DRAFT

Reductions in Medicare Spending Under Alternative Growth Caps

(Fiscal Years; Dollars in Billions)

Alternative Growth Caps	1996 - 2002	1996 - 2005
5% cap (Admin. / CBO)*	$ 303 / $ 339	$ 661 / $ 766
7% cap (Admin. / CBO)	$ 194 / $ 229	$ 417 / $ 520
Indexed cap** = approx. 6% (Admin. / CBO)	$ 250 / $ 285	$ 550 / $ 664

* Administration estimates based on FY 1996 President's Budget baseline (net of offsetting receipts); CBO estimates based on CBO's January 1995 10-year baseline (net of receipts).

** Cap set at enrollment growth + nominal GDP per capita + factor for aging of the population.

> If Social Security and defense were exempt from reductions, a 5% cap on Medicare growth would be required to achieve the level of Medicare cuts needed to reach a balanced budget by FY 2002. It is estimated that Medicare spending reductions of $322 billion over 1996-2002 would be required to achieve a balanced budget by 2002, assuming that Social Security and defense are excluded, and an across-the-board reduction is applied to all other federal spending.

> Sen. Packwood has publicly discussed the feasibility of imposing a 5% growth cap on Medicare (BNA, Feb. 28), and Sen. Gregg has publicly discussed limiting Medicare growth to 7% annually (BNA, Feb. 23).

> The indexed cap could be a reasonable alternative to an arbitrarily selected cap. First, the indexed cap allows for beneficiary enrollment growth. Second, the nominal GDP per capita factor links Medicare spending to growth in economy-wide prices and productivity. This factor may be a reasonable proxy of the economy's ability to support continued growth in Medicare spending.

> The Administration's Health Security Act included a cap on the growth of federal payments for private health insurance subsidies. The Cooper/Breaux Managed Competition Act also included indexed caps on Federal health subsidies. After 2000, the HSA's indexed cap was based on the CPI, U.S. population growth, real GDP per capita, and a factor for demographic changes. The proposed Medicare index has the same components, except that it substitutes nominal GDP for real GDP and the CPI.

DRAFT

> The use of nominal GDP would avoid many of the measurement problems associated with a price index like the CPI:

> a price index typically measures "list" prices. Payments for many health services include discounts off the list price (e.g., managed care plans negotiate discounts from a hospital's charges.) As a result, a price index may overstate price inflation.

> a price index does not always accurately adjust for the introduction of new goods and services, such as new medical technology and procedures.

> a price index does not adjust for changes in quality (e.g., performing cataract surgery on an outpatient basis rather than an inpatient basis). It can be difficult to adjust price indices for changes in quality. In most cases, the CPI would overstate or understate price inflation for this reason.

> the CPI uses a fixed basket of goods and services to measure changes in price levels from year to year. This assumes no substitution of lower-cost goods and services of similar quality, which in fact might provide consumers the same utility at a lower cost. Use of nominal GDP would account for changes in the composition of goods and services in the economy.

ALTERNATIVE MEDICAID CAPS

Reductions in Federal Spending Under Alternative Growth Caps

(Fiscal Years; Dollars in Billions)

Alternative Growth Caps	1996 - 2002	1996 - 2005
Total Program Block Grant		
5% cap (Admin / CBO)	$134 / $192	$309 / $415
7% cap (Admin / CBO)	$71 / $129	$170 / $275
Enrollment + CPI cap (Admin / CBO)	$66 / $136	$160 / $313
Enrollment + MCPI cap (Admin / CBO)	($10)** / $62	($14)* / $146
Acute Care Block Grant (Admin)		
5% cap (Admin / CBO)	$95 / $124	$218 / $266
7% cap (Admin / CBO)	$62 / $92	$145 / $195
Enrollment + CPI cap (Admin / CBO)	$59 / $96	$140 / $214
Enrollment + MCPI cap (Admin / CBO)	$20 / $58	$49 / $129

* Cap at enrollment + MCPI would increase the deficit over the periods under Administration baseline.

- None of the alternative growth caps achieve the level federal payment reductions discussed by House Leaders.
  - A 5% acute care cap achieves about one-half the federal reduction discussed by House leaders. Even though acute care is more amendable to managed care savings, such a cap would only permit a per capita rate of growth of just over 1%, much lower than growth in private per capita health spending.
- A per capita growth cap (e.g., enrollment + CPI) addresses some, but not all, of the problems associated with a Medicaid block grant.
  - A per capita cap accommodates changes in enrollment due to recessions, but does not address many other reasons for variations in state program growth such as differences in regional medical costs, enrollment patterns, or service mix.

- A per capita cap does not recognize the different capacities of states to achieve savings through expanded managed care.

DRAFT

Reductions in Medicare Spending Under Alternative Growth Caps

(Fiscal Years; Dollars in Billions)

Alternative Growth Caps	1996 - 2002	1996 - 2005
5% cap (Admin. / CBO)*	$ 303 / $ 339	$ 661 / $ 766
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MEMORANDUM

To: Distribution

From: Chris Jennings CCJ
Jennifer Klein

Date: March 16, 1995

Re: Jackson Hole's New Proposal and Senator Gregg's Entitlement Reforms

We have received copies of two initiatives that have significant implications relative to health policy changes. They are attached for your review.

First, Paul Ellwood has released his next edition of health reforms produced by the Jackson Hole Group. He is planning on referencing it during his testimony to the Labor and Human Resources Committee this week.

Second, Senator Gregg released his first edition of proposals to achieve hundreds of billions of dollars in deficit reduction, primarily through Medicare and Medicaid cuts. Over 5 years, the Medicare program is targeted for a least $100 billion in reductions and the Medicaid program is targeted for at least $115 billion in reduction.

Senator Gregg suggests that he can achieve the Medicare savings through a specific list of traditional Medicare cuts that amount to $50-65 billion and through the utilization of a new Medicare managed care program called "Choice Care." The managed care proposal does not clarify how it would achieve the $35-45 billion in savings. In the absence of the savings being achieved, he suggests a fall-back of non managed care Medicare cuts. However, this list does not add up to the $100 billion target.

The Medicaid cuts would be achieved through a block grant that caps Federal aggregate growth at 4%. States would be given complete flexibility to achieve the $115 billion 5 year number. Gregg suggests that these savings can be achieved through managed care and with no reduction in coverage or provider reimbursements. As we indicated in our analysis of a 5% cap, there is no evidence that suggests that cuts of this magnitude can be achieved solely through the use of managed care. In fact, we have received reports that the state of Wisconsin has called to explicitly reject Senator Gregg's assertion that Wisconsin has achieved its limited growth rate exclusively through the use of managed care.

We are in the process of analyzing the specific cuts and their implications as well as preparing some potential talking points to use as a possible response. We will circulate these as soon as they become available.

RESPONSIBLE CHOICES FOR ACHIEVING REFORM OF THE AMERICAN HEALTH SYSTEM

A Draft Discussion Paper
from the

Jackson Hole Group

Paul Ellwood, MD and Alain Enthoven, PhD

March 1995

"Responsible Choices" is a living document that will change as the market changes and in response to suggestions and criticisms. Comments should be directed to the respective chapter author(s) or to the overall editor, Ellen Wilson, at:

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INTRODUCTION

Paul M. Ellwood, MD

"Responsible Choices" identifies the actions that the private sector and government should take to improve the American health system and accelerate and expand the health care revolution that is already underway. It spreads the benefits of and responsibility for better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost. "Responsible Choices" is not based on untested economic and social theory. The recommendations are taken directly from actual clinical and operational experience gained in providing health care and health insurance to over 100 million Americans. These suggestions refocus the Jackson Hole Group's approaches outlined in "The 21st Century American Health System" (1991), which called for accelerating value-based competition in the health care marketplace and assured health care for all Americans.

We devised "Responsible Choices" as a set of practical, bold proposals to continue pushing the public policy process and keep the health care revolution on track. It identifies where progress can be increased while warning where it can be thwarted. It does not promise health insurance for everyone since that is an impossible goal without raising taxes, creating unfunded mandates, or prolonging the deficit. The Jackson Hole Group has not backed off of its commitment to adequate health protection for everyone but proposes that once the size of the problem is decreased and understood, we will be better able to identify and deal with those still left out of the system.

The United States has been rapidly transforming health care by implementing a market-driven system that works—a unique approach that has resulted in significantly reducing rate increases for private purchasers and consumers of medical services. This evolution, turned revolution, which has been underway for at least twenty-five years, is being driven by corporate purchasers and cost-conscious consumers. It has created an extraordinary array of health plans aggressively competing with one another on price and quality. HMO enrollment has grown by 30 percent since "The 21st Century American

Health System" was written. However, some consumers—such as most Medicare beneficiaries, individuals with preexisting illnesses, and the employees of small firms—are not fully benefiting from the health care revolution that is propelling us toward the twenty-first century. And, despite being the largest single purchaser of health care, the federal government has been particularly slow in bringing public programs into line with those in the private sector.

It has taken at least twenty-five years for the new American health system to become established. As it continues to evolve rapidly, care must be taken not to disrupt its progress. In the United States, the market works in health care because multiple purchasers, not just the government, are in a position to introduce bold new methods of buying health care and because providers and insurers have substantial freedom to respond with new approaches to organizing and paying for care. "Responsible Choices" makes proposals to foster this market driven progress and innovation.

Keeping the market working in health care requires the consideration of factors that are unique to the health sector. When a day in the hospital can cost thousands of dollars, people need health insurance. But when this is fee-for-service insurance, there are few incentives for sick individuals and their trusted physicians to try to save money. Those who are poorly insured or with a high deductible have an incentive to avoid costly health care but are too vulnerable to shop effectively for medical care based on price once they become truly sick. Historically, medical care has been a product best understood by doctors who were selling it and thus were in a position where they made both the key clinical and economic decisions for their patients and their practices. "Responsible Choices" intends to change this by enhancing the responsibility of consumers with better information and more power to make choices about their own lives. As in any industry, genuinely lowering costs means vast increases in productivity. In this case, change threatens the livelihood of more than 100,000 specialist physicians, one-half of the country's hospital beds, and hundreds of health insurers. The likely result is resistance to competition from these sectors.

"Responsible Choices" assumes that the combination of revolutionary change, health insurance, consumer vulnerability, inadequate information, extraordinary oversupply, and shared responsibility are factors unique to the health sector that cannot be ignored. It calls for intervention in selected facets of the marketplace to make it function better, while warning policy-makers that preventing or distorting further expansion of price and quality competition will disrupt the progress that the market is making.

The U.S. health system has been transformed thus far by adherence to the following principles:

- **Health plans and health insurance, including Medicare, should compete on the basis of price and quality.** Health plans that both finance and deliver comprehensive health care competing on price and quality are pacing the new health market. Combining health insurance with health care is perhaps the most important change in the structure of the health system. It shifts the emphasis from increasing earnings by subjecting the patient to more services to reducing demand for costly extended treatment by keeping people well. To effectively lower costs and improve quality, health plans must carefully select those providing care and match their numbers and skills to the needs of their consumers. This practice has been criticized for restricting doctor opportunities and patient choices, but shepherding resources remains as critical to health care quality and cost as to the management of any enterprise. Health insurers that offer more provider choices but greater consumer cost sharing should be given the same equal opportunities to compete.

- **Consumers can be cost-conscious when selecting health insurance.** Consumers can be motivated to be cost-conscious at the time they select health insurance and will choose lower cost plans when they are convinced that health care will be readily available and of good quality. Cost-consciousness at the time of illness is less predictable and can cause expensive and dangerous delays in seeking care. This is making limiting premium contributions more powerful than high deductibles in motivating consumer choice.

- **Group purchasing of health care is essential to spreading risk and reducing costs.** Health care must be purchased by groups large enough to exert real leverage over competing health plans. Size allows these groups to exploit their knowledge of health plan performance and, above all, to spread the cost of insurance over both healthy and unhealthy individuals. "Responsible Choices" requires shared responsibility by those who are still well for those who are sick. As in any market, the presence of many powerful buyers and multiple competing sellers has been shown to be beneficial to consumers and encourages continued innovation and vigorous price competition. Diminishing the clout of group purchasers or inadvertently dividing consumers into good and bad risks will destroy the burgeoning health market.

- **Information about the quality of care must be available to consumers.** For the health market to function properly, consumers, purchasers, and providers need understandable and comparable information on the cost and quality of care from various health plans. The quality of care information currently available to consumers is still incomplete and is perhaps the weakest link in the health care revolution. Because reliable and objective information is not available, the organizations providing the best quality of care are not necessarily attracting the most consumers. This information gap jeopardizes the entire health revolution. The lack of comparative information on quality also makes the system vulnerable to unsubstantiated criticisms about costs being down because quality is deteriorating.

Without expanding entitlements or mandates, "Responsible Choices" expands the revolution in health care by asking government to play by the same rules as the private sector, by increasing the power of consumers, and by minimizing risk selection against individuals and small employers. The various pieces of "Responsible Choices" can be implemented as stand alone proposals. However, they will most effectively generate progress and improvement in the health system if implemented in the designated incremental manner.

"Responsible Choices" has five objectives:

1. Align Medicare and Medicaid costs with revenues while expanding choices by offering public beneficiaries the same cost-conscious choices now available to private consumers through employers or purchasing groups. Use competition and consumer choices to limit the per capita growth of Medicare and Medicaid expenditures to revenue growth.

2. Make the tax benefits of health insurance coverage equitable, while increasing consumer awareness of cost and quality through a value-based tax credit for health insurance, health plans, and Medical Savings Accounts.

3. Give individuals and the employees of small firms, regardless of their health status, the same opportunity to purchase reasonably priced health insurance as large group purchasers. Insurance reforms mean all forms of health insurance—the self-insured, sellers of health insurance, health plans, and Medical Savings Accounts—should be subject to the same marketplace rules.

4. Ensure that consumers know what the various health plans offer in terms of benefits, satisfaction, access, and health outcomes.

5. Set timely realistic targets and measure results as reform proceeds. Manipulating a trillion-dollar enterprise may require a change in course if cost containment, health outcomes, consumer satisfaction, and access to health care do not improve as predicted.

21st CENTURY MEDICARE

Graham Rich, MD, MBA

As the largest purchaser of health care in the U.S., the federal government is responsible for the continual growth in Medicare cost by maintaining a dysfunctional payment methodology and by failing to encourage intensive price competition and cost-consciousness. Like any other purchaser, it needs to adopt some aggressive management policies so that all taxpayers, including seniors, can benefit from better quality and efficiency through competition among Health Plans and value based choices by seniors.

Even with the present underdeveloped system for encouraging enrollment in managed care, the number of seniors choosing this option increased by 25 percent in one year to 2.3 million at the end of 1994. To enable new seniors to stay in managed care and to offer more choice for current beneficiaries, we need a better Medicare payment methodology based on competitive bidding, better access to comparative information, and the option of enrolling in any participating Health Plan. Each senior should be able to use a sum of money (a voucher or specific contribution which will be referred to in this paper as a Medigrant) from the federal government to purchase health insurance from traditional Medicare or competing Health Plans and thus make cost-conscious decisions. Only then can seniors make responsible choices. This idea was originally proposed for Medicare in 1970 but got caught up in gridlock. Instead, the private sector successfully adopted the approach.

Why Update the Medicare Program?

Medicare expenditures were $160 billion, or 2.4 percent of gross domestic product (GDP), in 1994 and are projected to grow to $460 billion, or four percent of GDP, by 2005 which is obviously an unacceptable prospect. When the private sector faced the same prospect, and hence a threat to its own competitiveness, it completely changed the way it bought health care and achieved a projected decline in private sector HMO

premiums of, on average, 1.2 percent in 1995.[1] In addition, the one million member California Public Employees Retirement System, by adopting consumer incentives and price competition among Health Plans, achieved reductions in HMO premiums of 0.4 percent in 1993/4, 0.7 percent in 1994/5 and 5.2 percent for 1995/6.

If Medicare growth can be slowed to six percent per year, the cumulative savings between 1996 and 2004 will be $401 billion, and annual savings in 2005 will be $129 billion.[2] Medicare's traditional indemnity insurance structure and its conflicting role as purchaser and insurer have a negative impact on Medicare and the rest of the health care market. The traditional structure cannot be sustained because:

- Cuts in reimbursement cause cost shifting and drive up the cost of care for others.
- Hospitals suffer unpredictable changes in reimbursement rates.
- Physicians try to maintain income by increasing volume.
- Medigap policies that drive up use by covering first dollars become more attractive when consumer deductibles are increased in an effort to reduce program utilization. Seniors already spend, on average, $502 (18 percent of their out-of-pocket health spending) on additional Medigap insurance.[3]
- The system rewards doctor's office visits and hospital stays instead of improvements in the health of seniors.
- Medicare cost problems will only get worse under the current system as managed care Health Plans, using resources efficiently, force nonparticipating physicians (perhaps as many as 165,000)[4] to depend on Medicare to earn a living.

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[1] Group Health Association of America (GHAA), 1994 HMO Performance Report

[2] Based on growth projections contained in "The Economic and Budget Outlook: Fiscal Years 1996-2000." Congressional Budget Office, January 1995.

[3] Public Policy Institute, American Association of Retired Persons, "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," 1994.

[4] Weiner, Jonathan P., DrPH, "Forecasting the Effects of Health Reform on US Physician Workforce Requirement," JAMA, July 20, 1994, Vol 272, No. 3.

Parallels with the Private Sector

When unsustainable expenditures on health benefits threatened competitiveness, employers made the transition from traditional health insurance to offering a fixed payment for health care and a choice of competing managed care plans. As a result, they have seen a consistent increase in managed care enrollment with a corresponding reduction in costs. The government could experience the same savings by learning from enlightened employers and adopting the same strategy.

How Do We Get There?

There are a number of political and programmatic difficulties inherent in making the transition from a legally prescribed cost reimbursed Medicare indemnity plan with minimal consumer cost-consciousness to a program where consumers make value based choices. But, the practical problems in gearing up the private health system to compete on price and quality to serve seniors are not as great. For example, 74 percent of seniors live in an area where they have access to a Medicare risk contracting plan and, in 1995, 38 percent of HMOs are planning to develop new Medicare contracts. Early implementation would bring the greatest savings but would require the most support from seniors and a substantial managerial effort by the Health Care Financing Administration (HCFA) to effect the changes.

This proposal relies on competition among Health Plans coupled with a fixed Medigrant contribution for each senior. It expands the scope of benefits and offers beneficiaries access to well managed health care. It requires competing Health Plans to offer a more appropriate set of benefits than the traditional Medicare program, such as the federal standard HMO package with a prescription drug benefit. As a result, seniors who join Health Plans would not need to buy Medigap insurance. A Medigrant set at the average premium charged by the least costly half of the participating plans will give seniors access to a range of Health Plans.[5] The option to stay with traditional Medicare would still be available.

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[5] Competitive bidding to set the government contribution has been recommended by Bryan Dowd et al., in "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform": The Milbank Quarterly, vol. 70, no.3, 1992, 423.

Promoting Consumer Cost-Consciousness

Each senior should be able to choose between traditional Medicare or a range of Health Plans using a Medigrant. Seniors who choose a more expensive plan would be responsible for making up the cost difference be it traditional Medicare or a Health Plan. Those who choose a less expensive option would receive a refund. To ensure full choice, all participating competitive Health Plans should participate in a coordinated annual open enrollment.

The amount of the Medigrant for each Medicare enrollee who joins a Health Plan could be initially limited to the amount the government currently spends on traditional Medicare adjusted downward annually by at least a percentage point each year. It should ultimately be based on the average premium of the least costly half of the competing Health Plans in each market area. This could be calculated using the previous year's enrollment to weight premiums.

Moving to Competitively Driven Prices

The current formula for paying Health Plans in Medicare is based on traditional Medicare costs. Thus the more expensive traditional Medicare actually drives up government payments to Health Plans. Instead, the reverse should be true with traditional Medicare being required to compete with Health Plan prices. As long as this perverse linkage between traditional Medicare and Health Plans is built into Medicare law savings from competition will elude us. At some point, the program expenditure should become pegged to competitive Health Plan prices. There are two options for making this transition. The Fast Track option would require the government to set the same growth rate, say six percent per annum, for traditional Medicare and Health Plan Medigrants during a transitional period. The slower, or divided track would temporarily separate the payment rates and growth rates of traditional Medicare from those of Health Plans. Under this divided track option the growth rate for traditional Medicare using CBO projections would be ten percent, on average, while the Medigrant for Health Plans could be eight percent in the first year, seven percent in the second year, and six percent in the third year, at which point enrollment should be sufficient to allow competition to

set prices. Under both options, there ultimately would be a common method for calculating the amount of money to be spent on traditional Medicare and Health Plan payments which would be driven by competitive Health Plan premiums.

Transitional Techniques

Traditional Medicare can no longer be considered as a well designed or adequate insurance policy. It tries to control demand by cost sharing and deductibles. There is a need for a more comprehensive and appropriate set of benefits which should convince Medicare beneficiaries that they are not losing out in the transition to 21st century Medicare. The Health Plans competing for beneficiaries should be required to offer an improved benefit package which should preferably eliminate the need for Medigap policies.

Beneficiaries with preexisting illnesses are reluctant to leave the traditional Medicare fee-for-service program which drives up the costs for this option during the transition. Under this proposal, a richer set of benefits, lower out-of-pocket costs, and increased quality accountability should encourage the higher risk beneficiaries to make the switch to a Health Plan. However, beneficiaries with a higher risk will be attracted to Health Plans that have a reputation for providing superior care. Therefore, some method for identifying this uneven spread of risks and compensating for them by shifting Medigrant dollars from plans with better risks will be necessary.

The availability of Health Plans across the country is uneven and costs are variable between regions. Medicare is the last frontier for competitive Health Plans that are eager to provide a service to this large sector of the population and are confident they can provide better benefits for less. In 1995, the Medicare capitation rate is $467 in San Francisco and $559 in Los Angeles while the premium for a non-Medicare, non-Medicaid Kaiser plan is the same for northern and southern California. With the current formula, HMO rates in some counties factor in excessive use of services and so are too high for Medicare to realize the potential savings from managed care. In other counties with lower service use, Medicare rates are too low to encourage HMO participation in the

risk contracting program. In encouraging competition between Health Plans in areas of the country where health care costs are lower or where the number of providers are limited, some have suggested that there should be no initial limit on the government contribution for Health Plans. "Responsible Choices" assumes that as Medicare is such a large buyer and the oversupply of providers so great, competition will develop even in those areas where traditional Medicare payments are low. If competition fails to develop in those areas, the federal government might consider using savings from higher cost areas to increase payments.

Fast Track Option

Under this approach, the growth in expenditure for traditional Medicare and Health Plans could be explicitly budgeted for each year. These sums of money could be given to seniors in the form of a Medigrant which they could use to purchase care from traditional Medicare or a Health Plan. The method of calculating the federal government contribution, or Medigrant, and its maximum growth could be specified in legislation to be, say, six percent per year and adjusted for the increasing age of beneficiaries. The growth rate for traditional Medicare would be the same and program costs would need to be controlled using techniques such as high deductibles combined with Medical Savings Accounts (MSAs). By adopting this approach, the government would be defining, in advance, what it is prepared to spend per beneficiary on Medicare, as other purchasers are increasingly doing. This would not be the same as introducing price controls as set out in President Clinton's Health Security Act but would merely set the limit of the government contribution. In fact, it would be analogous to the current Medicare practice of setting provider fees or deductibles where individuals and providers must make up any difference.

Divided Track Option

With this approach, the federal government would temporarily allocate different rates of growth for traditional Medicare and competing Health Plans. Traditional Medicare could be budgeted to continue increasing at the current predicted rates, (ten percent per year), while the maximum Medigrant growth rates would be set at eight percent the first year

and at one percentage point less each ensuing year until the market penetration is great enough to determine payments.

Competitive Health Plan Prices to Drive Traditional Medicare Payments

Under both options, when more than, say, 30 percent of seniors in a particular market are enrolled in competing Health Plans and are satisfied with the benefits they are receiving, then the government's Medigrant payment for traditional Medicare and Health Plans should be based on the average of the least expensive half of competing Health Plan prices. It may be necessary to grant new managerial powers to HCFA to allow traditional Medicare to adopt Preferred Provider arrangements and other managed care cost containment developments that have been employed by transitional managed care plans. This may include the setting of premiums for traditional Medicare or other cost saving or revenue producing measures.

Ensuring Plan Competition on the Basis of Price and Quality

To enable Medicare beneficiaries to use their Medigrant wisely, the HCFA, or its designee, should provide information, including quality and price comparisons of traditional Medicare and Health Plans by market area. Health Plans should price and offer a standard benefits package. Seniors should be given comparative information on out-of-pocket costs for care of common conditions, consumer satisfaction data, etc. It would be particularly valuable if government pursued the same health accountability methods being used by the private sector (see Health Accountability System section, page 34). Responsible marketing should be encouraged to ensure that seniors understand the options.

Stage 1: Fiscal Year 1996

The Secretary of Health and Human Services should establish market areas to calculate the value of the Medigrant, as counties are too small for stable prices. If Congress elects to use the fast track option, the Medigrant value for traditional Medicare and Health Plans would be set at the level of payment for traditional Medicare the first year with an annual percentage increase of, say, six percent thereafter. If the divided track option is

chosen, the growth rate for the Health Plan Medigrant would be one percentage point less than traditional Medicare, as described above. Under both options, legislation should allow Health Plans that cost less than the Medigrant to give consumers rebates. A Health Plan that costs more than the Medigrant value should charge seniors the difference. HCFA should simplify its approval and other regulatory requirements, such as the 50 percent commercial rule, so that it is less costly for new Health Plans to enter the Medicare market.

Stage 2: Fiscal Year 1997

HCFA, or its designee, should establish and coordinate an annual open enrollment period to ensure that each individual can choose among all participating plans. Medigrant payments should be risk adjusted to allow for the extra risks involved in enrolling individuals with chronic diseases. All participating Health Plans should be required to offer at least the new standard benefits package.

Stage 3: Fiscal Year 1998 and beyond

Under either option, many markets will exceed the 30 percent market penetration when Medigrant payments to traditional Medicare and Health Plans are determined by the average of the least expensive half of Health Plan prices.

Stage 4: Fiscal Year 2004

If competitively derived Health Plan prices are growing more rapidly than the economy or if Medicare prices adjusted for health status are growing faster than private sector prices, the whole program should be reassessed. It may be necessary to use a different formula for calculating the government's contribution, such as paying 100 percent of the lowest cost high quality plan or using a formula which is closer to the premium of the lowest cost plan. If employers do not encourage retirees to make a cost-conscious choice of Medicare Health Plan by giving them a defined contribution, legislative reform of retiree benefits may be required. The federal government should consider relinquishing its responsibility for providing indemnity insurance by asking private

indemnity plans to take over this function, as long as there is no restriction on access to providers.

Benefits of Medicare Reform

The phased introduction of premium competition, starting with areas of high managed care enrollments and where Medicare costs have tended to be high, ensures competition and early savings. Over time, there should be a reduction in regional Medicare price and utilization variations. Prices in today's populous high cost areas should come down first, while utilization and prices may go up in those areas (mainly rural) where seniors seem to be underserved. Allowing seniors to make the same responsible choices as the rest of the population will provide greater incentive for plans to improve their cost-effectiveness while maintaining or improving quality. Seniors and the health system as a whole will benefit from an expansion of choice and an end to the cycle of cost shifting.

ENCOURAGING STATE SOLUTIONS FOR ACUTE MEDICAID

Graham Rich, MD, MBA

The dramatic increase in, and unpredictability of, costs in Medicaid programs is a persistent challenge to state governments. The nation spent $82 billion, or 1.2 percent of GDP, on Medicaid in 1994; expenditure is projected to increase to $234 billion, or two percent of GDP, in 2005. States should use the same methods as successful private purchasers of health care by offering a choice of managed care plans to encourage choice and effective price competition for the acute care portion of Medicaid. Although states are already ahead of Medicare in adopting price competition, they have been impeded by the federal waiver process and the lack of health plan availability.

The Jackson Hole Group is not certain that the concepts behind "Responsible Choices"—that medical care volume can be decreased and efficiency increased—necessarily apply to long term care. In addition, the Medicare health plan package is likely to be comprehensive enough and offer cost sharing provisions that are

low enough to allow states to cease supplementing Medicare for acute Medicaid or to have their contribution be minimal. We do encourage state experimentation with SSI, particularly if some satisfactory means of risk adjusting the premiums of this population could be devised. For these reasons, the following recommendations are only for the acute care portion of Medicare.

Accelerating the Use of Competitive Managed Care for Acute Medicaid

States that received section 1115 waivers from HCFA have introduced innovations tailored to local needs and preferences. These changes brought variations in eligibility based on income, categorical requirements, new services, and a choice of managed care plans. In an effort to protect the Medicaid population from what it views as ill-conceived or hasty reform, HCFA developed detailed criteria for approval and set goals for implementation. Because criteria and goals can vary from case to case, the approval process is lengthy and cumbersome, causing state dollars to support inefficient and ineffective financing mechanisms while the application is pending. To stop such waste, the 104th Congress should grant states the authority to make the transition to managed care for Medicaid without obtaining waivers.

The Federal Contribution

The federal government should give states per capita grants for the acute Medicaid program (i.e., the government would provide a fixed amount per eligible beneficiary). To facilitate state management of the program, the federal government should specify in advance the rate of growth in the federal share of the capitation rate. If the current GDP growth rate and inflation remain the same, this could be set at 6.5 percent per year in 1996, six percent in 1997, and five percent in 1998. These ground rules would need to be reconsidered if managed care premiums began to decline to the same extent that they are currently declining in the private sector or if there were a drastic change in the number of people eligible for Medicaid. States should face a maintenance of effort requirement in determining their contribution based on fiscal capacity. Additionally, disproportionate share payments to a state should be phased down to a level of around four percent over a period of five to seven years from the current level of 12.5 percent.

Medicaid eligibility requirements should be federally determined, but scope of benefits should be set by the state. States could adopt the benchmark benefits package, as suggested in the Benchmark Benefits section, page 29.

Minimizing Federal Reporting

Allowing states to define their own solutions puts at risk the comparison of quality, cost, and coverage information essential to enhance consumer choice and aid policy-making at the state and national levels. The problem can be overcome if states follow the example of other purchasers by requiring standardized accountability for quality by the health plans they use (see A Health Accountability System, page 34, and Health System Information, page 39) and adopt the benchmark benefits package for state Medicaid programs (see Benchmark Benefits, page 29).

INCREASING COST-CONSCIOUSNESS: REFORMING THE TAX TREATMENT OF HEALTH INSURANCE

Alain Enthoven, PhD and Sara Singer, MBA

The internal revenue code excludes employer paid health care and insurance from the taxable incomes of employees without limit. It also, through Section 125, allows employees to tax shelter their premium contributions, as well as contributions to medical spending accounts. The states generally conform. This exclusion will cost the federal budget $90 billion in 1995. The exclusion provides a powerful incentive for employers and employees to agree that part of pay will be in the form of health insurance benefits. This has contributed to the rapid growth and persistence of employment-based coverage.

The exclusion, however, has negative consequences—the most important of which is to make the additional cost of more costly coverage lower to employees, inducing them to choose more costly coverage than they would if they were using their own money. To motivate responsible, price sensitive choice of health plan and to limit the loss of revenue to the federal government, this provision should be changed.

A Tax Cap

The natural solution is to cap the exclusion: set limits for individual, couple, and family coverage low enough that the premiums of most health plans exceed them, and legislate that employer contributions above the limit must be included in taxable income. At the same time, repeal Section 125 which allows employees to tax shelter funds spent on health care, so that the total tax sheltered premium—not just the employer's part—is limited by the cap. This would correct the current government-created lack of cost-consciousness by motivating consumers to be responsive to the full differences in premiums when they make choices. To be maximally effective, employers must limit their contributions to a fixed dollar amount and should offer a choice of plans. Employers would have to estimate the value of coverage in the case of self-insured plans, making such employer contributions explicit.

Numerous issues arise in connection with the "tax cap" on health benefits. Should the caps be adjusted for geographic variations in the cost of living, like Medicare prospective hospital payments, or for medical costs? If they are not adjusted, people will argue inequity. On the other hand, the tax code is not indexed for the regional cost of living, and there is legitimate concern that to do so in this case would precipitate endless technical arguments and open a new field for pork barrel politics. It may be better to keep it simple. The categories in which the exclusions are allowed (e.g., individuals, couples, head of household, etc.) would need to match the categories in which insurance rates are quoted, both for equity and efficiency. There is no need to give individuals a tax break sufficient for a family. To do so would undermine their incentives for economical choice. So long as premiums may vary by age, the categories would need to include "age bands" so that older, higher cost people would not be disadvantaged by a tax cap set for the average. Some comparable limited tax-subsidized treatment of health care benefits would need to be extended to the self-employed, non-employed, and employed whose employers do not offer health insurance.

Substantive arguments against the tax cap include that it would perpetuate "job lock." Job lock is a two-edged sword in that it helps perpetuate a desirable pooling of "good

risks," with low expected medical costs with "bad risks," with high expected costs. A tax cap would also give more incentive to become insured to higher tax bracket people who need it less; less incentive to lower bracket people who need it more.

A Tax Credit

These shortcomings have led people to propose replacing the exclusion with a refundable tax credit, available only to those who buy coverage meeting certain criteria.[6] Again, Section 125 would be repealed. Taxpayers would be allowed to reduce their tax bill by a fixed amount (or by an amount determined by a formula) if they met certain conditions. Individuals would get cash refunds if the credit exceeded the rest of their tax bill.

The tax credit approach offers some distinct advantages over the tax cap:

- The tax credit would end job lock by providing portability of the tax subsidy. The credit would be available to the self-employed, non-employed, and those employed by an employer that does not provide health insurance. This seems particularly appropriate since such a credit could help to reduce the burden of adverse selection in the individual market by giving healthy people a strong incentive to maintain coverage.
- Both low and high income people would receive the same credit. The tax credit could also be designed so that the poor could receive more.
- The existence of a tax credit for the non-poor would ease the work disincentive associated with the reduction of benefits as subsidies for low-income people are phased out.
- It could be characterized as giving people something in exchange for the abolished exclusion, as opposed to a tax cap which has been perceived as taking something away.

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[6] Alain Enthoven, PhD. "A New Proposal to Reform the Tax Treatment of Health Insurance." Health Affairs. Spring 1984.

Tax Credit Structure

There are many variations on the tax credit theme that can result in a substantial improvement in the efficiency and equity of our health care system. Under one version, Congress would pick a dollar amount that reflects the price of an efficient comprehensive health plan meeting federal standards in most parts of the country, say $4000 per family. Next, it would pick a percentage for the credit that would make the whole program a budget-neutral trade for the exclusion, say 25 percent. A family buying coverage of up to $4000 could take a tax credit equal to 25 percent of the premium (i.e., up to $1000).

This would give everyone an incentive to buy coverage up to the $4000 amount. Above that amount, people would be required to use their own money, so they would be cost-conscious. In another version, Congress would set a fixed dollar credit amount for individuals, couples, etc. that would be a budget neutral replacement for the exclusion, say $750 per family per year.[7] The whole credit would be available to anyone buying coverage meeting federal standards.

Both proposals would require that, to qualify for the credit, the coverage purchased would meet federal standards of adequacy. Both would require people to pay more for more expensive coverage. Under appropriate conditions (see below), both could be recommended by the Jackson Hole Group as a means of increasing consumer cost-consciousness, reducing tax losses, and lowering the rate of medical inflation.

A switch to the tax credit approach risks creating other problems. The employment-linked tax exclusion is an important part of the "glue" that holds insurance purchasing groups together. Converting to a tax credit direct to individuals would weaken the glue and could threaten the employment-based group purchasing system because good risks might demand their employer contributions in cash and seek better rates elsewhere. Pooling of health risks within groups might be destroyed, although some employers might resist this, preferring to keep their risk pool together and their

[7] This credit would be slightly less than in the first example because people buying coverage for less than $4000 would forego some of the tax credit.

average costs per employee down by refusing to turn employer contributions into cash. Individuals not covered through employment groups (including those who successfully took their cash out of the group) would face a market beset by the pathologies that we observe today in the market for individual and small group coverage. To make this market work well, institutions need to be created for small employers and individuals that perform the functions now performed by large employers and purchasing groups (see Insurance Reforms and Group Purchasing section, page 23, for recommendations for reforming the small group and individual market.).

A Tax Credit Linked to Group Purchasing

The tax credit should be structured so as not to dismantle the group purchasing based system. Standards governing the use of a credit would be necessary. For example, if your employer offers coverage, the credit should be available only if you buy insurance through your employer. Employers might be mandated to offer, but not necessarily pay for, several coverage options and could do this by contracting with a voluntary, certified purchasing group. If you are self-employed, non-employed, or employed by an employer that does not offer health care coverage, you should be able to use the credit independently in the individual market, or through a voluntary certified purchasing group that would agree to take all comers within the market in which the purchasing group chose to participate (e.g., groups size 5-50 or 1-100) and to abide by the rules established for the rest of the insurance market.

Stage 1: A Tax Credit for the Self-Employed and Individuals in 1995

Since there is mounting urgency to reinstate the 25 percent tax deduction for the self-employed, this opportunity should be used to shift from tax exemption to a tax credit for this group. Tax policy changes should start with a tax credit program for the self-employed, non-employed, and employed whose employers do not pay for coverage to go into effect in 1995. This is attractive for the following reasons:

- A tax credit would give this group a greater tax subsidy than they received under the limited tax deduction. A tax credit would give these people tax-subsidized health benefits while making them price-sensitive. It would eliminate the tax code

inequities that the self-employed currently face, without expanding the cost-increasing incentives created by the present tax treatment of health benefits for employed persons.

- Anyone who does not currently receive employment-based health care benefits would benefit from the tax credit without threatening employment-based health care purchasing.

Stage 2: A Tax Credit for Employer-Based and Group Purchased Coverage

After successfully implementing a tax credit for individuals, employer-based tax deductions of health benefits should be replaced by a tax credit with provisions to avoid unraveling employment-based health care purchasing.

CATASTROPHIC COVERAGE AND MEDICAL SAVINGS ACCOUNTS

Alain Enthoven, PhD and Sara Singer, MBA

The Jackson Hole Group tended to object to the approach advocated by proponents of the tax-favored MSA theory because it favors one form of health insurance, catastrophic coverage, and because it would encourage good risks to leave the risk pool. But, recently Mark Pauly and John Goodman (one of the architects of the MSA idea) proposed a new version that is much more neutral and less likely to split the risk pool. Therefore, the Jackson Hole Group regards this as an approach worth trying. Under the Pauly-Goodman approach, Congress would set a fixed dollar tax credit amount (presumably one for individuals, couples, etc.). The whole credit would be available to anyone buying coverage meeting standards that would include a deductible no higher than, say, $3000 and a requirement that anybody choosing a plan with a deductible (possibly above another threshold such as $200) would have to fund the deductible up-front with after-tax dollars in an MSA. The purpose of the account would be to ensure that people would have the money to pay their bills up to the deductible. Individuals could select first dollar coverage, $3000 deductible coverage with an after-tax MSA, or anything in between. After-tax MSAs may still cause some risk selection

problems because the $3000 deductible would continue to be attractive to the healthy and wealthy. Risk selection should be monitored and an appropriate remedy employed if a problem occurs.

Tax-Favored MSAs with Catastrophic Coverage Could Damage the Market

Recently, we have seen great enthusiasm for the combination of insurance coverage with high annual deductibles (e.g., $3000, called "catastrophic coverage") and tax-favored MSAs to encourage people to set aside the money needed to pay for care below the deductible. The idea is that if consumers were using their own money to pay their own bills, they would be much more cost-conscious in their use of care. If they could have tax-favored MSAs, they would be much more likely to accept high deductibles.

Unfortunately, catastrophic coverage would do little to moderate cost growth in the long run. Health care spending is concentrated on a few people with expenses that exceed $3000. For them and their families the additional cost of more care is zero. Catastrophic coverage would also increase costs due to lack of preventive services and early detection and treatment. For example, a recent study of acute appendicitis patients in California found that patients covered under indemnity insurance were 20 percent more likely than those in prepaid (first-dollar) plans to develop ruptured appendices.[8] The important opportunity for savings is not in deterring primary care, but in motivating doctors to provide high cost care only when it is appropriate and to do that efficiently. Catastrophic coverage has no impact on provider incentives.

Some of the enthusiasm for catastrophic coverage comes from the segment of the insurance industry that would like to give indemnity insurance a better chance to survive in competition with managed care. But, managed care organizations would easily be able to develop products to compete with catastrophic insurance, taking advantage of their superior ability to control the costs of high cost cases.

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[8] Braverman, Paula et al., "Insurance-Related Differences in the Risk of Ruptured Appendix," New England Journal of Medicine, August 18, 1994.

The $3000 deductible policy would be especially attractive to the healthy and wealthy. Those who could afford to do so could save so long as they did not need to use their deductible. This would reduce the costs of the healthy who take catastrophic coverage—an ironic result when one considers that it is the expenditures of the sick that need to be reduced. The bad risks would increasingly bear the burden of the additional costs associated with their care. In a spiral of increasing costs and higher risks, first dollar coverage would be driven from the market—a desired outcome in the view of the proponents of tax-preferred MSAs. In the end, this raises a question of social policy: Do we want people with costly chronic conditions (e.g., a woman in a five-year struggle with breast cancer) to have to pay $3000 per year out-of-pocket more than those who have the good fortune to be healthy?

Tax-favored MSAs raise a number of additional problems. A dollar increase in deductible does not translate into a dollar decrease in premium. The additional money to fund a MSA would increase tax losses to the federal government. Some proposals effectively allow people to pass funds through tax-favored MSAs without limit, as long as the money is spent on IRS-eligible medical expenses. Like today's limited Section 125 accounts, this effectively cuts the cost of goods and services by 30 percent to 50 percent (depending on tax bracket), thus undermining cost-consciousness, and costing the Treasury a great deal. Consumer out-of-pocket health expenditures in 1993 were $158 billion, much—though not all—of which would be eligible for tax shelter.

INSURANCE REFORMS AND GROUP PURCHASING

Jay Carruthers and Ellen Wilson

The rising costs of health care over the last decade have affected the large and small group markets in two very different but instructive ways. Cost pressures on large groups have inspired major innovation, including greater use of managed care, incentives for cost-conscious purchasing, and better information for making choices. The same cost pressures when applied to the small group and individual market have had a deleterious

effect. Small groups are unable to spread risks, to achieve economies of scale, to benefit from competition, and usually to offer multiple plans. As a result, the small group and individual market is characterized by:

- High premiums with steep increases or denial of coverage (especially for individuals or small groups with individuals who get sick): small and mid-sized businesses faced an average increase of 14 percent over the last twelve months. Over the last three years, it totaled about 57 percent.[9]
- High administrative costs: a carrier's administrative expense, by one estimate, reaches 40 percent of claims in groups of one to four, compared with less than five percent for groups of more than 10,000.[10]
- Segmentation of the market by risk (i.e., health status).
- A growing number of uninsured or partially insured workers.
- A very imperfect market: no opportunity for people to examine all the alternatives with good information on price and quality, make and execute a choice (i.e., comparative shopping is costly and difficult); market segmentation and risk selection by health plans through non-standard benefits packages and non-standard rating categories.

Small employers and individuals need a purchasing infrastructure capable of putting the same pressure to bear on the market as large employers. The recommendations that follow encourage the formation of buying groups that would improve access to, and affordability of, coverage in the small group and individual insurance market. A stable insurance market, however, depends on the contributions of a broader population of healthy individuals to pay for the costs incurred by sick members of the risk pool. As long as insurance remains voluntary, you need some mechanisms or incentives to ensure that risk is spread sufficiently. We propose the following:

- Group purchasers should be prohibited from selecting members on the basis of health status or past claims experience.
- Receipt of the proposed tax credit (see page 18) should be linked to purchasing through a group for employees of firms of two or more.

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[9] Arthur Andersen, " Survey of Small and Mid-Sized Businesses: Trends for 1994."

[10] Congressional Research Service, "Private Health Insurance: Options for Reform," September 20,1990.

There are two ways to spread risk—modified community rating (across all groups within a defined market area) or within purchasing groups. The Jackson Hole Group favors the latter for several reasons. Purchasing groups offer a proven, powerful tool for structuring a competitive, well functioning market, including creating a market with choices among competing health plans, side-by-side comparisons, comparative information about cost and quality, standard coverage contracts, equal rating rules, etc. Such institutions spread risk more broadly and decrease the ability of health plans to discriminate on the basis of health status. They also significantly reduce administrative and marketing costs associated with contracting with individuals and small groups. If group purchasing is not extended to small groups and individuals, this market will continue to be beset by weak incentives for competition among plans and high costs. This favors large groups while being disadvantageous for small groups.

While both community rating and group purchasing require some form of incentive to keep good risks in the pool so that premiums remain affordable, we lack the cost shifting mechanisms, technical expertise, and standardization of benefits necessary to implement an effective risk adjusted community rate in a prospective reimbursement environment. Group purchasing offers a more feasible way of creating a competitive market with minimal government intervention.

To aid in the development of group purchasing, purchasing groups should not be mandated to take individuals due to potential adverse selection problems. In the individual market, "adverse risk selection" results when healthy persons choose to forgo coverage, leaving a sicker population in the pool. Ideally, these additional costs would be spread widely. While it would be possible to require all purchasing groups in the small group market to offer guaranteed issue to individuals, this would shift the excess burden of adverse selection in the individual market to small employers. Therefore, we encourage purchasing groups to take individuals—the tax credit would give healthy individuals an incentive to purchase coverage, and administrative savings and economies of scale associated with group purchasing should enable the groups to offset the

additional costs of adverse selection—but at the same time suggest that carriers serving the individual market be required to community rate and not be permitted to select on the basis of risk. This may, however, lead to a situation where the premiums of individuals are excessive. If that becomes the case, it may be necessary to implement a broad based tax or make adjustments among market segments to spread the costs of adverse selection more fairly.

National Standards

A prerequisite to effective group purchasing is a set of uniform market rules or standards. Despite current efforts to give states more power in developing local policy solutions in areas like welfare, there are several reasons why health system standards need to be national. First, health care markets do not adhere to state boundaries, making it impossible for states to structure rules that apply consistently across markets. Second, the preponderance of large multi-state employers reinforces the need for a federal framework. Moreover, with the rapid change in the delivery of medical services and the proliferation of varying levels of risk-bearing arrangements, state regulations designed to monitor traditional insurance carriers are outdated. Enforcing uniform federal standards, however, would be a logical extension of the state's traditional role as insurance regulator. Finally, and perhaps most importantly, national standards are needed—in the current system where there is tremendous variation in the regulation of health benefits from state to state and between the state regulated insurance market and federal regulation of self-funded plans—to uniformly shift the basis of competition from risk avoidance to the delivery of cost-effective high quality care.

Insurance Reforms

National standards should begin with enacting those insurance reforms at the federal level that have already been implemented in most states—e.g., guaranteed issue of all products, guaranteed renewal, portability, limitations of preexisting condition exclusions, and limited rating restrictions (not community rating) [see Table 1, Proposed Insurance Reforms, page 27]. In doing so, the most blatant forms of risk selection would be eliminated while providing greater uniformity to the system and the necessary

Table 1
Proposed Insurance Reforms

Guaranteed Issue of All Products - Health plans would be required to accept all individuals and their dependents, and all groups that apply for coverage. Health plans could not deny coverage based on health status. This would apply to all products sold in the marketplace by health plans.

Guaranteed Renewal - Health plans would be prohibited from terminating or otherwise failing to renew coverage for groups or individuals except under certain conditions - e.g. nonpayment, fraud, etc.

Limit on Preexisting Condition Exclusions - Health plans could not exclude coverage of treatment for a preexisting condition for more than six months from date of plan enrollment. A condition is preexisting if it was treated or diagnosed in the 6 months prior to the date of enrollment.

Continuity of Coverage - Health plans would be prohibited from applying preexisting conditions restrictions to applicants with continuous coverage (defined as coverage with lapses no greater than three months)

Limited Rating Restrictions - Health plans would be subject to limited rating restrictions, including age, family composition, and geography, to ensure that coverage is not denied through price.

*General language for the above taken from 6-28-94 Chairman's Mark of the Health Security Act, Senate Finance Committee.

preconditions for the formation of purchasing groups. These reforms are designed to prevent health plans from discriminating on the basis of health status and claims experience—a widely accepted principle—and should apply to all health plans regardless of risk-bearing arrangements, whether it is a traditional insurance carrier, a health plan, or an ERISA self-funded plan (see Table 2, ERISA reforms, page 28). Guaranteed issue, for example, would not mean that a self-insured plan would have to take anyone who wanted to join. They would, however, not be able to deny coverage to a sick employee or family member based on their health status. Portability and continuity of coverage provisions are particularly important because they not only reward those already in the system by improving access to coverage, but also foster a more competitive market by allowing people to change plans more easily—an essential component to any functioning

marketplace. As a result, health plans are less able to predict the health status of their enrollee population and must therefore rely on spreading risk.

Clearly, insurance reforms are limited in what they can achieve. Applied uniformly, however, insurance reforms serve as a critical step in shifting competition among health plans from risk avoidance to risk management. In addition to insurance reforms, all health plans, including ERISA plans, should adhere to uniform quality reporting standards adopted by the health industry (see Health Accountability Foundation section page 36).

Table 2
ERISA Reforms

- ERISA plans should have to allow employee family members the option of purchasing coverage through the plan. However, employers should in no way be required to pay for such coverage.
- ERISA plans should have to abide by marketplace rules relating to portability.
- ERISA health plans should be subject to the uniform quality reporting standards developed by the health care industry to allow employees to assess the coverage they receive.
- ERISA plans should be subject to solvency standards that ensure an appropriate level of capital reserves.
- States should be prohibited from taxing ERISA plans to finance efforts to expand coverage. Doing so would penalize those employers already providing coverage for their employees.

Certifying Voluntary Purchasing Groups and Enforcing Standards

To ensure compliance with national standards or market rules, the states should have the responsibility of enforcing those standards through the accreditation of voluntary, Certified Purchasing Groups (CPGs). Many existing purchasing groups already comply with similar standards and could easily receive state accreditation as a voluntary CPG. If multi-employer arrangements are afforded ERISA protection, as some have proposed, the federal government should enforce compliance of uniform standards. The one

overarching condition imposed on all purchasing groups would be accepting all who are eligible and wish to purchase from the group. Eligibility criteria would be left to the purchasing group as long as they precluded any discrimination on the basis of health status.

PRIVATE SECTOR INITIATIVES

"Responsible Choices" assigns two important initiatives to the private sector. The first initiative is the introduction and maintenance of a benchmark benefits package which will serve as a reference benefits standard for comparative purposes. The second initiative is the establishment of a new health accountability system which will focus on the provision of understandable quality information to consumers, based upon plan performance and health outcomes. Each function is described in some detail in the two sections which follow. The two proposed private sector groups, the Benchmark Benefits Group and the Health Accountability Foundation, could function under a single umbrella organization, funded primarily by user fees. Specific proposals for implementation are addressed on page 37.

THE FIRST INITIATIVE—BENCHMARK BENEFITS

Nancy Ashbach, MD, MBA

The Need for Fair Disclosure and Comparability

Health plans, consumers, pharmaceutical manufacturers, physicians, legislators, the courts, and others have struggled in the past with benefit plan offerings. In particular:

- Consumers have been unclear about the criteria for inclusion of specific benefits in their health plans. This has led to suspicion that managed care plans are motivated to skimp on needed care.

- Consumers have had difficulty comparing health plan offerings with differing benefits.
- Physicians and others have been unclear as to the benefit and technology review processes in health plans, leading them to view the process as secretive and unscientific.
- Health plans have been hampered in their ability to deny coverage for specific interventions clearly and concisely and to support such decisions with cogent reasons.
- Pharmaceutical and technology manufacturers have suspected that such decisions are based upon cost alone and that their products are not receiving a fair and open hearing by health plan policy-makers.
- The courts and legislators have received conflicting advice from interest groups.

It is for these reasons that a benchmark benefits package is needed. This product should be a voluntary, real, and valid offering of all health plans, but need not and should not be the only offering. Plans can and should be able to offer packages both richer and leaner to respond to the needs of purchasers. Many plans have had lengthy experience with the federal HMO benefits package, and we recommend that until the process for revising and improving upon it is in place, it serve as the initial benchmark package. A specific benefits package with a high level of detail will be developed as quickly as possible to deal with the ambiguity and lack of specificity inherent in the use of the federal HMO benefits package.

The process of defining and maintaining the benchmark benefits package should be open, fair, understandable, and for information purposes only. The criteria for additions and deletions should be available and the process should be clear so that coverage decisions by the health plan would be protected from unreasonable challenge. Physicians, drug manufacturers, consumers, purchasers, health plans, and others who might wish to influence the process of coverage inclusion and exclusion would therefore be able to do so. In addition, the public would be assured of appropriate care being provided and of coverage for expensive therapies not being denied solely because of cost. There should be no opportunity for collusion between health plans for the

inclusion or exclusion of benefits. For the purposes of avoiding antitrust law suits, health plans may need to be excluded from the process.

In addition to disclosing criteria for coverage, a standard product must be available for price and quality comparison. In the absence of a voluntary benchmark, plans will vary benefits to satisfy the demands of various customers and comparability to the consumer will remain elusive. By using a benchmark benefits package as a standard product against which the differing needs and requirements of purchasers can be measured, comparability of benefits and price offerings can be determined.

Maintenance of the Benchmark Benefits Package

The benchmark benefits package should be that collection of benefits that is most likely to produce health in the population. While the federal HMO benefits package is an excellent starting point, producing health in the population will require ongoing evaluation, revision, and updating of benefits. Also, a high level of specificity and detail will be required in the definition of the benchmark benefits package. Technology assessment and cost-effectiveness analysis will be needed to achieve this objective in a rational way.

Technology assessment and evaluation are necessary because:

- Technology in medicine is in a constant state of flux, with new technology entering the market at a staggering rate. The cost of such technology creates a strong economic requirement for a valid process to determine coverage under a typical benefits package.
- Much existing technology has not been evaluated for effectiveness. To date, we have had no mechanism for doing so, and many interventions in medicine are covered under existing benefits packages as a result of historical precedent.
- Cost-effectiveness has not been a major element of technology evaluation in the past but will surely become so in the future as group benefits are valued against individual demands.

An open, clear, fair, and scientific process to include or exclude specific technologies in the benchmark benefits package will benefit all parties. Since technology assessment is currently done in several different organizations, expertise would be available from the private market. This would mean purchasing technology assessment expertise from organizations such as ECRI (Emergency Care Research Institute) or the Blue Cross/Blue Shield Technology Evaluation Committee or networking current expertise. A principle of the new organization would be to utilize expertise currently available in the private market in the most effective way.

Additionally, individual coverage decisions on the part of health plans often require an independent evaluation and recommendation, which plans could implement on a voluntary basis. Such individual evaluations would be carried out by experts in the appropriate field of medicine and would be free of vested interests to deny coverage based on cost considerations. Independent expert reviews would support removal of coverage decisions from the legal system, where judges and jurors often rule in favor of coverage if there is uncertainty or urgency.

An Independent Approach

A new, independent organization, the Benchmark Benefits Group (BBG), should be formed to address these needs in the health system. The BBG's proposed functions are outlined in Table 3. It would be private and not-for-profit, although government collaboration would be possible in key areas, such as clinical trials, Medicare, and Medicaid. Representatives could come from purchasers, consumers, managed care organizations, self-funded employers, academic medical centers, physicians, and the government. Funding for the organization would come primarily from user fees—that is, per capita assessments of the participants and users of the organization's efforts. Special projects funding could come from foundation grants.

Table 3
Functions of the Benchmark Benefits Group

- Definition, updating, and maintenance of the benchmark benefits package using the criterion of production or maintenance of health.
- Recommendation of inclusion or exclusion of new technology into the benchmark benefits package based upon technology evaluation done by recognized groups.
- Recommendations regarding continuation, limitation, or exclusion of existing technology.
- Cost-effectiveness information and recommendations based upon information from competent entities.
- Individual disputed coverage decisions in defined situations. For example, an autologous bone marrow transplantation case for breast, ovarian, or cervical cancer denied as experimental by a health plan would be referred to a group of experts entirely outside the plan for scientific review.

A critical element to the success of the BBG will be its independence and autonomy. Many elements of the health care system are characterized by suspicion and doubt as to the methodology regarding coverage decisions in the policy-making and in the individual case. The autonomy of this organization will reassure doctors that an appropriate process exists with adequate clinical input. It will reassure patients that their interests are being dealt with fairly, and it will reassure new technology providers—e.g., drug and device manufacturers—that a fair process exists, facilitating level playing field competition for all. Thus, the processes and criteria of the BBG should be open, published, and available for revision as the health care industry develops and matures.

Target Goals:

- 90 percent of health plans offering the benchmark benefits package by 1998.
- Reconsideration of decisions made in individual cases by the Benchmark Benefits Group upheld by courts in 60 percent of cases by 1998.

THE SECOND INITIATIVE—A HEALTH ACCOUNTABILITY SYSTEM

Sarah Purdy, MD

A New Quality Accountability System for a New Health Care System

The expectation that consumers would be able to choose among competing health plans, on the basis of comparable quality and cost information, has not been realized. This failure is partly due to information about the quality of health care not being as easily available, understood, or compared, as information about costs. Consumers have been inhibited from assuming responsibility for their own health care choices by inadequate information that does not facilitate side-by-side comparison of health plans or encourage participation in decisions about health care and treatment. To evaluate the impact of health care on the population, it is necessary to measure the result, or outcome, of the interaction between individuals and health plans—to hold health plans accountable. At present, there is a health care quality measurement industry that uses different definitions of quality and differing methodologies to measure quality. While these initiatives are admirable and more extensive than any previously undertaken, there is pressure from the purchasing community to move forward at a more rapid pace. Therefore, we propose a new health accountability system which would not rely solely on the traditional systems of quality assurance that fail to disclose health outcomes or assure consumers of receiving excellent care by choosing a specific plan. The principles and assumptions upon which the new health accountability system is based are:

- Comparable, reliable, valid quality accountability data must be available to consumers.
- A move toward outcome based accountability data is feasible.
- Purchasers, consumers, and providers may have different information needs. Quality improvement activities should result from internal use of quality data.
- A clear distinction should be made between defining measurement and disclosure requirements and verifying that requirements are observed. Organizations that define data disclosure requirements, and those that audit data, should be independent of each other, with neither being subject to undue influence by the provider or insurance communities.

- Providers, health plans, and researchers create the capability for choices to be made on cost and quality, but group purchasers and individual consumers should have input on the requirements of the system.
- The same data on quality should be demanded by, and be available to, both private and public sector purchasers.
- Uniform data disclosure requirements could lead to the formation of regional and national data bases, which would inform providers, purchasers, and policy-makers.

These principles raise several potentially controversial issues. First, the intention of the system is to compare health plans, not individual providers. Second, there is debate on how to compare the results of care provided by different health plans when the health and demographic characteristics of the populations they serve are not comparable. The issues of severity adjustment, or case mix, and demographic variation require continuing refinement. Third, the system would require health plans to collect additional information about quality and use some form of standardized record keeping. By cooperating with this, plans would potentially be putting themselves in a position of being unfavorably compared with competitors. Finally, the degree to which consumers want and understand information about quality of health care is still uncertain. However, those whose lives are impacted by health care—patients and those who represent their interests—must have the dominant input into the quality accountability system.

The health accountability system would also require group purchasers, whether public or private, to provide valid, comparable information to consumers. To achieve this, and avoid further increase in the number of data sets requested by purchasers, collaboration is needed within the health industry.

What Would a Health Accountability System Look Like?

Table 4 outlines the proposed system, which suggests collaborative efforts to address two areas: the research, design, and evaluation of health accountability measures, and the selection and endorsement of uniform data disclosure requirements.

Table 4
Elements of a Health Accountability System

1. **Accountability Measures Clearinghouse**
   Clearinghouse function, to collate and disseminate information about measures, methodology, and previous experience. Identify areas that need further research.

2. **Health Accountability Foundation**
   Select and endorse uniform data disclosure requirements. Purchaser and consumer dominated board, permanent executive staff, input from other players.

3. **Auditing of Health Plan Data Disclosure**
   Verification that data has been collected, analyzed, and interpreted in a reliable and valid manner.

4. **Selection of Health Plans by Group Purchasers and Consumers**
   On the basis of uniform, comparable data disclosed by plans.

5. **Quality Improvement**
   Assist health plans to be proactive in the improvement of quality and to respond to the results of the measurement process.

Health Accountability Foundation

A Health Accountability Foundation (HAF) should be established as an independent collaborative body between the private and public sectors. Its responsibilities would include setting quality accountability goals and selecting and endorsing uniform measures of health plan accountability. These measures and the agreed methodology by which they are collected would then form the core of all health plan reporting activity. Care must be taken to ensure that standardization does not quash innovation, and that evolution of the core measures is assured as information capabilities improve. It is important to consider the clinical implications for plans and providers, and to build incentives and feedback mechanisms for quality improvement activities to result from the internal use of quality data. Standard setting should not be isolated from the implementation of quality improvement activities. The experience of the health plans and the accrediting bodies will be vital to ensuring a link between the foundation and clinical practice.

It is envisaged that the HAF would have a permanent staff of scientists, who would systematically consult with outside experts. They would present recommendations to the foundation's board, whose majority would be represented by purchasers and consumers from the private and public sectors. A mechanism needs to be devised, by which health plans, providers, researchers, the pharmaceutical and technology industry, and the health care quality organizations would have input. The closest existing model for the HAF is the Financial Accounting Standards Board (FASB). The recommendations endorsed by the HAF should be scientifically justified and subject to scrutiny at public hearings. It is important to link health plans into the system, in order to ensure that the data requirements specified by the board inform quality improvement and the furthering of medical knowledge, and are fair and feasible. Data that is valuable to providers is more likely to be included in medical records and incorporated in computerized medical information systems.

Funding of the HAF should preserve its independent status. Funding should be assured, but not dominated by health plans. A possible mechanism would be an annual subscription, and an assessment on the health plan premiums of those plans that choose to participate.

Implementation of Private Sector Initiatives

The two private sector initiatives proposed in "Responsible Choices" are benchmark benefits and the health accountability system. These two functions could work synergistically under a private umbrella organization sponsored by a broad range of participants and involved parties, and funded by user fees. The organization would be a not-for-profit entity. We propose to convene a representative set of purchasers and consumers in June 1995 to determine if there is agreement on the idea of the Health Accountability Foundation and the Benchmark Benefits Group and to get their thoughts on how funding for these initiatives would be accomplished. Initial estimates of cost suggest that funding in the range of $0.10 per member per month would be sufficient to accomplish the task with a broad membership. It is intended that participants at the June

meeting will define and adopt a set of initial health plan benefit and accountability requirements.

Once sufficient support is generated for the new organization, a board of directors should be chosen and an executive director selected. The new organization should move quickly to begin work on its primary goals. The proposed benchmark benefits should be available by July 1996. The goals of the Health Accountability Foundation will be more difficult to accomplish due to the lack of uniformity of quality data in the health system today but even if a single meaningful measure is chosen, the expansion of goals can proceed from that starting point.

The other elements of the proposed health accountability system are as follows:

Accountability Measures Clearinghouse

Many groups and individuals have developed considerable expertise in devising and implementing health plan performance measures. Currently, no organization documents all of these efforts and evaluates them, or assists others with questions of methodology or implementation. A collaborative approach would achieve economies of scale, resulting in more funding for such projects, greater availability of information, and a reduction in the duplication of effort. It is proposed that a scientific assembly be formed that serves two main functions:

- To act as a clearinghouse for the collation and exchange of information about quality accountability measures and methodology.
- To call attention to the need for research, development, and continual evaluation and improvement of performance measures.

The clearinghouse is not meant to engage in research. It should be a private/public partnership, perhaps set up to collaborate with an existing organization, such as the Agency for Health Care Policy and Research (AHCPR) or a consortium of government and private research institutions. Funding would come from foundation grants and government agencies.

Completing the Health Accountability System

The other criteria for the proposed system can be satisfied by well-established mechanisms already in place. Because organizations like the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations have considerable experience in accrediting plans and providers, they could play a major role in auditing the process and facilitating quality improvement activities. The organizations that focus on internal quality improvement, such as the Institute for Healthcare Improvement, would be an obvious medium for the quality improvement role. Continuing education of physicians and other health plan staff members is important to each stage of the process. There will be considerable overlap between the components, and continuous feedback to the clearinghouse and HAF functions will be necessary.

Target Goals:

- Comparable information about the quality of care provided by health plans should be available to 100 percent of consumers purchasing through groups by 1998.
- Preliminary health plan data on condition specific outcomes by 1998.

HEALTH SYSTEM INFORMATION

Robyn Lunsford, MSE, Nancy Ashbach, MD, MBA and Sarah Purdy, MD

Why Is Coordinated Health Data Needed?

Making responsible choices will require that better information be available on who is insured, what it costs, and whether better health is the result. As the system changes, data must be collected faster and from different sources: per capita expenditures by health plans, for example, are becoming more valuable than the numbers of physician visits and hospital days. Attempts at federal health care reform last year showed that the data available was not sufficiently timely or accurate. In fact, inadequate data on consumers' responses to price competition tilted some proposals toward price controls. Congressional Budget Office estimates of the cost of various bills were hampered by their

inability to evaluate the effects of undocumented improvements that were under way and differences in inflation rates from community to community. While in some areas premiums are reported as declining, these figures do not show if there is a corresponding increase in copayments. In order for policy-makers to address the problems of attaining broader coverage while containing the cost of health care, they must have data about the numbers and characteristics of the insured and uninsured and the cost of different delivery systems. Though multiple sources of health care data are available, one of the major obstacles is how to access, analyze, and compare this disparate information.

Why Are the Current Data Inadequate?

- Multiple data sets are not comparable or accessible from one source: For example, information about coverage and utilization of services is collected in the annual National Health Interview Survey (NHIS), but it does not provide information about household income or costs.
- Data regarding costs and coverage is not timely: e.g., the information from the NHIS takes twelve months to process. The National Medical Expenditures Survey is completed only once every ten years.
- The validity and accuracy of some sources of health data has been questioned; e.g., the medical care component of the consumer price index (CPI) does not measure costs borne by third-party payers, hence it reflects price to the consumer, not true overall cost. In fact, the CPI is a poor measure of medical cost to the consumer.
- Data are not available in useful formats: e.g., it would be very helpful to have data sorted by state to deal with issues such as Medicaid reform.

The problems associated with the existing data sets and with setting up an alternative system are acknowledged by federal agencies[11] and at the state level. We have set out some basic principles for the development of a coordinated system in the following sections.

[11] Physician Payment Review Commission, Annual Report, 1994.

What Should Be Collected?

Data will be required in four basic areas in the health system:

1. Cost—What is the per capita cost of health care, to third-party payers and to the individual?
2. Coverage—Who is and is not covered by the health insurance system?
3. Vital Health Statistics—Morbidity, mortality, reportable diseases.
4. Quality—What are the measures of quality of services provided?

Quality of services (health status, outcomes, and consumer satisfaction was covered in: A Health Accountability System, page 34). This section focuses on the data needs of cost, coverage, and vital statistics.

The process of collection should be guided by some basic principles:

- Confidentiality of records and privacy rights of individuals must be preserved. Use a unique, encrypted identifier.
- Data must be exchanged electronically, either directly or indirectly.
- Data must represent the minimum required to serve the basic needs of the health system.
- The information needs of the health system will change as the payment system changes.
- Data collection must be timely.
- The aim of the uniform data system should be to reduce administrative costs in the health care system.
- Determination of which data elements are collected should be driven by a clear mission—to improve the health of the population.
- Data should be collected at the state level, and then aggregated nationally.

Cost: Information is needed on per capita costs for all individuals in the health care system. The purpose of information at this level is to determine the per member costs of health care—those borne by a health plan and those borne by the individual. It will be necessary during a period of transition to reconcile the methodology of data collection

between capitated systems and fee-for-service systems. It will be the responsibility of a federal entity (see page 43) to define appropriate standards to integrate information from the two payment systems.

Coverage: Information will be required from health plans and self-insured groups with respect to numbers of enrollees (including dependents) and member demographics. Timely information on enrollment and disenrollment will be needed. Information will be required both on the insured population and on the uninsured population. The basic questions to be answered in this context are: "Who is covered?" "Is their coverage adequate?" and "Who is not covered and why?" Surveys, using demographically representative subsamples, should be conducted at least annually with the resulting data forwarded to the responsible federal agency. These surveys should incorporate questions regarding coverage status—including an accurate assessment of why an individual or family does not have coverage; the cost of coverage—including premium amount and health plan provider, deductible and copayment amounts, and out-of-pocket expenses for the most recent one-week period; type of coverage—i.e., fee-for-service, managed care, Medicare, and Medicaid; and the family's source of coverage (employer, purchasing group, individual, other group plan, etc.). Data on the characteristics of both groups, such as employment or lack thereof, income, and demographics, should be collected. Information should also include an employer's size and industry classification. Data on the various health plans offered to an individual would also be helpful. Care should be taken to ensure that data on the Medicaid eligible population is incorporated in any survey.

There are two possible methods for conducting surveys:

- The ideal means to collect this information would utilize a national sample size of 50,000 to 80,000 households and result in national average data. Difficulties associated with this method are the expense and inability to analyze data with respect to localized market areas. In order to eliminate the possibility of duplication, unique

identifiers should be used for each survey respondent and all family members included in the survey with appropriate safeguards for confidentiality of the data.

- Alternatively, surveys of discrete market areas, at differing stages of market reform, should be conducted. Collecting longitudinal data in these areas would allow analysis of the changing market. The effect of reforms in other areas could then be more accurately estimated. Particular attention should be focused on states undergoing policy changes.

Vital Statistics: The new health data system should continue to collect information on morbidity, mortality, reportable diseases, births, and other issues, possibly including immunizations. Such information should be collected in a standardized way and integrated with information collected by providers and health plans for purposes of comparability and to reduce administrative costs in the health care system.

How Can the Goal Be Accomplished?

We believe that the ability to collect uniform, timely, accurate health system cost and coverage data is a goal that justifies a federal presence. Private industry collaboration alone will be neither comprehensive nor sufficiently rapid. However, it is in the interest of the health care industry to encourage federal financing of this endeavor. This function could be performed by an existing agency, such as HCFA's Office of National Health Statistics or the AHCPR, or by inter-agency collaboration. It should be separate from all purchasers, including Medicare. The agency should be advised by a broad group of experts from the private and public sectors, to include those with expertise in information systems, health care financing, health economics, and other scientific and technical fields. We propose that the delegated agency take responsibility for reporting on cost, coverage, and vital statistics. Information on quality reporting will fall within the purview of the Health Accountability Foundation. Federal legislation will be required to ensure reporting of the chosen data elements by all parts of the health care delivery system as well as by states.

Target Goals:

- Health data system should be functioning by the end of 1996.
- Data on costs of health services should be available quarterly.
- Data on coverage should be available annually, and within the first three months of the following year.

CONCLUSION

"Responsible Choices" recognizes that the health care market is moving rapidly toward reform and offers proposals to foster this restructuring. Private purchasers are driving the market and causing health plans to compete on price and quality. However, not all purchasers are exerting this force on the market. As the largest purchaser of health care in the U.S., the federal government has tremendous potential to drive improvement in the market which it has not yet exercised. Small groups and individuals have limited access to group purchasing arrangements that pool risk, provide choice, and achieve administrative savings that would enable them to be active, value purchasers of health care.

This demonstrates that market mechanisms alone are not solving all of the problems. "Responsible Choices" depends on the willingness of government and the private sector to work together to improve the American health system. Federal involvement is necessary to bring public programs into line with the private sector, increase consumer cost-consciousness, establish a fair market, promote group purchasing that offers the small group and individual market access to reasonably priced health coverage, and provide information. "Responsible Choices" recommends a tax credit as the means for bringing structure to the market. Without the tax credit device, bringing order to the health care market will be much more complicated and require considerable regulation.

For its part, the private sector must be willing to be more accountable. Benchmark benefits and quality reporting are the first steps that the private sector should take to

voluntarily hold itself accountable. Implementing these policies would bring comparability to the market and provide information enabling consumers to make informed decisions and drive competition. If the private sector cannot follow through, it may be necessary to link these proposals to the tax credit by requiring health plans to price and offer the benchmark benefits package and report on quality in order to receive tax credit eligibility for their plan.

"Responsible Choices" does not address the issue of achieving universal coverage but recognizes that other primary problems must be solved first, such as building a better marketplace so consumers and purchasers can make informed decisions. Other important issues, such as malpractice and antitrust, are not taken up directly since they are being actively addressed by others and dealt with in the market. These proposals are the necessary incremental steps forward in containing costs and fostering effective public and private purchasing. With these reforms in place, there will be more data and the capability to effectively and efficiently deal with those left out of the system. The elements of this proposal can be put in place rapidly and will accelerate the reforms already taking place in the market.

DRAFT -- NOT FINAL

Report on Options for Non-Social Security Entitlement Reform

Prepared by the Office of Senator Judd Gregg

1. Health Care

1. Health Care

A. Medicare --

- The Medicare system must be reformed and its service delivery improved. Our nation's seniors deserve to have this important program placed upon sound financial footing, and they deserve better health care than the current system provides. The Medicare Trustees project that the Medicare Trust Fund will go bankrupt in 2001. Our parent's and grandparent's Medicare benefits should not continue to be subject to such a fiscal crisis. Medicare's financial troubles are worsened by the fact that the program operates under a terribly outdated structure. Designed for medicine as it was practiced in the 1960's, Medicare has not adapted well to thirty years of medical advancements. While private sector health care costs fell last year, Medicare costs rose by 10.5 percent. Accordingly, appropriate Medicare reform can both contain the rate of Medicare spending to sustainable levels, and improve the delivery of health care services to our nation's seniors.

- These options propose that Medicare savings accrue from two levels of improvements and restructuring reforms, providing nearly $100 billion in 5-year savings. This would result in Medicare growth of roughly 7.5 percent, as opposed to the current 10.5 percent growth rate. A 7.5 percent growth rate corresponds to an additional $990 billion in Medicare spending over the next five years, rather than the $1.1 trillion that would be spent if no changes were made.

  - Level One: Prevent Insolvency: First, because the current fee-for-service Medicare system would be fully preserved for seniors who choose to remain in that system, it would be improved where needed to increase fairness and maintain solvency. These policy improvements would be balanced between physicians, hospitals and benefit recipients, and would achieve $50-65 billion in savings. Such adjustments could include:

    -- Establish Home Health Coinsurance at 20% -- $19.7 billion (over 5 years)
    -- Establish Lab Coinsurance at 20% -- $6.1 billion
    -- Income-relate Part B premium -- $10.0 billion
    -- Extend HI tax to all state and local workers -- $7.6 billion
    -- Implement Physician Payment Review Commission Recommendations -- $10.0
    -- Reduce Hospital Inflation Update by 1.5% -- $10.2 billion
    Total 5-Year Savings from Options List: $64 billion [LIST TENTATIVE]

- Level Two: Choice Care: Second, seniors would be provided **a "Choice Care" option.** This new Medicare approach would result in $35-45 billion in 5-year savings. Choice Care would expand insurance choices and options, take advantage of private market forces, and provide a non-coercive and completely voluntary incentive for seniors to move out of the antiquated fee-for-service culture. A brief description of Choice Care follows.

Choice Care -- Brief Description

- The "Choice Care" plan offers a way to redesign and improve the Medicare system for our nation's seniors, by increasing their medical insurance choices and health care opportunities.
  - Choice Care will make available to all seniors a new and completely voluntary system that delivers medical care in a modern fashion, instead of under the antiquated fee-for-service system. It will be provided in addition to the present options available to seniors, not in lieu of those options.
  - Within Medicare, Choice Care will establish monetary incentives for seniors to move away from the costly fee-for-service system which is filled with inefficiencies and considerable fraud and abuse. It will allow for such change to occur slowly and naturally, as seniors realize the benefits and choices of the new, more open, system.
  - Choice Care will establish within the Medicare system the same types of private sector incentives that prompted private sector medical costs to decrease last year. This private sector drop occurred even while Medicare costs grew by 10.5 percent.
  - Choice Care will further respond to the Medicare Trustees' warning of the impending insolvency of Medicare, and their call for Congressional action to preserve Medicare for our nation's seniors.
- Under Choice Care, seniors each year would receive a "Choice Check," which would be equal to a regional capitated amount. With their Choice Checks, during an annual open season, seniors could choose from a wide range of health care insurance options, under a system much like that available to federal employees. The seniors would be offered a broad array of insurance choices, including the provision of additional benefits (e.g., vision care or prescription drug coverage) or the payment of the Part B premium.

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- If the plan a senior chooses costs less than the Choice Check, the senior could keep 75 percent of the difference. If the selected plan costs more, the senior could use his or her own money to pay the extra amount. Current Medicare benefits would be offered, and the present Medicare system would remain intact for those seniors who choose to remain in fee for service care.

- The Clinton health care reform plan projected $207 billion in savings under Medicare from forcing all seniors into a managed care system with per capita spending limits. Choice Care does not share the Clinton plan's coercive aspects, and only budgets $35-45 billion in savings over 5 years. It is likely that Choice Care will be positively received by seniors, and that even more savings will accrue.

- In addition, a "Look Back" mechanism would enforce the budgeted Choice Care savings, by imposing an automatic schedule of Medicare adjustments if necessary.

  - These Look Back adjustments would parallel those used in the past budget packages, but would be analogous to a sequester and held in abeyance pending the operation of the Choice Care system.

  - Under the Look Back mechanism, each year HCFA would review the operation of the Choice Care system after the open season, and determine how much savings the system will achieve for that year. If that amount falls below the savings planned for upon enactment, then HCFA will implement the schedule of adjustments, on a pro rata basis, to the extent necessary to make up the difference in planned savings.

  - The Look Back adjustments would be imposed only as a last resort, but their potential imposition would give providers an incentive to make the Choice Care system work. Savings of $35-45 billion would be budgeted, based upon the expected 7.5 percent rate of Medicare growth. Such Look Back adjustments could include:

-- Freezing Prospective Payment System rates -- $6.6 billion
-- Reduce Hospital inpatient capital 10% -- $4.4 billion
-- Reduce Hospital indirect medical education adjustment, etc. -- $5.0 billion
-- Reduce Outpatient capital -- $1.0 billion
-- Impose moratorium on new Long Term Care hospitals -- $0.3 billion
-- Extend Medicare Secondary Payor policy - $3.0 billion

Total 5-Year Savings from Options List: $20.3 billion

[LIST TENTATIVE -- due to sequester they should be percentage reductions, etc. so levels can be adjusted]

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- Choice Care will essentially expand upon, and make available to all seniors, the current Medicare HMO option. This limited HMO option has offered considerable additional benefits to seniors, and over 3 million seniors have already chosen to enroll within HMO plans. Over 150 Medicare HMO risk plans currently exist. Under the present HMO option, if the carriers can deliver Medicare services for less than the capitated amount, additional benefits must be offered. Under this system:

  -- 131 plans offer routine physical benefits
  -- 34 plans offer health education benefits
  -- 47 plans offer foot care benefits
  -- 7 plans offer lens benefits
  -- 5 plans offer hearing aid benefits
  -- 116 plans offer immunization benefits
  -- 65 plans offer prescription drug benefits
  -- 121 plans offer eye care benefits
  -- 100 plans offer ear exam benefits
  -- 48 plans offer dental benefits

- Plainly, the results under the current HMO option prove that a Choice Care system is viable. Providing seniors with the choice of receiving additional benefits as under current law, or a cash back award, or a combination of both, would greatly expand their health care options and provide a strong incentive for millions more to move out of the antiquated and costly fee-for-service system.

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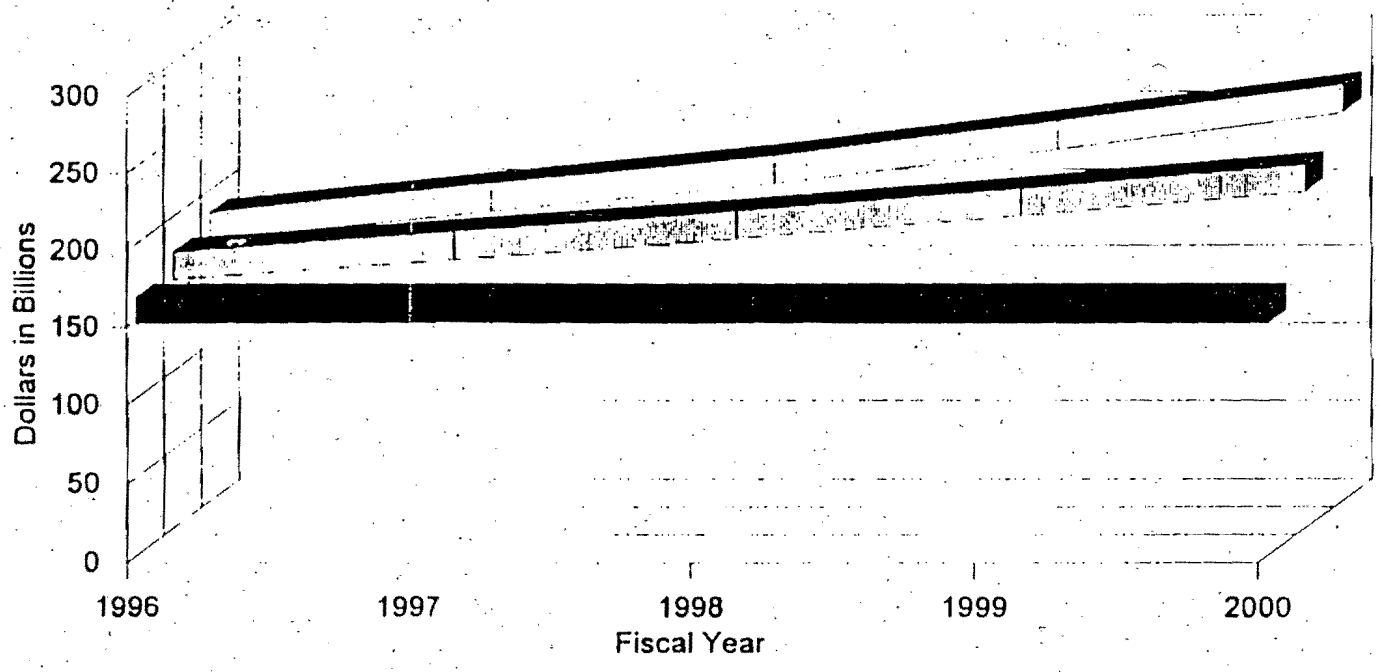
Medicare Spending
1996-2000



Projected 5-Year Savings = $100 Billion

Current Policy -- 10.5% Growth

Balanced Budget Plan

Spending Freeze (1995 Level -- 0% Growth)

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B. Medicaid --

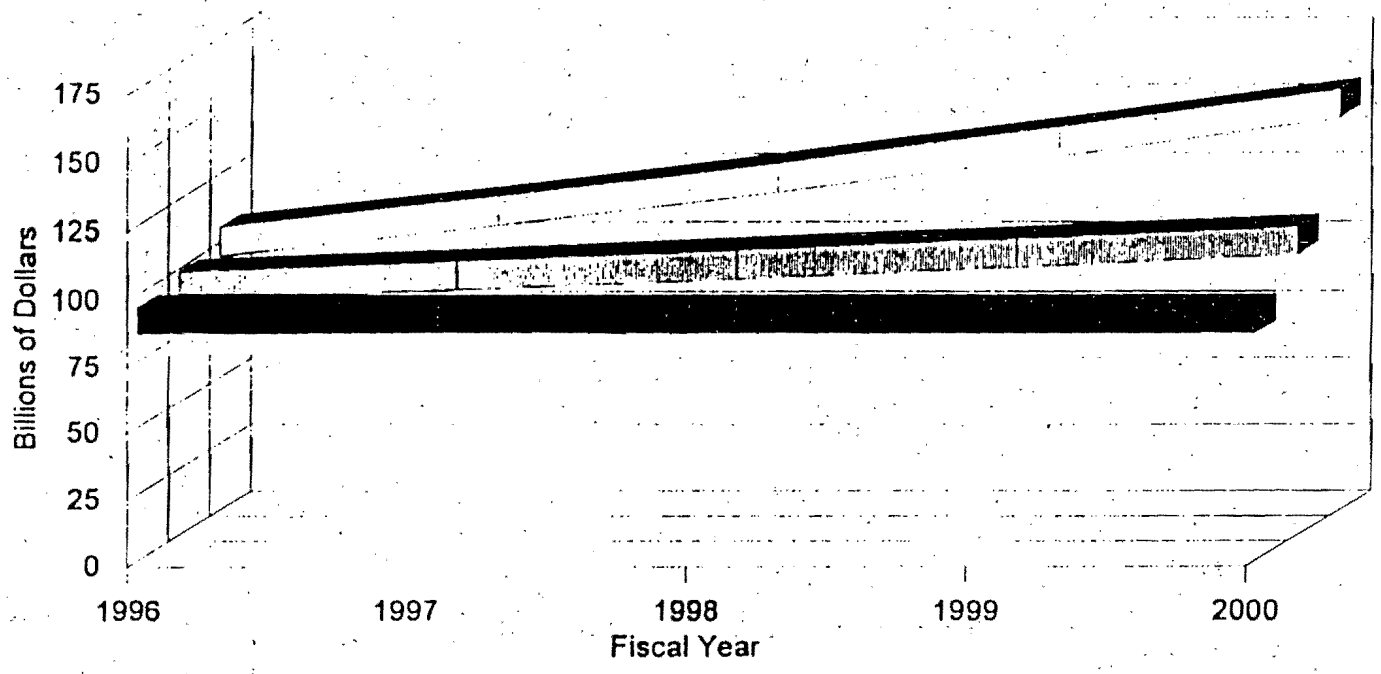
- These options recommend that Congress work with the Governors to implement a new Medicaid system, under which the funding would be provided on a block grant basis and at capitated amounts necessary to achieve a 4 percent rate of growth. This growth rate would achieve $115 billion in savings from 1996-2000. Even with these savings, $505 billion in additional Medicaid spending would occur over the next five years, in contrast to the $620 billion in new spending that would occur if no reforms were made. In return for receiving a slower-than-projected growth in federal Medicaid dollars, states would be given great flexibility to design Medicaid systems free of federal mandates.

- As with Medicare, Medicaid was designed in the 1960's and has become increasingly inefficient. The Medicaid system can be restructured to simultaneously contain costs and improve service. The current Medicaid system is so riddled with federal mandates and complex requirements, that states in the past have actively sought to take financial advantage of system "loopholes" for non-medical purposes. Further, a majority of states are already seeking Medicaid waivers to get out of the crushing mandates imposed by the current structure. However well-intended, the old system no longer works. For the dollars being spent, the recipients and the nation deserve much better results. It's time that the federal government allowed the states true flexibility to design modern systems to deliver better Medicaid services.

- Even better results can be achieved than are budgeted under this recommendation. For example, Wisconsin moved its Medicaid program into a capitated managed care system, and the state's Medicaid costs fell dramatically. For several years now, Wisconsin's Medicaid growth was 1/3 to 1/2 below the national rate. Wisconsin's Medicaid costs now grow at only two percent per year and continue to decline. This dramatic drop in Wisconsin's Medicaid costs occurred without any reduction in coverage or provider reimbursements. Tennessee's Medicaid managed care program has also reduced program cost growth dramatically (less than 0.2 percent last year). Other successful managed care initiatives have been established in Massachusetts and Michigan. Given the flexibility, several states have already proven that spending growth can be slowed while better services are provided.

- [Recent Johns Hopkins Study = significant cost savings in Medicaid not inconsistent with better quality health care]

Medicaid Spending
1996-2000



Projected 5-Year Savings = $115 Billion

- Current Policy
- Balanced Budget Plan
- Spending Freeze (1995 Level)

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C. Baseline Savings --

- The President's budget contained Office of Management and Budget (OMB) Medicare and Medicaid assumptions that differ rather dramatically from those used by the Congressional Budget Office (CBO). While the reasons behind these different assumptions were not completely explained, the result was an OMB baseline that contained more than $70 billion less in five year Medicare and Medicaid spending (see Table below). Because accepting the OMB's assumptions could be viewed as a "baseline game," these options do not count on these savings to achieve its overall $385 billion target.

(Dollars in Billions)	1996	1997	1998	1999	2000	5-Year Total
Medicare/Medicaid Spending -- OMB Assumptions	270.8	296.5	323.1	352.6	385.7	
Medicare/Medicaid Spending -- CBO Assumptions	275.9	305.2	335.8	370.9	407.7	
Difference Between OMB and CBO	***5.1***	***8.7***	***12.7***	***18.3***	***22.0***	***70.2***

- These options propose that the Republican budget consider utilizing the President's health care assumptions. In the health care arena, where responsible proposals must be put forth and debated, reform efforts should not be disadvantaged simply by insisting on a set of assumptions that make long-term spending projections $70 billion higher, and that therefore make necessary reductions appear deeper. Medicare and Medicaid reform efforts should not have to sustain political attacks based upon inflated numbers.

- The President's health care assumptions result in a lower Medicare and Medicaid baseline, and therefore would lessen the amount of savings that would be achieved by the previously discussed Medicare and Medicaid proposals. Because the baseline path is lower, however, not as much would need to be saved to obtain a balanced budget. Thus, at least $20 billion in additional "savings" should accrue from using the President's assumptions.

2. Welfare Reform

2. Welfare Reform

A. Block Grants --

- The problems with our current welfare system, and the need for significant reform, are well-known and will not be repeated here. These options recommend continuing to work with the Governors and the House on the block granting of federal welfare programs. During these discussions, the Congress should insist upon reform that slows the rate of growth of these entitlement accounts by at least $40 billion over the next five years. Proposals already made by the Governors would achieve these results. While pursing a block grant approach will inevitably be labelled as mean-spirited or lacking in compassion, there is certainly no compassion in allowing the present system to continue without significant reform. A block grant approach, which allows local tailoring and state experimentation can only result in better results for those the welfare programs are meant to serve.

B. SSI Reform --

- Welfare reform cannot be pursued without also reforming the Supplemental Security Income (SSI) system. The growth in this entitlement program, which provides assistance to the elderly, blind and disabled poor, has exploded over the last several years. SSI is the largest, and fastest-growing, cash benefit welfare program in the nation, and it is being administered by the Social Security Administration (SSA). Its growth will continue to skyrocket over the next five years, and into the next century, unless cost containment action is taken soon. In 1985 SSI cost $7 billion; today it costs $19 billion; and it will cost $40 billion in 2000 without reform.

- Deep structural problems cause SSI's fiscal woes and, like other welfare programs, SSI must be fundamentally reformed. The disability portion of SSI has undergone considerable regulatory and court-ordered expansions, and it now provides benefits so liberally that it operates at cross-purposes with the basic work ethic and the Americans with Disabilities Act (many SSI recipients could sue employers that refused to hire them). Furthermore, SSI status means automatic eligibility for other federal programs, including Medicaid, Food Stamps, and housing assistance. Welfare recipients therefore often prefer to receive SSI, and find ways to make themselves eligible, often using SSI as an "escape hatch" when they lose eligibility under other programs. In addition, many states aggressively place their welfare recipients onto SSI, to remove them from state rolls and put them on the federal dole. These practices should not be allowed to continue, particularly when other welfare accounts are consolidated and funded on a block grant basis.

- SSI eligibility has exploded in recent years due to liberal expansion of its disability coverage well beyond what was originally intended. It is now far too easy to be deemed "disabled," which subjects SSI to considerable abuse. Currently, three-quarters of SSI recipients are those deemed disabled. Drug addicts, alcoholics, and those with mental "impairments" (such as those who have trouble performing in a "competitive work environment" and children who do not act in an "age appropriate manner") can now qualify for SSI disability. This allows those who engage in socially dysfunctional behavior, or who simply have a bad work ethic, to receive large monthly cash payments.

- Other SSI problems derive from SSA administration. SSA's monitoring of program requirements has become virtually non-existent. SSA presently devotes its resources to quicker enrollment, and ignores legal mandates to conduct disenrollment reviews. Thus, while SSA reviewed 436,000 cases in 1983 and terminated 182,000 of them, the agency reviewed less than 50,000 in 1993 and terminated less than 5,000. SSA now annually adds 100 times more people to SSI rolls than those it terminates. Furthermore, although SSA initially determines that sixty-eight percent of mental impairment cases have expected or possible improvement within three years, the average beneficiary remains on the rolls for 15 years. Less than 1 percent of drug addicts and alcoholics, who are given cash benefits, return to work. Disability attorneys say that an SSA denial of disability eligibility has become practically impossible for the agency to defend on appeal.

- These options recommend significant restructuring of SSI, to at least limit SSI's growth to a rate of 7 percent. This growth rate would still be well above inflation, and would result in about $22 billion in five year savings. Achieving this result could occur simply by returning eligibility rules to their original construction. SSI should stop providing cash benefits to drug addicts, alcoholics and those with behavioral or emotional "disabilities" that are easy subjects of fraud and abuse. These improvements will result in $17 billion in five-year savings. Also, an additional $5 billion in savings could result from requiring those receiving SSI disability benefits to reaffirm their disability status after an appropriate period of time, particularly for those whose disabilities were classified as subject to improvement when initially declared SSI eligible. The indefinite continuation of SSI benefits runs counter to recent progressive advancements within the disability area, and should not be allowed to continue.

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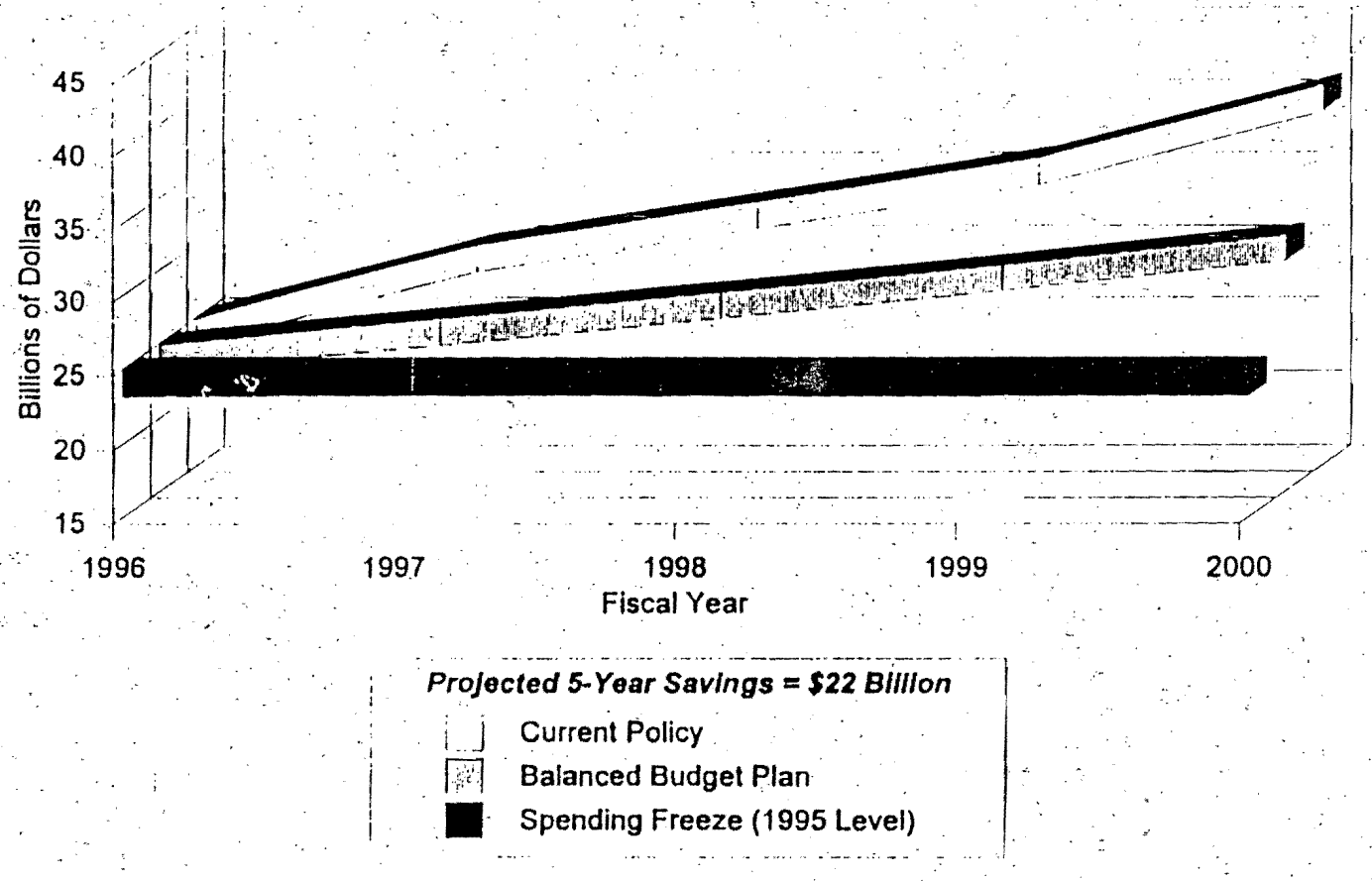
SSI Spending
1996-2000



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C. EITC Reform --

- The Earned Income Tax Credit (EITC) program possesses many characteristics of the SSI program. It is a worthwhile program that has unfortunately grown out of control. Like the SSI program, the EITC will result in significant long-term fiscal hemorrhaging unless action is taken to contain it soon. The program contains rampant fraud and abuse, which the IRS has awkwardly tried to restrain this year. Congress can no longer afford to let the glowing rhetoric surrounding this program immunize it from needed reform, but rather must admit that the EITC has serious problems. We must also act to improve the program, better target its benefits, and thus restrain its unsustainable rate of growth.

- These options propose accepting the President's plan to count interest and dividend income while computing EITC eligibility. There is no reason that the definition of the "working poor" should include those who are investment rich. These options further propose to end the indexation of the EITC eligibility formula. The basic credit amount is still scheduled to undergo a significant expansion under provisions in the 1993 budget act, and a further expansion through eligibility indexation is unaffordable and unwarranted. Finally, the options propose that the EITC should no longer be available for undocumented workers. These changes to the EITC program would result in $27 billion in savings during the 1996-2000 period.

3. Retirement

3. Retirement Accounts

A. COLA Equity --

- The retirement programs of the federal government are different than other entitlement programs because they reflect the obligations of the federal government as an employer, not merely as a benefit provider. Still, the civil service and military retirement accounts represent a significant portion of entitlement spending, and aspects of the programs can be reformed.

- When the federal retirement system was established, no cost of living adjustments (COLAs) were contemplated. Instituted in the 1970s, COLAs have become a large entitlement cost driver. The CBO has estimated that over the next five years, entitlement spending will grow by $221 billion due to COLAs alone. We can no longer afford to provide unlimited COLAs.

- ***First, Congressional pensions should be limited to equal the pensions provided to all other federal employees.*** Second, the options recommend that COLAs continue to be provided to all federal retirees, but only up to a maximum dollar amount. The maximum COLA amount that any pension beneficiary could receive would equal the maximum COLA amount that a Social Security beneficiary could receive in any given year. In other words, a retired Congressman or senior executive branch official with a $100,000 pension would not receive a COLA on the full pension amount, but only up to the amount received by the maximum Social Security beneficiary. This change would result in savings of $9 billion over the next five years.

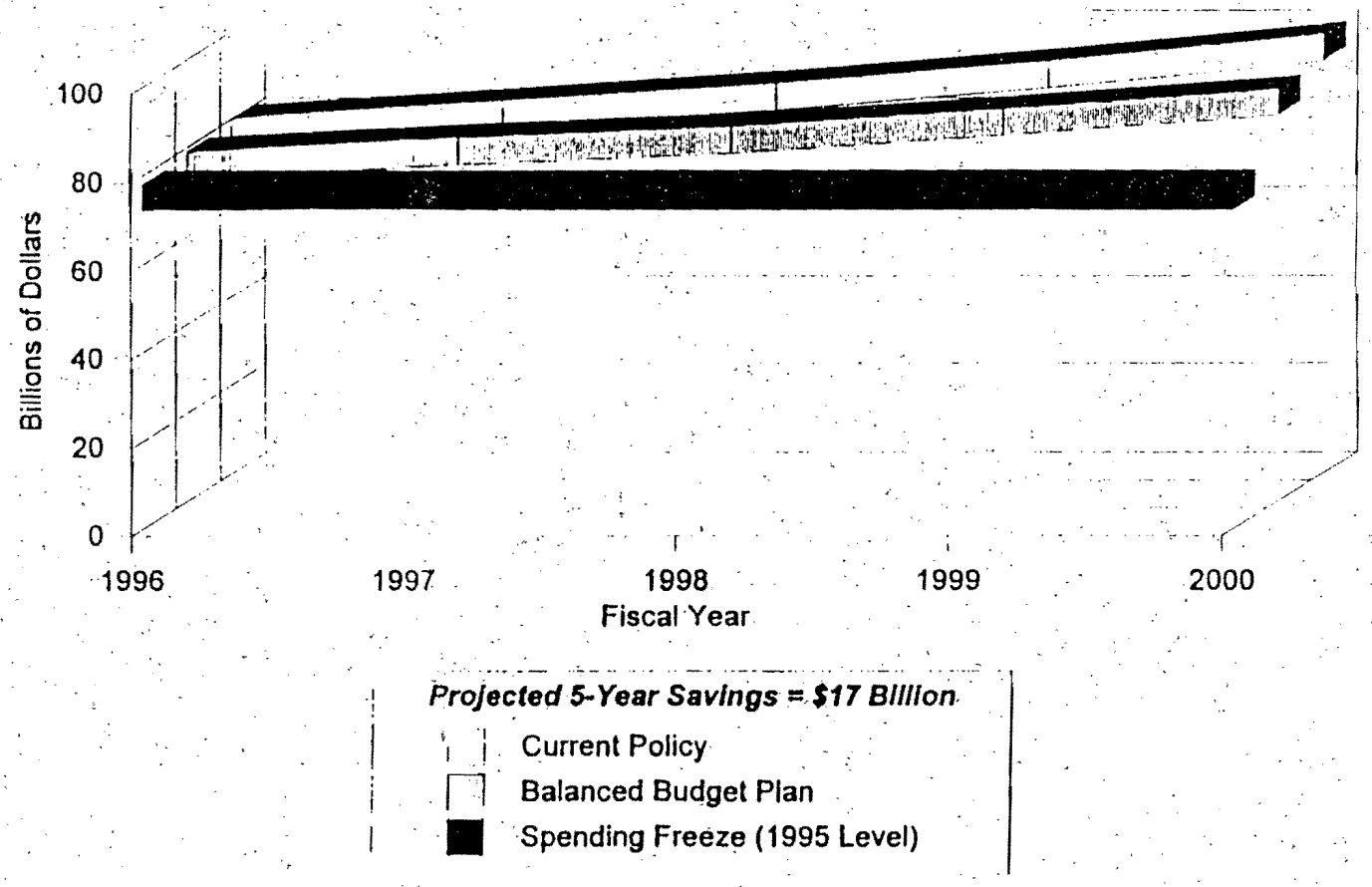
B. COLA Contributions -- [TENTATIVE]

- The federal pension system consists of two sectors -- current employees, who are contributing toward their retirement pensions while working, and retirees, who are receiving the pensions. Under current law, CSRS workers contribute 28 percent to their eventual pensions, while the federal government contributes 72 percent. Under FERS, the ratio is 26 percent to 74 percent. The employees' contribution used to be much larger, until COLAs were enacted. Since their inception, the federal government has borne the full cost of COLAs.

- These options propose that, if the federal government is to provide COLAs to its retirees, then federal workers should contribute toward at least a portion of their cost while employed. This proposal would have both CSRS and FERS employees contribute an additional 2 percent of their salaries to the pension program to help partially defray the federal government's cost of providing COLAs. This would result in $8 billion of savings during 1996 - 2000.

Federal Retirement Spending

1996 - 2000



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4. Other Entitlement Programs

4. Other/Miscellaneous Entitlement Accounts

- A recent GAO report identified over 435 mandatory spending accounts in existence during Fiscal Year 1993. Only 18 of these programs cost more than $10 billion, and only 41 cost more than $1 billion.

- The programs labelled "miscellaneous" here consist of all those not encompassed under previously discussed entitlement categories. They include some popular programs, such as the agriculture, veterans, and unemployment compensation programs, as well as many programs that are virtually unknown except to those who benefit from them.

- Without reform, these miscellaneous entitlement accounts will spend $350 billion over the next five years. These options recommend reducing that total by $55 billion, resulting in $295 billion of new miscellaneous spending from 1996-2000. The savings can be achieved as follows:

  A. **Agriculture Programs** -- Significant savings can and should be achieved from the agriculture programs. Absent reform, the federal government will spend $42 billion on farm price supports over the next five years. These options recommend accepting the proposals made by Senator Lugar in testimony before the Senate Budget Committee, in which he proposed reducing deficiency payments by lowering target prices by 3 percent, and eliminating the export enhancement program. These changes would result in $15 billion in five-year savings.

  B. **Veterans Programs** -- The federal government will spend $110 billion on veterans programs in 1996-2000. While care must be taken when reforming the accounts that serve those who have served our country, extending several OBRA-93 provisions, and halting compensation for future non-service-connected disabilities, will save nearly $4 billion.

  C. **Unemployment Compensation** -- Unreformed 1996-2000 unemployment compensation spending will total $128 billion. Imposing a uniform two-week waiting period on unemployment benefits will result in $7 billion in savings.

  D. **Other Programs** -- For the remaining 300-plus miscellaneous entitlement accounts, these options propose that these programs be subject to a strict review in light of current budget realities. Programs that have achieved their purpose or are no longer affordable should be repealed; programs that are still worthwhile, but can be improved, should be reformed; and only those programs that work well and justify their costs should be maintained. An options list that achieves the recommended $30 billion in savings from these miscellaneous accounts directly follows.

Reform Options -- Miscellaneous Entitlement Accounts

Program Reform	5-Year Savings	
• Agriculture		
- Reduce deficiency payment by lowing target prices by 3 percent	$11.45 billion	
- Eliminate Export Enhancement Program	$3.40	Total: $15 billion
• Veterans		
- No comp. for future non-service related disabilities	$1.09	
- No double comp. for future disabilities	$0.15	
- Extend OBRA-93 provisions	$1.92	
- Restore GI bill education funding ratio to 9:1	$0.35	Total: $4 billion
• Others		
- Unemployment Compensation -- impose uniform 2 week waiting period	$7.25	
- Sell Power Marketing Associations	$1.96	
- Initiate Hydropower leasing	$0.05	
- Lease National Petroleum Reserves	$0.62	
- Lease ANWR for oil drilling	$2.60	
- National Park Service user/entrance fees	$0.32	
- CORP: Regulatory program permit fee	$0.05	
- Mining royalty	$0.05	
- Terminate unneeded RTC employees	$0.78	
- Implement pay cap at banking agencies	$0.54	
- HUD: Loosen restrictions of multifamily property disposition	$0.43	
- Refinance Sec. 235 mortgages	$0.05	
- SBA: 4 proposed fees	$0.13	
- NOAA: Sanctuary and Areo chart	$0.03	
- Tonnage duty increase	$0.50	
- Railroad inspection fees	$0.17	
- Eliminate in-school interest subsidies for grad./prof. students	$1.70	
- Eliminate 6-month grace period for grad./prof. students	$1.60	
- Raise student loan origination fee to 5 percent	$1.50	
- Include farm and home equity in determining financial need	$0.40	
- Other education, training and social service	$1.50	
- Terminate cash benefit portion of Trade Adjustment Assistance	$0.96	
- Penalty for early redemption of savings bonds	$0.24	
- Auction landing/takeoff slots at 4 major airports	$1.50	
- Increase FCC user fees to cover full cost of licensing	$0.58	
- Terminate flood insurance subsidy on preform structures	$2.65	
- Eliminate market promotion program	$1.37	
- End judicial auto fund	$0.46	
- Terminate public telecommunications & facilities program	$0.09	
- Eliminate public funding of presidential conventions	$0.08	
- End information infrastructure grants	$0.06	Total: $30 billion

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5. Prospective Reforms

5. Prospective Reforms

- In 1963, entitlement spending plus interest payments totalled 30 percent of federal spending. Today, entitlements and interest account for 62 percent of all federal spending. Left unreformed, entitlement and interest payments will comprise 72 percent of all federal spending ten years from now, and entitlement spending alone will exceed total federal revenues in 2030.

- Just as the growth of entitlement spending drives the continued growth of the federal budget deficit, unavoidable demographic trends will eventually drive an explosion in entitlement spending. The baby boom generation continues to advance toward retirement age, and Americans continue to live longer and longer. As a consequence:
  - the life expectancy of those born in 1935 is 61 years, while it is 76 years for those born today;
  - the share of Americans over 65 will grow from 14 percent today, to 20 percent by 2025;
  - the number of Americans over 65 will grow from 24 million today, to 48 million in 2030; and
  - the number of working Americans available to support each retiree's benefits will fall from 5:1 today to 3:1 in 2025.

- Because the federal government's retirement programs operate on a cash basis, with current workers supporting current retirees, we cannot sustain the present programs in the face of such demographic trends. The reforms proposed in this package thus far will not solve the long-term problems that result from the aging of the baby boom generation. These options therefore recommend that those programs benefitting the nation's retirees should undergo additional change. While these additional changes will result in no 5-year budget savings, they are extremely important as a matter of fiscal responsibility.

- It would be unfair to make significant structural changes to the federal government's retirement programs and have those changes take effect immediately. First, we should not significantly alter the retirement system of those who are presently retired, or close to retirement, because they made long-term plans on the basis of the current structure. Second, we should allow present employees enough time to plan sufficiently for their own retirements. For both reasons, these options recommend that we undertake a series of structural reforms on a prospective basis -- to allow as much time as possible for people to adjust, and to not treat unfairly those who no longer have the time to adjust.

- The prospective nature of these recommendations does not mean that they can be postponed. Rather, they should be enacted as soon as possible, both to allow the federal government time to plan for inevitable demographic trends, and to allow the public time to plan around the changes that must be made. Changes like these will have to be made. We should not wait until it becomes impossible to ensure that they occur in a fair manner. A listing of the recommended prospective changes immediately follows.

Recommended Options for Prospective Reform

1. End accrual of Congressional pensions after 12 years of service [a pension term limit]
2. Increase Medicare's retirement age requirements to match the increases occurring under Social Security.
3. Raise federal Civil Service full benefit retirement age to 60, effective 1/1/2005.
4. Provide no federal pension (Civil Service or Military) COLAs to those under 62, effective 1/1/2005.
5. Adjust CSRS and FERS benefit formula from "high three" to "high five" pay, effective 1/1/2005.
6. Eliminate government match on TSP contributions for [4th and] 5th percentile.
7. Others??
8.
9.
10.

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6. Consumer Price Index Accuracy

- Over the years, Congress has established automatic increases within many programs to prevent the erosion of a program's purposes due to the effects of inflation. Social Security and federal recipients receive such cost of living adjustments (COLAs), for example, and the break points of the federal income tax rate brackets are indexed as well. The Congressional Budget Office estimated in January 1995 that COLAs alone will result in over $220 billion in federal spending over the next five years.

- The automatic indexation of most programs occurs with reference to increases in the Consumer Price Index (CPI), which is calculated by the Bureau of Labor Statistics (BLS). Most economists agree that the CPI overstates inflation, due to the way the measure is calculated and adjusted by BLS. The result is that COLA beneficiaries receive more than the true increase in cost of living would warrant. Their benefits are not only being protected against the corrosive effects of inflation, but they are also being over-paid.

- The amount of CPI's overstatement is quite significant. The Congressional Budget Office has estimated that CPI, which was 2.6 percent in 1994, was overstated by 0.2 to 0.8 points. CBO further estimates that a 0.5 point reduction in CPI would result in $64 billion of budget savings over 5 years, as COLA overpayments are halted. Federal Reserve Board Chairman Alan Greenspan estimates that CPI is overstated by 0.5 to 1.5 points. Chairman Greenspan estimates that up to $150 billion would be saved over 5 years if BLS calculated CPI accurately.

- The BLS is well-aware of CPI's overstatement of inflation, but basically refuses to correct it. BLS states that it will undertake any corrections in 1998, when a ten-year periodic revision is scheduled to occur. The BLS provides several reasons to support its four-year delay, but we cannot afford the agency's continued intransigence. While the BLS is principally worried about the measure's credibility, and legitimately so, at this point the measure completely lacks credibility to begin with. Any BLS corrective action would restore CPI credibility, not undermine it.

- These options recommend that the BLS act immediately to correct the overstatement of CPI, and calls upon the President to make sure this correction occurs swiftly. Congress should be extremely wary of enacting a legislative change to the CPI. However, knowledge of a significant CPI overstatement, coupled with BLS non-action, will soon make continued Congressional silence a breach of its fiduciary responsibility to the nation.

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6. Consumer Price Index Accuracy

Options for Entitlement Reform

5-Year Savings Target: $385 Billion; 5-Year Savings Recommended: $475-495 Billion

Entitlement Category ($$ in Billions)	1996-2000 Spending	5-Year Savings	Summary of Proposals*
1. Health Care	**1,820**	255-275	
A. Medicare	1,200		
- *Improvements/Adjustments*		*65-75*	*Line-item improvements and adjustments to prevent insolvency.*
- Choice Care		35-45	Give seniors option of purchasing insurance (e.g., managed care plan) with capitated payments. Incentive to join through receipt of cash-back or additional benefits if choice costs less than capitated amount. "Look Back" provision to enforce savings.
B. Medicaid	*620*	*115*	*Block grant, declining to 4% growth (work with Governors' recommendations).*
C. Baseline Differences		20	Accept part of Administration's health care baseline assumptions ($70 billion less than CBO).
2. Welfare	**600**	89	
A. Block Grants	*320*	*40*	*Block grants (work with Governors' recommendations).*
B. SSI reforms	160	22	Deny benefits to drug abusers, alcoholics, and recently expanded categories of "disabled" (i.e., re-devote program to truly disabled); require periodic reaffirmation of disabled status.
C. EITC reforms	*120*	*27*	*Accept Administration's investment income inclusion, eliminate indexing of benefit thresholds, and end benefit for undocumented workers.*
3. Retirement	**415**	17	
-- **Congressional Pensions**		--	**Limit Congressional pensions to equal those given to all other federal employees, plus:**
A. COLA Equity		*9*	*Limit all COLAs to maximum Social Security COLA amount.*
B. COLA Contributions		8	Reform employee contributions to begin partial offset of COLA costs.
4. Others/Miscellaneous	**350**	50	
A. Agriculture		*15*	*Reduce deficiency payments & repeal Export Enhancement Program.*
B. Veterans		5	Extend OBRA-93 provisions; plus other small adjustments.
C. Other		30	*Strict review and reform/repeal of 350+ other entitlement programs.*
5. Prospective Reforms	---	0	Policy adjustments to improve 20-30 year window, where entitlement growth truly explodes.
6. CPI Accuracy		64	The Federal Reserve Board estimates CPI is overstated by 0.5 to 1.5 percentage points; CBO pegs the overstatement at 0.2 - 0.8. Calculating accurately saves $64 billion.
Totals	**$3,200**	**$475-495**	Range depends upon Health Care numbers.

* Expanded details of these proposals appear in the attached appendices

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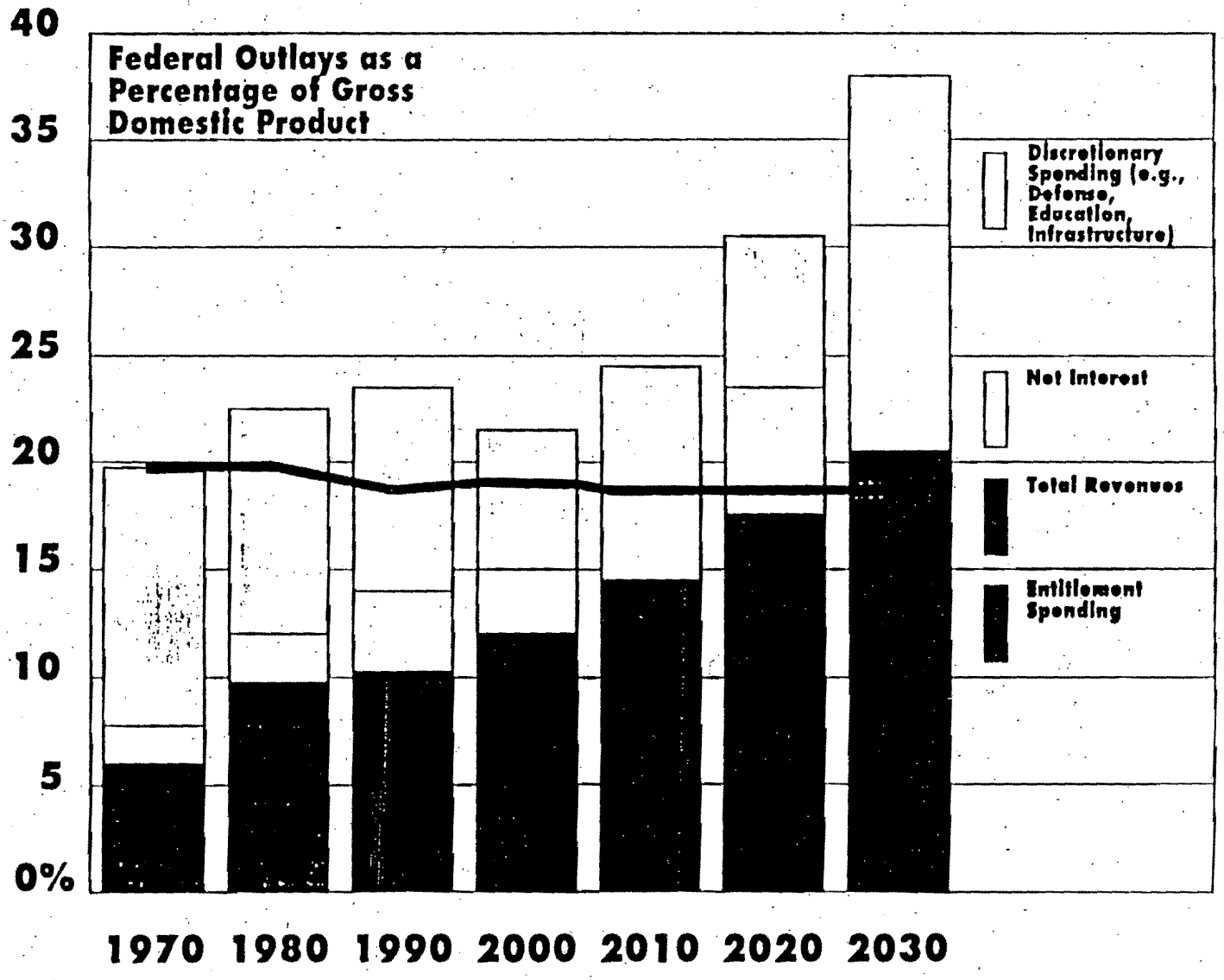
Current Trends Are Not Sustainable



Options Goal:

5-Year Savings of $385 Billion

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Options Goal

- The Working Group on Entitlement Reform was asked by Senate Majority Leader Bob Dole and Senate Budget Committee Chairman Pete Domenici to develop reform proposals in non-Social Security entitlement accounts that would achieve $385 billion in savings over the next five years (1996-2000). These savings would place the federal budget on a glide-path toward balance in the year 2002.

- Under these recommendations, which achieve the requested savings, non-Social Security entitlement accounts would still result in $2.82 trillion in spending from 1996 to 2000. Without reform, over $3.2 trillion would be spent. Annual spending on these programs would increase from $511 billion in 1995 to $600 billion in 2000.

- While overall entitlement spending continues to grow under this balanced budget plan, a dramatic reduction does occur in one mandatory spending account -- interest on the public debt. Due to lower annual deficits under these recommendations, over $172 billion in interest payments would be saved between now and 2002. The savings on this dead-weight account would accrue even more swiftly once balance is achieved.

- Further, former Congressional Budget Office director Robert Reischauer testified before the Senate Budget Committee this year that if Congress acted to balance the budget by the year 2002, an additional $140 billion in 7-year interest payments would be saved due to the 1 percent drop in interest rates that could be expected to result. The savings to be achieved under these options do not include this additional $140 billion.

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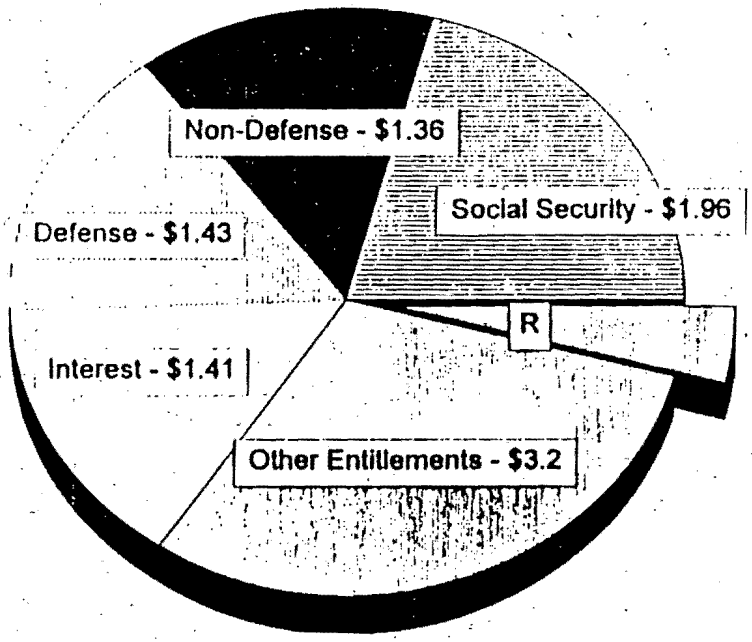
Total Government Spending: 1996 - 2000

(Dollars in Trillions)



Total 5-Year Spending = $9.36 Trillion

R = Recommended Savings ($385 Billion)

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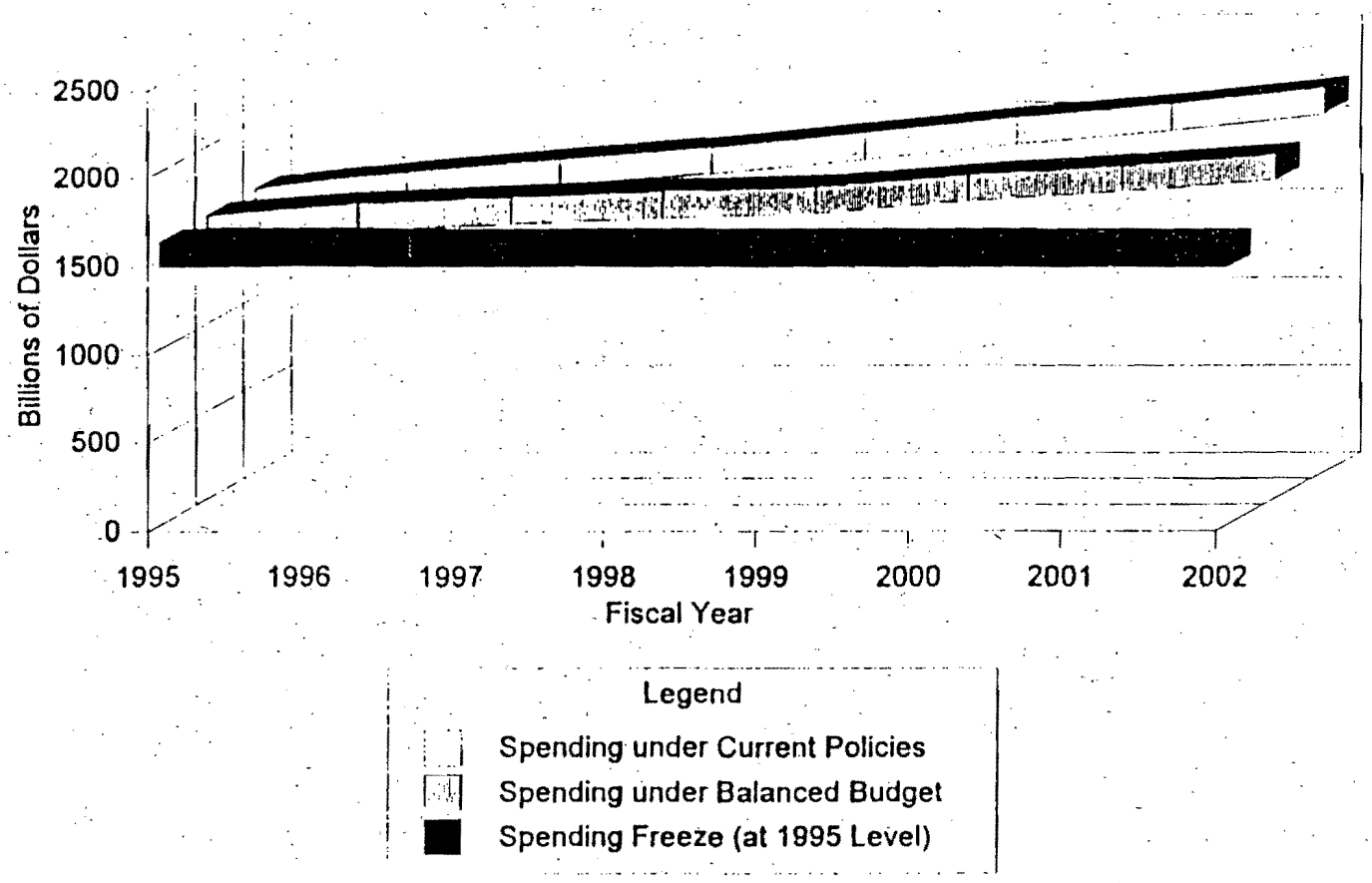
Total Government Spending

1996 - 2002



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Deficit Reduction Required for Balanced Budget by 2002

(Dollars in Billions)

	1996	1997	1998	1999	2000	5 Year Total	2001	2002	Grand Total
Current Baseline Deficit*	195	215	214	228	242		233	239	
Defense Discretionary	---	---	---	---	---	---	---	---	---
Non-Defense Discretionary	-12	-24	-36	-46	-46	**-164**	-46	-46	-256
Social Security	---	---	---	---	---	---	---	---	---
Non-Soc. Sec. Entitlements	*-24*	*-51*	*-80*	*-111*	*-119*	[illegible]	*-127*	*-136*	*-648*
Total Policy Changes	-36	-75	-116	-157	-165	**-549**	-173	-182	-904
Interest on Debt	- 1	- 5	-11	-21	-32	**-70**	-44	-58	-172
Total Deficit Reduction	-37	-80	-127	-178	-197	**-619**	-217	-240	-1,076
Resulting Deficits	158	135	87	50	45		16	-1	

* = Assumes Clinton's 1995 defense request and a continued freeze on discretionary spending after 1998
Source: CBO & SBC Majority Staff

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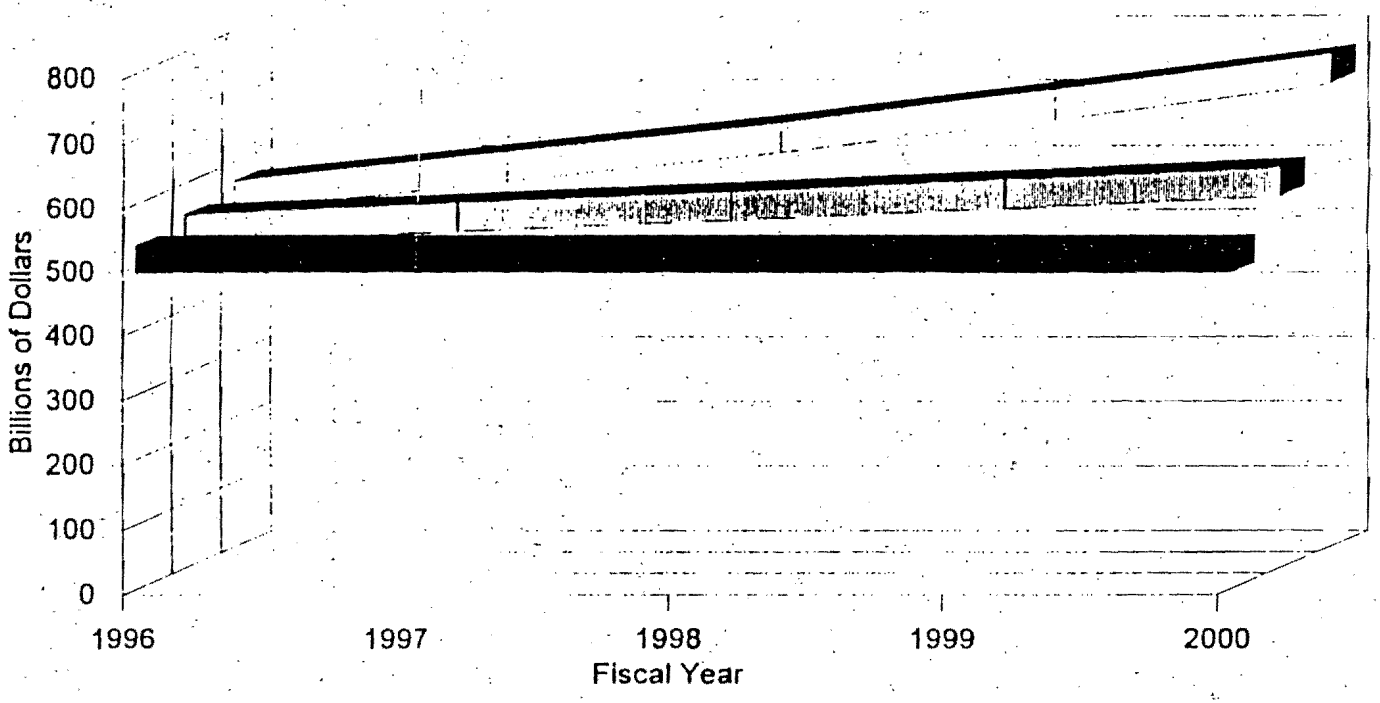
Non-Social Security Entitlements
1996-2000 Spending



Projected 5-Year Savings = $385 Billion

- Current Policy
- Balanced Budget Plan
- Spending Freeze (1995 Level)

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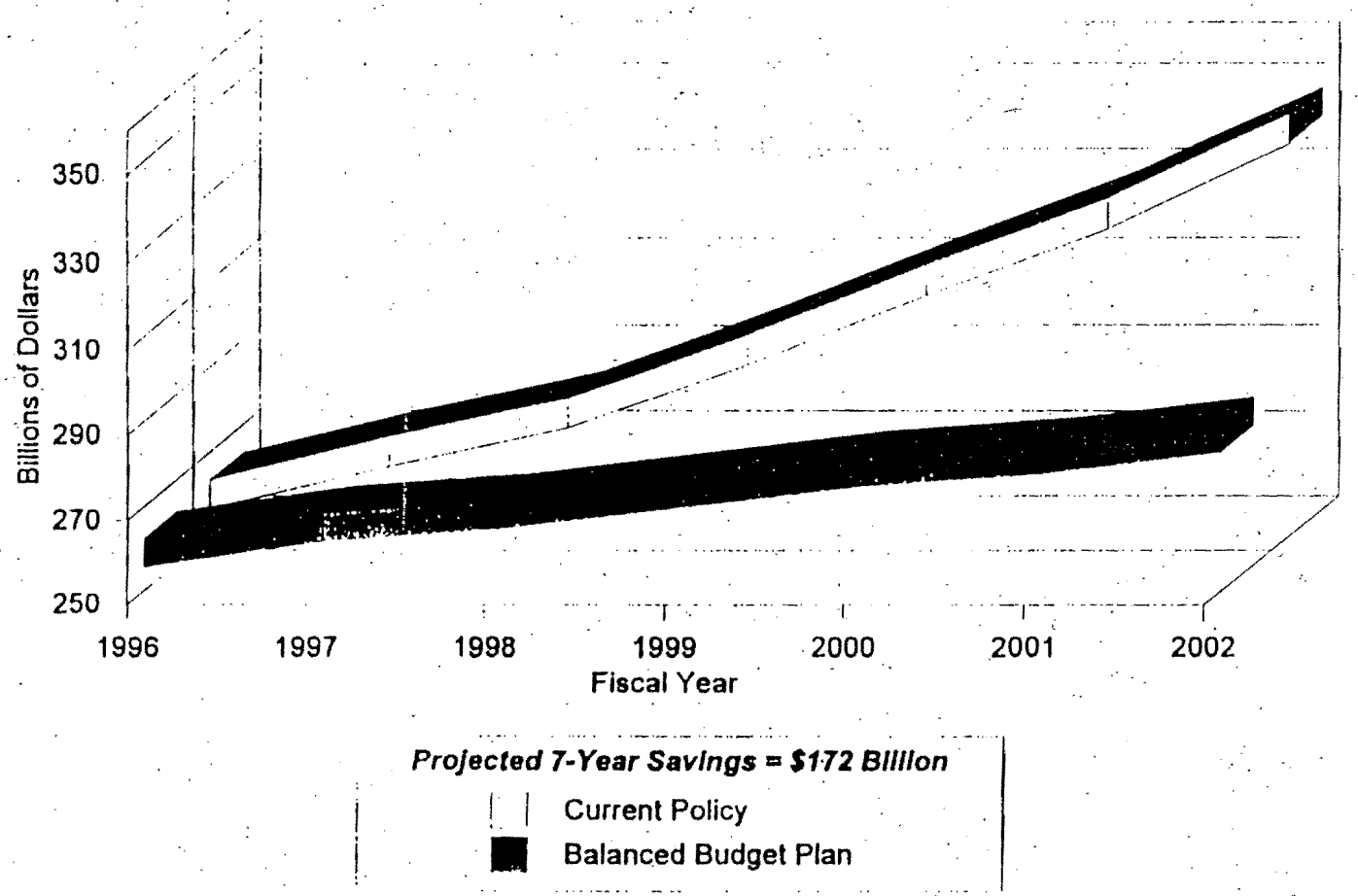
Interest on the Debt
1996 - 2002 Spending



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