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Divider Title: Growth Rates

**HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS**

M E M O R A N D U M

TO: Nancy-Ann, Chris, and Mark
FROM: Debbie Chang
DATE: October 23, 1995
RE: Medicaid Projected Growth Rate

=====

Bruce Leslie requested the Medicaid per capita growth rates for a \$54 billion reduction and a \$62 billion reduction comparable to the 1.4% growth rate for the \$182 billion cut. The attached table shows the calculation of these percentages. We wish to have your clearance by 10:00 tomorrow so that we can answer Bruce during the morning. The answer to Bruce would be only the final percentages, not the complete table and a note explaining that these growth rates do not reflect a per capita policy. ASMB has not yet reviewed this table.

Please provide comments/clearance to Jake Jones at 690-7865.
Thank you for your cooperation.

Note to Bruce Leslie

Subject: Medicaid Per Capita Growth Rates

Per your request, a series of per capita growth rates were calculated assuming several different levels of savings off of the CBO baseline. These rates of growth do not reflect the growth rates that would result from a per capita cap or any other specific policy. These rates are simply a mathematical calculation of the resulting per capita growth rates if the indicated amount was taken off of the CBO Medicaid baseline.

Current law per capita growth rate	7.0%
Growth rate at \$182 billion reduction	1.4%
Growth rate at \$62 billion reduction	6.2%
Growth rate at \$54 billion reduction	6.3%

Impact of Reductions on Per Capita Growth
CBO March Medicaid Baseline Projections
(Federal Dollars in Billions, Fiscal Years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-02
CBO Baseline Expenditures									
Benefits	\$77	\$87	\$96	\$108	\$119	\$132	\$146	\$160	\$847
Administration	\$3	\$4	\$4	\$5	\$5	\$6	\$6	\$7	\$37
DSH	\$9	\$9	\$9	\$10	\$10	\$11	\$11	\$11	\$71
Total	\$89	\$99	\$110	\$122	\$135	\$148	\$163	\$178	\$955
Beneficiaries (in millions)	36.8	38.4	40.0	41.2	42.4	43.7	44.9	46.0	ACRG
Per Capita	\$2,422	\$2,587	\$2,752	\$2,964	\$3,179	\$3,391	\$3,625	\$3,871	
Annual growth	***	6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%	7.0%

Requested Reduction Options

\$182 billion Reduction

baseline savings	\$96 (\$4)	\$102 (\$8)	\$106 (\$16)	\$110 (\$24)	\$115 (\$33)	\$119 (\$43)	\$124 (\$54)	\$773 (\$182)
Per capita spending annual growth	\$2,492 2.9%	\$2,555 2.5%	\$2,579 0.9%	\$2,605 1.0%	\$2,630 1.0%	\$2,664 1.3%	\$2,706 1.6%	ACRG 1.4%

\$54 billion Reduction

baseline savings	\$95 (\$4)	\$105 (\$5)	\$116 (\$6)	\$128 (\$7)	\$140 (\$8)	\$152 (\$11)	\$164 (\$13)	\$901 (\$54)
Per capita spending annual growth	\$2,480 2.4%	\$2,635 6.3%	\$2,824 7.2%	\$3,022 7.0%	\$3,198 5.8%	\$3,387 5.9%	\$3,579 5.7%	ACRG 6.3%

\$62 billion reduction

baseline savings	\$95 (\$5)	\$105 (\$5)	\$115 (\$7)	\$127 (\$8)	\$138 (\$10)	\$150 (\$12)	\$162 (\$15)	\$893 (\$62)
Per capita spending annual growth	\$2,463 1.7%	\$2,617 6.2%	\$2,803 7.1%	\$2,998 7.0%	\$3,169 5.7%	\$3,352 5.8%	\$3,535 5.5%	ACRG 6.2%

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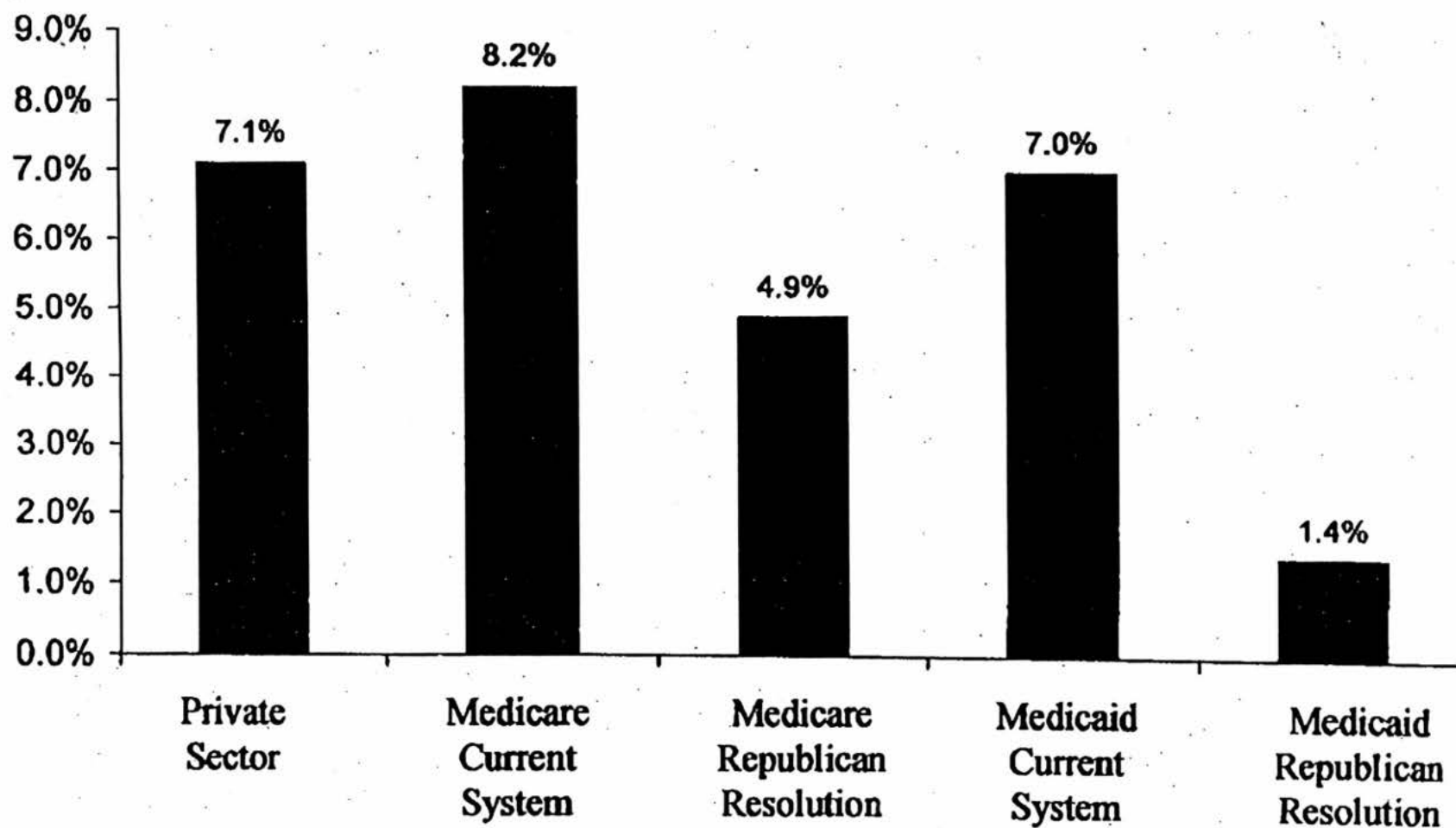
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Per Capita (Growth Rates)

Private Sector, Medicare, and Medicaid, FY 1996-2002



Administration estimates using CBO Baseline

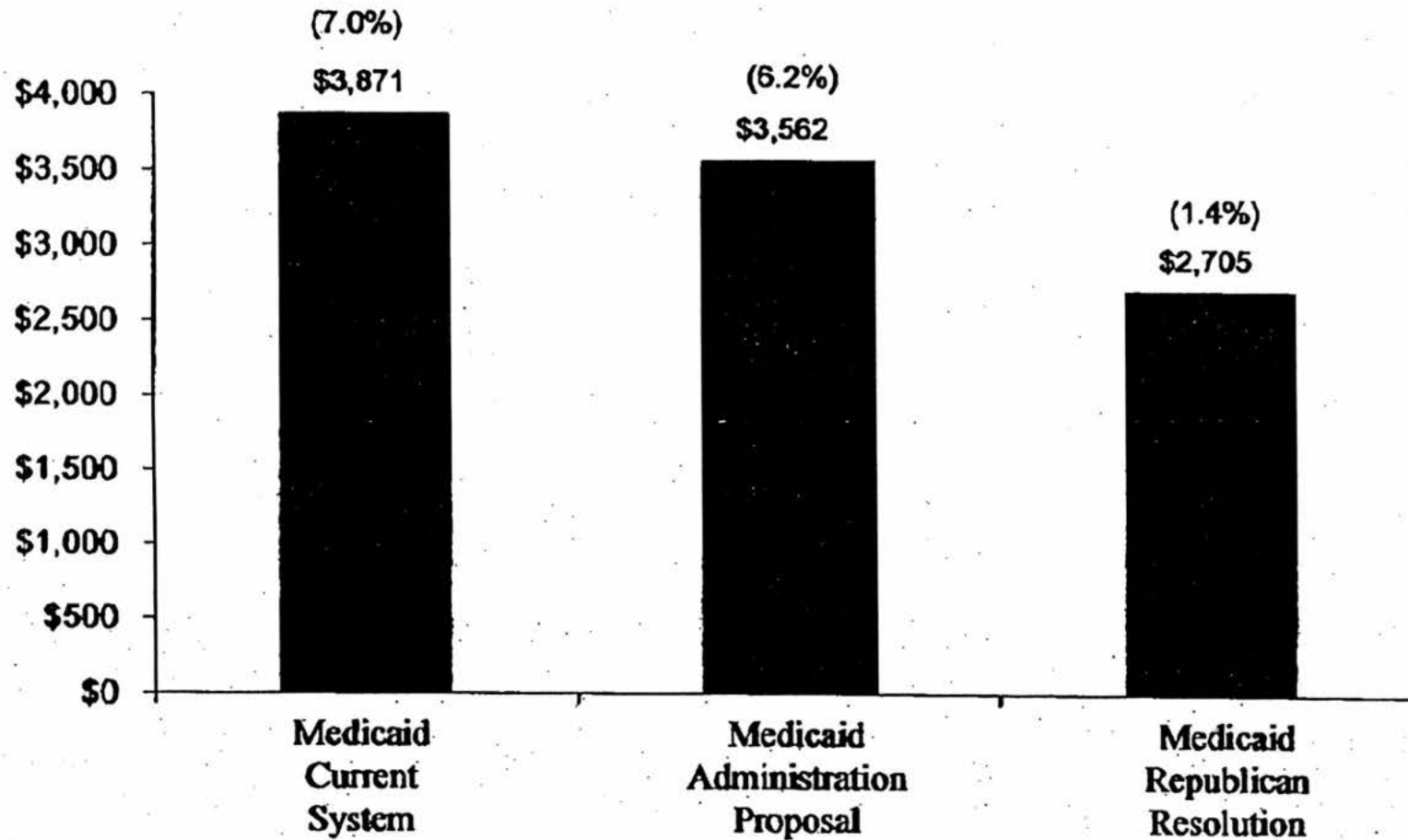
1-Sept-95

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Medicaid Spending Per Beneficiary

Current System, Administration, and Republican Proposals, FY 2002
Per Capita Growth Rates, FY 1996-2002, Provided in Parentheses

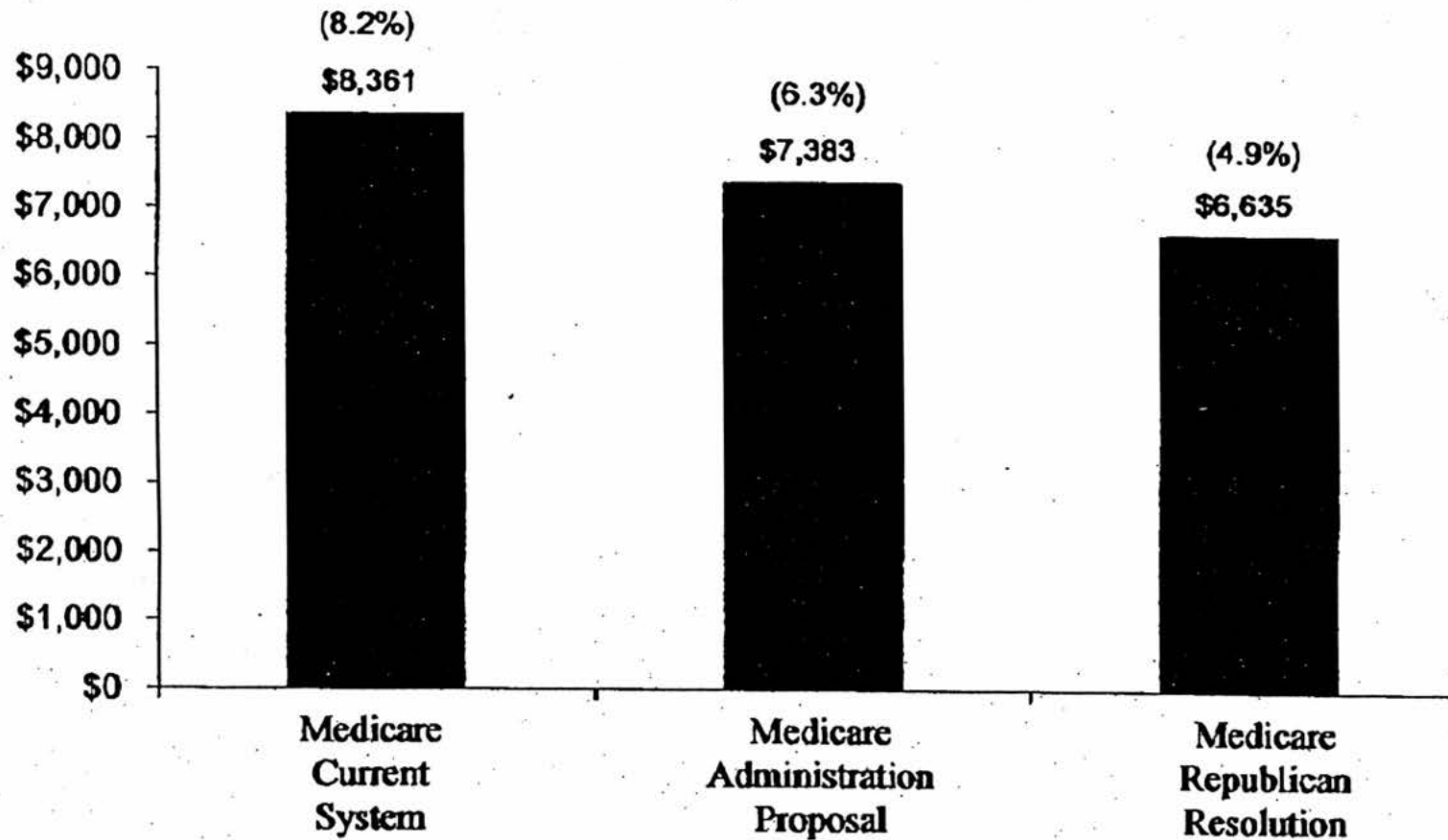


Administration estimates using CBO Baseline

14-Sept-93

Medicare Spending Per Beneficiary

Current System, Administration, and Republican Proposals, FY 2002
Per Capita Growth Rates, FY 1996-2002, Provided in Parentheses



Administration estimates using CBO Baseline

14-Sept-95

MEDICAID PROPOSALS: GROWTH RATES
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICAID BASELINE										
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8	614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%	10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9	3.3%	3.0%
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%		
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871	7.0%	7.0%
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%		
Administration Medicaid Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Spending	89.2	95.2	105.8	115.7	127.2	138.3	150.6	163.6	582.2	896.4
		6.7%	11.1%	9.4%	9.9%	8.7%	8.9%	8.6%	9.8%	9.5%
Spending per Recipient	2,422	2,479	2,646	2,810	2,999	3,166	3,358	3,562	6.3%	6.2%
		2.4%	6.8%	6.2%	6.8%	5.6%	6.0%	6.1%		
Savings		-4	-4	-6	-8	-10	-12	-14	-32	-58
Budget Resolution Medicaid Proposal (CBO Baseline)										
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3	4.7%	4.5%
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%		
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705	1.4%	1.4%
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%		
Savings		-4	-8	-16	-24	-33	-43	-54	-85	-182

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

02-Sep-95

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
Aggregate Growth		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
Per Capita Growth									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
Per Capita Growth									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)										
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0		
Aggregate Growth		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	7.9%	7.8%
Per Capita Growth									6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9		
Aggregate Growth		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
Per Capita Growth									6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
Per Capita Growth									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
Per Capita Growth									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
Aggregate Growth		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
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Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
Per Capita Growth									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
Aggregate Growth		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
Per Capita Growth									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
Aggregate Growth		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
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Budget Resolution Medicare Proposal (CBO Baseline)										
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Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
Per Capita Growth									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
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Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

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02-Sep-95

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MEDICAID PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3 11.3%	110 10.8%	122.1 11.0%	134.8 10.4%	148.1 9.9%	162.6 9.8%	177.8 9.3%		614.3 10.5%	954.7 10.2%
Recipients	36.8	38.4 4.2%	40.0 4.1%	41.2 3.1%	42.4 3.0%	43.7 3.0%	44.9 2.7%	45.9 2.4%		3.3%	3.0%
Spending per Recipient	2,422	2,587 6.8%	2,752 6.4%	2,964 7.7%	3,179 7.2%	3,391 6.7%	3,625 6.9%	3,871 6.8%		7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3 6.8%	106 11.2%	116.1 9.5%	127.8 10.1%	139.1 8.8%	151.6 9.0%	164.8 8.7%		9.9%	9.6%
Spending per Recipient	2,422	2,483 2.5%	2,652 6.8%	2,819 6.3%	3,014 6.9%	3,185 5.7%	3,380 6.1%	3,588 6.2%		6.4%	6.3%
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
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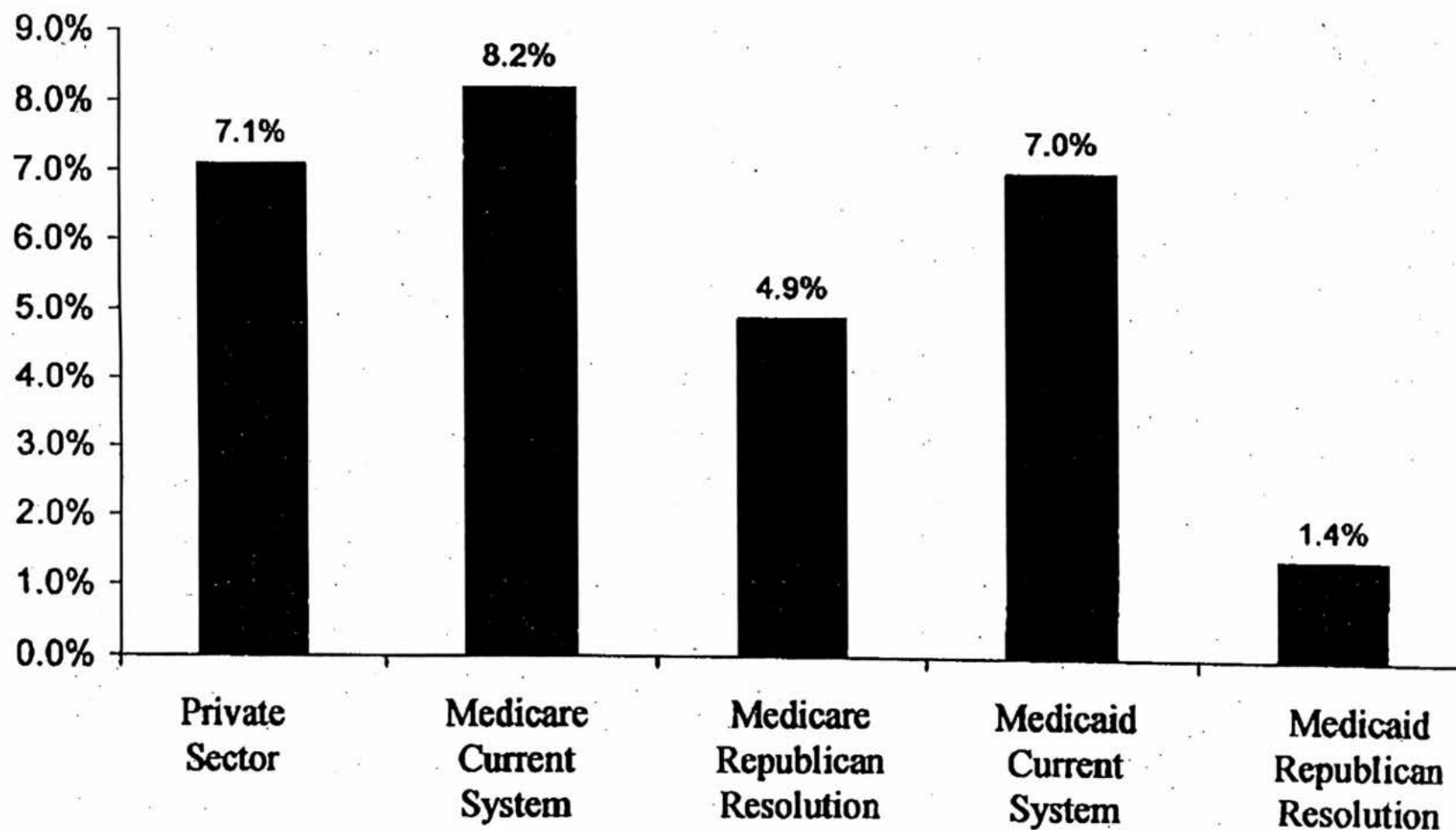
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Per Capita (Growth Rates)

Private Sector, Medicare, and Medicaid, FY 1996-2002



Administration estimates using CBO Baseline

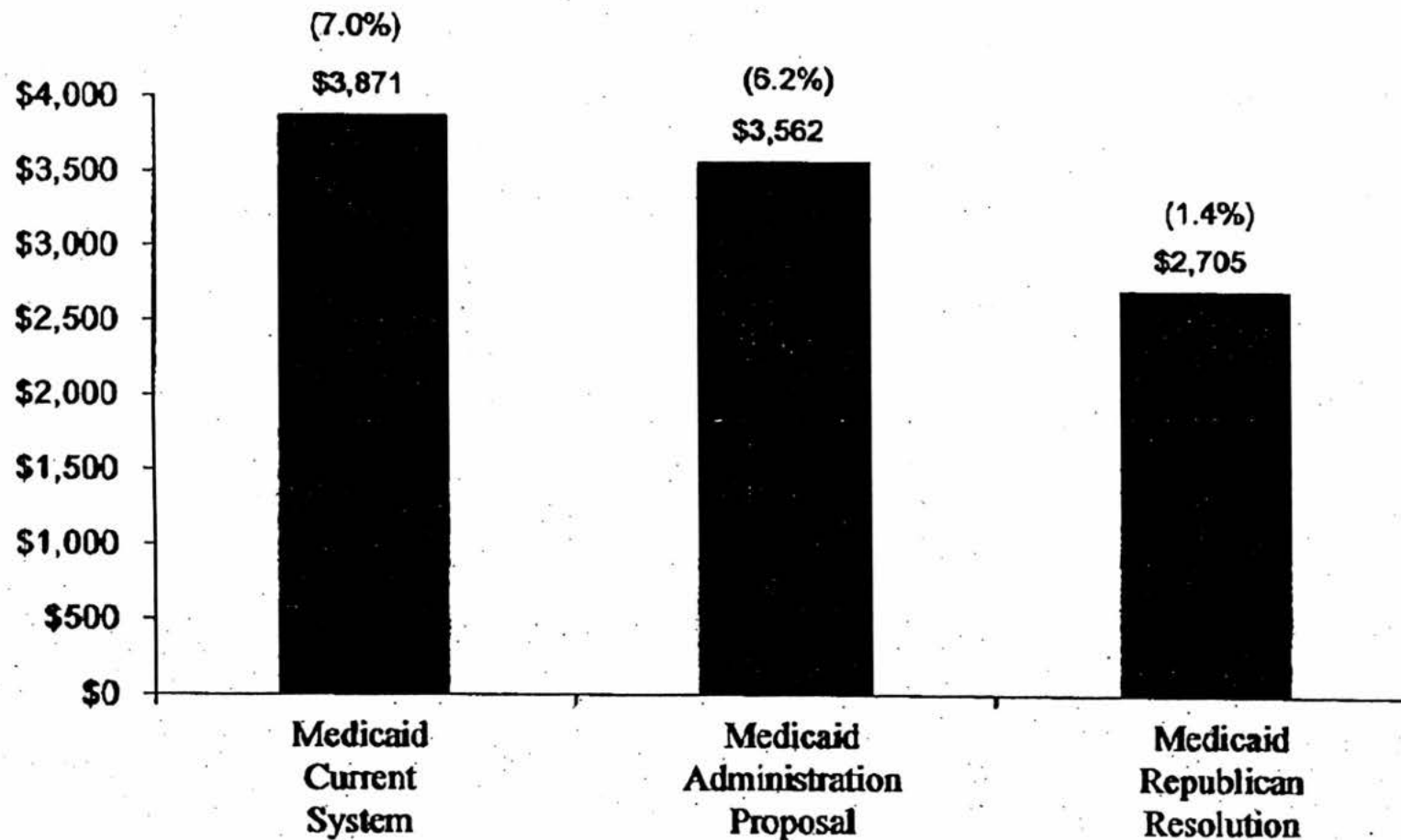
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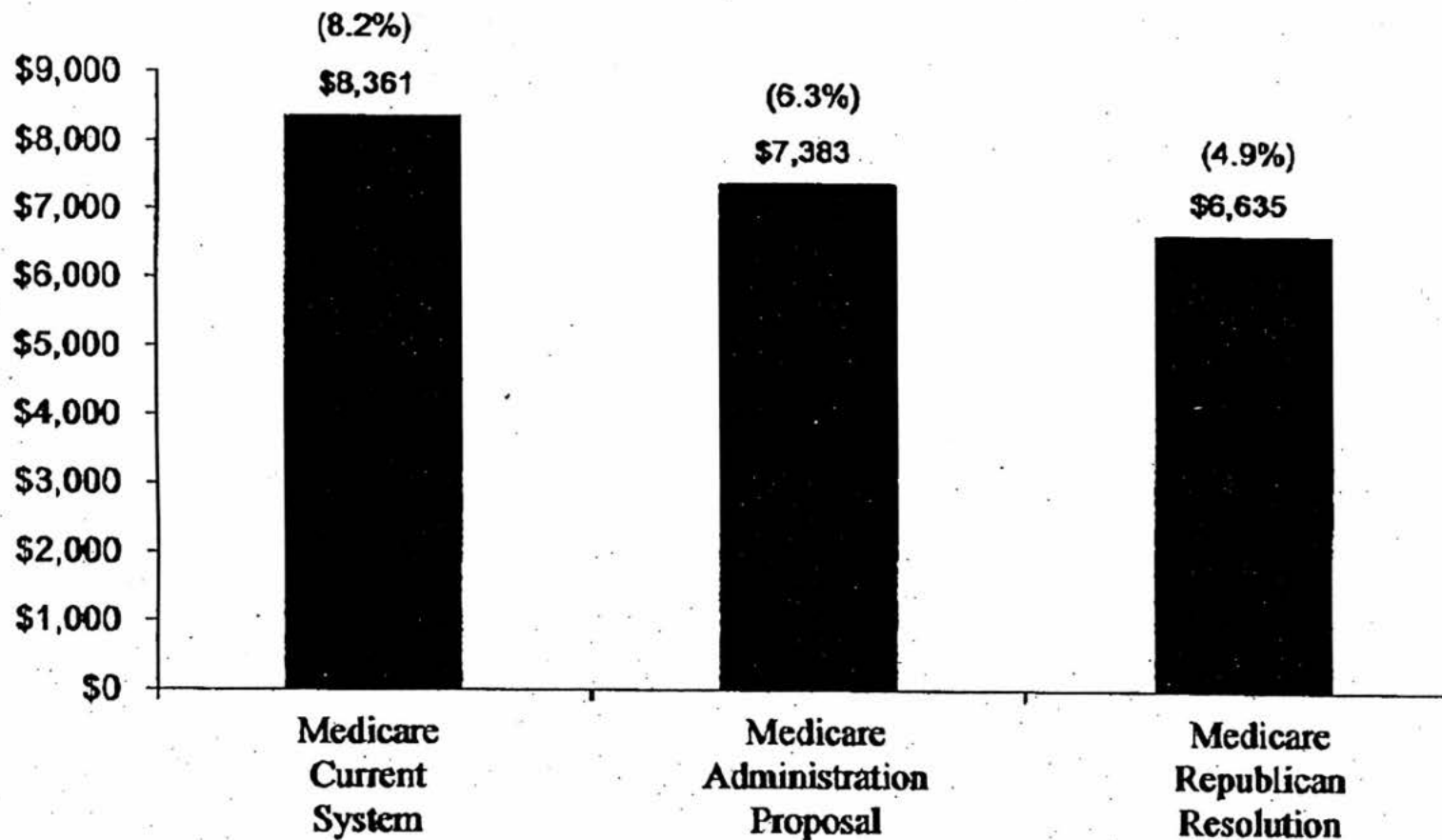
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14-Sept-93

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02-Sep-95

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Administration Medicare Proposal (CBO Baseline: Administration savings estimates)										
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0		
Aggregate Growth		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	7.9%	7.8%
Per Capita Growth									6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9		
Aggregate Growth		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
Per Capita Growth									6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
Per Capita Growth									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
Per Capita Growth									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
Aggregate Growth		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

2000-01-01

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
Aggregate Growth		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
Per Capita Growth									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
Per Capita Growth									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
Aggregate Growth		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
Per Capita Growth									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
Aggregate Growth		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
Per Capita Growth									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
Per Capita Growth									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
Per Capita Growth									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
Aggregate Growth		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

02-Sep-95

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MEDICAID PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3 11.3%	110 10.8%	122.1 11.0%	134.8 10.4%	148.1 9.9%	162.6 9.8%	177.8 9.3%		614.3 10.5%	954.7 10.2%
Recipients	36.8	38.4 4.2%	40.0 4.1%	41.2 3.1%	42.4 3.0%	43.7 3.0%	44.9 2.7%	45.9 2.4%		3.3%	3.0%
Spending per Recipient	2,422	2,587 6.8%	2,752 6.4%	2,964 7.7%	3,179 7.2%	3,391 6.7%	3,625 6.9%	3,871 6.8%		7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3 6.8%	106 11.2%	116.1 9.5%	127.8 10.1%	139.1 8.8%	151.6 9.0%	164.8 8.7%		9.9%	9.6%
Spending per Recipient	2,422	2,483 2.5%	2,652 6.8%	2,819 6.3%	3,014 6.9%	3,185 5.7%	3,380 6.1%	3,588 6.2%		6.4%	6.3%
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6 7.2%	102.1 6.8%	106.2 4.0%	110.5 4.0%	114.9 4.0%	119.5 4.0%	124.3 4.0%		4.7%	4.5%
Spending per Recipient	2,422	2,491 2.8%	2,555 2.6%	2,579 0.9%	2,605 1.0%	2,630 1.0%	2,664 1.3%	2,705 1.6%		1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.
02-Sep-95

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)										
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0		
<i>Aggregate Growth</i>		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	7.9%	7.8%
<i>Per Capita Growth</i>									6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9		
<i>Aggregate Growth</i>		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
<i>Per Capita Growth</i>									6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

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02-Sep-95

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Growth Rate

MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
<i>Per Capita Growth</i>									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
<i>Per Capita Growth</i>									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

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02-Sep-95

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MEDICAID PROPOSAL GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8		614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%		10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9			
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%		3.3%	3.0%
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871			
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%		7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3	106	116.1	127.8	139.1	151.6	164.8			
		6.8%	11.2%	9.5%	10.1%	8.8%	9.0%	8.7%		9.9%	9.6%
Spending per Recipient	2,422	2,483	2,652	2,819	3,014	3,185	3,380	3,588			
		2.5%	6.8%	6.3%	6.9%	5.7%	6.1%	6.2%		6.4%	6.3%
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3			
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%		4.7%	4.5%
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705			
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%		1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.
02-Sep-95

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MEDICAID PROPOSAL GROWTH RATES
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICAID BASELINE										
Spending	89.2	99.3 11.3%	110 10.8%	122.1 11.0%	134.8 10.4%	148.1 9.9%	162.6 9.8%	177.8 9.3%	614.3 10.5%	954.7 10.2%
Recipients	36.8	38.4 4.2%	40.0 4.1%	41.2 3.1%	42.4 3.0%	43.7 3.0%	44.9 2.7%	45.9 2.4%	3.3%	3.0%
Spending per Recipient	2,422	2,587 6.8%	2,752 6.4%	2,964 7.7%	3,179 7.2%	3,391 6.7%	3,625 6.9%	3,871 6.8%	7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Spending	89.2	95.2 6.7%	105.8 11.1%	115.7 9.4%	127.2 9.9%	138.3 8.7%	150.6 8.9%	163.6 8.6%	582.2 9.8%	896.4 9.5%
Spending per Recipient	2,422	2,479 2.4%	2,646 6.8%	2,810 6.2%	2,999 6.8%	3,166 5.6%	3,358 6.0%	3,562 6.1%	6.3%	6.2%
Savings		-4	-4	-6	-8	-10	-12	-14	-32	-58
Budget Resolution Medicaid Proposal (CBO Baseline)										
Spending	89.2	95.6 7.2%	102.1 6.8%	106.2 4.0%	110.5 4.0%	114.9 4.0%	119.5 4.0%	124.3 4.0%	4.7%	4.5%
Spending per Recipient	2,422	2,491 2.8%	2,555 2.6%	2,579 0.9%	2,605 1.0%	2,630 1.0%	2,664 1.3%	2,705 1.6%	1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54	-85	-182

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

02-Sep-95

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
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<i>Aggregate Growth</i>		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
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Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
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<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
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<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

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02-Sen-95

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Growth Rate

MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
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Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
<i>Per Capita Growth</i>									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
<i>Per Capita Growth</i>									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

02-Sep-95

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MEDICAID PROPOSALS GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8		614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%		10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9		3.3%	3.0%
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%			
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871		7.0%	7.0%
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%			
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3	106	116.1	127.8	139.1	151.6	164.8		9.9%	9.6%
		6.8%	11.2%	9.5%	10.1%	8.8%	9.0%	8.7%			
Spending per Recipient	2,422	2,483	2,652	2,819	3,014	3,185	3,380	3,588		6.4%	6.3%
		2.5%	6.8%	6.3%	6.9%	5.7%	6.1%	6.2%			
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3		4.7%	4.5%
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%			
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705		1.4%	1.4%
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%			
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

02-Sep-95

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MEDICAID PROPOSAL GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3 11.3%	110 10.8%	122.1 11.0%	134.8 10.4%	148.1 9.9%	162.6 9.8%	177.8 9.3%		614.3 10.5%	954.7 10.2%
Recipients	36.8	38.4 4.2%	40.0 4.1%	41.2 3.1%	42.4 3.0%	43.7 3.0%	44.9 2.7%	45.9 2.4%		3.3%	3.0%
Spending per Recipient	2,422	2,587 6.8%	2,752 6.4%	2,964 7.7%	3,179 7.2%	3,391 6.7%	3,625 6.9%	3,871 6.8%		7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Percent Reduction from Administration Baseline)											
Spending	89.2	95.2 6.7%	105.8 11.1%	115.7 9.4%	127.2 9.9%	138.3 8.7%	150.6 8.9%	163.6 8.6%		582.2 9.8%	896.4 9.5%
Spending per Recipient	2,422	2,479 2.4%	2,646 6.8%	2,810 6.2%	2,999 6.8%	3,166 5.6%	3,358 6.0%	3,562 6.1%		6.3%	6.2%
Savings		-4	-4	-6	-8	-10	-12	-14		-32	-58
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6 7.2%	102.1 6.8%	106.2 4.0%	110.5 4.0%	114.9 4.0%	119.5 4.0%	124.3 4.0%		4.7%	4.5%
Spending per Recipient	2,422	2,491 2.8%	2,555 2.6%	2,579 0.9%	2,605 1.0%	2,630 1.0%	2,664 1.3%	2,705 1.6%		1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

02-Sep-95

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MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)										
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0		
<i>Aggregate Growth</i>		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	7.9%	7.8%
<i>Per Capita Growth</i>									6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9		
<i>Aggregate Growth</i>		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
<i>Per Capita Growth</i>									6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending. Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates. These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

02-Sep-95

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Growth Rate

MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
<i>Per Capita Growth</i>									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
<i>Per Capita Growth</i>									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.
02-Sep-95

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MEDICAID PROPOSAL GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8		614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%		10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9		3.3%	3.0%
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%			
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871		7.0%	7.0%
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%			
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3	106	116.1	127.8	139.1	151.6	164.8		9.9%	9.6%
		6.8%	11.2%	9.5%	10.1%	8.8%	9.0%	8.7%			
Spending per Recipient	2,422	2,483	2,652	2,819	3,014	3,185	3,380	3,588		6.4%	6.3%
		2.5%	6.8%	6.3%	6.9%	5.7%	6.1%	6.2%			
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3		4.7%	4.5%
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%			
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705		1.4%	1.4%
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%			
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

02-Sep-95

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MEDICAID PROPOSAL GROWTH RATES
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICAID BASELINE										
Spending	89.2	99.3 11.3%	110 10.8%	122.1 11.0%	134.8 10.4%	148.1 9.9%	162.6 9.8%	177.8 9.3%	614.3 10.5%	954.7 10.2%
Recipients	36.8	38.4 4.2%	40.0 4.1%	41.2 3.1%	42.4 3.0%	43.7 3.0%	44.9 2.7%	45.9 2.4%	3.3%	3.0%
Spending per Recipient	2,422	2,587 6.8%	2,752 6.4%	2,964 7.7%	3,179 7.2%	3,391 6.7%	3,625 6.9%	3,871 6.8%	7.0%	7.0%
Administration Medicaid Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Spending	89.2	95.2 6.7%	105.8 11.1%	115.7 9.4%	127.2 9.9%	138.3 8.7%	150.6 8.9%	163.6 8.6%	582.2 9.8%	896.4 9.5%
Spending per Recipient	2,422	2,479 2.4%	2,646 6.8%	2,810 6.2%	2,999 6.8%	3,166 5.6%	3,358 6.0%	3,562 6.1%	6.3%	6.2%
Savings		-4	-4	-6	-8	-10	-12	-14	-32	-58
Budget Resolution Medicaid Proposal (CBO Baseline)										
Spending	89.2	95.6 7.2%	102.1 6.8%	106.2 4.0%	110.5 4.0%	114.9 4.0%	119.5 4.0%	124.3 4.0%	4.7%	4.5%
Spending per Recipient	2,422	2,491 2.8%	2,555 2.6%	2,579 0.9%	2,605 1.0%	2,630 1.0%	2,664 1.3%	2,705 1.6%	1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54	-85	-182

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

02-Sep-95

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MEDICARE PROPSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02
CBO MEDICARE BASELINE													
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3		
Aggregate Growth		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.9%	10.1%	9.7%	9.6%
Per Capita Growth												8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9		
Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%
Per Capita Growth												8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)													
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0	334.1	362.5	392.4		
Aggregate Growth		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	8.8%	8.5%	8.2%	7.9%	7.8%
Per Capita Growth												6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	258.6	276.9	302.5	329.3	358.0		
Aggregate Growth		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	9.2%	8.9%	8.7%	8.0%	7.9%
Per Capita Growth												6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)													
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274	291	309	328		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%
Per Capita Growth												4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	5.5%	6.1%
Per Capita Growth												4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130	-139	-270
CBO PRIVATE GROWTH RATES													
Aggregate Growth		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	6.9%	6.6%	6.4%	7.6%	7.4%
Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	6.6%	6.5%	6.2%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

07-Aug-95

MEDICARE PROPSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	95-00	96-02
CBO MEDICARE BASELINE													
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3		
Aggregate Growth		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.9%	10.1%	9.7%	9.6%
Per Capita Growth												8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9		
Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%
Per Capita Growth												8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)													
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0	334.1	362.5	392.4		
Aggregate Growth		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	8.8%	8.5%	8.2%	7.9%	7.8%
Per Capita Growth												6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9	302.5	329.3	358.0		
Aggregate Growth		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	9.2%	8.9%	8.7%	8.0%	7.9%
Per Capita Growth												6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)													
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274	291	309	328		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.6%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%
Per Capita Growth												4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8		
Aggregate Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	5.5%	6.1%
Per Capita Growth												4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130	-139	-270
CBO PRIVATE GROWTH RATES													
Aggregate Growth		8.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	6.9%	6.6%	6.4%	7.6%	7.4%
Per Capita Growth		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	6.6%	6.5%	6.2%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

07-Aug-95

MEDICARE PROPSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02
CBO MEDICARE BASELINE													
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3		
Aggregate Growth		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.9%	10.1%	9.7%	9.6%
Per Capita Growth												8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9		
Aggregate Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%
Per Capita Growth												8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)													
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0	334.1	362.5	392.4		
Aggregate Growth		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	8.8%	8.5%	8.2%	7.9%	7.8%
Per Capita Growth												6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	258.6	276.9	302.5	329.3	358.0		
Aggregate Growth		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	9.2%	8.9%	8.7%	8.0%	7.9%
Per Capita Growth												6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)													
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274	291	309	328		
Aggregate Growth		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%
Per Capita Growth												4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8		
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07-Aug-95

C. H. QUINN R. 10/22

Medicaid

Baseline Medicaid beneficiaries in 2002

Total	45.7 million
Aged	4.8 million
Disabled	7.5 million
Individuals in Families	33.4 million

Nursing home residents	1.9 million
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Children	22.9 million
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Note: For each group, the reduction in coverage is 19 percent

My Ben Gamir
690-6157

Stark

5470001

Via Parale
AL Gore

Cont. for return

Sue Nider

- Best first result
= from 1998-2000

- Parale rates
- Medicaid
- 1998-2000
- 1998-2000

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My Ben G...
1900 1997

Stark

5470001

Vice Pres
AL Gov

Contractor

Sue Miller

- Best first result
= from 1990s and early

- Public rates
- Medicaid
- more in the
- public sector

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Republican Proposals Medicare

Book-Rep. ymcme

Notes from Finance Member Staff
on Finance Briefing 9-22

Medicare

Hospitals - \$65.9 billion over 7 yrs

\$92 billion in FY96 to \$125.6 b in 2002 - 5% annual rate of growth

Home Health - \$21.7 bill. over 7 yrs

\$17.2 b in FY96 to \$25.3 b in 2002 - 8.1% annual rate of growth

Nursing Home - \$10.0 b over 7 yrs

\$10.6 b in 1996 to \$15.6 b in 2002 - 8.2% (compared to 10.8% in current law)

Hospital, Home Health, Nursing Home sub-total - 97.6 b

Physician - \$19-20 over 7 yrs

\$37 b in 1996 to 63 b in 2002 - 8.3% annual increase (compared to 9.8 % current baseline)

Labs - \$6.1 B over 7

\$5.3 b in 1996 to 8.5b in 2002 - 8.8% annual growth rate (compared to 11.7% baseline)

Durable Medical Equipment - \$6.3 b over 7 yrs

\$3.1 b in 1996 to \$5.8 b in 2002 - 10.4% growth rate (compared to 14.3 %)

Physician, Labs, Medical Equip. Sub-total \$31.4 over 7

Medicare Choices - \$49 billion over 7 yrs

Fraud and Abuse - \$4.1 billion over 7 yrs

MSP - \$ 6 billion over 7yrs

Part B deductible - \$10 b over 7

Part B premium - \$50 b over 7

Means Test - \$12 b.

Part B Beni Hits - \$72

other???

Total - \$260.1 billion of all Bold

Medicaid DSH - \$36 b over 7 yr

Notes from Finance Member Staff
on Finance Briefing 9-22

Book - Rep. ymlne

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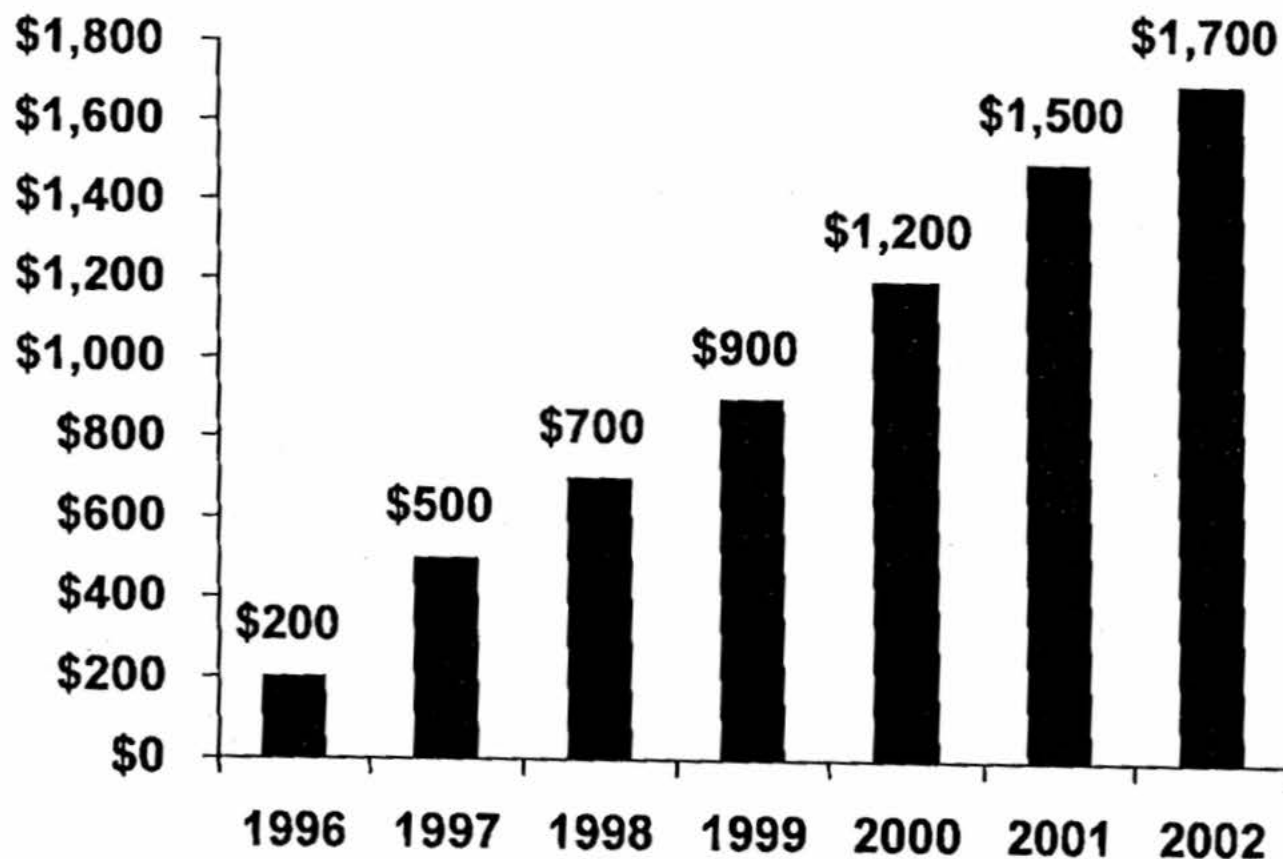
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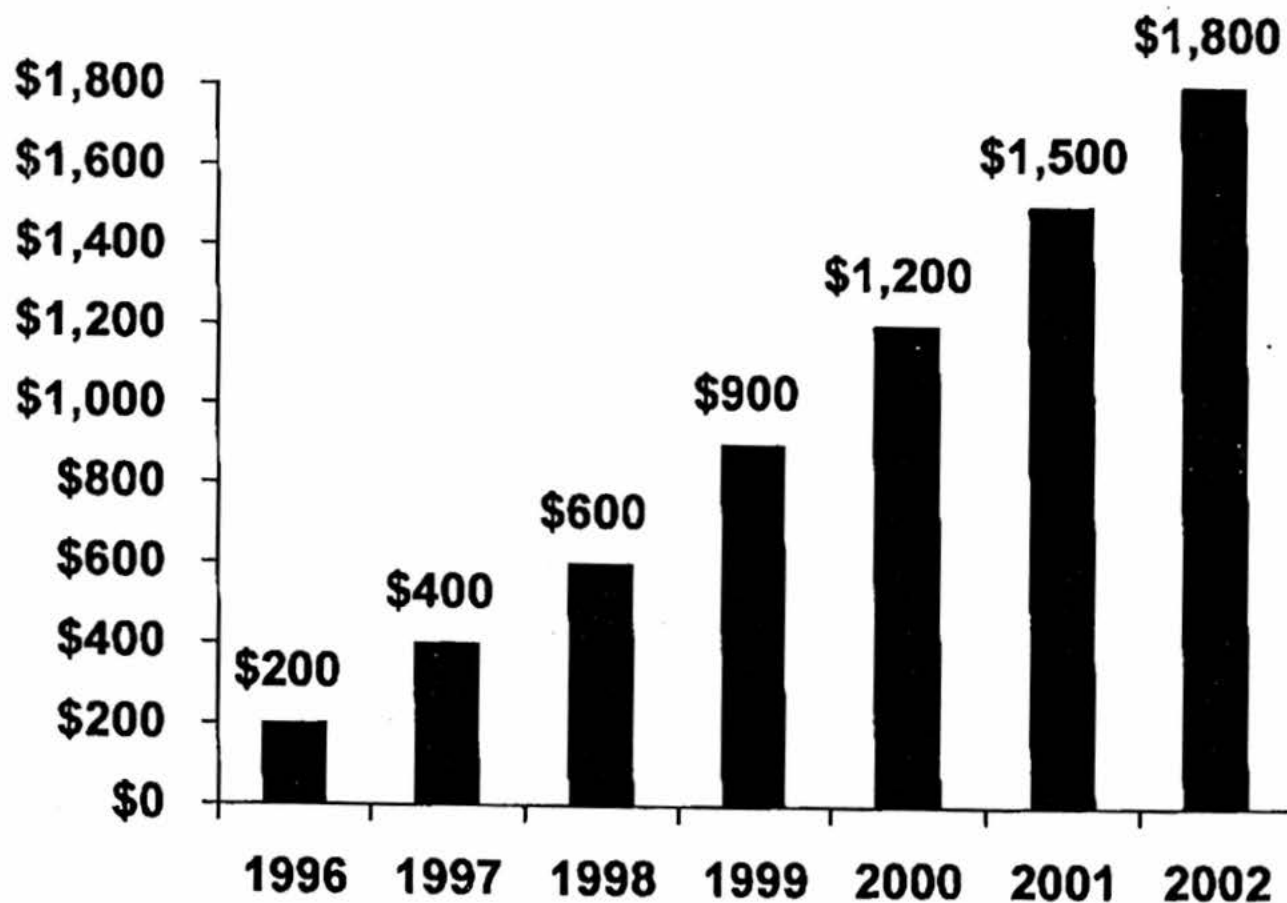
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Reduction in Medicare Spending Per Beneficiary Under the Senate Republican Plan



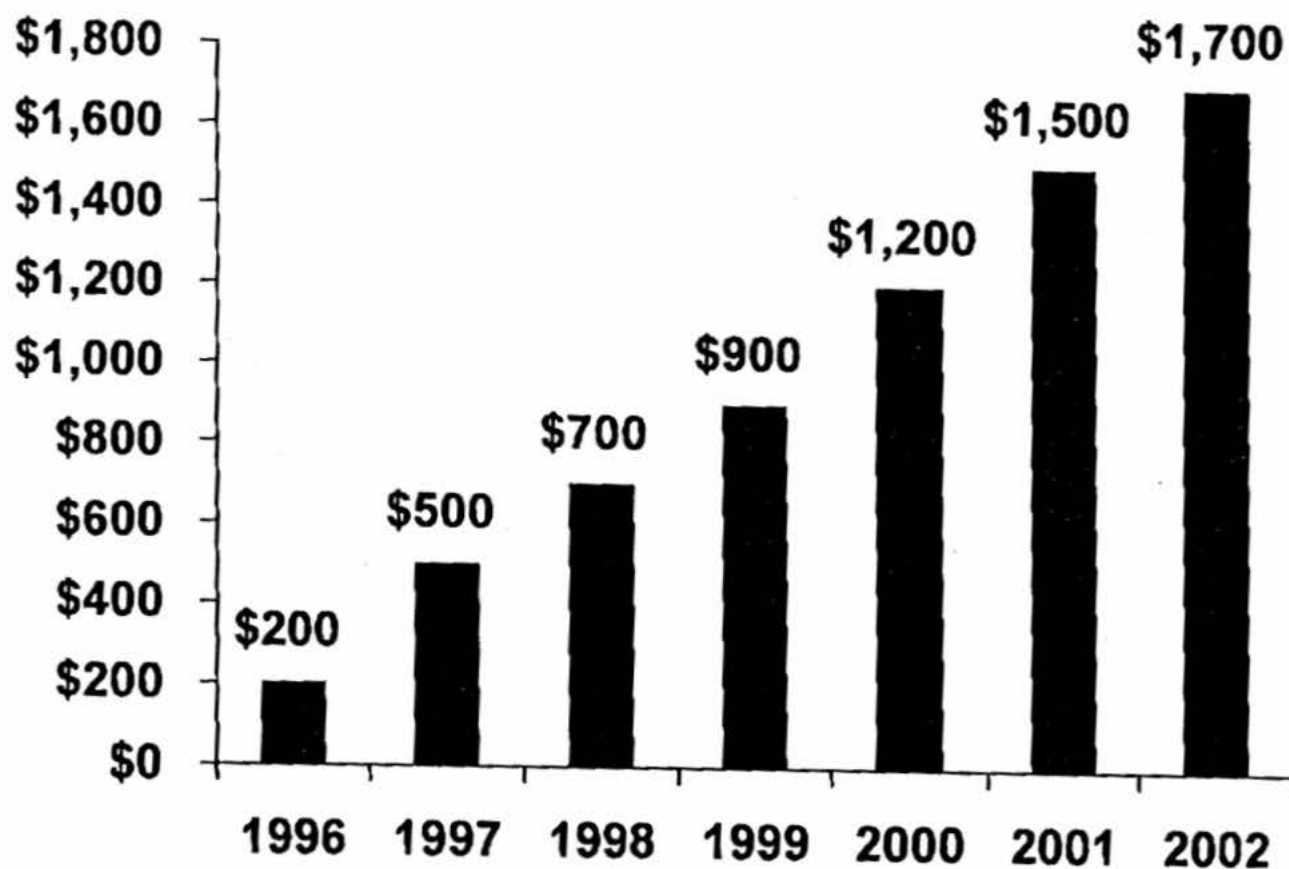
Note: Total Medicare spending reductions divided by projected number of beneficiaries; fiscal years
Source: US Dept. of Health and Human Services

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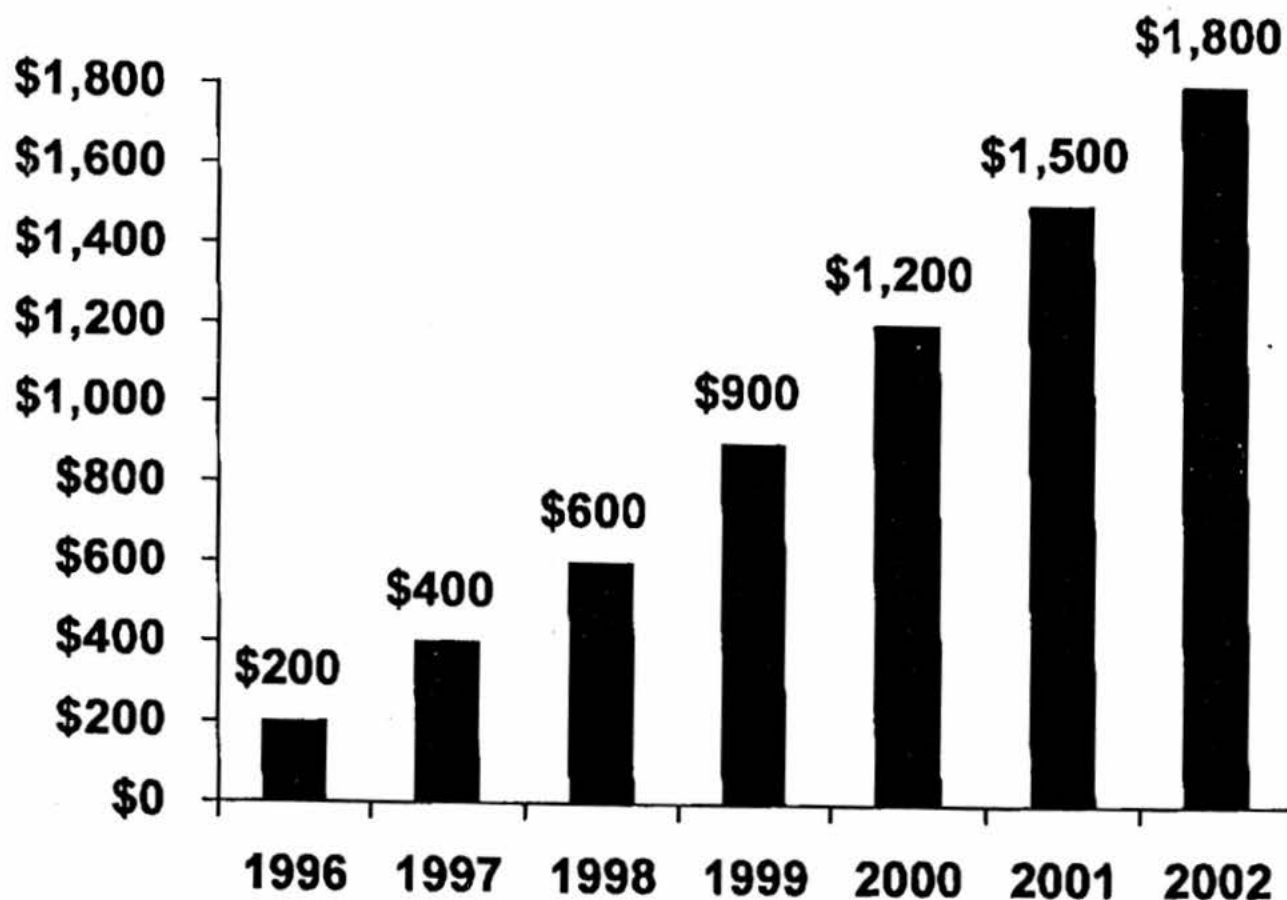
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REPUBLICAN MEDICARE PLAN: PAY MORE FOR SECOND-CLASS HEALTH CARE

- 1. ANY WAY YOU SLICE IT, THE GOP MEDICARE CUT IS THREE TIMES LARGER THAN ANY CUT IN HISTORY AND IT MEANS YOU WILL PAY MORE TO GET LESS.**
- 2. MEDICARE RECIPIENTS WILL PAY MORE OUT-OF-POCKET -- TO FUND A TAX BREAK FOR THE WEALTHY:**
 - \$1,700 less per beneficiary in 2002
 - Double Deductibles
 - Raise Premiums
 - Raise the Medicare eligibility age to 67
- 3. MEDICARE RECIPIENTS WILL PAY MORE, YET THE CUTS WILL MEAN AN INFERIOR, SECOND-CLASS MEDICARE PROGRAM:**
 - Hospital closings threatened
 - Doctors driven out of the program and turning away recipients
 - Costs shifted to people with private health insurance

REPUBLICAN MEDICARE PLAN: PAY MORE FOR SECOND-CLASS HEALTH CARE

Pay More and Get Less -- For Tax Cuts for the Wealthy. Any way you slice it, the Republican Medicare cuts will force you to pay more to get less -- just to fund a tax cut for the wealthy. The GOP plan will increase out-of-pocket costs for all seniors -- regardless of their income or health. Medicare *benefits per beneficiary will be cut \$1,700 in 2002*, forcing spending to grow *33 percent slower than the private sector*. Both the House and Senate plans increase premiums, and the Senate plan cuts benefits and doubles deductibles from \$100 a year today to \$210 a year in 2002. And not one penny of the increased premiums will go to the Medicare trust fund. Instead, seniors will pay more out-of-their-pockets to fund a huge tax cut for the wealthy.

Pay Taxes for Two More Years and Wait Two More Years for Benefits. The Senate plan would gradually delay the Medicare eligibility age from 65 to 67 beginning in 2003. Tens of millions of Americans would have to work longer and pay more taxes to get fewer years of Medicare. For someone working a desk job in Washington, that may not seem too bad, but to millions of Americans with physically demanding jobs, it is not just bad -- it is unfair.

Everyone Will Pay More Through Cost Shifting. Lewin-VHI, an independent research firm, found that the Republicans' \$452 billion cut in Medicare and Medicaid will lead doctors and hospitals to *raise their fees on private patients by at least \$90 billion -- essentially a new \$90 billion tax on everyone with private health insurance.* This cost-shifting will reduce wage increases by 2.7%, and by as much as 10% for lower-wage workers.

Untried Experimenting with Medicare. The Republican plan would experiment with Medicare by creating Medical Savings Accounts that would let the healthiest and wealthiest gamble at the expense of everyone else. **ADD**

Hospitals Will Close and Doctors May Refuse Medicare Patients. By making the deepest cuts to health care provider payments in history, the Republican plan would lead to rural and urban hospital closures and create huge incentives for physicians to refuse to take Medicare patients. **ADD**

Raises Taxes on Working Americans. The Senate plan imposes new payroll taxes on many state and local government employees at a time when the Republicans are cutting taxes for the wealthy. Medicare does not currently cover government workers in many states who began work before 1986 and they therefore are not subject to the Medicare payroll tax. Republicans would require all state and local workers to pay Medicare payroll taxes, raising taxes and imposing an "unfunded mandate" on state government in violation of the unfunded mandates law that Congress enacted earlier this year.

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Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle A—Medicare Plus Program		-0.5	-1.0	-1.8	-3.3	-5.6	-7.9	-10.6	-30.7
Subtitle B—Fraud and Abuse /1									
Payment Safeguards		0.4	0.1	-0.2	-0.4	-0.6	-0.6	-0.6	-1.6
Doubling Civil Monetary Penalties		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.3
Other Provisions		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Total, Subtitle B		0.4	0.0	-0.2	-0.4	-0.6	-0.6	-0.6	-2.0
Subtitle C—Regulatory Relief									
Physician Ownership Referral		0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Other Regulatory Relief		0.0	0.1	0.2	0.2	0.2	0.2	0.2	1.1
Physician Self Policing /2									
Total, Subtitle C		0.1	0.2	0.2	0.2	0.3	0.3	0.3	1.6

NAM - FYF - CBO scoring of Medicare proposals by Title. Very interesting...

[Signature]

Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle D—Medical Liability Reform									
Subtitle F—Medicare Part A									
Reduction in PPS update (MB-2.5 in 96; -2 to 2002)	-0.2	-1.1	-2.4	-3.8	-5.4	-7.2	-9.0	-29.1	
Reduce Disproportionate Share Payments /3	-0.8	-0.8	-1.0	-1.1	-1.1	-1.2	-1.2	-7.0	
Reduce PPS capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0	
Rebase Capital rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7	
Reduce nonPPS capital by 15%	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5	
Adjustment for capital-related tax costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Capital exceptions revisions /4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Reduce IME adj to 6% thru 98, 5.5% through 2002	-0.7	-0.8	-0.8	-1.0	-1.1	-1.1	-1.2	-6.7	
Reduce DME /5	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.6	-2.8	
Reduction in nonPPS update (MB-1 to 2002)	0.0	0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.4	
Rebase LTC hospitals /6	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7	
Units within hospitals /7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Eliminate Payments for Hospital Bad Debt	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-1.1	
Hemophilia pass through /8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Christian Science providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Sole Community Hospitals									
EAC/RPC Hospitals /9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
REACH - Part A/B /10	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Rural referral centers	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Floor on area wage index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Skilled Nursing Facilities /11	-0.2	-0.6	-1.0	-1.4	-1.8	-2.2	-2.6	-10.0	
Total, Subtitle F	-3.1	-5.1	-7.2	-9.5	-11.9	-14.3	-16.8	-68.0	

included in reduction in PPS update

Medicare Proposal (based on specs through 2029): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle G—Medicare Part B									
Reduce Payments for Physicians' Services /12	-0.7	-1.6	-2.9	-3.8	-4.7	-5.7	-6.8	-8.8	-28.4
Eliminate Formula Driven Overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-6.8	-18.9
Freeze Dur Med Eqp't update, oxygen -20% /13	-0.1	-0.3	-0.4	-0.5	-0.7	-0.8	-1.0	-1.8	-3.8
Freeze Clinical lab update, 65% of median	-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.5	-1.8	-8.0
Extend Outpatient capital reduction	0.0	0.0	0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.6
Extend Outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-0.4	-1.4
Ambulatory Surgical Centers	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-1.3
Interactions	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-1.4
Extension of Part B premium at 31.5%	-3.2	-4.1	-3.9	-4.9	-7.4	-9.8	-12.7	-12.7	-46.1
Income-related Part B premium	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	-2.0	-7.5
Total, Subtitle G	-5.1	-5.3	-10.3	-14.1	-18.9	-23.8	-29.8	-29.9	-110.5
Subtitle H—Medicare Parts A and B:									
Payment for Home Health Services /14	0.0	-1.4	-2.3	-2.8	-3.2	-3.6	-4.1	-4.1	-17.3
Medicare Second Payer	0.0	0.0	0.0	-1.3	-1.4	-1.6	-1.8	-1.8	-8.0
Total, Subtitle H	0.0	-1.4	-2.3	-4.0	-4.6	-5.2	-5.8	-5.8	-23.3
Change in Medicare Outlays w/o Fall-Safe	-5.2	-15.6	-21.6	-31.1	-41.3	-51.5	-63.5	-63.5	-232.9
Additional Provider Payment Reductions Required by Fall-Safe, Net of Premiums	0.0	0.0	-5.2	-5.3	-7.9	-8.4	-7.8	-7.8	-37.4
Change in Medicare Outlays with Fall-Safe	-5.2	-15.6	-26.8	-39.5	-49.2	-59.8	-71.1	-71.1	-270.2
Subtitle E									
Mandatory Appropriations to GME Trust Fund	0.0	0.4	0.8	2.0	3.0	4.0	5.8	5.8	15.8

Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars

1995

1996

1997

1998

1999

2000

2001

2002

Total

COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING

Gross Mandatory Outlays for Medicare Benefits

Current Law, BR baseline	177.8	198.8	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law without fallback	177.8	193.6	208.0	223.0	238.0	255.4	274.8	298.0	
Difference	0.0	-5.0	-11.1	-17.1	-25.0	-32.3	-40.0	-46.8	-179.3

Less: Flat Part B Premiums

Current Law, BR baseline	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	
Proposed Law without fallback	-20.1	-23.5	-26.1	-28.4	-31.0	-34.8	-38.5	-42.6	
Difference	0.0	-3.2	-4.1	-3.9	-4.9	-7.4	-9.8	-12.7	-48.1

Less: Income-Related Part B Premiums

Current Law	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Proposed Law without fallback	0.0	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	
Difference	0.0	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	-7.5

Net Mandatory Outlays Without Fallback

Current Law	157.7	178.3	197.1	215.6	237.0	260.4	288.1	314.7	
Proposed Law without fallback	157.7	170.1	181.5	194.0	205.8	219.1	234.7	251.2	

Change in Net Medicare Outlays without Fallback

	0.0	-8.2	-15.6	-21.6	-31.1	-41.3	-51.5	-63.5	-232.8
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Net Mandatory Outlays With Fallback

Proposed Law with fallback	157.7	170.1	181.5	188.8	197.5	211.2	226.3	243.6	
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Change in Net Medicare Outlays with Fallback

	0.0	-8.2	-15.6	-26.8	-39.5	-49.2	-59.8	-71.1	-270.2
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Medicare Proposal (based on specs through 12/29): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
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FOOTNOTES:

- /1 These estimates assume that final legislative language would meet scorekeeping requirements.
- /2 Estimate under review.
- /3 Payments are reduced 20% in 96; 25% in 97; and 30% in subsequent years.
- /4 Legislative language must stipulate that the redistribution for exceptions will not exceed 10% of total capital payments and that this is an allocation issue, not a provision that increases reimbursements.
- /5 Does not include effects of provision to eliminate payments for residents after first residency period.
- /6 This estimate assumes that the provision will only be applied to existing LTC facilities.
- /7 This is probably budget neutral if language is provided that clarifies the intent is to grandfather existing long term care hospitals that are currently located within or on the same campus as the "acute care PPS-related" hospital.
- /8 This provision would cost approximately \$5 million per year.
- /9 This provision is budget neutral if only hospitals currently designated as EACH/PPCH will have this designation and no other hospitals/facilities can be designated as such.
- /10 This estimate will be reduced substantially if the policy is to cover only Part B services.
- /11 Based on Senate proposal, except MB-2.
- /12 This estimate assumes PPRC recommended proposal, cumulative spending targets at GDP+2, 5.9% update and target reduction in 96.
- /13 This line includes a 1% annual update for prosthetics and orthotics.
- /14 Based on Senate proposal, except MB-2.

NOTES:

1. Details may not sum to total because of rounding.
2. These estimates assume an enactment date of November 16, 1995. The estimates would change if the proposal was enacted at a later date.
3. These estimates are based on draft legislative language as of 8/28 and subsequent changes specified by Committee staff.
4. The effects of medical savings account provision are embodied in the Medicare Choice line.
5. To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall.
6. These estimates do not incorporate changes in discretionary spending for administration.

Medicare Proposal (based on specs through 29): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
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COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING**Gross Mandatory Outlays for Medicare Part A Benefits Without Fallsafe**

Current Law, BR baseline	112.0	123.7	135.2	146.6	158.6	170.7	183.6	197.1	
Proposed Law		120.6	128.4	138.3	144.1	152.6	161.6	171.2	
Difference		-3.1	-6.8	-10.3	-14.4	-18.1	-21.8	-25.9	-100.3

Gross Mandatory Outlays for Medicare Part B Benefits Without Fallsafe

Current Law, BR baseline	85.8	74.9	83.9	93.5	104.6	117.0	131.2	147.7	
Proposed Law		73.0	79.5	86.7	94.0	102.8	113.1	124.6	
Difference		-2.0	-4.3	-6.8	-10.6	-14.2	-18.2	-22.9	-79.0

Total Mandatory Outlays for Medicare Benefits Without Fallsafe

Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law		193.6	208.0	223.0	238.0	255.4	274.8	296.0	
Difference		-5.0	-11.1	-17.1	-25.0	-32.3	-40.0	-48.8	-179.3

Gross Mandatory Outlays for Medicare Part A Benefits With Fallsafe

Current Law, BR baseline	112.0	123.7	135.2	146.6	158.6	170.7	183.6	197.1	
Proposed Law		120.6	128.4	133.2	139.1	147.9	156.8	166.7	
Difference		-3.1	-6.8	-13.4	-19.4	-22.8	-26.8	-30.4	-122.7

Gross Mandatory Outlays for Medicare Part B Benefits With Fallsafe

Current Law, BR baseline	85.8	74.9	83.9	93.5	104.6	117.0	131.2	147.7	
Proposed Law		73.0	79.5	84.6	90.6	99.7	109.7	121.7	
Difference		-2.0	-4.3	-8.8	-13.9	-17.4	-21.5	-26.0	-93.9

Total Mandatory Outlays for Medicare Benefits With Fallsafe

Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law		193.6	208.0	217.8	229.7	247.5	265.5	288.4	
Difference		-5.0	-11.1	-22.3	-33.3	-40.2	-49.3	-56.4	-216.7

Very Preliminary CBO
Part B Premium #5

1996	1997	1998	1999	2000	2001	2002
\$54	\$57	\$60	\$64	\$72	\$78	\$87

Medicare Proposal (based on specs through 9): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle A--Medicare Plus Program		-0.5	-1.0	-1.8	-3.3	-5.6	-7.9	-10.6	-30.7
Subtitle B--Fraud and Abuse /1									
Payment Safeguards		0.4	0.1	-0.2	-0.4	-0.6	-0.6	-0.6	-1.9
Doubling Civil Monetary Penalties		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.3
Other Provisions		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Total, Subtitle B		0.4	0.0	-0.2	-0.4	-0.6	-0.6	-0.6	-2.0
Subtitle C--Regulatory Relief									
Physician Ownership Referral		0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Other Regulatory Relief		0.0	0.1	0.2	0.2	0.2	0.2	0.2	1.1
Physician Self Policing /2									
Total, Subtitle C		0.1	0.2	0.2	0.2	0.3	0.3	0.3	1.6

NAM - FYF - CBO scoring of Medicare proposals by Title. Very interesting...

[Signature]

Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

Fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle D—Medical Liability Reform									
Subtitle F—Medicare Part A									
Reduction in PPS update (MB-2.6 in 96; -2 to 2002)	-0.2	-1.1	-2.4	-3.8	-5.4	-7.2	-9.0	-29.1	
Reduce Disproportionate Share Payments /3	-0.8	-0.8	-1.0	-1.1	-1.1	-1.2	-1.2	-7.0	
Reduce PPS capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0	
Rebase Capital rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7	
Reduce nonPPS capital by 15%	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5	
Adjustment for capital-related tax costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Capital exceptions revisions /4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Reduce IME adj to 6% thru 98, 5.6% through 2002	-0.7	-0.8	-0.8	-1.0	-1.1	-1.1	-1.2	-6.7	
Reduce DME /5	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.6	-2.8	
Reduction in nonPPS update (MB-1 to 2002)	0.0	0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.4	
Rebase LTC hospitals /6	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7	
Units within hospitals /7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Eliminate Payments for Hospital Bad Debt	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-1.1	
Hemophilia pass through /8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Christian Science providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Sole Community Hospitals									
EAC/RPC Hospitals /9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
REACH - Part A/B /10	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Rural referral centers	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Floor on area wage index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Skilled Nursing Facilities /11	-0.2	-0.8	-1.0	-1.4	-1.8	-2.2	-2.8	-10.0	
Total, Subtitle F	-3.1	-5.1	-7.2	-9.5	-11.9	-14.9	-16.8	-68.0	

included in reduction in PPS update

Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle G—Medicare Part B									
Reduce Payments for Physicians' Services /12	-0.7	-1.6	-2.9	-3.8	-4.7	-5.7	-6.8	-8.4	-26.4
Eliminate Formula Driven Overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-5.9	-18.9
Freeze Dur Med Eqpt update, oxygen -20% /13	-0.1	-0.3	-0.4	-0.5	-0.7	-0.8	-1.0	-1.3	-3.8
Freeze Clinical lab update, 65% of median	-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-2.0	-8.0
Extend Outpatient capital reduction	0.0	0.0	0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.6
Extend Outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-0.5	-1.4
Ambulatory Surgical Centers	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-1.3
Interactions	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-1.4
Extension of Part B premium at 31.5%	-3.2	-4.1	-3.9	-4.9	-7.4	-8.8	-12.7	-16.1	-46.1
Income-related Part B premium	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	-2.0	-7.5
Total, Subtitle G	-5.1	-8.3	-10.3	-14.1	-18.9	-23.8	-29.9	-36.9	-110.5
Subtitle H—Medicare Parts A and B:									
Payment for Home Health Services /14	0.0	-1.4	-2.3	-2.8	-3.2	-3.6	-4.1	-4.1	-17.3
Medicare Second Payer	0.0	0.0	0.0	-1.3	-1.4	-1.6	-1.8	-1.8	-8.0
Total, Subtitle H	0.0	-1.4	-2.3	-4.0	-4.6	-5.2	-5.8	-5.8	-23.3
Change in Medicare Outlays w/o Fall-Safe	-5.2	-15.6	-21.6	-31.1	-41.3	-51.5	-63.5	-71.1	-232.9
Additional Provider Payment Reductions Required by Fall-Safe, Net of Premiums	0.0	0.0	-5.2	-5.3	-7.9	-8.4	-7.8	-7.8	-37.4
Change in Medicare Outlays with Fall-Safe	-5.2	-15.6	-26.8	-39.5	-49.2	-60.8	-71.1	-71.1	-270.2
Subtitle E									
Mandatory Appropriations to GME Trust Fund	0.0	0.4	0.6	2.0	3.0	4.0	5.8	5.8	15.6

Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars

1995 1996 1997 1998 1999 2000 2001 2002 Total

COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING

Gross Mandatory Outlays for Medicare Benefits

Current Law, BR baseline	177.8	198.8	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law without failsafe	177.8	193.8	208.0	223.0	238.0	255.4	274.8	296.0	
Difference	0.0	-6.0	-11.1	-17.1	-25.0	-32.3	-40.0	-48.8	-179.3

Less: Flat Part B Premiums

Current Law, BR baseline	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	
Proposed Law without failsafe	-20.1	-23.5	-26.1	-28.4	-31.0	-34.8	-38.6	-42.6	
Difference	0.0	-3.2	-4.1	-3.9	-4.9	-7.4	-9.9	-12.7	-46.1

Less: Income-Related Part B Premiums

Current Law	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Proposed Law without failsafe	0.0	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	
Difference	0.0	0.0	-0.4	-0.7	-1.2	-1.5	-1.7	-2.0	-7.5

Net Mandatory Outlays Without Failsafe

Current Law	157.7	178.3	197.1	215.6	237.0	260.4	286.1	314.7	
Proposed Law without fail-safe	157.7	170.1	181.5	194.0	205.8	219.1	234.7	251.2	

Change in Net Medicare Outlays without Failsafe

0.0	-8.2	-15.6	-21.6	-31.1	-41.3	-51.5	-63.5	-232.9
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Net Mandatory Outlays With Failsafe

Proposed Law with fail-safe	157.7	170.1	181.5	188.8	197.5	211.2	226.3	243.6	
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Change in Net Medicare Outlays with Failsafe

0.0	-8.2	-15.6	-26.8	-39.5	-49.2	-59.8	-71.1	-270.2
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Medicare Proposal (based on specs through 1999): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
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FOOTNOTES:

- /1 These estimates assume that final legislative language would meet scorekeeping requirements.
- /2 Estimate under review.
- /3 Payments are reduced 20% in 96; 25% in 97; and 30% in subsequent years.
- /4 Legislative language must stipulate that the redistribution for exceptions will not exceed 10% of total capital payments and that this is an allocation issue, not a provision that increases reimbursements.
- /5 Does not include effects of provision to eliminate payments for residents after first residency period.
- /6 This estimate assumes that the provision will only be applied to existing LTC facilities.
- /7 This is probably budget neutral if language is provided that clarifies the intent is to grandfather existing long term care hospitals that are currently located within or on the same campus as the "acute care PPS-related" hospital.
- /8 This provision would cost approximately \$5 million per year.
- /9 This provision is budget neutral if only hospitals currently designated as EACH/VRPCH will have this designation and no other hospitals/facilities can be designated as such.
- /10 This estimate will be reduced substantially if the policy is to cover only Part B services.
- /11 Based on Senate proposal, except MB-2.
- /12 This estimate assumes PPRC recommended proposal, cumulative spending targets at GDP+2, 6.9% update and target reduction in 98.
- /13 This line includes a 1% annual update for prosthetics and orthotics.
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NOTES:

1. Details may not sum to total because of rounding.
2. These estimates assume an enactment date of November 15, 1995. The estimates would change if the proposal was enacted at a later date.
3. These estimates are based on draft legislative language as of 8/28 and subsequent changes specified by Committee staff.
4. The effects of medical savings account provision are embodied in the Medicare Choice line.
5. To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall.
6. These estimates do not incorporate changes in discretionary spending for administration.

Medicare Proposal (based on specs through 29): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	Total
COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING									
Gross Mandatory Outlays for Medicare Part A Benefits Without Fallsafe									
Current Law, BR baseline	112.0	123.7	135.2	146.8	158.5	170.7	183.6	197.1	
Proposed Law		120.6	128.4	138.3	144.1	152.6	161.6	171.2	
Difference		-3.1	-6.8	-10.3	-14.4	-18.1	-21.8	-25.9	-100.3
Gross Mandatory Outlays for Medicare Part B Benefits Without Fallsafe									
Current Law, BR baseline	65.8	74.9	83.9	93.5	104.0	117.0	131.2	147.7	
Proposed Law		73.0	79.5	86.7	94.0	102.8	113.1	124.6	
Difference		-2.0	-4.3	-6.8	-10.6	-14.2	-18.2	-22.9	-79.0
Total Mandatory Outlays for Medicare Benefits Without Fallsafe									
Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law		193.6	208.0	223.0	238.0	256.4	274.8	296.0	
Difference		-5.0	-11.1	-17.1	-25.0	-32.3	-40.0	-48.8	-179.3
Gross Mandatory Outlays for Medicare Part A Benefits With Fallsafe									
Current Law, BR baseline	112.0	123.7	135.2	146.8	158.5	170.7	183.6	197.1	
Proposed Law		120.6	128.4	133.2	139.1	147.6	156.8	166.7	
Difference		-3.1	-6.8	-13.4	-19.4	-22.8	-26.8	-30.4	-122.7
Gross Mandatory Outlays for Medicare Part B Benefits With Fallsafe									
Current Law, BR baseline	65.8	74.9	83.9	93.5	104.0	117.0	131.2	147.7	
Proposed Law		73.0	79.5	84.6	90.6	99.7	109.7	121.7	
Difference		-2.0	-4.3	-8.8	-13.9	-17.4	-21.5	-26.0	-83.9
Total Mandatory Outlays for Medicare Benefits With Fallsafe									
Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law		193.6	208.0	217.8	229.7	247.5	266.5	288.4	
Difference		-5.0	-11.1	-22.3	-33.3	-40.2	-48.3	-56.4	-216.7

Very Preliminary CBO
Part B Premium #5

1996	1997	1998	1999	2000	2001	2002
\$54	\$57	\$60	\$64	\$72	\$78	\$87

From Hill?

Questions Americans Should Ask Newt Gingrich and the Republicans About Their Medicare Plan

September 15, 1995

1. According to Republicans, the reason for cutting Medicare spending by \$270 billion is to "save" Medicare from going bankrupt.
 - How much of the \$270 billion in cuts goes to "save" the Medicare Trust Fund?
2. The New York Times reports that there is an \$80 billion shortfall in the Republican plan.
 - Is this true?
 - How are these savings going to be achieved?
 - Who will bear the brunt of these secret cuts -- the beneficiaries? inner-city hospitals? rural clinics? **Who?**
2. The Congressional Budget Office has reported that Medicare cuts of this magnitude end-up being shifted to families covered under private health insurance.
 - How much will private health insurance premiums rise because of these Medicare cuts?
3. Earlier this year, Republicans cut taxes to upper-income seniors that will result in a loss of \$87 billion to the Medicare Part A Trust Fund over the next decade.
 - Has this money been put back into the Part A Trust Fund in order to protect its solvency?
4. If Medicare's solvency was of such critical import to Republicans, why did they make no mention of it during the entire health care debate in 1993 and 1994?"

- Furthermore, why did they oppose reasonable Democratic efforts to slow the growth in Medicare? in that debate?
- 5. If Medicare's solvency was of such critical import to Republicans, why was there no mention of it in their "contract with America?"

PART B CUTS:

1. News reports indicate that the Part B premium will double under the Republican plan between now and 2002.
 - Is this accurate?
 - How much will the Part B premium actually be?
2. How much of this increased premium seniors will pay out of their pockets will go back into the Medicare Trust Fund?
3. If seniors on a fixed income such as Social Security face a higher premium, where will the money come from?
4. Currently, the Medicare and Medicaid programs build on each other in providing coverage to seniors of modest incomes.
 - As such, Medicaid covers the Part B premium of seniors at or below 120% of the poverty level.
 - Will this protection be maintained under the Republican plan?
 - In addition, current federal law provides protection for seniors with incomes at or below 100% of poverty by covering their deductibles and copayments.
 - Will this protection be preserved?
 - If these protections are not maintained, won't low and moderate-income seniors be forced into HMOs?

5. Couldn't seniors actually lose coverage for doctor visits and outpatient services if they can't afford the Part B premium?
6. Why are Republicans going to raise premium taxes on upper-income Medicare recipients if they are going to just turn around and give the money away in tax breaks to some other group of upper-income Americans?
7. If we are going to means-test the Part B premium, why don't we put the money toward strengthening the Medicare Trust Fund?

MEDICAL TRAINING

1. Under the Republican plan, will funding for training our nation's doctors be cut?
 - Who is going to pick-up this cost?
2. What will be the impact of the Republican policy of ending payment for international medical graduates on inner-city hospitals which are heavily dependent on these individuals for providing basic medical services?
 - Do the Republicans intend to provide any transitional assistance to these hospitals?

CHOICE

1. Republicans claim to expand choice for Medicare beneficiaries, but it seems that their plan will in fact damage the choices already available to beneficiaries. How is choice really expanded?
 - What doctors will they be able to see under the Republican plan that they cannot see today?

- If payments to doctors are dramatically cut, as it appears the Republican plan will do, won't the number of doctors willing to participate in Medicare decline, and drastically?
- 2. Over three-quarters of all beneficiaries already have the choice of one or more managed care plans, many that offer added benefits like some prescription drug coverage and eye glasses.
 - If the payment to these HMOs is reduced by 24%, won't the "extras" offered by these plans disappear?
 - Won't this have the effect of reducing the choices available to seniors?
- 3. Reportedly, Medicare payments to contracting HMOs will not be set as they are today -- based upon the costs of treating Medicare beneficiaries in the area served by the plan. Instead, HMO payments are going to be capped in order to match the Republicans' budget goals.
 - What happens if the capped payment to the HMOs is insufficient and the HMOs run out of money?
 - Who picks-up the tab?
 - Will beneficiaries have to pay more?
 - After all the "extras" are gone, will managed care plans ration care?
- 4. In prior years, the Congress has considered a medical savings account (MSA) option under Medicare but concluded that such a proposal would actually damage the Medicare program.
 - Won't beneficiaries who are healthy and wealthy enough to take the risk opt for the MSA, leaving the sick behind?

- If this is done, won't the Medicare Trust Fund lose millions of dollars that would otherwise be available for beneficiaries when they are sick?

CONSUMER PROTECTIONS

1. Are there any changes to the beneficiary protections provided in current law?
2. It is rumored that the quality standards in effect today for nursing home care will be eliminated.

- Is this true?

3. Horror stories appear constantly in the press about managed care plans.

- Are there protections in this bill against these abuses?

- Are the beneficiaries protections introduced by Members on both sides of the aisle included in the bill?

- If not, why not?

4. The Republican plan states that managed care plans must meet "solvency" standards.

- What about the other standards that are in current law?

5. The Republican plan apparently proposes to let unlicensed networks act as insurance companies.

- Is this true?

- Who will oversee these plans providing services to Medicare beneficiaries if they are not licensed and supervised like other insurance companies?

OVERVIEW, REPUBLICAN MEDICARE PLAN

PROPOSAL	COMMENT
Traditional Medicare/keeping commitment 1. Average payment per beneficiary will rise to \$6,700 in 2002 2. No change in copayments, deductibles. 3. Keep premium at 31.5 percent	That is a cut of \$1700 per beneficiary from CBO baseline Current premium analysis
The better Medicare - more choices Choose between traditional Medicare and private sector options in new Medicare Plus. Any private insurer who at least covers Medicare benefits and meets consumer protection standards can apply. Options include: 1. Coordinated care - must meet solvency, and offer minimum benefit package equal to that of Medicare -- 2. Medical savings accounts - high deductible policy plus MSA deposit. 3. Provider service networks -- meet solvency and marketing requirements. 4. Per beneficiary contribution adjusted for age, other factors, indexed to specified growth rates. 5. Plans agree to take all applicants.	Multiple choice of different types of plans with different benefits raises consumer information/ comparison issue, and adverse selection issue What are standards -- implies that they may not be same as current?[Note - health plan quality, access, beneficiary protection standards issue may be an underlying weakness] This means that it is not the standard Medicare benefit (which is promised in introductory language) Adverse selection - Tyson argument Standards issue again How tight index? This means that \$ contribution unrelated to benefits - buys less and less -- and beneficiary pays more and more in premium -- balance billing at premium level

PROPOSAL	COMMENTS
Waste, fraud, and abuse 1. Reward beneficiaries who report incidences 2. Require SNFs/HHAs to provide cost estimates up front. 3. Imposes significant penalties on those who defraud Medicare	Much of this already occurs today
Seeking value for the government as a health care buyer 1. Phases out funding for residency programs for non-citizens and graduate education subsidies that draw doctors into highly specialized fields, targeting funds on primary care. 2. Provide doctors options. 3. Enable doctors to escape paper burden and restrictive payment rules	What happens to hospitals, areas that rely on these providers (NYC issue) How deep a cut -- what are specifics Does this mean allow balance billing -- either in standard Medicare, in within health plans?
Affluence testing for subsidized premiums 1. Single seniors with income over \$75,000 and couples over \$150,000 will pay higher premiums 2. Gives states the ability to reduce costs	What is maximum %?
Guaranteeing solvency through failsafe 1. Set growth rates by provider type 2. Monitor, revise payment updates to reach target	This is the cost containment. What are growth rates required to achieve targets? Have we ever achieved them? Black box - magic

HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS

M E M O R A N D U M

TO: John Callahan, Jack Ebeler, Jerry Klepner
FROM: Debbie Chang
DATE: September 14th
RE: Issues, Implications, and Summary of House Rep. Proposal
=====

Attached is a document which discusses issues and implications of the House Republican "proposal."

Sharon Arnold can be reached at 690-5705 and Peter Hickman can be reached at 690-5950 for questions.

cc: Bruce
Kathy King
Christy Schmidt
Karen Pollitz
Jeanne Lambreaux

DRAFT September 14, 1995

Summary of Provisions and Issues
The House Republican Leadership's
"MEDICARE PRESERVATION ACT OF 1995"

1. Retaining Traditional Medicare--Summary of Provisions

- ♦ Beneficiaries automatically enrolled in traditional Medicare unless they choose a Medicare Plus Option.
 - ▶ No changes in deductibles or coinsurance
 - ▶ Increase Part B premium to 31.5% of projected program costs (see increase in premium for high income beneficiaries in Section 5).
- ♦ Average per beneficiary spending will increase from \$4,800 in 1996 to \$6,700 in 2002.

Retaining Traditional Medicare--Issues

- ♦ The MPA claims to allow beneficiaries to remain in traditional Medicare. However, under the MPA physicians could serve beneficiaries enrolled in private fee-for-service plans, MSA/high deductible plans and provider service networks. There is no indication in the proposal that beneficiaries would have extra-billing protection under these plans. If a significant portion of physicians in an area begin serving beneficiaries only through these alternative plans in order to avoid extra-billing limits under traditional Medicare, choosing to remain in traditional Medicare will not be a "real" option for beneficiaries.

2. Increasing Choices--Summary of Provisions

- ♦ Beneficiaries may choose from several private sector options in a new Medicare Plus system.
- ♦ Each year, beneficiaries would receive a booklet describing approved plans available in their geographic area. All plans must meet consumer protection standards, cover at least Medicare benefits, and meet solvency standards.
- ♦ The federal contribution would be adjusted for age and other factors. Each year the federal contribution would increase according to specified growth rates.
- ♦ All plans must take all applicants; applicants cannot be involuntarily disenrolled by the plan.
- ♦ Options include:

- ▶ Coordinated care plans. These plans (e.g., HMOs, PPOs, POS) may reduce out-of-pocket expenses and offer additional benefits.
- ▶ Medical savings accounts (MSAs). Referred to as "Medisave", these accounts would provide a high-deductible insurance policy and a cash deposit to the MSA that would cover a significant portion of the deductible. The policy would have no copayments, so beneficiaries would be assured a limit on their out-of-pocket costs.

Beneficiaries can spend their MediSave funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could use MediSave funds for non-health related purposes as long as a minimum balance of 60% of the high deductible is maintained. Funds used for non-health care expenses and interest earned on MediSave accounts would be taxed as income.

The high-deductible amount would be capped.

Provider Service Networks. Doctors and hospitals could form networks without being licensed as an insurance company or managed care company.

- ▶ Private fee-for-service plans. While not addressed in the general description, the attachments indicate that private fee-for-service plans will also be available.

Increasing Choices--Issues

- ◆ Under the MPA, the federal contribution is based upon a fixed amount increased in subsequent years by a fixed growth rate. Based on the per capita spending amounts assumed under the Budget Resolution, the growth rate for the federal contribution would be far less than projected per capita growth rates for traditional Medicare and even private health insurance. Thus, it appears unlikely the fixed contribution would be sufficient over time for beneficiaries to purchase their plan of choice without incurring significant out-of-pocket expenses. In addition, it is questionable whether adequate numbers of private plans would participate in Medicare Plus system if the federal contribution is inadequate.
- ◆ The MPA states that the federal contribution would be risk adjusted for age and other factors. However, development of reliable risk adjustment methods is in its early stages. Risk adjustment will be critical to ensure that plans are

not penalized if their enrollee population is sicker than average or rewarded if their enrollment is healthier than average.

- ◆ In order for beneficiaries to compare competing alternative plans under the Medicare Plus system, they will need comparative information quality as well as price, network composition, benefits, cost-sharing, and other factors. Comparative information on the quality of care provided by competing plans is difficult to measure--but of vital importance to potential enrollees, particularly if they can only change plans on a yearly basis, as proposed in the MPA. The need for reliable quality of care assessments is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages
- ◆ It is unclear in the MPA what entity would ensure that standards (e.g., consumer protections, solvency requirements, marketing standards) would be met by plans.
- ◆ The Medical Savings Account option could lead to a self-selection bias against traditional Medicare, with healthy individuals choosing the MSA and others left in the traditional Medicare program.
 - ▶ According to the Medicare Continuous History sample, average per capita spending in 1993 for was \$3,486.
 - ++ Within this sample, however, 55 percent of the beneficiaries had less than \$1,000 in reimbursement in the previous three years. For this group, average per capita spending in 1993 was \$1,598, only 46% of the average for the entire sample.
 - ++ There was also a large group, 24 percent of sample, that had no reimbursement made on their behalf in the last three years. For this group, the average per capita spending was \$1,122 only 35% of the average for the whole sample.
 - ▶ Thus, a MSA Option for Medicare could potentially be costly to the program if low cost beneficiaries opted for MSA's.
 - ▶ Under this scenario, the per capita cost of providing care in traditional Medicare would escalate dramatically since the costs of care for sicker

beneficiaries would be spread across a smaller base. This escalation in per capita spending resulting from selection could trigger provider cuts under the "fail safe" provisions further destabilizing traditional Medicare.

- ♦ There is no indication that the MSA option is a one-time choice. If beneficiaries are allowed in and out of the MSA option selection problems will be even worse.

3. Waste, Fraud, and Abuse--Summary of Provisions

- ♦ The Department of Health and Human Services is provided with the authority to reward beneficiaries who report instances of waste, fraud and abuse.
- ♦ SNFs and Home Health Agencies would be required to provide up-front cost estimates to any patient.
- ♦ Significant penalties imposed on anyone who defrauds Medicare.

Waste, Fraud and Abuse--Issues

- ♦ A large proportion of beneficiaries currently report instances of waste, fraud and abuse. Providing rewards to beneficiaries who already do so would result in added costs. This provision would also be administratively complex.

4. Government as a Health Care Buyer--Summary of Provisions

- ♦ Limits updates for hospitals and physician services
- ♦ The bill phases out funding for medical residency programs for non-citizens and graduate medical education funding subsidies that draw doctors into highly specialized fields, targeting the funds for primary care.

Government as a Health Care Buyer--Issues

- ♦ In general, we support both the goals of reducing the number of residency positions in the U.S. and focusing more resources on primary care training. However, in any policy which focuses on reducing or eliminating the number of international medical graduates we would be very concerned about the impact on hospitals which rely heavily on those IMGs for providing services.

5. Income-Related Premium--Summary of Provision

- ♦ Single beneficiaries with incomes over \$75,000 and couples with incomes over \$150,000 would pay higher Part B premiums instead of receiving a subsidy from the taxpayers.

Income-Related Premium--Issues

6. "Fail Safe"--Summary of Provision

- ♦ The MPA would set spending growth rates for provider categories such as inpatient hospital services, physician services, home health care, durable medical equipment and laboratory services.
- ♦ Each year the Secretary of HHS would determine if the level of services being provided would exceed designated spending growth. If it would, the Secretary would reduce payment updates to guarantee that spending growth targets were met.

"Fail Safe"-- Issues

- ♦ It is unclear how a target system would work in a world where enrollment in the traditional Medicare would be in flux and where traditional Medicare would be subject to significant adverse selection.
- ♦ To the extent that provider payment updates are unreasonably low, the viability of traditional Medicare is threatened.

The attachments to the general description also note the following provisions of the MPA:

- ♦ Repeals of Stark I and II "excessive" regulations
- ♦ An advisory commission on Medicare
- ♦ A commission to recommend Medicare policy changes to prepare for retirement of the baby boom generation

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THE MEDICARE PRESERVATION ACT OF 1995

A bill to preserve, protect and strengthen Medicare

An outline released by the House Republican Leadership

INTRODUCTION

According to the Medicare Board of Trustees, which includes three Clinton Administration cabinet secretaries, Medicare Part A next year begins spending ~~out~~ more than it takes in for the first time in the program's 30 year history. By 2002, the Trust Fund will be bankrupt.

If the program is ~~insolvent~~, the Treasury can not issue checks to pay hospital bills. If nothing is done, the health care of millions of current beneficiaries and millions more nearing retirement who have paid into the system all their working lives will be ~~threatened~~. Bankrupting Medicare is unacceptable public policy.

Republicans propose to ~~preserve~~, protect and strengthen Medicare with the Medicare Preservation Act of 1995. Legislative language and budgetary scoring are not presently available, but the following outline covers ~~the~~ policy options contained in the bill.

THE MEDICARE PRESERVATION ACT OF 1995

The Medicare Preservation Act of 1995 (MPA) will ~~preserve~~ the system for current beneficiaries, protect it for future beneficiaries, and strengthen it through reforms that have worked in the private sector.

Legislation to save Medicare from bankruptcy revolves around six key components:

1. Keeping our government's commitment to traditional Medicare.
2. Allowing seniors the same health care choices available to other Americans.
3. Rooting out rampant waste, fraud and abuse.
4. Maximizing the taxpayer's health care dollar.
5. Affluence ~~testing~~ for taxpayer subsidized premiums.
6. Guaranteeing solvency through a budgetary "fail safe" provision.

[Policy proposals are in italics].

1. TRADITIONAL MEDICARE: KEEPING OUR COMMITMENT

Just as Republicans promised throughout the summer, traditional Medicare will continue to be an option for all current and future beneficiaries, with four important aspects:

- ▶ *Average per beneficiary spending will rise from \$4,800 in 1996 to \$6,700 in 2002.*
- ▶ *No change in copayments.*
- ▶ *No change in deductibles.*
- ▶ *No change in the current rate for premiums.*

Today, premiums are 31.5 percent of Part B costs. Premiums will continue to be calculated that way, so that they will increase slightly every year, just as they have done since the inception of the program.

The bill exposes the shameless fear tactics of the past few months and the lie that premium would rise by \$2,000 per year. According to the Congressional Budget Office, the difference between President Clinton's proposal to drop the current 31.5% rate to 25% at current spending levels and maintaining the current rate at lower levels of increased spending amounts to only \$7.10 per month, per beneficiary. And beneficiaries will not face any increase in deductibles and payments, in contrast to the months of demagoguery.

For Medicare beneficiaries who want to remain in the existing system, keeping it is as simple as checking a box every year. Indeed, it's as simple as not checking a box every year, since failure to do so results in a beneficiary's automatic enrollment in traditional Medicare.

THE BETTER MEDICARE: GIVING SENIORS MORE CHOICES

The MPA would root out waste and bring private sector efficiency to the system. First, the bill lets Medicare beneficiaries choose between traditional Medicare and several private sector options in a new Medicare Plus plan. Every year, beneficiaries will receive a booklet describing the approved plans available in their area. Any private insurer who at least covers the Medicare benefits meets consumer protection standards can submit an application for the Medicare Plus booklet. Beneficiaries will simply check off the plan of their choice. If a beneficiary makes no choice, he is automatically enrolled in fee-for-service Medicare.

The Medicare Plus program will offer a wide range of choices to seniors.

Coordinated Care. Coordinated care companies are likely to offer several options for seniors. In choosing a coordinated care plan, a senior might agree to a limited choice of physicians or other providers in return for more benefits than Medicare now offers. Such benefits could include less out-of-pocket expenses for coinsurance and deductibles, and/or added benefits like outpatient prescription drugs, preventive care, eyeglasses and hearing aids.

All coordinated care plans must meet solvency requirements, and offer a minimum benefit package equal to that of Medicare.

Medical Savings Accounts. The Medicare Plus program will also offer a Medical Savings Accounts (Medisave) option to all seniors. A senior choosing Medisave would get a high-deductible insurance policy along with a cash deposit in a Medical Savings Account that would cover a significant portion of the deductible. The high-deductible policy would have no copayments, so that seniors would be assured a limit on their out-of-pocket costs—a quality many are likely to find attractive.

Seniors choosing this option would have complete control over the dollars they spend on routine medical care. They could make important medical decisions with their doctors, without worrying about an insurer's or Medicare's payment policies. They can spend their funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could take funds out of her Medisave account for non-health related purposes as long as she maintains a minimum balance of 60 percent of her catastrophic insurance deductible. If the funds are used for non-health care expenses, they are taxed as income. All interest earnings would be considered taxable income.

The maximum deductible would be capped to insure consumer protection.

Provider Service Networks. *Doctors and hospitals will be allowed to form provider service networks to cover Medicare benefits, without the insurance company or managed care company as intermediary. A group of doctors or hospitals that forms a network would be required to meet solvency and marketing requirements.*

Per beneficiary contributions will be adjusted for age and other factors, so that Medicare is providing funds according to need. Each year, the per beneficiary contribution will increase according to specified growth rates, established to ensure that Medicare remains solvent. Every plan participating in Medicare must agree to take all applicants and allow everyone to stay in the plan as long as they want — no one will be shut out due to an illness or a pre-existing condition.

3. ROOTING OUT WASTE, FRAUD AND ABUSE.

Ask just about any senior who has used the Medicare system and they can tell you why Medicare spending is out of control. The system is riddled with waste, abuse and outright fraud. In hundreds of town hall meetings and tens of thousands of letters from angry seniors, Republicans listened this spring and summer to story after story of a Medicare system that needs greater scrutiny. Whether it was the story of a woman who went into the hospital for eye surgery and was charged for an autopsy, or the gentleman who was charged \$14,000 for a three and a half hour hospital stay, the message from seniors all over American is the same: Get rid of the fraud and abuse.

The General Accounting Office notes "Since Medicare was enacted in 1965, the delivery of health care services has become more complex, but Medicare's fraud and abuse controls have not kept pace." In other words, like much of the Medicare program, the enforcement component has not adapted to the new realities of the health care market.

Market incentives and private sector competition as described above are not enough to clean up fraud and abuse. The Medicare Preservation Act will enhance the enforcement system and give patients incentives to scrub their bills for mistakes. *The Medicare Preservation Act provides the Department of Health and Human Services the authority to reward beneficiaries who report incidences of waste, fraud and abuse.*

The bill would require skilled nursing facilities and home health agencies to provide cost estimates up front to any patient, because making pricing publicly available guards against later bill-padding. The plan also imposes significant penalties on anyone who defrauds Medicare.

The Medicare Preservation Act Myths, Facts, Questions and Answers

THE PROCESS

MYTH: You're ramming this bill through without any real hearings.

- Since the Trustees' report came out in April, we've had dozens of hearings and heard thousands of pages of testimony. Outside Washington, Representatives have been talking to seniors, providers, hospitals and insurance companies, explaining the problem and looking for advice and solutions.
- This has been an open process, and will continue to be as we work through the bill in committee, on the floor, and with the Senate.

Q. President Clinton is going to veto this bill. Why go through all this?

- President Clinton admitted Medicare is going broke and it must be changed if it's to be around for our seniors. I truly hope he doesn't choose politics over securing Medicare's future solvency.

Q. What's wrong with Ross Perot's idea to try some of these reforms as "pilot projects?"

- Medicare is in critical condition. And unless we enact these reforms, Medicare will be bankrupt.
- We aren't forcing new ideas on anyone — instead of bureaucrats deciding what's best, we're letting 37 million seniors and disabled Americans make their own choices. And for those who don't want to change, traditional Medicare will remain as an option and seniors will always be able to switch back to it.

HOW SENIORS WILL BE AFFECTED

MYTH: You are forcing people into HMOs.

- Seniors will have the option to stay in the current program, move into a private fee-for-service or managed care plan, or purchase a MediSave Account. No one will be financially pushed into any plan — it's up to each senior to decide what's best for him or her.

MYTH: If premiums increase, the practical effect will be to force people into managed care, whatever their choice.

- In 7 years, seniors will pay between \$7 and \$10 a month more than they would under the President's budget. We believe this is a reasonable and practical cost to ask from seniors to save the program from bankruptcy.

Q. Will seniors get a better benefit package than they have right now?

- Seniors will be guaranteed the same benefits they have now, no matter what plan they choose. But they will have the option to choose a plan that may offer, for example, prescription drugs or eyeglasses, or preventative care or better hospital coverage in addition to traditional Medicare benefits. Or, they may choose a MediSave account with a

catastrophic policy that will allow them total control over their health care dollars. It's up to seniors to decide what's best for them.

MYTH: Managed care doesn't work in areas like rural America.

- That's why seniors will have choices of many types of plans. We know that what works in Los Angeles won't work in rural South Dakota.
- We're also going to make it easier for doctors and hospitals to network together, to provide health care at a better value.

MYTH: The poorest and most vulnerable seniors won't be assured Medicaid will cover their nursing care.

- Rather than relying on Medicare and Medicaid interacting properly, we are streamlining the programs so Medicare provides direct relief to low-income seniors.

MYTH: Seniors' out-of-pocket costs are going to skyrocket.

- Because Medicare is a top-down, government-designed program, seniors are getting a raw deal. For example, their hospital -- Part A -- deductible is more than \$700, and after 2 months, it's about \$180 a day. That's far higher than private insurance. And too many things aren't covered, like prescription drugs and hearing aids, meaning 70% of seniors have to purchase Medigap insurance, at about \$1,200 a year.
- We're offering choices so seniors can choose a plan that offers low copayments and deductibles. And we're not increasing co-payments and deductibles for those who wish to remain in traditional Medicare.

Q. Will seniors be guaranteed they can keep their own doctor?

- A senior choosing traditional Medicare will continue to have complete choice over what doctors they see. If their physician is affiliated with a plan they like, they can choose that plan. If a senior opts for a MediSave account, he or she can continue to see whatever doctor he wants.

MYTH: President Clinton's plan doesn't affect seniors, and it makes Medicare solvent. Why do seniors have to pay for the government's screw-ups?

- President Clinton has never submitted a Medicare reform plan. His original budget simply let it go broke. We don't know what he plans to do -- he talks a good game, but we've never seen any bill.
- And President Clinton has used some funny math. If he used the same figures we do, which are more conservative about growth rates and inflation rates, his savings work out to be \$192 billion -- not the \$128 billion he claims. In seven years, that means the difference between his plan and ours is about a dime on the dollar.

Q. How will Seniors sign up for these new plans?

- Every year, the government will send seniors a brochure that outlines the different options available. This is how federal employees make insurance choices each year. Beneficiaries who do nothing will automatically be enrolled in traditional Medicare. If they want to choose one of the new private plans, they just fill out a form in the booklet and mail it in.
- After you're enrolled in the new plan, you have a short time frame to change your mind. And then every year after that, you have the option to switch to whatever plan you choose.

Q. What if the voucher isn't enough to buy any plan?

- This is not a voucher program. The federal government is not simply going to give each elderly a coupon and tell them to find their own insurance. Every plan that participates in Medicare will have a contract with the federal government, assuring they meet consumer protection standards. Every participating plan must agree to take all applicants. They can't differentiate between older and younger seniors, or between healthy or ill seniors.

- Right now, Medicare spends about \$4,800 per beneficiary. In seven years under our plan, Medicare will spend about \$6,700. We've worked with providers and doctors, and they assure us that's plenty of money for high-quality health care.

Q. Will you increase co-payments?

- No.

Q. Will you increase deductibles?

- No.

Q. Seniors like the convenience of Medicare -- there's no need to deal with insurance agents. Now they'll have to buy a plan, file claims forms with insurance companies, and deal with all that hassle, won't they?

- Seniors don't have to choose a private plan if they wish to stay in traditional Medicare.
- But anyone who has ever filed a claim with Medicare knows it's not exactly user-friendly. And if you have Medigap, you have to deal with two bureaucracies instead of one. Many of the private plans eliminate a lot of the paperwork for seniors.

MYTH: Fly-by-night crooks will set up scams to rip off seniors, taking their vouchers & running off with the money, leaving them without health coverage.

- Seniors will never receive a check from the government with which they have to buy insurance. They'll get a booklet, make their choice, and mail in a form. Medicare will directly reimburse health plans. And Medicare will only allow plans to participate in Medicare if they meet strict consumer protection and other standards. That will prevent seniors and taxpayers from getting ripped off.

HOW OUR PLAN SOLVES THE PROBLEM

Q. What does this mean for Medicare's bankruptcy?

- Our plan makes Medicare solvent until 2014, just before the baby-boomers retire. We're ensuring that Medicare is there for today's current and future seniors. We will also appoint a commission to look beyond 2014, and recommend policies to address the huge demographic shift coming then.

Q. What about waste, fraud, and abuse?

- Everywhere every Congressman went over the summer, he or she heard horror stories about waste, fraud, and abuse. They heard about government bureaucrats who simply didn't care about their complaints, they heard about hospitals that didn't worry about correcting mistakes because "seniors aren't paying for it anyway."
- They told us about unnecessary tests and procedures because unscrupulous providers are trying to make a quick buck. They told us about receiving medical devices they don't need because someone got a hold of their Medicare number. We'll fix that by giving beneficiaries who stay in traditional Medicare a reward for reporting fraud. We'll also require all private Medicare plans to maintain a 1-800 number to receive billing complaints.
- And most importantly, we're bringing this system into the 21st century. By introducing competition and making providers and insurers compete for seniors' business, seniors will be assured the best bang for their buck. And that means providers and insurers will lose business if they continue to waste money -- they won't be able to afford to tolerate waste and fraud.

Q. Experts believe that options like coordinated care and Medisave will attract only the healthiest seniors, leaving a sicker and sicker population in traditional Medicare. How will that solve the bankruptcy issue?

- They're wrong. Those seniors with higher health costs will find several attractive private sector options. The fact is, Medicare leaves seniors exposed to far more out-of-pocket risk than the average private insurance plan. Beneficiaries with major illnesses, who are those generally on fixed incomes, face the prospect at the beginning of each year of a \$718 Part A deductible, a \$100 Part B deductible, and 20 percent copayments on most additional medical services, along with no coverage for prescription drugs.
- The only way to avoid these possibly unlimited costs right now is to spend \$800 to \$1,400 on Medigap insurance. Our Medicare Plus options likely will, as is the practice in private insurance for those under age 65, offer explicit limits on out-of-pocket liability. That will be very appealing to a senior on a fixed income who is worried about incurring large medical bills during the year.

Q. HCFA right now claims that the Medicare risk contract program actually costs more than traditional Medicare. How will managed care solve the bankruptcy problem?

- Other studies have shown that Medicare risk contracts save money. But it's available in only certain areas, not across the country and with major restrictions, so we simply can't compare today's limited program to the new Medicare Plus system.

HOW DOCTORS & HOSPITALS WILL BE AFFECTED

MYTH: Cutting doctors' fees means they won't want to see seniors -- that will ration care.

- Doctors and hospitals must contribute to saving Medicare. But under a more efficient Medicare system, Medicare dollars will go a lot farther than they have in the past.
- If the system goes bankrupt, the government can't pay bills. That's what will ration care, and we won't let that happen.

Q. Doesn't cutting doctor and hospital fees for Medicare mean they'll just pass on those costs to the rest of us? It sounds like a hidden tax increase.

- We are making the system more efficient and giving doctors and hospitals more flexibility so they can better treat patients at reasonable costs.

Q. Are you doing anything about malpractice reform?

- We've already passed a limit on non-economic damages in our Contract legal reform bill.

Q. Won't these cuts mean some rural hospitals will have to close?

- Hospitals are going to have to change, to become more efficient. That's happening all around the country, because Medical technology has changed. Surgeries that once required four and five days in the hospital are now outpatient procedures. We think rural hospitals are as able to achieve efficiencies as urban ones.

Q. Are you cutting funding for graduate medical education?

- We are making modest reductions in funding and at the same time improving the targeting of medical education funds toward their best use -- training primary care physicians rather than highly specialized doctors who treat fewer patients.

Q. Will the fail safe mechanisms mean hospitals and doctors won't see me if Medicare runs over budget?

- No. The fail safe is designed to make minor adjustments in payments for medical services. In fact, if providers don't overspend, the fail safe won't even be triggered.

GENERAL QUESTIONS

Q. It's only Part A that's ~~going~~ bankrupt. Why do you have to increase Part B premiums and make reforms to that program?

- Part A pays hospital bills. Part B pays doctor bills. But it's doctors who put people into hospitals -- you can't separate the two. And the same report that warned us about Part A's bankruptcy also said that Part B was growing at unsustainable levels -- 12.1% a year for the rest of the decade, while private insurance costs actually dropped last year.

MYTH: Right now, the government spends only pennies on the dollar for administering Medicare. Private insurers spend far more money -- meaning seniors will get less bang for the buck, and pay more in paperwork costs.

- Today, we spend billions to contract out administering Medicare, and it's impossible to know exactly how much Medicare spends on paperwork and bureaucracy.
- Seniors will get a better value by opening up Medicare to competition. Insurers will have real incentives to keep their overhead down, and that translates into more money being spent on health care, and less on paperwork. Any plan that cannot keep its costs down simply will not be able to compete for seniors' business.
- Seniors will compare plans and see which plan is spending more on paperwork and overhead, and which one is spending more on health care.

Q. I've heard horror stories about insurers canceling policies if someone gets very sick. They also deny or limit coverage if someone is already sick and wants to purchase coverage. Will that happen to seniors who choose to buy from private insurers?

No. If a senior chooses to purchase a private plan, they will be guaranteed coverage and renewability of their policies each year. No Medicare Plus participating insurer can deny any senior a plan.

Q. Is this like what the Clintons tried to do last year?

- The Clinton health care plan proposed to take everyone's private health insurance and turn it over to the government. We're going to take a government insurance program and apply the lessons of the private sector.
- We're increasing choices for Medicare beneficiaries, they proposed to decrease choices for everyone, and their plan would have let Medicare go bankrupt.

MYTH: Your plan is going to chase doctors out of traditional Medicare.

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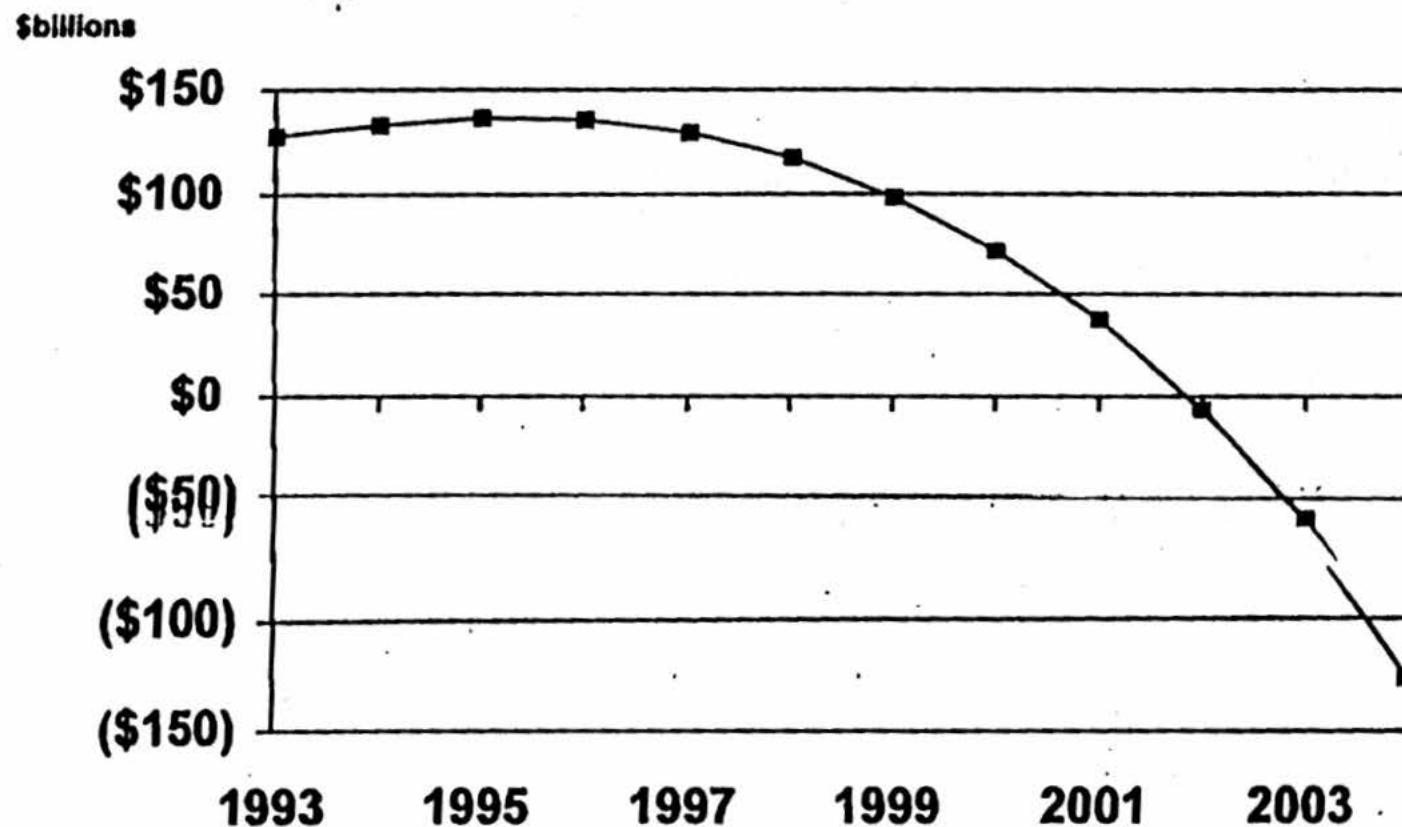
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MEDICARE HOSPITAL TRUST FUND EMPTY IN SEVEN YEARS

(Trust Fund Reserves)

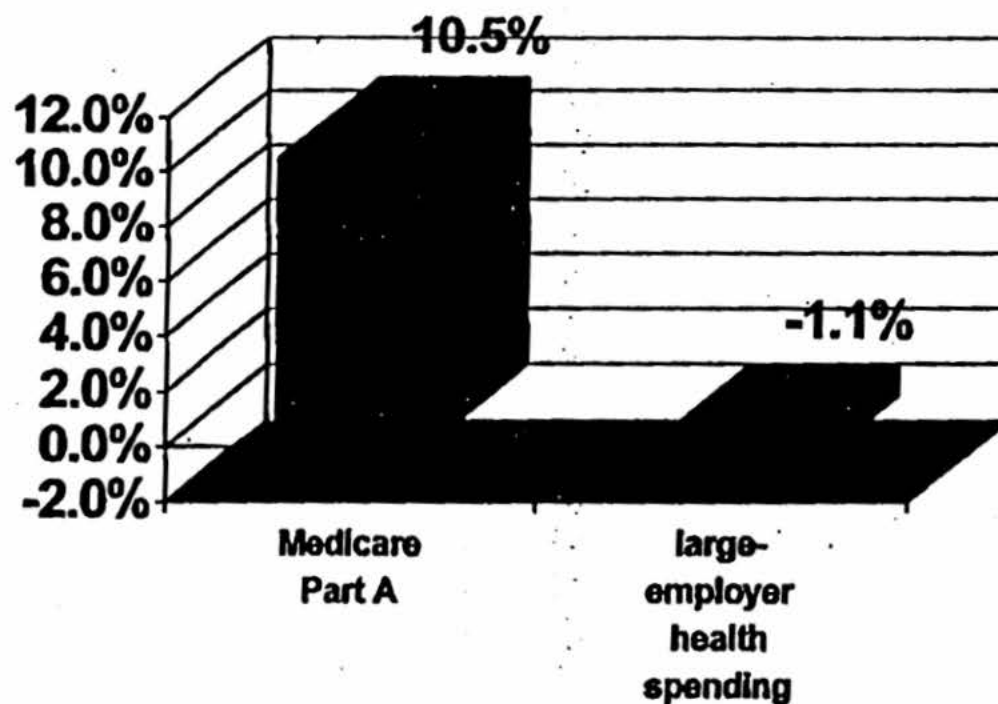


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Traditional Medicare

Keeping the Commitment

Copayments: No Change

Deductibles: No Change

Premiums: Current 31.5% Rate

In 2002, the premium for an average retiree will be \$7 more than under President Clinton's proposal.

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HMO

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Choices

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POS

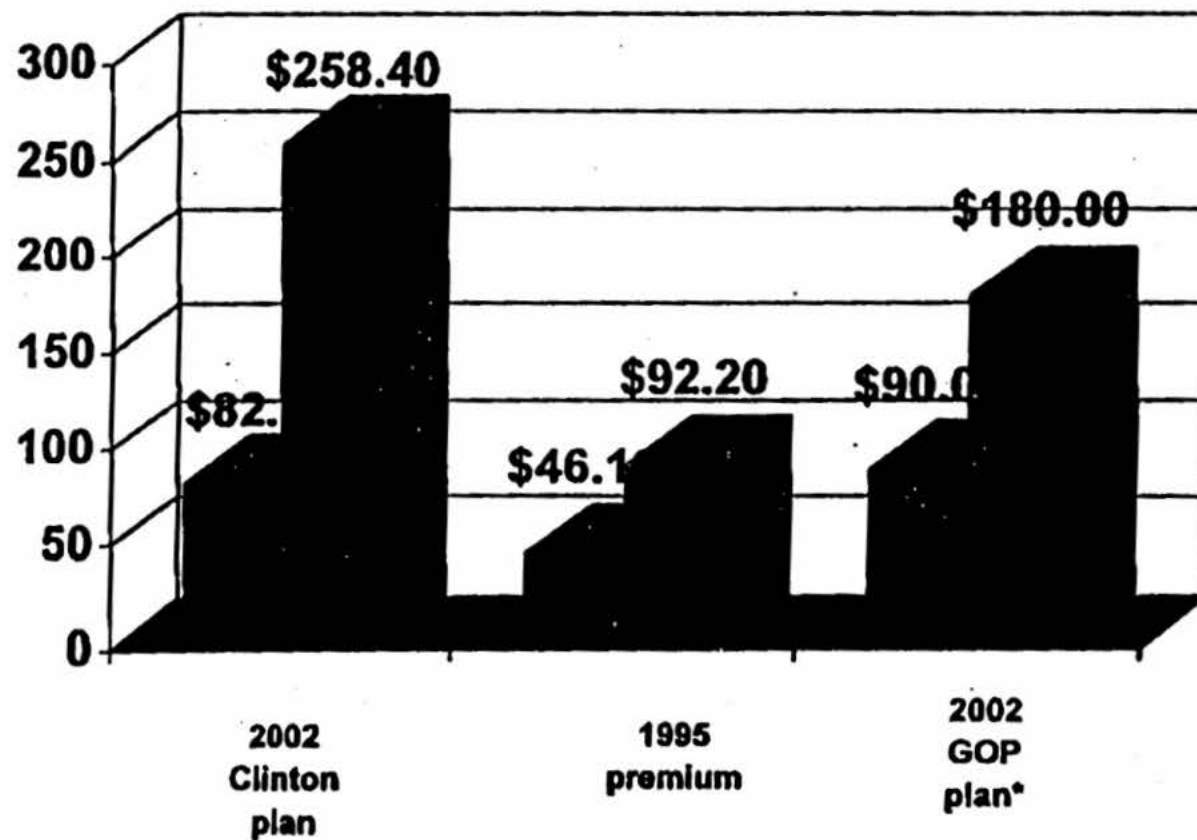
Provider Service
Networks

Private Sector
Insurance Policies

Medical Savings
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Monthly Part B Premium: Beneficiary Cost vs Taxpayer Cost

(portion of premium paid by beneficiary vs. portion of premium paid from general revenues)



*estimate

page 7

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No

Targets Exceeded?

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75-year old, average income senior

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THE MEDICARE PRESERVATION ACT OF 1995

A bill to preserve, protect and strengthen Medicare

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If the program is ~~insolvent~~, the Treasury can not issue checks to pay hospital bills. If nothing is done, the health care of millions of current beneficiaries and millions more nearing retirement who have paid into the system all their working lives will be threatened. Bankrupting Medicare is unacceptable public policy.

Republicans propose to ~~preserve~~, protect and strengthen Medicare with the Medicare Preservation Act of 1995. Legislative language and budgetary scoring are not presently available, but the following outline covers the policy options contained in the bill.

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Just as Republicans promised throughout the summer, traditional Medicare will continue to be an option for all current and future beneficiaries, with four important aspects:

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The MPA would root out wastes and bring private sector efficiency to the system. First, the bill lets Medicare beneficiaries choose between traditional Medicare and several private sector options in a new Medicare Plus plan. Every year, beneficiaries will receive a booklet describing the approved plans available in their area. Any private insurer who at least covers the Medicare benefits meets consumer protection standards can submit an application for the Medicare Plus booklet. Beneficiaries will simply check off the plan of their choice. If a beneficiary makes no choice, he is automatically enrolled in fee-for-service Medicare.

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All coordinated care plans must meet solvency requirements, and offer a minimum benefit package equal to that of Medicare.

Medical Savings Accounts. The Medicare Plus program will also offer a Medical Savings Accounts (Medisave) option to all seniors. A senior choosing Medisave would get a high-deductible insurance policy along with a cash deposit in a Medical Savings Account that would cover a significant portion of the deductible. The high-deductible policy would have no copayments, so that seniors would be assured a limit on their out-of-pocket costs—a quality many are likely to find attractive.

Seniors choosing this option would have complete control over the dollars they spend on routine medical care. They could make important medical decisions with their doctors, without worrying about an insurer's or Medicare's payment policies. They can spend their funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could take funds out of her Medisave account for non-health related purposes as long as she maintains a minimum balance of 60 percent of her catastrophic insurance deductible. If the funds are used for non-health care expenses, they are taxed as income. All interest earnings would be considered taxable income.

The maximum deductible would be capped to insure consumer protection.

Provider Service Networks. *Doctors and hospitals will be allowed to form provider service networks to cover Medicare benefits, without the insurance company or managed care company as intermediary. A group of doctors or hospitals that forms a network would be required to meet solvency and marketing requirements.*

Per beneficiary contributions will be adjusted for age and other factors, so that Medicare is providing funds according to need. Each year, the per beneficiary contribution will increase according to specified growth rates, established to ensure that Medicare remains solvent. Every plan participating in Medicare must agree to take all applicants and allow everyone to stay in the plan as long as they want — no one will be shut out due to an illness or a pre-existing condition.

3. ROOTING OUT WASTE, FRAUD AND ABUSE.

Ask just about any senior who has used the Medicare system and they can tell you why Medicare spending is out of control. The system is riddled with waste, abuse and outright fraud. In hundreds of town hall meetings and tens of thousands of letters from angry seniors, Republicans listened this spring and summer to story after story of a Medicare system that needs greater scrutiny. Whether it was the story of a woman who went into the hospital for eye surgery and was charged for an autopsy, or the gentleman who was charged \$14,000 for a three and a half hour hospital stay, the message from seniors all over American is the same: Get rid of the fraud and abuse.

The General Accounting Office notes "Since Medicare was enacted in 1965, the delivery of health care services has become more complex, but Medicare's fraud and abuse controls have not kept pace." In other words, like much of the Medicare program, the enforcement component has not adapted to the new realities of the health care market.

Market incentives and private sector competition as described above are not enough to clean up fraud and abuse. The Medicare Preservation Act will enhance the enforcement system and give patients incentives to scrub their bills for mistakes. *The Medicare Preservation Act provides the Department of Health and Human Services the authority to reward beneficiaries who report incidences of waste, fraud and abuse.*

The bill would require skilled nursing facilities and home health agencies to provide cost estimates up front to any patient, because making pricing publicly available guards against later bill-padding. The plan also imposes significant penalties on anyone who defrauds Medicare.

The Medicare Preservation Act Myths, Facts, Questions and Answers

THE PROCESS

MYTH: You're ramming this bill through without any real hearings.

- Since the Trustees' report came out in April, we've had dozens of hearings and heard thousands of pages of testimony. Outside Washington, Representatives have been talking to seniors, providers, hospitals and insurance companies, explaining the problem and looking for advice and solutions.
- This has been an open process, and will continue to be as we work through the bill in committee, on the floor, and with the Senate.

Q. President Clinton is going to veto this bill. Why go through all this?

- President Clinton admitted Medicare is going broke and it must be changed if it's to be around for our seniors. I truly hope he doesn't choose politics over securing Medicare's future solvency.

Q. What's wrong with Ross Perot's idea to try some of these reforms as "pilot projects?"

- Medicare is in critical condition. And unless we enact these reforms, Medicare will be bankrupt.
- We aren't forcing new ideas on anyone -- instead of bureaucrats deciding what's best, we're letting 37 million seniors and disabled Americans make their own choices. And for those who don't want to change, traditional Medicare will remain as an option and seniors will always be able to switch back to it.

HOW SENIORS WILL BE AFFECTED

MYTH: You are forcing people into HMOs.

- Seniors will have the option to stay in the current program, move into a private fee-for-service or managed care plan, or purchase a MediSave Account. No one will be financially pushed into any plan -- it's up to each senior to decide what's best for him or her.

MYTH: If premiums increase, the practical effect will be to force people into managed care, whatever their choice.

- In 7 years, seniors will pay between \$7 and \$10 a month more than they would under the President's budget. We believe this is a reasonable and practical cost to ask from seniors to save the program from bankruptcy.

Q. Will seniors get a better benefit package than they have right now?

- Seniors will be guaranteed the same benefits they have now, no matter what plan they choose. But they will have the option to choose a plan that may offer, for example, prescription drugs or eyeglasses, or preventative care or better hospital coverage in addition to traditional Medicare benefits. Or, they may choose a MediSave account with a

catastrophic policy that will allow them total control over their health care dollars. It's up to seniors to decide what's best for them.

MYTH: Managed care doesn't work in areas like rural America.

- That's why seniors will have choices of many types of plans. We know that what works in Los Angeles won't work in rural South Dakota.
- We're also going to make it easier for doctors and hospitals to network together, to provide health care at a better value.

MYTH: The poorest and most vulnerable seniors won't be assured Medicaid will cover their nursing care.

- Rather than relying on Medicare and Medicaid interacting properly, we are streamlining the programs so Medicare provides direct relief to low-income seniors.

MYTH: Seniors' out-of-pocket costs are going to skyrocket.

- Because Medicare is a top-down, government-designed program, seniors are getting a raw deal. For example, their hospital -- Part A -- deductible is more than \$700, and after 2 months, it's about \$180 a day. That's far higher than private insurance. And too many things aren't covered, like prescription drugs and hearing aids, meaning 70% of seniors have to purchase Medigap insurance, at about \$1,200 a year.
- We're offering choices so seniors can choose a plan that offers low copayments and deductibles. And we're not increasing co-payments and deductibles for those who wish to remain in traditional Medicare.

Q. Will seniors be guaranteed they can keep their own doctor?

- A senior choosing traditional Medicare will continue to have complete choice over what doctors they see. If their physician is affiliated with a plan they like, they can choose that plan. If a senior opts for a MediSave account, he or she can continue to see whatever doctor he wants.

MYTH: President Clinton's plan doesn't affect seniors, and it makes Medicare solvent. Why do seniors have to pay for the government's screw-ups?

- President Clinton has never submitted a Medicare reform plan. His original budget simply let it go broke. We don't know what he plans to do -- he talks a good game, but we've never seen any bill.
- And President Clinton has used some funny math. If he used the same figures we do, which are more conservative about growth rates and inflation rates, his savings work out to be \$192 billion -- not the \$128 billion he claims. In seven years, that means the difference between his plan and ours is about a dime on the dollar.

Q. How will Seniors sign up for these new plans?

- Every year, the government will send seniors a brochure that outlines the different options available. This is how federal employees make insurance choices each year. Beneficiaries who do nothing will automatically be enrolled in traditional Medicare. If they want to choose one of the new private plans, they just fill out a form in the booklet and mail it in.
- After you're enrolled in the new plan, you have a short time frame to change your mind. And then every year after that, you have the option to switch to whatever plan you choose.

Q. What if the voucher isn't enough to buy any plan?

- This is not a voucher program. The federal government is not simply going to give each elderly a coupon and tell them to find their own insurance. Every plan that participates in Medicare will have a contract with the federal government, assuring they meet consumer protection standards. Every participating plan must agree to take all applicants. They can't differentiate between older and younger seniors, or between healthy or ill seniors.

- Right now, Medicare spends about \$4,800 per beneficiary. In seven years under our plan, Medicare will spend about \$6,700. We've worked with providers and doctors, and they assure us that's plenty of money for high-quality health care.

Q. Will you increase co-payments?

- No.

Q. Will you increase deductibles?

- No.

Q. Seniors like the convenience of Medicare -- there's no need to deal with insurance agents. Now they'll have to buy a plan, file claims forms with insurance companies, and deal with all that hassle, won't they?

- Seniors don't have to choose a private plan if they wish to stay in traditional Medicare.
- But anyone who has ever filed a claim with Medicare knows it's not exactly user-friendly. And if you have Medigap, you have to deal with two bureaucracies instead of one. Many of the private plans eliminate a lot of the paperwork for seniors.

MYTH: Fly-by-night crooks will set up scams to rip off seniors, taking their vouchers & running off with the money, leaving them without health coverage.

- Seniors will never receive a check from the government with which they have to buy insurance. They'll get a booklet, make their choice, and mail in a form. Medicare will directly reimburse health plans. And Medicare will only allow plans to participate in Medicare if they meet strict consumer protection and other standards. That will prevent seniors and taxpayers from getting ripped off.

HOW OUR PLAN SOLVES THE PROBLEM

Q. What does this mean for Medicare's bankruptcy?

- Our plan makes Medicare solvent until 2014, just before the baby-boomers retire. We're ensuring that Medicare is there for today's current and future seniors. We will also appoint a commission to look beyond 2014, and recommend policies to address the huge demographic shift coming then.

Q. What about waste, fraud, and abuse?

- Everywhere every Congressman went over the summer, he or she heard horror stories about waste, fraud, and abuse. They heard about government bureaucrats who simply didn't care about their complaints, they heard about hospitals that didn't worry about correcting mistakes because "seniors aren't paying for it anyway."
- They told us about unnecessary tests and procedures because unscrupulous providers are trying to make a quick buck. They told us about receiving medical devices they don't need because someone got a hold of their Medicare number. We'll fix that by giving beneficiaries who stay in traditional Medicare a reward for reporting fraud. We'll also require all private Medicare plans to maintain a 1-800 number to receive billing complaints.
- And most importantly, we're bringing this system into the 21st century. By introducing competition and making providers and insurers compete for seniors' business, seniors will be assured the best bang for their buck. And that means providers and insurers will lose business if they continue to waste money -- they won't be able to afford to tolerate waste and fraud.

Q. Experts believe that options like coordinated care and Medisave will attract only the healthiest seniors, leaving a sicker and sicker population in traditional Medicare. How will that solve the bankruptcy issue?

- They're wrong. Those seniors with higher health costs will find several attractive private sector options. The fact is, Medicare leaves seniors exposed to far more out-of-pocket risk than the average private insurance plan. Beneficiaries with major illnesses, who are those generally on fixed incomes, face the prospect at the beginning of each year of a \$718 Part A deductible, a \$100 Part B deductible, and 20 percent copayments on most additional medical services, along with no coverage for prescription drugs.
- The only way to avoid these possibly unlimited costs right now is to spend \$800 to \$1,400 on Medigap insurance. Our Medicare Plus options likely will, as is the practice in private insurance for those under age 65, offer explicit limits on out-of-pocket liability. That will be very appealing to a senior on a fixed income who is worried about incurring large medical bills during the year.

Q. HCFA right now claims that the Medicare risk contract program actually costs more than traditional Medicare. How will managed care solve the bankruptcy problem?

- Other studies have shown that Medicare risk contracts save money. But it's available in only certain areas, not across the country and with major restrictions, so we simply can't compare today's limited program to the new Medicare Plus system.

HOW DOCTORS & HOSPITALS WILL BE AFFECTED

MYTH: Cutting doctors' fees means they won't want to see seniors -- that will ration care.

- Doctors and hospitals must contribute to saving Medicare. But under a more efficient Medicare system, Medicare dollars will go a lot farther than they have in the past.
- If the system goes bankrupt, the government can't pay bills. That's what will ration care, and we won't let that happen.

Q. Doesn't cutting doctor and hospital fees for Medicare mean they'll just pass on those costs to the rest of us? It sounds like a hidden tax increase.

- We are making the system more efficient and giving doctors and hospitals more flexibility so they can better treat patients at reasonable costs.

Q. Are you doing anything about malpractice reform?

- We've already passed a limit on non-economic damages in our Contract legal reform bill.

Q. Won't these cuts mean some rural hospitals will have to close?

- Hospitals are going to have to change, to become more efficient. That's happening all around the country, because Medical technology has changed. Surgeries that once required four and five days in the hospital are now outpatient procedures. We think rural hospitals are as able to achieve efficiencies as urban ones.

Q. Are you cutting funding for graduate medical education?

- We are making modest reductions in funding and at the same time improving the targeting of medical education funds toward their best use -- training primary care physicians rather than highly specialized doctors who treat fewer patients.

Q. Will the fail safe mechanisms mean hospitals and doctors won't see me if Medicare runs over budget?

- No. The fail safe is designed to make minor adjustments in payments for medical services. In fact, if providers don't overspend, the fail safe won't even be triggered.

GENERAL QUESTIONS

Q. It's only Part A that's ~~going~~ bankrupt. Why do you have to increase Part B premiums and make reforms to that program?

- Part A pays hospital bills. Part B pays doctor bills. But it's doctors who put people into hospitals -- you can't separate the two. And the same report that warned us about Part A's bankruptcy also said that Part B was growing at unsustainable levels -- 12.1% a year for the rest of the decade, while private insurance costs actually dropped last year.

MYTH: Right now, the government spends only pennies on ~~the~~ dollar for administering Medicare. Private insurers spend far more money -- meaning seniors will get less bang for the buck, and pay more in paperwork costs.

- Today, we spend billions to contract out administering Medicare, and it's impossible to know exactly how much Medicare spends on paperwork and bureaucracy.
- Seniors will get a better value by opening up Medicare to competition. Insurers will have real incentives to keep their overhead down, and that translates into more money being spent on health care, and less on paperwork. Any plan that cannot keep its costs down simply will not be able to compete for seniors' business.
- Seniors will compare plans and see which plan is spending more on paperwork and overhead, and which one is spending more on health care.

Q. I've heard horror stories about insurers canceling policies if someone gets very sick. They also deny or limit coverage if someone is already sick and wants to purchase coverage. Will that happen to seniors who choose to buy from private insurers?

No. If a senior chooses to purchase a private plan, they will be guaranteed coverage and renewability of their policies each year. No Medicare Plus participating insurer can deny any senior a plan.

Q. Is this like what the Clintons tried to do last year?

- The Clinton health care plan proposed to take everyone's private health insurance and turn it over to the government. We're going to take a government insurance program and apply the lessons of the private sector.
- We're increasing choices for Medicare beneficiaries, they proposed to decrease choices for everyone, and their plan would have let Medicare go bankrupt.

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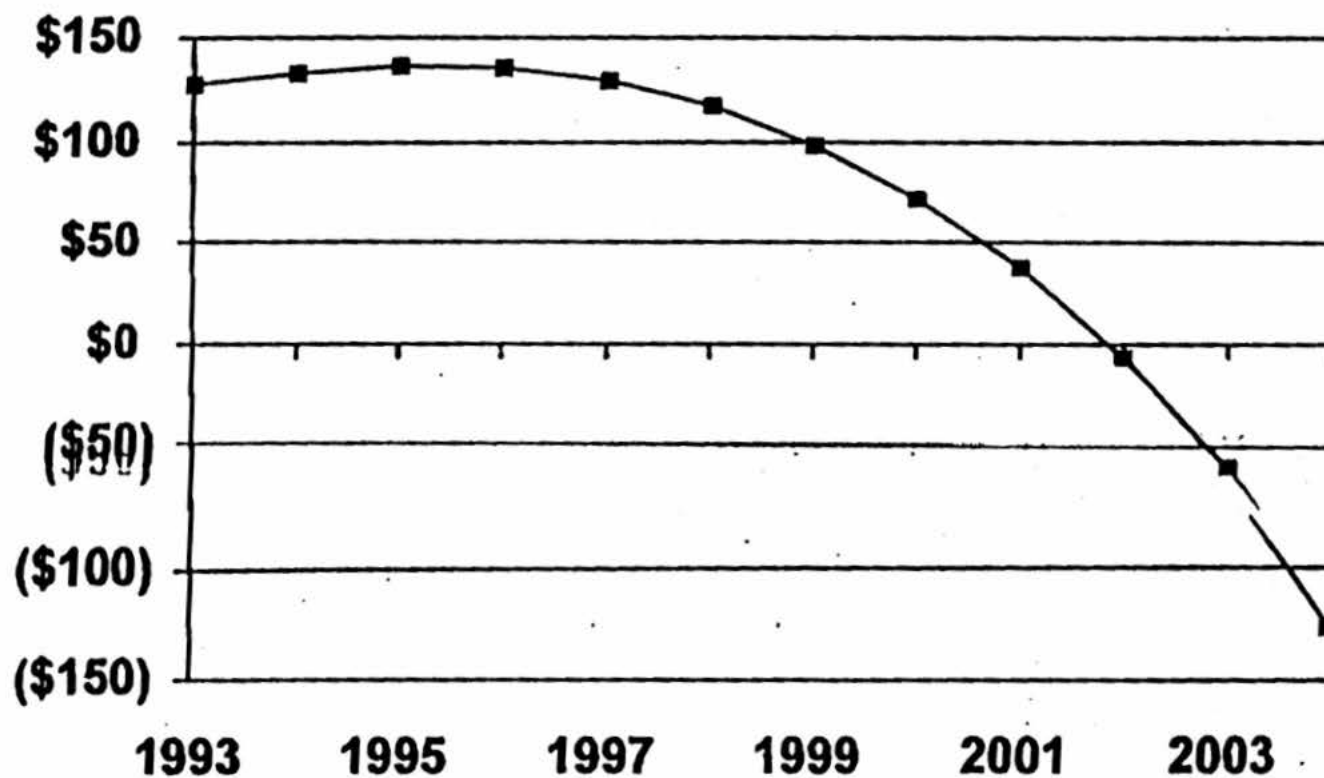
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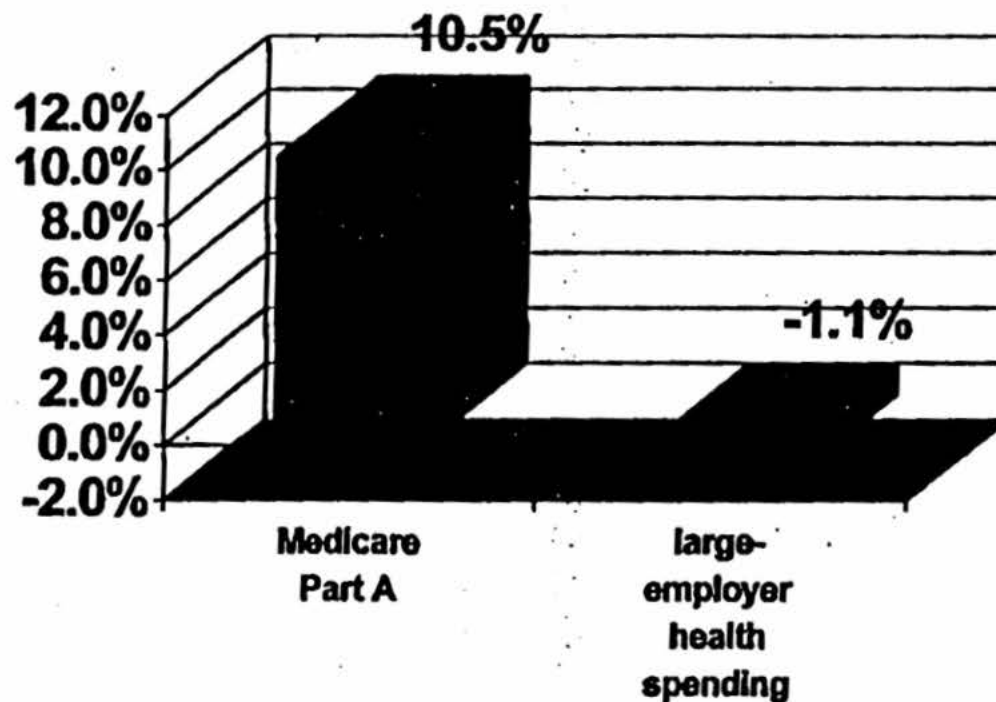


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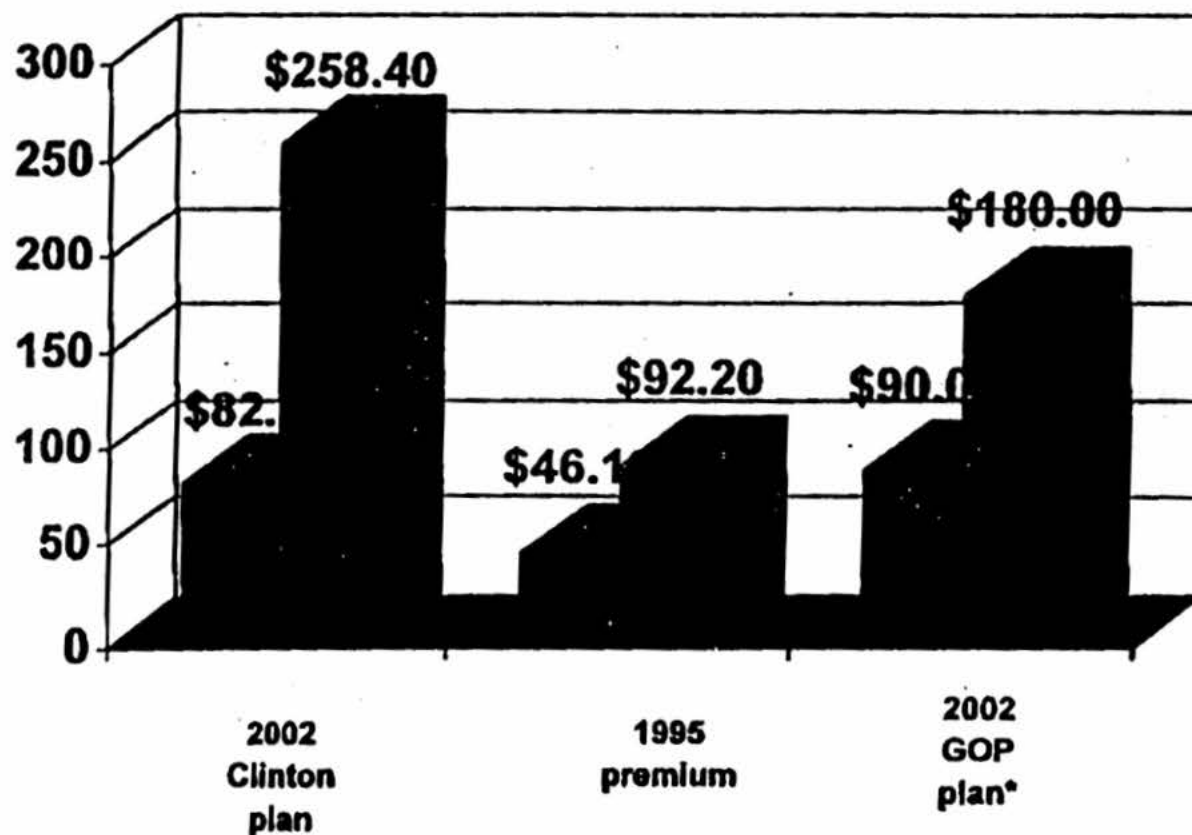
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All coordinated care plans must meet solvency requirements, and offer a minimum benefit package equal to that of Medicare.

Medical Savings Accounts. The Medicare Plus program will also offer a Medical Savings Accounts (Medisave) option to all seniors. A senior choosing Medisave would get a high-deductible insurance policy along with a cash deposit in a Medical Savings Account that would cover a significant portion of the deductible. The high-deductible policy would have no copayments, so that seniors would be assured a limit on their out-of-pocket costs—a quality many are likely to find attractive.

Seniors choosing this option would have complete control over the dollars they spend on routine medical care. They could make important medical decisions with their doctors, without worrying about an insurer's or Medicare's payment policies. They can spend their funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could take funds out of her Medisave account for non-health related purposes as long as she maintains a minimum balance of 60 percent of her catastrophic insurance deductible. If the funds are used for non-health care expenses, they are taxed as income. All interest earnings would be considered taxable income.

The maximum deductible would be capped to insure consumer protection.

Provider Service Networks. *Doctors and hospitals will be allowed to form provider service networks to cover Medicare benefits, without the insurance company or managed care company as intermediary. A group of doctors or hospitals that forms a network would be required to meet solvency and marketing requirements.*

Per beneficiary contributions will be adjusted for age and other factors, so that Medicare is providing funds according to need. Each year, the per beneficiary contribution will increase according to specified growth rates, established to ensure that Medicare remains solvent. Every plan participating in Medicare must agree to take all applicants and allow everyone to stay in the plan as long as they want — no one will be shut out due to an illness or a pre-existing condition.

3. ROOTING OUT WASTE, FRAUD AND ABUSE.

Ask just about any senior who has used the Medicare system and they can tell you why Medicare spending is out of control. The system is riddled with waste, abuse and outright fraud. In hundreds of town hall meetings and tens of thousands of letters from angry seniors, Republicans listened this spring and summer to story after story of a Medicare system that needs greater scrutiny. Whether it was the story of a woman who went into the hospital for eye surgery and was charged for an autopsy, or the gentleman who was charged \$14,000 for a three and a half hour hospital stay, the message from seniors all over American is the same: Get rid of the fraud and abuse.

The General Accounting Office notes "Since Medicare was enacted in 1965, the delivery of health care services has become more complex, but Medicare's fraud and abuse controls have not kept pace." In other words, like much of the Medicare program, the enforcement component has not adapted to the new realities of the health care market.

Market incentives and private sector competition as described above are not enough to clean up fraud and abuse. The Medicare Preservation Act will enhance the enforcement system and give patients incentives to scrub their bills for mistakes. The Medicare Preservation Act provides the Department of Health and Human Services the authority to reward beneficiaries who report incidences of waste, fraud and abuse.

The bill would require skilled nursing facilities and home health agencies to provide cost estimates up front to any patient, because making pricing publicly available guards against later bill-padding. The plan also imposes significant penalties on anyone who defrauds Medicare.

The Medicare Preservation Act Myths, Facts, Questions and Answers

THE PROCESS

MYTH: You're ramming this bill through without any real hearings.

- Since the Trustees' report came out in April, we've had dozens of hearings and heard thousands of pages of testimony. Outside Washington, Representatives have been talking to seniors, providers, hospitals and insurance companies, explaining the problem and looking for advice and solutions.
- This has been an open process, and will continue to be as we work through the bill in committee, on the floor, and with the Senate.

Q. President Clinton is going to veto this bill. Why go through all this?

- President Clinton admitted Medicare is going broke and it must be changed if it's to be around for our seniors. I truly hope he doesn't choose politics over securing Medicare's future solvency.

Q. What's wrong with Ross Perot's idea to try some of these reforms as "pilot projects?"

- Medicare is in critical condition. And unless we enact these reforms, Medicare will be bankrupt.
- We aren't forcing new ideas on anyone — instead of bureaucrats deciding what's best, we're letting 37 million seniors and disabled Americans make their own choices. And for those who don't want to change, traditional Medicare will remain as an option and seniors will always be able to switch back to it.

HOW SENIORS WILL BE AFFECTED

MYTH: You are forcing people into HMOs.

- Seniors will have the option to stay in the current program, move into a private fee-for-service or managed care plan, or purchase a MediSave Account. No one will be financially pushed into any plan — it's up to each senior to decide what's best for him or her.

MYTH: If premiums increase, the practical effect will be to force people into managed care, whatever their choice.

- In 7 years, seniors will pay between \$7 and \$10 a month more than they would under the President's budget. We believe this is a reasonable and practical cost to ask from seniors to save the program from bankruptcy.

Q. Will seniors get a better benefit package than they have right now?

- Seniors will be guaranteed the same benefits they have now, no matter what plan they choose. But they will have the option to choose a plan that may offer, for example, prescription drugs or eyeglasses, or preventative care or better hospital coverage in addition to traditional Medicare benefits. Or, they may choose a MediSave account with a

catastrophic policy that will allow them total control over their health care dollars. It's up to seniors to decide what's best for them.

MYTH: Managed care doesn't work in areas like rural America.

- That's why seniors will have choices of many types of plans. We know that what works in Los Angeles won't work in rural South Dakota.
- We're also going to make it easier for doctors and hospitals to network together, to provide health care at a better value.

MYTH: The poorest and most vulnerable seniors won't be assured Medicaid will cover their nursing care.

- Rather than relying on Medicare and Medicaid interacting properly, we are streamlining the programs so Medicare provides direct relief to low-income seniors.

MYTH: Seniors' out-of-pocket costs are going to skyrocket.

- Because Medicare is a top-down, government-designed program, seniors are getting a raw deal. For example, their hospital -- Part A -- deductible is more than \$700, and after 2 months, it's about \$180 a day. That's far higher than private insurance. And too many things aren't covered, like prescription drugs and hearing aids, meaning 70% of seniors have to purchase Medigap insurance, at about \$1,200 a year.
- We're offering choices so seniors can choose a plan that offers low copayments and deductibles. And we're not increasing co-payments and deductibles for those who wish to remain in traditional Medicare.

Q. Will seniors be guaranteed they can keep their own doctor?

- A senior choosing traditional Medicare will continue to have complete choice over what doctors they see. If their physician is affiliated with a plan they like, they can choose that plan. If a senior opts for a MediSave account, he or she can continue to see whatever doctor he wants.

MYTH: President Clinton's plan doesn't affect seniors, and it makes Medicare solvent. Why do seniors have to pay for the government's screw-ups?

- President Clinton has never submitted a Medicare reform plan. His original budget simply let it go broke. We don't know what he plans to do -- he talks a good game, but we've never seen any bill.
- And President Clinton has used some funny math. If he used the same figures we do, which are more conservative about growth rates and inflation rates, his savings work out to be \$192 billion -- not the \$128 billion he claims. In seven years, that means the difference between his plan and ours is about a dime on the dollar.

Q. How will Seniors sign up for these new plans?

- Every year, the government will send seniors a brochure that outlines the different options available. This is how federal employees make insurance choices each year. Beneficiaries who do nothing will automatically be enrolled in traditional Medicare. If they want to choose one of the new private plans, they just fill out a form in the booklet and mail it in.
- After you're enrolled in the new plan, you have a short time frame to change your mind. And then every year after that, you have the option to switch to whatever plan you choose.

Q. What if the voucher isn't enough to buy any plan?

- This is not a voucher program. The federal government is not simply going to give each elderly a coupon and tell them to find their own insurance. Every plan that participates in Medicare will have a contract with the federal government, assuring they meet consumer protection standards. Every participating plan must agree to take all applicants. They can't differentiate between older and younger seniors, or between healthy or ill seniors.

Right now, Medicare spends about \$4,800 per beneficiary. In seven years under our plan, Medicare will spend about \$6,700. We've worked with providers and doctors, and they assure us that's plenty of money for high-quality health care.

Q. Will you increase co-payments?

• No.

Q. Will you increase deductibles?

• No.

Q. Seniors like the convenience of Medicare -- there's no need to deal with insurance agents. Now they'll have to buy a plan, file claims forms with insurance companies, and deal with all that hassle, won't they?

- Seniors don't have to choose a private plan if they wish to stay in traditional Medicare.
- But anyone who has ever filed a claim with Medicare knows it's not exactly user-friendly. And if you have Medigap, you have to deal with two bureaucracies instead of one. Many of the private plans eliminate a lot of the paperwork for seniors.

MYTH: Fly-by-night crooks will set up scams to rip off seniors, taking their vouchers & running off with the money, leaving them without health coverage.

- Seniors will never receive a check from the government with which they have to buy insurance. They'll get a booklet, make their choice, and mail in a form. Medicare will directly reimburse health plans. And Medicare will only allow plans to participate in Medicare if they meet strict consumer protection and other standards. That will prevent seniors and taxpayers from getting ripped off.

HOW OUR PLAN SOLVES THE PROBLEM

Q. What does this mean for Medicare's bankruptcy?

- Our plan makes Medicare solvent until 2014, just before the baby-boomers retire. We're ensuring that Medicare is there for today's current and future seniors. We will also appoint a commission to look beyond 2014, and recommend policies to address the huge demographic shift coming then.

Q. What about waste, fraud, and abuse?

- Everywhere every Congressman went over the summer, he or she heard horror stories about waste, fraud, and abuse. They heard about government bureaucrats who simply didn't care about their complaints, they heard about hospitals that didn't worry about correcting mistakes because "seniors aren't paying for it anyway."
- They told us about unnecessary tests and procedures because unscrupulous providers are trying to make a quick buck. They told us about receiving medical devices they don't need because someone got a hold of their Medicare number. We'll fix that by giving beneficiaries who stay in traditional Medicare a reward for reporting fraud. We'll also require all private Medicare plans to maintain a 1-800 number to receive billing complaints.
- And most importantly, we're bringing this system into the 21st century. By introducing competition and making providers and insurers compete for seniors' business, seniors will be assured the best bang for their buck. And that means providers and insurers will lose business if they continue to waste money -- they won't be able to afford to tolerate waste and fraud.

Experts believe that options like coordinated care and Medisave will attract only the healthiest seniors, leaving a sicker and sicker population in traditional Medicare. How will that solve the bankruptcy issue?

They're wrong. Those seniors with higher health costs will find several attractive private sector options. The fact is, Medicare leaves seniors exposed to far more out-of-pocket risk than the average private insurance plan. Beneficiaries with major illnesses, who are those generally on fixed incomes, face the prospect at the beginning of each year of a \$718 Part A deductible, a \$100 Part B deductible, and 20 percent copayments on most additional medical services, along with no coverage for prescription drugs.

- The only way to avoid these possibly unlimited costs right now is to spend \$800 to \$1,400 on Medigap insurance. Our Medicare Plus options likely will, as is the practice in private insurance for those under age 65, offer explicit limits on out-of-pocket liability. That will be very appealing to a senior on a fixed income who is worried about incurring large medical bills during the year.

Q. HCFA right now claims that the Medicare risk contract program actually costs more than traditional Medicare. How will managed care solve the bankruptcy problem?

- Other studies have shown that Medicare risk contracts save money. But it's available in only certain areas, not across the country and with major restrictions, so we simply can't compare today's limited program to the new Medicare Plus system.

HOW DOCTORS & HOSPITALS WILL BE AFFECTED

MYTH: Cutting doctors' fees means they won't want to see seniors -- that will ration care.

- Doctors and hospitals must contribute to saving Medicare. But under a more efficient Medicare system, Medicare dollars will go a lot farther than they have in the past.
- If the system goes bankrupt, the government can't pay bills. That's what will ration care, and we won't let that happen.

Q. Doesn't cutting doctor and hospital fees for Medicare mean they'll just pass on those costs to the rest of us? It sounds like a hidden tax increase.

- We are making the system more efficient and giving doctors and hospitals more flexibility so they can better treat patients at reasonable costs.

Q. Are you doing anything about malpractice reform?

- We've already passed a limit on non-economic damages in our Contract legal reform bill.

Q. Won't these cuts mean some rural hospitals will have to close?

- Hospitals are going to have to change, to become more efficient. That's happening all around the country, because Medical technology has changed. Surgeries that once required four and five days in the hospital are not outpatient procedures. We think rural hospitals are as able to achieve efficiencies as urban ones.

Q. Are you cutting funding for graduate medical education?

- We are making modest reductions in funding and at the same time improving the targeting of medical education funds toward their best use -- training primary care physicians rather than highly specialized doctors who treat fewer patients.

Q. Will the fail safe mechanisms mean hospitals and doctors won't see me if Medicare runs over budget?

- No. The fail safe is designed to make minor adjustments in payments for medical services. In fact, if providers don't overspend, the fail safe won't even be triggered.

GENERAL QUESTIONS

Q. It's only Part A that's ~~going~~ bankrupt. Why do you have to increase Part B premiums and make reforms to that program?

- Part A pays hospital bills. Part B pays doctor bills. But it's doctors who put people into hospitals -- you can't separate the two. And the same report that warned us about Part A's bankruptcy also said that Part B was growing at unsustainable levels -- 12.1% a year for the rest of the decade, while private insurance costs actually dropped last year.

MYTH: Right now, the government spends only pennies on the dollar for administering Medicare. Private insurers spend far more money -- meaning seniors will get less bang for the buck, and pay more in paperwork costs.

- Today, we spend billions to contract out administering Medicare, and it's impossible to know exactly how much Medicare spends on paperwork and bureaucracy.
- Seniors will get a better value by opening up Medicare to competition. Insurers will have real incentives to keep their overhead down, and that translates into more money being spent on health care, and less on paperwork. Any plan that cannot keep its costs down simply will not be able to compete for seniors' business.
- Seniors will compare plans and see which plan is spending more on paperwork and overhead, and which one is spending more on health care.

Q. I've heard horror stories about insurers canceling policies if someone gets very sick. They also deny or limit coverage if someone is already sick and wants to purchase coverage. Will that happen to seniors who choose to buy from private insurers?

No. If a senior chooses to purchase a private plan, they will be guaranteed coverage and renewability of their policies each year. No Medicare Plus participating insurer can deny any senior a plan.

Q. Is this like what the Clintons tried to do last year?

- The Clinton health care plan proposed to take everyone's private health insurance and turn it over to the government. We're going to take a government insurance program and apply the lessons of the private sector.
- We're increasing choices for Medicare beneficiaries, they proposed to decrease choices for everyone, and their plan would have let Medicare go bankrupt.

MYTH: Your plan is going to chase doctors out of traditional Medicare.

- Doctors today are turning away new Medicare patients, because the bureaucracy is so overbearing. HCFA employees with no medical training regularly overrule doctors' judgments, and declare billed services medically unnecessary. That means the doctors and patients get stuck with bills Medicare won't pay. Our plan will give doctors the flexibility to work with beneficiaries to determine the best treatment for given circumstances, without a government bureaucrat looking over his shoulder.
- Doctors can choose to participate in Medicare Plus plans, so they have the freedom to put a patient's needs first.

What the Clinton Trustees Said This Year About Medicare's Hospital Program:

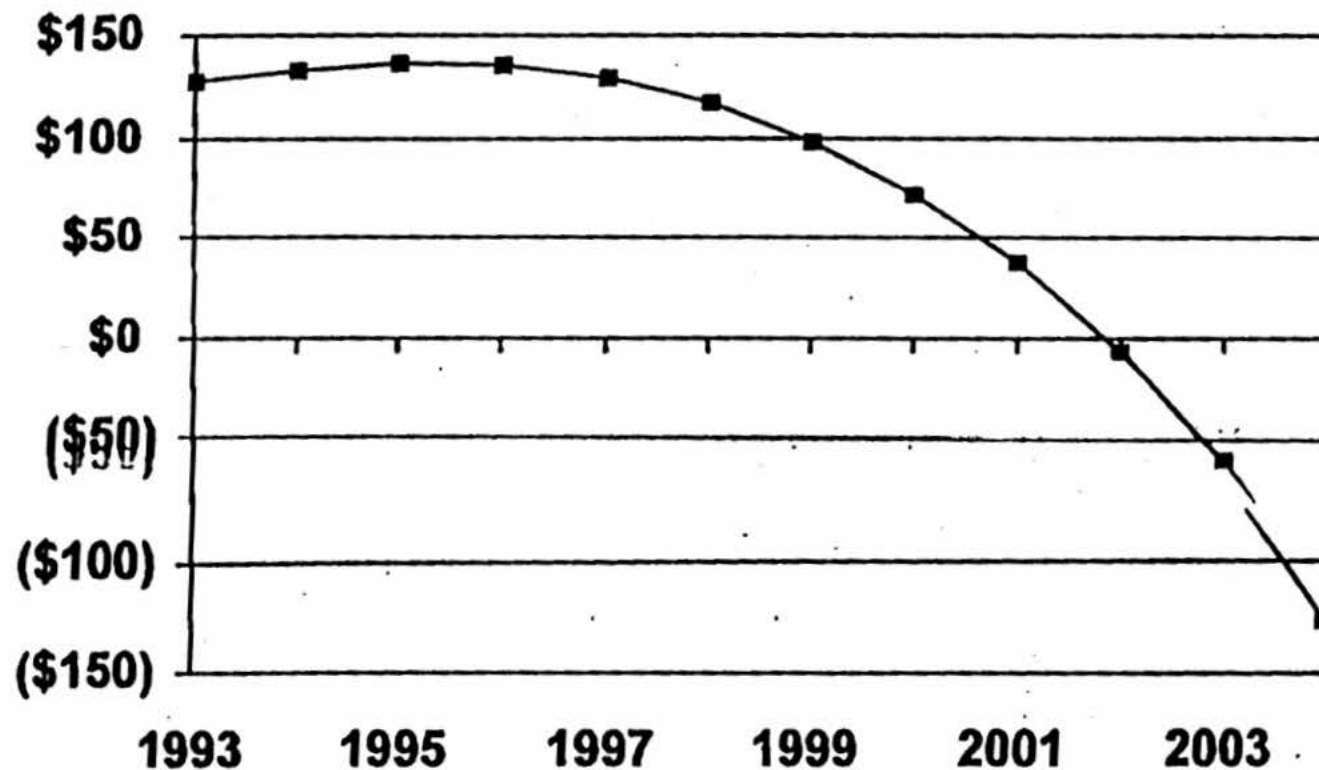
- *"Under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins." (page 3)*
- *"The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI trust fund's financial imbalance." (page 13)*

Source: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Program,
signed by Secretaries Rubin, Shalala and Reich

MEDICARE HOSPITAL TRUST FUND EMPTY IN SEVEN YEARS

(Trust Fund Reserves)

\$billions

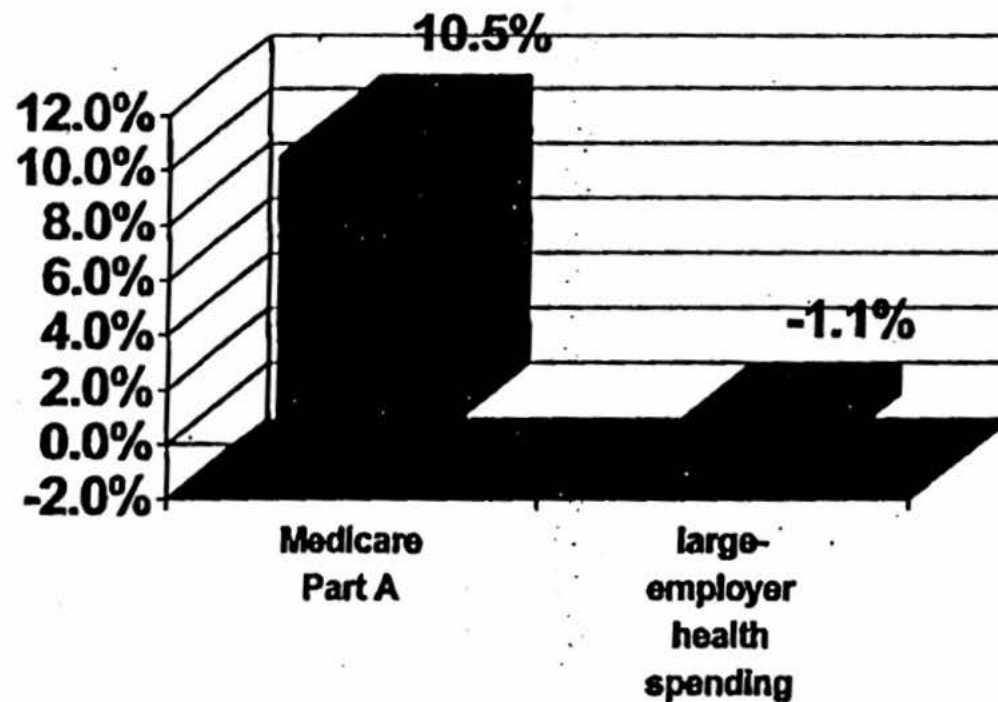


Source: 1995 Annual Report of the HI Trustees, April 1995, p. 13

If We Don't Reform Medicare,
Payroll Taxes Will Have to
Double by 2020
to Avoid Bankruptcy

Source: 1995 Annual Report of HI Trustees, page 20

Private Sector Has Made Improvements that Can Help Medicare (1994 Spending Growth)



Sources: 1995 Annual Report of HI Trustees and HCFA actuaries

page 4

Traditional Medicare

Keeping the Commitment

Copayments: No Change

Deductibles: No Change

Premiums: Current 31.5% Rate

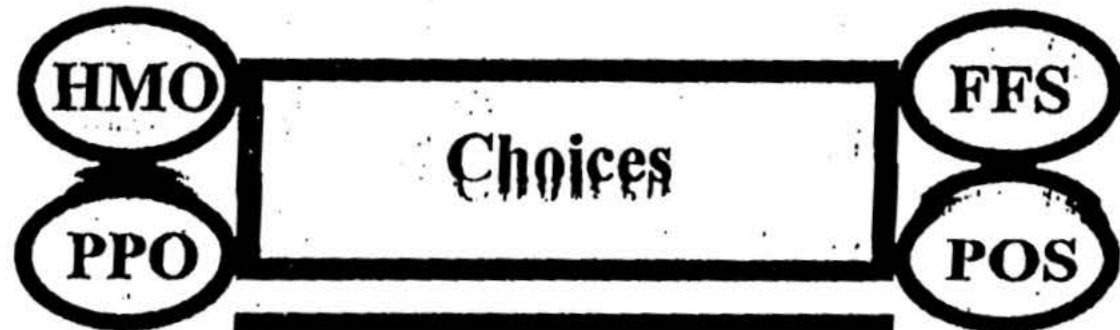
In 2002, the premium for an average retiree will be \$7 more than under President Clinton's proposal.

CHOICE IN MEDICARE

Fee-For-Service

MedicarePlus

Current System



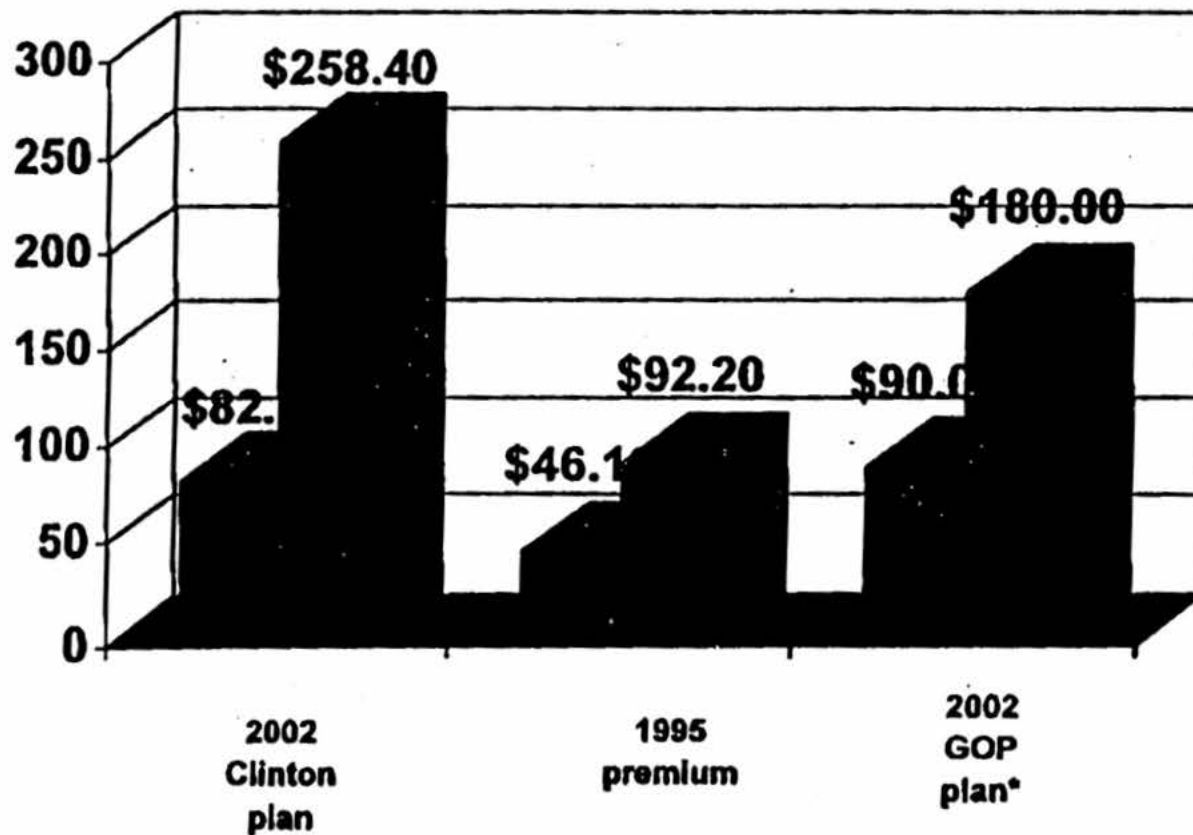
Provider Service
Networks

Private Sector
Insurance Policies

Medical Savings
Accounts

Monthly Part B Premium: Beneficiary Cost vs Taxpayer Cost

(portion of premium paid by beneficiary vs. portion of premium paid from general revenues)



*estimate

page 7

Fail-Safe Mechanism

**Growth Targets Set
by Provider Sector**

Payment Reforms to Reduce Excessive Growth and Waste

Annual Sector Growth Rate Targets Projected

No

Targets Exceeded?

Yes

**Full Provider
Payment Update**

**Reduction of
Payment Updates**

EXAMPLE:

75-year old, average income senior

Costs:

- no additional deductible or copayment
- continued 31.5 percent premium rate

Options:

- can stay in traditional Medicare
- can choose a managed care option with drug coverage
- can choose a Medisave plan, limiting out-of-pocket costs

Doctors Can Put Their Patients First

The Medicare Preservation Act:

- includes a Medisave option
- allows creation of provider sponsored networks
- emphasizes previously passed malpractice reform
- repeals Stark I and II excessive regulations

Hospitals Will Be More Efficient

The Medicare Preservation Act:

- allows creation of provider sponsored networks
- repeals Stark I and II excessive regulations
- establishes an advisory commission on Medicare
- establishes a commission to recommend Medicare policy changes to prepare for retirement of the baby boom generation

DRAFT**OVERVIEW, REPUBLICAN MEDICARE PLAN**

PROPOSAL	COMMENT
Traditional Medicare/keeping commitment 1. Average payment per beneficiary will rise to \$6,700 in 2002 2. No change in copayments, deductibles. 3. Keep premium at 31.5 percent	That is a cut of \$1700 per beneficiary from CBO baseline Current premium analysis
The better Medicare - more choices Choose between traditional Medicare and private sector options in new Medicare Plus. Any private insurer who at least covers Medicare benefits and meets consumer protection standards can apply. Options include: 1. Coordinated care - must meet solvency, and offer minimum benefit package equal to that of Medicare -- 2. Medical savings accounts - high deductible policy plus MSA deposit. 3. Provider service networks -- meet solvency and marketing requirements. 4. Per beneficiary contribution adjusted for age, other factors, indexed to specified growth rates. 5. Plans agree to take all applicants.	Multiple choice of different types of plans with different benefits raises consumer information/ comparison issue, and adverse selection issue What are standards -- implies that they may not be same as current?[Note - health plan quality, access, beneficiary protection standards issue may be an underlying weakness] This means that it is not the standard Medicare benefit (which is promised in introductory language) Adverse selection - Tyson argument Standards issue again How tight index? This means that \$ contribution unrelated to benefits - buys less and less -- and beneficiary pays more and more in premium -- balance billing at premium level

DRAFT

PROPOSAL	COMMENTS
Waste, fraud, and abuse 1. Reward beneficiaries who report incidences 2. Require SNFs/HHAs to provide cost estimates up front. 3. Imposes significant penalties on those who defraud Medicare	Much of this already occurs today
Seeking value for the government as a health care buyer 1. Phases out funding for residency programs for non-citizens and graduate education subsidies that draw doctors into highly specialized fields, targetting funds on primary care. 2. Provide doctors options. 3. Enable doctors to escape paper burden and restrictive payment rules	What happens to hospitals, areas that rely on these providers (NYC issue) How deep a cut -- what are specifics Does this mean allow balance billing -- either in standard Medicare, in within health plans?
Affluence testing for subsidized premiums 1. Single seniors with income over \$75,000 and couples over \$150,000 will pay higher premiums 2. Gives states the ability to reduce costs	What is maximum %?
Guaranteeing solvency through failsafe 1. Set growth rates by provider type 2. Monitor, revise payment updates to reach target	This is the cost containment. What are growth rates required to achieve targets? Have we ever achieved them? Black box - magic

DRAFT September 14, 1995

**Summary of Provisions and Issues
The House Republican Leadership's
"MEDICARE PRESERVATION ACT OF 1995"**

1. Retaining Traditional Medicare--Summary of Provisions

- ♦ Beneficiaries automatically enrolled in traditional Medicare unless they choose a Medicare Plus Option.
 - ▶ No changes in deductibles or coinsurance
 - ▶ Increase Part B premium to 31.5% of projected program costs (see increase in premium for high income beneficiaries in Section 5).
- ♦ Average per beneficiary spending will increase from \$4,800 in 1996 to \$6,700 in 2002.

Retaining Traditional Medicare--Issues

- ♦ The MPA claims to allow beneficiaries to remain in traditional Medicare. However, under the MPA physicians could serve beneficiaries enrolled in private fee-for-service plans, MSA/high deductible plans and provider service networks. There is no indication in the proposal that beneficiaries would have extra-billing protection under these plans. If a significant portion of physicians in an area begin serving beneficiaries only through these alternative plans in order to avoid extra-billing limits under traditional Medicare, choosing to remain in traditional Medicare will not be a "real" option for beneficiaries.

2. Increasing Choices--Summary of Provisions

- ♦ Beneficiaries may choose from several private sector options in a new Medicare Plus system.
- ♦ Each year, beneficiaries would receive a booklet describing approved plans available in their geographic area. All plans must meet consumer protection standards, cover at least Medicare benefits, and meet solvency standards.
- ♦ The federal contribution would be adjusted for age and other factors. Each year the federal contribution would increase according to specified growth rates.
- ♦ All plans must take all applicants; applicants cannot be involuntarily disenrolled by the plan.
- ♦ Options include:

- ▶ Coordinated care plans. These plans (e.g., HMOs, PPOs, POS) may reduce out-of-pocket expenses and offer additional benefits.
- ▶ Medical savings accounts (MSAs). Referred to as "Medisave", these accounts would provide a high-deductible insurance policy and a cash deposit to the MSA that would cover a significant portion of the deductible. The policy would have no copayments, so beneficiaries would be assured a limit on their out-of-pocket costs.

Beneficiaries can spend their MediSave funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could use MediSave funds for non-health related purposes as long as a minimum balance of 60% of the high deductible is maintained. Funds used for non-health care expenses and interest earned on MediSave accounts would be taxed as income.

The high-deductible amount would be capped.

Provider Service Networks. Doctors and hospitals could form networks without being licensed as an insurance company or managed care company.

- ▶ Private fee-for-service plans. While not addressed in the general description, the attachments indicate that private fee-for-service plans will also be available.

Increasing Choices--Issues

- ◆ Under the MPA, the federal contribution is based upon a fixed amount increased in subsequent years by a fixed growth rate. Based on the per capita spending amounts assumed under the Budget Resolution, the growth rate for the federal contribution would be far less than projected per capita growth rates for traditional Medicare and even private health insurance. Thus, it appears unlikely the fixed contribution would be sufficient over time for beneficiaries to purchase their plan of choice without incurring significant out-of-pocket expenses. In addition, it is questionable whether adequate numbers of private plans would participate in Medicare Plus system if the federal contribution is inadequate.
- ◆ The MPA states that the federal contribution would be risk adjusted for age and other factors. However, development of reliable risk adjustment methods is in its early stages. Risk adjustment will be critical to ensure that plans are

not penalized if their enrollee population is sicker than average or rewarded if their enrollment is healthier than average.

- ◆ In order for beneficiaries to compare competing alternative plans under the Medicare Plus system, they will need comparative information quality as well as price, network composition, benefits, cost-sharing, and other factors. Comparative information on the quality of care provided by competing plans is difficult to measure--but of vital importance to potential enrollees, particularly if they can only change plans on a yearly basis, as proposed in the MPA. The need for reliable quality of care assessments is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages
- ◆ It is unclear in the MPA what entity would ensure that standards (e.g., consumer protections, solvency requirements, marketing standards) would be met by plans.
- ◆ The Medical Savings Account option could lead to a self-selection bias against traditional Medicare, with healthy individuals choosing the MSA and others left in the traditional Medicare program.
- ▶ According to the Medicare Continuous History sample, average per capita spending in 1993 for was \$3,486.
 - ++ Within this sample, however, 55 percent of the beneficiaries had less than \$1,000 in reimbursement in the previous three years. For this group, average per capita spending in 1993 was \$1,598, only 46% of the average for the entire sample.
 - ++ There was also a large group, 24 percent of sample, that had no reimbursement made on their behalf in the last three years. For this group, the average per capita spending was \$1,122 only 35% of the average for the whole sample.
- ▶ Thus, a MSA Option for Medicare could potentially be costly to the program if low cost beneficiaries opted for MSA's.
- ▶ Under this scenario, the per capita cost of providing care in traditional Medicare would escalate dramatically since the costs of care for sicker

beneficiaries would be spread across a smaller base. This escalation in per capita spending resulting from selection could trigger provider cuts under the "fail safe" provisions further destabilizing traditional Medicare.

- ♦ There is no indication that the MSA option is a one-time choice. If beneficiaries are allowed in and out of the MSA option selection problems will be even worse.

3. Waste, Fraud, and Abuse--Summary of Provisions

- ♦ The Department of Health and Human Services is provided with the authority to reward beneficiaries who report instances of waste, fraud and abuse.
- ♦ SNFs and Home Health Agencies would be required to provide up-front cost estimates to any patient.
- ♦ Significant penalties imposed on anyone who defrauds Medicare.

Waste, Fraud and Abuse--Issues

- ♦ A large proportion of beneficiaries currently report instances of waste, fraud and abuse. Providing rewards to beneficiaries who already do so would result in added costs. This provision would also be administratively complex.

4. Government as a Health Care Buyer--Summary of Provisions

- ♦ Limits updates for hospitals and physician services
- ♦ The bill phases out funding for medical residency programs for non-citizens and graduate medical education funding subsidies that draw doctors into highly specialized fields, targeting the funds for primary care.

Government as a Health Care Buyer--Issues

- ♦ In general, we support both the goals of reducing the number of residency positions in the U.S. and focusing more resources on primary care training. However, in any policy which focuses on reducing or eliminating the number of international medical graduates we would be very concerned about the impact on hospitals which rely heavily on those IMGs for providing services.

5. Income-Related Premium--Summary of Provision

- ♦ Single beneficiaries with incomes over \$75,000 and couples with incomes over \$150,000 would pay higher Part B premiums instead of receiving a subsidy from the taxpayers.

Income-Related Premium--Issues

6. "Fail Safe"--Summary of Provision

- ♦ The MPA would set spending growth rates for provider categories such as inpatient hospital services, physician services, home health care, durable medical equipment and laboratory services.
- ♦ Each year the Secretary of HHS would determine if the level of services being provided would exceed designated spending growth. If it would, the Secretary would reduce payment updates to guarantee that spending growth targets were met.

"Fail Safe"-- Issues

- ♦ It is unclear how a target system would work in a world where enrollment in the traditional Medicare would be in flux and where traditional Medicare would be subject to significant adverse selection.
- ♦ To the extent that provider payment updates are unreasonably low, the viability of traditional Medicare is threatened.

The attachments to the general description also note the following provisions of the MPA:

- ♦ Repeals of Stark I and II "excessive" regulations
- ♦ An advisory commission on Medicare
- ♦ A commission to recommend Medicare policy changes to prepare for retirement of the baby boom generation

DRAFT**OVERVIEW, REPUBLICAN MEDICARE PLAN**

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DRAFT September 14, 1995

**Summary of Provisions and Issues
The House Republican Leadership's
"MEDICARE PRESERVATION ACT OF 1995"**

1. Retaining Traditional Medicare--Summary of Provisions

- ♦ Beneficiaries automatically enrolled in traditional Medicare unless they choose a Medicare Plus Option.
 - ▶ No changes in deductibles or coinsurance
 - ▶ Increase Part B premium to 31.5% of projected program costs (see increase in premium for high income beneficiaries in Section 5).
- ♦ Average per beneficiary spending will increase from \$4,800 in 1996 to \$6,700 in 2002.

Retaining Traditional Medicare--Issues

- ♦ The MPA claims to allow beneficiaries to remain in traditional Medicare. However, under the MPA physicians could serve beneficiaries enrolled in private fee-for-service plans, MSA/high deductible plans and provider service networks. There is no indication in the proposal that beneficiaries would have extra-billing protection under these plans. If a significant portion of physicians in an area begin serving beneficiaries only through these alternative plans in order to avoid extra-billing limits under traditional Medicare, choosing to remain in traditional Medicare will not be a "real" option for beneficiaries.

2. Increasing Choices--Summary of Provisions

- ♦ Beneficiaries may choose from several private sector options in a new Medicare Plus system.
- ♦ Each year, beneficiaries would receive a booklet describing approved plans available in their geographic area. All plans must meet consumer protection standards, cover at least Medicare benefits, and meet solvency standards.
- ♦ The federal contribution would be adjusted for age and other factors. Each year the federal contribution would increase according to specified growth rates.
- ♦ All plans must take all applicants; applicants cannot be involuntarily disenrolled by the plan.
- ♦ Options include:

- ▶ Coordinated care plans. These plans (e.g., HMOs, PPOs, POS) may reduce out-of-pocket expenses and offer additional benefits.
- ▶ Medical savings accounts (MSAs). Referred to as "Medisave", these accounts would provide a high-deductible insurance policy and a cash deposit to the MSA that would cover a significant portion of the deductible. The policy would have no copayments, so beneficiaries would be assured a limit on their out-of-pocket costs.

Beneficiaries can spend their MediSave funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could use MediSave funds for non-health related purposes as long as a minimum balance of 60% of the high deductible is maintained. Funds used for non-health care expenses and interest earned on MediSave accounts would be taxed as income.

The high-deductible amount would be capped.

Provider Service Networks. Doctors and hospitals could form networks without being licensed as an insurance company or managed care company.

- ▶ Private fee-for-service plans. While not addressed in the general description, the attachments indicate that private fee-for-service plans will also be available.

Increasing Choices--Issues

- ◆ Under the MPA, the federal contribution is based upon a fixed amount increased in subsequent years by a fixed growth rate. Based on the per capita spending amounts assumed under the Budget Resolution, the growth rate for the federal contribution would be far less than projected per capita growth rates for traditional Medicare and even private health insurance. Thus, it appears unlikely the fixed contribution would be sufficient over time for beneficiaries to purchase their plan of choice without incurring significant out-of-pocket expenses. In addition, it is questionable whether adequate numbers of private plans would participate in Medicare Plus system if the federal contribution is inadequate.
- ◆ The MPA states that the federal contribution would be risk adjusted for age and other factors. However, development of reliable risk adjustment methods is in its early stages. Risk adjustment will be critical to ensure that plans are

not penalized if their enrollee population is sicker than average or rewarded if their enrollment is healthier than average.

- ◆ In order for beneficiaries to compare competing alternative plans under the Medicare Plus system, they will need comparative information quality as well as price, network composition, benefits, cost-sharing, and other factors. Comparative information on the quality of care provided by competing plans is difficult to measure--but of vital importance to potential enrollees, particularly if they can only change plans on a yearly basis, as proposed in the MPA. The need for reliable quality of care assessments is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages
- ◆ It is unclear in the MPA what entity would ensure that standards (e.g., consumer protections, solvency requirements, marketing standards) would be met by plans.
- ◆ The Medical Savings Account option could lead to a self-selection bias against traditional Medicare, with healthy individuals choosing the MSA and others left in the traditional Medicare program.
 - ▶ According to the Medicare Continuous History sample, average per capita spending in 1993 for was \$1,486.
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 - ++ There was also a large group, 24 percent of sample, that had no reimbursement made on their behalf in the last three years. For this group, the average per capita spending was \$1,122 only 35% of the average for the whole sample.
 - ▶ Thus, a MSA Option for Medicare could potentially be costly to the program if low cost beneficiaries opted for MSA's.
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beneficiaries would be spread across a smaller base. This escalation in per capita spending resulting from selection could trigger provider cuts under the "fail safe" provisions further destabilizing traditional Medicare.

- ♦ There is no indication that the MSA option is a one-time choice. If beneficiaries are allowed in and out of the MSA option selection problems will be even worse.

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- ♦ The Department of Health and Human Services is provided with the authority to reward beneficiaries who report instances of waste, fraud and abuse.
- ♦ SNFs and Home Health Agencies would be required to provide up-front cost estimates to any patient.
- ♦ Significant penalties imposed on anyone who defrauds Medicare.

Waste, Fraud and Abuse--Issues

- ♦ A large proportion of beneficiaries currently report instances of waste, fraud and abuse. Providing rewards to beneficiaries who already do so would result in added costs. This provision would also be administratively complex.

4. Government as a Health Care Buyer--Summary of Provisions

- ♦ Limits updates for hospitals and physician services
- ♦ The bill phases out funding for medical residency programs for non-citizens and graduate medical education funding subsidies that draw doctors into highly specialized fields, targeting the funds for primary care.

Government as a Health Care Buyer--Issues

- ♦ In general, we support both the goals of reducing the number of residency positions in the U.S. and focusing more resources on primary care training. However, in any policy which focuses on reducing or eliminating the number of international medical graduates we would be very concerned about the impact on hospitals which rely heavily on those IMGs for providing services.

5. Income-Related Premium--Summary of Provision

- ♦ Single beneficiaries with incomes over \$75,000 and couples with incomes over \$150,000 would pay higher Part B premiums instead of receiving a subsidy from the taxpayers.

Income-Related Premium--Issues

6. "Fail Safe"--Summary of Provision

- ♦ The MPA would set spending growth rates for provider categories such as inpatient hospital services, physician services, home health care, durable medical equipment and laboratory services.
- ♦ Each year the Secretary of HHS would determine if the level of services being provided would exceed designated spending growth. If it would, the Secretary would reduce payment updates to guarantee that spending growth targets were met.

"Fail Safe"-- Issues

- ♦ It is unclear how a target system would work in a world where enrollment in the traditional Medicare would be in flux and where traditional Medicare would be subject to significant adverse selection.
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The attachments to the general description also note the following provisions of the MPA:

- ♦ Repeals of Stark I and II "excessive" regulations
- ♦ An advisory commission on Medicare
- ♦ A commission to recommend Medicare policy changes to prepare for retirement of the baby boom generation

DRAFT**OVERVIEW, REPUBLICAN MEDICARE PLAN**

PROPOSAL	COMMENT
Traditional Medicare/keeping commitment 1. Average payment per beneficiary will rise to \$6,700 in 2002 2. No change in copayments, deductibles. 3. Keep premium at 31.5 percent	That is a cut of \$1700 per beneficiary from CBO baseline Current premium analysis
The better Medicare - more choices Choose between traditional Medicare and private sector options in new Medicare Plus. Any private insurer who at least covers Medicare benefits and meets consumer protection standards can apply. Options include: 1. Coordinated care - must meet solvency, and offer minimum benefit package equal to that of Medicare -- 2. Medical savings accounts - high deductible policy plus MSA deposit. 3. Provider service networks -- meet solvency and marketing requirements. 4. Per beneficiary contribution adjusted for age, other factors, indexed to specified growth rates. 5. Plans agree to take all applicants.	Multiple choice of different types of plans with different benefits raises consumer information/ comparison issue, and adverse selection issue What are standards -- implies that they may not be same as current?[Note - health plan quality, access, beneficiary protection standards issue may be an underlying weakness] This means that it is not the standard Medicare benefit (which is promised in introductory language) Adverse selection - Tyson argument Standards issue again How tight index? This means that \$ contribution unrelated to benefits - buys less and less -- and beneficiary pays more and more in premium -- balance billing at premium level

DRAFT

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

October 23, 1995

THE DIRECTOR

Honorable J. James Exon
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Senator Exon:

I am writing to transmit the Administration's views on the actions that Senate committees have taken to comply with their budget reconciliation instructions.

You should have no doubt about the President's position: If reconciliation legislation were sent to him with the extreme spending cuts and huge tax cuts called for in the budget resolution, he would veto the bill. The President has stressed the importance of finding common ground with Congress on a budget plan that will best serve the interests of the American people.

As you know, the President shares with congressional leaders the goal of balancing the budget. But, as the President and his senior advisors have repeatedly noted, the Administration has profound differences with the overall approach that Congress has adopted to reach that goal:

- **The President's plan:** The plan, which the President announced in June, would protect Medicare until 2006 and retain Medicaid as an entitlement; invest in education and training and other priorities; and provide for a targeted tax cut to help middle-income Americans raise their children, save for the future, and pay for postsecondary education.

To reach balance, the President would eliminate wasteful spending, streamline programs, and end unneeded subsidies; take the first, serious steps toward health care reform; reform welfare to reward work; cut non-defense discretionary spending (other than the President's investments) 22 percent in real terms in 2002; and target tax relief to those who really need it.

- **The Republican plan:** The Republican plan -- as reflected in the committee reconciliation provisions -- seeks to balance the budget while providing a huge tax cut whose benefits would flow disproportionately to those who do not need them.

To reach balance, the Republican plan would cut deeply into such mandatory programs as Medicare, Medicaid, student loans, and food stamps, and would raise taxes on millions of working families by slashing the Earned Income Tax Credit (EITC). By extending the discretionary caps at Republican-proposed levels, the Republican plan would force deep cuts in virtually all discretionary programs, including education and training, science and technology, environmental protection, and other priorities.

The President believes strongly that, while his approach reflects the common ground that Americans share, the Republican plan reflects an extreme and unwise approach that will hurt average Americans and help special interests. He has repeatedly urged Congress to work with him on a more reasonable path that will help raise average living standards in the future.

The Republican majority, however, has shown little inclination to move to a more responsible path. The Finance Committee, for instance, has passed deep, unwarranted cuts in Medicare that would raise costs for beneficiaries and sharply cut payments to providers, jeopardizing access to, and the quality of, care. In addition, Finance would convert Medicaid into a block grant, which is unacceptable. Under the Finance Committee approach, states would face untenable choices: cutting benefits, dropping coverage for millions of beneficiaries, or reducing provider payments to a level that would undermine the ability to adequately serve beneficiaries. Furthermore, Finance would end standards needed to protect residents of nursing homes, and would not ensure coverage for some of the most vulnerable Americans -- poor children.

The Republican tax plan hurts working Americans. The Finance Committee would raise taxes on 17 million working families by cutting the EITC. And it would make unwise changes to pension fund asset reversions -- making it easy for companies to withdraw "excess" pension assets -- threatening the retirement benefits of workers and increasing the exposure of the Pension Benefit Guaranty Corporation, which guarantees these benefits. In addition, the Governmental Affairs Committee would raise Federal employee retirement contributions -- which is tantamount to raising employees' taxes.

The Finance Committee has included the Senate-passed welfare reform bill in the reconciliation bill. Overall, food program and EITC cuts elsewhere in reconciliation, together with other low-income program cuts, are excessive. For welfare reform to succeed, it must save money by moving people from welfare to work, not by merely cutting them off or shifting costs to the states. The cost of excessive program cuts -- to working families, families with small children, low-income immigrants, disabled children, and the elderly receiving Supplemental Security Income -- would be grave. The Administration proposes a more acceptable level of cuts, coupled with strong programmatic reforms.

Other committees are making cuts in programs that would adversely affect millions of students and their families, children, the poor of all ages, farmers, and the environment.

The Senate Labor and Human Resources Committee would raise college loan costs to middle- and low-income students and parents, and tax colleges and universities. In particular, the Committee would cap the Direct Student Loan Program, reversing the program's significant progress and ending the participation of over 600 schools and hundreds of thousands of students. These actions hurt middle- and low-income families, make student loan programs less efficient, perpetuate unnecessary red tape, and deny to students and schools the free-market choice of guaranteed or direct loans.

The Agriculture Committee would cut farm spending over three times more than the President, reducing farm income and jeopardizing recent record gains in U.S. farm exports. Also, it would cut food stamps too much -- even more than the Senate welfare bill -- threatening the nutritional safety net for children, the elderly, and working families.

The Energy and Natural Resources Committee would open the Arctic National Wildlife Refuge (ANWR) to oil and gas drilling, threatening a rare, pristine ecosystem, in hopes of generating \$1.3 billion in federal revenues -- a revenue estimate based on wishful thinking and outdated analysis. Moreover, the potential for long-term damage to this biologically-rich wilderness is simply too great. The Administration, instead, supports efforts to protect the refuge's coastal plain permanently.

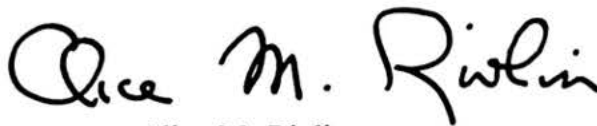
Already, the President has made it clear that he will veto any reconciliation bill that includes Medicare and Medicaid cuts of the size that the budget resolution calls for. Also, as I wrote to the Energy and Natural Resources Committee on September 21, the President will veto any reconciliation bill that opens ANWR to oil and gas drilling. But our serious concerns do not end with the specific veto threats that we have issued. For the wide array of reasons discussed in this letter, this bill remains unacceptable to the Administration and to the American people.

This nation was founded on the dream that all families should be given the opportunity to improve their lives and the future of their children. The Republican plan undermines that dream and promotes the wrong set of priorities for the nation.

Attached is a more detailed review of our concerns.

Although we have major differences with Congress at this point, we hope to work with you to find a common path to balance the budget in a way that will improve the standard of living of all Americans.

Sincerely,

A handwritten signature in dark ink, reading "Alice M. Rivlin". The signature is fluid and cursive, with the first name "Alice" written in a larger, more prominent script than the middle initial "M." and the last name "Rivlin".

Alice M. Rivlin
Director

Attachment

Identical letters sent to Honorable Pete V. Domenici,
Honorable Robert Dole, and Honorable Thomas Daschle

CONCERNS WITH SENATE RECONCILIATION PROVISIONS

SENATE AGRICULTURE

Farm policy

The Administration objects to the \$13.4 billion cut in farm program spending over seven years -- well over the \$4.2 billion in seven-year savings in the President's balanced budget plan. Cuts of the Senate's magnitude would unacceptably reduce U.S. farm income and damage U.S. agricultural export opportunities in the world economy.

The bill does not direct funding to those who most need it, and would punch holes in the safety net for family farmers; while it would significantly protect large-scale farming, it would not significantly protect small-scale farming.

Moreover, farmers would no longer have to participate in the Federal Crop Insurance Program as a condition of receiving farm program benefits, potentially undoing the major reforms only recently achieved in that program.

The bill would cut international trade promotion and market development assistance. It would cut the Export Enhancement Program by 20 percent a year, and the Market Promotion Program by 32 percent a year, diminishing our ability to compete in international markets -- in stark contrast to our competitors who continue to subsidize their farmers substantially.

In addition, the bill would cut incentives for voluntarily accomplishing conservation goals. It would cut the Conservation Reserve Program in half (costing about 15 million acres of resource protection) compared to the Administration's baseline. It would prohibit the Wetland Reserve Program from offering permanent easements, thus requiring USDA to pay multiple times for the same piece of land in order to protect wildlife and water quality. Especially at a time when regulatory controls for wetlands protection are under attack, Congress should not cut incentive-based programs so drastically.

Food Stamps and Child Nutrition

The committee's proposal includes the Senate welfare bill's food stamp provisions and other provisions. All told, the committee would cut food stamps by \$31 billion -- \$4 billion more than the Senate welfare bill. The President's balanced budget plan includes a preferable funding level, saving \$19 billion over seven years but preserving uniform, national eligibility for most of those now entitled to the program. We must preserve the national nutrition safety net, which assists about 27 million low-income children, elderly and working families.

While, generally, Senate-proposed changes to nutrition programs improve on those in the House welfare bill -- such as by rejecting block grants for child nutrition programs and WIC -- the Administration strongly opposes the food stamps block grant option, which the Senate welfare bill includes. By not requiring that all assistance go for food, the Senate would endanger the national program and move toward abdicating the federal role in combating hunger. Especially if Congress creates an AFDC block grant, we must preserve a national food stamp entitlement program; a national nutrition program helps put food on the table for low-income families who may lose their cash assistance, and it helps agricultural producers.

Moreover, the Administration strongly believes that all food stamp spending should go for food assistance, not just 80 percent, as the Senate block grant option would permit. Federal nutrition programs have produced measurably better health among the many people who get food assistance. National nutrition standards and a funding mechanism that lets the programs expand to meet greater needs in times of national or regional economic hardship are essential to feasible welfare reform.

SENATE ARMED SERVICES

The Administration is pleased that the Senate chose not to break faith with our service men and women by changing the method for computing military retirement pay, but instead chose to allow increased sales from the National Defense Stockpile to offset defense mandatory program increases.

The committee also proposes to sell the Naval Petroleum Reserves, as the President proposed. The Administration urges Congress not to rush the sale, enabling the federal government to receive fair market value for the assets.

SENATE BANKING, HOUSING, AND URBAN AFFAIRS

Banking Insurance Fund (BIF)/Savings Association Insurance Fund (SAIF)

The Administration strongly supports the Committee's action to deal with the financial problems of the Savings Association Insurance Fund (SAIF). It is essential to eliminate the perverse incentives created by a premium differential between SAIF and the Bank Insurance Fund (BIF). The bill would do so through a one-time special assessment on SAIF-insured deposits and by spreading Financing Corporation payments pro rata over all FDIC-insured institutions. In addition, we believe that the legislation should unambiguously provide for the SAIF's merger with BIF, which is essential to assuring that SAIF's structural vulnerabilities cause no further problems. While the Administration supports an ultimate merger of the thrift and bank charters, the difficult issues involved in the charter merger (including tax issues) should not interfere with enactment of a comprehensive solution to SAIF's financial problems that includes merging the deposit insurance funds. The Administration is also concerned that future congressional action to trigger the fund merger may carry a budgetary cost, creating an obstacle to it.

HUD Rental Subsidy Annual Adjustment Factor

The Administration is concerned about the equity of limiting the 1 percentage point cut in HUD's annual adjustment factor for subsidized rents to only one form of Section 8 rental assistance -- tenant-based certificates. The Administration prefers the House approach -- consistent with the Administration's 1995 and 1996 budget proposals -- of extending this reduced adjustment to all forms of Section 8 subsidies, including tenant-based certificates and subsidies attached to projects. Congress enacted this approach for one year only as part of the 1995 VA/HUD Appropriation Act, and will likely enact it again in the 1996 Appropriation.

SENATE COMMERCE, SCIENCE, AND TRANSPORTATION

Spectrum Auction

The Administration commends the Committee for including legislation to raise funds from spectrum auction, and believes the Committee's spectrum language is preferable to the House Committee's. Unlike the House provision, the Senate provision provides for paying (from auction proceeds) the costs that federal agencies bear in migrating from one portion of the telecommunications spectrum to another. This provision could be particularly important for the Departments of Defense and Justice and the Federal Aviation Administration. We should not require agencies to absorb these costs in their discretionary appropriations.

Rail Infrastructure

The Administration objects to the Committee's decision to spend \$70 million over seven years to make available up to \$100 million a year in guaranteed loans under the Federal Railroad Administration's Section 511 program. Railroads are financially healthy and have access to substantial financing through the private capital markets. In this era of declining discretionary budgets, subsidized loans to private, profitable corporations are objectionable.

The Administration also objects to spending \$75 million to revive the Local Rail Freight Assistance program. The Administration proposed to terminate this program in the 1996 Budget, and both House and Senate appropriators chose to eliminate it as well. The federal government should not be in the business of handing out grants to private corporations.

SENATE ENERGY AND NATURAL RESOURCES

Arctic National Wildlife Refuge

As noted above, the President will veto any reconciliation bill that opens the Arctic National Wildlife Refuge (ANWR) to oil and gas drilling. Exploration and development activities would bring physical disturbances to the area, unacceptable risks of oil spills and pollution, and long-term effects that would harm wildlife for decades. Moreover, the estimate that ANWR will generate \$1.3 billion in federal revenues from oil and gas leasing is wishful thinking, based on projected oil prices in the year 2000 of above \$30 per barrel -- even though the Energy Information Agency now predicts prices will only be about \$19 per barrel. The estimate also fails to consider new geological information showing lower recoverable oil estimates and Alaska's claims that its Statehood Act entitles it to 90 percent of all revenues -- not 50 percent, as the estimate assumes.

Hardrock Mining Reform

The Administration is concerned that the Committee's proposal to reform the antiquated 1872 hardrock mining law would, in fact, leave it largely intact. Most notably, the proposal essentially retains the notorious patenting provision whereby the government transfers billions of dollars of publicly-owned minerals at relatively little charge to private interests. The proposed "net" royalty on proceeds from minerals production on federal lands has excessive deductions, and would raise only a small amount of money to compensate taxpayers or fund the cleanup of abandoned mines that are degrading water supplies and otherwise harming the environment.

Additional Concerns

The Administration opposes the proposal to sell an additional 32 million barrels of Strategic Petroleum Reserve (SPR) oil, beyond the seven million proposed in the President's 1996 Budget and included in the 1996 Interior Appropriations Conference Report. The Administration is pleased with provisions which advance prospects for selling the United States Enrichment Corporation (USEC), although we are concerned about Senate provisions that would transfer exclusive rights to gaseous diffusion technology from the Energy Department to USEC and believe some changes are needed to successfully implement the Russian uranium agreement. In addition, while we appreciate inclusion of the Alaska Power Administration sale to current customers -- as the Administration has proposed -- we believe that all Power Marketing Administrations, except the Bonneville Power Administration, should be sold to their customers.

The Committee also has chosen to use the reconciliation bill as a catch-all for various objectionable policies, many of them having nothing to do with balancing the budget. The oil and gas royalties proposal includes a number of provisions that would make royalty collection far more difficult and costly for the federal government. The Ward Valley (CA) Land Transfer (which the Administration supports in concept) includes no environmental conditions. The Communication Site Fees proposal would prevent the National Forest and Bureau of Land Management (BLM) lands from implementing a fair market value fee

schedule that they developed over the past three years, reducing and delaying revenues to the Treasury and to states and counties where the sites are located. The aircraft services proposal would raise the Interior Department's federal procurement costs and reduce efficiency. The Reclamation Reform Act proposal would unjustifiably allow large landowners to prepay, at a discounted rate, the highly subsidized debt they owe the U.S. for their share of capital costs of Bureau of Reclamation irrigation projects. The Collbran Project Transfer proposal, by delaying the transfer until 2000 but not adjusting the price tag or covering the power debt, would provide an unwarranted triple subsidy to the project's water district conservancy.

SENATE FINANCE

Medicare

The Administration strongly opposes the magnitude of the proposed Medicare cuts -- \$270 billion over seven years. While Republicans say we need cuts of this size to "save" the Medicare Part A Trust Fund, in fact we need only about \$90 billion in Part A savings to ensure the trust fund's solvency for the next 10 years. The rest of the Republican Medicare cuts would finance the Republican tax cut.

Further, the Republican plan imposes almost \$70 billion in new financial burdens on beneficiaries. Most of it comes from setting the Part B premium to cover 31.5 percent of program costs. This increase is excessive. The Republican plan also more than triples the Part B premiums for some higher-income beneficiaries. For all beneficiaries, the Part B deductible would more than double by 2002. The Republican plan then compounds these direct new burdens on beneficiaries by imposing many hidden cuts that will force them, over time, to pay much more for their health care services.

For example, the Senate's new "Medicare Choice" option actually gives beneficiaries less choice. Though it promises to give beneficiaries free choice between traditional Medicare and all the options under Medicare Choice, the legislation applies distinctly uneven rules to Medicare and Medicare Choice, making the former much less attractive to providers than the latter. These incentives, along with a provision that applies the so-called "budget expenditure limiting tool" (BELT) of more cuts only to the traditional program, would reduce providers' willingness to serve beneficiaries in traditional Medicare. This will restrict beneficiary choice, not enhance it. Medicare Choice, as structured in the Republican plan, also would promote adverse risk selection that could increase costs for the traditional program. The Administration does not support efforts to use Medicare beneficiaries to experiment with untested concepts that could weaken the program.

The Medicare Choice "choice" is also a bad one for beneficiaries because they will lose protection from "balance billing," whereby providers charge beneficiaries more than Medicare approves. Medicare permits no balance billing by hospitals and only limited balance billing by physicians. Medicare Choice plans, however, will widely permit it. Physicians, and possibly other providers such as hospitals and skilled nursing facilities, in fee-for-service Medicare Choice plans will be able to charge patients whatever they want.

The same will be true for patients electing the catastrophic or medical savings account (MSA) plans. For managed care plans, the Senate bill appears to let each private plan decide whether to offer beneficiaries any protection from unlimited provider charges. There would be no Federal protection for beneficiaries in these plans. Whenever patients receive non-emergency care outside of the plan -- even if the plan authorizes such care -- beneficiaries would not be protected from excessive charges by physicians. Given the very tight caps that this bill would impose, provider pressures to balance bill will grow. If providers begin to move to Medicare Choice plans to escape balance billing limits, beneficiaries will face the choice of following them and paying more, or remaining in traditional Medicare where fewer doctors and hospitals are able to care for them.

Medicaid

The Administration strongly opposes both the magnitude of proposed Medicaid cuts -- which would cut federal payments to states by \$182 billion, or 20 percent, below current law -- and the conversion of Medicaid into a block grant, eliminating guaranteed coverage to millions of Americans. By 2002, the cuts would amount to a 30 percent reduction below CBO's estimate of the cost to maintain current services. To reach these savings, per capita health care spending growth under Medicaid would have to fall to an average of 1.4 percent a year over the next seven years; by contrast, per capita spending in the private sector is projected to grow by 7.1 percent a year over this period. Given such a low rate of growth, states would face untenable choices: cutting provider payment rates, cutting benefits, or dropping coverage for millions of beneficiaries.

Furthermore, in converting Medicaid into a drastically smaller block grant program, the Committee bill reduces the guarantee of coverage on which millions of low-income families have depended. Over 36 million Americans -- individuals with disabilities, children, pregnant women, elderly nursing home residents, mentally retarded children and adults, mentally ill persons, and others -- who cannot pay for their own health care are now assured access to a package of basic services. Because this guarantee is eliminated, millions of children and many other vulnerable Americans could lose access to health care.

Although the Chafee amendment purported to "guarantee" coverage to certain groups, it does not define coverage. For example, it leaves the definition of who is disabled and, thus, eligible for guaranteed coverage entirely to the states. Further, given the size of proposed Medicaid cuts, the level of benefits that the states could guarantee could be minimal.

The Senate bill jeopardizes the income, homes, and cars of nursing home residents and their spouses. Under current law, federal Medicaid eligibility standards, which the Senate bill would repeal, protects these residents and their spouses from losing their homes and cars. Also under current law, spousal impoverishment provisions protect a minimum level of income and assets, not including the home and car. Because the Senate bill leaves both eligibility requirements and spousal impoverishment protections up to the states, the federal government would no longer assure that the income, homes, and cars of Medicaid recipients will be protected.

The bill also repeals federal nursing home quality standards for Medicaid and directs states to adopt whatever standards they choose. With an enormous cut in federal financial assistance, states may not be able to afford to develop and enforce standards to ensure a high quality of care and quality of life.

The bill also repeals protection for low-income Medicare beneficiaries under Medicaid. Currently, an estimated 5 million individuals receive Medicaid assistance with their Medicare premiums, deductibles, and other cost sharing. The need was so great that congressional Democrats and Republicans came together to create the Qualified Medicare Beneficiary (QMB) program. President Reagan signed legislation to create the program; President Bush signed a bill to expand it. These beneficiaries are doubly hit by Republican proposals. First, Republican *Medicaid* proposals eliminate guaranteed coverage of Medicare cost-sharing, potentially leaving beneficiaries ultimately liable. In addition, Republican *Medicare* proposals will exacerbate the hardship by increasing the premium amounts they must pay.

The Administration is concerned that the Committee bill repeals the Vaccines for Children Program (VFC), a 100 percent federally-funded entitlement for Medicaid-eligible, uninsured, under-insured, and Indian children. Although the bill requires states to cover immunizations for Medicaid-eligible children, thousands of uninsured, under-insured, and Indian children would lose coverage. Further, in converting Medicaid into a drastically reduced block grant, federal funding dedicated to immunizing children would decline, threatening our efforts to insure that 90 percent of all children under age 2 are properly immunized for the initial, and most crucial, doses of vaccine.

Earned Income Tax Credit (EITC)

The Administration strongly objects to the Committee's proposal to cut the EITC by \$43.5 billion over seven years, raising taxes on 17 million households. The changes would affect nearly 24 million children.

By partially repealing the indexing of the EITC, the Committee's proposal would generate creeping tax increases each year. Working families would see their taxes rise by \$302 in 1996 and by \$471 in 2005 (in 1996 dollars). Families with two or more children would fare the worst under the proposal. In 1996, taxes would increase, on average, by \$410 for over 7.4 million families with two or more children. Their taxes would increase by \$644 by 2005 (1996 dollars). By 2005, 22 percent of all families with children eligible for the EITC under current law would lose that eligibility.

Under the proposal, 1 million EITC recipients would be taxed on their full social security benefits, increasing their taxes by an average of \$859. The proposal also would repeal the EITC for very low-wage workers who do not reside with qualifying children. For these workers whose adjusted gross income is less than \$9,500, average taxes would rise by \$173.

The Administration believes strongly that Congress should not raise taxes on working families to finance tax breaks for the well-off. It should limit its changes to the compliance improvements that the Administration has proposed.

Tax Cuts

The Administration strongly opposes the Committee tax cut; it is fiscally irresponsible and would provide a disproportionate share of benefits to high-income families. At a time when Congress seeks to cut over \$1 trillion to balance the budget, adding another \$245 billion to the deficit through lower taxes forces more drastic cuts in public services and benefits for lower- and middle-income families. Without this huge tax cut, Congress would not need the drastic cuts in Medicare in the budget resolution, including the increase in premiums for the elderly at all income levels.

The tax cuts provide large benefits to those who need them the least. The capital gains cut, among other provisions, is overly generous and disproportionately benefits upper-income families. Overall, about 48 percent of the benefits from the Finance tax bill will accrue to families with incomes over \$100,000 (the top 12 percent of families). At the same time, the combined effects of the tax cuts and cuts in the EITC will raise taxes on families with income under \$30,000.

Pension Reversion

The Administration strongly opposes the "pension reversion" provision that would permit companies to withdraw "excess" pension assets. As the Pension Benefit Guaranty Corporation's board members stated in their October 17 letter to Chairman Roth, the Senate provision would "result in the removal of billions of dollars from the pension system, endangering workers' retirement income for the purpose of paying current expenses. This would increase the risk of loss for workers, retirees and the pension insurance system. Despite the nominal restrictions imposed ..., the proposal would effectively allow companies to remove assets from retirement plans and use these funds for any purpose... This is not the intended use of funds that have accumulated with the aid of the valuable tax incentives explicitly designed to promote pension savings for workers."

Such reversions risk a repeat of the pension raids of the 1980s, when reversions helped fuel corporate takeovers and buyouts. This short-sighted provision risks undermining our private retirement system. We must increase our savings for retirement and enhance, not diminish, public confidence in our pension system.

Health Benefits for Retired Unionized Coal Miners and their Families

A 1992 law combines federal and company funding to finance the health care for retired coal miners and dependents that was promised them in collective-bargaining agreements. A proposed amendment would release certain coal companies from their obligations, including those that signed an agreement to pay future costs for their former employees. The resulting lack of revenue could threaten the health care of nearly 100,000 retired coal miners and their families.

Child Support Enforcement

The Administration has significant concerns about a Committee proposal mandating that, in order to recoup administrative expenses, States collect an amount equal to a \$25 application fee and a 10 percent fee on all non-AFDC child support collections. Such a fee, amounting to a cut in income, would withdraw vital support for children, unduly burdening low- and moderate-income families and possibly forcing some back on AFDC.

Welfare Reform

AFDC, Work and Child Care. The Committee included the Senate-passed welfare reform bill in its reconciliation package. The Senate bill is significantly preferable to the House welfare bill in promoting work and protecting children, but the bill nevertheless raises important issues:

- The Administration strongly supports the bipartisan Senate improvements to provide the child care that people need to move from welfare to work. Without sufficient child care funding, welfare reform will prove an enormous unfunded mandate on states. The Administration recommends that Congress improve the final bill by adding more child care money, not less. The Administration strongly supports the Senate child care provisions that gives states a separate funding stream for child care and provide services to help families stay off welfare.
- The Administration is pleased that the Senate has included maintenance of financial effort provisions in the bill. Congress should clarify these provisions, however, to tighten the definition of allowable expenditures.
- Congress should provide states with greater protection in a serious recession by strengthening the Senate's contingency grant fund. From 1989-93, AFDC caseloads grew by 32 percent and AFDC spending by \$8 billion. But the Senate welfare bill's contingency fund provides only \$1 billion over seven years.

Foster Care. The Administration has strong reservations about the bill's proposed cap on foster care administrative costs. At a time when sharp changes in welfare policy may affect foster care caseloads substantially, the proposed cap would restrict states' ability to safeguard the well-being of abused and neglected children.

Supplemental Security Income. Both the House and Senate bills go too far in the changes they would make to the SSI children's disability program. In general, the Administration favors the Senate provisions over the House bill's deep cuts, which go far beyond what's needed to correct the program's recent growth. The House bill would eventually prevent nearly a million disabled children who could be eligible under current rules from receiving cash. We support the bipartisan Senate decision to continue to provide SSI cash benefits for all eligible children. We strongly urge Congress to reduce hardship to disabled children now on SSI by exempting them from these new, stricter eligibility rules. If Congress applies these rules to current SSI recipients, however, the Administration recommends only applying them to children eligible as a result of maladaptive behavior.

The Administration also recommends the deletion of a Senate provision that would gradually raise the age requirements to elderly poor applying for SSI from 65 to 67, paralleling the rising age requirements for Social Security. The apparent consistency of this change masks an important difference between these two programs: Social Security recipients can retire early and get benefits, and most do so, but no early eligibility age exists for SSI. The Senate added this provision at the last minute without adequate public scrutiny and debate; Congress should drop it.

Benefits to Immigrants. Both the House and Senate bills go too far in cutting benefits to legal immigrants, and shifting costs to states with high numbers of immigrants. The Administration supports holding sponsors who bring immigrants into this country more responsible for their well-being, but Congress should make these changes equitably. The House bill bans benefits for over a million immigrants who are now enrolled in SSI, Medicaid, or food stamps. The Senate bill's benefit restrictions, however, distinguish between immigrants with and without sponsors (except for purposes of SSI). Focusing benefit restrictions on immigrants with sponsors is a more sensible approach than the House bill. The Senate bill, however, should include the immigrant exemptions of the House bill.

The Administration strongly opposes the Senate provision that would discriminate against U.S. citizens by denying benefits to legal immigrants even after they became naturalized citizens. We cannot have two categories of citizens, and a provision that treats naturalized citizens less favorably than the native born raises serious constitutional concerns. Equally objectionable is the Senate provision that would establish a class system for American citizenship by requiring sponsors' income to exceed 200 percent of poverty. Working families who are U.S. citizens should not have to pass a wealth test to be reunited with a family member. In addition, fairness dictates that Congress adopt the House provisions that exempt from benefit cut-offs those over age 75 and those too disabled to complete the naturalization process.

Several further changes could make the legislation more acceptable to the Administration. Immigrants who become disabled after entering the country should be able to get SSI. In addition, benefit restrictions should not apply to discretionary programs and such mandatory programs as student loans and the social services block grant; the administrative burdens on these programs of verifying everyone's citizenship is significant, and the budget savings are negligible. Refugees and others who came to the U.S. to avoid persecution should get adequate time to naturalize before being subject to benefit restrictions. Finally, the Administration has serious reservations about the bill's application of these provisions to Medicaid.

SENATE GOVERNMENTAL AFFAIRS

Civil Service Retirement

The Administration is concerned about the Committee's proposal to raise employee retirement contributions, which is tantamount to raising employees' taxes. We should not raise taxes on federal employees at a time when we are reducing their numbers and asking those that remain to provide the American people with a government that works better and costs less.

Also, the Administration is concerned about a Committee proposal to delay the cost of living adjustment (COLA) from January to April for federal civilian retirees. Unlike private and military retirees, most current federal civilian retirees are not covered by Social Security, making them entirely dependent on their retirement benefits to maintain an adequate standard of living.

SENATE JUDICIARY

Patent and Trademark Office (PTO) fees

The Administration is concerned about the Committee's proposal to extend the patent surcharge fund, and to deny PTO full access to its fees without discretionary appropriations. This withholding of fees increases patent pendency and delays the deployment of new technology to the marketplace. The President's budget supports the elimination of the patent surcharge fund beginning in fiscal 1999 and the PTO's full access, without appropriation, to all fees.

SENATE LABOR AND HUMAN RESOURCES

Student Loans

The Committee would get over 60 percent of its \$10.8 billion in savings by cutting educational assistance to students and parents, and taxing colleges and universities. The Administration strongly opposes all of these provisions.

The President's direct lending program has been a great success, saving money and increasing access to education. Thus, the Administration strongly opposes the Committee's proposal to cap it. The program is easier for institutions to administer than the guaranteed loan program and gives students more flexible repayment options, including income-contingent repayment. By capping the program at 20 percent of total federal student loan volume, the Committee would eliminate up to half the institutions that are participating in this streamlined loan program. It also would prohibit other institutions from participating, including those that have already applied.

The Administration strongly opposes the Committee's proposed end to the federal subsidy of interest payments that Stafford loan recipients receive during the 6-month "grace period"; these undergraduate students' costs could rise as much as \$700. In addition, the Administration strongly opposes the Committee's increase in the PLUS loan interest rate, as well as its tax of 0.85 percent of total federal loan volume on institutions of higher education, which would penalize institutions in which a high proportion of students take out loans.

The Committee proposes large cuts in the administrative funding needed to effectively manage the guaranteed student loan program, and to avoid student loan fraud and abuse. These cuts would seriously weaken the Education Department's ability to ensure that taxpayer funds are properly used and accounted for. The Administration also opposes the Committee's proposed changes which would severely weaken the department's ability to oversee guaranty agencies and to protect federal assets under their control.

SENATE VETERANS' AFFAIRS

GI bill

The Administration is concerned about the Committee's proposed increase in the GI bill contribution rate, which would effectively cut the base pay of most first-year enlistees by 3.5 percent. The GI bill is a valuable recruiting tool of the Services; an increase in the required contribution could have an adverse effect on military recruitment.

MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
CBO MEDICARE BASELINE										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
<i>Per Capita Growth</i>									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
<i>Per Capita Growth</i>									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
CBO PRIVATE GROWTH RATES										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

02-Sep-95

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MEDICAID PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002		96-00	96-02
CBO MEDICAID BASELINE											
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8		614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%		10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9		3.3%	3.0%
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%			
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871		7.0%	7.0%
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%			
Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)											
Spending	89.2	95.3	106	116.1	127.8	139.1	151.6	164.8		9.9%	9.6%
		6.8%	11.2%	9.5%	10.1%	8.8%	9.0%	8.7%			
Spending per Recipient	2,422	2,483	2,652	2,819	3,014	3,185	3,380	3,588		6.4%	6.3%
		2.5%	6.8%	6.3%	6.9%	5.7%	6.1%	6.2%			
Savings		-4	-4	-6	-7	-9	-11	-13		-30	-54
Budget Resolution Medicaid Proposal (CBO Baseline)											
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3		4.7%	4.5%
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%			
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705		1.4%	1.4%
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%			
Savings		-4	-8	-16	-24	-33	-43	-54		-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

02-Sep-95

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