8
Medicaid Managed Care	1.2	4.5	10.8
Medicaid DSH (High Option)	22.3	34.4	56.1
Republican Medicare Savings (Low Option)	61.4	105.9	194.6
TOTAL FINANCING:*	$84.9	144.8	261.5
NET SAVINGS/DEFICIT IMPACT:	**$63.4**	**107.8**	**195.7**
PERCENTAGE OF CBO DEFICIT:	10%	10%	N/A

*FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by HHS and Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included
Dollars in billions

OPTION IV

FOR ILLUSTRATIVE PURPOSES ONLY

Initiatives

LONG TERM CARE INITIATIVES

PUBLIC HEALTH INVESTMENT

Sources of Funds

MEDICAID MANAGED CARE

MEDICAID DSH (LOW OPTION)

MODERATE REPUBLICAN MEDICARE & MANAGED CARE SAVINGS (HIGH OPTION)

	1996–2000	1996–2002	1996 –2005
Long Term Care Initiatives	9.2	14.8	24.6
Public Health Investment	1.4	2.0	3.0
TOTAL COSTS:*	$ 10.6	16.8	27.6
Medicaid Managed Care	1.2	4.5	10.8
Medicaid DSH (Low Option)	16.0	24.0	38.0
Moderated Republican Medicare & Managed Care Savings (High Option)	84.5	150.9	293.6
TOTAL FINANCING:*	$101.7	179.4	342.4
NET SAVINGS/DEFICIT IMPACT:	**$91.1**	**162.6**	**314.8**
PERCENTAGE OF CBO DEFICIT:	15%	15%	N/A

*FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by HHS and Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included
Dollars in billions

White House Conference on Aging Speech

Message: As Medicare and Medicaid are being threatened by deep and arbitrary cuts proposed by Republicans, I am fighting to protect coverage, choice, quality and affordability for seniors.

Outline:

- **Background on Medicare and Medicaid. Medicare and Medicaid have provided a safety net for our nation's elderly for 30 years.** Today, Medicare covers 37 million elderly and disabled Americans. And, while most people think that Medicaid helps only low-income women and children, about two-thirds of Medicaid funds are spent on services for older Americans and people with disabilities.

  These programs are an example of government that works. This year, as we celebrate the 30th anniversary of their passage, we must remember that:

  - Medicare and Medicaid have lifted millions of older Americans out of poverty. Before Medicare, almost 30 percent of our nation's elderly lived in poverty -- as compared with 12 percent today.

  - Before Medicare, about 45 percent of the elderly had no health insurance and even more were underinsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise. And Medicaid has helped middle class families who have exhausted their savings to manage the overwhelming costs of nursing home care.

- **The Need to Address Health Care Spending.** But there are real problems in Medicare and Medicaid that need to be addressed. We cannot get a hold of the deficit without addressing growing health care entitlement spending. Over the next five years alone, almost 40 percent of the growth in Federal spending will come from rising costs in Federal health care programs. They are growing faster than GDP, than overall inflation, than almost all other items of government spending. If we want to bring the deficit under control and reduce the debt we bequeath to future generations, we must address the growth in these programs. In addition, the long-term solvency of the Medicare Trust Fund remains a problem. **We must contain costs in these programs, but there is a right way and a wrong way to do so.**

- **The Wrong Way to Address Health Care Spending. The wrong way is:**

  - **To simply slash Medicare and Medicaid;**

  - **To use these programs as a bank to pay for tax cuts for the wealthy;**

- **To go backward and reduce coverage; and**

- **To make changes in Medicare that call for coercion over choice.**

  The Republicans claim that they would increase choice by giving Medicare beneficiaries vouchers to buy insurance in the private market. In reality, these vouchers would pay for only the low cost health plans in an area. Your choice would be simple: take the cheapest plan or pay more. That's not choice, that's financial coercion.

- **<u>The Right Way to Address Health Care Spending.</u> The right way is through health care reform.**

  - First, we need to build for our future and our childrens' futures by addressing the long-term solvency of the Medicare Trust Fund.

    - The Medicare Trust Fund is in better shape now than it appeared two years ago because of the actions we took in our 1993 budget and because of the strong 1994 economy.

    - But, as with Social Security, we need to make a bipartisan commitment to keep Medicare sound and secure throughout the 21st century. The Trustees have recommended that a bipartisan commission be appointed to review this problem thoroughly, and I am prepared to work with Congress to get the commission in place.

  - **And as we consider changes to Medicare and Medicaid this year, we must ensure that any proposed change maintains coverage, choice, quality and affordability for beneficiaries.**

    I will have a simple test for every proposal. I will ask:

    (1) **Coverage.** Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans or take away services -- like the limited nursing and home care services now provided under Medicaid -- that Americans have now?

    (2) **Choice.** Does it expand choice -- so that Medicare beneficiaries have the range of choices (like managed care and preferred provider plans) available in the private market -- or does it financially coerce beneficiaries into managed care plans?

    (3) **Quality.** Will this proposal reform the Medicare and Medicaid programs to make them more efficient without harming the delivery system, threatening quality and increasing cost shifting to small businesses? Or are these simply arbitrary and excessive cuts used to

pay for other priorities -- like tax cuts for the wealthy?

(4) **Affordability.** Will this proposal increase costs for beneficiaries so much as to make Medicare unaffordable?

- We also can and should work toward guaranteeing health security to all Americans and containing costs for all families and businesses and for the government. As I have said before, this year I believe we can take the first steps. Congress has already passed legislation that will make insurance more affordable for self-employed workers and their families. We can also:

  - Reform the insurance market -- so that people don't lose their health insurance when they lose their job or change jobs or a family member falls ill, and so that small businesses can afford to buy insurance for their workers;

  - Make coverage more affordable for working families;

  - Help workers who lose their jobs keep their health insurance;

  - Continue the start already made to level the playing field for the self-employed; and

  - And help families provide long-term care for a sick parent or disabled child. That is why we support expanding state administered home care services. And that is why we support tax clarifications for private long-term care insurance as well as consumer standards so that long-term care insurance policies are worth more than the paper they are written on.

- My Administration is also taking steps now to reform our health care system and to improve Federal health care programs. We have cracked down on fraud and abuse and will increase these efforts through a new program I am announcing this week as part of our "Reinventing Government" proposal. This is just one example of the "right way" to reform our health programs.

DRAFT

EFFECTS OF REPUBLICAN MEDICARE CUTS

MAGNITUDE OF THE PROPOSED CUTS

- Republicans are considering proposals that would cut Medicare funding by $250 billion between now and 2002 -- a 20% cut in 2002 alone.

  These cuts would mean that older and disabled Americans could pay more for health care, the health care delivery system would be threatened, rural Americans would lose access to needed services, and businesses would bear the burden of increased costs.

BURDENS ON THE ELDERLY AND DISABLED, THE HEALTH CARE SYSTEM AND ON BUSINESSES

- Even if one assumes optimistic managed care savings and the remaining cuts are allocated evenly between beneficiaries and health care providers:

  - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about **$2,630 more** for Medicare. In 2002 alone, they would be required to pay about $680 more.

  - In 2002 alone, a $28 billion cut in Medicare payments to hospitals, physicians and other health care providers would be needed.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.

  - There are now 40 million uninsured Americans, and this number will continue to grow, particularly in light of the Medicaid cuts being advocated by the Republicans.

- These unprecedented Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

  - Republicans are talking about combined Medicare and Medicaid cuts between $400 billion and $500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts by raising their rates for private patients. Even if only one-quarter of these cuts are passed on to private payers, businesses and families will be forced to pay between $100 billion and $125 billion more for health care between now and 2002.

- In the last Congress, bills sponsored by both Republicans and Democrats contained large Medicare cuts. However, unlike current Republican proposals, the bills last year reinvested their savings into the health care system. Reinvesting the savings would have reduced the uncompensated care burden on providers and businesses.

DRAFT

BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
  - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
  - Significant reductions in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often already substantial local subsidies.
  - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

MANAGED CARE WON'T ACHIEVE SUBSTANTIAL SAVINGS UNLESS BENEFICIARIES ARE COERCED OUT OF FEE-FOR-SERVICE PLANS

- Medicare managed care cannot produce the magnitude of savings being suggested by the Republicans. Claims that substantial savings can be achieved through Medicare managed care actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.
- Although Senator Gregg predicts that managed care could save $35 – $45 billion between 1996 and 2000, there is no evidence that managed care can produce Medicare savings of this magnitude. Even if one assumes the type of overly optimistic savings Senator Gregg suggests (extended for seven years), the savings would represent less than one-fourth of that targeted by Republicans.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
  - Under Administration estimates, Medicare spending <u>per person</u> is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about 1% faster than private health insurance.
  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

DRAFT

EFFECTS OF CAPPING MEDICAID

MAGNITUDE OF THE PROPOSED CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities. About 60% of Medicaid spending is for elderly and disabled people.
- Republicans are considering cutting (through the use of a block grant with a 6% cap on growth) federal Medicaid funding by more than $160 billion between now and 2002 -- a 25% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really suggesting is cutting $160 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. It is unlikely that managed care can produce more than $5 billion in "scorable" savings between now and 2002.
- The remaining $155 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.

EFFECT ON PROVIDERS, BENEFITS, AND COVERAGE

- Providers: Cutting provider payments by $155 billion would mean an 10% reduction in revenues providers receive from Medicaid between now and 2002. In 2002 alone, the cut in provider payments would amount to 16%.
- Benefits: Cutting $155 billion out of Medicaid by reducing benefits would require the outright elimination of a long list of critical services by 2002. Even if Republicans eliminate coverage for prescription drugs, home health care and other home and community-based services, and preventive and diagnostic screening services for children, they still would not offset the cuts.
- Coverage: Cutting $155 billion by limiting eligibility would require, for example, eliminating coverage for almost all children covered by Medicaid (over 20 million in 2002) or for over 3 million elderly or disabled people.
- Combination of Benefits and Coverage: Cutting $155 billion through a combination of benefit and coverage reductions would require:
  - Elimination of coverage for prescription drugs, dental care, preventive and diagnostic screening services for children, and hospice in 2002, and
  - Elimination of Medicaid coverage for more than 5.8 million kids and for more than 800,000 elderly or disabled people.

- Combination of Benefits and Coverage: Cutting $155 billion through a combination of cuts in provider payments, benefits and coverage reductions would require:

  - Reducing payments to hospitals, physicians and other health care providers by over $50 billion between now and 2002. The cut in 2002 alone would be about $14 billion, and

  - Elimination of outpatient prescription drugs for the tens of millions of Medicaid beneficiaries in 2002, and

  - Eliminating coverage for roughly 3.5 million children and over half a million elderly and disabled together would offset the remainder of the cuts in 2002.

MEDICARE/MEDICAID CUTS:
ADVOCACY AND PROVIDER GROUP'S RESPONSES

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least $2000 more out of pocket than they would pay under current law. And over the next seven years they would pay $3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to chose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)

In

Melanne
Bruce Vladeck
Chris
Geo. S.
Tyson
Rivlin
Griffin
Panetta
Reich
Rubin
T. Gore
HRC
Ira / Stu / Sperling
Out

Bowles
Ickes
Gearan
Ira (HRC to decide)
Stiglitz
Angel
Feder
Harris
Galston
Jennifer
Klepner
Mark Maguire
Meredith
Nancy Ann Min
Munnell
Janet Murguira
Jack Quinn
Gene Sperling

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1995-2000	Total 1995-2002	Total 1995-2005
OUTLAYS														
Kids' Program (1,2)														
Free to 133%, Phase-Out to 240%	0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	34.8	56.7
Temporarily Unemployed Program (2,3)	0.0	0.0	3.0	4.2	4.6	5.1	5.6	6.1	6.6	7.2	7.7	16.9	28.6	50.1
Public Health/ FQHC	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	1.5	2.0
Long Term Care Program														
Expand Home & Community Based Services	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	9.7	15.4
REVENUES (4)														
Program Revenue Offsets (6)	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	1.2	2.0
Self-Employed Deduction														
100% Deduction Phased In (5)	-0.5	-0.5	-0.9	-1.4	-2.0	-2.2	-2.4	-2.7	-3.0	-3.2	-3.5	-7.5	-12.6	-22.3
Long Term Care														
Long-Term Care Insurance Tax Incentives	0.0	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-1.0	-1.1	-1.2	-1.4	-2.5	-4.3	-8.0
Personal Assistance Services Tax Credit	0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4	-0.7	-1.2

Note: Administrative costs are not included in these estimates; ASSUME NO INTERACTION BETWEEN KIDS' AND TU PROGRAM (STAND-ALONE ESTIMATES)

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues. ASSUMES TEMPORARILY THAT ESI PARTICIPATE AT 100%

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

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

(5) Phase in: 25% in 1994, 25% in 1995, 50% in 1996, and 75% in 1997 and 100% in 1999. Assumes the self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

(6) Does not include the revenue offsets from the temporarily unemployed program.

28-Apr-95
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LAST

(ANT)

Participants in the Temporarily Unemployed Program, 1997
(Persons in Millions)

Health Insurance Status Prior to Unemployed Spell

	Formerly Uninsured	Medicaid	Employer-Sponsored	Non-Group	Other	Total
Participants	1.0	1.0	3.3	0.9	0.1	6.3

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▸

To JENNINGS | From THORPE

Dept./Agency | Phone #

Fax # | Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To CHRIS	From KEN THORPE
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Brief Program Descriptions

Temporarily Uninsured.

All families that have a head or spouse who is unemployed at least one month during the year and receiving unemployment compensation are eligible. Families with monthly cash incomes at or below 100% of poverty will receive vouchers for the full cost of health insurance premiums for up to 6 months provided the spouse of the unemployed person is not receiving employer-sponsored insurance where the employer contributes 80% or more of the premium.

Families with incomes between 100 and 240% of poverty (again measured on a monthly cash income basis) will be eligible for subsidies on a linear sliding scale for up to 6 months. The stipulation concerning the spouse's ESI also applies here.

Benefits provided are assumed similar in actuarial value to the BCBC standard option.

Issues

1. Health insurance subsidies for persons who are unemployed are likely to increase the duration of unemployment, and in turn, the costs of subsidies and unemployment compensation.

2. What to include in the monthly definition of income--should UI be included?

Kids Program

Full subsidies are provided to children in months when their family cash income is below 133% of poverty. Partial subsidies are provided on a linear scale up to 240% of poverty. There is no limit on the number of months that children can receive subsidies.

Mandatory medicaid-eligible children, including those eligible under OBRA-90 phase-ins are not eligible for subsidies. Children in families receiving ESI where the employer contributes 50% or more toward dependent coverage are not eligible. Children receive benefits equivalent to BCBS standard option. By assumption, the estimates assume that all kids receiving optional Medicaid coverage will come into the new program.

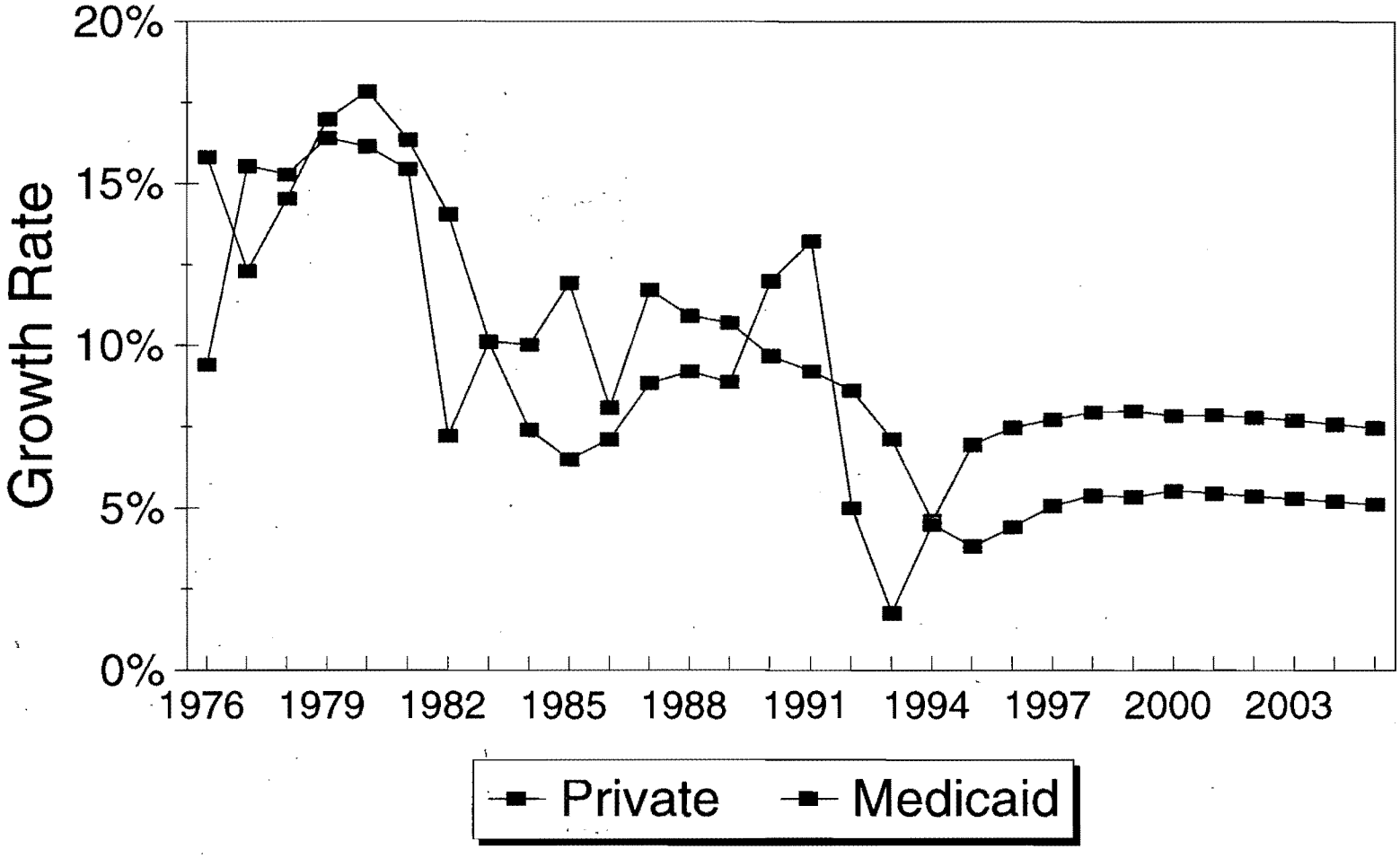
Issues

1. Extent to which employees/employers that provide dependent coverage drop it in favor of the new program (design trade-off--the higher the subsidy schedule, the more dropping).

2. Should eligibility be based on monthly, quarterly or annual. Easier to administer shorter income definition--also substantially more expensive.

Per Capita Expenditure Growth *

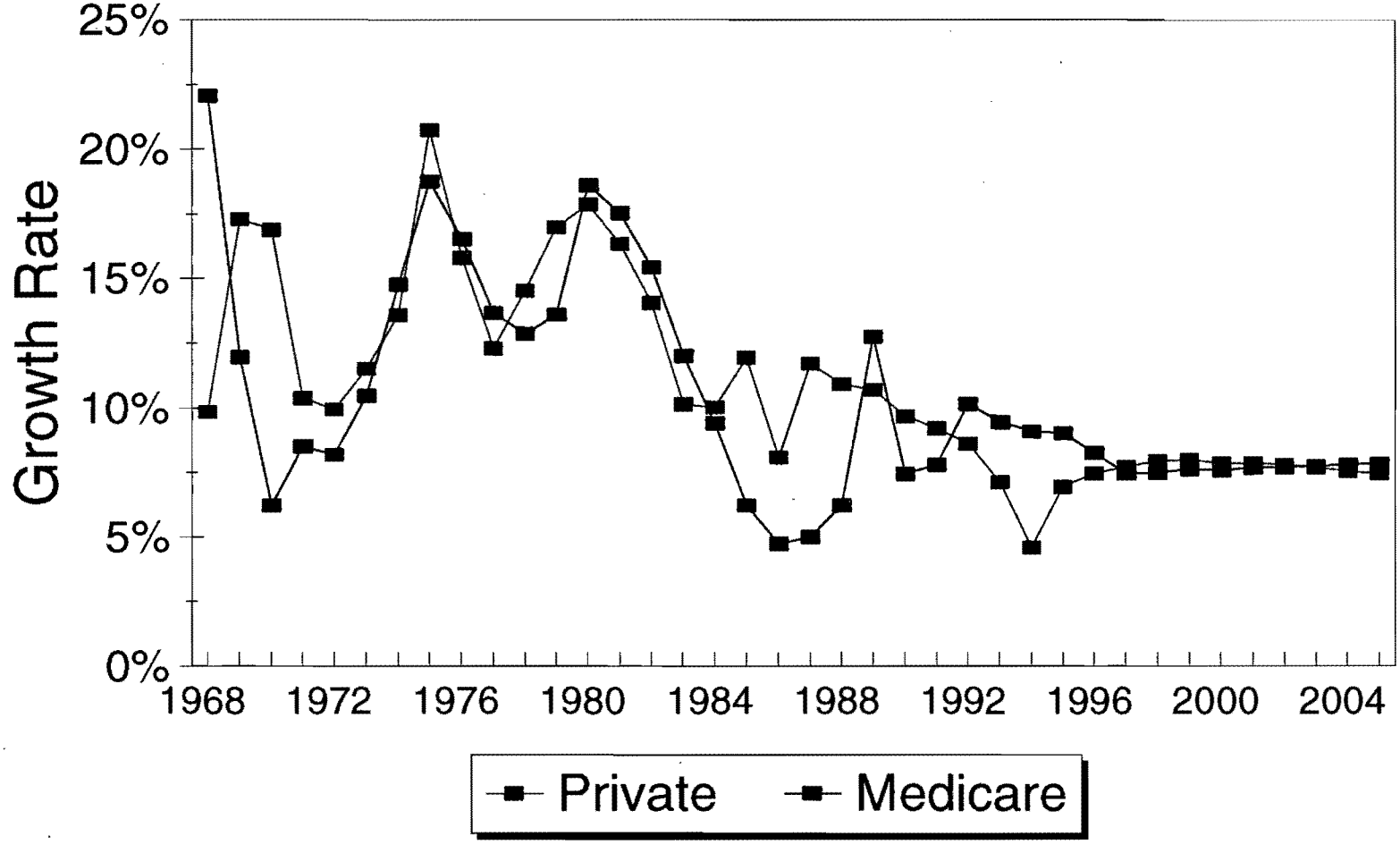
Private v. Medicaid



* Private health expenditures per insured person & Medicaid expenditures per recipient

Per Capita Expenditure Growth *

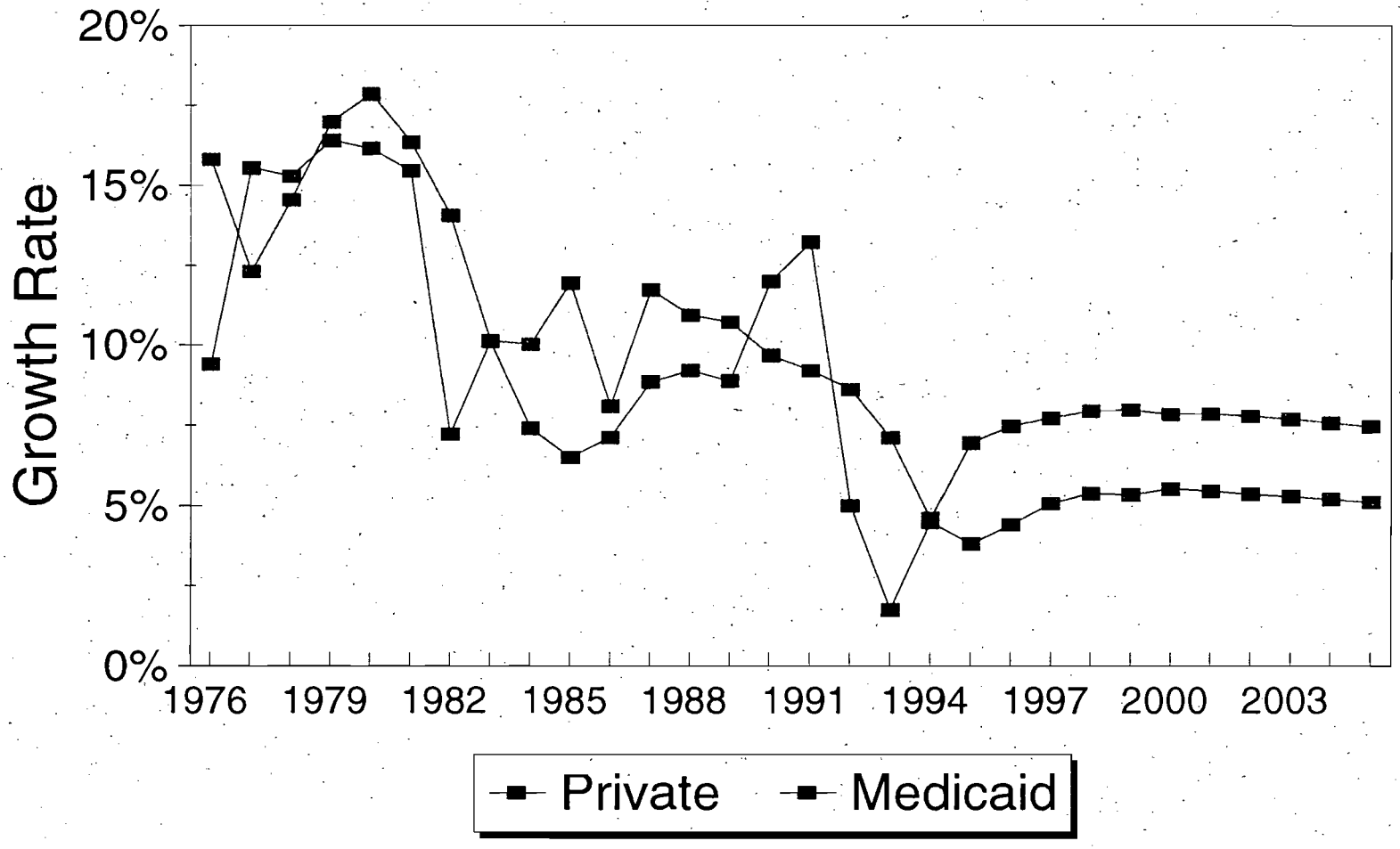
Private v. Medicare



* Private health expenditures per insured person & Medicare expenditures per enrollee

Per Capita Expenditure Growth *

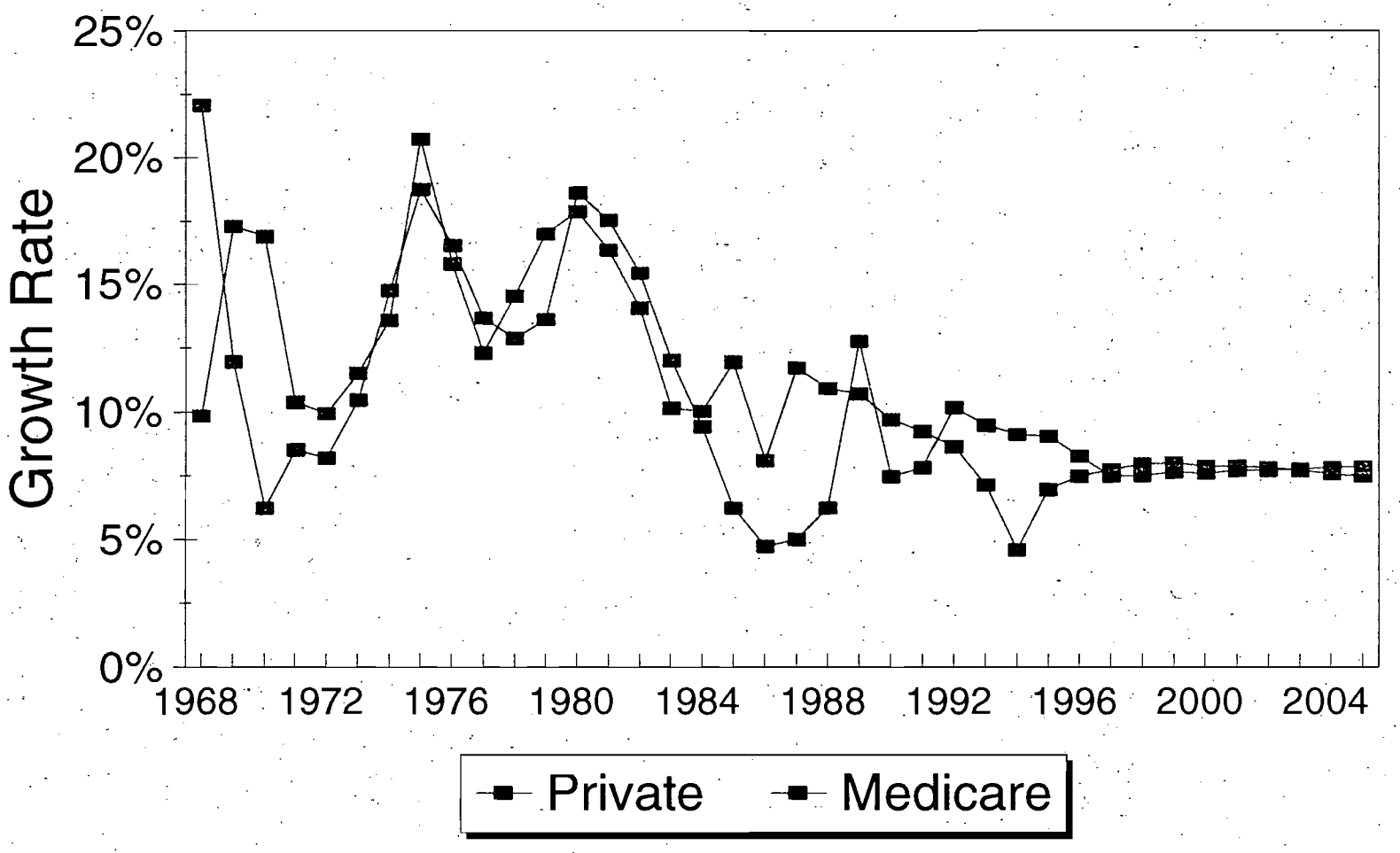
Private v. Medicaid



* Private health expenditures per insured person & Medicaid expenditures per recipient

Per Capita Expenditure Growth *

Private v. Medicare



* Private health expenditures per insured person & Medicare expenditures per enrollee

A Program to Increase Health Insurance Coverage for Young Adults, Persons Age 18-24

Issue

Young adults are the age group most likely to be uninsured. The percentage of those 18-24 without health insurance is 27 percent compared with 15 percent for the population as a whole. Almost 40 percent of 23 year old males are uninsured. The question is how best to enhance coverage for this population.

Background

The age of 18 is traditionally the age when children are considered to be adults. The age of 25 is the age when most young adults have jobs and are well on their way to longer-term living arrangements. Between those two ages, young adults undergo a number of transitions in family or living arrangements, occupation and educational status that traditionally change their health insurance status. The first transition is from high school to training, first job, or college. A second transition is from training or college to first job. A further transition is to a new family status, either living separately from parents or forming a new family.

Colleges and Universities. For the college bound, health insurance coverage is often required during the undergraduate years, optional during any years of graduate school, and then provided with a first job. Parents' policies often cover young adults who are full-time students until they reach 22 or 23. Problems arise for students whose health insurance plans -- most frequently managed care plans -- do not cover non-emergency care out of state, for those who are older than the cutoff age, and for those whose families cannot or do not have coverage. A recent newsletter of the American College Health Association estimates that "at least one-third" of students enrolled in American colleges or universities do not have health insurance coverage, a proportion which reflects graduate students, undergraduates older than the cutoff age, and those whose parents do not have coverage. For those who do not go on to higher education, health insurance coverage from a parent's policy typically ends between age 18 and 21, depending upon state law. Some HMOs and managed care plans are experimenting with policies that allow out of area coverage or portability for college students; Blue Cross-Blue Shield, for example, is expected to offer a program that allows coverage away from the home area for its 18.5 million members in July.

Health Insurance. Health insurance gaps between the ages of 18 to 25 are the norm. Many young adults find that their first full-time jobs don't have any health insurance coverage; others perceive the coverage as too expensive. There is also evidence that most young adults consider themselves healthy and unlikely to need much medical care, a further incentive not to purchase health insurance if the price of the policy is perceived as expensive and the person does not believe anything catastrophic could happen. For those not offered health insurance through their jobs or a parent's policy, individual policies may be available, but again may be expensive relative to income, perceived risk, or both.

State Laws. Coverage of dependents generally is defined in state law for insured persons, though it is unregulated for self-funded arrangements. The rules vary. Unmarried, non-disabled children are considered dependents through age 18 to 21, depending upon the state. Full-time students are covered generally through age 22 or 23. Many states provide for a continuation option (i.e., a "conversion" policy) for dependents no longer eligible under a parent's policy, but the terms of the conversion vary across states. Most states require a policy to be offered without regard to health status, but underwriting is permitted in at least one state. A quick survey of states did not find any cases where health status could be used as a rating factor. In some cases, carriers are permitted to segregate conversion policies into a separate rating pool, meaning that the policies would be quite expensive as a result of adverse risk selection. In other cases, it appears that rates are constrained based on the premium paid by the employee. There is also variation among insurers: some aggressively market individual policies; others provide only the minimum notice that such policies exist. Individual coverage is available from a number of carriers, with a high deductible policy (for example, $1,000 deductible) costing $40 to $80 per month for 20 to 30 year olds. The relatively low cost must be weighed against the widespread perception among young adults of low discretionary income and a relatively low priority for health insurance.

General facts about young adults and health insurance:

- The percent uninsured grows throughout the 18-24 year old bracket, peaking at age 23, where one-third of the young adults are uninsured. About 19 percent of 18 year olds lack health insurance, a percentage that increases to over 30 percent of the 23 and 24 year olds. The percentage then drops through the late 20s. At age 27, for example, it is 26 percent.

- Young men are more likely to be uninsured. The percentage of males 18-24 without health insurance is 30 percent; for females, 23 percent.

- Of the young adults who work full-time, 27 percent have no health coverage. Among part-time workers 18 to 24 years old, 23 percent are uninsured. Of those unemployed, 31 percent have no health coverage.

- The leading causes of death for 18-24 year olds are unintentional injuries, homicide, and suicide, followed by cancer, heart disease, and HIV infection.

- Data from the 1994 National Health Interview Survey and the 1995 Current Population Survey show that 43 percent of 18-24 year olds consider their own health to be "excellent," and 32 percent consider their health to be "very good." Only 4 percent consider their health to be "fair" or "poor."

Future Trends. Projections show that the number of 18-24 year olds will rise from 25.5 million in 1995 to 30.6 million in 2025. As a proportion of the population, however, 18-24 year olds will rise from 9.7 percent in 1995, to 10.1 percent in 2010, but then fall

slightly to 9.0 percent in 2025.

Recommended Options

Begin a campaign, in cooperation with employers, insurance companies and the National Association of Insurance Commissioners, to propose and adopt a model family health insurance program with a uniform extended age through which all young adults would be able to be carried on their parents' health insurance policies. To accomplish this end, we recommend calling a meeting of employers and major insurers to discuss the feasibility of making family coverage through a standard age in the mid-20s a national standard. We would also work with the National Association of Insurance Commissioners to propose and adopt a model family health insurance program. These proposals would be discussed during the next several weeks in several commencement addresses and in other forums.

Design an education campaign on the purchase of health insurance for young adults in transition. There is evidence that some young adults feel that health insurance is not needed. An education campaign through public service announcements, reminders on pay stubs, and a message on the new Social Security earnings statement would remind a group that has never purchased health insurance that its purchase can help with unforseen accidents and illnesses.

18-24 Year Olds

Persons (Millions) by Health Insurance (18-24 Year Olds Only)

This chart shows the types of health insurance for 18-24 year olds. Compared with the entire population.

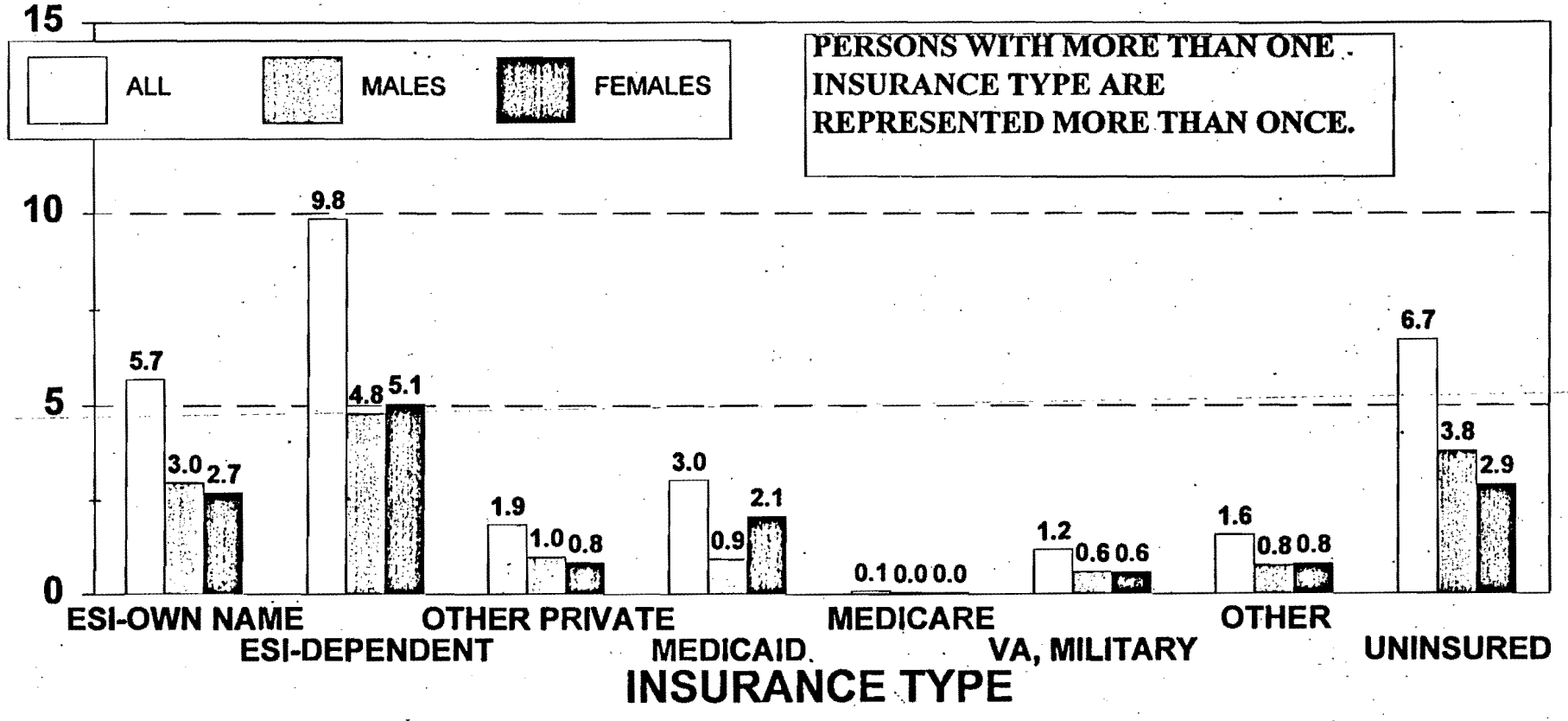
- 18-24 year olds have many more persons in the Employer Sponsored Insurance--Dependent category compared with Employer Sponsored Insurance in their own names. For the population as a whole these numbers are almost equal; for this population, there are many more covered as dependents than covered in their own names.

- As expected, relatively few have Medicare or VA/Military coverage.

- Relatively more are uninsured.

PERSONS (MILLIONS) BY HEALTH INSURANCE MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

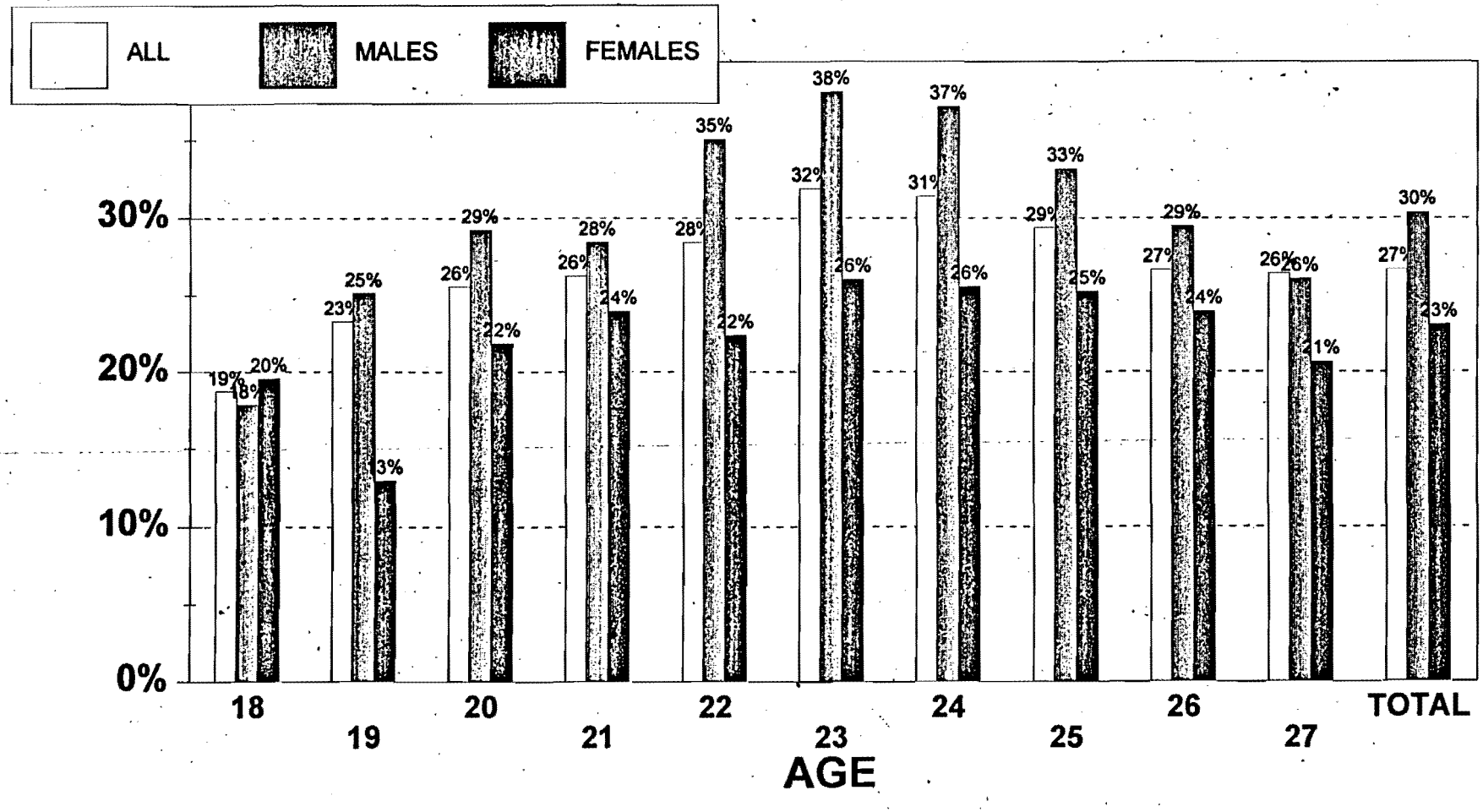
Percent Uninsured by Age: Aged 18-27

- The percent uninsured grows throughout the age bracket, peaking at age 23 where 32 percent are uninsured.

- The percent uninsured begins to decline at age 25.

% UNINSURED BY AGE: AGED 18-27

MARCH 1995 CURRENT POPULATION SURVEY



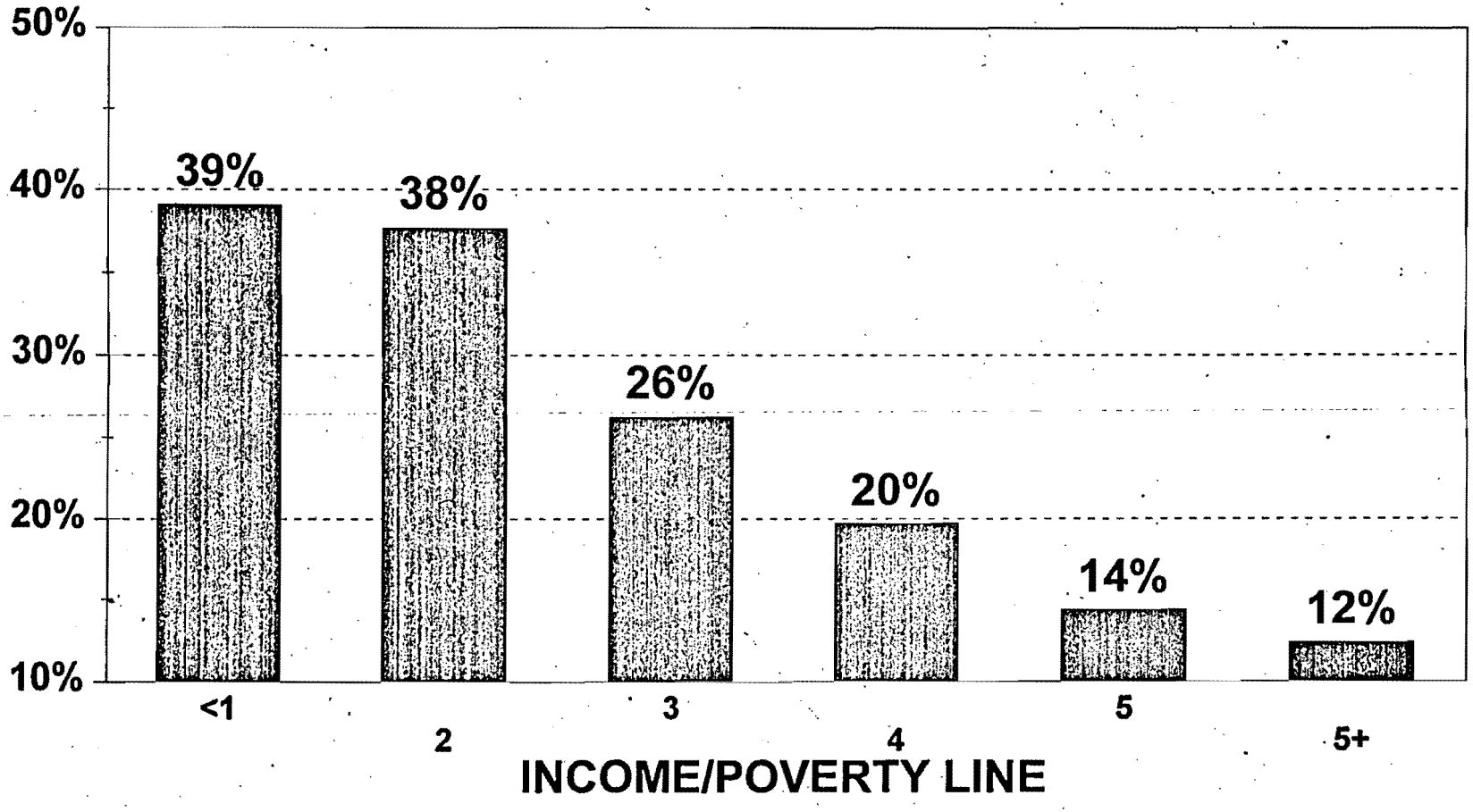
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY .

Percent Uninsured by Poverty Class (18-24 Year Olds Only)

- 39% of those below poverty are uninsured.
- This percentage drops as income rises until 12% are uninsured at 5 times or more of the poverty line..

% UNINSURED BY POVERTY CLASS
MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



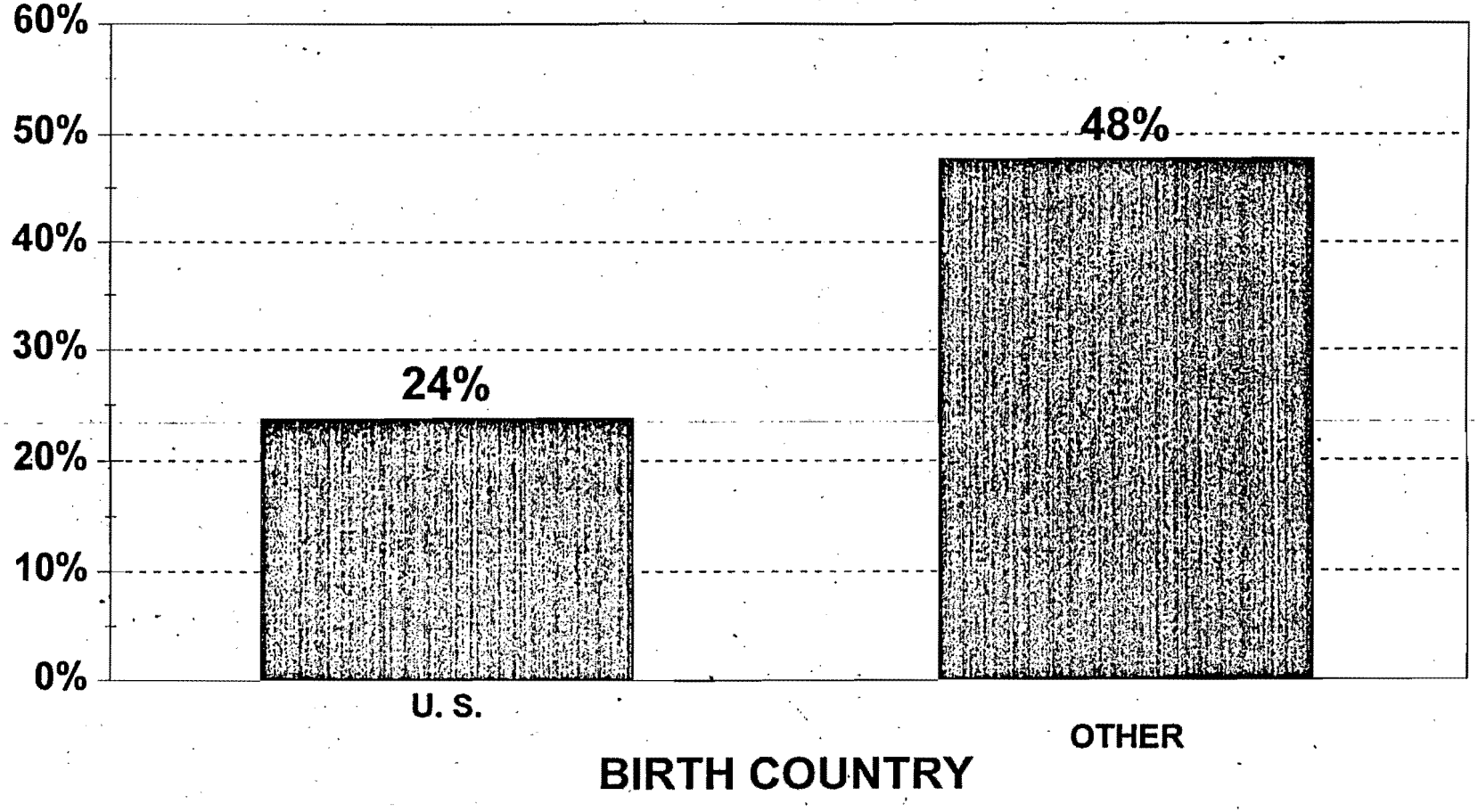
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

Percent Uninsured by Country of Birth (18-24 Year Olds Only)

- For the uninsured, the gap between those born in the U.S. vs. those born in other nations is even wider than it is for the entire population: 48% vs. 24% compared with 31% vs 13% for the population as a whole.

% UNINSURED BY COUNTRY OF BIRTH
MARCH 1995 CURRENT POPULATION SURVEY

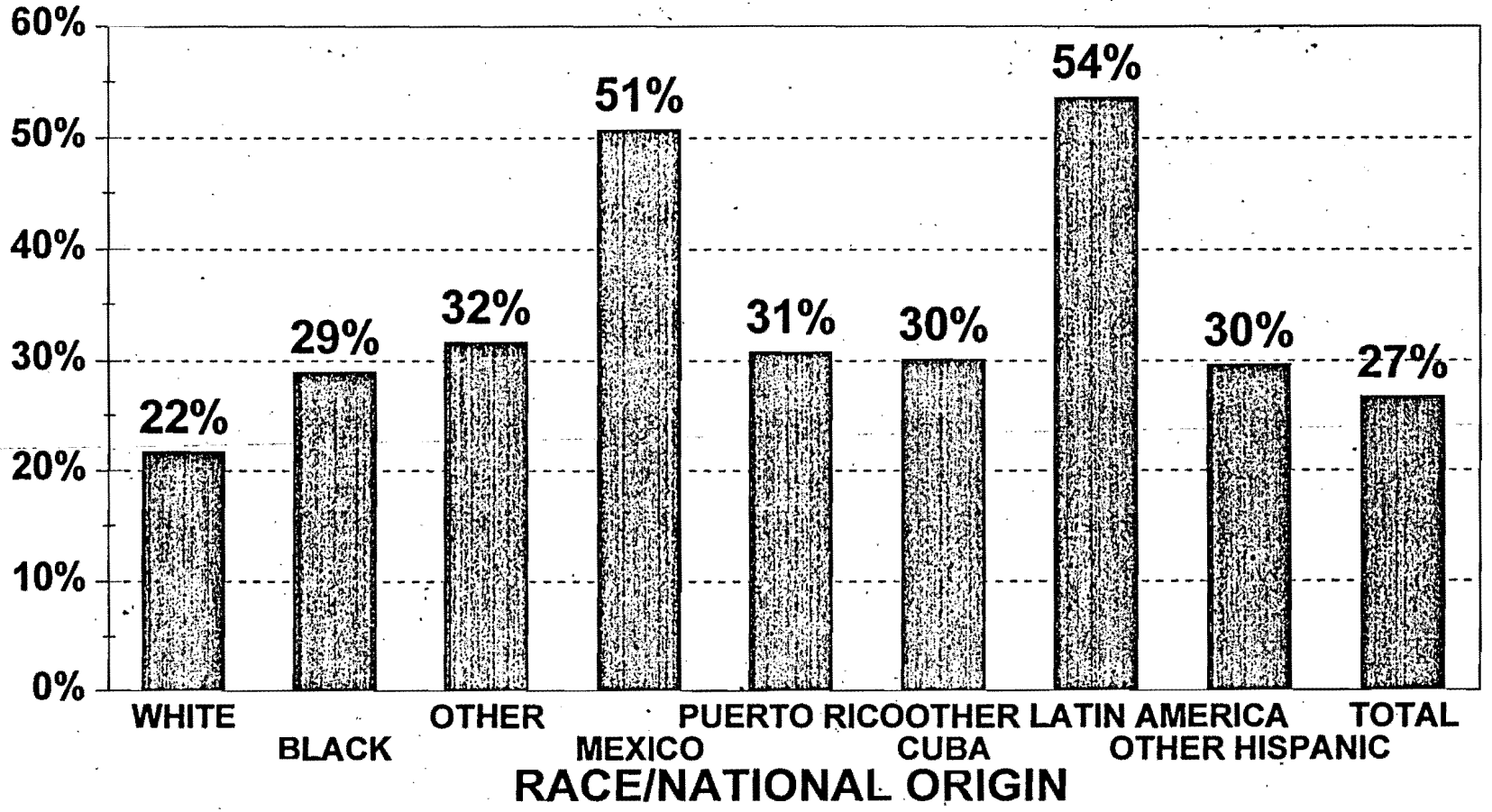
18-24 YEAR OLDS ONLY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

% UNINSURED BY RACE/ORIGIN: AGED 18-24

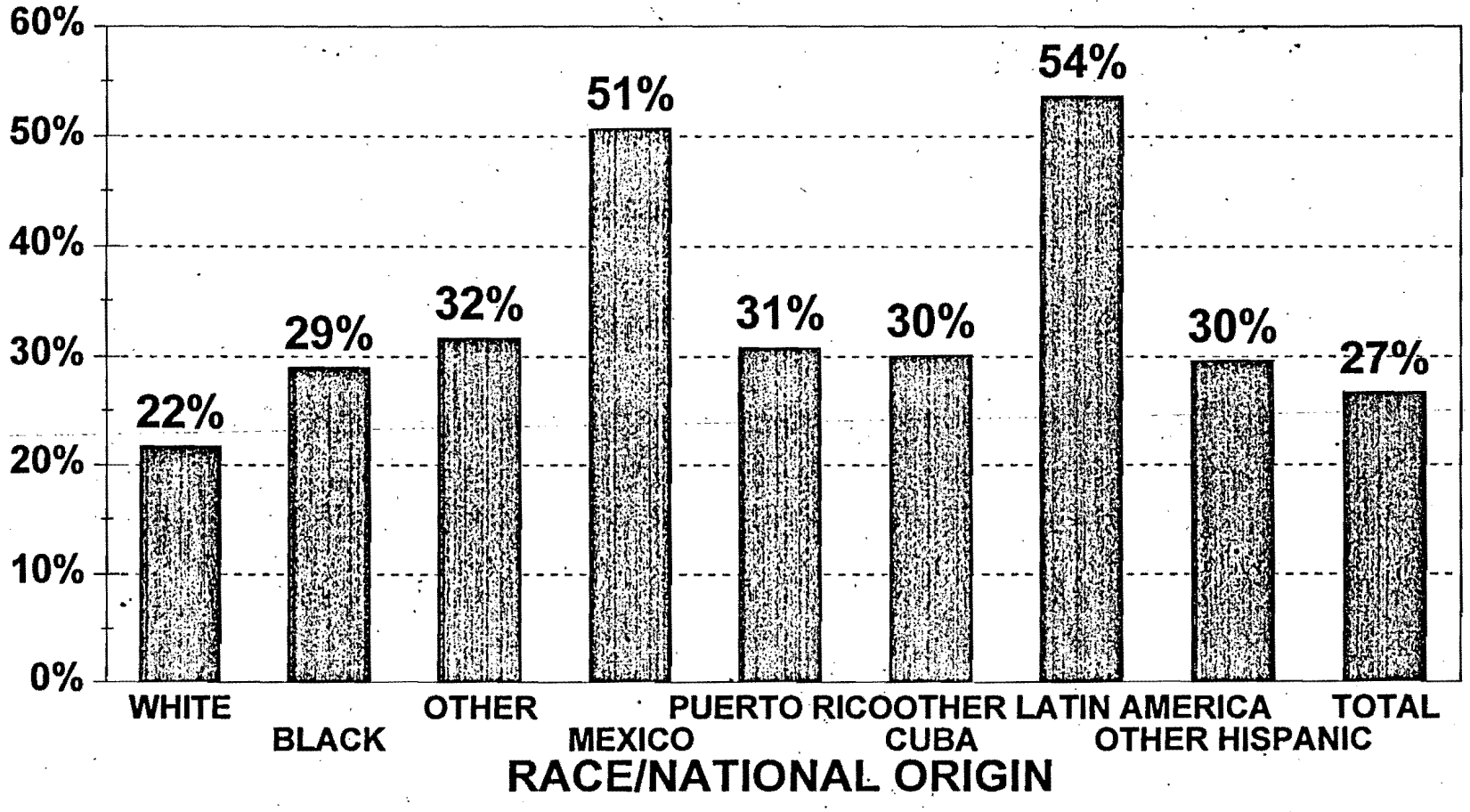
MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY .
HISPANICS OF ANY RACE ARE COUNTED AS HISPANICS.

% UNINSURED BY RACE/ORIGIN: AGED 18-24

MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY .
HISPANICS OF ANY RACE ARE COUNTED AS HISPANICS.

Percent Uninsured by Work and Student Status (18-24 Year Olds Only)

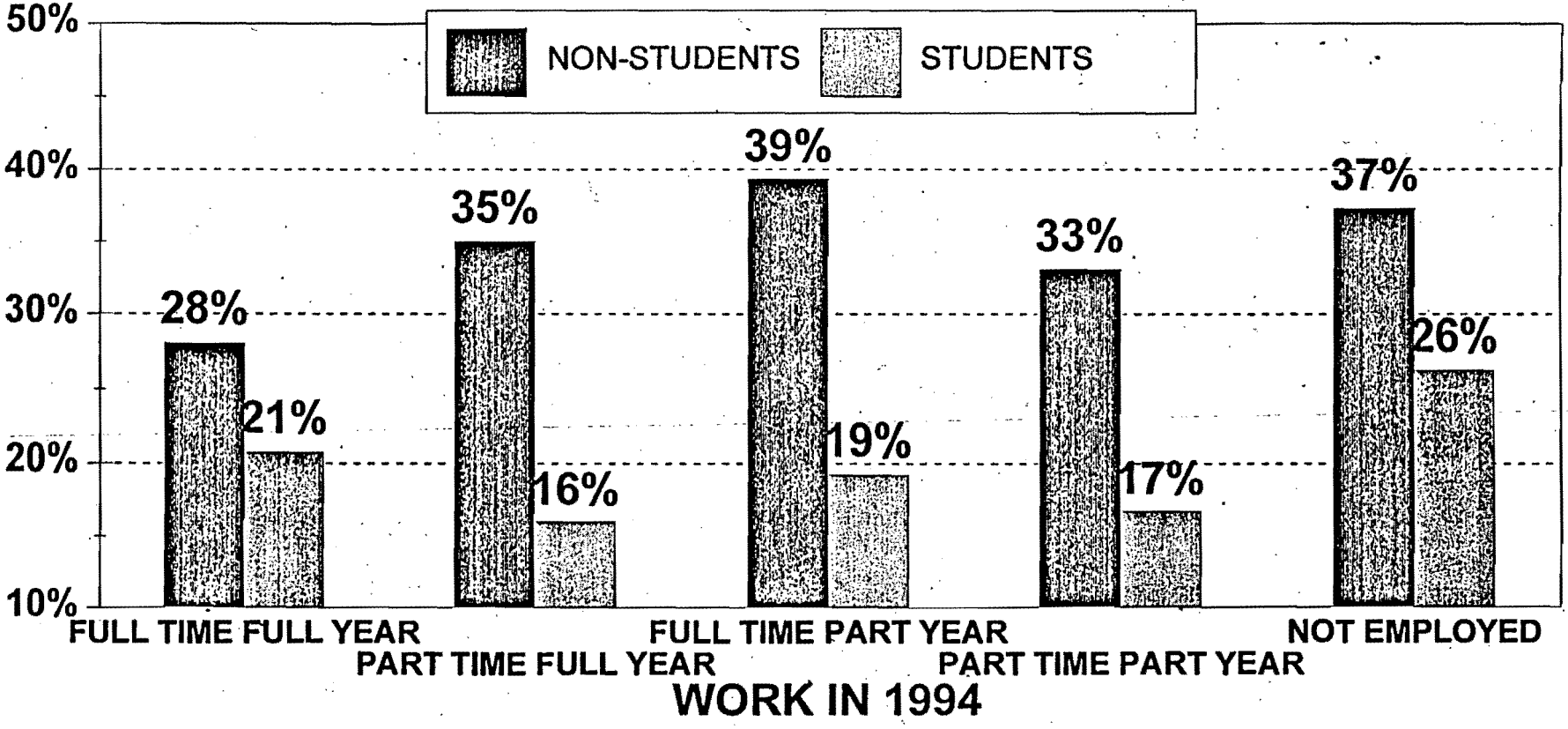
- This chart shows the percent without health insurance for various types of work status. For each, we show those whose predominant activity was work compared with those who were in school.

- In each case, the students were **less** likely to be **un**insured.

- Among those not in school, those who work full-time for the full year were least likely to be uninsured.

% UNINSURED BY WORK AND STUDENT STATUS MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

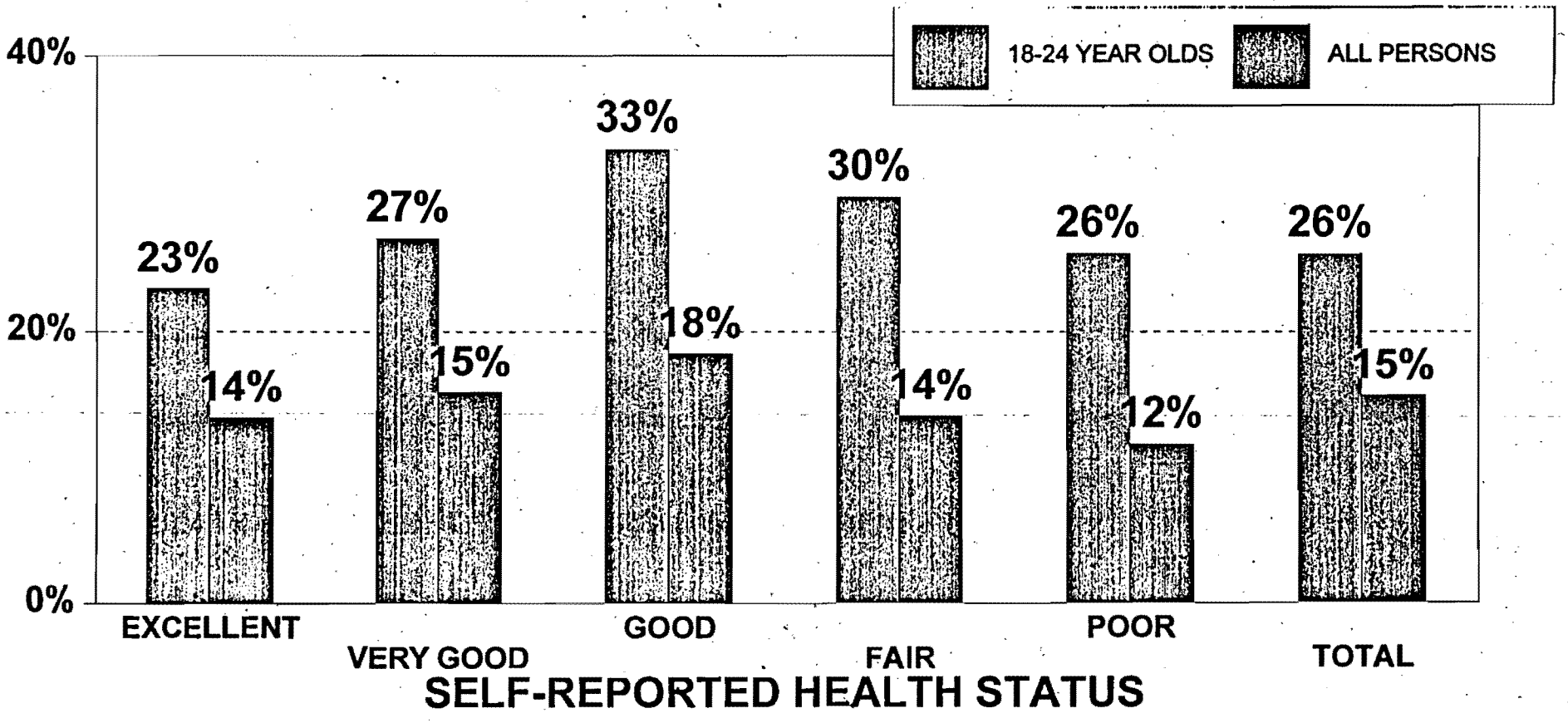
Percent Uninsured by Health Status (18-24 Year Olds and All Persons)

- This chart has both the total population and 18-24 year olds on it. 18-24 year olds are the bar to the left in each set.

- Again, health status is basically uncorrelated with having or not having health insurance.

% UNINSURED BY HEALTH STATUS

MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.