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CENTER ON BUDGET AND POLICY PRIORITIES

THE STENHOLM ENTITLEMENT CAP PROPOSAL

Representative Charles Stenholm has crafted a proposal that would establish annual caps on all entitlement and mandatory spending programs, including Social Security, for each fiscal year through 2000. These caps would be set significantly below the levels that entitlement spending is expected to reach under current law. Rep. Stenholm estimates that Congress would have to make approximately $100 billion in entitlement cuts over the next five years to comply with these caps. That estimate appears conservative; the amount of cuts needed might be significantly higher.

Originally developed by former OMB director Richard Darman, the entitlement cap idea was a centerpiece of the 1992 Bush presidential campaign. Under the Stenholm entitlement cap proposal, the caps would be based on the total fiscal year 1995 expenditure level for all entitlements except deposit insurance and net interest. The fiscal year 1996 cap would equal the fiscal year 1995 expenditure level, adjusted for the general rate of inflation and also adjusted up or down to reflect changes in the number of beneficiaries in entitlement programs since fiscal year 1995. The same type of adjustments would be made in the cap for each subsequent year. There also would be an adjustment in the cap of one percent in fiscal years 1996, 1997, and 1998. Because these adjustments do not reflect such factors as the rapid rates of increases in health care costs that characterize Medicare, Medicaid, and the U.S. health care system as a whole, they produce caps that are well below projected entitlement costs.

An automatic sequester — or across-the-board cut — of entitlement programs would occur in any year the caps would be breached, unless Congress passed reconciliation legislation bringing entitlement spending within the caps. Virtually all entitlement programs — including Social Security and basic benefits for the poor — would be subject to sequestration. Any benefit reductions made as a result of sequestration would be permanent; they would not be lifted at the end of the fiscal year.

Last year, an entitlement review mechanism was implemented through the combination of an Executive Order governing the executive branch and a change in the rules that govern House procedures. These measures were designed to put into effect the entitlement control language passed by the House last year as part of its budget reconciliation bill. Under the Executive Order and the changes in House rules, the Office of Management and Budget is required to establish entitlement spending targets for each year through fiscal year 1997. When the Administration submits its budget each year, it must report on whether the targets for the prior fiscal year, the current fiscal year, or the coming fiscal year have been or are expected to be breached. If so, the President must recommend — and Congress must vote on — whether to cut spending, raise taxes, or raise the entitlement targets. Rep. John Spratt recently introduced legislation to write these procedures and requirements into law.

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Robert Greenstein, Executive Director

The Stenholm entitlement cap would go far beyond the entitlement review procedure embodied in the President's Executive Order and the change in House rules. One key difference involves the levels at which the targets or caps are set. The Executive Order set the entitlement targets at the levels projected for entitlement spending after taking into account the entitlement savings contained in the 1993 budget reconciliation bill. The Executive Order is designed to prevent entitlement costs from climbing above the spending levels envisioned in that bill. By contrast, the new Stenholm proposal sets the entitlement caps at much lower levels and requires large, additional entitlement cuts beyond those enacted last year.

As noted, the Stenholm plan would require that if entitlement costs would otherwise exceed the cap, entitlements would have to be cut (unless Congress raised the cap). If specific cuts were not enacted, across-the-board reductions would be triggered automatically, and no entitlements would be exempt — not even Social Security or basic benefits for the poor, which are exempt from sequestration under the Gramm-Rudman-Hollings law. Moreover, in seeking to avoid sequestration, Congress and the President would have no options other than cutting entitlements or raising the entitlement cap. In a departure from the Executive Order, no increase in taxes would be allowed to offset any part of an "overage."

Entitlements and the Deficit

Congressional Budget Office analyses show that when the deficit begins to rise again later in this decade, *all* of the rise will be due to the increasing costs of the health care entitlements. Over the next 10 years, total spending for entitlements other than Medicare and Medicaid will not increase the deficit; to the contrary, the CBO forecast shows that such spending will *decline* as a percentage of the Gross Domestic Product.[1]

This underscores the point that comprehensive health care reform with tough cost containment measures which slow the long-term rate of growth in health care costs is crucial for fiscal stability. Without health care reform of this nature, it will be virtually impossible to address our long-term deficit problems without much larger reductions in Social Security benefits and increases in taxes than the nation is likely to tolerate.

Effects of the Stenholm Proposal

The Stenholm entitlement cap proposal would have far-ranging effects.

1. It would make comprehensive health care reform more difficult to implement.

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[1]After the baby boom generation begins to retire, Social Security costs also will enlarge the deficit.

The Stenholm proposal would require that at least $100 billion in entitlement reductions be achieved over the five years from fiscal year 1996 to fiscal year 2000. Virtually all of the $100 billion gap between current entitlement cost projections and the Stenholm caps stems from the fact that the caps would limit entitlement expenditures to a rate of growth far below the projected growth rates for Medicare and Medicaid costs. (The growth rates for Medicare and Medicaid are similar to the rate of growth in private sector health costs.)

As a result, if health care reform legislation is enacted that is deficit-neutral over this five-year period, the entitlement cap proposal will almost surely force the health care legislation to be reopened and altered in subsequent years. Such action will be necessary to produce large savings in Medicare and Medicaid, on top of those savings measures contained in the health care reform bill, or to scale back substantially various costs in the reform bill such as the costs of extending coverage to the uninsured.

The health care reform legislation on which Congress is now working would be deficit-neutral over the next five years. This is primarily because the costs of covering many or all of the uninsured will largely have to be absorbed and paid for during this period. Health care reform has the potential to produce significant savings in years after that, depending on various decisions Congress makes in the weeks ahead.

Under the Stenholm proposal, however, the entitlement caps would be set at levels that would essentially require health care reform to generate large savings quickly. Achieving deficit neutrality in the legislation's first five years as health care coverage was extended to millions of uninsured Americans would be insufficient. This is why it would be very difficult to comply with the Stenholm caps for the next five years without extracting very large additional savings from Medicare and Medicaid or scaling back health care reform.

Accordingly, health care legislation enacted in 1994 would almost certainly have to be reopened. Revamping the legislation to achieve very large deficit reduction in the next few years would run a high risk of producing measures that compromise those features of health care reform that are designed to make major progress toward universal coverage.

Proponents of the Stenholm proposal are likely to note that the proposal contains a provision under which the entitlement caps would be adjusted following passage of health care reform legislation; the proposal's proponents may cite this provision as evidence the proposal would not interfere with health care reform. The provision in question, however, is minor and does address the issues discussed here. The provision does not alter the need, under the Stenholm proposal, for deep reductions in health care programs in the years just ahead. (See box on next page.)

Doesn't the Stenholm Proposal Adjust for Health Care Reform?

Proponents of the Stenholm plan are likely to argue their proposal does not stand in the way of health care reform and that, in fact, it contains an adjustment specifically to accommodate whatever health care reform bill Congress passes. This argument misses the mark. While the Stenholm proposal does contain a provision to adjust the caps after enactment of health care reform legislation, this is a minor provision with no significant bearing on the issues discussed here.

The Stenholm proposal includes a provision that would adjust the entitlement caps for each of the next five years up or down to reflect the amount that a deficit-neutral health care reform law is projected to increase or decrease entitlement spending in each of these years. For example, if a deficit-neutral health care reform law is projected to increase entitlement spending by $3 billion in fiscal year 1997, the fiscal year 1997 entitlement cap would be raised $3 billion.

While modestly useful, all this provision does is to keep the huge gap between the caps the Stenholm proposal would set and current projections of entitlement costs for the next five years from growing even larger. The provision does nothing to help close this gap. Steep cuts would still be needed, and they presumably would come primarily in the health care entitlement programs. This means that a deficit-neutral health care bill enacted this year would have to be reopened and potentially unraveled to produce tens of billions of dollars in additional health care entitlement cuts in fiscal years 1996 through 2000.

2. ***The Stenholm proposal would restrict the flexibility of authorizing committees and shift substantial power to the budget committees.***

In a novel provision included in the Stenholm proposal, reconciliation instructions contained in the Congressional budget resolution would dictate to the authorizing committees how much to cut from each of the 20 budget functions in the federal budget. Entitlement caps would be set annually for each budget function containing entitlement programs. These caps would be in addition to the overall cap placed on total entitlement spending.

The annual budget resolution would establish entitlement ceilings for each budget function. Once the budget resolution was approved, these function-by-function ceilings would be packaged as a separate bill and brought quickly to the House and Senate floors for a vote. If the bill passed and was signed by the President, these function-by-function ceilings would become legally binding caps. As a consequence, if an authorizing committee wished to cut an entitlement program in one budget function by less than the amount required in its reconciliation instructions — and to offset that shortfall through additional entitlement cuts in another budget function under its jurisdiction — the committee would be prohibited from doing so.

Under current budget rules, committees with broad jurisdictions — such as the House Ways and Means Committee and the Senate Finance Committee — may meet a reconciliation target by cutting any entitlement within their jurisdictions. Under the

Stenholm proposal, however, these committees would be required to produce specific amounts of entitlement savings by budget function and not be permitted to save less in one budget function and more in another budget function. If a committee failed to comply with the instructions for any budget function, every program in that budget function — including programs under the jurisdiction of other committees — would be cut by a uniform percentage. In other words, there would be a sequester of all entitlement programs in that budget function.

The proposal also would bar an authorizing committee from designing deficit-neutral legislation that increased one entitlement and cut another entitlement by the same amount, unless the two entitlement programs were in the same budget function or this shift was reflected in advance in the function-by-function entitlement caps set under the budget resolution. This restriction could create difficulty for proposals such as welfare reform that help finance increases in the cost of entitlements in one budget function by reducing entitlement programs in other budget functions.

3. The Stenholm proposal also would be likely to have unforeseen consequences.

The proposal would require cuts in entitlements when the cap would be exceeded, including some circumstances in which the cap was breached as a result of economic or other factors beyond policymakers' control. Although the caps would be adjusted to reflect certain basic economic factors, those adjustments do not cover other economic factors that also affect entitlement costs and could cause the cap to be exceeded.

For example, entitlement cuts could be triggered if income growth was slower than forecast, poverty rates were higher than anticipated, health care costs rose more swiftly than forecast, unforeseen weather conditions or international crop developments caused farm program costs to rise, or a national disaster struck. If unforeseen conditions such as these caused the entitlement cap to be exceeded, specific entitlement cuts would have to be enacted or across-the-board entitlement cuts would occur. The only way to avoid such a development would be through enactment of legislation raising the entitlement cap, and such legislation would likely prove very difficult to pass. Legislation to raise the cap could be subject to a filibuster or become a vehicle for other extremely contentious provisions.

Another unintended consequence would be the creation of incentives for the use of rosy economic forecasts and budget gimmicks that made it appear as though the entitlement caps were being met. In seeking to place fixed, arbitrary targets on entitlement costs that necessarily fluctuate with the economy and with other factors beyond policymakers' control, the Stenholm entitlement cap proposal is akin to the Gramm-Rudman-Hollings law. As with Gramm-Rudman-Hollings, the Stenholm entitlement cap proposal would likely generate a plethora of gimmicks to shove entitlement costs into the following year, accelerate receipts or delay payments in entitlement programs to meet the cap for the current year, and above all, use rosy economic and technical assumptions to make it appear as though entitlement costs would remain within the caps. The pressure to resort to such devices would become particularly intense in election years.

The Stenholm proposal also could lead to sharp reductions in a number of entitlements whose costs are not growing rapidly or adding to the deficit. This could occur because the entitlements growing most dramatically could prove too difficult politically to cut.

4. The Stenholm proposal raises significant equity issues.

The proposal would bar the use of reductions in tax expenditures or any other revenue measures to offset even part of a projected breach of the cap. This raises equity issues.

Benefits and subsidies provided through spending entitlements primarily benefit low- and moderate-income households. By contrast, tax expenditures, many of which are essentially subsidies provided on an open-ended entitlement basis through the tax code, disproportionately benefit those at higher income levels. By walling off — and thereby protecting — subsidies provided on an entitlement basis through the tax code, the Stenholm proposal tilts in favor of the affluent. The proposal would not cap tax expenditure growth, which is contributing to the nation's deficit problems. Nor would it allow use of measures to restrain such growth as part of a package designed to offset part of a projected breach of the entitlement cap.

The Stenholm proposal would even rule out measures that sought to reduce entitlement benefits for people at higher income levels by using the income tax system to identify these people and recapture a portion of the benefits they received during the year. In programs like Medicare and Social Security — where the Social Security office lacks information on beneficiaries' current incomes — this is the only practical means of scaling back benefits for beneficiaries at higher income levels. Such measures would not count toward meeting the Stenholm entitlement cap, however, because the savings they produce are technically classified as an increase in revenues rather than a decrease in entitlement spending.

Conclusion

The Stenholm entitlement cap proposal is ill-advised. It would hamper the achievement of health care reform, the most important reform needed to slow the long-term rate of growth in entitlement costs. In addition, by setting entitlement caps by budget function, it would alter the Congressional decision-making process in ways that restrict the ability of authorizing committees to make sound policy choices.

It also would likely produce regressive effects, tilting in favor of the wealthy and hitting the middle class and the poor hardest. That would be a likely result of its protection of entitlements delivered through the tax code, its prohibition on using the tax code to reduce entitlement benefits for people at higher income levels, and its bar on revenue measures to help achieve any part of the required savings.

How the Budget Process Would Work under the Stenholm Entitlement Cap Proposal

1. The annual Congressional budget resolution would specify the amounts to be saved from entitlement programs in the coming fiscal year in order to meet the cap for that year. As under the current budget process, the budget resolution would include reconciliation instructions to various committees with jurisdiction over entitlements. And as at present, the reconciliation instructions would specify the amount of entitlement cuts each committee would have to produce. The instructions would, however, differ from current reconciliation instructions in two key respects: each committee would be told how much to cut by budget function, and committees would be barred from using revenue measures to meet any part of their instruction.

2. Once the budget resolution was passed by Congress, a "spin-off" bill would be brought to the House and Senate floors. The spin-off bill would set function-by-function entitlement caps, corresponding to those reflected in the budget resolution.

3a. *If the spin-off bill was enacted,* Congress would have to pass legislation cutting entitlements enough to meet the caps set for each function. If Congress failed to meet the cap for a particular budget function, all entitlement programs in that function would be reduced by a uniform percentage to meet the cap. In other words, *targeted sequestration* would occur.

3b. *If Congress failed to approve a budget resolution or if the spin-off bill was vetoed,* Congress would be required to pass legislation achieving sufficient entitlement savings to meet the overall cap. If legislation cutting entitlements enough to meet the cap was not enacted, comprehensive sequestration covering virtually all entitlements would occur.

The proposal has basic design deficiencies as well. Its mechanisms to adjust the entitlement caps to reflect changes in the economy are flawed, failing to reflect such factors as slower-than-anticipated income growth, higher-than-expected poverty rates, or unforeseen weather conditions or international crop developments that temporarily affect agriculture program costs.

July 13, 1994

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

file

FOR IMMEDIATE RELEASE
December 8, 1993

Contact: Barry Toiv
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STATEMENT BY DR. ALICE RIVLIN
DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

The Lewin-VHI study essentially verifies our estimates and the soundness of the financing of our proposal. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

Our initial review of the Lewin-VHI study indicates that it substantially confirms our estimates of the financial impact of the Health Security Act. Because of slightly different assumptions, the study yields slightly different results. Despite these differences, the important point is that Lewin-VHI's estimates of the costs of the Health Security Act are roughly the same as the Administration's estimates; and their estimates of the savings that will be realized from the Health Security Act are roughly the same as the Administration's.

Lewin-VHI's estimates of the cost of the discounts for small, low-wage employers and for low-income workers are slightly lower than our estimates. Therefore, the Lewin-VHI analysis confirms that the entitlement caps we have placed in the Health Security Act are not likely to be exceeded.

We look forward to having an opportunity to review the Lewin-VHI study more thoroughly.

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Note: The Lewin press release appears to contain an inadvertent factual error. The Lewin estimate of the discounts is $153 billion; the Administration's estimate is $161 billion, which is the amount of funding assumed in the entitlement caps in the Health Security Act. Therefore, contrary to a statement in the Lewin release, the study actually concludes that the cost of the discounts for individuals and businesses will not exceed the entitlement cap in the legislation.

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LEWIN-VHI REPORT FINDS ADMINISTRATION COST ESTIMATES OVERLY OPTIMISTIC BUT STILL REDUCES BUDGET DEFICIT

WASHINGTON, D.C., December 8, 1993 - In the first complete independent analysis of the financing of President Clinton's Health Security Act, Lewin-VHI says the administration's plan to provide universal coverage will cost the country and the business sector more than advertised.

However, according to Lawrence S. Lewin, Chairman and CEO of Lewin-VHI, the internationally recognized health care policy and management consulting firm, the report "shows that the plan's financing structure works: it meets the President's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes.

"We think it is time first to focus on the validity of the assumptions underlying the plan, modify it as necessary, and then get on with the passage and implementation of a Health Care Reform Plan, says Lewin-VHI's President Robert J. Rubin, M.D., former Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services in the early 1980s.

"The broader issue -- finding ways to control costs while expanding access and retaining high quality care -- should not be lost in a contest of predicting winners and losers," Rubin adds, noting that "any restructuring of this magnitude is bound to create gains for some, and losses for others."

This analysis came as a part of a press conference today at which Lewin-VHI announced publication of a detailed 196-page study "The Financial Impact of the Health Security Act" explaining the Plan's complex financing scheme. The report's findings and an analysis of its impact on providers of care, federal and state governments, employers, households, and the pharmaceutical and biotechnology industries will be presented at an all-day public meeting tomorrow, "Health Care Reform by the Numbers" at the Omni Shoreham, in Washington, DC. The purpose of releasing these independent estimates, is "to inject a measure of objectivity into the debate;" according to Lewin.

"These findings come at a time when there is growing skepticism about whether the President's plan could work. "This report", Lewin adds, "validates the logic of the plan's financing; it also clearly reveals how critical the underlying assumptions are". The Lewin-VHI study includes calculations showing the sensitivity of the bottom line to different behavioral assumptions. The "bottom line" here is the impact the plan's financing has on the federal budget deficit.

The calculations in this report rely on Lewin-VHI's Health Benefits Simulation Model (HBSM) the most commonly used model for estimating the impact of health care reform proposals.

The Lewin-VHI analysis also shows that American families as a group are the major beneficiaries under President Clinton's health care reform package, with employers, especially those not now providing insurance, bearing most of the cost of expanded national coverage.

"The 'magic' in the administration's plan, is community rating" says John Sheils, author of the study and an architect of Lewin-VHI's Health Benefits Simulation Model, created ten years ago to estimate the impacts of alternative health reform plans. Community rating is the phenomenon through which the costs of relatively sicker individuals are spread across a larger population. "This is quite simply a return to the way insurance used to work before insurers competed to avoid risk" Sheils said.

Under the Health Security Act, all individuals in a given health plan would pay the same premium for their type of family, regardless of age or health status. By putting individuals with high utilization into the larger community pool, younger, healthier populations and their employers would share in the cost of their care. While community rating spreads these costs among employers and individuals, the federal government contributes subsidies to those employers and families unable to pay.

"Our analysis indicates that premiums in the Regional Alliances would be about 17 percent higher than those estimated by the administration and this influences much of the resulting financing." says Sheils. Lewin-VHI's estimate of higher premiums results in federal subsidies to employers and families of $153 billion from 1996 through 2000, a figure that is $37 billion higher than the Administration's five-year estimates.

Because of the higher premiums and the expansion of coverage to the 40 million uninsured, private employer health spending (after subsidies), will increase gradually from 1996 through 1998 and will be higher through the end of the century than under current policies. However, the growth rate of private employer spending is expected to decline after 1998.

The Act relies upon price competition among insurers as the primary means of cost containment. As a backstop measure, however, the plan places limits on the rate of growth in premiums to assure that the rate of growth in health spending is constrained.

"There is ample evidence that the kind of managed care the Health Security Act envisions can slow health care spending growth, but whether it will do so on a national scale and to the extent the President's plan requires, remains a bet, not a certainty." says Lewin. "On the other hand, premium caps, while a sure thing on paper, have to be achievable in practice, and will depend on the political will of elected officials and the voting public; so they are not a sure thing either."

The administration estimated a total deficit reduction between 1994 and 2000 of $103.0 billion including $45 billion reserved as a cushion against unanticipated increases in spending. The Lewin-VHI estimates predict that the reserve cushion will be exceeded and that the net deficit reduction will be about $25 billion over the same period.

In addition to detailing the financial effects of the plan, Lewin speakers at the all-day workshop will describe their analyses of the effects on key sectors of the health care economy. Highlights are:

States:

- States will spend less ($12.4 billion in 1998) under HSA but will have the responsibility of supervising the Regional Alliances.

- Strong incentives to begin implementing alliances in 1996 will tax the capacity of most state governments.

- Alliance budgets will exceed the current state budget in a majority of states.

Local Governments

- Local governments will spend $3.4 billion more in 1998 than they would under current policy, primarily due to the loss of DSH and the mandate to cover local workers.

- The HSA, although, addressing many of local governments historic needs, leaves gaps: many mental health and substance abuse services, prisoners and undocumented immigrants.

Providers of Care

- Hospital spending will be $23.8 billion less in 1998, chiefly because of the impact of reduced utilization due to managed care and cuts in Medicare

- Physicians will see $20 billion more in 1998, due to the impact of managed care and providing coverage for those currently uninsured, however, there will be distributive effects among physicians.

- Physicians will face a ban on balance billing and other regulatory restraints if they remain in a fee for service setting.

- HSA will accelerate the current trend of provider integration.

Employers

- HSA's effect on employers is varied and complex. As a group they will pay more through the year 2000 then under current policy - a finding different than the Administration's.

- In general, firms that now offer insurance will see a reduction in spending while those that do not will see an increase.

- Manufacturing, transportation, communications, and utility companies will see a reduction in costs by 1998 while retail trade and service companies will see increases.

Pharmaceutical Industry

- The HSA expands access to pharmaceuticals and will result in a 6 percent increase in spending by 1998; there will however be an increase in regulation of drug prices especially new products.

Lewin-VHI, a subsidiary of Value health, Inc. is a health care consulting firm providing health policy, research and management consulting services to government agencies, health care providers, health industry suppliers, Insurers and Investors. It has offices in the Washington, D.C. and San Francisco bay areas.

Value Health, Inc. is a leading provider of specialty managed care benefit programs and health care information services.

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 10, 1993

THE DIRECTOR

MEMORANDUM FOR THE FIRST LADY

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 8/6/93 Draft of the Health Care Reform Plan

The attached memorandum to Ira Magaziner responds to your request last week that we provide our comments and suggestions regarding the draft Health Care Reform Plan dated 8/6/93. The memorandum is organized into two parts; the first section provides an overview of some of the areas of the plan where we believe further clarification is needed, while the second section provides detailed, chapter-by-chapter comments about aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. This detailed analysis was conducted under our supervision by OMB's staff of budget examiners who have the day-to-day responsibility for analyzing the various Federal health programs.

As noted in the memorandum, we are continuing to review the draft plan in order to ensure that it is consistent with the policy assumptions we have made in the preliminary budget estimates that have been used in the modelling process. Because the chapter on financing was incomplete at the time we reviewed it, and several elements of the financing proposal are still evolving, our analysis of this critical element of the draft plan is still preliminary. Our understanding is that the new estimates of the most current financing proposal will be delivered from the modellers next week. We will direct OMB staff to analyze these cost estimates along with the revised 9/7/93 draft of the plan that we have just received, in order to ensure that the estimates are consistent with the policy. We also want to highlight any budget "scorekeeping" issues that we see as a result of this review, so that we will not be surprised by CBO's scoring of the reform plan. We will provide you and Ira with our analysis of these issues as soon as possible.

We appreciate the opportunity to review this draft of the plan, and stand ready to discuss and clarify any of our comments and to work with you and Ira on subsequent drafts.

Attachment

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

September 10, 1993

MEMORANDUM FOR IRA MAGAZINER

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 8/6/93 Draft of Health Care Reform Plan

We appreciate the opportunity to review the draft Health Care Reform Plan dated 8/6/93. In general, the draft reads well and reflects the tremendous amount of work that has gone into the development of the plan. You and your staff are to be congratulated for addressing this important issue with such dedication and persistence.

A number of detailed comments and questions, organized by chapter, are attached. The comments represent our initial reaction to aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. We are continuing to review the draft policy in order to ensure that it is consistent with the policy assumptions we have made in our budget estimates and modelling; however, because the chapter on financing is not complete (and indeed, was still in the process of being discussed with the President last week), our analysis of this critical element of the draft plan is still preliminary. A few more general comments follow here, highlighting major issues that our initial review has uncovered, and that we believe need clarification.

It is my understanding that OMB staff met with you and your staff this weekend to discuss the chapters of the draft plan dealing with public health initiatives. We are prepared to do that with respect to other aspects of the draft plan if a fuller explanation of the detailed comments that follow would be helpful to you.

Allocation of Responsibility

The draft calls for a complex set of responsibilities to be shared by the Federal government, the new National Health Board, States, and Health Alliances. At each of these levels, there is further division of responsibilities as well. For example, within the Executive Branch, responsibilities are distributed across DHHS, Labor, Treasury, Justice, Commerce and others.

We appreciate the essential American traditions of pluralism and decentralized sharing of powers. At the same time, the practical complexity of the interrelationship of the various agencies and levels of government requires more specificity concerning duties, powers, shared responsibilities and -- most importantly -- final accountability. Specific issues related to implementation and long-term management of the Nation's health sector are difficult at best to predict. It is critical that the structure created to manage this reform be well-designed and easily understood by all concerned.

It is certainly the case that the precise allocation of responsibilities will be a primary focus of negotiations with the Congress, and in that sense, leaving the lines deliberately vague is a rational opening gambit. Insofar as we have not had the opportunity to discuss the contours internally very much, we believe it would be productive to focus on this issue and begin to develop our preferred outcome of this distribution before serious negotiations with the Congress begin.

One particular assignment merits mention here: we strongly object to the proposal set forth in the draft plan that the National Health Board will be organized as an independent agency that will issue regulations without the benefit of OMB review (see Chapter 5, p. 48). We believe it would be extremely unwise to cede Executive Branch control over the Board, especially in the early years, when the Clinton Administration will bear sole responsibility for its successes and failures. For example, the Board will be responsible, at least initially, for developing and enforcing the national health care budget. It is far from clear that it would even be possible, much less desirable, for an agency located outside the Executive Branch to assume such responsibility. Further, the purpose and effect of OMB review of agency-issued regulations is to ensure compliance with the goals and policies of the President. Ceding the authority to review regulations issued by the Board, and in general interposing an independent body between the President and the Executive agencies in effect relinquishes control of a crucial policy. As there may also be constitutional issues involved, at a minimum there should be further discussions about this proposal within the Administration.

<u>Federal Budget Risk</u>

Related to concerns about authority and management, the draft plan calls for a number of new programs, policies, and initiatives that involve Federal dollars, either in direct funding or as a "backstop" for a potentially turbulent early implementation phase. Several direct subsidies are mentioned, including premium subsidies for low-income persons, an iron-clad cap for employer premium contributions set at 7.5% of payroll, additional subsidies for small, low wage firms, full tax

exemption for health insurance payments by the self-employed, and subsidies for co-pays and deductibles for low-income persons.

Several new sources of funding or funds (similar in concept to national trust funds) are discussed in the draft, including a national Fund/Risk Pool for the Uninsured, Fraud and Abuse Fund, the Veterans Administration Fund for Development into Health Plans, Long-Term Care Trust Fund, State Plan Guaranty Funds, the graduate medical education All-Payer National Pool, and the Inter-Alliance Security Trust Fund. Some or all of these funds could be substantial, both in terms of new tax burdens or potential outlays of Federal dollars. For example, the risk pool/fund discussed in Chapter 29 could be larger than either the Medicare Trust Fund or current Medicaid funding -- with as many as 50 million newly entitled persons. In most cases, the estimated cost or size of these funds is not specified.

We note that the draft plan itself is a discussion of the policy proposals without detailed budget tables. Of course, we have seen and helped to prepare draft estimates of various pieces of the overall reform plan, including proposed Medicare and Medicaid reductions, but as you know, the net cost of the draft health reform proposal has not been estimated as a total package. This is particularly true with respect to the proposal for financing the subsidies discussed with the President late last week, which we understand is still evolving. Interactive effects can be significant, especially in a systematic reform as complicated as this one. Thus, any numbers we have at the moment must be considered preliminary, and must be so regarded and described.

The further point is that there is quite a bit of irreducible uncertainty in any estimate of the ultimate effects of health reform on the Federal deficit. Given that, it seems prudent to spend more time and detailed effort designing "stopgap" protection for the Federal purse, especially in the early years. We at OMB would be glad to undertake this effort.

Our understanding is that estimates of the current financing proposal will be delivered from the Urban Institute next week. Armed with a fuller appreciation of the reform proposal as a whole, we will direct OMB staff to assess the new cost estimates to ensure that they are consistent with the policy as we understand it and will provide you with our analysis of this early next week.

Global Budget Enforcement

Nancy-Ann Min's memorandum to you dated July 29 expressed our concerns about the preliminary versions of the global budget. Although the guidelines for calculating the global budget have been amended to change the focus from GDP to CPI, the current version of the policy is similar to the one her memorandum

discussed, and therefore our concerns remain. Several dimensions of this policy raise related concerns about the unpredictability of Federal outlays. The Federal health budget enforcement and responsibility for Years 1 through 3 poses a number of challenges, including the following:

- Although the policy calls for Federal enforcement by the National Health Board of each State's global budget, currently there is no reliable state-by-state baseline of spending for the guaranteed benefit package. The only data available are gross estimates of total spending by HCFA's Office of National Cost Estimates, the accuracy and timeliness of which leave a great deal to be desired;

- Premium bids by plans could be skewed by estimates of increased demand for services by the newly-insured, estimates of adverse risk selection, and general market uncertainty. It will be difficult at best -- without better utilization and risk status information -- to assess the extent to which premium bids reflect efficient plans or delivery of services.

Taken together, these factors could have enormous implications for short-term Federal outlays, and thus for our ability to meet the global budget targets. With respect to the Federal health programs in particular, your argument that Medicare and Medicaid continue to grow at a rate higher that the private sector under the plan's scenarios is a persuasive one; but the fact remains that the global budget scenarios call for the growth rates in these Federal programs to be cut in half very quickly. We should not underestimate the difficulty of persuading the Congress that this is possible, and of actually doing it.

Administration of Subsidies

Under almost any plan, the administration of specific subsidies requires a fair amount of complexity and detail, which may in turn be less than helpful to the average reader. Perhaps under separate cover or in the next draft, it would be useful to share the details of the current proposals for the several provisions that imply or directly call for administration or distribution of funds. These include areas such as:

- subsidies to small businesses and/or businesses with low-wage workers;

- subsidies for Medicaid wrap-around coverage, as well as subsidies for co-pays and deductibles for the low-income groups;

- coverage and eligibility rules for the working aged, relative to both the worker and the spouse;

- tax incentives and tax credits for long-term care coverage; and

- transitional policy issues such as moving from a single national payer fund for the uninsured to coverage in private plans under a state-based alliance structure.

We strongly believe that the administration of these aspects of the plan must be reviewed carefully to ensure that there is coordination and streamlining across these administrative structures, rather than duplication and needless fragmentation.

Thank you again for the opportunity to review this draft and provide you with preliminary reactions. OMB stands ready to discuss and clarify any of these comments and to work with you on subsequent drafts.

Specific Comments by Chapter

Chapter 2: Ethical Foundation

- Missing are two ideas: a principle of medical care is that it should be provided only with the "informed consent" of the patient. Informed consent is a means to ensure that treatment is expected to be in the best interests of the patient, as understood by the patient. One concern that has been expressed about managed competition is that it will accelerate the abandonment of this principle. A clear signal to consumers about the importance of their welfare could be made by appealing to this principle.

- The notion of "wise allocation of resources" (p. 11) could be made more informative and specific by adding to it a note about the importance of cost-effective medical care. Presumably reform should help people get well while imposing no **avoidable** costs. Care of a given quality should be delivered at the lowest possible cost.

Chapter 3: Coverage

Categories of Eligibles

- "Long-term non-immigrants": The draft indicates at page 13 that "long-term non-immigrants" would be covered under the plan. It is unclear what is meant by this category. In the long term, the only non-immigrants in this country are Native Americans. They are already covered as American citizens, raising a question about the apparent need for this new category.

  Alternatively, the term long-term non-immigrants may refer to illegal aliens, or undocumented workers. It has been our understanding that these populations were not intended to be covered. Therefore, if this phrase is intended to refer to populations that are in this country illegally over long periods, then it should be clarified and explained in terms of exactly how they are covered and how their coverage is financed.

- Territories: the policy states that individuals who reside in territories of the U.S. receive the comprehensive benefit package "in a manner consistent with their existing systems" (p. 18). What does this mean? Are there alliances in the territories? Does the mandate extend to the territories? Are low-income subsidies available to citizens living in the territories? Non-citizens?

- American citizens: The draft indicates that all "American citizens" will be covered. Does this mean that we intend to cover U.S. citizens living abroad?

- Unemployed workers: The draft states on page 14 that health care coverage continues without interruption for individuals who become unemployed. Unemployment insurance funds assume payment of the employer's share of premiums for up to 26 weeks on behalf of any employee who works at least 20 hours per week for the preceding four quarters and becomes unemployed.

  Alliances provide financial assistance to unemployed workers and their families on the basis of income, subsidizing all or part of the employee's contribution toward the cost of the premium, deductibles, and co-payments. If an unemployed individual is covered through a corporate alliance, the unemployed individual may remain in the corporate alliance for up to one year. There are several potential issues that need to clarified.

  (1) Is this program for all unemployed workers or only for those who qualify for unemployment benefits? For example, in the late 1980's, only about 1/3 of the unemployed received unemployment insurance (UI); while this proportion increases during recessions, a gap still remains. Even looking at workers who have lost their jobs (a subset of the unemployed) shows a gap; a recent CBO study of dislocated workers reported only about 70 percent of those jobless for at least five weeks collected UI.

  (2) The proposal limits the benefit to those employees who works at least 20 hours per week for the preceding four quarters. State UI laws are typically based on quarters worked or wages received, not numbers of hours per week. This means an individual may qualify for UI benefits but not for coverage of health benefits.

  If this 20-hour requirement is supposed to be a proxy for part-time, this is not consistent with definition of part-time employee on p. 18 ("as defined for purposes of Social Security withholding"), which has no hours worked requirement.

  (3) The proposal looks very expensive for the Unemployment Trust Fund (UTF) and could require an increase in payroll taxes. What part of the UTF pays -- individual state accounts or a Federal accounts?

  Correspondingly, what happens after 26 weeks -- who pays the employer's share for the long-term unemployed?

(4) Will there be any special provision for UTF payment of the employer's share of premiums for participants in UI programs that provide benefits beyond 26 weeks -- e.g. temporary Emergency Unemployment Compensation program or permanent stand-by Extended Benefits program?

(5) How long will the alliance provide a subsidy for the employee's contribution -- only for 26 weeks or until the unemployed worker finds a job or qualifies for Medicaid?

(6) What happens in terms of coverage and financial liability if an unemployed worker stops paying for health insurance? Page 15 states that no health plan may cancel an enrollment until the individual enrolls in another plan. Does this mean that a worker will continue to be enrolled in a health plan whether on not the premium is paid? Page 69 says that if a corporate alliance fails to make premium payments to a health plan, the plan may terminate coverage after reasonable notice. If coverage is terminated, the corporate alliance is responsible for providing coverage to individuals previously insured under the contract.

(7) Is there a different outcome for a worker who doesn't pay his share within the first 26 weeks (when the employer's share is being covered) versus a worker who doesn't pay after 26 weeks?

(8) Are unemployed members of corporate alliances eligible for subsidies?

- Student insurance coverage costs: This chapter mentions at page 18 that students would enroll in the alliance in the region where they go to school. Currently, most students are insured by their university at a relatively low cost due to the age and health characteristics of this pool of enrollees. Under community rating, however, the premiums for these students could be increased to reflect the greater health care needs of non-students. The cost of students obtaining health insurance may increase sharply, depending upon how subsidy levels are calculated.

  An important issue, therefore, is how subsidy levels related to income will be calculated for students. With little or no income, they could be eligible to receive large subsidies, unless their income is determined based upon the income of their family. Administrative and financing issues surrounding health insurance for students need to clarified.

- Employer payment obligations are discussed at page 16 as 80% of the premium, but later there is a discussion that employers can contribute more than 80% to offset any out-of-pocket or cost sharing of employees. To the extent employers contribute more than a flat dollar amount, consumer price sensitivity to choosing the most efficient plans will be watered down. Correspondingly, plans will tend to "shadow price," as well as market themselves based less on efficiency and more on other aspects such as equipment or amenities -- similar to what providers do currently.

Choice

- According to page 14, employed persons choose a health plan through a corporate or regional health alliance. It is not clear whether family members of employed individuals also can exercise choice about the plans in which they enroll. In other words, can spouses who are not connected to the workforce, as well as divorced spouses and their children, voice their plan preferences independently from the employed family member through whom they gain coverage?

Chapter 4: Guaranteed National Benefit Package

Covered Services

- Preventive services: Are the preventive services listed on page 22 illustrative, a minimum, or a maximum for the package? (For example, was a PSA test for prostate cancer discussed?)

  Regardless, it should be considered whether the list of preventive services should be included as a tentative list subject to change, rather than being enacted as part of the American Health Security Act. Changes in the understanding of effective medical practice could easily render this list obsolete. For example, although covered on this list, the Harvard Community Health Plan no longer provides annual medical screenings for its patients since there is no clinical data supporting it. If research were to support the Harvard Community Health Plan's practice, the list of clinical preventive services would be difficult to amend if it were enacted as part of the Act.

- Immunizations: The list of immunizations discussed is fairly comprehensive. If covered, this should be taken into account in Public Health Initiative section which would enhance grant support for immunizations. Additional grant funds for immunizations will not be needed. Since immunizations will be covered,

some of the base funding for vaccine purchase grants could be retargeted to address education, outreach and infrastructure.

Instead, the National Health Board, in consultation with other bodies, should have the flexibility to amend this list based upon the findings of outcomes research on effective practice patterns. As a better understanding of effective practice patterns develops, the types of preventive services that should be covered in a standard benefit package will also have to change.

- The draft at page 32 states that services and procedures will be included in the standard benefit package to the extent that these are found to be "effective". The overwhelming majority of services and procedures routinely covered by insurers -- public and private -- have little or no accompanying evidence of effectiveness. Often these are high volume procedures. Carotid endarterectomy, for example, is performed at a rate of nearly 100,000 per year in the U.S. with little or no evidence of clinical effectiveness.

  The effect of this language is to either raise questions about what is currently covered relative to new procedures (effectively a double standard) or to slow down the process of covering new procedures that would be subjected to multi-year trials. While the latter problem is no different from the current policy for most insurers, whether private or government (e.g., Medicare), it is not clear whether that is the result.

- Clinical trials: Also at page 32, the draft states that the benefit package includes coverage for medical care provided as part of an "approved clinical trial." The text goes on to say that the intention of this provision is to cover routine medical costs associated with an investigational treatment that would occur even if the investigational treatment were not administered.

  Sometimes, however, no costs would occur if the investigational treatment were not administered (e.g., if there is no alternative or the patient would not have been hospitalized), producing no coverage, which seems inconsistent with the intent of the policy. As written, the provision is unclear and invites arguments about what constitutes "routine medical costs."

  A simpler approach more likely to achieve the policy goal could be for the benefit package to cover room and board charges for individuals involved in approved clinical trials. This way, there is no guessing (or cost-shifting) about which portion of the treatment regimen would have been provided anyway and what portion was experimental.

- Research guidelines: The draft states at page 33 that research guidelines will be centralized and promulgated by DHHS. This will politicize scientific inquiry and/or reduce it to a bureaucratically defined straitjacket. It may also slow down willingness to initiate research (e.g., scientists waiting for the release of periodic regulations).

  The Federal government does not currently approve all research, nor is it a desirable policy to establish. A more desirable policy would be to require research trials to be peer-reviewed and consistent with requirements for the protection of human subjects.

  Government funded research: Also at page 33, coverage for investigational procedures is described as automatic for government-conducted research only. This tends to bias interest in the scientific and medical community towards government-funded science only. Again, science will become more politicized, more centralized, and may be less able to accommodate room for truly innovative and new ideas/projects. Secondly, scientific funding may become more vulnerable to annual congressional appropriations and/or changes in ideology in the Executive Branch.

Providers

- The draft plan states that plans "will be expected" to "provide a sufficient mix" of providers. This leaves unstated what the penalties would be for plans that fail to "provide a sufficient mix" of providers.

- The intentional vagueness of not requiring any plan to pay any provider or category of provider makes it very difficult to price the overall proposal. It is not clear, for example, whether or not end stage renal disease is covered under this chapter.

  One alternative is to specify that the same services covered by Medicare are required of all health plans, plus explicitly identified services, i.e., pregnancy-related and preventive services.

Cost Sharing and Limits

- Mental health: Limitations on inpatient and resident mental health and substance abuse treatment are established at 30 days per episode and 60 days annually for all settings (p. 24). The paper should define what constitutes an "episode" of

care, or state that the National Health Board will promulgate regulations governing the definition of "an episode".

- Vision/hearing: Limitations on coverage for vision and hearing care should include a dollar limit on coverage, and/or a limitation of one pair per year (p. 31).

- Low cost-sharing option: The low cost-sharing option would not require a coinsurance on home health, extended care, preventive care, durable medical equipment, or most mental health services. We are concerned that the lack of any cost-sharing requirements on these services may encourage excessive utilization and higher spending.

  Medicare's experience with home health care is illustrative. Medicare does not require any cost-sharing for home health services, and the benefit has been the fastest growing Part A benefit over the last five years. The decrease in inpatient stays in response to PPS encouraged home health providers to increase the variety and amount of services provided to Medicare beneficiaries. The lack of any cost-sharing required of beneficiaries has only fueled the growth in home health outlays.

  An alternative would be to require some cost-sharing with respect to all services to encourage more appropriate utilization. Home health care, preventive services and mental health services could require $5 per visit cost-sharing, while consumers could pay 10% of the costs of durable medical equipment.

  In almost all cases, this cost-sharing structure will continue to be less expensive to the consumer than the high cost-sharing alternative.

- Prescription drugs: Federal policy should encourage the substitution of chemically equivalent generic drugs for brand-name prescription drugs. Differential cost-sharing amounts for generic and brand-name drugs should be established, as well as differential payments to pharmacies to encourage generic substitution.

Public Services for Mental Health and Substance Abuse

- Maintenance of Public Funding: The draft states that "the benefit package requires the maintenance of the existing public system for mental health and substance abuse" (p. 31). We note that mental and addictive disorders are the only illnesses for which the plan mandates maintenance of public-tier services.

We question the requirement of special protection for these public funds for the following reasons:

(1) It relieves the private sector of its responsibility to provide these essential services. If public funding is required to be maintained, plans will be able to shift mentally ill and addicted patients onto the public sector by making it difficult enough for enrollees to obtain services that they turn to the public tier, which may be perceived as second-rate. Indeed, the existence of the public tier provides an incentive for plans to avoid treating this difficult population.

(2) It misses an important opportunity to bring the quality of mental health and addiction treatment up to par with other treatments. Without the capitated payment's incentives to improve quality and reduce costs, mental health and substance abuse services will continue to be perceived as inferior to "medical" services in quality and scientific rigor. In addition, the public tier will relieve pressure to expand the mental health and substance abuse benefit in the year 2000, so health plans will never have to deal comprehensively with their enrollees' mental and addictive disorders.

(3) It makes the treatment of mental health and substance abuse services under health reform inconsistent with the comprehensive approach to health care embodied in the basic benefit package. The basic package requires health plans to prevent and/or deal with the whole range of potential illnesses, including mental illness and addictive disorders, because insurers and even many providers do not accept the validity of the connection between medical and mental health. Health reform should not let plans "off the hook" by maintaining a set of public services not on a par to meet the requirements of a capitated, market-oriented system.

HHS now spends some $2 billion annually on two mental health and substance abuse services block grants -- some or all of which could be used to offset an even more generous benefit than the one included in the basic package, and/or to phase-in benefits more quickly.

Chapter 5: National Health Board

- We strongly object to the proposal to designate the National Health Board an independent agency, exempt from Executive Branch coordination, and do not think that the Board could perform the responsibilities outlined with this status.

- Clarification of role: The 8/6/93 and 9/1/93 drafts generally assign overall responsibility for policy development to the National Health Board, an approach which makes sense. In some cases, however, this pattern is not followed and responsibilities are mistakenly assigned to HHS or its subcomponents or to other cabinet departments. The draft should be modified to clarify the roles and missions of the players involved.

  Secondly, the role of the National Health Board relative to other entities -- Congress at the Federal level, States, health entities, and plans should be clarified.

- Regulatory review: We object to the proposal that OMB does not review the regulations issued by the Board. The purpose of OMB regulation review is to ensure consistency with White House understanding of the law and policy, and exemption from OMB review raises the following concerns:

  (1) What entity primarily responsive to the White House will coordinate policies from the Board, HHS, Labor and Treasury?

  (2) Will the Board have an obligation to ensure cost-effective regulation? Who will oversee the policy analysis of a regime that regulates what is approaching one-sixth of the nation's economy?

  (3) The structure of the National Health Board seems unable to sustain its intended functions. The board is given substantial executive functions with only advisory board support and the ability to "contract" with agencies and outside entities. We do not endorse a new and expansive bureaucracy, but some staffing even for more of an oversight function will be necessary for the Board to perform even an oversight function. Depending upon the set of responsibilities assigned to the Board, it may require the attention of a relatively large professional staff, including skilled medical personnel of all types, health economists, lawyers, budget analysts, auditers, and experts in all manner of health-related professions, including insurance, information systems, hospital administration, medical education, etc. A professional staff of 300-500 could be expected. If the Board will not be staffed then HHS or other Cabinet-level agencies (Labor, Justice, Treasury) should probably have more of the regulation

writing, implementation, and enforcement responsibilities, leaving the Board to have more of a policy development, audit, and oversight function.

- The discussion at page 44 is unclear as to whether the benefit package can be amended through regulation rather than legislation. Although the words "issue regulations" are included, the draft also discusses "recommendations" to the President and Congress. Our view is that given the fast changing pace of medical treatment, changes in legislation would be entirely too cumbersome or political.

- Clarification of responsibilities: to make the draft consistent with better delineated roles and missions, corrections may need to be made to clarify the Board's responsibilities relative to:

  (1) determining the research agenda for health services/outcomes research (p. 147);

  (2) information systems (pp. 113-127);

  (3) quality standards and management systems (p. 112);

  (4) supervision of corporate alliances through ERISA (p. 49);

  (5) assuming responsibility for out-of-compliance health plans (p. 49);

  (6) ensuring individuals have access to benefits (p. 48);

- The Board will develop state measures of performance. Measures of state performance used in the document as illustrative appear process-based; measures should be outcome-based to the extent possible. This allows more in the way of true state flexibility. We can make recommendations for more outcomes-based measures if that would be helpful.

  There is no discussion of how large the Board might be in terms of authorization monies. It should be considered that, to the extent that HHS' (or other Cabinet agency) responsibilities are reduced, their operating budget and FTE levels could be reduced to offset the costs of the National Health Board.

Chapter 6: State Responsibilities

- Single payer: The draft indicates at page 57 that states that establish a single-payer system would be prohibited from imposing cost-sharing requirements that exceed those charged by regional alliances. Since there are nationally-standardized cost-sharing schedules, it is unclear whether the single payer systems would be held to the rules established for fee-for-service plans or for HMOs.

- Alliance Boards: The specifications for the boards of directors of health alliances (p. 53) may be so exclusionary as to impede effective functioning of the boards. For example, the specifications seem to exclude everyone with any specific knowledge of the health care field even if they aren't connected financially with a health plan (e.g., university professors). We question whether that is what is intended.

- Qualification process: The draft details that "States qualify health plans to participate in alliances," and then lists qualifications of alliances that states will set. The logic for requiring states to qualify plans for participation, instead of alliances doing this using state guidelines, is not clear. The proposed arrangement divests alliances from an appropriate responsibility while lengthening implementation time -- for no obvious advantage.

- Service requirements: States must establish requirements on health plans related to the levels of service and geographic distribution of service to ensure adequate choice in low-income and inadequately served areas (p. 54). Are there any broad standards that should be met (outcomes regarding service level achieved, perhaps determined by the National Health Board), or is it entirely up to the state? Secondly, this new role of the states may help render Federal subsidies for direct provision of services in low-income communities no longer essential.

- State Guaranty Funds: The draft also states that state guaranty funds will provide financial protection to health care providers if a health plan becomes insolvent (p. 56). It is not clear why the entire burden falls on the state, and hence the state's taxpayers. Burden-sharing among losing parties, including providers, should be considered as an alternative.

- Expansion of benefits: The draft addresses ways in which states could finance additional benefits beyond those in the proposed package (p. 57). The draft would place limits on the sources of financing states could tap for these additional benefits. This raises two concerns:

(1) Does this raise constitutional issues regarding the relationship of the Federal government and the states?

(2) Does the requirement that states use revenues "from sources other than those established by this Act [for the] guaranteed benefit" mean that states are limited to those sources of funding for all expenditures under the single-payer system opt-out, or only for the reduced cost-sharing portion of health care expenditures in the state?

- Capital Standards: The concept of "capital standards" is not defined and, because the concept is not in common use, it is not clear what it is intended to encompass.

- State Guaranty Funds: Will there be any minimum standards on the size of the state guaranty funds? Given the experience of state guaranty agencies and the guaranteed student loan program, this should be carefully examined to avoid the possibility of yet another Federal bail-out.

- The last paragraph of the chapter states that "All health plans must participate in a guaranty fund," but the conditions of "participation" are not defined. Does participation mean that all health plans must pay an assessment into the fund?

Chapter 7: Regional Alliances

- Advertising: Rather than get the alliances into the business of premarket approval of advertising why not establish general standards for plan marketing and a post-market penalty?

- Enrollment: The draft sets fixed dates of enrollment at the beginning of the month based on whether or not the application is submitted by the 15th of the prior month (p. 60). Fixed timing of that sort can create unnecessary administrative pile ups. Why not leave this to the alliance to sort out with an absolute maximum on it taking no longer than X days.

- Allocation of consumers to plans: The draft provides at page 60 for random allocation of consumers to plans in the event there is not enough capacity. This This fundamentally collides with freedom of choice, and could be politically inferior to allowing consumers second and third choices.

- Fee-for-service requirement: The plan proposes that every state create a fee schedule and conversion factors for the state's fee-for-service plans. HHS

would develop a national fee schedule, expanded beyond Medicare services to all services, that would serve as a model, or default fee schedule, for states. Aside from the difficulties in developing and implementing such a fee schedule in time for the reformed plan, this approach is overly rigid and we question whether such a regulated approach is consistent with the commitment that each alliance would provide at least one fee-for-service plan. A fee-schedule does not allow the flexibility to adjust fees to respond to changing market conditions. We would suggest an alternative that plans should be allowed to establish their own fee schedules to assure timely responsiveness to the market.

- Alliance administration: It is not clear who is responsible for financing the administration of alliances, nor is the role of the Provider Advisory Board is not clearly spelled out.

Chapter 8: Corporate Alliances/ERISA

- Oversight responsibility: We question the proposal to bifurcate regulatory responsibility between the National Health Board for state plans and the Labor Department for corporate plans.

  Government experience with divided regulatory responsibility arising from political and bureaucratic reasons is bad. This is most notably true in the related case of ERISA, now twenty years old. Because of feuding committees and agencies, ERISA administration is divided in three among the DOL, the IRS, and the PBGC. Sponsors of ERISA benefits plans have to comply with regulations of all three, although for most purposes they have to be concerned about only two:

  (1) the IRS, which must annually certify the tax deductibility of plans for compliance with coverage and participation requirement; and

  (2) the DOL for compliance with fiduciary behavior requirements.

  This division increases regulatory complexity in the eyes of employers that sponsor pension and health plans for their workers. The duplication and resulting complexity probably results in fewer benefits being provided because the cost of regulatory complexity consumes resources available in company budgets that would otherwise be available for benefits.

The division also gives rise to expensive and difficult coordination within the Federal government that too frequently requires Executive Office of the President intervention to coordinate or settle agency disagreements.

In addition, there is the question of agency experience and role. Most Labor Department experience with benefit plans under ERISA has been with pension plans and not with health plans. DOL experience with health plans is limited to collecting information and to some enforcement of ERISA's fiduciary standards among company sponsors and service providers who may profit wrongly from sponsorship or administration of health plans.

For these and other reasons we question the wisdom of setting up a bifurcated system of administration and enforcement. We recommend further analysis of this proposal.

Chapter 9: Health Plans

- The draft states at page 75 that plans with limited capacity can turn away enrollees if/when approved by state. We question this authority being given to the state, when giving this authority to health alliances might be more consistent with other parts of the plan and would probably allow decisions which are more timely and less cumbersome bureaucratically.

- This chapter, at page 80, states there will be 2 levels of cost sharing -- this conflicts with Chapter 4 which states there will be 3 levels of cost sharing.

- The plan allows supplemental insurance to cover cost sharing (p. 81), but also requires that the premiums for these plans cover the cost of any additional utilization caused by the insurance. To be consistent, therefore, this "utilization surcharge" should apply to supplemental cost-sharing plans under Medicare as well.

- Utilization Review protocols must be revealed by plans -- revealed to whom? This could discourage innovative approaches being developed by plans; it would also take away yet one more competitive dynamic between and across plans.

Chapter 10: Risk Adjustment

- The document should state whether the risk-adjustment system will apply to individuals or to groups. Language indicated individual adjustors. Accurate

individual adjustors are not yet fully developed, and will require intensive developmental work.

-- Data have not been refined to the point of yielding great predictive powers on a case-by-case basis.

-- Data often currently available, i.e., past use of health care utilization, may reflect abuse and inefficiency in health care delivery. As a basis for prospective payment of a risk-adjusted amount, past use of health care resources may reward inefficient providers who allow payment for duplicative services and lack strong utilization review controls.

-- As a result, classification schemes that rely on measures of morbidity (e.g., diagnosis) might be more useful that purely utilization. Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs) represent two approaches that use a combination of diagnostic information and utilization experience. Both of these approaches demand evaluation and refinement over the next few years if considered for use by Health Alliances.

-- Insurers may continue to find ways to "cream-skim" the "healthiest" sick cases, e.g., a cancer diagnosis early in the disease's progression in any risk category. And providers and/or payers could have incentives to upcode diagnoses and health risk categories to receive a larger payment from the pool and/or pay less into it. These issues imply ongoing monitoring and refinement may be needed.

-- Other administrative issues remain. For example, a purely prospective system could hamper a plan's efforts to be reimbursed for an enrollee who joins half-way through the year. No look-back mechanism appears to exist in the document to address enrollment turnover and will need to be thought through.

-- Risk adjustors are intended to account for an individual's level of risk; they may not necessarily account for the differing practice patterns among regions, which may have heavy influences in the amount of health care resources consumed.

-- Risk adjustors could entail overhead costs in enforcement and implementation for private plans and regulatory bodies; improved

software or actuarial methods being tested by Blue Cross and Blue Shield and HIAA (among others) may minimize these burdens.

The draft plan appears to include community rating, a standard benefit package, and annual open enrollment periods. Inclusion of these elements will add to the "arsenal" available to HA's to prevent or discourage risk selection, though some individual variance will continue to exist.

- Allowing for a waiver if the alliance demonstrates an alternative system as "at least as effective and accurate" could create opportunities in the first few years for waivers.

Chapter 11: Rural Communities in the New System

- The financial incentives for providers seem generally skewed toward physicians specifically, rather than all health professionals generally.

- In describing the infrastructure development grants, it may be clearer to state the level of loan guarantees committed per year (note: the BA level of $16 million per year mentioned on page 86 is probably the estimated subsidy level -- which sheds little light on the actual volume of lending and scope of the program). Does the plan envision an increase in these guarantees or maintenance of the current level of support?

- It is not clear why only community-based organizations would be eligible to receive these guarantees. What about health plans expanding into rural areas?

- Page 87, do the cost estimates for the expansion of the National Health Service Corps (NHSC) take into account the cost of the tax expenditures of the proposed tax incentives? In addition to awarding more scholarships and loan repayments and supporting a greater field staff?

- NHSC loan repayment recipients already receive a payment equal to 39% of the loan repayment award for the purpose of completely offsetting the additional tax liability. Setting up a special exclusion from gross income is not necessary.

- Given that hospitals in rural areas have excess capacity, could some of the excess capacity of rural facilities be converted to serve underserved areas?

Chapter 12: Integration of Workers' Compensation and Automobile Insurance

- The plan should deal more forthrightly with the fact that workers' compensation and health insurance have been set up for different purposes. The purposes of medical, rehabilitative, and care requirements in state and federal workers compensation laws are very broad. The care allowed under most medical care insurance is limited. The state workers' compensation laws are all different, and there are two federal laws (covering longshore and harbor workers and federal workers). Under all workers' compensation laws coverage of treatment and procedures allows for no deductibles. Coverage may even extend, for example, to providing comfort, in addition to unlimited medical treatment, care, and rehabilitation. The different purposes mean that programs of workers' compensation are not usually able to adopt fee schedules of "regular" health insurance.

- Page 89 of the draft plan states that "The [workers' compensation] case manager ensures that ... the health plan complies with medical and legal requirements related to workers' compensation." This suggests that the care provided must suit the purposes of the workers' compensation law that covers an injured worker. On the same page it states that "Health plans are reimbursed by workers' compensation insurance carriers ... in accordance to the fee-for-service schedule in the alliance," and that "alliances are permitted to adopt ... per case capitation payments." It further states (page 90) that "Health benefits for work-related injuries and illnesses continue to be defined by states." These apparent contradictions suggest that the plan should be expanded or clarified so that:

  (1) Alliances are required to have fee schedules that allow for the broad purposes in the workers' compensation laws in effect in the area(s) they cover; or

  (2) The broad purpose of care in workers' compensation state and Federal laws is preempted in the Federal law so that it will match the purposes of health care that will otherwise be under President's plan.

Chapter 13: Inter-Alliance Health Security Fund

- Page 93, what is the average "float" or reserve that will be available to this fund, and how will it be used -- entirely loans? This discussion needs clarification with regard to safeguards.

- Page 94, the Administration component of the Reserve needs to be specified with more detail; in particular, will this reserve be part of the funds flow of the Federal government? Or will it be part of some banking and holding operation in Kansas City, etc.?

- This fund duplicates functions currently performed by the Automated Clearing House for substantially similar activities that collect and disburse funds. The Automated Clearinghouse processes billions of dollars of transactions efficiently, with an established network of corporations and financial institutions. A second, new health payment network, seems unnecessary, duplicative and costly. Use of the Automated Clearinghouse should be considered to route payments from employers to health alliances.

- Creating a separate fund that "holds" billions of dollars of health contributions and payments could engender the gaming of cash flow and other financial techniques that are not efficient in applying these funds to health uses. In an era of budget stringency, the temptation to tinker with this fund may be irresistible, particularly with the commingling of the Funds financial and loan functions.

Chapter 14: Budget Development and Enforcement

Covered Expenditures

- Current version: Medicare and Medicaid expenditures are included under separate budgets. Suggested revision: All Federal direct health expenditures are included under separate budgets. This would include Medicare, the Federal portion of Medicaid, the IHS, DoD, and VA.

Adjusting the Budget Inflation Factor

- Current version: "If, however, an alliance's actual weighted average premium in a given year exceeds its premium target, then the inflation factor for that alliance is reduced for the following two years to recover the excess spending." Issue: Is the two-year "lookback" sustainable from the beginning, particularly with the uncertainty in setting the per-capita premium in the early years? Is it possible to keep track of the "lookback" recovery over a number of years? This mechanism sounds good, but the implementation could be quite complicated if the alliance or state miss the target over a number of years.

Second Level of Enforcement: Compliance with Federal Cost Containment

- Current version: state alliances are in compliance with national cost containment goals if the increase in the weighted average premium falls within a 1% band above the inflation factor. Question: 1% of what? 1% of premium costs, 1 percentage point of the inflation factor?

- Current version: If spending is below the inflation factor plus 1%, the 50% of the unused amount may be rolled over to the following year, up to a 5 percentage point maximium. Suggested revision: Eliminate the 50% roll-over, except with National Board approval. The states, alliances, and enrollees all benefit from coming in "under budget" through lower premium payments in the following year. Allowing premium rates to climb faster than needed in the market is unnecessary.

- Current version: Actual weighted average premium is no more than 10% higher than the per capita budget target for the state. Suggested revision: Narrow the variance from 10% to 1-5%. A ten percent error band is too large a cushion, with the temptation to allow the premium to match the 10% band every year. An alternative is to allow the 10% variance for X number of years to allow for stabilizing the baseline, then reducing the variance to a lower level.

Budgets for Corporate Alliances

- Current version: After the third year of implementation of health reform, each corporate alliance annually reports its average premium equivalent for the previous three years to the Department of Labor. Suggested revision: Instead of the Department of Labor needlessly developing its own health insurance pricing and analysis capability, give the reporting requirements for large corporate employers to the National Health Board. Since it set the corporate alliance premium equivalent originally, it would best be suited to review, and enforce as necessary, the corporate alliance cost performance.

- There is little or no discussion of developing a state-by-state or alliance by alliance baseline. Of course, this does one not now exist so the issue is whether one will be developed to allow enough precision for the National Board to distinguish between appropriate and inappropriate premium targets. If one is not available that can both track spending and adjust for various degrees of risk, it may be both technically difficult and perhaps politically impossible for the National Board and the Federal Government to develop enforceable targets.

Chapter 15: Quality Management and Improvement

- In general: the entire section is very unclear as to who is doing what and instead attributes actions to the program.

- There seems to be unnecessary overlap between HHS functions and the National Board functions regarding evaluation of health care (see p. 106 and p. 119) and assessing the impact on the health care system.

- The discussion (p. 107) of state licensure and certification does not appear to comport with current DHHS initiative to license and certify essential health providers in the PHS sections.

- Is there duplication of effort between the National Quality Management Program of the National Health Board (pp. 110-111) and AHCPR activities?

- Are quality standards of the Indian Health Service, Medicare, VA, or DoD superseded by National Board standards?

- It is unclear who is auditing the plan's measure and disclosure of performance on quality.

- Demonstration projects are to be completed by 1/1/96 for new performance standards and standards will be revised according to findings. Most demonstrations take up to a year to design and implement; as such this timeline may be heroic.

- Regional centers are stated as auditing for data integrity where we were previously told they were only going to serve a switch function.

Relation to Existing Legislation

- OBRA-87 nursing home reforms: this chapter does not the address the requirements of OBRA-87, which created stringent quality standards and enforcement authority regarding Medicaid and Medicare nursing homes. These requirements are responsible for the bulk of survey and certification spending. Annual surveys of all Medicaid and Medicare nursing homes are mandated, and the average cost per survey is approximately $14,000. While the nursing home standards are the most burdensome and costly responsibility for Federal and State quality assurance programs, they also have strong Congressional support. Congress enacted the nursing home reforms in response to widespread concerns

over the treatment of the elderly and disabled. Changing or eliminating the current nursing home survey and certification program will be very difficult politically.

- CLIA: proposed changes to the Clinical Laboratory Improvement Act (CLIA) are extremely vague. This section should address at least the general principles for reform of the program.

Chapter 16: Information Systems and Administrative Simplification

- In general, this chapter does not appear to have been sufficiently vetted. There is a confused division of responsibility between HHS and the National Health Board, not to mention between the States, Health Alliances, health plans and the Federal government.

- Page 115 states that "health providers will use current information system technology as the foundation for the system," which implies that all providers and not just plans will be automated. The sense of the working group was it would be left to the plans and the pressures of a competitive environment whether automation would occur at the point of service. We recommend replacing "providers" with "plans."

- The draft at page 119 assigns responsibility for conducting surveys to a particular department -- DHHS -- which seems to be an unnecessary amount of detail for this document, given its purpose of communicating to a broad public. It would be better to vest authority for such activities in the National Health Board, which will be in the best position to decide how it wants to collect data, etc.

- Consistent with the National Performance Review, consumer satisfaction surveys should be conducted at the lowest possible organization levels, closest to the people being served.

- The privacy section states that the Federal government would stipulate that individuals "have the right to know and approve the uses to which data are put" (p. 121). Although this is an example, it should probably state "non-routine" or "certain" uses. The approval should not create health care delivery inefficiencies.

- At pages 125-127, the draft discusses streamlining Medicare: Medicare data systems are not currently designed to collect information on plans -- only fee-

for-service experience. This is clearly one of the many information challenges facing HCFA. Many of the specific ideas have conceptual merit, but are premature, and should be developed in consultation with HCFA's Medicare Technical Advisory Group (M-TAG). In particular:

-- delete the proposal requiring performance evaluations of carriers by physicians. This appears to involve a direct conflict of interest, because carriers may feel increased pressure to liberalize coverage rules and payment policies to obtain positive evaluations from providers. At a minimum, the current five-state pilot project should be evaluated to determine its effects before deciding whether to commit to national implementation of such an approach.

-- check with the OIG on whether enforcement abilities are weakened by moving from an annual requirement to a one-time requirement for physicians to sign an acknowledgement of awareness of penalties associated with falsifying claims information;

-- clarify that the proposal that "repeals legislation requiring review of at least ten surgical procedures" refers to PRO review;

-- delete the proposal to limit system changes in Medicare and Medicaid to once every six months, and to require 120-day advance notice for major billing procedure changes. This would be administratively costly and burdensome, requiring simultaneous review of thousands of pages of regulations every six months as HHS responds to deadlines with last-minute completions of regulations. The likely effect would be delays in regulatory improvements and fee schedule adjustments (i.e., increases for inflation)by six months every time a deadline is missed. This proposal may inhibit needed actions to live within budgeted amounts.

-- revise the proposal to develop standards for single annual inspections of health care institutions to single, periodic inspections. Some facilities with quality problems may require more frequent inspections, while others may require less frequent inspections. There is no need for uniform schedules among a diverse group of institutions.

- Medicaid: There is little or no discussion about Medicaid information systems. There could be a critical need -- even on an interim basis -- to collect better information on Medicaid experience.

This is especially crucial in the context of Medicaid managed care programs. As states shift their entire Medicaid population to managed care organizations (e.g., New York and Tennessee), HCFA data systems "lose" the ability to track these groups, because current HCFA data systems are designed only to track fee-for-service experience.

- HHS Control of Information: HHS proposes that it control information collection and dissemination in several instances. The National Health Board should assume this function.

- National, uniform standards -- timing: development of national standards for coding and content requirements for all insurance transactions by July 1, 1994 seems ambitious. In addition, the plan calls for "immediate" adoption of national standards by all government health programs. It is unclear whether this means the day after enactment of health care reform, or what may be a more realistic timetable for implementation of this measure.

Chapter 17: Creating a New Health Workforce

General Points

- There is a heavy Federal regulatory role in determining and distributing physician residencies as presented in this section. The approach outlined represents a fairly radical departure from more market-oriented approaches, and it is unclear whether such a system would be politically feasible. These points were raised early on during the tollgates.

- In addition to advocating heavy Federal regulation and control of residencies, this approach will do little over the short term to narrow the gap between primary care and specialists. The goal of the draft's proposed Federally managed system would be to make sure that at least 50% of new physicians are trained in primary care fields (after a five year phase-in period). Yet, even if this goal were achieved, it would take 40 years to achieve the desired distribution between primary care and specialist physicians.

- This section discusses options for tinkering with Medicare's physician payment schedule to create incentives for providing primary care services. First, Medicare is not and should not become the spearpoint of policy for health care reform. The reform package must create incentives for primary care delivery

on a system-wide basis, because Medicare fee-for-service incentives alone will be too weak to change overall physician behavior.

Medicare physician payment on the fee-for-service has already undergone the radical shift toward primary care called for in this section. OBRA 89 enacted the most sweeping changes in physician payment since Medicare was created in 1965. In 1989, Congress required the use of the Resource-Based Relative Value Scale (RBRVS) which fundamentally shifted the distribution of Medicare physician payment away from surgical procedures and toward primary care services. For example, fees for family and general practice services increased by 10 percent when the RBRVS was implemented, while fees for general surgery decreased by 10 percent.

OBRA 93 has put even more pressure on physicians to focus on providing primary care services, and in many cases the provisions of OBRA 93 supersede the specific policies suggested in this section:

- the reductions that will be applied to physician fee increases in 1994 and 1995 will not apply to primary care services, resulting in relatively higher payments for primary care services;

- the separate "expenditure target rate of growth for primary care services" called for in this section has been enacted in OBRA 93. The separate target will eventually result in higher fee increases for primary care services. An arbitrarily higher target for primary care is unnecessary;

- the physician overhead component of the RBRVS was reduced in relative value by OBRA 93, increasing the overhead reimbursement for primary care services relative to other services. HHS is already working on a methodology for basing overhead payments on actual resources used. The FY94 President's Budget proposed that this methodology would be implemented by 1997.

- The Administration and Congress have already created incentives for primary care by drastically altering Medicare physician payment. The other proposals in this section (increasing payments for office visits and bonus payments to primary care physicians in Health Professional Shortage Areas) should also be advanced as Medicare reform proposals, not health care reform proposals. Medicare should not be in the vanguard of health reform, but should take advantage of and build on the successful policies implemented by the health

alliances. The entire section on Medicare physician payment changes is either premature or outdated, and should therefore be deleted.

- The report, instead, should make the point that managed care plans are the best friends of primary care. It is HMOs and other organizational arrangements that have historically valued primary care relative to specialty care -- the report's chapter should be built more around this theme. Medicare payment policies can and should build on integrated networks of care. For example, bonuses should revolve around use of primary care case managers in HMOs or some adjustment to the AAPCC payment. Continued tinkering with fee-for-service bonuses to physicians will only encourage fee-for-service style of medicine which could be both fragmented and volume-driven, placing increased risk on Federal outlays.

  If one end result of health reform is a much broader application of managed care, the demand for primary care physicians should increase. Why wouldn't this market response encourage more medical students to enter primary care, as well as practicing specialists to change over to primary care?

Specific Comments

- Page 130, the draft outlines an approach that would pay teaching hospitals which are required to reduce their residency training positions at a rate of 150% of the national average for direct medical education payments. In essence, these transition payments would reward non-performers more than performers and establish perverse incentives for non-compliance.

- Page 131, use of the word "appropriation" is confusing. Does this suggest that the Federal government would appropriate $6 billion or is this what the balance of residency training fund would be?

- It is not clear who would collect the revenue raised from the premium tap on the insurers and on Medicare. It is also not clear what body would administer this fund.

- The draft does not specifically state how much it would cost to administer the fund, as well as the new system for determining the distribution of residencies. It is not clear whether these costs have been taken into account.

- Page 131, the draft also does not specify the amount or the source of financing for the transition payments mentioned. It is not clear whether these costs have been taken into account.

- Pages 132-135, the section on "other workforce related programs" discuss expansion of existing health professions curriculum assistance grants. The draft, however, makes no reference to the current investment of $270 million in these programs, why additional investment in these programs is warranted, and what the net effect of the additional investment.

- The investment in "other workforce related programs" essentially builds on existing health professions programs. However, many of these existing programs have not had much effect in achieving desired policy goals. Could some of these expansions be funded by downsizing low-priority health professions programs?

- An alternative approach would take advantage of changes in physician employment market within the context of health reform and build off of the retraining proposal contained on page 131. Health reform's emphasis on managed care settings will increase the demand for primary care physicians, and reduce the demand for specialist physicians. As health reform takes hold, an increasing number of physicians currently practicing subspecialties will have to be retrained to practice primary care.

- Rather than continue Federal subsidies for training medical students, this alternative would phase-out Medicare GME payments overall and allocate a portion of Medicare GME funds on sharing the cost of retraining specialists for primary care work with HMOs and other managed care providers. Retraining physicians would provide a much shorter "pipeline" -- already practicing physicians would not need the same basic medical training that a medical student receives. Channeling funds for retraining through HMOs and other managed care providers would enable HMOs to determine who to retrain and extent and nature of retraining. Federal cost sharing would decline as specialists gradually met the need for primary care physicians. HMO's and other providers would have to pay back a portion of the Federal cost sharing if specialists did not stay in primary care for at least five years.

Chapter 18: Academic Health Centers

- The draft states that Medicare payments and a surcharge on private health premiums would flow into a pool to support academic health centers. The

analytic justification for this separate funds flow has not been identified, nor is the size of the fund made explicit. Is this in addition to other GME & premium funds? What is the total burden of these "taps"? Is the total dollar flow necessary for the level of academic health centers needed? Aside from this tap, how much increased funds will be flowing to such health centers through increased reimbursements due to universal coverage and due to some experimental treatment expenses being covered through the benefit package? Would any additional tap be required?

The draft would create a separate set of grants to encourage people to have access to academic health centers. Is this necessary, given increased reimbursements, benefit plan coverages, the proposed pool, and existing NIH grants -- and the access initiatives described in another chapter? If access assistance is necessary for these specific type of centers, it should be part of a single assistance package coordinated by the access initiative described elsewhere.

- The document states that plans will be required to provide coverage for routine patient care associated with approved clinical trials. This could be a disproportionate burden to plans, depending upon the relative number of individuals enrolled in trials. Trials tend not to be randomly allocated across areas and providers, but often concentrated in areas in large research institutions and academic medical centers.

  Secondly, plans could discourage patients to either not enroll in trials or else encourage them to disenroll from plans if there was such a burden. This would have the effect of discouraging over time good clinical trial activity.

- There is little or no discussion about rebuilding rural academic health centers. Good empirical evidence to date indicates that rural centers tend to be an effective approach for attracting and retaining a rural workforce of medical professionals.

Chapter 19: Health Research Initiatives

- Page 140-142 lists many, many areas of research interest, implying that all of them will receive additional funding. Text should be modified to present the items on the list as illustrating the types of areas in which investments could be made.

- The draft states that an additional $1.5 billion would be used for "prevention" research. NIH will spend about $2.6 billion (roughly 25%) of its total $10.8 billion FY94 budget on research which can be labeled "prevention-related". It is not clear whether more of this type of research would help Health Reform accomplish its goals. If desired, "prevention" research could be made a higher priority within NIH or within PHS' total FY95 planning ceiling, which would not require additional discretionary financing.

- Page 146 lists specific agencies which would assume responsibility for research on the impact of health care reform. The document states that AHCPR and HCFA/ORD will take the administrative leads in developing new research and demonstration initiatives. The document should note the DOL's contribution and importance in future activity related to employment-based health insurance. Secondly, HHS/ASPE, and OMB have played critical roles in developing and guiding longer-term strategies in these areas, and should continue to do so. Finally, this is not consistent with the chapter on the National Health Board, which assigns ultimate responsibility for determining such details with the Board.

Chapter 20: **Public Health Initiatives**

- Public Health Service programs: In general, many current Public Health Service programs are "gap fillers," providing services to groups not currently covered by comprehensive health service benefits. These benefits include mental health and substance abuse services, immunizations, prevention, breast cancer screening, community health centers, etc. These services are included in the standard benefits package, and therefore the full array of PHS programs are no longer necessary.

  Rather than phasing-down these benefits, PHS assumes full continuation of current funding levels, as well as expansion of these PHS duplicative benefits by another $3 billion per year.

  These increased Federal health costs are unnecessary and wasteful. These funding levels and programs undermine the objective of health reform --- to lower cost, consolidate disparate delivery mechanisms, and improve quality and access.

- The chapter is written as if public health will continue to be separate from the rest of the reformed health system. This would simply perpetuate the 1930's

model of public health -- a two-tiered system. Re-drafting this section to talk about public health as integrated into a reformed health system should be considered.

- This section calls for the creation of series of new state formula grants for a variety of functions already supported by the Federal government and state public health departments. It is unclear why such additional support for state public health departments would be needed within the context of the reforms mentioned in the other sections of the document.

- The document refers to "core" public health functions, which seems to protect activities that might no longer be essential within the context of a reformed health system.

- Pages 149-152 describe a new block grant that states could use for any of the "essential functions" outlined in the draft. However, the draft seems to ignore current Federal assistance provided to states for many of these same activities. Since most of these responsibilities are not new, why is additional funding required?

- Several of the core functions described on pages 149-152 appear to duplicate investments that would be made elsewhere, including assistance of underserved populations, health data collection and outcomes monitoring, training and education, and quality assurance. It is not clear how funds provided through these grants relate with grants described in other sections of the document.

Chapter 21: **Long-Term Care**

- Clarify the relationship between expanded home and community-based service program and Medicaid. Previous information indicated that this new program would be completely independent of Medicaid home and community-based services. The program had been described as wholly Federally funded. In contrast, this chapter describes funding for the program as a Federal/state match with the state contribution set roughly equal to current state Medicaid spending on the severely disabled. This new information raises several issues:

  -- Are Medicaid long-term care services for the non-institutionalized to be pulled into this program? If so, a significant cost-shift from Medicaid to the new program should be accounted for in our scoring tables.

- -- Many individuals currently receiving Medicaid home and community-based care may not qualify for services under the more stringent disability determination standards of the new program. Will these individuals continue to receive services from Medicaid; and if so, should this situation be accounted for when calculating the State contribution towards the new program?

- -- The non-cash Medicaid home and community-based care recipients will be moved into health alliances where, presumably, they will no longer receive such services. Should costs for these individuals be counted towards the State match?

- -- Will the same rates be paid for both Medicaid and non-Medicaid recipients? If Medicaid rates are increased, the resulting fiscal impact should be scored. If providers are paid lower rates for services to Medicaid recipients, how will the distinction be handled in an otherwise "non-means-tested" program?

- -- Alternatively, if current Medicaid home and community-based services are not supplanted by the new program, State spending for these services will double under the match formula.

- Medicare beneficiaries' premium. The chapter indicates that Medicare beneficiaries will pay a premium of $20 dollars per month to help finance the new home and community-based service program. At recent health care reform meetings, HHS policy officials appeared to indicate that Medicare beneficiaries will not pay this premium. The latest budget impact tables are based upon a $10 dollars per month premium. The final draft should reflect the President's decision on this issue.

- "Cash-only" rule. Recent policy documents and discussions have referred to the residual Medicaid program as available only to cash recipients. This draft makes it clear that Medicaid will retain and expand eligibility for non-cash institutional recipients through more liberal spend-down programs. References to the Medicaid program should specify that the "cash-only" eligibility rules do not apply to institutional care. In addition, eliminating Medicaid long-term care services for non-cash recipients who are disabled but who do not meet the 3-ADL standard could create political problems.

- Transfer-of-asset and estate recovery proposals. OBRA 93 provisions regarding transfers of assets and estate recovery overlap with many of the proposals advanced in this chapter. OBRA 93 has already made the following changes:

  -- estate recovery programs are now required in all States;

  -- consecutive (rather than concurrent) penalties are required for transfers of assets;

  -- transfer-of-asset penalties now apply to many transfers of income; and

  -- the lookback period for transfers of assets has been increased from 30 months under previous law to 50 months for trusts and 36 months for all other transfers;

  -- capping transfers of assets to an institutionalized patient's spouse was proposed during OBRA 93, where the provision met stiff Congressional resistance and was eliminated from the bill; and

  -- the proposal to protect additional assets for purchasers of long-term care insurance does not address the OBRA 93 provision making such assets subject to estate recovery. These assets may not be recovered in five "grandfathered" states. Nevertheless, individuals in most states are now unlikely to purchase long-term care insurance in order to protect their assets.

- Demonstration study of acute and long-term care integration: The proposed demonstration could overlap significantly with current HCFA demonstrations involving social HMOs (S/HMOs) and On Lok or PACE projects. While the proposed demonstration may be more comprehensive in scope, differences between it and current projects should be specified in order to avoid duplicative efforts.

- Quality and utilization control: Expanding home and community-based services raises a host of related concerns. The recent explosion in Medicare home health spending indicates the potential for abuse and overutilization in this area. Issues to consider include:

  -- Who will be allowed to provide these services?

- What, if any, medical authorization will be required before the government pays for these services?

- Will there be limits on the amount of services individuals may receive?

- Will there be any utilization review?

- How will quality care be defined and assured?

- Cash payments to individuals: According to this chapter, the new home and community-based service program will permit States to make cash payments to disabled individuals. Direct cash payments may create a moral hazard problem, reduce government control over quality of care, and significantly increase program participation.

- The Federal match rate formula for home and community-based program will treat states inequitably. Spending for non-institutional, long-term care varies greatly from state to state. For example, New York alone accounts for more than 70% of all Medicaid personal care spending. Basing the Federal matching rate on current state spending creates a bonus for states like New York while penalizing states that have not been big spenders in this area.

- Fiscal impact of eligibility expansions for institutional care. Liberalization of the financial eligibility standards for institutional coverage may significantly increase Medicaid costs. All states would be required to establish medically needy programs for institutionalized patients. Currently, 15 states do not have such programs. In addition, single individuals with up to $12,000 in assets will be eligible for Medicaid. The current asset standard is $2,000 in most states. These changes will make more individuals eligible for Medicaid coverage sooner, thus increasing Medicaid costs. The resulting costs should be taken into account when projecting the Medicaid baseline, especially in light of the entitlement caps requirement and global budget targets.

- Why is the tax incentive limited to individuals with disabilities who work? Why not all individuals with disabilities? Advocates for individuals with disabilities will argue that all individuals with disabilities who can work want to work but have great difficulty finding jobs. They will argue that if the goal of this policy is to encourage individuals with disabilities to get jobs, it is unnecessary; they want jobs. If the goal of this policy is to help individuals with disabilities afford the services they need to live independently, the policy

should be expanded to all individuals with disabilities because they all need that kind of help.

- In addition, the cost of expanding the tax credit to the entire disabled population would likely be small since the taxable income of the non-working disabled as a group is not great, thus the loss in tax revenue would not be significant.

- If the tax credit is limited to the employed, how will "employed" be defined? How many hours a year will have to be worked? Many individuals with disabilities are employed sporadically; would they lose the ability to afford the services they need to find a new job while they were unemployed? A case can be made that all individuals with disabilities who are capable of holding a job should be eligible for the tax credit at all times. Furthermore, the tax credit itself--the marginal increase in the value of their earnings--would be enough of an incentive to get individuals with disabilities who can work to look for work.

- Does the income tax deduction apply to unearned income? This distinction is important because if employed individuals with disabilities are allowed to deduct unearned income, unemployed and unemployable individuals with disabilities will want the same right.

Chapter 24: **Fraud and Abuse**

- This section describes specific types of health care fraud and abuse that would be expressly prohibited under reform, and it describes the penalties to be applied for breaches of the law. While detailed in these respects, the section is somewhat vague in describing actual enforcement mechanisms (aside from procedural legal mechanisms, e.g, the role of administrative law judges).

- The text says that the Departments of Justice and HHS will coordinate "federal, state and local law enforcement activities aimed at health care fraud and abuse." Further, the two agencies will "jointly direct the program." This policy raises the following questions:

  -- Is there a successful precedent for this kind of coordination activity that one could present as a model(s)? Exactly **how** will these two Federal agencies coordinate with each other and with myriad state and local law enforcement agencies? Primarily through data-sharing? By actually making joint raids, inspections, undercover investigations, etc.?

-- How will fraud investigations be coordinated with quality assurance activities? Will case-by-case quality review be used in abuse investigations? There may be some question whether the same evidence can be used for two very different purposes.

-- The text mentions that funding for enforcement activities will be "supplemented" by monies and assets recovered or confiscated by successful fraud and abuse prosecutions. In which agency will funding for implementation and regular operations originate? Will law enforcement agencies receive funding from the alliances (i.e., from premiums) or will general funds at all levels be diverted or increased to support enforcement activities?

- Will an exception on self referral for rural areas be allowed? If so, the conditions and back-up alliance monitoring mechanisms should be specified.

Chapter 25: Programs for the Underserved

- The draft outlines steps to continue Federal subsidies to selected classes of providers in underserved communities (i.e., community health centers, health care for the homeless centers, family planning clinics, and others). Through an "essential community provider" designation, the draft would also give these providers competitive financial advantages in serving underserved communities. These efforts could discourage other plans and providers from expanding into underserved communities. Maintenance of a two-tiered system would seem to undermine some of the overall goals of health reform.

Chapter 26: Medicare

- Medicare is kept virtually intact in the health reform plan, except for the prescription drug addition. Cost-effective innovations in service delivery will be incorporated into the Medicare program over time, but the consensus is clearly to have Medicare remain a follower, not a leader/experimenter, in health reform. There is plenty of room for reform within the Medicare program itself, but there is also awareness that reform with the elderly and disabled populations should proceed prudently.

- The status of working Medicare-eligible beneficiaries is not clear in this chapter. We understand that the plan assumes $59 billion in federal savings

(from 1996-2000) from workers who would get primary coverage through their employers. This raises the following questions:

-- Does the mandate apply to employers of Medicare eligibles, or is employment sponsored insurance merely a mandated option for Medicare eligibles?

-- Does the mandate apply to the cohort of working aged in corporate alliances?

-- Suppose both spouses are Medicare beneficiaries, and only one works. Does the mandate force the worker/employer to buy a couples policy or a single?

-- If a Medicare beneficiary is married to a non-Medicare worker, does the worker/employer have to buy a couples policy or could they decide to purchase only a single plan?

State Integration

- HHS position: "If only an enhanced benefit package is offered, the cost to the beneficiary still can be no greater than under traditional Medicare."

- Suggested revision: "If only an enhanced package is offered, the cost to the federal government and the beneficiary still can be no greater than under traditional Medicare."

Assurances

- Current position: "Savings accruing to the state are shared with the federal government and/or Medicare beneficiaries (savings may be used to reduce the Medicare Part B premium in the state.)"

- Suggested revision: strike language regarding giveback to beneficiaries, particularly mentioning the Part B premium. If a giveback is allowed, let the state decide how. If the Medicare beneficiaries cost less than expected, the savings should not be applied to "rewarding" the beneficiaries. The following year's lower premium estimates should be sufficient.

Cost sharing

- Current position: the annual deductible amount is set at a variable rate to assure that the same number of beneficiaries meet the deductible each year as during the first year of coverage.

- Suggested revision: the deductible should be adjusted so that the same **percentage** (emphasis added) of beneficiaries meet the deductible each year as during the first year of coverage. This accounts for absolute beneficiary growth.

Prescription Drugs

- Single-pricing. The Medicare drug policy includes a rebate provision, specifically tied to the ratio of average wholesale and retail prices. Medicaid has long had a "best price" drug price rebates. Extending the forced rebate to a larger portion of the market threatens cost shifting. This could then have the perverse effect of eroding large hospital and HMO discounts, especially if further actions (e.g., "single price" policies) are put into place to protect retail pharmacists, as was once part of the short-term cost control strategy.

Chapter 27: Medicaid

- State flexibility. State-option Medicaid benefits seem to be frozen not just for purposes of maintenance of effort, but the specific benefits that are covered. This is not only a change from current policy, but seems to run contrary to State flexibility and the desire to have states develop and run more efficient health care systems. Even if the decision was made to avoid political opposition, perhaps we could have a time in the future when states could again determine what optional benefits are provided. Such a time frame could coincide with the expanded benefits in the year 2000. This does not have to be tied to maintenance of effort. States could be required to redirect the funding for other health care purposes.

- Eligibility. The description implies that both cash and non-cash Medicaid recipients would be enrolled in Alliance health plans and that Medicaid would be responsible for paying specially-determined capitated payments to plans on their behalf. This is inconsistent with our understanding that non-cash recipients would no longer be eligible for Medicaid and would enroll in Alliance health plans at the going rate with Federal low-income subsidies, if eligible. Whether non-cash recipients are "in" or "out" affects the computation of the State maintenance-of-effort requirement, the costs of low-income subsidies, and whether to include a Medicaid savings offset associated with

switching these individuals from Medicaid to the low-income subsidy payment stream.

- Many individuals, particularly pregnant women and children, gain and lose Medicaid eligibility frequently. How will the Alliances assure smooth transitions between payments from employers, Medicaid, and Federal low-income subsidies?

- Apparently, Medicaid recipients could choose any Alliance plan, but would be charged if they chose a plan costing more than the weighted-average premium. Will Medicaid recipients receive a "refund" if they choose a plan that is cheaper than the weighted-average premium?

- State-by-State variation and wraparound coverage. According to the plan, Medicaid will function as a secondary payer, providing wrap-around coverage for Medicaid recipients. Many potential wraparound services are optional. States differ dramatically in what kinds of optional services they offer and in the amount, duration, and scope of mandatory services they provide. Will the wrap-around package vary State-by-State, depending on the mix of services each State now provides? Can States alter the wrap-around package? Will non-cash recipients receive any wraparound services, post-reform? If so, don't they then have to maintain a "dual" eligibility within the Medicaid program?

- Will wraparound services be funded as Medicaid is now, i.e., a Federal/State matching arrangement? Will States or Alliances be responsible for coordinating the delivery of wrap-around services?

- As noted above, Medicaid recipients gain and lose eligibility frequently. How will the States or Alliances that coordinate wrap-around services accommodate a continuing changing eligible population?

- Under the plan, would Medicaid continue to finance the Medicare cost-sharing expenses of Qualified Medicare Beneficiaries now covered by Medicaid?

- There is an apparent inconsistency between the global budget and maintenance-of-effort requirements. Under the global budget, States can spend no more for Medicaid capitated payments to plans than 95% of each State's historic per capita spending for services in the benefit package multiplied by the number of recipients enrolled. Under the maintenance-of-effort requirement, States must spend at least 100% of what they used to spend under Medicaid for these services. If Medicaid enrollment stays constant, the level of State spending

required for maintenance-of-effort would exceed a State's global budget expenditure limit.

- Do the maintenance-of-effort and global budget requirements include disproportionate share hospital expenditures?

- Provider tax limitations. If the match rate system is retained, States will continue to have an incentive to generate Federal funds through "costless spending" programs involving provider taxes. Current provider tax limitations may need to be reviewed to maintain the integrity of the State-Federal financing relationship. Existing limitations were created to apply to the taxing and reimbursing of numerous providers, rather than a small number of plans.

Chapter 28: Government Programs

Department of Defense

- It is not sufficiently clear that DoD beneficiaries cannot obtain health care coverage from both a health alliance and from DoD. It is critical to controlling costs that individuals choose a single plan (either a DoD plan or a health alliance plan) for all of their health care coverage. The VA section (on page 215) makes explicit that an individual may receive health care coverage under only one plan. DoD should do the same either on pages 13 to 15 or on page 213 under eligibility.

- Is the intent to give Alliances real power to certify or refuse to certify DoD and VA plans? The requirements of the plans and the latitude given Alliances in certifying allowable plans should be made very clear.

- The word **"centers"** in paragraph 2 on page 212 **should** be changed to **"care"**. There is no debate that DoD must be ready to provide necessary medical care for contingency operations. It is less clear that DoD needs to maintain large numbers of expensive medical centers in peacetime.

- In the second paragraph under "Appropriations and Reimbursement" the word "since" should be changed to "prior to". (p.213) DoD's intention is to protect current beneficiaries, not necessarily future beneficiaries, from any increase in costs. As written, the proposal could be very expensive.

- On page 213, add "Title 10 of the United States Code" after "described in" in the first paragraph, and after the word "under" in the fourth paragraph.

- DoD currently spends an estimated $1.3 billion to provide medical care to Medicare beneficiaries. Most of these costs would be shifted to Medicare under the proposal. In order to control total health care costs and limit the DoD incentive to provide a richer than national reform health care benefit, we could impose conditions that would limit Medicare payment to circumstances in which:

  -- Medicare beneficiaries pay at least the minimum premium and cost share they would pay in a private health alliance; and

  -- benefit levels are the same as the standard benefit package; and

  -- DoD costs, as certified by either HHS, OMB, or GAO, do not exceed the costs of local health alliance plans.

Veterans Administration

Start-Up Costs:

- The plan would establish a revolving fund to provide seed money to VA facilities through a one-time appropriation. The seed money would have to be paid back by the borrowing facilities, with interest, over several years.

- This proposal implies that VA will need a substantial funding increase because of health reform. In the current budget guidance, VA Medical Care is not treated as a priority program. In fact, it is currently funded significantly below what the VA will likely request. The proposed revolving fund could set the stage for VA's requested increase in FY 1995 -- expected to be $2 billion over FY 1994.

- If the one-time appropriation, which is likley to be substantial, is scored as discretionary it will crowd out other discretionary priorities under the "hard freeze" budget caps.

Global Budgets:

- It is not clear whether VA would be included in global budget targets. IF VA is permitted to compete within health alliances, then the VA spending should be

included in global budgets. Otherwise, VA would not be subject to the same level of oversight and pressures for efficiency as its competitors in the alliance.

Exemptions for VA plans:

- The draft states that VA facilities participating in the health alliance must live by the alliance rules, except when the rules are in conflict with laws governing the VA system (Title 38).

- This gives the VA a wide loophole for circumventing reform requirements (e.g., global budgets, providing data for quality management, following rules for enrollment).

- VA should not have exemptions to the rules of the health alliance if they are to compete on a level playing field under health reform.

Indian Health Service

- As described, the proposal is significantly broader (at least $3 billion per annum in additional resources *just for IHS*) than the estimates provided to Bob Anderson (roughly $3 billion per annum in additional resources *for all public health* functions in the first year of reform).

- Duplicate coverage: Current direct Federal coverage through IHS is continued, as well as an employer mandate. Should not working IHS eligibles choose either employment sponsored insurance or IHS but not both, as VA and DoD eligibles are forced to do?

- Duplicate funding: Current direct Federal appropriation, plus added appropriations, plus premium collections, plus reimbursements for services. Multiple, over-lapping financing sources for each individual.

- Open-ended entitlement: Removing Anti-Deficiency Act requirements from IHS, while keeping IHS a Federal agency, allows IHS to obligate current and future funds irrespective of annual appropriations or revenue, and which the Federal Government would be required to finance. Essentially, this creates a separate Indian Health entitlement program. Current budget estimates do not take this effect into account.

- Removes current eligibility rules (p. 218). Traditionally, IHS has provided health care only to American Indians and Alaska Natives living "on or near"

reservations. These rural Indian populations have limited access to medical care, and IHS was designed to fill that role. Urban Indians have access to the same health care as any other American. By removing current eligibility rules, IHS expands its eligible population from roughly 1 million to 2.2 million American Indians and Alaska Natives, urban and rural. Further, this puts IHS in the business of providing direct care in urban areas, which is both unnecessary and wasteful.

(Note: the Health Reform Work Group 16A did discuss building brand-new IHS hospitals and clinics throughout the country, including large "Indian medical centers." Removing current eligibility restrictions, and creating an open-ended IHS entitlement, seems to be heading in this direction.)

- Creating specific organizational positions in this document borders on excessive micromanagement, e.g., creation of a titular Assistant Secretary for Indian Affairs with no line authority.

Questions

- The package states that *tribal* employers are exempt from the national employer mandate. However, the term "Tribal" is not defined. Can any employer become a tribal employer by moving to a reservation? Why should tribal employers be treated differently from any other employers?

- Are IHS facilities capped under the global budget? What mechanism to control costs exist for IHS, since IHS is outside of the Health Alliance structure?

Federal Employees Health Benefits

- In the last paragraph before the heading "Eligibility" regarding enrollees moving, add a new second sentence: "For those moving in the opposite direction, the reverse is true."

- The last point on page 220 reads: "Annuitants will be held harmless." It is not clear what this means for annuitants under age 65, both current and future. If the policy is for government to continue paying the employer share for such annuitants until they reach Medicare eligibility at 65, the text should say so explicitly.

- Under the "Transition" section: last paragraph, last sentence calls for automatically enrolling people from terminated plans in the Standard Option of the government-wide Service Benefit Plan. This assumes that Service Benefit Plan will continue to be available everywhere during the transition. Add: ", or the most comparable plan available, as determined by OPM."

- Under "Contributions during Transition" the first statement should be restated as: "During the phase-out-period, the employer contribution continues at the level provided by current law." The modification is to the end of the statement. This reflects action in 1993 Reconciliation legislation which made a small change in the outyears to the "Big 6" formula that determines the government share of the FEHB premium.

- Under "Employee Health Benefits Fund:" What happens if reserves are not sufficient to pay the remaining claims after old plans close out? Does the Federal government then bear all the risk as the employer, or are remaining plans assessed? If the Federal government has to bear all the risk, it would seem consistent to allow the Federal government to claim all remaining resources -- the enrollees contributed to their health insurance for a specified period, and they were covered for that period.

Chapter 29: Transition

Financial

- States that expedite implementation of the plan would receive some type of relief from the Medicaid maintenance-of-effort requirement. Given that States will be required to pay their current share of Medicaid costs when Medicaid recipients are enrolled into Alliances, how could a change in the maintenance-of-effort requirement reduce States' expenditures? There is either a contradiction in the policy, or some share of assumed maintenance-of-effort should be discounted when pricing the package.

- Medicaid maintenance of effort specifies current levels of financial support from the States. For what year do these current levels refer? Do the current levels remain constant or are they adjusted (e.g., for inflation, changes in population that would have been Medicaid-eligible) over time?

- States are required to match Federal financial support. Is the match dollar-for-dollar or at some other rate?

Timing

- Rulemaking (p.225): The use of interim final rules is likely to impose large costs because it forces immediate compliance while leaving open the possibility of changes between the interim final rule and the final rule. Such changes would likely require costly changes in contractual arrangements. Delays between interim final rules and final rules tend to raise the costs of such changes.

- The lack of court authority over the implementation of interim final rules may be viewed as an affront and result in increased lawsuits rather than decreased lawsuits. Since the Board is not required by the Statute to implement final rules by a particular date, and may be sued only after failing to implement final rules without "unreasonable delay", the effect of this clause is to delay court action for a period of years, but not to prevent it. Such delays raise compliance costs, by prolonging the uncertainty about how to comply with regulations. An inelegant solution would be to require that the final rules be issued by a particular deadline.

- Current: "States that do not begin implementation by January 1, 1995 enter the new health care system either on January 1, 1996."

- Question: What is the assumed alternative to January 1, 1996?

- Current: "Relief from short-term cost controls imposed as part of the transition to reform."

- Suggested revision: If short-term controls are off the table now, a different form of incentive must be found to replace this relief.

- Corporate alliances are given the option to join regional alliances after health reform is implemented in all States. Are there any restrictions on this option? Is this an open-ended option? Are there penalties or incentives for early or late enrollment in the regional alliance by a corporate alliance?

Other

- The concept of "group credibility" is not defined and, because the concept is not in common use, is not clear.

- In the phrase, "the pool is voluntary" -- Voluntary for whom? If the pool is voluntary for insurers' participation, it appears to contradict the previous paragraph regarding insurer assessments. If enrollment is voluntary by individuals seeking health insurance, this should be stated more clearly.

- In the phrase, "[the pool] operates under traditional insurance rating methods" -- "Traditional" rating methods would appear to include rating based on claims experience. However, the next sentence suggests that only age, gender, and place of residence can be used as rating factors. This should be stated more clearly.

- How do the phrases "first year," "second year," and "until full implementation" relate to January 1, 1995; January 1, 1996; etc.?

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 24, 1993

THE DIRECTOR

MEMORANDUM FOR: Ira Magaziner

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Timetable for Budget Estimates

As you have often emphasized, it is important for the credibility of the health reform proposal that all Federal cost and savings estimates be thoroughly scrubbed. In order to provide thorough the estimates, our OMB budget examiners will need clarification of some of the policies in the health reform plan. Decisions are also needed on certain economic and technical assumptions to be used in preparing estimates of the Federal budget effects of the reform.

This memorandum lists the points that need clarification. We understand the pressures for a very rapid turnaround. We will be able to produce cost estimates 2 weeks after we get a complete set of programmatic specifications to price out.

Policy Clarifications: There are a number of policy questions that must be clarified before OMB can estimate the plan's total costs to the Federal budget. A list of these questions is attached at Tab A. (These should look familiar: Many of our questions were forwarded to you as an attachment to our memorandum on the 8/6/93 draft of the health reform plan, and we have compiled an additional list of new questions pertaining to the 9/7/93 draft, which was forwarded earlier this week.)

Economic and Technical Assumptions: Up until now, the economic assumptions used for estimating the costs and savings from the health reform proposal have been the January 1993 "CBO" assumptions, the same assumptions used for the President's February and April budget submissions to the Congress. They include the assumption that inflation will average 2.7 percent per year in 1996-2000. In August, the Administration revised its economic assumptions for the Mid-Session Review. The new assumptions are no longer based on the CBO economic forecast. Inflation averages 3.5 percent per year in 1996-2000 in the new projections.[1] We recommend basing the budget estimates for health reform on the new Administration economic assumptions so that we will be able to compare it with other Clinton Administration proposals and forecasts and to produce an internally consistent estimate of the impact of the proposal on

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[1] CBO has also revised its economic forecast. The current CBO economic forecast calls for an inflation rate of 3.0 percent rather than 2.7 percent.

the deficit. You should also be aware that the health reform proposal, as a pending Administration legislative proposal, will have to be re-estimated for the President's FY95 budget submission, using revised economic and technical assumptions. The practice has been that these budget estimates are made by the affected agencies on a budget-account basis using the Administration's own economic assumptions. These are likely to differ somewhat from current forecasts, but the disparities are likely to be minimized by adopting the current Administration forecast now.

"Scorekeeping" Issues: As we have discussed, there are certain Budget Enforcement Act (BEA) "scorekeeping" issues that will need to be resolved before legislation is proposed to implement the health reform proposal. We will need about two days after the OMB/Treasury estimates are final to assess these scorekeeping issues. Please note that for presentation to Capitol Hill, OMB and Treasury estimates will have to be divided into the following categories: discretionary, PAYGO (receipts and mandatory), and indirect impacts. Depending upon how the current policy divides into these categories, we may want to suggest changes in the language used to describe the policy in the detailed specifications you are drafting. Moreover, it might be productive for us at OMB to surface any scorekeeping issues with CBO in advance of finalizing the policy specifications.

In addition, it appears that there will be BEA issues relating to the proposed increases in discretionary spending in the health reform plan, which appear to be far too large to fit within the existing discretionary caps. We have discussed this issue with respect to the proposed increased spending for various programs of the Public Health Service; if these increases are maintained, the BEA will have to be amended, because it sets an absolute limit on discretionary spending that would be breached by this additional spending. While this might conceivably justify a proposal in the health reform bill to amend the BEA to raise the discretionary caps (which might be justified with the argument that the new discretionary spending is more than offset by PAYGO savings that will be achieved by the Medicare savings proposals), this depends on how much of the increase in receipts and the decrease in mandatory spending will be scoreable under the BEA. (It appears that some of the receipts that are currently being scored may reflect indirect impacts that cannot be scored under BEA). As you can see, these issues involve complicated technical questions, as well as questions regarding our approach to the Congress that must be carefully considered as part of the overall legislative strategy for the reform effort.

Attached at Tab B is a proposed schedule for completion of our work. Please let me know if you have any questions.

cc: The First Lady

Attachments

The following code applies to each question or set of questions:

Priority 1: Cross-cutting questions that more than one group needs answered before pricing can begin.

Priority 2: Questions that must be answered before pricing of a specific component.

Priority 3: Questions whose answers may not affect the pricing but which may highlight the need to sharpen the focus of legislative specs.

PRIORITY 1

15 Sep 93

1. From/To health coverage status over time (FY94 - 2000) - where are people now, where will these go each year — detailed pricing and modelling assumptions and data.

   - state and local coverage - mandated? subsidized?
   - uninsured
   - movement from one of two spouses employer's paying premiums to two working spouses having employers pay contributions - When? Alliance by alliance, time period
   - are welfare recipients induced off the AFDC, General Assistance, or Food Stamp rolls
   - coverage of temporary employees — particularly federal temporaries

2. What is the premium plus surcharge, guaranty assessments and other amounts — Are the weighted average premiums *ex ante* or *ex post*?

   - Timing of development of health alliance premium by major state and concentrations of federal beneficiaries

   - Breakout the surcharges for Nationally desired activities, their timing, State Guaranty funds

   - Growth of premiums, and surcharges, etc. over time and changes in benefits — 2000 etc.

3. Amount of payment by FEHB on behalf of over 65 non-Medicare annuitants and the increase in premium cost

4. Interaction of Medicare and Medicaid drug benefits — what are the rules?

5. Maintenance of Effort for Medicaid — detailed description and HHS pricing over time.

6. Assumptions on VA Health Plan participation and direct appropriations — same with Indian Health, DoD/Champus

7. National Health Board function and staffing

8. Health cost containment, its effect on the CPI — and federal revenues/outlays

9. Income and firm subsidy designs E. G. What is income, etc. and the costs of administration and including underlying eligibility, participation and error

rates.

10. Changes in federal tax income from for profit health plans and physician and other provider income.

11. Details on early retiree policy especially DoD and FEHB early annuitants

12. Interaction of Medicaid and Medicare with the new long term care benefits (prec 4-1 rules, etc.

13. Treatment of Federal auto and workers compensation — Federal Tort Claims Act, FECA

13. Are those in Federal State and other institutions covered (jails, mental hospitals, juvenile centers, etc.)

15. If calculations are on a CY basis, please provide your methodology for estimating the FY/CY switch.

16. Pleaase provide the cash flow incurred costs, outlay lags and related assumptions.

Please provide a list of contact for each of the items.

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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Current Law							
Baseline updated for August CEA economics							
Beneficiary Population							
Per-Beneficiary Outlays							
Less Employer-covered Aged (assumes full-time work for full year)							
Outlay savings							
Beneficiaries opting out							
QMB offset							
Admin. costs							
Early Retiree Coverage Effect							
Outlay Change							
Number of Early Retirees							
Admin. costs							
Revised Pre-Savings Baseline							
Outlays							
Beneficiary Population							
Savings Package Assumed for HCR							
Outlay savings							
Effect on Beneficiary Population							
Change in Admin. costs							
Post-Savings Baseline							
Outlays							
Beneficiary Population							

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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
HCR Effect on Baseline							
Number of enrollees in "standard" Medicare							
QMBs							
Dual Eligibles							
Standard Medicare HMO							
Other/Fee-for-service							
Total							
NON-ADD Supplemental coverage effect on outlays							
Number of enrollees moved to alliances							
QMBs							
Dual Eligibles							
Other							
Total							
Enrollees in VA health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Where does Medicare pay (plan or point of service)							
Admin. costs VA							
Medicare							
Enrollees in CHAMPUS/VA health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Admin. costs CHAMPUS/VA							
Medicare							

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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Enrollees in CHAMPUS health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Admin. costs CHAMPUS							
Medicare							
Enrollees in DoD/Champus health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Admin. costs DoD/CHAMPUS							
Medicare							
Average Federal Medicare contribution for Alliance-based Medicare beneficiaries							
Average Beneficiary Contribution							
Admin. costs							
Average Federal Medicare contribution for DoD plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							
Average Federal Medicare contribution for VA plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							
POST-HEALTH CARE REFORM, NET MEDICARE OUTLAYS							

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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Related Assumptions							
Drug price growth rate							
Drug premium							
Pre rebate							
Post rebate							
W/O rebate							
Admin costs							
Cost shift/capturing secondary effects							
Revenue affects							
Employer taxes							
Employee taxes							
State and local government taxes							
Medicare Beneficiary Cost-Sharing							
Average for standard plan							
Premium							
Deductible							
Copay.							
Total							
Plus: Drug Premium							
Drug Copay.							
Total							
Effect of supplemental coverage on drug utilization							

September 24, 1993

Health Care Reform Pricing Issues – Medicare

The cover table and the following list of pricing and policy questions contains significant overlap and duplication. The intent is that the answers to these questions and stated assumptions will provide enough specification to provide estimates of health care reform's impact on Medicare.

On a fiscal year-by-fiscal year basis through the year 2000, what are the assumptions concerning:

- Medicare beneficiary enrollment through the Alliance rather than traditional Medicare? Does the percentage of enrollees gaining coverage through the Alliance increase over time? **(See table; Categories 1 & 2)**
  - What percentage of them enroll in HMOs? **(See table; 2)**
  - Do Medicare beneficiaries pay the surcharges on the premium, or does the Federal subsidy include them? **(1, 2, 3)**
  - What incentives, e.g., differential premiums, will exist to encourage enrollment in managed care settings? **(3)**
  - What is the assumed deductible in health plans for Medicare-eligible enrollees? **(1, 2)**
- How many (and what percentage of) non-working, non-QMB people who would have been in Medicare will elect to enroll in alliances instead? **(1, 2)**
- Does the employer mandate apply to employers of Medicare-eligibles or is employment sponsored insurance merely a mandated option for Medicare-eligibles? **(3)**
  - Does the mandate apply to the cohort of working aged in corporate alliances? **(3)**
  - Suppose both spouses are Medicare enrollees, and only one works. Does the mandate require worker/employer to buy a "couples" policy or a single policy? **(1, 2, 3)**
  - If a Medicare beneficiary is married to a non-Medicare worker, does the worker-employer have to buy a couples policy or could they decide to

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

purchase only a single plan? **(2, 3)**

- What limits on enrollee choice of policies/coverage exist? **(3)**

- How will savings accruing to the States be shared between beneficiaries and Medicare? **(1, 2, 3)**

- For the Medicare-eligible alliance enrollees, what will be the total amount the alliances charge, and the average per capita amount, to Medicare?

  - What are the assumptions regarding the amount charged to Medicare, e.g., is it based on the average per capita amount? **(See table; 3)**

  - Is it risk-adjusted to a level lower than the average Medicare fee-for-service level to reflect an assumed better health status and/or younger average age of Medicare-eligible alliance enrollees? **(See table; 3)**

  - Is it geographically adjusted by state? Would Medicare subtract lost premium income from the amount paid to the alliance? How much? **(See table; 3)**

- Are Medicare IME outlays folded into the funding pool for academic health centers, along with the GME payments? Or are they held separate, but at a lower IME rate of payment, e.g., 3%? **(1 & 2)**

  - What are the assumed impacts on Medicare GME/IME payments under the workforce changes contemplated by the 9/7 draft?

- Are those eligible for Medicare through disability enrolled in a separate pool, or do they continue to receive care under Medicare? What are the assumptions about the disabled's enrollment through Alliances and the effect of marriage status? **(1, 2, 3)**

- Are dual eligibles folded into the Alliances along with the rest of the Medicaid population, or does Medicare cover them?

  - Who is the primary payor for prescription drug cost-sharing for dual eligibles, Medicare or the States? **(See table; 1 & 2)**

  - Are States required to cover Rx cost-sharing for QMBs? Is this going to

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

be reflected in the MOE calculation? How will the Medicare and Medicaid drug benefits be integrated? **(1, 2)**

- What percentage of QMBs will enroll through Alliances?

- Are there separate assumptions about elderly utilization of health care services under different cost-sharing schemes? If so, what is assumed about Medicare beneficiary utilization with lower cost-sharing requirements, e.g., managed care enrollment with no Medigap allowed? **(2)**

- Will the elderly be allowed to purchase Medigap if they enroll in managed care settings? **(3)**

  - What are the assumptions about reduced Medigap purchasing as the result of the new Medicare benefits/options, e.g., coverage of copayments on drugs rather than the entire drug? **(See table)**

- What income levels are assumed of veterans before Medicare will pay VA for covered services? **(1, 2, 3)**

  - What are the assumptions about the number of Medicare beneficiaries also eligible for VA care? What is the assumption about Medicare payment to the VA for care rendered Medicare enrollees? **(2)**

- What are the assumptions about Medicare beneficiary utilization of VA and DoD facilities? What are the assumptions about Medicare enrollees enrolling in DoD, VA, CHAMPUS, and CHAMP/VA plans? **(2)**

- What assumptions are made about the average out-of-pocket cost for a Medicare-eligible alliance enrollee (i.e., 20% of premium with subsidies for low-income, $200 deductible, some coinsurance), versus the average out-of-pocket cost if they choose to stay in Medicare (i.e., 25% of Part B costs, $676 Part A deductible, $100 Part B deductible, and copays). Are these relative costs taken into account in developing a model to determine how many will opt for alliances versus staying in Medicare? **(See table; 3)**

  - In addition, do the assumptions about how many Medicare-eligibles enroll in alliances take into account the varying levels of income-related subsidies for alliance premiums? **(3)**

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

- The plan asserts that States will assume Medicare administrative costs in situations in which Medicare is enrolled into the alliance (pg. 191). If Medicare is not reimbursing the States for these costs, how much administrative savings are assumed for the Medicare program? **(1, 3)**

- What are the assumptions regarding Medicare beneficiaries already enrolled in managed care plans? **(See table)**

  - How many stay in existing plans versus joining plans under the health alliances?

- What are the assumptions regarding beneficiaries joining Medicare point-of-service plans (pg. 193)?

  - How many from current baseline enrollees in Medicare managed care plans will switch to point-of-service networks? How many additional beneficiaries will join point-of-service networks? What will be the average per-capita Federal cost and savings versus the baseline for these plans? What Federal administrative costs are assumed for these point-of-service plans? **(3)**

- What are the assumptions about physician discretion in waiving Medicare coinsurance requirements in cases of "financial hardship and professional courtesy" (p. 120)? What is the induced utilization effect? **(2, 3)**

- What are the assumptions about the effects of Medicare proposals on administrative costs? **(2)**

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

Pricing Questions Concerning the Medicare Drug Benefit

1. What effect do you assume the drug benefit will have on drug usage and expenditures among Medicare Part B beneficiaries? (2)

2. How many beneficiaries do you assume will enroll in Medigap policies that cover the cost-sharing requirements included in the drug benefit and what affect will Medigap coverage have on drug usage and Federal expenditures? (2)

To: Lew Nichols
Ron DKK

Kronick 9/22

Ag - HF - 3

Medicare As Secondary Payer Policy

Policy questions that need to be answered in order to accurately estimate the size of the 'Offset for Medicare Eligibles in the Alliance':

1) Is policy that Medicare beneficiaries who are full-time workers must be members of the alliance (either corporate or regional) with Medicare as a secondary payer, or that they can choose to be alliance members with Medicare as secondary payer? 1+2

a) If a Medicare beneficiary works for an employer who only contributes the required 80%, then choosing alliance coverage will require an additional payment (20% on average, more for a more expensive plan less for a less expensive). For a single person, this will average $380, for a couple perhaps $800. For most this will be a better value than Medigap has to offer. It is reasonable to require the full-time worker beneficiary to take alliance coverage; however, it is, at a minimum, politically sensitive to require payments for the 20% (more or less) for people who are eligible for Medicare.

If it is decided to require alliance membership for a full-time over-65 worker, it would make sense also to require membership for the spouse of a full-time worker even if the spouse is a Medicare beneficiary.

b) To avoid disruption and reduce expenditures, if a beneficiary is working full-time during annual open enrollment but subsequently stops working, could potentially leave them in the alliance for the rest of the calendar year and provide the 80% retiree subsidy (this would probably be less expensive to the federal till then returning them to Medicare because of the community rating effect). Alternatively, if a full-time worker stops working during the year, could end alliance coverage and return them to Medicare. (If there is thought of leaving them in the alliance, would we require this or leave it as an option?)

c) If a Medicare beneficiary is not working at time of open enrollment but starts working full-time during the year, makes sense to add them to the alliance rolls during the year. Same questions about what to do if they stop working during the year.

2) Part-time workers

1+2

a) If a Medicare beneficiary works part-time, could potentially require employer pro-rata payment, require the beneficiary to join the alliance, and provide the retiree subsidy to fill in the unpaid portion of the 80% employer

contribution. Similar issues as for full-time workers on whether we are willing to require such persons to pay the 20%.

3) Modelling, not policy question: If we leave to workers the decision on whether or not to join the alliance and pay (more or less) the 20%, what will OACT and/or others assume about beneficiary behavior?

a) What was assumed, either for policy or behavior, in the estimate that the Medicare offset is $59 billion?

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MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Current Law									
Caseload									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
Institutionalized (non-add)									
Per Capita Costs (Basic Benefits) 1/									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									

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MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Current Law									
Per Capita Costs (Supplemental Benefits) 1/									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
Per Capita (Long Term Care) 1/									
Nursing Facilities									
ICFs/MR									
Non-Institutional Care									
Aggregate MAP Costs 1/									
Administration Costs 1/									
Total Medicaid Costs 1/									

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MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Health Care Reform									
Caseload									
AFDC (under 65)									
SSI (under 65)									
QMBs									
Dual Eligibles									
Institutionalized (non-add)									
Former Recipients									
Community-Based Long Term Care									
Alliance Buy-Ins									
Per Capita Costs 1/									
Basic Benefits (Budgeted Premium)									
Supplemental Benefits									
Institutionalization									
Community-Based Long Term Care (new LTC program)									
Aggregate MAP Costs 1/									
Administration Costs 1/									
Total Medicaid Costs 1/									

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MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Health Care Reform									
Table Line Items									
Aggregate State Maintenance of Effort									
Liberalized Long-Term Care Eligibility (Institutionalized)									
Offset for Current Law Medicaid Eligibles 1/									
Community-Based Long-Term Care									
Alliance Buy-Ins									
Savings Due to Budget Cap 2/									

Notes

1/ Show State, Federal, and total computable costs where appropriate.

2/ Break out for specific savings provisions, including DSH.

Questions About Pricing of Medicaid Provisions

General.

3 • HCFA is largely dependent on State data to estimate future Medicaid spending and to disaggregate projected, as well as actual, Medicaid spending into particular categories, e.g., acute care spending for AFDC recipients. What data sources have been used in pricing the President's plan, e.g., determining State's maintenance-of-effort contribution, estimating the number of employed Medicaid recipients, and carving out current Medicaid spending for services in the national benefit package?

3 • Will these same sources continue to be used or will there be special State data queries, surveys, or audits to validate currently-available data?

2 • Which Medicaid service categories will be included in the national benefit package and which are defined as long-term care services?

2 • What assumptions were made about the behavior of States in response to the proposed changes in Medicaid? For example, what assumptions, if any, were made about the effect of likely State efforts to reduce Medicaid spending during the year prior to reform or to move individuals from Medicaid to fully-Federally financed low-income subsidies? Also, if the match rate system for financing Medicaid is retained, what assumptions were made about States' ability to generate Federal funds through "costless spending" programs involving provider taxes?

Caseload.

2 • On a fiscal year basis through the year 2000, what are the assumptions regarding the size of the Medicaid caseload in the absence of reform and where these Medicaid eligibles "go" under the President's plan, i.e., how many obtain coverage through:

- their employers?
- low-income subsidies?
- remaining on Medicaid?

(see attached table).

2 • In developing these caseload estimates, what assumptions were made

about the behavioral effects of increased work incentives on the number of Medicaid cash recipients?

Per Capita Costs. Please provide a detailed description of policy, assumptions, and pricing over time.

3 • Will different premiums be computed for AFDC and SSI recipients?

2 • According to page 201 of the 9/7 draft of the plan, annual rates of increase in the per capita payments from Medicaid to alliances will be "subject to the national health care budget." Does this imply that annual increases will be equal to, no greater than, or otherwise related to the budgeted amounts? Please explain how the negotiating process with plans will work and how the budgeted annual increases in State Medicaid payments to alliances will be computed and enforced.

2 • Will Medicaid per capita payments be adjusted to include costs associated with services that will be included in the national benefit package but are not currently covered by Medicaid, e.g., coverage for treatment of persons age 21-65 in institutions for mental diseases (IMDs)?

Wrap Around Coverage.

2 • Will the wrap-around package vary State-by-State, depending on the mix of services each State now provides? Can States alter the package? Who will be eligible for these wrap-around services, who will pay for these services, and how will payments be computed? If Federal funding for wrap-around services is provided through block grants, will the grant amounts be established to approximate the Federal portion of current State spending on wrap-around services?

2 • Will Medicaid recipients in the Alliance be subject to the same cost-sharing requirements as other low-income individuals or would cost-sharing subsidies be included as part of Medicaid wrap-around coverage?

2 • Under the plan, would Medicaid continue to finance the Medicare cost-sharing expenses for Qualified Medicare Beneficiaries and dual eligibles now covered by Medicaid?

Maintenance of Effort.

2 • What are the various components of the State's maintenance-of-effort

(MOE) contribution?

- Does the MOE contribution include States' share of DSH payments, as well as payments for services not included in the national benefit package? If the MOE contribution does not include State DSH spending, will these dollars be netted out of the initial calculation of Medicaid per capita payments to alliances?

- Does the MOE contribution include current State spending for:

  - Medicaid services that are not included in the national benefit package; and

  - for individuals who are no longer eligible for Medicaid, but also not eligible for low-income subsidies, e.g., pregnant women with incomes between 150% and 185% of poverty?

2 • In calculating the annual growth in the MOE offset, what assumptions were made about the level of budgeted growth in States' average weighted premiums?

3

3 • Will States be given an opportunity to appeal the calculation of their initial MOE contribution, i.e., will there be some sort of appeals process for States?

Long-term Care.

2 • Exactly how will State contributions and Federal matching be calculated for new community-based long-term care (both low-income and non-means-tested)?

2 • What will the Medicaid offset be for home and community-based spending folded into the new long-term care program?

2 • How will acute care for Medicaid institutionalized patients be coordinated and financed?

2 • How will institutional long-term care spending be budgeted?

Working (AFDC cash) Recipients.

2 • Will Medicaid continue to buy into employer health plans?

2 • What are the transition payment rules for those moving into and out of AFDC and into and out of employment?

DSH.

2 • What is the schedule for phasing-out DSH?

2 • Medicare DSH payments are computed according to a formula that is based on the number of the Medicaid inpatient days. What assumptions have been made regarding the effect on Medicare DSH payments resulting from the substantial reduction in the number of Medicaid eligibles under reform?

Cash Flow.

3 • What assumptions were made about the effect on Medicaid spending at the point of implementation when States are paying for Medicaid costs that have been incurred by current beneficiaries, as well as paying prospective premiums to Alliances?

Long-term care program questions

By year, how many individuals are projected to receive services from the new community-based LTC program? Please show projections for both the 3-ADL program and the low-income program. How many of these individuals would otherwise have been Medicaid-eligibles?

Will reimbursement rates under the new program be comparable to those under the current Medicaid program? Will there be a difference between reimbursement rates for the 3-ADL program and the low-income program?

What assumptions are being made about the phase-in of coverage over several years?

How will program spending be budgeted? What annual growth rates are assumed?

What assumptions are being made about utilization rates and costs per recipient under the new program? Do these assumptions change over time?

Will Medicare beneficiaries have to pay a premium for the new program? Who will pay and how much will the premium be? What is the projected revenue from premiums?

What will the Medicaid offset be for home and community-based spending folded into the new program?

Exactly how will State contributions and Federal matching payments be calculated under the new program? How much are the State and Federal government expected to spend?

Are the costs of tax credits for the working disabled included in the LTC program estimate, or do these costs only affect the "receipts" line item?

Long Term Care (pp.151-165)

Status: Changed

Budget Issues

- P. 152. It is possible that a portion of the SSI/DI population who are not currently receiving institutional care or home based care would qualify for community based care as under the eligibility standards described. Limited ADLs are used as eligibility criteria for SSI/DI, but this population rarely uses institutional care.

- P. 158 Would the monthly living allowance change for recipient of federal benefits (SSI, VA) change?

- P. 162 This tax deduction would represent a double exclusion for SSI/DI recipients. Work related expenses are deducted from an SSI/DI recipients total income when calculating benefits.

Policy Issues or Clarifications

- Medicare beneficiaries pay a premium toward coverage, with individuals having incomes below 100% of poverty exempt from the premium. Should assets be included in the in the computation of the premium exemption threshold?

- Matching rates: The Secretary of HHS determines matching rates for allowable costs.
  How are administrative costs treated under the matching rate computation?

- Tax treatment of premiums for long-term care insurance. Such premiums for qualified plans are excluded from taxable income.
  Are the premiums excluded for both income and FICA/FUTA payroll taxation? What is the tax treatment for the self-employed?

- Tax incentives for individuals with disabilities who work. Employed disabled individuals who require assistance with daily living receive a 50% tax credit. Is this credit refundable? Does the credit only apply to earned income? How does the credit interact with EITC? Was this considered in pricing.

- SD, RP
(IM branch comments)

23 September 93

Financing for the Under 65 Population

(based on provisions listed in prior drafts,
however these items were mentioned in the President's speech.)

Policy Questions or Clarifications

An employer premium subsidy is limited to firms with 50 or fewer employees. Employers also have a cap on premiums for all employers equal to 7.5% of payroll.

3

- Subsidies for Employers: for firms with less than 50 employees in which the average full-time *wage* is less than certain thresholds, employers receive government subsidies for health premium contributions on workers with wages under certain thresholds. All employers benefit from a cap on premiums limited to 7.5% of payroll.

  The eligibility criteria for subsidies for employees and employers, and premium caps for employers could be based on total employee compensation, including fringe benefits, instead of payroll. Large segments of the nation's working population receive employer provided fringe benefits such as health and life insurance, flexible benefit packages, housing, and pensions. Such benefits accounted for 16 percent of total employee compensation in 1989, up from 8 percent in 1960. Most of the growth in employee remuneration over the past 20 years is attributable to the growth in benefit spending. For example, inflation-adjusted benefit spending per full-time employee grew by 63 percent between 1970 and 1989, while average cash wages remained almost flat. The proposed employer subsidy could further encourage firms to pay employees in fringe benefits in order to remain eligible for the government health subsidy, or meet the 7.5% payroll cap.

The President has stated that under the proposed plan, the self-employed will be able to deduct 100% of alliance premiums.

2

- Premiums for Self-employed The self-employed are currently allowed to deduct only 25% of their health insurance premiums for tax purposes. Would the proposal result in a reduction in SECA income to the OASDI and HI trust funds?

Priority Code 2

HCR Administration: Overview

The fundamental issue is to clearly specify the functions that will be performed by each entity, new or existing, and to draw the boundaries between these entities as clearly as possible.

Since there is so much Federal oversight and backup or default control, in the absence of a clear demarcation, we will have to assume the function will be performed at the Federal level, either by an existing agency or the National Health Board (perhaps through a contract with an existing agency).

We intend to provide an estimate of the total administrative cost associated with each function and the portion of that cost that would be borne by the Federal government.

Priority Code 2

HCR Administration Questions
Pricing Issues: Scope & Parameters

(I) Define administration. Is this Federal only? Or system-wide (Federal, State, local, Alliance, plan, corporate, etc.)? Keeping pricing limited to the Federal level makes the task 'easier' (though not necessarily possible), and begets the question of whether Federal costs are being shifted to other levels of the system.

How is this to be measured? Dollars? Staffing? Paperwork burden? All?

What encompasses administration? Is it 'direct only (i.e. Health insurance administration; Provider administration)? Or does it include 'indirect' but essential support functions (i.e. Fraud and abuse investigation and prosecution; Data system management; Data analysis)? What about consumer education, advertising, etc.?

(II) Assignment of administrative functions in the plan. There are a host of administrative functions identified in the plan, but little consistent assignment of these functions to a specific entity, or discussion of how they will be financed.

Examples of unfunded, vague (difficult to price accurately), or unassigned functions: State qualification of health plans. State establishment of demographic service requirements. State Guaranty Funds. Establishment of 'capital standards.' Regional alliance administration. Administration of allocation of consumers to plans when capacity is insufficient. Development of State fee for service schedule. Alliance administration. Federal coordination among principal agencies (DOL, DHHS, VA, DOD), and with States, local grantees, alliances, plans, etc. Health professions loan administration, as well as other Federal programs (training and education oversight and administration). Administration of the Inter-alliance Health Security Fund. Budget administration, oversight, and enforcement. State licensure and certification of plans, health professionals. Federal licensure and certification of 'essential providers.' Survey administration and analysis (outcomes, quality, satisfaction, etc.). Premium tap fund collection and administration. Research and demonstration administration. Income monitoring and subsidy administration. Administrative capacity for Federal assumption of alliance operation for non-starting States or or States in default. Quality control program.

(III) Funding sources. There are numerous, over-lapping funding sources for data-

related activities. Presumably some data costs (capital, maintenance, administration, data processing and analysis, etc.) are funded within alliance or plan budgets. But, PHS also includes some start-up funds for state data systems, as well as separate funds for special surveys (the data from which could easily come from hospital admitting records, coroner reports, etc). PHS also includes funds for data analysis. PHS also has a separate 'administrative cost' category, which we have no idea what is contained therein. These need to be identified.

Are funds for data activities also included under more generic administration funding sources, such as premium taps? What about HCFA ORD? Medicare administration? VA, DOD, and IHS administration? This gets back to assignment of functions to specific entities, and funding sources for each. What is a centralized, Federal function, and what are private responsibilities?

(IV) Medicaid Administrative Expenses

Will current Federal policy with regard to matching of administrative expenses be changed to reflect a smaller, simpler Medicaid program?

Have potential savings from the reduced administrative burden in the Medicaid program been identified? Even if Federal matching policies remain intact, some savings could be expected.

Will States and Alliances continue to administer wrap-around benefits (i.e. current Medicaid benefits not included in the basic benefit package)?

(V) National Health Board

Fundamental questions about the board's functions, responsibilities, and operations require clarification (e.g. contract, in-house..):

Is the board to be advisory to an existing or new Executive Branch agency which is under control of the President or is the board to be free-standing and accountable primarily to Congress?

Will the states be responsible for enforcing budgets within the states (subject to board monitoring), as requested by NGA on 9/23/93, or will the board have both monitoring and enforcement responsibilities?

Will the benefits package be defined in law or by the board, through regulatory rulemaking? Will the benefit package be exhaustively described or

merely sketched out, deferring details to States? Will the Board adjudicate disputes between individuals and plans regarding the benefit package or will such disputes be handled in Federal district courts?

Will data and quality management systems be operated by states and monitored by the board or operated by the board? What will the adjudicatory responsibilities of the board be?

What will be the extent of the board's actions to oversee state plan implementation? How much flexibility will be left to states and how much will this monitoring role resemble the current Medicaid waiver process?

Indicate which portion of each of the functions described above are to be carried out by Federal employees of the board and which may be contracted out.

Priority Code: 2

Questions for Pricing 9/7/93 HCR Package: Public Health

Contacts for Public Health Q's -- Bill Dorotinsky (x 4926; h-301-916-1227)
Richard Turman (x4926; h-301-270-0895)

Part One: Basic Questions on Scope & Parameters

In order to evaluate the PHS funding proposals, we need the following for each proposal or initiative.

(I) Proposed Increases. Exactly what are these funds for? Specific programs? What will these funds buy (number of vaccines, trips to the doctor,etc.)? What are the assumptions for these estimates?

Do these duplicate items funded through the benefit package?

What is the amount of the proposed increase above current appropriation levels? What is the amount of funding in the current 'base' reallocated to each initiative?

How much of the increases and reallocations are for administrative costs versus services? What are the bases for these assumptions? How many more Federal staff will be required for these proposals?

How much money will flow to these activities from alliances, plans, and insurance? (Include basic payment rates, as well as any special incentives to rural/underserved/primary care providers, etc.)

Does initiative funding increase over time? How was the timing of increases determined?

(II) What are the secondary and interactive effects of these proposals? For example, assuming a simple linear relationship between NIH funding and new discoveries, what is the effect of increasing NIH funding on the cost of the health system for new procedures produced? What will happen to the cost of research when we suddenly increase demand significantly (researcher salary, etc.)? If academic health centers receive special subsidies, special grants,

and indirect cost funding through NIH, how many times are we funding the same things? What effect does this have on the cost of research? The type of health innovations produced? What effect do these have when adopted into the health system? Does this excessively favor high-tech medicine?

Or, if we have PHS health professions programs in addition to DME/IME and other provider incentives, what happens to the absolute number of health professionals as well as their distribution by specialty? What happens of we have too many doctors (in Canada, it increases total cost, as each doctor produces roughly the same volume; in Germany, with global budgets, increased number of doctors means lower average physician salary, so physician' associations tightly regulate medical school entry)? How many types of supply-management do we really need?

Or, States are required to establish service requirements for health plans related to the level of service and geographic distribution of service to ensure adequate choice and in low-income and underserved areas. Plans will spend funds to provide access, or face penalties. This is a regulatory approach. What effect, then, do all the PHS 'access' and 'enabling' services have on utilization? Will it increase utilization beyond medically-necessary limits? Is it necessary? (This applies to mental health & substance abuse, as well as general medical care.) And where does personal responsibility come into the equation? How broad is "enabling service" (e.g. public health police)?

(III) Proposed Off-sets. What are the assumptions underlying the proposed off-sets? How were they calculated? How were individual programs categorized between service and non-service aspects? On what basis was this done?

What are the administrative expenses associated with these off-sets? Are administrative costs included in the off-sets? How many FTEs are associated with the off-sets?

Do off-sets increase over time? How was the timing of off-sets determined?

For all facts and figures used in calculations or estimates, please cite the source. Please provide copies of internal studies or documents used to support the proposals or assumptions (e.g. MDS study referenced in HRSA off-set background material).

Part Two -- Questions about Specific Sections of Proposal

"Prevention" Research -- What is the basis for the $1.5 billion (58%) increase in biomedical and behavioral research labeled "prevention"-related. How many more multi-year research projects would be funded? How much out-year funds would commencing so many projects commit? Is there sufficient capacity in the health research system to make such an expansion without requiring massive new capital spending by Federal and university laboratories? What specific connections do these increases have with the implementation of Reform during FY96-2000, since the results of such research funding would not be available until well into the 21st Century?

Health Services Research -- How much of this increase would be spent on each of the categories listed on pp. 138-9 of the draft plan, and what would be accomplished with each allocation? How soon would the results of the consumer choice and decision-making research be available, if funds are appropriated in FY96 and initiated in FY96-7?

Workforce -- Please provide estimate details, including numerical outputs desired and how $204 million would be used to achieve the outputs.

Access

NHSC -- how would the $75 million increase for NHSC be split between state loan repayment, Federal loan repayment, and Federal scholarships? How many more doctors and other health professionals would this bring into the field over a 20-year period, starting in FY96? How much of an increase in field staff support spending would be required in FY2000-2010 to support the increased numbers of scholarships &loan repayment agreements awarded in FY96-2000? What is the cost of maintaining NHSC field staff on a per person basis?

Capacity -- How many additional low-income Americans currently uninsured would these funds help? How many low-income Americans would this funding help connect up to health plans so that they no longer need assistance through publicly-subsidized clinics? How many health plans would this funding encourage to serve rural and other uninsured Americans? How many provider networks would be established? If the design assumes continued maintenance funding as opposed to short-term capacity expansion linked to the implementation of Reform, please describe and explain. Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario?

School-based Expansion -- How many schools with high proportions of low-income Americans would this funding assist? How many students would be served? How much of clinic funding would be captured from health plan payments for covered services provided through these clinics? What is the start-up costs of opening a clinic? What are the annual costs of maintaining a clinic? What portion of each of these costs would the Federal assistance provide in the first, second, third, etc. years?

Formula grants -- what services would the formula grant support, and how would they differ from the capacity expansion grants? Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario? How many low-income Americans would be connected to health plans each year through these grants?

Indian Health

> The package states that *tribal* employers are exempt from the national employer mandate. However, the term "tribal" is not defined. Can any employer become a tribal employer by moving to a reservation? Why should tribal employers be treated differently from any other employers?
>
> What mechanism to control costs exist for IHS, since IHS is outside the Health Alliance structure?

Mental health/substance abuse -- what will the additional funds pay for (e.g. short term treatment vs. long-term treatment; residential vs. outpatient; heave users vs. casual users; inside or outside of the criminal justice system, etc.).

If the policy is to provide high-quality, cost-effective drug abuse treatment, will the parameters described meet that objective? Most of the studies on the effectiveness of drug abuse treatment indicate that time in treatment is the most significant indicator of success (as measured by reduced drug use and criminality and increased employment). The substance abuse treatment benefit is capped at 60 days initially, expands by 1998 to 90 days, and by the year 2000 the day limits appear to drop off entirely. The benefit structure appears to provide incentives for 30-day programs, far less than 12-24 months in treatment recommended for heavy users. Moreover, thirty days in a hospital setting can cost than one year in a community-based residential program.

What is the rationale and/or underlying assumptions for placing a day-limit -

-as opposed to a dollar-limit -- on residential substance abuse treatment, given that the community-based programs which tend to provide more days of care cost substantially less than the hospital-based programs that tend to provide fewer days of care? If two of the principles of HCR are **cost-containment** and **quality**, why design a benefit that may encourage higher costs (hospital rates versus alternative settings) and lower quality care (fewer versus more days in treatment)?

"Core" Public Health functions

- **Health-related data collection, surveillance, and outcomes monitoring:**

  1) How will funds for these activities be allocated, and who is eligible to receive these funds?

  2) Will these funds support Federal data efforts or will States, Alliances, providers, and insurers also receive funds?

  3) What exactly will these funds purchase: What kind of data processing hardware would be purchased (computers, printers, network support, dedicated phone lines), and exactly how many of each type of unit would be purchased? What kind of software would be purchased to operate the envisioned hardware?

  4) How many and what type of personnel would be hired to support these activities (i.e., computer programmers and operators, epidemiologist, statisticians)?

- For each of the four categories of listed below, please answer questions 1-4:
  Protection of environment, housing, food, and water
  Investigation and control of diseases and injuries
  Public information and education
  Accountability and quality assurance

  1) How will funds for these activities be allocated, and who is eligible to receive these funds?

  2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

  3) How many and what type of personnel would be hired to support these activities?

4) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Laboratory services**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many laboratories would be supported and which specific laboratory services would be financed?

4) What is the estimated volume of each laboratory service.

5) How many and what type of personnel would be hired to support these activities?

6) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Training and education**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many of each type of health professional would be trained?

4) Would professionals trained using these funds then be hired and supported using Federal funds?

"Priority" Public Health

- Immunization

1) How many and what type of personnel would be hired to support these

activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

3) Will these funds be used to purchase vaccine, and if so how many doses of each specific vaccine would be purchased?

- For the four categories of funding listed below, please answer two questions:
  HIV/AIDS
  Tuberculosis
  Chronic and Environmentally Related Diseases
  Health-related Behavior and Other Priority Issues

1) How many and what type of personnel would support these activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

PRIORITY 2

9/23/94

National Health Reform
Cost Questions - Veterans Affairs

1. What should be the scope of the VA scoring effort (i.e., should it reflect only reform's impact on VA appropriations or should it include estimates of Federal and non-Federal receipts that VA will receive)?

2. Will VA plans be subject to premium/price restraints that may be applied to private insurance plans?

3. What are estimated maximum allowable national average annual percentage increase is premiums/prices for 1995 through 2000?

4. Please provide the following national average cost data for plans covering individuals as currently assumed in the health care package for 1995 through 2000 (In each case we are requesting dollar amounts, not percentages.)
   a. annual average premium,
   b. annual average employer contribution,
   c. annual average employee contribution, and
   d. annual average employee deductibles/co-payments.

5. What is the current poverty level for:
   a. an individual, and
   b. a family of four?

6. What are the anticipated national average health alliance subsidies for an individual and a family of four for 1995 through 2000 at the following annual income levels:
   a. 25% of poverty level,
   b. 50% of poverty level,
   c. 75% of poverty level,
   d. 100% of poverty level,
   e. 125% of poverty level, and
   f. 150% of poverty level?

7. What is the projected national average health alliance subsidy for 1995 through 2000 for:
   a. an unemployed individual, and
   b. an unemployed family of four?

8. What are the projected national average Medicare part A and B reimbursements for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
   a. office visits (i.e., outpatient care), and
   b. hospital care.

9. What are the projected national average Medicare beneficiary copayments for parts A and B for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
   a. office visits (i.e., outpatient care), and
   b. hospital care.

10. What is the anticipated timeline for implementing national health reform in the VA, DOD, PHS and other public health organizations?

11. With regard to the VA revolving fund that would be established with national health reform:
   a. What would these loans fund (e.g., new facilities, expand current facilities, hire additional staff, high-tech equipment)?
   b. Will there be a limitation on the dollar amount an individual hospital can borrow from the fund?
   c. What will be the repayment conditions for hospitals that borrow from the fund?
   d. What happens if a hospital is incapable of repaying the loan it receives from the fund?
   e. Who will manage the revolving fund?
   f. The fund is for the "start-up costs of VA health plans". The fund would continue "without fiscal year limitation". Does "without fiscal year limitation" apply to new loans made, or does it refer to the loan repayment schedule? If it refers to new loans made, why would start-up requirements continue for more than 5 years?

If there are any questions concerning the information requested please contact Todd Grams or Alex Keenan at 395-4500.

PRIORITY 2

September 24, 1993

SUBJECT: Federal Employees Health Benefits Program: Costing Assumptions

1. Medigap: Addressing Medigap the policy reads: "annuitants with Medicare obtain coverage through an OPM-administered Medigap plan." Will OPM develop and price the Medigap plan or are there central estimates to use in pricing the cost to the Government of Medigap for Federal retirees?

2. Early Retirees: Please clarify the policy for Federal early retirees?

3. Annuitants: Addressing coverage of annuitants with or without Medicare, the policy reads: "In both cases, OPM pays a premium contribution sufficient to prevent an increase in annuitants' costs over current fees."

   a) Is the policy that the annuitants' share of the premium contribution or the dollar amount of the premium contribution remains constant?.

   b) If the answer is dollar amount, do we use nominal or constant dollars, and how long would that deal remain in effect?

4. Civilian Downsizing: Should our estimates assume a 252,000 reduction in Federal civilian personnel as called for in the President's Executive Order of September 11, 1993 (while a majority would fall into the retiree/early retiree categories, a portion would be employees who simply leave Government service)?

5. Option to continue coverage: Currently, under certain circumstances employees that would otherwise lose FEHB coverage (including employees that separate from Government service) may elect temporary continuation of coverage at 102% of premium price. Under reform, will Federal employees retain this option or will they be required to move immediately to the alliances?

6. Transition: Are assumptions available about the expected time frame for phasing-in the states?

Christine Lidbury
OMB: 395-4641 (desk)
395-5017 (secretary)
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PRIORITY 2

o DoD indicates that it has final approval to receive Medicare payments for care provided by DoD to Medicare eligibles. If true, will:

-- the reimbursement be on a fee-for-service basis or only on a capitated basis?

-- DoD have to comply with Medicare rules and regulations including beneficiary co-payments, beneficiary premium payments (for Part B services), and cost-accounting standards?

o Is it the President's intention to sustain benefits significantly higher than the national benefit (and unrelated to DoD's readiness requirements) for new DoD beneficiaries or is the national benefit sufficiently generous for post national reform entrants into the DoD work force?

o DoD will be providing medical services and paying for the care of active duty military personnel. In the case where there is a working spouse of a military member:

- What will be DoD's payment responsibility when the spouse (or the spouse and dependents) choose a non-military health plan?

- What will the private employers responsibility for payment to DoD when the spouse (and family) choose a DoD plan?

o If the DoD health plan functions as a corporate alliance, will DoD have to pay the 1% surcharge to regional health alliances that has been discussed?

o Will DoD have to pay for care for a period of time after personnel separate from the military? If so, what will have to be paid for how long?

o What exactly does the proposed health care legislation authorize?

o Will DoD be treated as any other employer with respect to retirees over age 55 (i.e. will DoD be relieved of the obligation to pay for health care for non-working retirees over age 55)?

J. Fish Ext. 3776

September 20, 1993

Questions on Pricing for Medicare Payment to DoD and VA

We believe that the issue of Medicare payment to DoD and VA facilities warrants further attention. We have raised some of the questions involved below, albeit in a somewhat disorganized fashion. Additional questions and comments will follow.

- Will DoD and VA health plans be required to meet the same standards as other Medicare providers, e.g., cost reporting, JCAHO standards, peer review, mortality and morbidity data collection, etc.? **(3)**

- What does it mean to say that Medicare will only pay for services to higher-income veterans eligible for Medicare? Medicare does not currently income-relate any part of the program and the rationale for implementing this policy on this particular population is unclear. **(1, 2)**

- How will Medicare payment to DoD and VA facilities be calculated and adjusted? VA and DoD pay on a national scale, whereas other facilities will naturally reflect geographic wage differences. **(1, 2)**

- How much care do DoD and VA currently provide beneficiaries who are also eligible for Medicare? What are the five-year outlay projections, broken down by veterans and military retirees? **(1, 2)**

- If a Medicare-eligible individual does not enroll in DoD/VA health plans, but receives care at a VA facility (for a service-connected injury) or at a DoD facility (on a space available basis), is Medicare liable for payment? **(1, 2)**

- What, if any, are the assumptions about adjustments in DoD and VA appropriations to reflect Medicare payments? How will DoD and VA appropriations be adjusted if Medicare is to make payments for such care? **(1, 2)**

- What are the assumptions about beneficiary cost-sharing in these settings? What are the corresponding assumptions concerning utilization? Will DoD and/or VA be required to offer high or low cost-sharing plans? What are the assumptions on subsidies for cost-sharing? **(1, 2, 3)**

  - Will DoD and/or VA be allowed to offer supplemental, "wrap-around" coverage of cost-sharing liabilities? High cost-sharing plans are required to offer wrap-around policies. **(1, 2, 3)**

  - What are the assumptions about DoD and/or VA acting as secondary payors to Medicare? **(1, 2, 3)**

  - How will Medigap and other possible third-parties be treated for cost-

sharing coverage? **(1, 2)**

-- Is Medicaid the payor of last resort for any veterans or their family members? **(1, 2, 3)**

- What benefit packages will these dually-eligible individuals receive? Will the DoD and VA plans be required to offer the standard benefit package? Or will the Medicare benefit package be required to be offered those individuals otherwise eligible for Medicare? **(1, 2, 3)**

- Will Medicare Secondary Payor rules also apply to VA and DoD? Will DoD and VA be required to collect from other parties under TPL guidelines, as well as Medigap and retiree health policies? **(1, 2, 3)**

TO: DK
FM: Bill C.
cc: BC

LN Keystuff for Medicaid et al. D.K.

9-24-93

QUESTIONS REGARDING INSTITUTIONALIZED POPULATIONS

We will need to establish baseline estimates on persons and per capita costs pertaining to any flows between non-institutionalized and institutionalized populations, with focus on the following issues:

1. We assume no first order shifts between Medicaid and institutional populations. However, we need clarification as to:

- o whether some/all of the voluntarily institutionalized will get 60 days psychiatric care,

- o whether this would apply only to those newly entering institutions, (again voluntarily).

2. While some involuntarily institutionalized populations have been specifically ruled out of any added coverage costs (eg., prison populations), other populations may need to be dealt with more specifically, e.g.:

- o the reform school population,
- o the involuntarily institutionalized in mental institutions.

Schedule

Friday, 9/24	--	OMB delivers list of policy, economic, and technical questions. OMB receives final premium and subsidy estimates from the modellers.
Monday, 9/27	--	OMB receives policy clarifications and economic and technical assumption decisions.
Tuesday, 10/12	--	OMB delivers estimates of health reform plan's effects on outlays and the deficit. (Note: This assumes Treasury supplies new revenue estimates by 10/12.)
Thursday, 10/14	--	OMB delivers estimates of the BEA implications of health reform.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

November 3, 1993

TO: DISTRIBUTION [see below]

FROM: Nancy-Ann Min

RE: Director's Testimony before Senate Finance Committee

I have attached a draft of the joint testimony that the Director and the Deputy Director will be giving before the Senate Finance Committee tomorrow. Also attached are the charts that we propose to use. I would appreciate receiving any comments or suggestions as soon as possible, as we need to get this to Finance Committee staff by late afternoon today.

DISTRIBUTION:
Ira Magaziner
Melanne Verveer
Jack Lew
Marla Romash
David Cutler
Chris Jennings

DRAFT

TESTIMONY OF LEON E. PANETTA AND ALICE M. RIVLIN
DIRECTOR AND DEPUTY DIRECTOR,
OFFICE OF MANAGEMENT AND BUDGET
COMMITTEE ON FINANCE
UNITED STATES SENATE
NOVEMBER 4, 1993

Mr. Chairman, it is a pleasure to be here today to discuss the Clinton Administration's health care reform plan. No one needs to remind this Committee that our health care system is in crisis. While the quality of health care in the United States is the best in the world for those who can afford it, the total cost of care is unnecessarily high and rising at frighteningly rapid rates. Moreover, millions of Americans are without adequate health care coverage and millions more live in fear that they will lose their health insurance.

The challenge before the Congress is to develop a plan that preserves what is best in our current system while controlling costs and providing universal access to high quality health care. The plan presented to you by the President and the First Lady does that. It controls costs and guarantees health security: For the first time, every American will have health insurance coverage with a comprehensive package of benefits that can never be taken away.

We would like to focus first this morning on the vital part the Administration's health reform plan plays in our overall strategy to improve the future vitality of the American economy.

Then we would like to turn to the impact of the plan on the Federal budget -- what new costs would be incurred and how we propose to pay for them.

HEALTH REFORM IS AN ECONOMIC IMPERATIVE

If we are to have the productive, high wage economy that we all want, we must reform the health care system. Indeed, it may be the single most important change that is needed to make the economic future better for our children and grandchildren. The current health financing system threatens America's economic future in three ways: (1) health costs are unnecessarily high and rising too rapidly--draining resources from more productive uses to supporting an inefficiently organized health care system; (2) the rising costs of government health programs add to the Federal deficit; and (3) health care insecurity locks people into existing jobs or onto welfare rather than allowing them to move into more productive employment. These problems interact to weaken our economy as a whole, by draining resources from more productive uses and by increasing consumer anxiety about the always uncertain future. In 1992, we spent $3100 per person on health care compared with only $1700 per person on education, and $1200 per person on defense. We spend more on health care per person than on education and defense combined. Exploding health costs threaten funding for these and other public priorities.

The United States spends more of its Gross Domestic Product (GDP) on health care than any other country in the world. The numbers bear repeating: Today, 14% percent of our GDP goes for health care, and by the end of the decade, we could be spending an almost unthinkable 19% of GDP on health care. No other country spends more than 10% of its output on health care. During the last decade, our real per capita health care costs grew at a rate of 4.4% per year, while our real per capita GDP grew at only 1.6% a year. Only Canada's rate of health care cost growth, at 4.3%, was close to ours. By any measure, it must be said that our consumption is way out of proportion to our income.

And health care spending is "crowding out" other government spending and contributing to the deficit. The Federal government devotes 17% of its budget to health care right now. In FY 1993, Medicare spent an estimated $131 billion, and the Federal share of Medicaid was about $75 billion. If current projected trends continue, Medicare and Medicaid spending will rise from 14% of the Federal budget to 27% by the year 2000. This means that almost 2/3 of real Federal spending growth net of interest payments between FY 1993 and FY 1996 will be for health care.

Inflation in health care costs is robbing government budgets of scarce resources needed for critical investment in our future

-- education, job training, infrastructure, and technology development. Make no mistake about it: getting Federal health spending under control is essential to long-run deficit reduction.

Despite all this spending, 37 million Americans are uninsured, and all Americans are vulnerable to losing their insurance upon developing a serious illness or medical problem. Pre-existing condition restrictions lead to "job lock": it is estimated that 30% of workers restrict their search for better jobs for fear of losing their health insurance coverage.

WHAT TO DO -- REFORM THE MARKET

Economists have written volumes on why health costs are rising, and there are debates about how much each of the relevant factors has contributed to the cost spiral. There is no argument, however, that we need to change the incentives in the marketplace today.

There is broad consensus that the health insurance market, especially the small group insurance market, performs poorly today. The absence of universal coverage and community rating makes it more profitable to select healthy enrollees than to

organize the delivery of cost-effective health care. The current outcomes of this market are:

- Very expensive insurance for the covered -- we pay more per capita for health care than any other nation, and by quite a margin;

- All Americans feel vulnerable, for many of us are one serious illness away from being uninsured;

- No insurance at all for 37 million Americans, most of whom are working or in families with workers; and

- Higher health service prices for the insured, as we pay hidden taxes to cover the real costs of providing care to the uninsured and the underinsured.

The other market that is performing poorly today is the market for health services. The incentives for providers in traditional fee-for-service medicine and for patients with comprehensive indemnity coverage simply guarantee that too much care will be delivered in virtually every setting.

Insured patients have no incentive to learn or care about how little medical value per dollar is delivered on the margin. Fee-for-service providers have every incentive to provide low

marginal value care, because they are reimbursed for performing procedures.

Managed care providers, in most markets where fee-for-service still dominates, have strong incentives to gear their prices to those prevailing in fee-for-service plans. This generalized higher volume and intensity of services drives up prices and insurance premiums even further.

Faced with markets performing poorly because the incentives are so wrong, reformers have two basic choices:

- One option would be for the government to take over the functions of the health insurance industry. It could set the prices for providers, and draw up rules for allocating care. We rejected this alternative.

- Another option -- the one embodied in the Clinton plan -- is to restructure the incentives within our existing system to permit market forces to work better than they have up until now.

CREATING NEW INCENTIVES

Managed competition, as envisioned by the Clinton Administration, has three central elements that address the market failures we have discussed:

- It will increase price sensitivity;
- It will eliminate risk selection; and
- It will produce information designed to help consumers make informed choices about their health care.

Price sensitivity will be encouraged in two ways:

- Employees will have a choice of health plans that provide at least the the comprehensive benefit package at a variety of prices;

- Health plans will have to compete on the basis of price, forcing them to use selective contracting and other utilization review techniques to keep costs down.

Risk selection will be eliminated by the introduction of:

- A standard benefits package, to homogenize the product and make shopping among health plans easier for consumers;

- Community rating with risk adjusters to remove the incentive to select healthier enrollees; and by

- Ending pre-existing conditions restrictions, medical underwriting, and other techniques that deny many Americans coverage.

Meaningful and interpretable medical outcomes reporting at the plan level will be required in all alliances. This will provide Americans with the information they need to assess the relative quality of competing plans. In addition, it will provide insurers and providers with incentives to be efficient while satisfying their customers and patients.

These insurance market reforms will force insurers to organize cost-effective delivery networks which preserve choice for consumers while delivering medical value for the dollar. In this sense, our targets for the growth of insurance premiums should be viewed essentially as backstop devices to provide some breathing space while the various actors in the health care system learn to make managed competition work.

There is reason to think that introducing these new market incentives will lower the rate of growth of health care costs. The most effective means of cost control known to economists is

to let producers compete and consumers choose. There is evidence that when consumers have a stake in the outcome, they will choose the more efficient plan.

Other means of controlling costs may work in the short run, but are likely to be ineffective in the long run. Experience with price controls from other areas is sobering. The best chance of bringing health care costs under control is through market reforms such as the President has proposed.

ECONOMIC ADVANTAGES OF HEALTH SECURITY

Universal health insurance coverage will have economic advantages beyond providing a needed benefit to the uninsured. No longer will Americans have to be afraid to change jobs because they risk losing their health insurance. By ending "job lock", health security will increase economic flexibility and improve productivity.

No longer will Americans have to be afraid to leave welfare because they would lose Medicaid benefits. A welfare mom who gets a job will not have to turn it down to protect her children from uninsured illness. The end to "welfare lock" will also promote the health of our economy.

By basing universal coverage on the current system of employer funded health insurance, the President's plan minimizes disruption. Premium discounts funded by Government will ease the burden on small employers and low-wage workers.

Uncompensated care will not be a burden on responsible citizens and health care providers. Preventive care will help to improve the lives and productivity of Americans.

HEALTH REFORM AND THE FEDERAL BUDGET

The President's Economic Plan, which the Congress approved in August, will bring about a significant reduction in the Federal budget deficit -- $500 billion over the period from FY 1994 to FY 1998. But we have not conquered our deficit problem. Health reform is absolutely essential to further deficit reduction. [Chart 1]

The President's health reform plan will begin to get Federal health expenditures under control. It will take time. The bulk of the savings in the President's plan occur around the end of 1997, once the alliances are fully up and running.

In the interim some Federal expenditures will rise. After all, extending coverage to the uninsured will have some cost, as

will the new drug benefits for Medicare recipients and the public health access initiatives we propose. The President's plan offers a responsible means of financing the new health benefits it provides.

FINANCING HEALTH REFORM

Now I would like to turn to the specific effects of health reform on the Federal budget: what we propose to spend on the new system, and how we propose to finance it. [Chart 2]. Let me make clear at the outset that xx% of total health insurance spending comes from the same place it comes from now: the private sector -- businesses and households paying insurance premiums. The President's Health Security Act builds upon existing employer-sponsored insurance arrangements to create a new foundation of coverage for all Americans.

The Health Security Act proposes new Federal outlays in the following areas:

- <u>Expanded public health service activities and administrative costs of the new system</u> -- $30 billion. Approximately $18 billion of these funds will be devoted to new public health programs to ensure that underserved populations have access to the new system,

and to enhance funding for the WIC program, which provides nutrition services to impoverished children. We estimate that $9.6 billion will be needed for Federal administrative costs of the new system, including activities such as development of data systems, monitoring quality, and issuing health security cards. In addition, we will increase support to academic health centers to support medical education and training by $3.2 billion.

- Long-term Care -- $65 billion.
  There are three major components of our long-term care initiative: (1) a new home and community-based service program for the disabled; (2) liberalized spend-down rules for the Medicaid-eligible institutionalized; and (3) tax incentives for the purchase of long-term care insurance.

- Medicare drug benefit -- $66 billion.
  As you know, many elderly Americans are constantly worried about paying for necessary prescription drugs, prescriptions that can improve the quality of their lives, prevent more serious illnesses and help avoid hospitalization. Our plan introduces a prescription drug benefit with cost sharing identical to that in the standard benefit package for all Americans under

65: $250 deductible and 20% coinsurance with a $1000 limit on out-of-pocket spending for the year. This means that our elders will no longer have to worry about foregoing necessary prescriptions in order to buy food or pay the rent.

- 100% Tax Deduction for Self-Employed Health Insurance -- $9.7 billion.

  Historically, self-employed individuals have been penalized by being able to deduct only 25% of insurance premiums, while their counterparts in business and industry have been able to deduct the full amount. Our proposal will "level the playing field," and extend full deductibility to the self-employed for the first time when the plan is fully phased-in. This has been an issue with bi-partisan support for some time now; we must finally pass and implement this change. Until the full phase-in, the self-employed will be able to maintain the current 25% deduction for premiums. The total cost of this benefit is $9.7 billion over five years.

- New subsidies or Federally sponsored price discounts within the Alliances -- $116 billion [Chart 3].

To enable all Americans to take responsibility for their health insurance, we offer premium discounts to the following households:

- those with family income less than 150% of poverty;
- those with unearned income less than 250% of poverty if they don't have a full time worker;
- those with early retirees;
- those with relatively low income self-employed individuals.

Households and retirees receive $195 billion in discounts during 1995-2000.

To share the cost of insuring workers equitably across different firms, we offer the following firm level guarantees:

- no firm will pay more than 7.9% of payroll, and many will pay less;

- firms with fewer than 75 employees with low average wages will pay less than 7.9% of payroll, in fact as little as 3.5%, depending on their exact size and average wage.

Total employer subsidies equal $100 billion over the six year period.

Finally, we provide out-of-pocket discounts for individuals who earn less than 150% of poverty and do not have access to HMOs.

These out-of-pocket subsidies are estimated to total $9 billion dollars between 1995 and 2000.

In addition, we added 15% (about $44 billion) to the consensus point estimate of the subsidy cost, to cover potential behavioral changes that are difficult to model. Simulations of those potential behavioral changes suggest that our cushion is more than adequate to cover those extra subsidy costs.

- The total estimated cost of the discounts for people served by the Alliances is then $349 billion over 1995-2000.

- These Federal discounts will be offset by $75 billion in States' maintenance-of-effort payments that can be paid for out of their Medicaid savings.

- The remainder -- $274 billion -- is the net Federal contribution. This is the amount that is capped in the legislation.

- I want to emphasize that this capped entitlement for the discounts is not a net addition to the deficit. The net cost of the discounts to the Federal Government is estimated to be $161 billion. There are significant reductions in Medicare and Medicaid because of health reform beyond those savings already identified above. Private insurance will be available to working Medicare enrollees and to former Medicaid recipients who are not participants in the SSI or AFDC programs. The reduced Federal expenditures as these individuals gain private insurance is estimated to be $113 billion.

Sources of funds:

We propose to pay for these new Federal outlays in the following ways [Chart 2]:

- Reductions in the rate of growth in the Medicare program -- $123.4 billion.

  Medicare has been growing at a rate of almost 11% per year. We believe that once all Americans have health coverage, and we are controlling the rate of growth of premiums, we can begin to slow the growth in the Medicare program. We have identified a set of approximately 25 policy changes that will achieve $123.4 billion in savings. These policy changes include "reconciliation-type" reductions that affect the payment rates to providers, as well as new proposals to control utilization of certain aspects of the Medicare program. We have also included a proposal to income-relate the Part B premium for high-income Medicare beneficiaries -- singles with income of $100,000+ and couples with incomes of $125,000+. [Chart 4] As you can see, what sound like enormous savings from the Medicare program are in reality just small slices from enormous baseline growth. By FY 2000 the rate of growth in the Medicare program will have slowed from its current annual rate of 11% per year to around 8.4% even while adding new coverage for prescription drugs.

- Medicaid savings -- $65.3 billion.

  The Medicaid savings counted here result from two sources. The Health Security Act will provide all Americans with health coverage and, therefore, it will nearly eliminate hospital uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat low-income populations, including undocumented persons. In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because Medicaid recipients will be getting their care delivered through increasingly efficient alliance health plans. [Chart 5]

- Tobacco tax and corporate assessment -- $89 billion.

  These revenues will come from a combination of the increased tobacco tax, which the Treasury Department estimates will raise $65 billion in revenues, and a 17% of payroll assessment on the large corporations that will benefit from reduced cost-shifting, and thus lower health care costs, in the new system. Treasury estimates that this assessment will raise $24 billion.

- Federal Program Savings -- $39.6 billion. [Chart 2]

As the Federal health programs -- VA, DoD, FEHB, and Public Health Service -- are integrated into the reformed health system, we expect there will be savings from lower expected premiums and new revenues. For example, the VA and DOD health programs will receive new revenue from allowing them to receive Medicare reimbursement for Medicare-eligible recipients who choose to receive their care in VA or DOD facilities. I should emphasize that these savings estimates are not from reductions in services provided; in fact, we believe that the services provided to these beneficiaries will be improved.

- Other Revenue Effects -- $68 billion. Health reform will raise taxable incomes and thereby lead to new sources of tax revenue. Changes in the tax treatment of health insurance will also lead to increased revenue, as Secretary Bentsen explained on Wednesday. Finally, modest savings in debt service, about $4 billion, will be realized as the deficit is reduced.

How the Numbers Were Derived

There are three broad types of estimates underlying the summary budget data:

- Estimates of net effects on existing programs or additions to existing programs;

- Estimates of new revenues and/or effects on existing revenue streams;

- Estimates of subsidies, or premium and out of pocket discounts.

Standard OMB methods were used to determine the first type of estimates: OMB budget examiners worked in conjunction with HCFA and SSA actuaries as well as agency program personnel, to "scrub" the estimates and account for all interactive effects among programs.

The Treasury Department estimated all revenue effects and the tax-related provisions of the Medicare savings package, as they would for any other Administration proposal.

A unique interagency process produced the subsidy estimates. Economists and actuaries from many different departments and agencies including the Health Care Financing Administration, the Agency for Health Care Policy and Research, the Departments of Treasury and Labor as well as OMB and the Council of Economic Advisors worked to develop a consensus on analytical methods. Experts from private think tanks and consulting firms were also

involved. A team of private actuaries and health economists was brought in to evaluate and make suggestions about our estimation methods and data sources.

Estimating a complete health care system overhaul is obviously an immensely complex task. Reasonable people can differ about some of the many assumptions that must be made. Our team tried to consistently err on the side of conservatism.

For example, as I discussed earlier when I was outlining the new Federal outlays, we added 15% to the consensus point estimate of the subsidy cost, about $44 billion, to cover potential behavioral changes that are difficult to model. Simulations of those potential behavioral changes suggested that our cushion is more than adequate to cover those extra subsidy costs.

HOW ARE THE DEFICIT SAVINGS PROTECTED?

The total new costs of the Health Security Act to the Federal government are estimated at $331 billion, and we will have $390 billion in revenues to finance these new costs. We estimate that there will be approximately $58 billion in deficit reduction. These savings are real because of the protections we have built into the program.

We rejected the notion of an open-ended entitlement program. We believe that our estimates of the Federal funds that will be needed for the subsidies are conservative and reasonable, particularly in view of the 15% cushion and the mechanism allowing excess funds to be carried forward and applied to the next year's cap. It is unlikely that the caps will ever be in danger of being breached. In the event that this were to occur, because of a severe downturn in the economy or some other massive economic dislocation, it would mean we had a problem that the President and Congress would have to act to solve. That is how it should be.

We made realistic assumptions about the speed at which states would come into the new system. We looked long and hard at the most realistic phase in of the new system, and settled on a plan that assumes that states representing 15% of the population will be in alliances by the beginning of FY 1995; another 25% (for a total of 40%) will be in alliances by the beginning of FY 1996; and the remaining 60% will be phased into the new system by no later than October 1, 1998. We believe that these assumptions are not only realistic; they give the system a reasonable amount of time to get established and to provide for some valuable learning experiences.

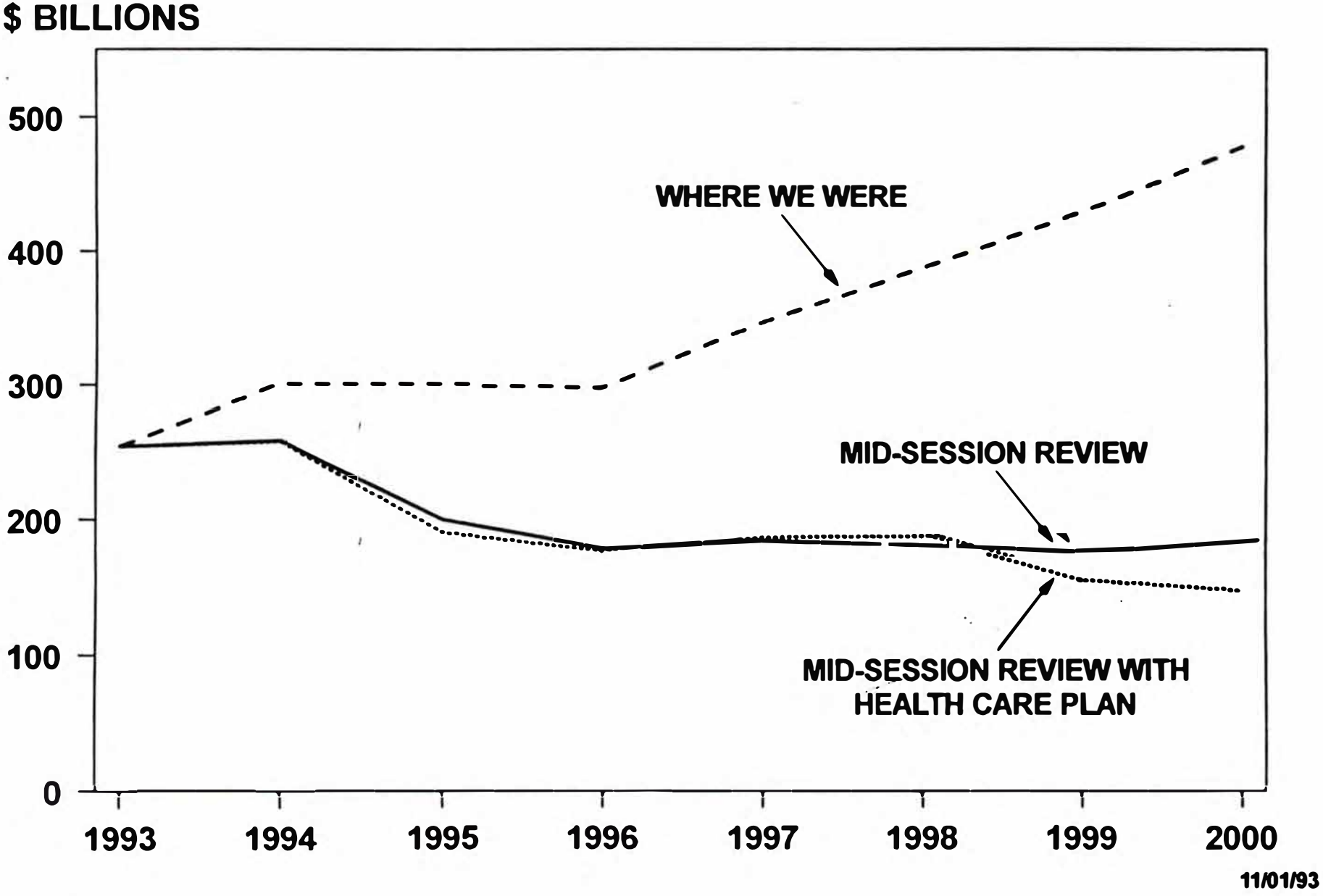
We have set targets for the rate of premium growth in the alliances. These targets are the key to projected savings. If

the caps work as we expect they will, then future savings will grow progressively, as the rising trend in health costs is broken.

THE BOTTOM LINE -- CONCLUSION

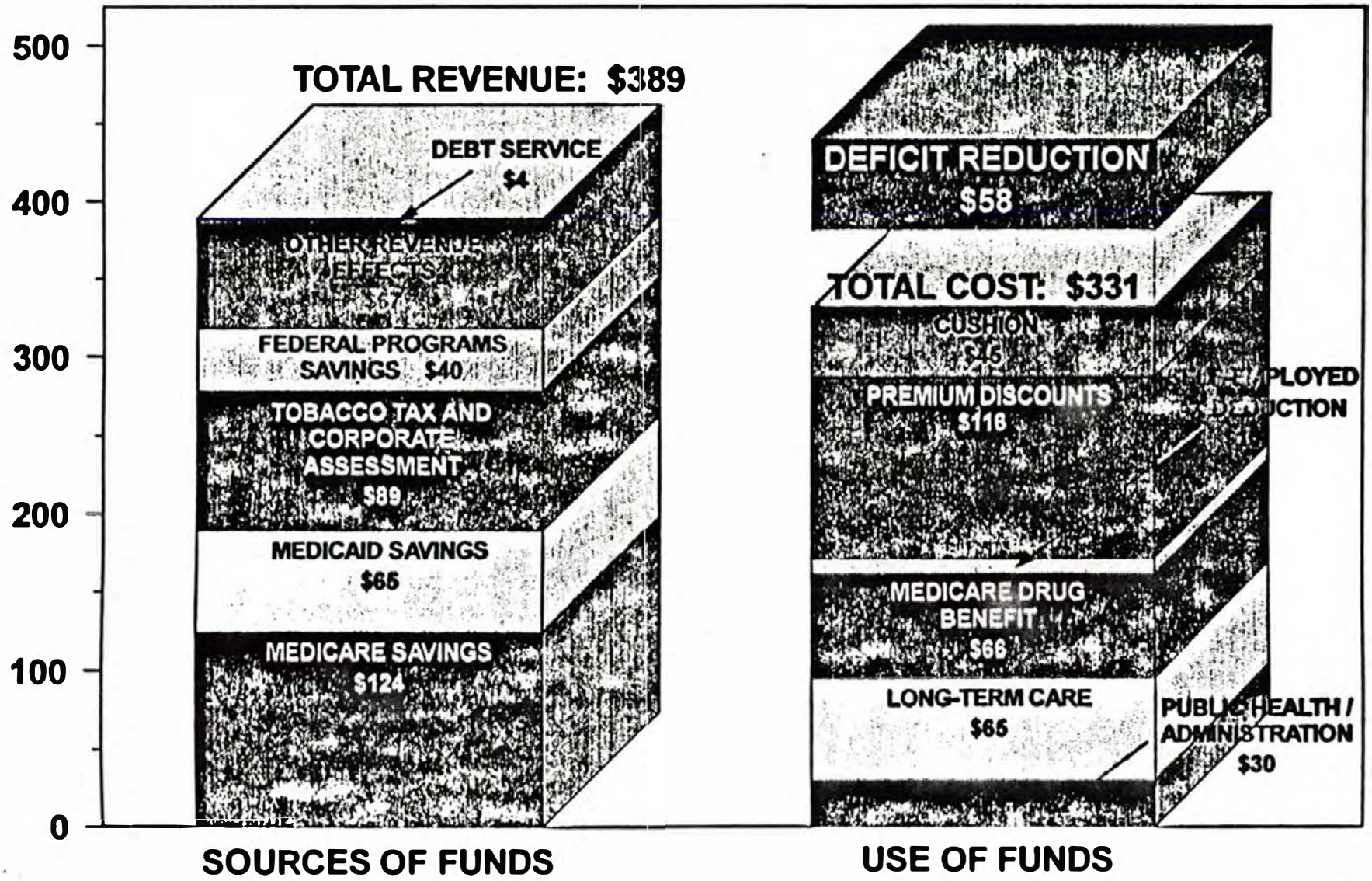
In enacting the President's economic plan, the Congress took a major step toward truly bringing the deficit under control. We have come a long way. [Chart 1] Health reform is the necessary next step in long term deficit reduction. If we fail to step up to the plate and get health care costs under control we will forfeit some of the progress we have all worked so hard to achieve.

ALTERNATIVE DEFICITS 1993 - 2000



FINANCING HEALTH CARE REFORM

TOTALS: 1995 - 2000



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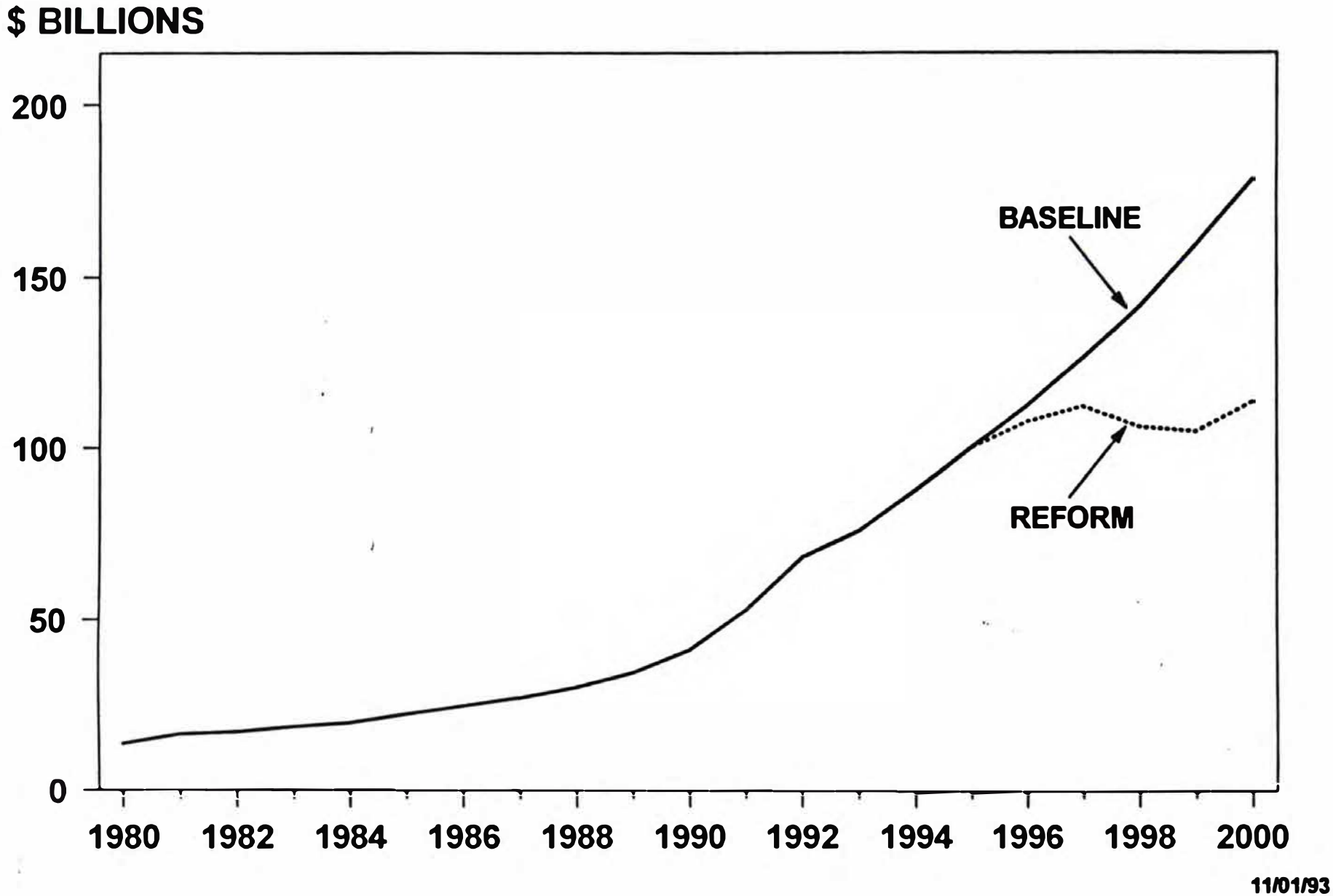
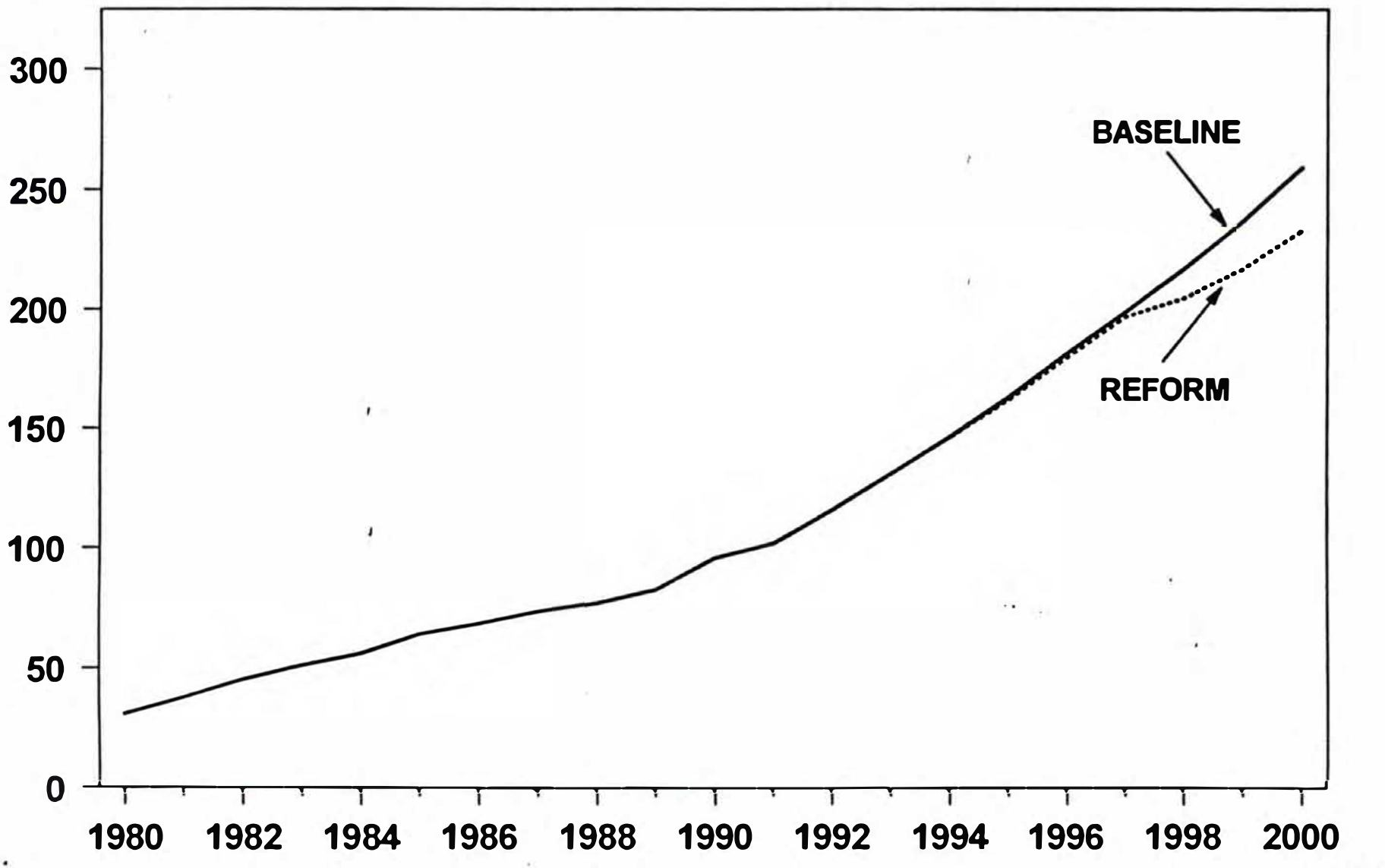
FEDERAL SPENDING FOR MEDICAID



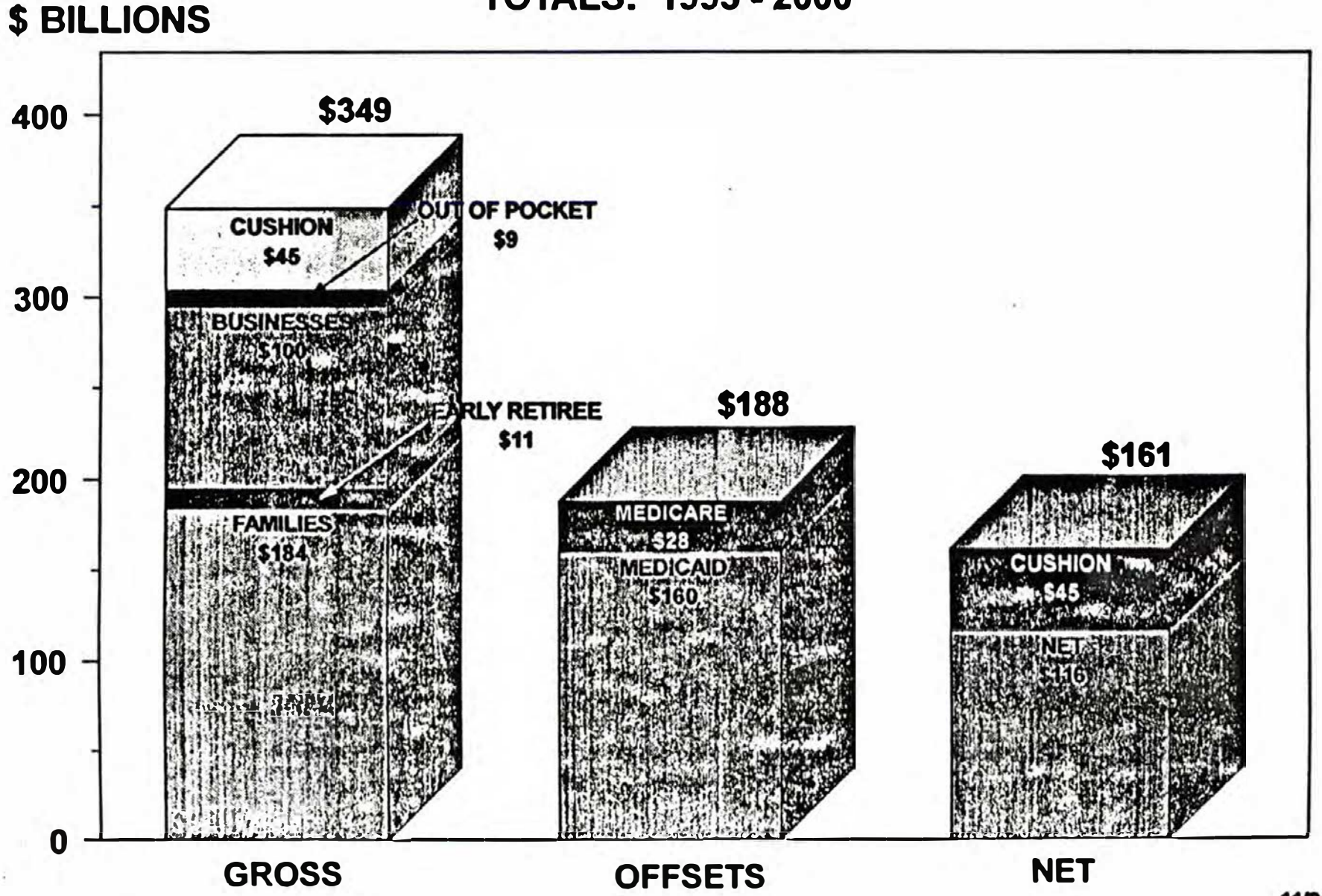
11/01/93

MEDICARE SPENDING UNDER HEALTH CARE REFORM



COST OF PREMIUM DISCOUNTS

TOTALS: 1995 - 2000



CENTER ON BUDGET
AND POLICY PRIORITIES

HOW WOULD THE STENHOLM ENTITLEMENT CAP AFFECT HEALTH CARE REFORM?

Representative Charles Stenholm has crafted a proposal that would establish annual caps on all entitlement and mandatory spending programs, including Social Security, for each fiscal year through 2000. Given the spiraling growth in health care costs, the single most important step that can be taken to control growing entitlement costs is comprehensive health care reform with stringent cost containment measures. The Stenholm entitlement cap proposal would, however, have the unfortunate consequence of making comprehensive health care reform more difficult to put in place.

Proposal Would Require Large Health Care Cuts In Next Five Years

The Stenholm proposal would set entitlement caps for the next five years at levels far below what entitlements are projected to cost under current law. Rep. Stenholm estimates that for the five years from fiscal year 1996 to fiscal year 2000, the caps would be set about $100 billion below current cost projections, an estimate that may be too conservative. As a result, at least $100 billion in entitlement cuts would be required. Virtually all of the $100 billion gap between current entitlement cost projections and the Stenholm caps stems from the fact that the proposed caps would limit entitlement expenditures to a rate of growth far below the projected rates of growth in Medicare and Medicaid. (The growth rates in Medicare and Medicaid are similar to the projected rate of growth in private sector health care costs.)

There is little question that the long-term rate of growth in health care costs needs to be slowed substantially. But the Stenholm proposal would create a profound dilemma for health care reform efforts to constrain long-term health care cost growth. If comprehensive health care reform legislation is enacted that is deficit-neutral over the next five years and generates significant savings after that, entitlement costs would remain far above the Stenholm caps for the coming five years. Deep entitlement cuts in the years just ahead would still be required.

Congress would not have many options for achieving entitlement reductions of that magnitude. Medicare, Medicaid and Social Security account for more than three-fifths of all entitlement spending. Large, immediate Social Security benefit cuts are highly improbable, especially since the Social Security Trust Fund will run a substantial surplus over this five-year period. To obtain the savings needed to meet the Stenholm caps, Congress would have little alternative but to seek to extract large savings from health care programs.

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Such a course of action would have one striking consequence — it would almost certainly mean that *if a health care reform package is enacted this year, it would have to be reopened soon after and redone.* Either large cuts would have to be made in Medicare and Medicaid, on top of those used to finance health care reform legislation, or basic health care reform measures to extend coverage to most or all of the uninsured would have to be abandoned or scaled back.

Either course of action would have major repercussions. Instituting cuts of this magnitude in Medicare and Medicaid, outside of the context of comprehensive health care reform and on top of the cuts used to help finance a health care reform bill, would likely mean shifting tens of billions of dollars in health care costs from the federal government to other payers, principally employers and state and local governments. That would risk damaging business growth and diminishing U.S. competitiveness, while saddling state and local governments with costly unfunded mandates that could weaken their finances. Such actions could cause particularly acute problems in states and localities with large numbers of elderly and poor people.

Abandoning or substantially scaling back the extension of coverage to many or all of the uninsured also would create unwelcome side-effects. Besides leaving many families uninsured, such an approach would weaken cost containment efforts because

Doesn't the Stenholm Proposal Adjust for Health Care Reform?

Proponents of the Stenholm plan are likely to argue their proposal does not stand in the way of health care reform and that, in fact, it contains an adjustment specifically to accommodate whatever health care reform bill Congress passes. This argument misses the mark. The Stenholm proposal does contain a provision to adjust the caps after enactment of health care reform legislation. But this is a minor provision with no significant bearing on the issues discussed here.

The Stenholm proposal includes a provision that would adjust the entitlement caps for each of the next five years up or down to reflect the amount that a deficit-neutral health care reform law is projected to increase or decrease entitlement spending in each of these years. For example, if a deficit-neutral health care reform law is projected to increase entitlement spending above current cost projections by $3 billion in fiscal year 1997, the fiscal year 1997 entitlement cap would be raised $3 billion.

While modestly useful, all this provision does is to keep the huge gap between the caps the Stenholm proposal would set and current projections of entitlement costs for the next five years from growing even larger. The provision does nothing to help close this gap. Steep cuts, which presumably would be made primarily in the health care entitlement programs, would still be needed. This means a deficit-neutral health care bill enacted this year would have to be reopened and potentially unraveled to produce tens of billions of dollars in additional health care entitlement cuts in fiscal years 1996 through 2000.

it would leave large uncompensated care costs in the health care system, with the result that substantial cost-shifting would continue.

Comprehensive health care reform that attains or comes close to attaining universal coverage and institutes tough, effective cost containment measures holds the most promise for getting spiraling government health care costs under control for the long term. But comprehensive health care reform is not likely to yield large-scale deficit reduction between now and fiscal year 2000 because substantial Medicare and Medicaid savings will be needed during this period to finance the costs of moving toward universal coverage. Once those coverage costs have been absorbed, comprehensive health care reform has the potential to lower substantially the rate of growth in both government and private sector health care expenditures, with savings rising as the years pass and ultimately reaching quite impressive levels. If reform legislation of this nature is enacted, it could yield large entitlement savings in future decades.

Medicare and Medicaid savings used to help finance comprehensive health care reform cannot, however, also be used for near-term deficit reduction. The same savings can't be used twice.

As a result, policymakers must choose. They can use such savings to help pay for comprehensive health care reform that holds promise of producing significant long-term pay-offs in reducing the deficit or they can use these savings to meet the rigid strictures of an entitlement cap in the years just ahead. Ironically, an entitlement cap such as that proposed by Representative Stenholm would have the probable effect of jeopardizing health care reforms essential to reining in deficits over the long term.

July 12, 1994