Priorities for a new century

SEIU
Leading the Way

Please return to:

Andrew L. Stern
International President
Service Employees International Union (SEIU)
1313 L Street NW
Washington DC 20005

Please respond by Friday, May 14, 1999

Priorities for a new century

Questions for U.S. Presidential candidates from SEIU members and their families

SEIU
Leading the Way

Strengthening Social Security and Medicare

Social Security and Medicare protect working families from birth to death. In childhood, Social Security provides basic support if a working parent is killed. In adulthood, Social Security replaces the income of a worker who becomes disabled and unable to work. In retirement, Social Security and Medicare ensure a basic level of income and health care.

Wall Street bankers and other corporate interests are proposing to undermine Social Security by diverting our hard-earned money to individual accounts – with no guarantee that benefits would be there when we need them or would be protected from inflation.

At the same time, big corporations are proposing to shift Medicare to a program of individual vouchers for health insurance, leaving those who most need help with the highest costs.

SEIU will defend these programs against benefit cuts (including increases in the retirement age) and other changes that jeopardize the financial security of Americans young and old. In addition, we believe that resources must be found to close gaps in the programs, such as the high number of elderly widows in poverty and the lack of prescription drug coverage.

Do you agree with our working family solutions instead of the schemes being promoted by Wall Street? What steps would you take to strengthen these programs?

Freedom to Choose a Voice at Work

Workers' freedom to choose to have a voice at work by joining a union is a basic right like freedom of religion or freedom of speech. The choice to join a union helps raise living standards and the quality of services for all working families. It also promotes the good jobs that strong, stable communities need.

Unfortunately, corporations often interfere with workers' freedom to choose by having supervisors urge employees not to join a union, by calling mandatory anti-union meetings, and by hiring outside consultants to orchestrate an anti-union campaign. Pressure from managers with the power to determine workers' job security and working conditions may be legal, but it interferes with one of our basic freedoms as Americans.

As President of the United States, will you publicly speak out in favor of workers' freedom to choose to join a union and against employer interference with that freedom? Will you encourage other public officials to join you in speaking out, and will you encourage the nation's employers not to involve themselves in a choice that belongs to the workers themselves?

Health Care for All

Although the United States is the wealthiest nation in the world, any American family can suddenly find itself without health coverage through no fault of its own. More than 43 million Americans are now in that situation—and the numbers continue to grow. Most are workers or children.

As the nation's largest union of health care workers, SEIU supports steps toward affordable, quality care for all Americans, including health insurance for all, improved quality of care, cost containment that does not harm health workers and their ability to provide care, equitable financing, and less bureaucracy.

If you become President, would you move to enact comprehensive, universal health coverage by the end of your first term? If not, do you support any of the following incremental steps—universal coverage for children, tax credits for health insurance premiums, mandatory coverage by all employers, or Medicare or Medicaid expansion?

Promoting Health Care Quality

Patients and health professionals are increasingly fed up with HMOs and managed care. The common complaint is that quality care is being sacrificed for profits. Patients are forced to give up preferred doctors, convenient hospitals, and certain medications. Nurses and other workers find themselves with unmanageable workloads and inadequate supplies. Doctors feel that treatment decisions are increasingly dictated by bureaucrats. Medicare managed care plans have made false promises to senior citizens, then socked them with big bills or even dumped them outright.

What standards do you support for health plans and facilities to guarantee quality care?

Efficient Public Services

Americans want greater efficiency and accountability in the public services we count on. Politicians and top government officials must be more accountable for the services they manage.

Public service workers must be provided the training and resources to do the job. Public services must not be turned over to private, outside profiteers who in many cases will cut corners on quality, fail to protect privacy, try to buy off politicians to get contracts, and abruptly abandon certain services they no longer consider profitable enough.

Do you favor making public services more efficient and accountable, or do you favor turning over these services to private corporations?

KEY MEDICARE FACTS

CURRENT PROGRAM

- Covers 39 beneficiaries, about 34 million elderly, 5 million people with disabilties
- In 1999, gross spending is $230 billion (Federal payments $210 billion net of premiums)
- About 15 percent of beneficiaries are in managed care
- Part B premium in 1999 is $45.50

ACCOMPLISHMENT

- 99 percent of the elderly are insured today, compared to 56 percent in 1963
- Since Medicare was created, life expectancy for 65 year olds has increased by 20 percent (live 3 years longer).
- Poverty rate among the elderly: from 29 percent in 1966 to 10.5 percent in 1995.

PRESIDENT'S ACCOMPLISHMENTS

President's 1993 Budget:

- Extended life of the Trust Fund from 1999 to 2002

Balanced Budget Act of 1997

- Savings over 5 years: $115 billion (CBO); $150 billion (OMB)
  Savings over 10 years: $385 billion (CBO); $457 billion (OMB)
- Life of the Trust Fund: Through 2008 (from 2002; OMB)
- Spending growth per beneficiary: 3.3% from 1998 to 2003, well below private projections of about 5% per capita
- Only slight growth as percent of Federal budget: From 12% in 1997 to 13% in 2002

Contribution to deficit reduction:

- One quarter — $800 billion — of the entire deficit reduction between 1992 and 2002 comes from reduced Federal spending on health care. 42 percent of the $1.8 trillion total reductions in spending (exclusive of the revenue increases) between 1992 and 2002

MODERNIZING MEDICARE: BALANCED BUDGET ACT OF 1997

NEW BENEFITS

- **New preventive benefits that should save Medicare money in the long-run:**
  - Mammography screening
  - Screening Pap smears & pelvic exams
  - Prostate cancer screening
  - Colorectal cancer screening
  - Diabetes self-management and test strips
  - Bone mass measurement

MANAGED CARE REFORMS

Improved payment methodology

- **Ends overpayment to managed care plans**. The well-documented, flawed payment rates will be corrected through slower growth rates for the next 5 years.

- **Reduces bias against rural managed care**. Managed care rates will phase in a 50 / 50 blend of local and national rates, with a "floor" for the lowest rate counties and a minimum growth rate for all.

New choices

- **New plan options for beneficiaries**. Beneficiaries' managed care options will be expanded to include preferred provider organizations, provider-sponsored organizations, private fee-for-service plans with consumer protections, and, on a demonstration basis, medical savings accounts.

- **Consumer information to encourage beneficiaries to participate**. Beneficiaries will be educated about their plan options through a series of reforms, including standardized information, enrollment periods, and nation education and publicity campaigns.

FEE-FOR-SERVICE PAYMENT REFORMS

- **Prospective payment systems for the fastest growing services:**
  - Home Health
  - Skilled Nursing Facilities
  - Hospital Outpatient Departments
  - Rehabilitation Hospitals

- **Prudent purchasing.** The ability to efficiently manage the program will be improved by new competitive pricing demonstrations and allowing Medicare to change payments by up to 15 percent per year to bringing line with inherent reasonableness.

MEDICARE TRUST FUND FACTS

December 15, 1998

HI TRUST FUND (billions)

	Income	Expend	Change
1998	136	144	-8
2007	195	221	-26

Trust Fund Exhaustion: 2008
75-Year Actuarial Deficit: 2.10 (difference in annual income & costs as % of taxable payroll)

Payroll tax rate: 1.45% employers and employees each

Effect of BBA: Halved the 75-year actuarial deficit (from 4.32 to 2.1)
Savings (CBO): $115 b / 5; $386 b / 10

EXTENDING THE BBA

(Estimates from last June / being revised)

For 5 years:
Trust Fund Exhaustion: 2009
75-Year Actuarial Deficit: 1.87

Permanently
Trust Fund Exhaustion: 2012
75-Year Actuarial Deficit: 0.34

REVENUE

To solve 75-year actuarial deficit, increase payroll tax from 2.9 to 5.0%

MIX OF REVENUE AND EXPENDITURE REDUCTION

Mix of revenue increases and expenditure decreases for actuarial balance through 2022

Revenue Increase	**Expend Reduction**
0%	18%
10%	10%
22%	0%

Effects of constraining per capita cost growth to:

	5%	4%	3%	2%
Trust Fund Exhaustion:	2008	2009	2016	Never

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	--	--	na
1974	--	--	na
1975	"Late 1990s"	--	na
1976	"Early 1990s"	--	na
1977	"Late 1980s"	--	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
1994	2001	7	- 4.14
1995	2002	7	- 3.52
1996	2001	5	- 4.52
1997	2001	4	- 4.32
1998	2008	10	-2.10

Sources: Annual Trustees Reports for 1978 and subsequent years; Reischauer & Aaron, 1995 for early years.
Note: All estimates assume the "intermediary" or, when applicable "intermediary B" assumptions

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Divider Title: PBOR, Privacy

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10%	10%
22%	0%

Effects of constraining per capita cost growth to:

	5%	4%	3%	2%
Trust Fund Exhaustion:	2008	2009	2016	Never

Effect of using percent of amount (very preliminary):

	10%	20%	30%
Trust Fund Exhaustion:	2016	2023	2027

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	--	--	na
1974	--	--	na
1975	"Late 1990s"	--	na
1976	"Early 1990s"	--	na
1977	"Late 1980s"	--	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
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1998	2008	10	-2.10

Sources: Annual Trustees Reports for 1978 and subsequent years; Reischauer & Aaron, 1995 for early years.
Note: All estimates assume the "intermediary" or, when applicable "intermediary B" assumptions

Medicare Estimates, Assuming 50 Percent of 17.5 Percent

If half for TF:

- Extension of 6 years (2014 with no other changes)

If half for prescription drugs:

- Benefit:
  - $100 deductible, copayments of $7 / generic, $15 / brand name, $1,000 cap
- Cost:
  - Assuming Part B Benefit (75% subsidy): $59 billion / 5, $163 billion / 10
  - Percent that could be subsidies using half of amount: 60 percent

    $47 billion / 5, $130 billion / 10

Funds for Medicare

2000	21	
2001	23	
2002	32	
2003	30	Five years
2004	34	140
2005	38	
2006	46	
2007	52	
2008	57	Ten Years
2009	63	396
2010	64	
2011	69	
2012	72	
2013	75	Fifteen Years
2014	75	751

Jeff B. Liebman 12/23/98 09:27:32 AM

Record Type: Record

To: rfoster1 @ hcfa.gov @ inet

cc: Jeanne Lambrew/OPD/EOP

Subject: Numbers relating to your discussion with Jeanne Lambrew

As Jeanne has explained, we are interested in the change in the trust fund exhaustion date and in the 75 year actuarial balance if the following stream of revenue were transferred to the Part A trust fund. It is likely that we are going to send you a number of similar requests over the coming weeks, so you might want to set up your spread sheet/model in a way that makes it easy to just plug in the latest revenue series. Please feel free to call me if you want to talk about any details of this. By the way, the data below are consistent with Trustees economic assumptions so you don't have to worry about any conversion between an OMB or CBO world and Trustees world -- you can simply plug in the nominal dollars as I have them here.

Finally, we would be thrilled if this could be done by the end of the day.

Many Thanks,
Jeff Liebman
202-456-5358

(Billions of current dollars)

1999	9.17
2000	9.70
2001	12.78
2002	22.92
2003	21.85
2004	26.08
2005	29.25
2006	32.69
2007	39.60
2008	43.95
2009	45.65
2010	47.11
2011	48.18
2012	47.97
2013	46.35
2014	43.84
2015	39.49
2016	35.55
2017	30.68
2018	23.76
2019	18.23
2020	11.47
2021	4.37
2022+	0



Richard Foster <RFoster1 @ hcfa.gov>
12/23/98 05:25:55 PM

Record Type: Record

To: Jeff B. Liebman/OPD/EOP

cc: Jeanne Lambrew/OPD/EOP
Subject: Numbers relating to your discussion with Jeanne Lambrew -Reply

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Jeff,

Jeanne has probably passed on the news to you by now but just in case...

We estimate that the revenue stream you provided would reduce the long-range HI actuarial deficit from 2.10% of taxable payroll to 1.92% (an improvement of 0.18%). This effect would be substantially greater if the revenue stream continued, rather than tapering off by 2021.

We also estimate that the HI trust fund would be depleted in calendar year 2019, as opposed to 2008 under present law. These estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.

Please let us know if you have any questions about this information.

Rick

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Divider Title: Medicare

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Divider Title: Coverage

11-17-98

THE WHITE HOUSE

WASHINGTON

98 NOV 13 PM 2:48

November 13, 1998

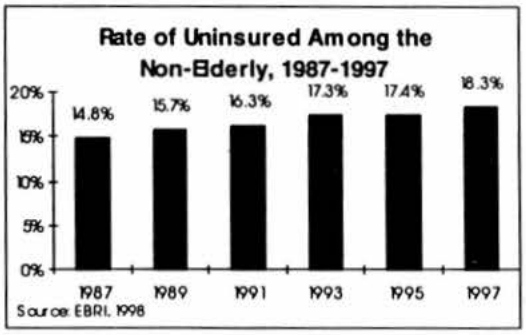
INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

THROUGH: Bruce Reed, Gene Sperling

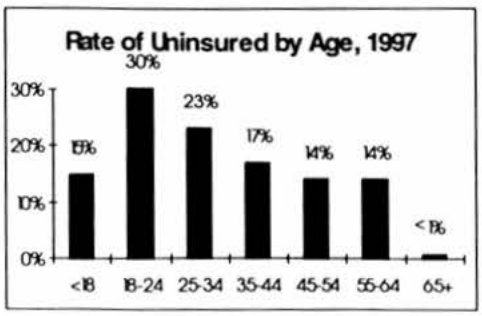
SUBJECT: Recent Uninsured Trends and Analyses

As you know, the Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million from 1992. Insurance coverage is one of the few social indicators that has not improved in the last several years. This contradicts the theory that a strong economy with low unemployment yields a high demand for workers, and thus better benefits like health insurance. It is even more disappointing given record-low health care cost growth in the last several years, which should make insurance more affordable and thus more common. This increase has important consequences since the uninsured are four times more likely to not receive needed health care, have hospitalization rates for preventable conditions that are 50 to 75 percent higher, and place growing uncompensated care burdens on the nation's providers.



Because of the importance of this problem and your expressed interest in these data, we are providing you an analysis of the numbers and recent insurance coverage trends, as well as a summary of their policy implications.

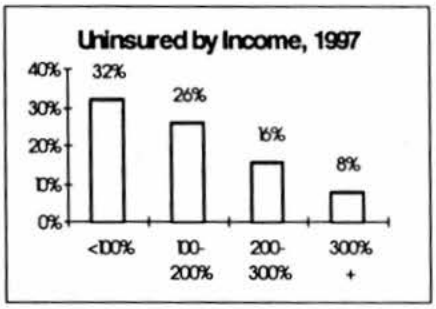
Uninsured by age: Most of the uninsured in America are young; over 80 percent are under age 45 (35.2 million). These uninsured are disproportionately ages 18 to 24 -- 30 percent of whom are uninsured compared to 15 percent of children. The number of uninsured children did not increase in 1997, remaining at 10.7 million. This contrasts dramatically with last year's data that showed that 800,000 of the 1.1 million additional people who were uninsured were children. The change appears to be the result of the unprecedented focus on children's health in 1997. Beginning with the State of the Union and ending with the establishment of your Children's Health Insurance Program (CHIP), the Federal Government and the states started taking actions to address this serious problem. Next year, after Census' data reflects a full year's operation of CHIP, we would expect the number of uninsured children to fall.



11-17-98

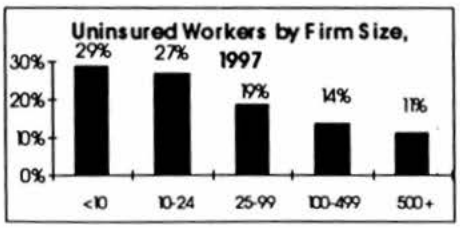
While the likelihood of being uninsured is higher among younger adults, the number of uninsured is growing faster among older adults. One million of the additional 1.7 million uninsured people in 1997 were age 35 or older. The increase is particularly concentrated among people ages 55 to 65: the number of uninsured people in this age group grew faster than all other age groups (7 percent growth). This trend is cause for concern because people ages 55 to 65 become more likely to develop a health problem and less likely to have employer insurance (because their spouses retire and join Medicare, they move to part-time or self-employment which typically does not offer insurance, or they retire). As a result, this age group is disproportionately relies on individual health insurance -- where premiums have been skyrocketing in recent years and underwriting practices remain prevalent. Because of the demographics, there is no doubt that the coverage problem will increase exponentially as the number of people in this age cohort is projected to rise by over 60 percent by 2010.

Uninsured by income: Not surprisingly, people with less income are less likely to have health insurance. Although only 13 percent of the U.S. population, poor Americans (with income less than $16,000 for a family of 4) represent 26 percent of the uninsured -- fully one-third have no insurance. However, reflecting the strong economy, the poverty rate continues to fall and the number of uninsured below 100 percent of poverty did not increase between 1996 and 1997.



Despite the link between lack of insurance and low income, over 80 percent of the uninsured are in working families. The lack of insurance is growing among the middle class; all of last year's additional 1.7 million uninsured had income above the poverty level, with the greatest concentration of people between 100 and 200 percent of poverty. Inexplicably, although still small in number, the uninsured with income above 500 percent of poverty (over $80,000 for a family of 4) rose at an extraordinary 20 percent growth rate in 1997.

Job characteristics and the uninsured: Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer than 25 employees. Compared to over 95 percent of large firms, about half of firms with fewer than 10 employees and three-fourths of firms with 10 to 24 employees offer coverage. These facts underscore the need to find better ways for small businesses to pool resources and leverage to bargain for more affordable benefits.



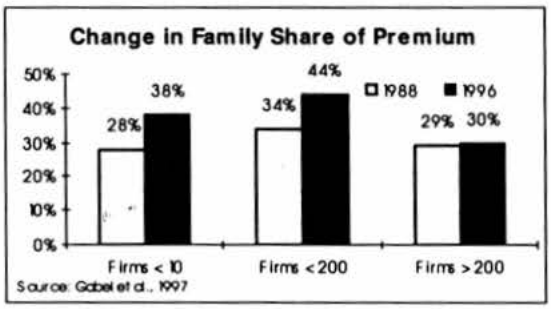
The rate of being uninsured is also high among people who work full time but only for part of the year, most likely due to job change or loss (27 percent). A recent Census study found that over 40 percent of workers with at least one job interruption had a gap in coverage. Because most people are insured through work, insurance coverage often ends with employment changes -- underscoring the importance of the Kassebaum-Kennedy portability and COBRA protections.

11-17-97

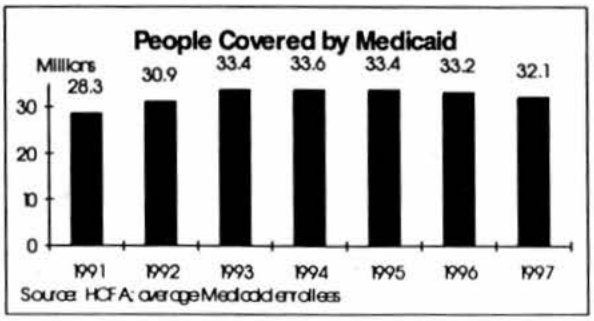
TRENDS IN EMPLOYER-SPONSORED INSURANCE. On the face of it, it does not appear that the increase in the uninsured is directly linked to a decline in employer-sponsored health insurance (ESI). The erosion that occurred in the late 1980s and early 1990s has ended. About 64 percent of nonelderly Americans had employer-based insurance in 1997, virtually unchanged from 1995 and 1996. In recent years, access to job-based health insurance has actually increased, even among small businesses. However, this has not translated into increased ESI coverage because a smaller proportion of people with access to ESI are purchasing it.



Even though more employers are offering health insurance, fewer employees are taking this coverage, primarily because they have to pay more of the premiums. The employee share of premiums has risen, especially in smaller firms. As a result, fewer employees are purchasing this coverage. For example, in 1987, 90 percent of workers in firms with fewer than 10 workers who had access to employer-based coverage took it, compared to 85 percent in 1996. These take-up rates drop as the share of the premium paid by the employee increases. This trend clearly affirms that health insurance affordability plays the most significant role in people's likelihood of buying health insurance.



TRENDS IN MEDICAID. The most notable drop in insurance coverage in 1997, reported by both the Census Bureau and HCFA, appears to come from the number of people covered by Medicaid. There are three possible explanations for this trend. The first and likely most significant factor is that, as the economy has strengthened, fewer people are eligible for Medicaid. This is supported by the fact that the poverty rate has declined, the number of poor covered by ESI has increased, and there was no increase in the number of uninsured children eligible for Medicaid (still 4.7 million). Second, there may be fewer people aware of their continuing Medicaid eligibility in the wake of state and Federal welfare reform. Third, it is becoming more likely that Medicaid beneficiaries misreport that they are covered by private insurance in the Census survey. States have been taking actions to "destigmatize" Medicaid by changing the name of their programs (e.g., TennCare, MinnesotaCare). Also, about 50 percent of Medicaid beneficiaries are enrolled in managed care plans, which are usually private plans. Thus, beneficiaries can easily mistake their coverage for private coverage.



11-17-98

FUTURE TRENDS IN THE UNINSURED. Given the complexity of these trends, it is unclear whether the rise in the number of uninsured will continue. Several compelling factors suggest that it will not and may actually decrease modestly. The Office of National Health Statistics projects that the proportion of Americans covered by employment-based insurance will rise as continued low unemployment will make employers more likely to use insurance to attract workers. Medicaid coverage may increase as well as additional low-income parents become eligible because of the "100-hour rule" welfare-to-work regulation you instituted this past summer and/or due to the states' continued use of Medicaid waivers, which have already covered over one million Americans. We also expect to see a decrease in the number of uninsured children beginning to showing up in next year's Census Report as the effects of CHIP take hold.

As the baby boom generation ages, however, more people will move into the 55 to 65 year old age bracket -- where the proportion of people with ESI is declining and uninsured is increasing. Furthermore, significant premium increases for next year, as some recent reports have projected, may make insurance unaffordable to greater numbers of Americans. While these conflicting trends make it extremely difficult to predict the future with any sense of confidence, it seems unlikely that we will see another significant increase in the uninsured next year.

IMPACT OF ECONOMIC AND EDUCATION SUCCESSES ON THE NATION'S HEALTH. This problem of the uninsured contrasts with tremendous improvements in other national health indicators. Your impressive economic accomplishments have had an impact on the costs of health insurance. For the first time in well over 30 years, health inflation was below general inflation in 1995 and 1996, thus actually reducing the real costs of health insurance. Moreover, gains in education, income and employment have contributed towards record high life expectancy (76.5 years for those born in 1997), a record low infant mortality rate (7.1 deaths per 1,000 live births), an AIDS death rate that is half of what it was in 1992, and a record-high immunization rates. And, historic increases in the investment in biomedical research during your Administration offer real hope for new (and hopefully cost-effective) treatments and cures for the diseases that will otherwise place unprecedented burdens on the nation's economy and health care system when the baby boom retires.

POLICY IMPLICATIONS. The uninsured in America remains one of the most challenging domestic social problems. Not only is the problem large in size, it is complex, crossing income, age and geographic boundaries. Despite its complexity, one fact is clear: making health insurance affordable is and always will be the key to significantly expanding coverage. Even for an employee whose employer pays for 80 percent of the premium, the family share of the premium is typically over $1,100 per year -- more than one out of every $10 of income for a minimum-wage worker. This cost is obviously much higher for people without access to employer-based insurance, especially if they have a history of illness. While traditional insurance regulation can help reduce insurance premium variation and discrimination, independent analysts will not project any substantial coverage expansions resulting from these interventions. In a non-mandate environment, they believe that only significant subsidies can induce a substantial reduction in the uninsured.

THE PRESIDENT HAS SEEN

Ironically, our ability to propose policies to make insurance more affordable is limited by our success in reducing national health spending. In the last 5 years, hundreds of billions of dollars in excess Medicare and Medicaid spending have been squeezed out of these programs and used productively to help eliminate the deficit, finance children's health coverage, extend the life of the Medicare Trust Fund, and to make the Medicaid program a much more predictable and affordable safety net. However, substantial reductions in Medicare and Medicaid mean that these traditionally utilized funding sources cannot be relied on as offsets for major coverage expansions, let alone long-term Medicare reforms. With this in mind, outside funding sources from the tax code, tobacco, or elsewhere would be needed for a significant coverage expansion.

Administration & Republican coverage expansion ideas. The range of coverage options, currently being prepared through the traditional NEC/DPC/OMB budget process, will include some previous and new targeted coverage expansions. As this memo has documented, the most recent data validate the case for coverage expansions to the pre-65 and "workers-in between-jobs" populations. We also will continue to focus on administrative and possibly legislative outreach policies to encourage enrollment in CHIP and Medicaid to ensure your children's health initiative is a success. However, recognizing the questionable political and budgetary viability of these proposals, we are also reviewing options more likely to be well received in this Congress.

First, we are contemplating policies to encourage states to expand using existing options. With the 100-hour rule regulation, all states can now cover parents of children on Medicaid. Other states have used Medicaid 1115 waivers to cover all people up to certain income levels. Because this would likely require greater financial incentives, one option is making coverage expansions a priority on a short list of acceptable uses for the Federal share of state tobacco settlements.

As an alternative to coverage expansion options, we expect Secretary Shalala to advocate for a significant investment in public health infrastructure. This investment would be used to adapt the safety net to the rapidly changing health system. This idea would likely be better received than a coverage expansion by Republicans. However, if not a capped mandatory grant program, it would either require raising the discretionary caps or place a major strain on the current caps. Also, it would likely be perceived by some Democrats as giving up on coverage expansions.

Since there is bipartisan concern about small businesses' problem in accessing insurance, we are also considering enhancing our previously-proposed small business purchasing coalition grant initiative. We could more aggressively encourage these coalitions by directing OPM to provide technical advice for their establishment and operation, so that they more closely resemble FEHBP. We are also examining granting them non-profit status, to facilitate foundation support.

In 1999, Republicans, too, may consider small business group purchasing policies (although in the past, their versions have been significantly flawed). It is more likely, however, that, if Republicans decide to address the coverage issue at all, they will focus on the use of tax incentives for the purchase of individual health insurance. Encouraging individual insurance is intriguing because nation's reliance on voluntary, employer-based coverage has clearly not been an unqualified success. Moreover, if there is to be any significant investment in health care that the Republicans could possibly support, it would almost inevitably come from the tax code.

While acknowledging that tax credits are at least initially appealing, they are no panacea. They are extremely inefficient and expensive, as many of the assumed recipients would already have coverage. For independent experts to validate that the previously uninsured would take advantage of this policy, the credit would have to be quite large. In addition, if used for individual (rather than employer-based) insurance, they would require the type of major insurance reforms that have been historically opposed by Republicans. The individual market is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market.

Notwithstanding legitimate concerns, we believe that tax credits may be the only health coverage expansion vehicle that could be produced by this Congress. As such, we are reviewing possible options for your consideration. For example, it might be possible to merge policies to promote small group purchasing coalitions with tax credits for participating employers or employees. Limiting the tax credit to such entities could further encourage a long-overdue expansion of small business coops. However, such approaches also raise equity concerns (e.g., why discriminate against an employee/employer who does not have access to, or does not want to be in, a purchasing coop) and political arguments (e.g., isn't this too similar to the Health Security Act). DPC, NEC, OMB, Treasury and HHS are reviewing this purchasing coalition/tax credit idea and other tax incentive approaches. We will keep you apprised of developments in this area, as well as other coverage options, as the budget process unfolds.

Thank Ira Magaziner, maybe best to longterm care—

DRAFT: PRESIDENT CLINTON'S INITIATIVE ENCOURAGING SMALL BUSINESSES TO PURCHASE HEALTH INSURANCE

This initiative would encourage small businesses to offer health insurance to their workers by developing and/or joining coalitions for purchasing health insurance. Fewer small businesses offer health insurance because of their higher administrative costs and premiums relative to large businesses. As a result, nearly half of uninsured workers are in firms with fewer than 25 employees. This three-part initiative would: (1) provide a tax credit to small businesses who decide to offer coverage by joining coalitions; (2) encourage private foundations to support coalitions by allowing their contributions towards these organizations to be tax exempt; and (3) offer technical assistance to small business coalitions from the Office of Personnel Management, which runs the Federal Employees Health Benefits Program (FEHBP). This initiative would cost about $44 million over 5 years, and provide thousands of workers and their families the option of affordable health insurance.

INSURANCE AND SMALL BUSINESSES

- Workers in small firms are less likely to have access to affordable, job-based health insurance. Although worker in firms with fewer than 25 employees make up about 30 percent of the workforce, they comprise nearly half of the uninsured. Over a quarter of private-sector workers in firms with fifty or fewer employees lack health insurance -- significantly more than the national average (about 17 percent of workers). Only one-third of firms with fewer than 10 employees and two-thirds of firms with 10 to 24 employees offer coverage, compared to over 95 percent of large firms.

- About the same number of small businesses are offering insurance, but fewer employees are participating because of higher cost sharing for employees.

  - The percentage of workers in small firms taking up employer-based insurance dropped from the 90 percent range to the mid-80 percent range between 1987 and 1996.

  - More white-collar small firms are offering coverage, while the rate among blue-collar firms has been declining.

- Small employers state that high premiums and the uncertainty in premium costs are major reasons why they do not offer health insurance.

- Premiums for the same benefits are higher for small firms than large firms because there are fewer people who can share in the risk of illness and because administrative costs per employee are higher. Insurers' administrative expenses ranged from approximately 5 percent of premiums for the largest employer plans to 30 percent or more of premiums for the smallest employers. As a result, small firms typically offer less generous benefits -- or do not offer coverage at all.

SMALL BUSINESS HEALTH PURCHASING COALITIONS

This three-part initiative would encourage the development of and participation in small business health purchasing coalitions. These coalitions pool employees across firms to gain market power; negotiate with insurers over benefits and premiums; provide comparative information about available health plans; and administer premium payments made by small employers and their participating employees. Despite these advantages, there are few small business health purchasing coalitions today. This in part reflects the lack of up-front funding to develop coalitions. Small businesses are willing to pay membership fees to cover the ongoing operation of coalitions, but the start-up costs -- hiring staff, developing a negotiating strategy, marketing to small businesses, etc. -- can be prohibitive. Additionally, coalitions that cannot quickly attract a large enough number of small firms to join them could find themselves without the bargaining power that they need to reduce costs.

TAX CREDIT FOR SMALL EMPLOYERS JOINING COALITIONS

- **Tax credit**: Eligible employers would receive a credit equal to ten percent of their contributions to employee health plans, up to $200 for a single policy and $500 for a family policy. This credit is temporary (up to two years) since this policy is intended to encourage the one-time action of joining the coalition. The small business health plan credit would be treated as a part of the general business credit, and would be subject to the limitations of that credit. The credit would be available only for employers taking this option before December 31, 2003.

- **Eligibility of firms**: A qualifying small business would have to have between 3 and 50 employees and purchase coverage through a qualified coalition. To target the credit to employers who would not otherwise offer coverage, eligible employers could not have had an employee health plan during any part of 1997 or 1998. Employers would need to cover seventy percent of those workers who have wages (including deferred wages) in excess of $10,000 and who are not covered elsewhere by a health plan. These conditions are typical in the group market.

- **Definition of "coalition"**: A qualified coalition would be a certified, non-profit organization that negotiates with health insurers for the purpose of providing health insurance to the employees of its small business members. Its members would include all interested employers with 50 or fewer employees in its area, without regard to the health status or occupation of their employees. It would collect and distribute health insurance premiums but would not be an insurer (bear risk) itself. Its board would include both employer and employee representatives of small businesses, but could not include service providers, health insurers, insurance agents or brokers, and others who might have a conflict of interest. Where feasible, the coalition would offer several health plan choices and at least one open enrollment period per year. These plans would follow state requirements and their premiums

could not be rated according to the occupation or existing health status of employees.

FINANCIAL ASSISTANCE IN CREATING COALITIONS

- **Limits on foundation support.** Private foundations are prohibited under the Internal Revenue Code from making grants for other than charitable purposes. Currently, funding the start-up expenses of small business health purchasing coalitions would not qualify as a "charitable purpose." Consequently, private foundations are reluctant or, in some cases, prohibited by their own rules from offering grants for this purpose. Notwithstanding this limit, foundations would likely support coalitions given the recent increase in the number of foundations due to not-for-profit conversions, greater foundation spending due to the strength of the economy, and the general interest in helping small employers access health insurance.

- **Changing the tax status for contributions to coalitions.** Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This special rule would apply only to grants (or loans) made to qualified coalitions for the purpose of funding qualified coalition start-up expenses made during the first two years of their operations. As with any other grant to a non-charitable organization for a charitable purpose, private foundations would be required to comply with the "expenditure responsibility" record-keeping and reporting requirements under current law. The special foundation rule would apply to grants and loans made prior to December 31, 2003 for start-up expenses incurred prior to December 31, 2005.

TECHNICAL ASSISTANCE IN CREATING COALITIONS

- **FEHBP as a model.** The Office of Personnel Management (OPM) runs the Federal Employees Health Benefits Program (FEHBP). This program serves as a model for consumer choice of health plans.

- **Technical assistance from OPM**. OPM has considerable experience in working with private plans in coordinating a bidding process, negotiating benefits and premiums, and distributing consumer information. To help small business health purchasing coalitions do the same, it would provided any needed technical assistance to qualified coalitions, sharing its administrative experience.

HHS Fact Sheet
January 11, 1999
Contact: HCFA Press Office (202) 690-6145

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Overview: *Proposed by President Clinton and passed as part of the historic, bipartisan Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP). CHIP is the largest single expansion of health insurance coverage for children in more than 30 years. Today, nearly 11 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, this new initiative set aside $24 billion over five years for states to provide new health coverage for millions of children -- the largest children's health care investment since the creation of Medicaid in 1965. States will be able to use part of their federal funds to expand outreach and ensure that all children eligible for Medicaid and the new CHIP program are enrolled. More than 4 million uninsured children are eligible but not signed up for Medicaid. To improve the health of our nation's children, the President has challenged the public and private sectors to work together to educate families and help them enroll their children in Medicaid or CHIP.*

The initiative is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy and strong. At President Clinton's insistence, the CHIP program requires that states use this new money to cover uninsured children -- and not replace existing health coverage. The program also includes important cost-sharing protections so that families will not be burdened with heavy out-of-pocket expenses.

Funds for the program became available to the states on October 1, 1997, and HHS is working closely with states as they design plans in accordance with the new law. During January and February 1998, HHS sponsored nine regional conferences to help inform states of all the options available to cover children under CHIP.

Majority of state CHIP plans have been approved. *In the 15 months since the program was created on October 1, 1997, 52 states and territories have submitted CHIP plans for approval by the Department of Health and Human Services. CHIP plans have been approved for 49 states and territories: Alabama, Colorado, South Carolina, Florida, Ohio, California, New York, Illinois, Michigan, Connecticut, New Jersey, Missouri, Rhode Island, Oklahoma, Massachusetts, Pennsylvania, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, the Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska, Vermont, and New Mexico. In addition, the following state plans have been submitted: Tennessee, Hawaii, and Guam. According to states' estimates, more than 2.8 million children will be covered when these CHIP plans are fully implemented.*

EXPANDING CHILDREN'S ACCESS TO HEALTH COVERAGE

The federal-state Children's Health Insurance Program (CHIP), created under the new Title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. It builds on Medicaid, the federal-state health insurance program that covers approximately 36 million low-income individuals, including 18 million children. Because Medicaid allows states flexibility in determining eligibility, states currently cover children whose family incomes range generally from below the federal poverty level to as high as 300 percent of poverty. (Note: One State, Tennessee, has no upper income cap.) The majority of states cover children in families between 100 and 150 percent of the federal poverty level (FPL). In the new CHIP

program, states may either cover children in families whose incomes are above the Medicaid eligibility threshold but less than 200 percent of poverty, or within 50 percentage points over the state's current Medicaid income limit for children.

Ensuring Meaningful Health Benefits. Under the new program, states have flexibility in targeting eligible uninsured children. States may choose to expand their Medicaid programs, design new child health insurance programs, or create a combination of both. States choosing a new children's health insurance program may offer one of the following benchmark plans: the standard Blue Cross/Blue Shield Preferred Provider Option offered by the Federal Employees Health Benefit Program; a health benefit plan offered by the state to its employees; or the HMO benefit plan with the largest commercial enrollment in the state. A state may also choose to offer the "equivalent" of one of the benchmark plans. If a state chooses this option, its plan's value must be at least equal to the benchmark plan's and it must include: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and X-ray services; and, well baby/child care services, including immunizations. In addition, if the plan a state chooses as its benchmark includes coverage for prescription drugs, mental health services, vision care, and hearing-related expenses, the state's "equivalent" plan must include similar benefits. Under the law, New York, Pennsylvania and Florida can continue to offer their current benefit arrangements (with some modifications to comply with the law's cost-sharing protections). States choosing the Medicaid option will offer Medicaid benefits for children.

Limiting Patient Costs. Patient out-of-pocket costs for this program are allowed but are limited. If a state expands its Medicaid program, then existing Medicaid limits apply to the newly enrolled children. If a new health plan is developed, premiums for families whose income is under 150 percent of the poverty level cannot exceed $19 per family per month and copayments must be nominal. Cost sharing is not permitted for well-child, well-baby visits. For families with incomes above 150 percent of poverty, cost-sharing must be based on an income-related sliding scale with an annual total for all children not to exceed five percent of the family's income.

Preventing Cost Shifting. To prevent states from shifting children from the traditional Medicaid program to this new program, states must not tighten the Medicaid eligibility standards for children that were in place on March 31, 1997. In addition, states must enroll all children who meet Medicaid eligibility rules in the Medicaid program not in the new CHIP plan. All states must design their programs to prevent private cost shifting as well. In their child health plans, states will describe methods they will use to prevent "crowd out" or the shifting of children from private insurance to CHIP.

ACCESSING FEDERAL FUNDING

Under the new law, states are eligible to receive an enhanced federal matching rate drawn from an "allotment" for state programs approved by the Secretary of Health and Human Services that expand access to targeted, low-income children under the new CHIP program. Funds will be allocated to each participating state according to their number of uninsured low-income children, accounting for regional cost differences. Available state allocations for FY 1998, which were published in the Federal Register in September 1997, range from $3.5 million for Vermont's relatively small population to a high of $855 million for California. States may use up to 10 percent of the CHIP benefit expenditures for outreach, services other than the standard benefit package for eligible children, and administrative costs. To access the FY 1998 allocation, states must have their CHIP plans approved by the Secretary of Health and Human Services by Sept. 30, 1999. The FY 1999 budget includes $4.275 billion for FY 1999 state allotments. Funds will be allocated in the same proportion as they were in FY 1998.

The Department of Health and Human Services (HHS) is working closely with states to design CHIP plans that meet the requirements of the new law. HHS has written to each state outlining the new program, and has published a list of the state allotments; a preliminary check-list of information states must submit to HHS when applying for their allotments; and answers to the most commonly asked questions from states about how to develop their children's health insurance programs. The department works with states to expedite the development and implementation of state CHIP plans.

EXPANDING OUTREACH

The Clinton Administration has made significant efforts to reach out to families whose children qualify for CHIP. These efforts include:

New Presidential Directive to Launch a Government-Wide Effort to Enroll Uninsured Children. On February 18, 1998, in an executive memorandum to all federal agencies with jurisdiction over children's programs, President Clinton directed the establishment of a multi-agency effort to enroll uninsured children. The Departments of Agriculture, Interior, Education, Health and Human Services, Housing and Urban Development, Interior, Labor, and Treasury and the Social Security Administration, run programs such as WIC, Head Start, food stamps and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. The memorandum instructed these agencies: to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and to report back in 90 days on their plan to help enroll uninsured children.

The Announcement of an Historic Private Sector Commitment to Provide Outreach. On February 18, 1998, the President announced unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

A new toll-free number that directs families around the nation to their state enrollment centers. The President announced that the National Governors' Association with a grant from Bell Atlantic will establish and operate a toll-free number to help states reach uninsured children and will automatically direct millions of families around the nation to their local state enrollment agency. The toll-free number and a radio advertising campaign to raise awareness were launched preliminarily in eight states - Colorado, South Carolina, Utah, Indiana, Idaho, Massachusetts, Pennsylvania, and Delaware -- on November 9, 1998. The toll-free hotline will be expanded nationwide in early 1999.

$45 million in commitments from private foundations across the country. The Robert Wood Johnson Foundation will spend $45 million over the next 3 years, to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and in collaboration with the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Schering Plough and local communities nationwide in children's health outreach efforts.

New initiatives from corporate and advocacy organizations to reach out to uninsured children. Procter and Gamble, the manufacturer of Pampers diapers, has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, providing families information about available health insurance options. Grocery stores and chain drug stores across the country will provide information about the new toll-free number to their customers. The National Education Association will launch an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

Since 1993, HHS has approved Medicaid waivers for 18 states for comprehensive health care reform projects that have allowed states to control costs and expand coverage. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.

President Clinton also signed into law the Health Insurance Portability and Accountability Act of 1996, creating important new protections for an estimated 25 million Americans (approximately 1 in 10) who

move from one job to another, who are self-employed, or who have pre-existing medical conditions.

CHIP also builds on the Clinton Administration's long standing commitment to improving health care for children. The President has issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. He also recently announced that in 1996, over 90 percent of America's toddlers received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal he set in 1993. And, the FDA recently released a rule that requires manufacturers to do studies on pediatric populations for new prescription drugs as well as those currently on the market.

Combined, this administration's efforts will help assure that children get the healthy start they need to live long and productive lives.

STATE CHIP PROGRAMS
Descriptions of approved state CHIP programs follow:

Alabama

Alabama could receive as much as $18 million in FY 1998 funds for its CHIP plan. The state is implementing its CHIP plan in two phases. The first phase expanded Medicaid eligibility to uninsured children under 19 years of age whose family incomes do not exceed 100 percent of the federal poverty level(FPL). The AL-Kids program, the second phase, is a separate state children's health insurance program that will expand coverage to children up to age 19 whose family income is between 100 and 200 percent of the FPL. AL-KIDS offers coverage comparable to the HMO with the largest insured commercial, non-Medicaid enrollment in the state. With both phases, Alabama expects to insure 36,000 children by September 1999. Alabama will hire extra outreach workers to increase the number of children located and enrolled in Medicaid. Information on the new program will be advertised through newspapers, public service announcements and through the school system. Alabama was the first state approved on January 30, 1998 and its amendment was approved August 18, 1998.

Alaska

Alaska could receive as much as $5.66 million in FY 1998 funds for its CHIP plan. Alaska will use its CHIP allocation to expand its Medicaid program. Currently, the state covers children to age 1 in families with incomes up to 185 percent of the FPL, children 1-6 in families with incomes up to 133 percent of poverty, and children ages 6-19 in families with incomes up to 100 percent of poverty. The state will use its Title XXI funds to expand Medicaid coverage to children in families with incomes up to 200 percent of the FPL. Eligible children will receive the full Medicaid benefit package and there are no cost sharing requirements. To reach eligible children, the state will work with local governments, schools, health care providers, tribal entities, and non-profit corporations serving children. The state plans to implement expanded eligibility on March 1, 1999 and it expects to enroll 4,900 children by October 2000. Alaska's plan was approved December 11, 1998.

Arizona

Arizona could receive as much as $113 million in FY 1998 funds for its CHIP plan. Arizona will use its CHIP allocation to create, KidsCare, a new health insurance program which will cover children from birth through age 15. Income eligibility will increase over time, beginning at 150 percent of the FPL and rising to 175 percent on July 1, 1999, then to 200 percent from 2000 through 2007. The state expects to insure nearly 50,000 children by September 2000. Enrollees will receive coverage through established Arizona Health Care Cost Containment System plans and state employee health maintenance organizations that elect to participate in the program. American Indians may choose to receive services through the Indian Health Service as well. Participants will pay a $5 copayment for non-emergency use of the emergency room. To assist with outreach, the state has created an Outreach Coordinator position and has sent applications to organizations that serve low-income children. Arizona was approved on September 18, 1998.

Arkansas

Arkansas could receive as much as $47 million in FY 1998 funds for its CHIP program. The state will use its CHIP allocation to expand Medicaid coverage to nearly 3,600 children who would otherwise not have health insurance. It will cover children born after September 30, 1982 and prior to October 1, 1983 whose family income is at or below 100 percent of the FPL. Arkansas is currently considering how to structure the second phase of its Title XXI program to cover even more children. The state currently has a Medicaid section 1115 waiver, ARKids First, that serves children through age 18 with family incomes up to 200 percent of poverty. Outreach activities will include radio and TV ads, a direct mail campaign, a toll-free number, and print advertising. Arkansas was approved on August 6, 1998.

California

California could receive as much as $855 million in new funds for FY 1998. The state will expand its Medicaid program, known as Medi-Cal, by implementing an income disregard and by making children under age 19 eligible if they have family incomes at or below 100 percent of the federal poverty level. The state will also expand its current state program, known as Access for Infants and Mothers (AIM), which will cover infants up to age 1 from 200 percent to 250 percent of poverty. Through CHIP, California will also expand its Healthy Families program, which will provide coverage for children age 1-19 with family incomes from 100 percent to 200 percent of the federal poverty level. California insuring 500,000 children by the end of FY 1998. As part of its outreach efforts, California will subcontract for a media campaign with private and community based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application form for the Medi-Cal and Healthy Families program. In addition, California will conduct a provider education campaign to support its outreach effort. California was approved on March 24, 1998.

Colorado

Colorado could receive up to $42 million in federal CHIP funds for FY 1998. The state will expand children's access to health coverage by building on its own Colorado Child Health Plan. The state expects to cover a total of 23,000 children under this non-Medicaid managed care plan by the third year. The benefit package will include services such as hospital and emergency room transport, inpatient services, medical office visits, and prescription drugs. Coverage will be provided to children from birth through age 17 for families whose income is at or below 185 percent of the federal poverty level. The state will publicize the program through press releases, public service announcements, schools, employers, county agencies and regional and social agencies. Colorado was approved on February 18, 1998.

Connecticut

Connecticut could receive approximately $35 million in new funds for FY 1998, which state officials will use to insure as many as 15,000 new children by June of 2000. The state will use its new allocation to both expand its Medicaid population and create a new program based on the state employee's health plan. Under the state's HUSKY program, Medicaid eligibility will be expanded to include children ages 14 through 18 with household incomes of up to 185 percent of the federal poverty level. Previously, the Medicaid program only covered children up to age 13 in families with incomes up to 185 percent of poverty. The state estimates that an additional 14,400 children will be added to the Medicaid program. The new health insurance program, Part B of HUSKY, will be targeted toward children up to age 18 in families with incomes up to 235 percent of poverty. The state will apply an income disregard - setting aside certain types of income the family may have - effectively bringing coverage to 300 percent of poverty. Before income disregards are applied, HUSKY Part B will charge families with incomes above 235 percent of poverty premiums of $30 per child, with an upper limit of $50 per family. Children with special physical and behavioral health needs will receive those services under a special third part of the program, HUSKY Plus. Outreach for the state will include radio and TV ads, a direct mail campaign, brochures/flyers, video, a toll-free number, web sites and state presentations and mail-in applications. Connecticut was approved on April 27, 1998.

Delaware

Delaware could receive as much as $8 million in FY 1998 funds for its CHIP plan. Delaware will use its CHIP allotment to create a separate state children's health insurance plan which targets children under age 19 whose family incomes are less than 200 percent of the FPL. Coverage will be provided through the state employee health plan and will include pharmacy services, mental health and substance abuse care. Monthly premiums will be charged on a sliding scale based on income. Delaware officials estimate they will insure about 10,500 children by October 1999. Delaware's plan was approved on September 1, 1998.

District of Columbia

The District of Columbia could receive as much as $12 million in new funds for FY 1998. The District plans to expand its Medicaid program to children from birth to age 19 whose family income is less than 200 percent of the FPL. Enrollees will receive the regular Medicaid benefits package and there will be no cost sharing for families. The District anticipates enrolling nearly 8,400 children in its program, which will be called Healthy DC Kids. As part of its outreach efforts, the District will set up a telephone hotline to handle inquiries and has created a single, two-page, mail-in application for both Medicaid and CHIP. The District of Columbia's CHIP plan was approved September 17, 1998.

Florida

Florida could receive as much as $270 million in fiscal 1998 funds for its CHIP plan. Phase One of Florida's new CHIP plan expanded Medicaid eligibility to children in families earning up to 100 percent of the FPL and expanded Florida's Healthy Kids program, a comprehensive program that was piloted in 20 counties, to additional counties. Phase Two will create the Florida KidCare Program which consists of: expanding the Healthy Kids program on a state-wide basis and expanding eligibility for the program to children through age 18 in families with incomes up to 200 percent of FPL; creating the MediKids program to provide coverage for children up to age 5; creating the Children's Medical Services Network for children up to 18 with special needs; and expanding Medicaid to cover children ages 15 - 19 to 100 percent of FPL. The state plans to simplify is enrollment form and enrollment process and is developing an outreach strategy. State officials hope to enroll 175,000 children in the combined Florida Kidcare program by July 1, 1999. Florida received its plan approval on March 5, 1998, and its amendment approval on September 8, 1998.

Georgia

Georgia could receive as much as $125 million in new funds for FY 1998. Georgia will create a separate insurance program for children from age 0-18 whose families have incomes of less than 200 percent of poverty and who are not eligible for Medicaid. Enrollees will receive benefits comparable to the current Medicaid package. There is no cost sharing for children under age 6; for children over age 6 there is a monthly premium of $7.50 for one child and $15 for two or more children. The state expects to insure 58,000 children by FY 2000. Georgia's plan was approved September 3, 1998.

Idaho

Idaho could receive as much as $15.8 million in new funds for FY 1998, which state officials will use to insure nearly 5,000 children. Idaho will use its new CHIP allocation to expand Medicaid eligibility to children up to age 19 in families with incomes up to 160 percent of the federal poverty level. Due to state legislation, the income threshold will be 150 percent of the federal poverty level effective, July 1, 1998. The state has formed a task force to study ways of further expanding Idaho's CHIP program. Children in the Medicaid expansion will receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health services, lab services, and prescription drugs. Outreach activities include mailing postcards to potential enrollees describing Title XXI. The mailing list is comprised of families who have lost cash assistance between April and December 1997. Idaho was approved on June 15, 1998.

Illinois

Illinois could receive as much as $123 million in new funds for FY 1998, which state officials will use

to insure 40,000 additional children within the next three years. With its new CHIP allotment, Illinois will expand Medicaid eligibility for children up to age 19 whose families have incomes at or below 133 percent of the federal poverty level. Prior to the CHIP expansion, the income level for Medicaid eligibility varied based on the age of the child. Under the new program, income thresholds have been equalized. State outreach efforts will include reviewing automated records to identify eligible participants followed by the notification of those individuals. In addition, the Illinois Department of Public Aid will send a notice to all non-assistance Child Support families informing them of the program and of locations where families can go to enroll their children. Illinois was approved on April 1, 1998.

Indiana

Under the CHIP program, Indiana could receive as much as $70.5 million in new funds for FY 1998. Indiana will use its new allocation to expand its Medicaid program and estimate that they will insure as many as 58,000 more children by the year 2000. The program will expand eligibility to children up to age 19 in families with incomes up to 150 percent of the federal poverty level, and the state has formed a task force to study ways to further expand its CHIP program. Children in the Medicaid expansion population will receive the state's standard Medicaid benefit package, which includes inpatient and outpatient hospital services, inpatient psychiatric care, physician services, dental services, home health care, lab services and prescription drugs. To raise awareness about the program, the state will launch a media campaign and conduct outreach through state and local government agencies and community organizations. Indiana's CHIP plan was approved on June 26, 1998.

Iowa

Iowa could receive as much as $32 million this year in new funds for FY 1998. Iowa will use its new CHIP allocation to expand Medicaid by raising income eligibility in several different age categories. The Medicaid expansion will allow children from age 6 - 18 in families whose incomes are up to 133 percent of FPL to enroll. The state's current Medicaid program covers infants up to one year of age whose families have incomes of up to 185 percent of FPL. The benefit package for CHIP will be the same as the current Medicaid package and the state will contract an organization to run an outreach program. This outreach program will work with community and statewide organizations including provider associations, advocacy groups, Native American Tribal Councils, and refugee resettlement programs. Officials expect to insure 16,000 children by June 30, 1999. Iowa's plan was approved September 1, 1998.

Kansas

Kansas could receive as much as $30 million in FY 1998 funds for its CHIP plan. With its new CHIP allotment, Kansas will create a separate insurance program called HealthWave for children through age 18 whose families have incomes of less than 200 percent of the FPL. The benefit package for children enrolled in CHIP will be the same as offered to as state employees. Families with incomes above 150 percent of FPL must pay a monthly premium. Families with income between 151 and 175 percent of poverty will pay $10 per month per family, and families between 176 and 200 percent of poverty will pay $15 per month per family. The state will target low-income children for outreach through the public schools and will offer a toll free number to access enrollment information. Kansas hopes to enroll 30,000 children by December 31, 1999. Kansas' plan was approved on September 1, 1998.

Kentucky

Kentucky could receive as much as $49.9 million in federal FY 1998 funds for its CHIP plan. Kentucky will use its allotment to both expand its Medicaid program and launch a separate insurance program called K-CHIP. Children ages 14-18 who are in families with incomes up to 100 percent of the FPL will be enrolled in CHIP as a Medicaid expansion. Children through age-18 in families with incomes up to 200 percent of the FPL, and who are not eligible for Medicaid, will be enrolled in K-CHIP. The K-CHIP benefit plan will be a benchmark equivalent to the Standard High Option HMO plan for state employees. Benefits will also include all basic services such as inpatient and outpatient hospital services, physicians' surgical and medical services; laboratory and x-ray services, and well-baby and well-child care. There is some cost sharing, but costs will not exclude 5 percent of family income. Families with incomes

between 100 and 133 percent of the FPL will pay a $10 premium for a six-month period. Families with incomes between 134 and 149 percent of the FPL will pay a maximum premium of $20 for a six-month period. Families with incomes between 150 and 200 percent of the FPL will pay a maximum of $120 for a six-month period, and payments can be made at $20 each month or $60 per quarter. To reach eligible children, the state will conduct a media campaign and outreach activities at schools, clinics, community centers, health fairs, health departments, and housing projects. Kentucky expects to enroll nearly 50,000 children by June 2000. Kentucky's plan was approved November 25, 1998.

Louisiana

Louisiana could receive as much as $102 million in federal FY 1998 CHIP funds for its CHIP plan. The state will use its allotment to expand Medicaid to children ages 6 through 18 whose family income is at or below 100 percent of the Federal poverty level. The benefit package will be the regular state Medicaid program and there will be no cost sharing for families. The state plans to launch a large outreach campaign to educate potential CHIP enrollees. The campaign will include media advertising and mailing to specific target audience groups, including low income working parents, current and former recipients of Families Independence-Temporary Assistance Program, children with special needs, Native Americans, and migrant children. Louisiana estimates it will enroll more than 28,000 children by the end of September 2000. Louisiana's plan was approved October 20, 1998.

Maine

Maine could receive as much as $12 million in federal CHIP funds for FY 1998. The state will use its new funds to expand coverage to 10,400 children by July 2000 by combining both a Medicaid expansion and a statewide children's health insurance program, Cub Care. Through CHIP, Maine will expand coverage to children through age 18 with family incomes up to 185 percent of the federal poverty level. The Medicaid expansion will cover children aged one through 18 in families with incomes up to 150 percent of poverty. The Cub Care program will cover children in families with incomes from 151-185 percent of poverty. State outreach efforts will include a targeted media and direct mail campaign. Maine was approved on August 7, 1998.

Maryland

Maryland could receive as much as $62 million in federal FY 1998 funds. Maryland will expand its Medicaid program with its new CHIP allotment to an estimated 15,500 uninsured children. Under the CHIP plan, children between birth and age 19 whose family incomes are below 200 percent of poverty will receive coverage. Children covered by CHIP will receive the Medicaid benefits package. To reach families who might be eligible for CHIP, the state will launch a grassroots information dissemination campaign involving state agencies, advocacy and community groups and provider organizations. In addition, the state will launch a public media and advertising campaign to include television, radio, mass transit, and newspaper advertising. Maryland was approved July 31, 1998.

Massachusetts

Massachusetts could receive as much as $43 million for FY 1998, which state officials will use to expand the state Medicaid program and create a separate Family Assistance Plan. With its federal allotment, the state hopes to bring annual enrollment in the program to 37,000 children. Massachusetts will provide the state's regular Medicaid benefit package to newly-enrolled children. The eligibility level for Medicaid will be increased from the current 133 percent of FPL to children in families with incomes of up to 150 percent of poverty. The state will also use its CHIP funds to create the Family Assistance Plan for children with family incomes between 150 and 200 percent of poverty. Uninsured children with family incomes over 150 percent of poverty will be eligible for either a "direct coverage option" or for financial assistance for families to purchase dependent coverage through their employers, the so-called "premium assistance option." The Family Assistance Program will provide coverage equivalent to the insurance plan offered to federal employees in the state. These families will pay a monthly premium of $10 per child with a family maximum of $30 per month. Proposed outreach includes school-based campaigns, distribution of promotional materials, and giving mini-grants to community organizations to help locate hard-to-find potentially eligible children. Massachusetts was approved on May 29, 1998.

Michigan

Michigan could receive as much as $92 million in federal FY 1998 funds, which state officials will use to insure as many as 133,000 new children by September 2000. The state will use its new allocation to implement MIChild. The program will provide comprehensive health care coverage to all children under age 19 whose families have incomes at or below 200 percent of the federal poverty level. The benefit package will mirror the state employees' plan and will be administered by multiple managed care providers. MIChild will not impose co-payments on families with incomes at or below 150 percent of poverty. Some co-payments will apply for families between 151-200 percent of poverty. The state's outreach efforts will include demographically-targeted media campaigns and coordination with relevant community programs and agencies. Michigan's plan was approved on April 7, 1998.

Minnesota

Minnesota has been among the most progressive states in the nation in providing health insurance coverage for children and families. The approval of Minnesota's plan enables the state to lay the groundwork for its CHIP program and to secure its CHIP allotment, which could be as much as $28 million for FY 1998. Minnesota currently covers approximately 50,000 children who would otherwise be uninsured. The state has accomplished this through a Section 1115 Medicaid waiver amendment, granted in 1995. The MinnesotaCare program provides health coverage to pregnant women and children with family incomes up to 275 percent of the federal poverty level. Minnesota's plan was approved July 17, 1998.

Mississippi

Mississippi could receive as much as $56 million in federal FY 1998 funds for its children's health insurance plan. Mississippi will expand Medicaid to cover children ages 15 through 18 in families with incomes up to 100 percent of the federal poverty level. The state estimates it will enroll 7,500 children by the end of FY 1999 and 12,000 children by the end of FY 2000. Recipients will received the regular Medicaid benefit package and there are no cost sharing requirements. As part of an outreach plan, Mississippi will develop a broad based media campaign that will include television, radio and print advertisements. In addition, it will provide information to community health care providers, hospitals, health clinics, Indian reservations and schools. Mississippi's plan was approved October 26, 1998.

Missouri

Missouri could receive as much as $52 million for FY 1998, which state officials will use to insure as many as 90,000 new children by June 30, 1999. Missouri will use its new allocation to expand insurance coverage to children within the state's existing Medicaid managed care program, known as MC+. The program will expand eligibility to children in families with incomes up to 300 percent of the federal poverty level. Missouri's statewide health care reform demonstration plan was approved through a Section 1115 Medicaid waiver. It will allow the state to slightly alter the Medicaid benefit package and also enroll the CHIP children in Medicaid after the state's CHIP funds are exhausted. This Medicaid waiver will also provide coverage for certain adults, including working parents leaving welfare and mothers who otherwise would have lost their Medicaid following childbirth. Outreach efforts will be coordinated at state offices in every county. Free materials will also be available and distributed to other entities such as social welfare organizations, schools and health care providers. Missouri's plan was approved on April 28, 1998.

Montana

Montana could receive as much as $9 million in FY 1998 funds for its CHIP plan. Montana expects to insure 9,000 children by June 2000 by creating a statewide children's health insurance program. Children under age 19 whose families have incomes of less than 150 percent of poverty will qualify for the Montana CHIP plan. The benefits package will mirror the state employee health plan, including prescription drugs, emergency room services, and mental health and substance abuse treatment services. For families with incomes at or above 100 percent of poverty, the state will charge an annual enrollment

fee of $12 for one child and $15 for families with two or more children enrolled. Copayments for some services will be charged for families whose income is above 100 percent of FPL. Copayments will be capped at $200 per family per year. Montana's plan was approved September 11, 1998.

Nebraska

Nebraska could receive approximately $15 million in federal CHIP funds for FY 1998. The first phase, Kids Connection Phase I, expanded Medicaid coverage to children age 15 through 18 whose family income is at or below 100 percent of the federal poverty level. Enrollees in Phase 1 received the state's regular Medicaid benefit package. Kids Connection Phase I was expected to enroll about 1,000 children. The amendment, Kids Connection Phase II, expanded Medicaid eligibility to children under age 19 whose family incomes are up to 185 percent of the Federal poverty level. Kids Connection II is expected to reach 16,000 children by October 2000. To encourage enrollment, the state will work with advocacy agencies in disseminating information as well as distribute pamphlets and brochures. Neither phase has cost-sharing for enrollees. The state's original plan was approved August 7, 1998, and an amendment was approved October 13, 1998.

Nevada

Nevada could receive as much as $30 million in new funds for FY 1998. With its new CHIP allotment, the state will create, Nevada Check Up, a statewide health insurance program which will provide coverage to children up to age 18 in families with incomes at or below 200 percent of poverty. The Nevada Check Up program is estimated to cover 43,500 children in its first year. To encourage enrollment, the state has simplified the CHIP eligibility application, which will be available statewide through schools, child care facilities, family resource centers, social service agencies, and other locations where eligible children and/or their parents frequent. The state has also established a toll-free information number, which is listed on posters, marketing brochures, and the application form. Public service announcements are also planned. Nevada's plan was approved on August 13, 1998.

New Hampshire

New Hampshire could receive as much as $11 million in new funds for the FY 1998 allocation of its CHIP funds. The state will use its CHIP allocation to expand its Medicaid program and create a separate statewide children's health insurance program. Healthy Kids-Gold, or Phase I, will expand Medicaid [illegible] Healthy Kids-Silver, or Phase II, will be a separate statewide health insurance plan that will mirror the benefit package offered to federal employees in the state. Healthy Kids-Silver is aimed at children ages 1 to 19 in families with incomes up to 300 percent of poverty. In order to expand its coverage to this level of family income, the state will apply an income disregard-setting aside certain types of income the family may have. The state expects to insure 4,000 children by September 2000. New Hampshire's plan was approved September 16, 1998.

New Jersey

New Jersey could receive approximately $89 million in new funds for FY 1998, which state officials will use to insure as many as 102,000 new children by the end of the program's first year. The state will use its new allocation to create NJKidCare which will include a Medicaid expansion and a new state CHIP plan. The Medicaid expansion will provide comprehensive health care coverage to all children under age 19 whose families have incomes at or below 133 percent of the federal poverty level. The new CHIP insurance program will be targeted to children in families with incomes above 133 percent to 200 percent of poverty. The new program will charge families a $15 per month premium. The state will have a fourfold outreach effort which will include: public awareness, targeted outreach, community education, and consumer education. The state is also committed to targeting outreach to special populations such as HIV and homeless populations. New Jersey's plan was approved on April 27, 1998.

New Mexico

New Mexico could receive as much as $57 million in federal FY 1998 funds for its CHIP plan. The state

will use its allotment to expand its Medicaid program for children from birth to age 18 in families with incomes up to 235 percent of the FPL. Enrollees will receive the state's Medicaid benefit package. Families with incomes between 186 and 235 percent of the FPL will pay copayments of $5 for most services, but cost sharing cannot exceed five percent of a family's income. In accordance with the CHIP law, preventive services and prenatal care are exempt from cost sharing. Working with a private contractor, the state will conduct a public awareness campaign to inform potential enrollees. In addition, New Mexico will work with the Indian Health Service to assure CHIP access to American Indians. New Mexico expects to insure 5,000 children by September 30, 2000. Its CHIP plan was approved January 11, 1999.

New York

New York was one of three states for which existing children's health coverage benefit packages were "grandfathered" into the CHIP legislation. The state could receive as much as $256 million in new funds for FY 1998, which state officials will use to insure as many as 360,000 additional children within the next three years. New York will use its new allocation to expand its existing CHPlus program, which currently provides insurance to children up to age 19 whose families have incomes at or below 185 percent of the federal poverty level. CHPlus is a partnership between the state and private insurers with the state subsidizing private coverage for enrollees. The benefit package includes a full range of inpatient and outpatient services. The state's outreach activities will include a statewide media campaign that will be conducted by the New York State Department of Health. New York's plan was approved on April 1, 1998.

North Carolina

North Carolina could receive as much as $79 million in new funds for FY 1998. North Carolina will use its CHIP allocation to create a separate state health insurance program to provide coverage to uninsured children whose family income does not exceed 200 percent of the federal poverty level. The state expects to insure 35,000 children. Families whose incomes rise above 200 percent of poverty up to a maximum of 225 percent will be able to buy into the program for one year. The benefit package is equivalent to that offered to state employees, plus Medicaid-equivalent benefits for children with special health care needs. North Carolina plans to improve outreach efforts by simplifying the application forms for both Medicaid and CHIP and by using existing public/private partnerships between local departments of health and social services. North Carolina's plan was approved on July 14, 1998.

North Dakota

North Dakota could receive as much as $5 million in FY 1998 CHIP funds. The approval of North Dakota's plan enables the state to lay the groundwork for its CHIP program and to secure its FY 1998 CHIP allotment. The first phase of the state's program will enroll 500 children by Oct. 1999 by expanding its Medicaid program to include 18 year old children whose family income is at or below 100 percent of the federal poverty level. Currently, North Dakota's Medicaid program covers children age seven through 17 whose families have incomes of 100 percent of poverty or less. Children up to age 6 are eligible if their families have incomes at or below 133 percent of poverty. The benefit package is the same as the Medicaid program in the state. North Dakota's plan was approved October 8, 1998.

Ohio

Ohio could receive nearly $116 million in federal FY 1998 funds for its CHIP plan. With its CHIP allotment, Ohio will expand eligibility within its existing Medicaid program. The state will expand Medicaid eligibility to cover children up to age 19 whose families have incomes at or below 150 percent of the federal poverty level and will expand coverage to as many as 133,000 uninsured children by 1999. To encourage enrollment, the state will survey community agencies on how they conduct Medicaid eligibility outreach, and develop media strategies for statewide education provided to Medicaid consumers and providers. Ohio's plan received approval on March 23, 1998.

Oklahoma

Oklahoma could receive as much as $81 million in new funds for FY 1998, which state officials will use to expand its Medicaid program. With its federal allotment, the state hopes to expand coverage to 71,000 children by the end of the program's first year. Oklahoma will provide the state's regular Medicaid benefit package to the newly-enrolled children. Oklahoma plans to use its CHIP allotment to provide Medicaid coverage to children born on or after October 1, 1983, with family incomes up to 185 percent of the federal poverty level. The Oklahoma Health Care Authority is collaborating with other interested agencies in the state to develop a marketing and outreach plan. The plan will consist of posters, public service announcements, fact sheets, press releases and outdoor advertising. Oklahoma's plan was approved on May 26, 1998.

Oregon

Oregon could receive as much as $39 million in new funds for FY 1998, which state officials estimate they will use to enroll approximately 17,000 children in their CHIP program by July 1, 1999. Oregon will use its new allocation to expand coverage to children from birth to age 6 with incomes between 133 percent and 170 percent of the federal poverty level. Coverage will also be extended to children from age 6 to age 19 with family incomes between 100-170 percent of poverty. Children in the new CHIP program will receive the same benefit package as children currently enrolled in the state's Medicaid section 1115 waiver demonstration. The benefit package includes inpatient and outpatient hospital services, inpatient psychiatric services, physician services, dental services, home health services, lab services, prescription drugs and other medically necessary services. Oregon will convene a task force of public and private partners to develop a consolidated Medicaid and CHIP outreach plan. Oregon's plan was approved on June 12, 1998.

Pennsylvania

Pennsylvania could receive as much as $117 million in new funds for FY 1998, which state officials will use to fund its existing Pennsylvania CHIP program. Pennsylvania is one of three states that had the benefit package of their existing state children's health program grand-fathered under CHIP. State officials estimate that with the state's initial plan -- approved May 28 -- and amendment approved October 28, Pennsylvania will be able to insure 80-100,000 children by September 1999. The first phase provided coverage to children age one through 16 with family incomes at or below 185 percent of poverty. The amendment to Pennsylvania's CHIP plan expands eligibility for children from birth to age 18 in families with incomes up to 200 percent of the federal poverty level. The benefit package includes a full range of inpatient services. Outreach activities in the state include canvassing local businesses, day care centers, school districts, hospitals, religious organizations, social service agencies and civic groups.

Puerto Rico

Puerto Rico could receive as much as $9.8 million in new funds for FY 1998 under the CHIP program. Puerto Rico will use its allotment to expand Medicaid eligibility. Medicaid coverage will be expanded to cover children through age 18 in families with incomes below 200 percent of the commonwealth poverty level ($8,220 for a family of four). Federal CHIP funding will allow Puerto Rico to cover approximately 20,000 children. Puerto Rico's program will also include children currently under its public health system, which receives no federal funding. Puerto Rico is also unique in that it has elected to contribute more money than the standard federal-state matching funds. Officials in Puerto Rico estimate that there will be 165,000 children in their CHIP plan by the end of FY 1998. Puerto Rico will develop a number of outreach efforts, including disseminating brochures, leaflets, and posters with information on the CHIP program; launching a broad-based media campaign; and appealing directly to eligible children and families. Puerto Rico's plan was approved June 26, 1998.

Rhode Island

Rhode Island could receive as much as $10.6 million for FY 1998, which state officials will use to insure as many as 3,000 children by the end of FY 2000. Rhode Island will use its allocation to expand its Medicaid program. The program will provide comprehensive health care coverage to children between the ages of 8 and 15 whose family income is between 100 and 250 percent of the federal poverty level. The program will also cover children 15 to 18 whose families have incomes up to 250

percent of poverty. Beginning at 185 percent of the federal poverty level, or about $30,432 for a family of four, families will begin paying modest premiums or co-payments. In order to effectively reach the target population, various outreach methods will take place. The first phase of Rhode Island's outreach efforts, a public information campaign, will last four months. The second phase of outreach will include follow-up and evaluation activities which will last approximately six months. Rhode Island's plan was approved on May 8, 1998.

South Carolina

South Carolina had already begun to expand its Medicaid program when the new CHIP law was enacted, and could receive over $63 million in new funds for FY 1998. The state will use its share of CHIP funds to expand its Medicaid program, and hopes to enroll an additional estimated 75,000 children. Regular cost-sharing rules apply and eligibility will be extended to children under age 19 whose family incomes are at or under 150 percent of the federal poverty level. The state has placed eligibility workers in public schools, hospitals, clinics, pharmacies and other places frequented by families with potentially eligible children. South Carolina's plan was approved on February 18, 1998.

South Dakota

South Dakota could receive as much as $7.5 million for FY 1998. The state will use its CHIP allocation to expand its Medicaid program to insure 7,400 children in its first year. The state will increase eligibility limits for children ages 6 to 18 from the current limit of 100 percent of FPL to 133 percent of FPL. The benefit package for children enrolled in CHIP will be the same as that offered to other children in the state's Medicaid program. Families will not be charged for medical care under this CHIP program. The state will identify eligible children and mail their families applications. South Dakota's plan was approved on August 25, 1998.

Texas

Texas could receive as much as $561 million in new funds for FY 1998, which state officials estimate that they will use to enroll nearly 58,000 children in their CHIP program by October 1, 1999. Texas will use its allotment to expand Medicaid eligibility to children up to age 19 in families with incomes below 100 percent of the federal poverty level. Texas currently covers children from birth to one in families with incomes up to 185 percent of poverty, ages 1-5 up to 133 percent of poverty, ages 6-14 up to 100 percent of poverty, and ages 15-19 up to 47 percent of poverty. The state also plans to expand coverage to additional low-income children and families by submitting an amendment to their CHIP program in 1999. Outreach activities will include working the entire network of public health providers to disseminate outreach materials to providers so that they may supply information to families with potentially eligible children. Texas' plan was approved on June 15, 1998.

Utah

Utah could receive as much as $24 million in new funds for FY 1998, which state officials estimate will insure 21,000 children in their CHIP program by 2000. Utah will use its CHIP allocation to create a separate state health insurance program to provide coverage to uninsured children up to age 19 whose family incomes do not exceed 200 percent of the federal poverty level. The plan does have some cost sharing for services, but no premiums or enrollment fees will be charged. Copayments and out-of-pocket maximums will be determined by income level. The state will use Medicaid eligibility workers already placed in 98 hospitals, community health centers, local health departments, and other allied agencies to determine CHIP eligibility. The state will also do outreach through community presentations, toll-free telephone lines, brochures, flyers and postcards. Utah's plan was approved July 10, 1998.

Vermont

Vermont could receive as much as $3.5 million in FY 1998 funds for its CHIP plan. The state will use its allotment to create a separate health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the FPL. Health services to children will be delivered by the managed care organizations that currently provide services under the Vermont Health Access Plan, a

Medicaid section 1115 waiver. An amendment to the Medicaid waiver was approved November 6, 1998, allowing the state to expand coverage to underinsured children up to 300 percent of the FPL. The benefits package for the Vermont CHIP program is the same as provided through the state's Medicaid program. The state will charge beneficiaries a premium of $10 per month per household. Beginning July 1, 1999, providers will be allowed to charge a $10 copayment for office visits. No copayments will be charged for well-baby and well-child visits. Maximum cost sharing will not be allowed to exceed 5 percent of a family's income. The state will integrate its outreach activities with the current outreach campaign for Medicaid, which includes advertising, brochures, flyers, and outreach through community health and social service providers. Vermont also offers a toll-free telephone line with information on Medicaid and CHIP. Vermont expects to insure 1,088 children by October 2000. Its CHIP plan was approved December 15, 1998.

Virginia

Virginia could receive as much as $68 million in FY 1998 funds to create a separate children's health insurance plan, the Virginia Children's Medical Security Insurance Plan. The plan has two components, the first of which provides coverage for children under age 19 in families with incomes up to 150 percent of the FPL. The second phase, which will begin at a later date, will cover children under age 19 in families with incomes up to 185 percent of the FPL. The difference between the two components is that families with incomes between 150 and 185 percent of the FPL will have out-of-pocket costs imposed through an amendment to this plan. The benefit package will be comprehensive and includes inpatient and outpatient care, laboratory services, and substance abuse treatment. To reach eligible children, the state will create a single mail-in application for both programs. The state will also place eligibility workers in different locations throughout the state, offer a toll-free hotline number, and will coordinate with school districts and local agencies to distribute applications. Virginia's plan was approved October 22, 1998.

Virgin Islands

The Virgin Islands could receive nearly $280,000 in new funds for FY 1998. The territory will use its CHIP allocation to expand its Medicaid program to children receiving services through a territory-funded program. CHIP funds will help strengthen federal support for children's health in the Virgin Islands. The local government will not expand eligibility, but the current income level for a family of four is $8,500 - or about half the level of states. The Virgin Islands' plan was approved September 17, 1998.

West Virginia

West Virginia could receive as much as $23 million in new funds for FY 1998. The state will use its CHIP allotment to expand Medicaid eligibility to children between the ages of one and five in families with incomes up to 150 percent of FPL. The state currently has an income cutoff for that group of 133 percent of FPL. The newly covered children will receive the regular Medicaid benefit package at no cost to their families. As part of their outreach efforts, the state will include Medicaid information in all free or reduced lunch and textbook applications and the state's toll-free 24 hour hotline will include information on the CHIP program. The state is currently planning a second expansion stage. West Virginia's plan was approved on September 15, 1998.

Wisconsin

Wisconsin could receive as much as $38 million in new funds for FY 1998, which state officials will use to expand its Medicaid program. The state will initially cover an additional 2,000 children under its Phase One plan for the new federal CHIP program, and will amend its program with a more comprehensive plan in the near future. Wisconsin plans to expand Medicaid eligibility to children ages 15-18 in families with incomes below 100 percent of the federal poverty level. Presently, the state's Medicaid program covers children under age 6 in families with incomes less than 185 percent of poverty, and children ages six to 14 in families with incomes less than 100 percent of poverty. All eligible children will receive the full Medicaid benefit package with no out-of-pocket costs for families. Wisconsin's outreach efforts will include: public health agencies coordinated efforts with schools; the

expansion of school-based clinics in 12 Milwaukee public schools; and inclusion of schools as potential outstation sites for Medicaid eligibility workers. Wisconsin's plan was approved May 29, 1998.

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Divider Title: Disability

PRESIDENT CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES
***BACKGROUND*: January 13, 1999**

Today, President Clinton will unveil an historic new initiative that will remove significant barriers to work for people with disabilities. This three-part budget initiative, which invests over $2 billion over five years, includes: (1) full funding of the Work Incentives Improvement Act which will be introduced by Senators Jeffords, Kennedy, Roth, and Moynihan next week; (2) a new $1,000 tax credit to cover work-related costs for people with disabilities; and (3) expanded access to information and communications technologies. With these new proposals, the Administration will have taken action on every recommendation made in the report of the President's Task Force on the Employment of Adults with Disabilities, which the Vice President accepted last month. Justin Dart, one of the foremost leaders of the disability communities, stated in response to today's proposals: "The Clinton-Gore Administration has a long history of supporting the disability community. This policy initiative is one of the boldest since the landmark passage of the ADA."

BARRIERS TO WORK FOR PEOPLE WITH DISABILITIES

- **Millions of working-age adults have disabilities**. About 1.6 million working-age adults have a disability that leads to functional limitations (i.e., needs help with at least one activity of daily living). About 14 million working-age adults are disabled using a broader definition (e.g., uses a wheelchair, or walker; has a developmental disability).

- **The unemployment rate among people with disabilities is staggering**. Nearly 75 percent of people with disabilities are unemployed. Not only is it more difficult for people with disabilities to work; when they do work, their earnings are lower. According to one study, the average earnings for men with disabilities are 15 to 30 percent below those of men without disabilities. These disparities are greater for those needing help with daily activities.

- **Multiple barriers to work**. People with disabilities face a number of challenges, including:
  - **Lack of adequate health insurance**. In most places in the U.S., people with health problems can be charged high premiums by private insurance companies or denied coverage altogether. Those who are insured may not be covered for some of their needs, such as personal assistance. Medicaid covers these services, but eligibility is generally restricted to people who cannot work. Thus, there is little incentive to return to work.

  - **Higher costs of work**. People with disabilities not only face lower than average wages, but typically pay more to get to and from work and to function at work. Thus, for some, returning to work may decrease rather than increase their savings.

  - **Disconnected employment service system**: A variety of vocational rehabilitation, educational, training and health programs exist to facilitate work for people with disabilities, but they rarely work together in a coordinated way.

  - **Inaccessible or unavailable technology**: Technological advances facilitate work, improve productivity and reduce the costs of such technology. Yet, people with disabilities often lack information on what exists, how to use it, and how to afford it.

ADMINISTRATION COMMITMENT TO IMPROVING OPPORTUNITIES

The President has made expanding economic opportunities to all Americans -- particularly people with disabilities -- a priority. His accomplishments include:

- **Most diverse Administration in history** by appointing a large number of people with disabilities to senior positions. The Federal government now employs about 127,000 employees with some type of disability.

- **Strong efforts to end job discrimination**. In July 1998, the President directed key federal civil rights agencies (Department of Justice, Equal Employment Opportunity Commission and the Small Business Administration) to increase outreach and implementation efforts.

- **New Medicaid buy-in option for workers with disabilities**. The Balanced Budget Act of 1997 created an optional program whereby states could allow people with disabilities who were earning up to 250 percent of poverty to purchase Medicaid coverage.

- **Improving employment services**. On August 7, the President signed the Workforce Investment Act (WIA), including the Rehabilitation Act Amendments of 1998. It establishes better links between the vocational rehabilitation and the workforce development systems.

- **Expanding accessible transportation**. In September 1998, the Department of Transportation issued the final regulation implementing the Americans with Disabilities Act (ADA) provisions for over-the-road bus (OTRB) accessibility.

- **Reauthorizing and expanding the Assistive Technology Act**. In October, 1998, the President signed the "Tech Act" which provides assistive technology to low-income people with disabilities and encourages small businesses to design and market innovative ideas.

- **TASK FORCE ON EMPLOYMENT OF ADULTS WITH DISABILITIES**. One of the most important actions taken by President Clinton was the signing of the executive order establishing the Presidential Task Force on Employment of Adults with Disabilities on March 13, 1998. Led by Alexis Herman, Secretary of Labor, and Tony Coelho, this Task Force is charged with coordinating an aggressive national policy to bring adults with disabilities into gainful employment. It produced a set of interim recommendations in December, 1998, summarized below:

RECOMMENDATION	ACTION
1. Work to pass the Work Incentive Improvement Act	President includes in budget
2. Work to pass the Patients' Bill of Rights	High Presidential priority
3. Examine tax options to assist with expenses of work	President includes in budget
4. Foster interdisciplinary consortia for employment services	President includes in budget
5. Accelerate development/adoption of assistive technology	President includes in budget
6. Direct Small Business Administration to start outreach	Vice President announced 12/98
7. Remove Federal hiring barriers for people w/ mental illness	Mrs. Gore announced tomorrow
8. Develop a model plan for Federal hiring of people w/ disabilities	Vice President announced 12/98

WORK INCENTIVES IMPROVEMENT ACT

The Work Incentives Improvement Act is an historic bill produced through the bipartisan efforts of Senators Jeffords, Kennedy, Roth and Moynihan in collaboration with leaders in the disability community and staff throughout the Administration. It is the centerpiece of the President's initiative to provide economic opportunities to people with disabilities. Altogether, it would cost an estimated $1.2 billion over 5 years. Its major components are described below.

HEALTH INSURANCE PROTECTIONS

Health care -- particularly prescription drugs and personal assistance -- is essential to enabling people with disabilities to work. This proposal would: (1) expand option and funding for the Medicaid buy-in for workers with disabilities; (2) extend Medicare coverage for people with disabilities who return to work; and (3) create a demonstration of a Medicaid buy-in for people with disabilities that have not yet gotten severe enough to end work and qualify them for disability, Medicaid or Medicare.

- **Expanding the State Medicaid Buy-In Option for Workers with Disabilities.** Two new optional eligibility categories would allow states to expand Medicaid coverage to workers with disabilities beyond the current option created in the Balanced Budget Act of 1997 (BBA). Additionally, a new grant program would be provide $150 million in funds to states taking these option to help them start their programs and outreach to eligible workers.

  The BBA option allows people with disabilities who would be eligible for Supplemental Security Income (SSI) but for earned income up to 250 percent of poverty to buy into Medicaid at a premium set by the state. This would be expanded through two new options:

  Workers with higher earned income, unearned income, and assets. The first new option allows states to expand this Medicaid buy-in to people with disabilities with earned income above 250 percent of poverty with assets, resources and unearned income to limits set by the state. This is important since many workers with disabilities have either assets and resources that exceed the current limit of $2,000 or are transitioning from Social Security Disability Insurance (SSDI) and have unearned income exceeding the limit of about $500.

  Workers whose conditions improve but still are disabled. The second new option would allow states that elect the first option (covering working people with disabilities with assets, resources and unearned income below limits set by the state) to also extend the Medicaid buy-in to people who continue to have a severe medically determinable impairment but lose eligibility for SSI or Social Security Disability Insurance (SSDI) because of medical improvement. Often, such improvements are possible only with health care.

To give an example of who might be helped by this option, a person with rheumatoid arthritis whose condition prevents work could receive disability and health coverage. If, at the medical review, laboratory tests were still positive but the therapy and a new drug allowed the person to work, benefits would essentially end. Although this temporary remission is mostly attributable to health care coverage, the improvement would disqualify the person from disability and thus health benefits under current law.

Grant assistance. States that take one or both of the new eligibility options for working individuals with disabilities would be eligible for a new grant program. This program would give states funds for infrastructures to support working individuals with disabilities as well as to build the capacity of states and communities to provide home and community-based services. Funds could also be used for outreach campaigns to connect people with disabilities with resources. A total of $150 million would be available for the first 5 years, and annual amounts will be increased at the rate of inflation for 2004 through 2009. States meeting these criteria would receive a grant no less than $500,000 and no more than equal to 15 percent of expenditures on medical assistance for individuals eligible under the new state options. Funds would be available until expended.

Both options would be treated like any other Medicaid eligibility option (e.g., same Federal matching rate, benefits rules). States could not supplant existing state spending with Medicaid funding under these options and would have to maintain effort for current spending for people made eligible under these options.

- **Continuation of Medicare Coverage for Working Individuals with Disabilities.** A ten-year trial program would allow people who are receiving Medicare because of their receipt of SSDI payments to continue to receive Medicare coverage when they return to work. Under current law, these individuals may receive Medicare coverage during the 39-month period following their trial work period, but have to pay the full Medicare Part A premium after that time. In many cases, people returning to work following SSDI either work part time and thus are not eligible for employer-based health insurance or work in jobs that do not offer insurance. This leaves them no alternative to the individual insurance market which can charge people with pre-existing conditions exorbitant premiums or deny them coverage altogether in many states. This option, which allows these workers to maintain their Medicare coverage so long as they remain disabled (as determined through continuing disability reviews), would remove a critical barrier to returning to work.

- **Demonstration of Coverage of Workers with Potentially Severe Disabilities.**
A demonstration program would allow states to offer the Medicaid buy-in to workers that, as defined by the State, have a disability that without health care could become severe enough to qualify them for SSI or SSDI. Funding of $300 million would be available for this demonstration, which sunsets at the end of FY 2004. States could participate in this demonstration if they have opted to expand coverage through at least one of the new Medicaid eligibility options for workers with disabilities. People covered in this demonstration would receive the same coverage as other workers with disabilities.

This demonstration is intended to help people whose condition has not yet deteriorated enough to prevent work but who need health care to prevent that deterioration. For example, a person with muscular dystrophy, Parkinson's Disease, or diabetes may be able to function and continue to work with appropriate health care, but such health care may only be available once their conditions have become severe enough to qualify them for SSI or SSDI and thus Medicaid or Medicare. This demonstration would provide new information on the cost effectiveness of early health care intervention in keeping people with disabilities from becoming too disabled to work.

TICKET TO WORK AND OTHER PROVISIONS

- **Ticket to Work.** Currently, SSDI and SSI disabled beneficiaries believed to benefit from employment-related services are mostly referred to state vocational rehabilitation (VR) programs administered by the Department of Education, which are then reimbursed based on cost. This provision would give more consumer choice in receiving employment services and increases provider incentives to serve SSI and SSDI beneficiaries. Components of the ticket proposal include:

  Consumer Options for Employment Services. The ticket would enable an SSI and SSDI beneficiary to go to either a public or a participating private provider.

  Provider Options for Reimbursement. Providers who accept the ticket would select their preferred reimbursement: (1) outcome payments system (e.g., 40 percent of benefits saved for five years once the recipient leaves the rolls), or (2) an outcome-milestone payment system (e.g., a flat payment when a specific employment related goal is achieved plus a portion of benefits saved once the recipient leaves the rolls).

  Temporary Suspension of Continuing Disability Reviews. During the period when a beneficiary is "using a ticket" the individual would not be subject to continuing disability reviews -- medically scheduled or triggered by work activity.

- **Demonstrations**. This provision requires SSA to undertake a demonstration project that reduces SSDI benefits by $1 for each $2 earned above a certain level. Under current law, a DI beneficiary in the extended period of eligibility who earns more than the substantial gainful activity level, currently $500 a month, does not receive a cash benefit. Another provision would extend SSA's SSDI demonstration authority which expired in June 1996.

- **Changes in Continuing Disability Reviews (CDRs)**. SSA uses CDRs to determine if a beneficiary continues to meet the definition of disability over time. This provision would prohibit using work activity as the sole basis for scheduling a CDR for individuals during the first 24 months of DDSI eligibility. Additionally, this proposal would provide an expedited eligibility determination process for SSDI applicants who received benefits for at least 24 months & engaged in substantial gainful activity during their extended periods of eligibility.

WORK INCENTIVE GRANTS

The Work Incentive Grant proposal would combine the strong ideas in Title IV of the Work Incentive Improvement Act with those of the Task Force on the Employment of Adults with Disabilities to improve the existing infrastructure for providing information and services to individuals with disabilities. The new grant program would build upon the *Workforce Investment Act (WIA)*, signed into law by the President last year, by ensuring that people with disabilities have access to the full range of employment and re-employment services in the One-Stop delivery system established by the WIA.

- **New partnerships.** Competitive grants (totaling $50 million a year) would be awarded to partnerships of organizations (public and private), including organizations of people with disabilities in every state. These partnerships will be responsible for working with the One-Stop system to augment that system's capacity to provide a wide range of high quality services to people with disabilities working or returning to work, including:
  - Providing benefits planning and assistance;
  - Facilitating access to information about services and work incentives available in the public, private, nonprofit sectors (e.g., availability of transportation services in the local area, eligibility for health benefits, and access to personal assistance services);
  - Better integrating and coordinating employment and support services on the Federal, state, and local levels of government.

- **Building on current efforts.** The new grant program would build upon the solid base formed by the state and local workforce investment boards mandated by the Workforce Investment Act. The WIA sets forth a new priority on ensuring that individuals with disabilities are provided access to employment and training information and services. The Federally-funded Vocational Rehabilitation agencies are required to participate in the One-Stop delivery system of employment and training services. Further, the local workforce investment boards are required to include representatives of community-based organizations, including those that represent persons with disabilities. DOL will encourage local boards to include business leaders with experience in employing such individuals.

- **Administration**. As the lead Federal agency for employment and training services for all Americans, DOL would administer these grants. DOL would consult with National Council on Disability, the President's Committee on the Employment of People with Disabilities, and the Task Force on the Employment of Adults with Disabilities, the Education Department, the Department of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Small Business Administration, the Department of Commerce, and others on the development of its solicitation for grant applications, on review of applications for quality and comprehensiveness, and on monitoring and evaluating the grants and the operations of the One-Stop system.

TAX CREDIT FOR WORKERS WITH DISABILITIES

Eligible workers with disabilities would receive a $1,000 tax credit beginning in 2000. This would help about 200,000 to 300,000 people, at a cost of $700 million for 2000-04.

- **Goal**. This new tax credit would help offset some of the formal and informal costs associated with employment for people with disabilities. As such, it would provide a greater incentive to begin working, and help those people with jobs maintain them. It would complement the Work Incentives Improvement Act and would be available to all people with disabilities, irrespective of their state Medicaid eligibility options. For participants in a Medicaid buy-in, it could pay for services not covered (e.g., special clothing, transportation). It also gives the person with disabilities flexibility in directing the credit toward the services that they need the most.

- **Amount of the credit**. The credit would be $1,000. It would phase out for higher income tax payers (taxpayer with modified adjusted gross income exceeding $110,000 for couples, $75,000 for unmarried taxpayers, and $55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). This credit cannot exceed the total amount of tax liability except, however, that it may be refundable for taxpayers with 3 or more dependents.

- **Eligibility.** A taxpayer (or his or her spouse) would qualify for the proposed tax credit if he or she had earnings and was disabled. "Disabled" for this credit would be defined as being certified within the previous 12 months as being unable, for at least 12 months, to perform at least one activity of daily living (bathing, dressing, eating, toileting, transferring and continence management) without personal assistance from another individual, due to loss of functional capacity.

- **Interaction with other tax provisions**. Worker with severe disabilities who also qualify for the President's proposed long-term care credit may receive both credits since they are intended to help with different types of costs.

  Individuals receiving this credit may also be eligible for the present-law deduction for impairment-related work expenses of persons with disabilities (this deduction is not subject to the 2 percent limit). However, many individuals with disabilities may not be able to itemize their deductions or incur significant work-related expenses outside the workplace (which do not qualify for the deduction).

- **Who benefits**. About 200,000 to 300,000 workers would receive this credit.

- **Cost**: $700 million over 5 years.

EMPOWERING AMERICANS WITH DISABILITIES WITH ASSISTIVE TECHNOLOGY

This multifaceted initiative would improve the development, adoption and prevalence of technologies that help people with disabilities work. It would cost $35 million in FY 2000, more than doubling the government's current investment in deploying assistive technology.

- **Goal**: This initiative would accelerate the development and adoption of information and communications technologies that can be easily used by Americans with disabilities. Information technology has the potential to significantly improve the quality of life for people with disabilities, enhance their ability to participate in the workplace, and make them full participants in the Information Society.

- **Elements of the initiative**. This initiative has five parts:

  - **Making the Federal government a model employer.** The government would expand its purchases of assistive technology and services to increase employment opportunities for people with disabilities in the federal government.

  - **Supporting state loan programs to make assistive technology more affordable.** The Department of Education's National Institute on Disabilities and Rehabilitation Research (NIDRR) would provide matching funds to states that create or expand loan programs to make assistive technology more affordable for people with disabilities.

  - **Investing in research and development and technology transfer to make technology more accessible**. NIDRR and the National Science Foundation would invest in research on technologies such as "text to speech" for people who are blind, automatic captioning for people who are deaf, or speech recognition and eye tracking for people who cannot use a keyboard.

  - **Developing an "Underwriters Laboratory" for accessible technologies**. The government would provide start-up funding to a private sector organization, analogous to the Underwriters' Laboratory, that would test information and communications technologies to see if they are accessible. This would help expand the market for accessible technologies.

  - **Encourage industry to make products more accessible**, Building on a successful partnership with the Internet industry (the Web Accessibility Initiative), the government would provide matching funds to industry consortia that work with disabilities community to make key technologies accessible, such as interactive television, small, hand-held computers, and cellular phones.

- **Cost**: $35 million per year.

PRESIDENT CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES
January 13, 1999

Today, President Clinton will unveil a historic new initiative that will remove significant barriers to work for people with disabilities. This three-part budget initiative, which invests over $2 billion over five years, includes: (1) full funding of the Work Incentives Improvement Act which will be introduced by Senators Jeffords, Kennedy, Roth, and Moynihan next week; (2) a new $1,000 tax credit to cover work-related costs for people with disabilities; and (3) expanded access to information and communications technologies. With these new proposals, the Administration will have taken action on every recommendation made in the report of the President's Task Force on the Employment of Adults with Disabilities, which the Vice President accepted last month. Justin Dart, one of the foremost leaders of the disability communities, stated in response to today's proposals: "The Clinton-Gore Administration has a long history of supporting the disability community. This policy initiative is one of the boldest since the landmark passage of the ADA."

CRITICAL NEED TO REMOVE BARRIERS TO WORK

Since President Clinton took office, the American economy has added 17.7 million new jobs, and unemployment is at a 29-year low of 4.3 percent. The unemployment rate among all working-age adults with disabilities, however, is nearly 75 percent. According to current estimates, about 1.6 million working-age adults have a disability that leads to functional limitations and 14 million working-age adults have less severe but still significant disabilities.

People with disabilities can bring tremendous energy and talent to the American workforce, but institutional barriers often limit their ability to work. Most critically, people with disabilities often become ineligible for Medicaid or Medicare if they work. This means that many people with disabilities are put in the untenable position of choosing between health care coverage and work. In addition, advances in technology and communications are often not accessible to people with disabilities.

THREE-PART INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES

- **Funding the Work Incentives Improvement Act in the President's budget.** Health care -- particularly prescription drugs and personal assistance -- is essential for people with disabilities to work. Today, the President is announcing that his FY 2000 budget will fund the full cost of the Work Incentives Improvement Act. This proposal, which costs $1.2 billion over 5 years, would:

  - <u>Improve access to health care by:</u>

    -- Expanding states' ability to provide a Medicaid buy-in to people with disabilities who return to work. This provision would enable states to offer the buy-in to people whose assets and/or income exceed current limits. It also would give states the option of offering the buy-in to people with medical conditions, such as rheumatoid arthritis, who do not meet the current disability standard, but who can work only because of medical treatment. Finally, this provision would give health care grants to those that do so.

-- Extending Medicare coverage, for the first time, for people with disabilities who return to work. Although Medicare does not provide as comprehensive a benefit as Medicaid, this aspect of the proposal ensures that all people with disabilities who return to work have access to health care coverage, even if they live in a state that does not take the Medicaid option.

-- Creating a new Medicaid buy-in demonstration to help people with a specific physical or mental impairment that is not yet severe enough to qualify for health care assistance, but that is reasonably expected to lead to a severe disability in the absence of medical treatment. This demonstration could help people with muscular dystrophy, Parkinson's Disease, HIV or diabetes who are able to work with appropriate health care.

- Modernize the employment services system by creating a "ticket" that will enable SSI or SSDI beneficiaries to go to any of a number of public or private providers for vocational rehabilitation. If the beneficiary goes to work and achieves substantial earnings, providers would be paid a portion of the benefits saved.

- Create a Work Incentive Grant program to provide benefits planning and assistance, facilitate access to information about work incentives, and better integrate services to people with disabilities working or returning to work.

- **Providing a $1,000 tax credit for work-related expenses for people with disabilities.** The daily costs of getting to and from work, and being effective at work, can be high if not prohibitive for people with disabilities. Under this new proposal, workers with significant disabilities would receive an annual $1,000 tax credit to help cover the formal and informal costs that are associated with employment, such as special transportation and technology. Like the Jeffords-Kennedy-Roth-Moynihan Work Incentive Act, this tax credit, which will assist 200,000 to 300,000 Americans, will help ensure that people with disabilities have the tools they need to return to work. The credit will cost $700 million over 5 years.

- **Improving access to assistive technology.** Technology is often not adapted for people with disabilities and even when it is, people with disabilities may not be able to afford it. This new initiative would accelerate the development and adoption of information and communications technologies that can improve the quality of life for people with disabilities and enhance their ability to participate in the workplace. The initiative would: (1) help make the Federal government a "model user" of assistive technology; (2) support new and expanded state loan programs to make assistive technology more affordable for Americans with disabilities; and (3) invest in research and development and technology transfer in areas such as "text to speech" for people who are blind, automatic captioning for people who are deaf, and speech recognition and eye tracking for people who can't use a keyboard. It would cost $35 million in FY 2000, more than double the government's current investment in deploying assistive technology.

With these steps, the Administration has taken action on all Task Force Recommendations. In December, the Vice President accepted the report of the President's Task Force on the Employment of Adults with Disabilities, took action on some of their recommendations, and pledged that the Administration would review others in the budget process. With the new steps taken today, as well as an announcement that Mrs. Gore will make tomorrow, the Administration has taken action on all the Task Force formal recommendations:

-- Work to pass the Work Incentive Improvement Act -- included in Adminstration's budget.
-- Work to pass a strong Patients' Bill of Rights -- high Administration priority.
-- Examine tax options to assist with expenses of work -- included in Administration's budget.
-- Foster interdisciplinary consortia for employment services -- included in Administration's budget.
-- Accelerate development and adoption of assistive technology -- included in Administration's budget.
-- Direct Small Business Administration to expand outreach -- Vice President announced in December.
-- Remove Federal hiring barriers for people with mental illness -- Mrs. Gore will unveil tomorrow.
-- Direct OPM to develop model plan for Federal hiring of people with disabilities -- Vice President unveiled in December.

Disability Initiative Q & A's
January 12, 1999

Q. How is this initiative funded?

A. This initiative is fully funded through offsets in the President's proposed FY 2000 budget. All of these provisions will be described in the budget documents released in early February.

Follow-up: Isn't it irresponsible to announce specific spending proposals without announcing how these proposals will be financed?

Not at all. The President will ensure that this -- and all other new initiatives -- will be fully paid for as part of his overall balanced budget proposal. Like most budgets, the President's FY2000 budget will not contain a specific dollar-for-dollar link between new proposals and offsets. The bottom line, however, will reflect the President's long-standing commitment to a balanced budget. Moreover, not one dime will be taken away from the surplus for this initiative.

Q. Shouldn't this tax credit be refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. The vast majority of low-income people with disabilities are already covered by Medicare and Medicaid. This initiative enables states to cover people who would be rendered ineligible by virtue of returning to work and gaining a higher income. Thus, most of the funding in this initiative is targeted toward those low-income people in the process of returning to work.

The tax credit helps offsets the higher costs of work (e.g., personal assistants, special transportation) for people with disabilities who pay taxes, irrespective of their income or state of residence. It also, unlike Medicaid and Medicare, allows the worker to use the funds for whatever expenses they incur.

Q. Why are we only doing tax initiatives? Are you rejecting traditional Medicare and Medicaid program expansions? Aren't you catering to Republicans?

A: Each policy in the President's budget was designed to be the most cost-effective approach to solving a particular problem. This tax credit for workers with disabilities is no exception. Workers with disabilities have very different costs -- for rural residents, it may be transportation; for people with limited use of their hands, it may be assistive devices. A tax credit offers the flexibility to assist with a wide-ranging and changing set of needs in a way that Medicaid expansions cannot.

Similarly, the informal, unmeasurable costs of family caregiving are best addressed through a tax credit, as proposed in our long-term care initiative. If Medicaid or Medicare expanded to cover respite care, for example, it would undermine rather than strengthen informal family caregiving and cost billions more.

In no way does the President's support for these tax credits undermine his commitment to Medicare and Medicaid. This President has an unparalleled record of protecting, strengthening and expanding these programs. For example, the President's aggressive actions to reduce Medicare fraud contributed to record-low spending growth in 1998 -- the same year that he added new preventive benefits, health plan choices, and low-income protections to Medicare.

Q. How many people will benefit from this proposal?

A. Between 200,000 and 300,000 people would likely benefit from the tax credit. Millions more could benefit from the new options, services and programs in the Work Incentive Improvement Act and the assistive technology initiative.

Q. What are this initiative's prospects of passing?

A. Removing barriers to work for people with disabilities goes beyond partisan politics. We can all agree that something must be done so that people with disabilities can fully participate in today's strong economy. Senators Jeffords, Kennedy, Roth and Moynihan have already committed to working hard for the Work Incentive Improvement Act. We hope that early passage of this bill can show the American public that this Congress and President can work together to address real problems that are affecting people's lives today.

LONG-TERM CARE
December 20, 1998

ELDERLY

Today's elderly are healthier than ever before.

- **Today's elderly.** About 34.3 million Americans are age 65 years or older. Of them, 4 million are over the age of 85 and 386,000 are age 95 or older. About 60 percent of the elderly and over 70 percent of the people age 85 and older are women (U.S. Census, 1998).

- **Life expectancy is longer**. Today's elderly are expected to live more than 20 percent longer than the elderly in the early 1960s (NCHS, 1998). Since 1940, life expectancy at birth has increased from 63 years old to 76 years old (CDC, 11/10/98).

- **Health status has improved**. It appears that chronic illness among the elderly has declined -- 1.2 million fewer elderly are disabled than would have been if trends had continued (Manton, 1996). The proportion of the elderly reporting fair to poor health status declined by nearly 10 percent since 1987 (NCHS, 1998). Hypertension among the elderly has dropped by about 20 percent among the elderly since the early 1960s (NCHS, 1998).

However, even while the proportion of elderly with health problems declines, the sheer number of elderly is skyrocketing.

- In the year 2000, older people will outnumber children in the world for the first time in history. (Secretary Shalala, on the announcement of 1999 International Year of Older Persons, 10/19/98) [note: not true in US]

- **Doubling of the elderly.** The number of people age 65 years or older will double by 2030 (from 34.3 to 69.4 million). This is an increase from 13 percent of the general population to 20 percent of all Americans. The number of people 85 years or older will grow even faster (from 4.0 to 8.4 million) (U.S. Census, 1998).

- **Although getting healthier, the elderly are less healthy than younger people.**

  - About 55 percent of elderly women have arthritis, compared to 40 percent of elderly men and 23 percent of people ages 45 to 64. Over half of all people age 75 or older have arthritis (NCHS, 10/98).

  - Of the elderly, about 13 percent have diabetes (22 percent of elderly African Americans), over 30 percent have heart disease (nearly half of all people with heart disease), 40 percent have high blood pressure (NCHS, 10/98).

- Nearly three-fourths of all deaths in 1996 occurred among the elderly (CDC, 11/10/98).

- The number of seniors with chronic diseases is expected to increase by 100 percent over the next several decades (HHS Fact Sheet, 10/14/98).

LONG-TERM CARE NEEDS

- **What is "long-term care."** People with chronic illness or disability not only need regular health care services, but often require assistance in managing their health conditions and performing basic tasks such as eating, bathing and leaving their homes to go to the doctor.

  - "Formal" long-term care is paid long-term care services provided by health providers. It mostly consists of nursing home care and home health care.

  - "Informal" long-term is less skilled, unpaid care provided by people other than health providers -- family or friends. It consists of activities such as assistance with changing feeding tubes or monitoring medications, and providing help in dressing or going to the doctor.

- **What causes the need for long-term care**. A wide range of diseases and disabilities can result in long-term care needs. As such, people are classified as having long-term care needs if their chronic illness or disability results in limitations in their activities (e.g., eating, toileting, transferring, bathing, dressing, and continence management). Conditions that typically require long-term care include: diabetes, heart disease, arthritis, Alzheimer's disease and other dementias.

- **Millions of Americans of all ages have long-term care needs**. Nearly 2 million Americans live in nursing homes and another 4 million Americans live in the community but have health problems that would qualify them for nursing home care (need assistance to perform at least 3 of 6 basic activities of daily living). (ASPE, 1998)

  - About two-thirds of people with long-term care needs are elderly.

  - Nearly half of all people age 85 and older need assistance with everyday activities.

  - Almost 1 million elderly people are severely cognitively impaired because they have Alzheimer's disease or another form of dementia (HHS, 1998).

- **Older women are more likely to have long-term care needs**. Even after controlling for the larger number of elderly women, women are 50 to 75 percent more likely to need

long-term care. (HHS, 1998)

HOME & COMMUNITY-BASED LONG-TERM CARE

Three-quarters of the elderly with long-term care needs live in the community

- Over 70 percent of the elderly with long-term care needs lives with a spouse or other adult. Over 95 percent of them receive unpaid help from their spouse, son, daughter or other adult. Of these people receiving informal long-term care, only 40 percent also receive some paid health (e.g., Medicare home health visit) (ASPE, 1998).

- About 30 percent of the elderly with long-term care needs lives alone. These elderly are much more likely to rely on paid assistance (60 percent versus one-third of those living with a spouse and other adult) (ASPE, 1998).

- What worries people the most about growing old is having to live in a nursing home. Alliance of Aging Research.

- Nearly one in three seriously ill patients reported that they would rather die than end up in a nursing home.

A large network of family and friends provides informal long-term care for people with long-term care needs at all ages.

- **Families and friends provide a major amount of long-term care.** One in three (52 million) Americans voluntarily provide unpaid informal care each year to one or more ill or disabled family members or friends. (HHS, 1998)

  - 38 percent of informal caregiving is provided by adult children for their parents.
  - 11 percent is provided by spouses, usually among elderly couples.
  - 7 percent is provided by parents to significantly disabled children.
  - 20 percent is provided to other relatives (e.g., grandparents, aunts or uncles).
  - 24 percent is provided to friends or neighbors.

- **Most informal caregivers are women**. Women are nearly 30 percent more likely to be informal caregivres. Women provide about 50 percent more hours of informal care per week than their male counterparts. Black women are more likely to provide informal care than white women. (HHS, 1998)

- **The majority of informal caregivers work** (65 percent). Women who work full time provide an average of 11 hours of long-term care a week. (HHS, 1998)

People caring for <u>elderly</u> relatives or friends provide more, intense assistance.

- **Over 7 million Americans provide nearly 30 hours per week of assistance to elderly people with long-term care needs.** Typically, more than one relatives or friends help to care for these people (HHS, 1998).

- **Over two-thirds of primary caregivers live in the same house**. The majority of caregivers for the elderly with long-term care needs are spouses (40 percent) or adult children (36 percent) (HHS, 1998).

- **Caregiving often conflicts with work**. Two-thirds of working caregivers report experiencing conflicts that cause them to rearrange their work schedules, work fewer hours, or take an unpaid leave of absence from work (HHS, 1998).

- **Primary caregivers for the elderly are themselves older.** Their average age is 60 years old, and half are older than 65. About one third described their own health as "fair to poor." (HHS, 1998) This presents problems since informal caregiving often requires physical work like heavy lifting, frequent bedding changes, dressing and bathing (Feinberg, 1997).

- **Caregivers often have emotional as well as physical strains.** One study found that 68 percent of caregivers experienced depression (Feinberg, 1997). Women tend to experience higher levels of stress, even when controlling for their disproportionate caregiving role (Rose-Rego et al., 1998).

    - **Especially true for families caring for people with Alzheimer's disease**. Such caregivers experienced greater time demands, family conflict, strain, mental and physical problems, and financial hardship (Ory et al., 1998).

- **Despite the strain, nearly 70 percent of caregivers use positive words when describing how they felt about their role** (NAC/AARP, 1997).

- **Over 40 percent of family caregivers have household incomes less than $30,000 per year** (NAC/AARP, 1997).

- **Over 40 percent of people caring for elderly relatives also care for children under 18** (NAC/AARP, 1997).

- **Minority families tend to provide more informal care.** Controlling for level of disability, non-Caucasian caregivers provided more care than Caucasian caregivers (Tennstedt & Chang, 1998). The actual number of caregivers in minority families is higher than the number of caregivers in non-minority families, due in part, to the involvement of modified extended families (Chatters et al., 1998, 1986; Miller et al., 1994; Hatch, 1991; and Cox and Monk, 1990).

ASSISTED LIVING

- Often called residential care or boarding homes, assisted living facilities are typically defined as state-licensed facilities that provide food, shelter and the provision of a range of long-term care services.

- All states have some regulation, often included with boarding homes, but not uniform.

- Marriot, Manor Care.

- NY, MA, NC covered assisted living as a state plan services. CO, GA, MO, MT, NV and VT reimburse personal care services in board and care facilities.

NURSING HOME CARE

- About 1.6 million older Americans and people with disabilities receive care in approximately 16,700 nursing homes. (HCFA, 1998)

- 75 percent of nursing home residents are women. (NCHS, 1998).

WHO PAYS FOR LONG-TERM CARE

Total spending on long-term care

- **Direct medical costs for persons with chronic conditions** represent nearly 70 percent of national expenditures on health care. (HHS Fact Sheet, 10/14/98)

    - **Nursing home care**: Nursing home costs average over $46,000 per year. (Wiener & Stevenson, 1998)

    - **Home health care**:

- However, a large amount of long-term care, provided by family and friends, is uncounted.

Medicare

- **Medicare was not designed to cover long-term care.** While its home health benefit has evolved into long-term care for many (it pays for about 40 percent of all formal home health costs), Congress is trying to reign in that cost growth. It is unlikely, in the face of the demographic challenges facing Medicare, that it will expand to cover more of this type of benefit.

- **Few beneficiaries realize that Medicare does not pay for long-term care.** Although 63 percent of Medicare beneficiaries recognize that they are not covered for prescription

drugs, only 44 percent of beneficiaries know that Medicare does not pay for long-term nursing home care. (Kaiser Family Foundation, 1998)

Medicaid

- **Medicaid is the largest insurer of long-term care in the nation**. It pays for two-thirds of nursing home residents, and 15 percent of home health care. However, it is a payer of last resort, covering the poor or those made poor by high health care costs. As with Medicare, Medicaid is unlikely to increase its coverage of long-term care since it already consumes a third of all Medicaid expenditures.

Private long-term care insurance

- **Little private insurance for long-term care.** Only 6 percent of the elderly and a very small percent of baby boomers have private long-term care insurance. This is because few businesses offer long-term care policies, they remain expensive, and few people recognize the need for this insurance.

- **Not the only answer.** Even if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030.

Out-of-pocket spending on long-term care

- **Most long-term care costs are paid for out of pocket, by families.** About $25 billion was paid out-of-pocket on formal nursing home and about $6 billion on home health care in 1996. Long-term care expenditures account for nearly half (44 percent) of all out-of-pocket health expenditures for Medicare beneficiaries.

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PRESIDENT CLINTON AND VICE PRESIDENT GORE UNVEIL HISTORIC LONG-TERM CARE INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND HELP ADDRESS GROWING LONG-TERM CARE NEEDS

January 4, 1999

Today, President Clinton is unveiling an historic new initiative to support Americans with long-term care needs and the millions of family members who care for them. This four-part, $6.2 billion (over five years) initiative takes important steps to address complex long-term care needs through: (1) an unprecedented $1,000 tax credit that compensates for formal or informal costs Americans of all ages with long-term care needs or the family caregivers who support them; (2) a new National Family Caregivers Support Program that provides a range of critical services for caregivers such as respite, home care services, and information and referral; (3) a national campaign to educate Medicare beneficiaries about the programs' limited coverage and how best to evaluate long-term care options; and (4) a proposal to have the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees at group rates.

The President is being joined by the First Lady, Secretary Rubin, Secretary Shalala, and OPM Director LaChance to unveil this initiative at the White House and the Vice President and Mrs. Gore are participating from an adult day care center in California, one of four States with model statewide family caregiving resource programs.

MILLIONS OF AMERICANS HAVE LONG-TERM CARE NEEDS

- **More and more Americans have a range of long-term care needs.** Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately, two-thirds are older Americans. Also, millions of adults and a growing number of children have long-term care needs because of health condition from birth or a chronic illness developed later in life.

- **The aging of Americans will only increase the need for quality long-term care options.** The number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster (from 4.0 to 8.4 million).

MULTI-FACETED INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND ADDRESS GROWING LONG TERM CARE NEEDS. The President is unveiling a four-part initiative that is designed to address the broad-based and varied long-term care needs. It will: provide immediate support and assistance for the millions of Americans who care for family members with major long-term care needs; educate the elderly and people with disabilities about long-term care issues and options; and promote new promising strategies directions for long-term care policy for the twenty-first century. The President also called on the Vice President to host a series of forums around the nation to raise awareness about the need to support family caregivers and address the growing need for long-term care options.

The long-term care proposal being unveiled today by the President and Vice President includes:

- **Supporting families with long-term care needs through an historic $1,000 tax credit.** This initiative, for the first time, acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a $1,000 tax credit. This new tax credit supports the diverse needs of families by compensating a wide range of formal or informal long-term care for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. This proposal, which supports rather than supplants family caregiving, would provide needed financial support to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children. It costs $5.5 billion over five years and phases out beginning at $110,000 for couples and $75,000 for unmarried taxpayers.

- **Creating an unprecedented National Family Caregiver Support Program.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's disease patients can delay institionalization for as long as a year. This new nationwide program, strongly advocated by the Vice President, would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to create "one-stop-shops" that provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support, such as teaching model approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as feeding tubes. This program, which costs $625 million over five years, would assist approximately 250,000 families nationwide.

- **Launching a national campaign to educate Medicare beneficiaries about the programs' limited coverage of long-term care and how best to evaluate their options.** Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care, and many do not know what long-term care services would best meet their needs. This $10 million nationwide campaign would provide all 39 million Medicare beneficiaries with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care policy; and how to access information about home-and community-based care services that best fit beneficiaries' needs.

- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** The President also called on Congress to pass a new proposal that allows OPM to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal, that costs $15 million over five years, will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

DRAFT: COMPARISON BETWEEN THE 1995 PROPOSALS AND THE PRESIDENT'S PROPOSED TAX CREDIT FOR LONG-TERM CARE

	1995 House Budget Proposal	1995 Conference Budget Proposal	1999 President's Budget Proposal
Basic Policy	$500 Credit for Caregivers of Parents with Long-Term Care Needs	$1,000 Deduction for Long-Term Care Expenses	$1,000 Credit for People with Long-Term Care Needs or their Caregivers
Cost over 5 years	$0.9 billion (JCT)	$0.56 billion (JCT)	$5.5 billion (Treasury)
Who Gets the Credit:			
Caregivers of Parents with Chronic Illness & Disability	Yes	Yes	Yes
If Parents have moderate Social Security income	No	No	Yes
Caregivers of Adults with Chronic Illness & Disability	No	No	Yes
Caregivers of Children with Chronic Illness & Disability	No	No	Yes
Spouses of People with Chronic Illness & Disability	No	No	Yes
People with Chronic Illness & Disability Themselves	No	No	Yes
Upper income limits	None	None	$95,000 for singles, $130,000 for couples

- The President's tax proposal is one part of a broader initiative that includes the new $625 million Family Caregiver Program that would provide real services -- respite care, counseling, information -- to caregivers. Aging advocates strongly support this initiative both because the tax proposal is much broader and more generous and because the financial assistance is complemented by the important, new Caregiver Program.

- The President did not veto the 1995 Republican budget because of the tax proposal -- he vetoed the legislation because of its massive cuts to Medicare, Medicaid, education, and environmental spending.

BACKGROUND: PRESIDENT CLINTON'S LONG-TERM CARE INITIATIVE

January 4, 1999

Americans of all ages, particularly the elderly and their families, fear developing a need for intense, ongoing long-term care. Unlike acute care, long-term care is rarely paid for by private insurance and Medicare, and is more likely to require out-of-pocket expenditures. It also takes a huge financial and emotional toll on family and friends who provide most of this care. Because of its complexity, however, no single policy can "solve" this problem. Thus, the President is proposing a multi-faceted initiative to provide immediate assistance with long-term care & help prepare for what will surely be one of the great challenges as the baby boom generation ages.

GROWING NEED FOR LONG-TERM CARE

- **Who needs long-term care.** People with chronic illness or disability not only need doctor, hospital and other acute care services -- they also need a wide range of services to manage their health conditions and perform basic activities of daily living. For example, people with strokes may be bed-bound due to paralysis and need help with eating, moving and changing their feeding tubes. Diabetics or people with congestive heart failure may require frequent injections, medication and doctor visits. People with Alzheimer's disease often need constant monitoring and changes to their physical environment to allow them to live at home safely. Long-term care encompasses these and other services. It is probably the most complicated area of health care, since it varies based on a person's specific condition and limitations as well as access to care from institutions, health providers, families and friends.

  About 5 million Americans of all ages have significant limitations (cannot perform 3 or more activities of daily living without assistance) because of illness or disability and thus require long-term care. Nearly 2 million of these people live in nursing homes; the remainder live in the community and benefit from irreplaceable and uncompensated caregiving from countless relatives and friends. In addition, millions more Americans have chronic illnesses or disabilities that are less limiting but still require long-term care.

  More than two-thirds of people with long-term care needs are elderly -- nearly half of all people age 85 and older need assistance with everyday activities. Older women are more likely to need long-term care than men; three-fourths of nursing home residents are women.

- **The aging of America will create a greater need for long-term care.** The sheer increase in number of elderly in the next century means more chronic illnesses. The number of people age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older will grow even faster (from 4.0 to 8.4 million). By 2050, the number of older, disabled people could double.

- **Not just a challenge for the elderly**. About 2 million people with substantial long-term care needs are younger than age 65. The rate of disability has been rising among children. In part, this reflects a little-noticed effect of the success in helping premature, sick, or disabled newborns. Their increased survival through infancy has led to a need for long-term care as they grow up. Also, many adults have long-term care needs due to lifelong health conditions (e.g., cerebral palsy) or conditions developed as adults (e.g., multiple sclerosis).

LONG-TERM CARE SYSTEM

- **Medicare was not designed to cover long-term care.** Long-term care costs account for nearly half (44 percent) of all uncovered, out-of-pocket health expenditures for Medicare beneficiaries. When it was created in 1965, Medicare was modeled after a typical private insurance policy and thus did not include long-term care coverage.

  Unfortunately, nearly 60 percent of all Medicare beneficiaries -- and two-thirds of people under age 65 -- do not realize that Medicare does not pay for long-term nursing home care. This means that the majority of Americans are unprepared for the financial and emotional challenges of paying for and/or providing long-term care.

- **Medicaid is already the major payer of long-term care, but historically has focused on nursing homes**. Medicaid is the largest payer of long-term care in the nation. It covers two-thirds of nursing home residents -- many of whom become eligible for this income-related program because long-term care costs impoverish them. Nursing home costs average almost $50,000 per year. About 80 percent of Medicaid long-term care costs are for nursing homes.

  The remaining 20 percent of costs are for home and community-base long-term care services. The share of Medicaid long-term care spending going toward home and community-based services has more than doubled in the last 10 years. Ten years from now, Medicaid spending on these services is projected to equal spending on nursing homes. The President has encouraged the shift away from Medicaid's "institutional bias" by approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers. Notwithstanding these advances, not all Medicaid beneficiaries with long-term care needs have community-based options, and many people with long-term care needs don't qualify for Medicaid at all.

- **Private insurance is relatively new, untested, and covers very few people**. Only about 4 million Americans -- 1.5 percent of all Americans -- have private long-term care insurance. In part, this reflects the newness of the coverage, the inconsistency of benefits across policies, variable regulation, and low demand. Given their cost, even if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030.

- **Families and friend provide most long-term care.** Informal caregiving is a part of family life for many Americans. About 70 percent of caregivers report it being a positive experience. Only about one-third of the 5 million people with substantial long-term care needs lives in a nursing home -- virtually all of the 3 million community-based people with similar needs rely on one or more relatives or friends for help. The millions of caregivers that provide nearly full-time assistance for these people with severe needs are part of a larger group of Americans that help people with less intense long-term care needs.

However, the costs of such caregiving -- in time, money, and physical and emotional strain -- can be large. Two-thirds of working caregivers report experiencing conflicts that cause them to rearrange their work schedules, work fewer hours, or take an unpaid leave of absence from work. Most of the primary caregivers for the elderly are elderly themselves. Their average age is 60 years old, and half are older than 65. About one third describe their own health as "fair to poor." This presents problems since informal caregiving often requires physical work like heavy lifting, frequent bedding changes, dressing and bathing. These stresses tend to be more severe for families of people with Alzheimer's disease. Such caregivers tend to experience greater time demands, family conflict, strain, mental and physical problems, and financial hardship.

LONG-TERM CARE INITIATIVE

The challenges of providing and financing long-term care are clearly large and multi-dimensional. No single policy can provide the answer. As such, the President is proposing a four-part, $6.2 billion (over five years) initiative takes important steps to address complex long-term care needs (described in detail in subsequent pages):

- **Direct financial support through a new tax credit for people with long-term care needs or their family caregivers.** This credit helps pay for the formal and informal costs associated with care for people with significant long-term care needs.

- **Direct service support through a new Family Caregivers Program** that provides information, education, counseling, and respite services directly to families that care for elderly, ill or disabled relatives.

- **Education for Medicare beneficiaries about long-term care issues and options**. Since most people who develop long-term care needs are Medicare beneficiaries, Medicare can be used to provide information on the limitations of its coverage, alternative sources of long-term care services and financing, and how best to choose the most appropriate options.

- **High-quality, affordable private long-term care insurance for Federal employees.** The Federal government would develop a model program to offer high quality, private long-term care insurance policies to its employees, retirees and eligible family members. By offering this coverage, the Federal government will both guide public policy by example and act responsibly as the largest employer in the nation.

TAX CREDIT FOR PEOPLE WITH LONG-TERM CARE NEEDS OR THEIR CAREGIVERS

Eligible people with long-term care needs or their caregivers would receive a $1,000 tax credit beginning in 2000. This would help about 2 million people, at a cost of $5.5 billion for 2000-04.

- **Goal**: This policy offsets some of the paid and unpaid long-term care costs incurred by people with chronic illness or the families with whom they live. A large proportion of long-term care costs are not covered by insurance, and studies suggest that the value of informal, unpaid long-term care provided by families is worth billions of dollars.

- **Amount of the credit**: The credit is $1,000. It phases out for higher income tax payers (taxpayer with modified adjusted gross income exceeding $110,000 for couples, $75,000 for unmarried taxpayers, and $55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). This credit cannot exceed the total amount of tax liability except, however, it may be refundable for taxpayers with 3 or more dependents.

  The flat $1,000 credit would be given on the basis of a certified need for long-term care rather than expenses for long-term care. This means that families and people with chronic illness or disability do not have to collect and submit receipts for paid home health or respite care. It also recognizes the costs associated with informal, family caregiving. For example, a wife whose husband has had a stroke would not have a receipt for her reduced hours at work, time spent bathing and feeding her husband and other real costs associated with care.

- **Eligibility**: Three types of people could receive this tax credit: (1) taxpayers with long-term care needs; (2) taxpayers whose spouses have long-term care needs; and (3) taxpayers with dependents with long-term care needs.

- **"Person with long-term care needs"**: For this credit, this includes:

  - People with 3 or more limitations in activities of daily living (ADL) (bathing, dressing, eating, toileting, transferring and continence management) who cannot perform these activities without substantial assistance from another individual due to a condition lasting for longer than 6 months, as certified by a licensed doctor in the previous 12 months.

  - People with severe cognitive impairments who require substantial supervision to be protected from threats to their health and safety due to this condition and have difficulty with one or more ADLs or one of four major instrumental ADLs.

  - Children ages 2 through 6 who have difficulty with 2 out of 3 ADLs (eating, transferring and mobility) or are under the age of 2 and require skilled caregiver in the parents' absence or specific durable medical equipment (e.g., a respirator) for over 6 months. Within one year, HHS and Treasury will report on whether these eligibility rules are appropriate and how to improve them if necessary.

- **"Caregivers"**: Families would be eligible for the credit as caregivers if their relatives with long-term care needs can be claimed as dependents. Under current law, a "dependent" is generally an individual who does not pay taxes, is related to the taxpayer, receives more than half of his or her support from the taxpayer, and has gross income less than $2,750. For purposes of this credit, this definition would be expanded significantly in two ways. First, individuals with long-term care needs would not have to meet the support test if they live with a taxpayer who is a close relative for at least half the year (the entire year in the case of a distant relative and other persons). Second, the limit on gross income would be raised to the sum of the exemption amount, the standard deduction, and the additional deduction for the elderly and blind (to $8,100 for single elderly person; in general, Social Security benefits are excluded from gross income for moderate to low-income individuals). Most people with income above this limit would file taxes and receive the long-term care credit themselves

  Broadening the definition of dependency for the purposes of this credit is a major change that allows many more families that house and care for relatives to receive the credit. It does so by allowing caregiving relatives of individuals with long-term care needs to claim the credit when those individuals themselves have insufficient income to pay taxes.

- **Who benefits**: About 2 million people would benefit from this credit: about 1.2 million elderly, about 500,000 nonelderly adults, and about 250,000 children. About three-fourths of people receiving the credit are expected to be spouses or family caregivers of these people with long-term care needs. Almost all recipients are middle class; about 75 percent of elderly taxpayers have income below $50,000.

- **Cost:** About $5.5 billion over the five-year budget window.

TAX CREDIT FOR PEOPLE WITH LONG-TERM CARE NEEDS: Examples Assuming 1999 Levels					
Elderly Single Person		**Elderly Married Couple (1)**		**Caregiver of Elderly Person (2)**	
INCOME					
Social Security (3)	9,420	Social Security (4)	16,086	Senior's Soc Security (3)	9,420
Pensions	13,765	Pensions	14,370	Son's Income	46,000
Interest Income	1,000	Interest Income	1,500		
Total Money Income	***24,185***	***Total Money Income***	***31,956***	***Total Money Income***	***55,420***
Adj. Gross Income	**14,765**	**Adj. Gross Income**	**15,870**	**Adj. Gross Income**	**46,000**
TAX LIABILITY					
Exemption	-2,750	Exemption	-5,500	Exemption	-8,250
Standard Deduction	-4,300	Standard Deduction	-7,200	Standard Deduction	-7,200
Elderly Deduction	-1,050	Elderly Deduction	-1,700	Elderly Deduction	
Taxable Income	***6,665***	***Taxable Income***	***1,470***	***Taxable Income***	***30,550***
Current Law Tax Liability	**1,000**	**Current Law Tax Liability**	**221**	**Current Law Tax Liability**	**4,583**
				Current Law Child Tax Credit	-500
Proposed LTC Credit	**-1,000**	**Proposed LTC Credit**	**-1,000**	**Proposed LTC Credit**	**-1,000**
Proposed Law Tax Liability	**0**	**Proposed Law Tax Liability**	**0**	**Proposed Law Tax Liability**	**3,083**

Dept of the Treasury; Office of Tax Analysis. (1) Only one individual needs long-term care; both are older than 65. (2) Single elderly person moves in with son, his wife & teenage son; total income (including grandfather's) roughly equals the median income for a family of 4. (3) Weighted average of benefits paid to retired workers, and widows and widowers, in 1996 adjusted for inflation. (4) Average benefits paid to retired workers and their wives in 1996 adjusted for inflation.

NEW FAMILY CAREGIVER SUPPORT PROGRAM

A new National Family Caregivers Support Program would support families who provide long-term care to elderly relatives with chronic illnesses or disabilities through state and local area agencies on aging. This $125 million program would help approximately 250,000 families.

- **Goal**: This policy provides support for families who care for relatives with chronic illness in hope of easing the emotional, physical and financial strain of caregiving. Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that counseling and support for families of Alzheimer's disease patients can delay institutionalization for as long as a year.

- **Eligibility**: Families -- especially low-income families -- who provide care to elderly relatives with limitations in activities of daily living would be eligible for services.

- **Services provided**: Funding would be used to help families that take care of elderly relatives with significant long-term care needs. This assistance would include:

  - Connecting families with information on caregiver resources and local services (e.g., detailed information on the condition affecting their relative; names and numbers of local home care and respite services);

  - Providing counseling, training and peer support to teach families how to face the challenges of caregiving (e.g., how to bath people who have had strokes; what exercises work best for people with severe arthritis; how to cook meals for people with diabetes; how to manage the stress of caregiving);

  - Providing and paying for respite care (e.g., attendants so that the caregiver can shop or leave the house for other reasons, adult day care centers, and temporary care in an assisted living facility or nursing home). For people providing intense long-term care, these services provide necessary, temporary relief from caregiving responsibilities, allowing them to restore balance to their lives that strengthens their ability to continue to provide assistance. Most of the funding of this program would pay for respite services.

  Additionally, a competitive grant program would test innovative interventions (e.g., use of computer information for distant caregivers) and challenges for subgroups of caregivers (e.g., minority caregivers; caregivers for people with severe conditions like brain injuries).

- **Administration:** All state agencies on aging would receive a grant from the Administration on Aging for distribution to local area agencies on aging. These Federal grants would be matched by the states and states could not reduce their current spending on such services. States would develop a sliding fee scale consistent with its other programs.

- **Who benefits**: Altogether about 250,000 families could be served by this program.

- **Examples**: The following programs serve as models for this new, nationwide program:

  - **California:** Its Department of Mental Health developed a program in 1985 to provide caregiver support services through eleven agencies statewide. These agencies target families caring for persons with Alzheimer's disease, Parkinson's disease, stroke, and traumatic brain injury. Services include needs assessment, information and referral, family consultation and training, support groups, and respite care.

  - **New Jersey:** The Statewide Respite Care Program was established in 1988 to help unpaid caregivers of the stress arising from providing intensive personal assistance to a family member. Annually, over 2,000 families receive respite care provided through adult day care centers, short-term placement in the home of a trained individuals, or overnight nursing home stays. One quarter of the families helped by the program are caring for someone with Alzheimer's disease; heart disease, stroke and arthritis are the next most common chronic conditions of the program's care recipients. A recent evaluation found that families helped through its adult day care had much lower feelings of worry, strain and overload, and fewer experienced depression or anger. Depression is a major problem for caregivers, not only limiting their ability to help their relative but restricting their own lives and activities.

  - **Washington**: Washington State Aging and Adult Services Administration established a program in 1989 to provide assistance to family caregivers. Through its area agencies on aging, it offers respite services to 2,800 families annually. Several thousand families receive caregiver training. Respite services are prioritized based on the caregiver's vulnerability, intensity of care provided by family members, and presence of other family and or community supports.

  - **Wisconsin**. Since 1986, Wisconsin Bureau on Aging has funded county aging and social services offices to work with families to identify the types and amounts of assistance needed to care for relatives diagnosed with Alzheimer's disease or a related disorder. Covered services include respite care, provided in the home or in adult day care, and in-home help. In addition, assistive devices, caregiver training, and peer group supports are financed. Families share in the cost based on income. About 1,000 families benefit from funded respite care or in-home help and another 4,600 families are helped through caregiver training, information and peer group supports.

- **Cost**: The total funding is $125 million in FY 2000 and $625 million over five years, most of which would be distributed among all states, and a small part of which would be used for the competitive grant program. Additionally, funds would be set aside for an evaluation of these efforts -- in an effort to identify what works and doesn't work so that future efforts are best targeted.

LONG-TERM CARE INFORMATION CAMPAIGN FOR MEDICARE BENEFICIARIES

A National Long-Term Care Information Campaign will be conducted to help Medicare beneficiaries and their families better understand their long-term care options. All 39 million Medicare beneficiaries would receive this information through this $10 million initiative.

- **Goal**: This policy provides information on long-term care to Medicare beneficiaries -- who comprise most of the people who have or will develop long-term care needs. Since nearly 60 percent of beneficiaries do not realize that Medicare does not cover most long-term care, this information is critical to educating them about their coverage and directing them to financing and delivery systems.

- **Information provided**: The Health Care Financing Administration (HCFA), working with other components of DHHS, would conduct this information campaign. It would include information about long-term care coverage under the Medicare and Medicaid programs; what to look for in a private long-term care insurance policy; how to access home and community-based care; and other consumer information. Components of the campaign would include:

  - Developing and distributing printed educational materials about long-term care options and resources to beneficiaries and their families;

  - Incorporating information about long-term care options and resources into the Medicare handbooks, toll-free phone numbers and the consumer internet site, www.Medicare.gov;

  - Enhancing training on long-term care options in organizations that provide information to beneficiaries including state health insurance assistance programs, Medicare carriers and fiscal intermediaries, area agencies on aging and Social Security Administration offices;

  - Working with groups representing the elderly, people with disabilities, the long-term care industry, employers, states and others to disseminate information to their constituencies.

  In addition, HCFA would conduct pilot information campaign projects focusing on the needs of particular populations such as people with disabilities, people who don't speak English, or the rural elderly. An evaluation component would be included to identify what works best in assisting beneficiaries in making informed long-term care decisions.

- **Who benefits**: All 34 million seniors and 5 million people with disabilities are covered by Medicare would receive this information. Since a large proportion of people with long-term care needs are elderly or adults with disabilities, Medicare is an extremely efficient way to target such people.

- **Cost**: $10 million in FY 2000.

OFFERING PRIVATE LONG-TERM CARE INSURANCE TO FEDERAL EMPLOYEES

This proposal would authorize the U.S. Office of Personnel Management (OPM) to make private long-term care insurance available to Federal employees, retirees, and eligible family members at negotiated group rates. The cost of administration of this benefit would be about $15 million over 5 years and an estimated 300,000 people would participate.

- **Goal**: This initiative would educate Federal employees and retirees about long-term care options and encourage the purchase of high-quality, long-term care insurance at 15-20 percent below market rates. This is one in an ongoing series of efforts in which the Federal government has taken a leadership role by both guiding public policy by example and acting responsibly as the largest employer in the nation.

- **Eligibility**: People eligible to purchase this insurance would include: Federal employees and retirees, and their spouse; former spouses who are entitled to annuities under a Federal retirement system; and parents, and parents-in-law. In its first year, OPM would run a campaign to educate possible participants about long-term care insurance and solicit and evaluate potential insurers. In the second year, it would hold an open enrollment for all eligible participants. New employees and employees electing coverage during the open enrollment period would be subject to either minimal or no underwriting. All others will be required to disclose additional information about their health status in order to acquire coverage. Once enrolled, coverage would be guaranteed renewable and could not be canceled except for nonpayment of premium.

- **Types of insurance policies offered**: OPM would select a single qualified carrier, or a very small number of carriers, to provide one or more long-term care insurance policies. This selection of carriers would be based on quality, service and price. At a minimum, carriers must be licensed under state law, compliant with the Health Insurance Portability and Accountability Act standards, and offer guaranteed renewability of their policies. OPM would set a basic benefit package consistent with the National Association of Insurance Commissioners' standards (e.g., with a minimum benefit level; inflation protection; contingent nonforfeiture) and may offer plans with additional coverage (e.g., higher reimbursement levels for nursing home care or a more flexible benefit that can be used for whatever type of service the person needs). OPM would have the flexibility to administer the program as the market for long-term care services and protections evolves over time.

- **How much participants would pay**: The full cost of premiums would be paid by the participant. OPM would negotiate group rates that it expects will be 15 to 20 percent lower than the cost of individual long-term care policies. Employee and annuitant premiums would be withheld from salary or annuity and sent directly to respective contractors.

- **Cost**: The Federal administrative costs would be about $15 million over 5 years.

LONG-TERM CARE INITIATIVE
QS AND AS, January 4, 1998

Q. How is this tax policy different than the $500 credit in the Republican Contract with America?

This proposal is quite different -- and we think much better. First, it would give twice as much assistance ($1,000 credit). Second, many more people would be eligible under this proposal. It would go to people who have long-term care needs or their spouses, not just to relatives who qualify as caregivers. It also would broaden significantly the definition of a "caregiver" by eliminating the "support test," which essentially excludes people with Social Security income. Our proposal also targets the dollars on middle-class families by phasing out the credit at higher income levels. Finally, it is part of a larger, well-rounded initiative that would help caregivers both financially and through real services in the new Family Caregiver Program.

We are glad, however, that Republicans have supported a similar concept, and seem to want to take credit for this proposal. It makes us optimistic that Republicans and Democrats in Congress can work together to pass this initiative and provide meaningful support for family caregivers.

Q. Didn't the President veto a family caregivers' tax credit in 1995?

A. The President vetoed the 1995 Republican budget, which included massive cuts to Medicare, Medicaid, education, and environmental spending. Someplace within that budget was a long-term care tax deduction that was poorly targeted and disproportionately benefited upper income families. For obvious reasons, the President was not willing to sign the whole 1995 Republican budget to gain this poorly constructed long-term care tax proposal.

Background: There were actually two different proposals offered by Republicans in 1995: a **$500 tax credit** that was introduced in early 1995 as a refundable credit for taxpayers housing certain family members (parent, grandparent) needing "custodial care" (2 + ADLs or similar level of disability due to cognitive impairment); and a **tax deduction** of $1,000 for taxpayers housing certain family members (parent, spouse or former spouse) who are "physically or mentally incapable of caring for himself." The latter was in the Balanced Budget Act of 1995 that was vetoed by the President.

Q. How is this initiative funded?

A. This initiative is fully funded through offsets in the President's proposed FY 2000 budget. The tax proposal is funded through tax offsets such as closing tax loopholes. All

of these provisions will be described in the budget documents released in early February.

Follow-up: Isn't it irresponsible to announce specific spending proposals without announcing how these proposals will be financed?

Not at all. The President will ensure that this -- and all other new initiatives -- will be fully paid for as part of his overall balanced budget proposal. Like most budgets, the President's FY2000 budget will not contain a specific dollar-for-dollar link between new proposals and offsets. The bottom line, however, will reflect the President's long-standing commitment to a balanced budget. Moreover, not one dime will be taken away from the surplus for this initiative.

Q. Why isn't the tax credit refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. Eligibility for the tax credit was carefully designed so it reaches virtually all taxpayers with significant long-term care needs. In addition, many individuals who do not pay taxes will be able to gain some benefit from this credit because their caregiver files tax returns. Finally, other aspects of the initiative announced today will benefit all people with long-term care needs, regardless of tax status. The new Family Caregiver Program targets assistance to low-income families who provide long-term care to their elderly relatives, and the Medicare long-term care information campaign will help all beneficiaries regardless of income.

Q. Why isn't there a greater emphasis placed on private long-term care insurance in your initiative?

A. The Federal employees' insurance initiative and the Medicare education campaign are both designed to give people information and encourage them to purchase high-quality long-term care insurance. However, even according to optimistic industry projections, if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030. This initiative explicitly recognizes that long-term care will continue to be funded and provided through multiple sources and thus addresses it through a multi-faceted response.

Q. By focusing on family caregivers, are you implying that you are not interested in expanding Medicare and Medicaid long-term care coverage?

A. The President has a strong track record of encouraging innovative long-term care services through Medicaid. Today, 20 percent of Medicaid long-term care spending is devoted to home and community-based long-term care services -- double the percent in 1987. The President has encouraged the shift away from Medicaid's "institutional bias" by

approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers.

Medicare was not designed to cover long-term care, as the Bipartisan Commission on the Future of Medicare has noted. The President looks forward to the recommendations of this Commission on long-term care and other benefits. But given the financing crisis facing Medicare, it seems unlikely that the Commission will vote for a significant expansion of Medicare coverage in this area.

While Medicare and Medicaid cannot be relied on to finance all long-term care, the President will continue to support creative targeted policies, both administrative and legislative, that cost-effectively and appropriately provide for effective long-term care services.

Q. Isn't this a drop in the bucket relative to the size of the long-term care problem?

A. Any initiative that spends $6.2 billion over 5 years has to be considered a significant proposal. It would make a major contribution toward helping over 2 million Americans afford and obtain much-needed long-term care services. No one in this Administration has or will suggest that this initiative on its own will address all of the problems. But it recognizes and provides meaningful support for the caregiving provided to Americans of all ages with chronic illness or disability.

Q. Isn't this policy another attempt to distract from impeachment?

A. Anyone who has followed this President since he has taken office will recognize his ongoing commitment to help meet the needs of American families. This initiative is a classic example of that commitment. The President has been working on it since the Spring of 1998 and, because it is a new initiative that will be included in his upcoming FY2000 budget, wanted to release it early to ensure that it receives the attention and consideration that it deserves.

Q How do you think Republicans will respond to this initiative? Will it pass this year?

A. The President believes that this initiative has great potential to attract strong bipartisan support in this Congress. It addresses a set of real problems through an approach that both Republicans and Democrats can embrace. And he believes that any policy to recognize and relieve the tremendous responsibilities that caregivers shoulder should and will receive favorable consideration by both parties in the upcoming Congress.

Q. Is the Medicare buy-in, the Jeffords-Kennedy bill, etc. in this year's budget?

A. The President will not address any other health-care initiatives today. In the coming weeks, he will unveil other proposals and initiatives in the budget. For today, we want to focus on this new and historic commitment to address Americans' long-term health care needs.

before retirement.
The bottom line is that compared to private health insurance plans, Medicare?s benefits package is parsimonious, not generous. The same conclusion applies to a comparison of Medicare?s benefits package with health insurance coverage for the elderly in the other advanced industrial societies.
If the purpose of Medicare is to cover the health care needs of the elderly in ways that are consistent with the scope, quality and structure of insurance available to the rest of the population, then the Medicare benefits package should be reformed to conform more closely the benefits package offered by private plans.

2. INEQUITIES IN MEDICARE

As a result of gaps in the Medicare benefits package, Medicare covers only about 50% of total health care spending by the elderly, leaving them exposed to large out-of-pocket expenses. The access of many elderly Americans to necessary health care is limited by their income, and poorer households are forced to devote a much larger fraction of their income to health spending than are richer ones. Overall, Medicare is regressiveit is a generous program only for the elderly with incomes in the top 25 percentile.
Recognition of the financial burden of the Medicare system on poorer beneficiaries is the reason behind the development of low-income protection programs of MedicaidQMBs and SLMBsto help such individuals cover their Medicare premiums, co-pays, and deductibles and to provide limited coverage for prescription drugs. Participation in these programs has been limited to the poorest beneficiaries, and participation among those eligible has been incomplete and variable across states. A recent article in the New England Journal of Medicine found that even with such low-income protections, inadequate coverage for costly drug prescriptions for the low-income elderly and disabled remains a serious problem in the nation?s health care system.

3. FINANCING PROBLEMS OF MEDICARE

Even with its parsimonious benefits package and with the reforms introduced by the 1997 BBA, Medicare faces a large and growing gap between anticipated revenues and expenditures, in part because of the aging of the population and in part because of continued rapid growth in health care spending driven by technological breakthroughs and growing intensity of use. The best available estimates indicate that even if future Medicare spending were to grow at the same rate as the economyimplying a slowdown unprecedented for both Medicare and private health care spendingthe Medicare program as currently financed would become insolvent by 2020, well before the time at which most Baby Boomers join the ranks of the elderly.

During its existence, Medicare spending per capita has grown at about the same average rate as private health care spending per capita. There is no justification for assuming or requiring that Medicare spending per capita will grow markedly more slowly than private health care spending per capita in the future. In the absence of major reforms in the private health care system or unforeseen cost-reducing technological improvements, private health care spending will continue to grow faster than the economy over the next twenty-five years; it follows that Medicare spending will rise both as a share

of GDP and as a share of the federal budget and that Medicare?s revenues will be inadequate to cover its expenditures.

4. INEEFICIENCIES OF MEDICARE

Medicare?s current structure, which relies on extensive price controls to control costs, fosters inefficiencies in the practice and utilization of medical services. Providers face strong financial incentives to encourage the utilization of services to compensate for their controlled prices while beneficiaries face weak financial incentives to use Medicare services in a cost-sensitive manner. It is impossible for Congress and HCFA to adjust the prices of tens of thousands of medical services to reflect rapidly changing market and technological conditions in a timely way. As a result, Medicare prices can diverge from market prices for the same product or service for substantial periods of time, resulting in a serious misallocation of resources. And as with any system that relies on price controls to control spending, there is a strong inducement for fraud within the Medicare system.

In addition, current law prevents Medicare from using such efficiency-enhancing measures as competitive bidding, selective contracting with preferred providers, and disease and case management techniques to control coststechniques which are regularly used in the private health care system. Efforts to reform current law to allow Medicare to use such techniques are actively and usually successfully opposed by many provider and hospital groups.

Perhaps the most telling evidence of inefficiencies in the Medicare system is the existence of large and persistent regional differences in Medicare costs per beneficiary that cannot be explained by either regional differences in living costs or regional differences in demographics. According to experts, at least one-quarter of the four to one regional differences in Medicare spending per capita is the consequence of regional differences in intensity of use and practice patterns, with no observable effects on regional health outcomes. In other words, Medicare beneficiaries in high-spending regions use more health services and spend more per capita on such services, but do not enjoy better health than their counterparts in low-spending regions.
If Medicare reforms encouraged all regions to move toward the intensity and practice patterns of the low-cost regions of the country, a substantial fraction of the financing problems of the Medicare system would be resolved. Unfortunately, provider groups in high-cost regions actively and usually successfully oppose Medicare reforms which would have this effect.

II. ALTERNATIVE DEMOCRATIC APPROACHES FOR REFORMING MEDICARE

Two basic approaches for addressing the challenges confronting Medicare have been suggested by health care experts and advocates within the Democratic Party. At the risk of simplification, these two approaches can be defined in the following way.

1. Incremental Approach

This approach would build on Medicare?s current structure in which the government through HCFA pays providers of Medicare services at controlled prices and in which the majority of Medicare?s beneficiaries would continue to enroll in Medicare?s traditional fee-for-service indemnity plan.
Incremental proposals include the following: restraining provider payments by

reducing updates for payments to hospitals, physicians, and other providers; adopting prospective payment systems for certain types of services to be reimbursed on the basis of anticipated costs rather than controlled prices; allowing Medicare the flexibility to negotiate prices with preferred providers and to use competitive bidding for some services; changing the structure of the Medicare fee-for-service benefits package, for example by raising Medicare deductibles, co-pays, or premiums or by adding a drug benefit to the basic fee-for-service package; raising the age of eligibility for Medicare; and ameliorating the regressive features of Medicare by expanding low-income protections and/or by income-relating beneficiary premiums.
Incremental approaches to reform usually also call for reform of the private Medigap insurance market. Medigap insurance, which covers Medicare co-pays and deductibles, increases the demand for Medicare services and hence Medicare spending without increasing premium payments for Medicare. Correction of this so-called ?first-dollar coverage problem? created by Medigap would ease Medicare?s financial difficulties, but both the elderly and the insurance industry oppose fundamental changes in Medigap options and prices.

An incremental approach was supported by a majority of the Democratic appointees to the National Commission on the Future of Medicare (the Breaux-Thomas Commission), although no formal proposal by these appointees was developed for consideration by the Commission.

2. Premium-Support Approach

This approach would restructure Medicare to allow beneficiaries to choose between the Medicare fee-for-service program operated by HCFA and modified by some or all of the incremental reforms listed above and a variety of competing private health care plans. Medicare would make a contribution toward the payment of the premium of the plan chosen by each Medicare beneficiary, with the remainder of the premium paid by the beneficiary. The government contribution would be calculated as a certain percentagefixed and adjusted by law over timeof the weighted average premium for all of the plans, including the HCFA traditional fee-for-service Medicare plan, competing for Medicare beneficiaries. The Medicare contribution would not be set by in dollar amountsthat is, Medicare would not operate as a defined contribution programbut would be set as a percentage of the weighted average of the costs of all plans certified to compete for Medicare beneficiaries. Increases in these costs over time would result in increases in both Medicare?s premium contributions and the premiums paid by Medicare beneficiaries.
Medicare would continue to operate under an open-ended federal spending commitment, but the risks and burdens of increases in the costs of services covered by Medicare would be automatically shared by a set percentage between Medicare and its beneficiaries. Over time, the government?s premium contribution and the beneficiaries? premium payment would be expected to increase at about the same pace as the costs of overall health services to the general populationin other words, the risk of rising costs would be borne by both the government and by the elderly according to a given sharing rule..
In a premium-support approach, all plans competing for Medicare beneficiaries would be required to offer at least the same standard benefits package as the fee-for-service package offered by HCFA, and this benefits package would continue to be established by law. The standardization of benefits across plans is necessary in a premium-support approach to encourage plans to compete on price and efficiency rather than on benefits, and to reduce the likelihood

of biased selection whereby less generous plans would compete to attract the healthiest beneficiaries, driving up the price of the plans available to the sickest and neediest.

A premium support approach was supported in principle by Breaux, Kerry, Tyson, and Altman, among the Democratic appointees of the National Medicare Commission and by all of the Republican appointees. But neither Tyson or Altman supported the specific version of the premium support approach drafted by the Commission?s majority because the proposal did not provide an adequate drug benefit for Medicare, did not provide adequate safeguards, and did not provide a credible long-term financing plan for Medicare.

III. POLICY RECOMMENDATIONS AND CONCLUSIONS

1. There are several basic principles that should guide reform of Medicare:

Over time, the quality and delivery system of Medicare should not differ materially from the quality and delivery system of private health insurance plans available to the non-elderly.

Medicare should be structured in ways that provide incentives for the provision of the highest quality services at the lowest cost. To the extent that Medicare dollars can be spent more efficiently through reform, it will be easier to address Medicare?s other challenges. The potential savings from greater efficiency can be used to expand benefits, to increase low-income protections, and to cover projected gaps in Medicare finances. But the magnitude of these potential savings is highly uncertain.

Most experts in the health care field believe that even under the most optimistic assumptions about potential efficiency gains, additional revenues will be required to cover the costs of current benefits and any benefit expansions. In short, the likely efficiency improvements in Medicare from a premium-support approach will not be large enough to eliminate the necessity of dedicating additional revenues to cover Medicare?s costs over time.

Over time, Medicare costs per beneficiary should be expected to rise at about the same pace as private per capita health care spending. If private per capita health care spending continues to grow more rapidly than the overall economy in the future as it has done in the past, then Medicare spending will rise as a share of the economy, as a share of payroll taxes, and as a share of the budget. Reform proposals which call for arbitrary numerical caps on such shares and require that per capita Medicare costs grow more slowly than private per capita health care spending would erode the quality and availability of Medicare services over time. And there is no economic justification for such proposalsthe economy can absorb the projected increases in Medicare spending, even in the absence of further reform. The justifiable reason for Medicare reform is not to save the economy from such increases, but to address Medicare?s inadequacies, its inequities, its inefficiencies, and its financing challenges.

Health care spending for the elderly is financed by several interrelated programs, the most important of which are Medicare, Medicaid, and Medigap. Moreover, these programs have evolved over time in an interdependent way: Medicaid provides low-income protections for the poor elderly in Medicare and Medigap provides first-dollar coverage and drug coverage for the elderly who can afford to purchase Medigap policies. In addition, about one-third

of all elderly have employer-based health policies that supplement Medicare. Since health care spending on the elderly comes from many public and private sources through interrelated programs, a piecemeal approach to reform will not be as effective as an integrated approach which makes complementary adjustments in Medicare, Medicaid, and Medigap. In addition, an inevitable consequence of expanding benefits in either Medicare or Medicaid will be some reduction in private dollars spent on the same benefitsfor example, adding a prescription drug benefit to Medicare will reduce drug coverage offered by employer-provided supplementary insurance.

2. There are two promising approaches to enhancing Medicare?s efficiency, both of which should be used:

First, giving HCFA both the responsibility and statutory authority to adopt management innovations developed in private health plans including flexible purchasing authority, competitive bidding, negotiating pricing authority, selective contracting with preferred providers and disease and case management techniques. In return for its greater discretion, HCFA should be held to a higher standard of accountability and reporting requirements for cost and quality outcomes.

Second, establishing a premium support system that would allow private plans to compete with one another and with the fee-for-service Medicare program operated by HCFA for the provision of a standards benefits package established by law. Competition among plans would slow the growth of program costs over time; in addition, a premium support system would be better able to weed out unscrupulous providers and restrict provider participation than the current system in which virtually any licensed professional or facility can offer Medicare service and in which decisions to exclude participation are subject to political pressure.

(Both of these approaches are discussed in greater detail in two recent reports from the National Academcy of Social Insurance: Transforming Traditional Medicare, January 1998; and Structuring Medicare Choices, April 1998)

3. There are several technical issues that would have to be resolved to develop a premium support model with adequate safeguards for beneficiaries.

First, an appropriate sharing rate would have to be determined to set the government share of the premium price of a participating plan and the beneficiary share. The government?s share would have to be large enough to insure that an adequate benefits package is available and affordable to all beneficiaries regardless of income, health status, or location. (In the particular premium support proposal of the majority of the National Medicare Commission, the government share was set at 88% of the weighted average premium price, based on the fact that under the current Medicare system, government revenues cover about 88% of the total costs of providing the Medicare benefits package.)

Second, geographic adjusters would be required to make sure that beneficiaries did not pay more for the same package of services because they lived in high-cost regions or because of the market power of providers available in their region. In other words, the government premium payments for individual beneficiaries would have to be adjusted to make sure than they are held harmless against higher prices in their regions stemming from these two factors.

Third, risk adjusters would be required to make sure that beneficiaries did not pay more for the same package of services because of their age, sex, disability status, or other health risk indicators. A risk adjustment mechanism would adjust the government?s premium contribution to participating plans on the basis of the risk characteristics of the individuals they enroll but would not affect the beneficiary contribution. Specifically, a risk adjustment factor based on beneficiary characteristics would adjust the premium for each plan based on its typical beneficiary, and the government would pay the difference between this adjusted premium and the beneficiary premium.

Fourth, while the principles behind the need for risk adjusters and geographic adjusters in a premium-support approach are understood, the development of such adjusters is still in its rudimentary stage. Therefore, the transition to a premium-support will have to be gradual; in the transition phase, the government?s premium contribution to a particular plan could be based on its costs of delivering the Medicare benefits package at Medicare?s controlled prices rather than on the weighted average bid of plans competing to deliver such services.

Fifth, as in the Medicare Choice Model introduced in BBA 1997, a premium-support model would require that the elderly commit to stay in the plan they chose until the next open enrollment period, and the minimum lag between such periods should be one year. Allowing more frequent switches would aggravate the already complicated risk selection problems of the Medicare system.

(For a more detailed discussion of the technical issues involved in a premium-support model, see a recent report from the Henry J. Kaiser Family Foundation by Mark Merlis: Medicare Restructuring: The FEHBP Model, February 1999)

4. As indicated earlier, Medicare has become a distinctly regressive system with the poorer elderly paying a larger fraction of their disposable income for health than the richer elderly and with the poorer elderly utilizing medical services less extensively than the richer elderly. As a result of the weakening of some of the low-income protection programs by the BBA of 1997, Medicare is likely to become even more regressive over time. The regressive nature of Medicare is a justification for introducing a degree of means-testing or income-testing into Medicare?s premiums. But the income-related premium must not be set so high and the ?high-income? threshold for paying a higher premium must not be set so low that Medicare ceases to function as a social insurance entitlement program and becomes primarily a program for the poor. Additional Medicare revenues earned from higher premium payments by ?high-income? individuals should be used to finance an expansion of low-income protections, not to reduce overall Medicare spending.

5. An increase in the Medicare eligibility age should be considered cautiously because of its potential to leave many older Americans with no other opportunity to obtain health insurance. Almost 1 in 8 Americans aged 62-64 have no insurance today and that number is rising. At a minimum, increasing the eligibility age should be coupled with a buy-in option for 65-66 year olds along the lines of the Administration?s earlier proposed buy for 62-64 year olds. If the goal is to make Medicare eligibility parallel Social Security eligibility, then such an early eligibility buy-in could be extended to 62-64 year olds.

6. Carving out funding for Direct Medical Education from the Medicare program would reduce its projected spending. But this approach begs the question of how to guarantee teaching hospitals with the support they need not only to provide education and research in medicine but also to cover the cost of their treatment of difficult medical cases and uninsured patients. One promising approach is to move funding for DME out of Medicare into a dedicated trust fund financed by a special fee paid by all providers, on the grounds that they benefit from the creation of knowledge and training by the teaching hospitals.

7. Democratic supporters of both the incremental approach and the premium support approach agree on the need for broadening Medicare?s benefit package to include a prescription drug benefit. When the Medicare program was enacted more than thirty years ago, drugs were not as important in medical treatment as they are today, and drug coverage was not the norm in private health care plans. As the effectiveness and cost of drug therapies have increased, elderly Americans have been forced to find sources other than Medicare to cover their prescription drug needs or forego them altogether. The resulting patchwork system for covering the drug needs of the elderlyincluding Medicaid support for some of the poorest Medicare beneficiaries, employer-provided retiree health insurance for some of the richest Medicare beneficiaries, and increasingly expensive and inadequate supplementary insurance packages offered by private insurersis riddled with inequities, inefficiencies, and wasteful administrative costs. These problems were left unsolved by the proposal for drug coverage offered in the majority report of the National Medicare Commission. This proposal included a limited drug subsidy for the poorest Americansthose with incomes of less than $11000 per yearbut failed to offer any subsidy toward the purchase of prescription drug coverage for the majority of Medicare beneficiaries. The Democratic appointees believe that such a subsidy is required on both equity and efficiency grounds.

The equity grounds are straight-forwardMedicare is a social insurance program for all elderly Americans, not just the poorest. The efficiency grounds are less obvious but equally compelling. Estimates by the federal government actuary for Medicare indicate that a 50% government subsidy toward the premium for a drug benefit would be adequate to encourage the vast majority of Medicare beneficiaries to opt to purchase such a benefit. With lower subsidy rates, a progressively smaller share of the Medicare population would opt for such a benefit. Those who chose to forego purchase of a drug benefit would generally be younger beneficiaries who do not anticipate significant drug expenditures in the near term and for whom the premium they would have to pay would exceed the value of the drug coverage to them perhaps for several years. Those who chose to purchase the drug benefit would be those most likely to need it, and this in turn would drive up the premium of the benefit, pricing it out of reach for many of those who need it the most.

On the other hand, there is no reason why the government?s subsidy rate for a new drug benefit has to be the same as the government?s subsidy rate on the current Medicare benefits package. And in light of the substantial cost of a meaningful drug benefit and the financing challenges confronting Medicare on its current benefits package, it is advisable to set the government subsidy rate for a drug benefit significantly lower--no larger than the 50% necessary to encourage the majority of beneficiaries to participate.

On policy grounds, a catastrophic drug benefit, which has a large upfront deductible but no overall cap, is preferable to a capped drug benefit with a

small deductible. A catastrophic approach would direct the coverage to those who need it the most and would discourage demand for non-essential drugs, a problem which the HMOs have encountered. However, a front-end approach is likely to more popular with beneficiaries and with a low overall cap would cost less than a catastrophic approach.

The cost of adding a meaningful drug benefit to the Medicare programeven a limited front-end onewould be substantialin the order of $10 billion to $24 billion a year. (According to recent analysis of five possible drug benefits by the non-partisan and respected National Academy of Social Insurance, the costs to Medicare in the first full year of the drug benefit would be between $17 billion and $24 billion.) There is no credible evidence that efficiency-enhancing reforms of Medicare would generate enough savings to pay for a new drug benefittherefore, some additional source of revenue would be required. (I support the Administration?s proposal of dedicating a fraction of projected surpluses to pay for new drug coverage.)

The addition of a drug benefit to Medicare would raise concerns from the drug industry about the imposition of price controls on its productsafter all, if the government controls the prices it pays for all other Medicare benefits, then it follows that the government will try to control the prices of a new drug benefit. To ease such concerns and the opposition they engender, a Medicare drug benefit should be designed and managed in ways comparable to private managed care plan coverage. In particular, HCFA drug payments should based on payments and formularies available in the private market, without recourse to price controls or rebates.

MEDICARE: BASE PACKAGE

I. BASE PACKAGE: $100 BILLION

(Savings in Billions, 2000-2009)

• **Modernizing Medicare and Making it More Competitive**	
◦ Traditional Medicare: Adding Private Sector Management Tools	-$14
◦ Competitive Pricing in Managed Care	-$10
• **Improving Medicare's Financing**	
◦ Income-Related Premium	-$25
◦ Dedicating 15 Percent of the Surplus to Strengthen Medicare ($350 billion / not counted towards savings)	
• **Modernizing Medicare's Benefit Structure**	
◦ Cost Sharing Changes	-$12
• **Provider Savings** (modified BBA extenders/subject to change)	-$40
• Other	
TOTAL	-$100

MODERNIZING TRADITIONAL MEDICARE

- **Goal**: Give traditional Medicare effective private sector cost management tools, to help the program constrain costs and become more efficient.

- **Options**: A number of provisions that save about $14 billion over 10 years, including:
  - Competitive Bidding and Negotiated Pricing Authority
  - Preferred Provider Arrangements
  - Other Contracting Reforms

- **Issues**:
  - Unanimously supported by Medicare Commission and elite validators
  - Providers will oppose

COMPETITION IN MANAGED CARE

- **Goal**: Improve competition and efficiency without achieving savings through traditional plan premium increases
- **Option**:
  - Allow beneficiaries to pay reduced premiums for choosing low-cost private plans
  - Replaces competition on extra benefits with price competition (as under all competitive options, including Breaux-Thomas)
  - Maintains current beneficiary contribution towards Medicare Part B premium
  - Savings: $10 billion from 2004-09 (Begins in 2004)
- **Issues**:
  - The removal of indirect subsidies for supplemental benefits would be criticized by industry
  - Base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough

INCOME-RELATED PREMIUM

- **Goal:** Make Medicare financing more progressive and achieve savings for prescription drugs

- **Option:**
  - Begins at $80,000 for a single, $100,000 for a married beneficiary, indexed to inflation
  - Saves about $25 billion over 10 years, and affects about 2 million beneficiaries
  - Indexed to inflation, does not limit subsidy altogether (to avoid wealthy flight), and administered by Treasury

- **Issues:**
  - Opposed by some base Democrats because "inconsistent" with traditional social insurance construct and considered a move towards means testing Medicare
  - The definition of "high income" may not be aggressive enough for conservative Democrats

COST SHARING

- **Goals:** Rationalize current policies and / or produce savings for drug benefit
- **Options:**
  - Eliminate all preventive cost sharing:
  - Add 20% lab coinsurance
  - Change nursing home cost sharing
  - Index Part B deductible
  - Home health copay (advisors recommend not including)
- **Issues:**
  - Beneficiaries should contribute since we are adding a valuable prescription drug benefit
  - Could be criticized nonetheless as imposing new burdens on beneficiaries

PROVIDER SAVINGS

- **Goals:** Help offset cost of prescription drug benefit and possibly increase early-year spending to appease provider groups

- **Options:**
  - Extending expiring Balanced Budget Act provisions from 2003-2009;
  - Modifying and moderating extenders; and/or
  - Moderating BBA 1997 reductions in the early years (2000-2002) administratively and/or legislatively

- **Issues:**
  - Opening up the BBA could lead to an unraveling of it, and start a "bidding war"
  - If the plan does not smooth out the BBA, it could be difficult to launch

HOW THE PRESIDENT'S FRAMEWORK FOR MEDICARE WOULD WORK

Budget surpluses would be used to reduce the debt held by the public. The Medicare Trust Fund would receive bonds that would extend its solvency. And new safeguards would protect these funds from being used for other purposes. Here is how the President's framework would work step by step:

- **Step 1 -- Reduce the Debt:** The Treasury would use 15 percent of the budget surpluses we now project to pay down $686 billion in publicly held debt over the next 15 years, reducing the government's demands on the credit market.

- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).

- **Step 3 -- Lock-Box Protections:** Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

Like a Thrifty Family: The President's framework is like a family that pays off credit card debt now so that they will not have monthly bills to pay later. When its children get ready for college, the family can take the money that they would have been spending each month on the credit cards and use it to help with college. In contrast, the Republican budget, with its expanding tax cuts, is like a family that goes on a spending spree on credit that comes due just when their children reach college age.

WHAT WOULD HAPPEN IF THE SURPLUS IS USED FOR A TAX CUT RATHER THAN FOR MEDICARE

- **Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases and/or tax increases to extend the life of the Trust Fund.**

- **The Republican Budget Neglects Medicare:** The Republican budget fails to extend the life of Medicare by one day, fails to set aside even one penny of the surplus to strengthen Medicare, fails to guarantee any specific allocation for Medicare, and fails to make a rock-solid commitment to debt reduction. While it ignores Medicare, the Republican budget also fails to strengthen and extend the life of the Social Security Trust Fund; undermines key investments in our children, the environment, and law enforcement -- forcing cuts of 10 percent in 2000 and more than 20 percent in 2004; and chooses instead large tax breaks targeted to the wealthy.

- **Using the surplus for tax cuts would have the following effects**:

  - **Effect # 1:** It would create permanent and growing federal government obligations.

  - **Effect # 2:** It would allow federal debt and interest costs to continue at high levels.

  - **Effect # 3:** It would yield no extension of the life of the Medicare Trust Fund.

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

MYTH: The President's framework increases the future obligations of the government.

FACT: We already have a commitment to pay benefits to current workers when they retire. The President's framework does not increase these benefits. Instead, it pays down debt and frees up resources so that we can better meet our existing obligations.

MYTH: By providing additional funds to the Medicare Trust Fund, the framework creates a commitment to pay benefits after 2015.

FACT: We now have both the commitment and the fiscal resources to pay benefits through 2015; after that we have resources to pay part of the benefits for many years to come. The President's framework provides the additional resources to pay benefits for roughly another decade after that.

MYTH: The bonds in the Medicare Trust Fund will be merely IOUs, just an unenforceable paper promise.

FACT: Treasury bonds convey the soundest promise in the world -- the full faith and credit of the United States. The federal government has never failed to honor Treasury bonds. One can imagine no better guarantee of paying a debt. As well, the framework creates the fiscal soundness and additional resources that will help make it easier to honor those obligations when they come due.

MYTH: The President's framework will have no effect on the unified budget surpluses or the on-budget surpluses and therefore have no effect on the debt held by the public.

FACT: The President's framework would lock in $686 billion from the unified surplus for debt reduction that, under the Republican plan, would go for tax cuts, not debt reduction or Medicare. Merrill Lynch praised the President's overall strategy: "Allocating a portion of the budget surpluses to debt reduction, as the President proposes, is a conservative strategy that makes sense. Reduced debt will result in increased national savings, lower interest rates, and stronger long-term economic growth than would otherwise be the case." (Merrill Lynch, February 10, 1999).

MYTH: Because the President's framework gives a dollar in bonds to the Trust Fund for every dollar of debt reduction, it does not really pay down the total government debt.

FACT: The President's framework pays down debt held by the public exactly as much as paying down the debt without crediting the trust fund. Thus, it creates the same economic

THE PRESIDENT'S FRAMEWORK FOR MEDICARE: HOW IT WORKS IN THE BUDGET

The President's framework ensures that we protect and extend the solvency of Social Security and Medicare before taking on new obligations. The framework would lock in our commitment to debt reduction and guarantee the benefits of debt reduction for Social Security and Medicare.

- **President's Commitment to Addressing Medicare's Long-Term Solvency**: The President has an unparalleled record of strengthening and improving Medicare. When he took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be bankrupt this year -- 1999. Today, the Trust Fund is projected to be solvent through 2015 and its growth rate per beneficiary is below that of private health spending. However, Medicare's Trust Fund will become insolvent about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries. As such, the President has proposed a framework for dedicating part of the surplus to Medicare. This will be combined with a plan to modernize the program, make it more efficient and competitive, and add a long-overdue prescription drug benefit.

- **A Time-Tested Use of Funds:** The President's framework would extend the solvency of the Medicare Trust Fund by another decade by adding new financial resources -- about $690 billion over the next 15 years. These bonds will guarantee that Medicare will get the benefits from the fiscal improvement that debt reduction and lower net interest costs will bring about.

- **Lower Interest Costs:** By reducing debt held by the public, the framework would dramatically reduce the amount of net interest that the government would have to pay to service debt in the future. This reduction in net interest costs will help free up the resources to allow the government to meet its existing Social Security and Medicare commitments.

- **A Stable Share of the Economy:** Social Security and Medicare costs are projected to rise in the future, but the reduction in net interest costs resulting from the President's framework for Social Security and Medicare will offset those rising program costs. As a result, under the President's framework, the sum of Social Security, Medicare, and net interest costs will remain the same (or smaller) share of the economy through 2020.

The Sum of Social Security, Medicare, and Net Interest Payments as a Share of GDP

Year	Share of GDP
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- **Additional Benefits to the Economy:** These results flow from the simple benefits of carrying less debt. They do not depend on improvement in the economy, even though most economists project that a significant improvement will result from reduced federal government borrowing. As the government borrows less (that is, reduces its demand for credit), interest rates (the price of credit) should come down, making private sector investment more economical, and increasing economic growth, yielding a fiscal dividend of increased budget surpluses in addition to the effects of declining net interest costs.

HOW THE PRESIDENT'S FRAMEWORK FOR MEDICARE WOULD WORK

Budget surpluses would be used to reduce the debt held by the public. The Medicare Trust Fund would receive bonds that would extend its solvency. And new safeguards would protect these funds from being used for other purposes. Here is how the President's framework would work step by step:

- **Step 1 -- Reduce the Debt:** The Treasury would use 15 percent of the budget surpluses we now project to pay down $686 billion in publicly held debt over the next 15 years, reducing the government's demands on the credit market.

- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).

- **Step 3 -- Lock-Box Protections:** Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

Like a Thrifty Family: The President's framework is like a family that pays off credit card debt now so that they will not have monthly bills to pay later. When its children get ready for college, the family can take the money that they would have been spending each month on the credit cards and use it to help with college. In contrast, the Republican budget, with its expanding tax cuts, is like a family that goes on a spending spree on credit that comes due just when their children reach college age.

WHAT WOULD HAPPEN IF THE SURPLUS IS USED FOR A TAX CUT RATHER THAN FOR MEDICARE

- **Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases and/or tax increases to extend the life of the Trust Fund.**

- **The Republican Budget Neglects Medicare:** The Republican budget fails to extend the life of Medicare by one day, fails to set aside even one penny of the surplus to strengthen Medicare, fails to guarantee any specific allocation for Medicare, and fails to make a rock-solid commitment to debt reduction. While it ignores Medicare, the Republican budget also fails to strengthen and extend the life of the Social Security Trust Fund; undermines key investments in our children, the environment, and law enforcement -- forcing cuts of 10 percent in 2000 and more than 20 percent in 2004; and chooses instead large tax breaks targeted to the wealthy.

- **Using the surplus for tax cuts would have the following effects:**

  - **Effect # 1:** It would create permanent and growing federal government obligations.

  - **Effect # 2:** It would allow federal debt and interest costs to continue at high levels.

  - **Effect # 3:** It would yield no extension of the life of the Medicare Trust Fund.

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

MYTH: The President's framework increases the future obligations of the government.

FACT: We already have a commitment to pay benefits to current workers when they retire. The President's framework does not increase these benefits. Instead, it pays down debt and frees up resources so that we can better meet our existing obligations.

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MEDICARE PRINCIPALS' MEETING
DRAFT: MAY 24, 1999

DB -
Still changing
not gone
to Gene
Yet

I. Budget Neutral / Paid-For Options

- Medicare Buy-In
- Medicare "Medigap" Option
- Medicare Board
- Coordinated Care for Dual Eligibles [May be Dropped] → SB.

II. Base Package and Additions

I. BUDGET-NEUTRAL OPTIONS
MEDICARE "MEDIGAP" OPTION: BACKGROUND

- **Limited benefit causes beneficiaries to purchase supplemental insurance:** Medicare's benefits are less generous than 4 of 5 private employers' since it lacks prescription drug coverage, has a high hospital deductible, and has no catastrophic cost protection. For this reason, about 85 percent of Medicare beneficiaries have additional sources of health insurance coverage. Some beneficiaries – one fourth of Medicare managed care enrollees and one-seventh of those in retiree health plans – also buy Medigap, resulting in duplication of coverage.

- **Expensive and declining**: The typical Medigap premium for a 65-year old is from $80 to $100 per month (without drug coverage). It can be much higher in certain areas or for older or sicker people. The proportion of beneficiaries covered by Medigap declined by one-fourth in the last decade. Although more affordable, retiree health coverage has also been declining, and premiums paid for by beneficiaries has been increasing.

- **Supplemental insurance is inefficient**: Individual supplemental insurance typically has mark-ups of 30 percent, compared to 10 percent for employer insurance and 2 percent for Medicare. Moreover, Medigap provides first-dollar coverage, resulting in higher Medicare use and costs than beneficiaries in retiree plans which usually have some type of cost sharing.

MEDICARE MEDIGAP OPTION

- **New Medicare Option:** Optional Medicare policy that:
  - Eliminates hospital deductible and copays, since hospitalization is rarely optional
  - Reduces most cost sharing from 20 percent to nominal levels (e.g., $10 per physician visit, $15 per nursing home day); and
  - Caps out-of-pocket cost sharing liability at $2,500 per year.

  Premium: $50 to $60 per month according to preliminary estimates

  Enrollment: When they become eligible for Medicare; when they transition out of other forms of supplemental coverage (private Medigap, retiree coverage).

  Private Medigap: Allowed to offer same plan in addition to existing options (which may have to be modified to reflect cost sharing changes).

- **Pros**:
  - Affordable, rationale alternative to expensive, inefficient Medigap
  - Mitigates against cost sharing increases
  - Viewed as structural reform – one of major points for premium support advocates and economists. Moves towards private sector benefits package

- **Cons**:
  - Opposed by insurers and conservatives as a government take-over
  - Complicated policy that may not be worth the political pain

MEDICARE BOARD

- **Commission Proposal: Medicare Board**. Stemming from IRS-like concerns about HCFA, the Commission proposed to create a new Board outside of Medicare to administer Medicare. Appointed by the President and confirmed by the Senate, the members would represent health care providers, beneficiaries, and working taxpayers.

- **Functions of the Board:**

  - Certify plans and negotiates over covered benefits and premiums

  - Operate annual open enrollment process, including information distribution

  - Enforce quality and program integrity requirements (including traditional Medicare)

- **HCFA Role**: Overall program management would be transferred to the Board. HCFA would remain responsible for the traditional program only. It would be treated as any other private health plan, and would have to develop a reserve fund and rely only on capitation payments to provide services.

ALTERNATIVE TO THE MEDICARE BOARD

- **Modernized Medicare Administration:**
  - New public/private boards to (1) improve coverage policy; (2) advise on management; and (3) review and strengthen beneficiary education efforts.
  - Contracting reform to improve ability to use private sector for certain activities
- **Pros:**
  - Improves rather than replaces management; targets areas for private involvement
  - Does not create duplicate, unaccountable bureaucracy that could increase costs
- **Cons:**
  - May not go far enough Republicans and conservative Democrats
  - Already in the budget; could be perceived as dressing up existing action

COORDINATED CARE FOR DUAL ELIGIBLES

- **Medicare-Medicaid dual eligibles**: About 4 million beneficiaries are fully eligible for both programs (another 2 million receive Medicaid coverage of premiums and, in some cases, cost sharing). Despite representing only 16 percent of beneficiaries, they account for about 30 percent of Medicare and 35 percent of Medicaid costs.

- **Duplicative and uncoordinated care:** Since dual eligibles typically are sicker, older, and lower income, the problems with having different sources of coverage are more serious.

  - **Complicates clinical and management coordination:** Typically, Medicare and Medicaid rely on different providers to authorize health care service use. Medicare providers have no systematic way to know that a beneficiary is enrolled in Medicaid.

  - **Different financial incentives and Medicare "maximization":** Medicare and Medicaid differ in reimbursement and coverage policies, especially related to managed care. Also, some state have developed programs to ensure that providers bill Medicare whenever possible.

  - **Separate pools of money not being managed in ways that are best for beneficiaries and best for the program.** [add]

OPTIONS FOR COORDINATING CARE FOR DUAL ELIGIBLES

- **Identification and assessment of dual eligibles**: Medicaid would notify Medicare when it enrolls a dual eligible. Newly-enrolled dual eligibles would be sent information on their coverage and could receive a Medicare clinical assessment. This assessment, designed by geriatricians, would aid in the early detection of high risk beneficiaries who could benefit from care coordination. Can we do more?

- **Demonstration of care coordination models**: Medicare would fund a demonstration of three models to pay for care coordination: (a) a managed care option, where Medicare and Medicaid pay capitation amounts to a single plan for coordination of care; (b) a "gatekeeper" model, where a primary care provider authorizes Medicare and Medicaid services; and (c) a coordinator model, where a provider suggests but does not authorize services.

- **Pros**:
  - Improves care and allocates resources more efficiently and, in so doing, reduces cost
  - Responds to Congressional proposals to give states Medicare managed care payments – can argue that coordination does not require capitation

- **Cons**:
  - Depending on scope of our proposals, it could look modest relative to Congressional proposals
  - States would object to data requirements, focus on Medicare rather than Medicaid

II. BASE PACKAGE

(NOTE: All estimates preliminary / subject to change. 2000-2009 estimates in billions)

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE *	**-$343**

OPTIONS:

Prescription Drug Benefit Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start $19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000	+$160
Modernizing Traditional Medicare	-$14
Additional Provider Savings (modified BBA extenders)	-$45
Income-Related Premium ($80/100,000)	-$25
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Budget Neutral / Paid for Policies Medicare Buy-In, Medigap Option, Dual Eligible Coordination, etc.	
TOTAL:	**+$70**

** Does not offset costs*

ADDITIONS (Incremental costs of polices in bilions)

SAVINGS OPTIONS (Billions)	10-Yr	SPENDING OPTIONS	10-Yr
State and Employer Maintenance of Effort on Prescription Drugs	-$10-20	Balanced Budget Act Fixes	+$10-25
Income-Related Premium for Prescription Drug Benefit	-$5	Drug Benefit in 2001 (rather than 2002)	[getting]
Managed Care Competition	-$10	Drug Benefit in 2002, Catastrophic Coverage in 2006	[getting]
Additional Provider Savings	-$12	Drug Benefit in 2001, Catastrophic Coverage in 2006	[getting]
More Aggressive Income-Related Premium ($50/75,000)	-$15	Drug Benefit in 2002, Catastrophic Coverage in 2002	[getting]
$5 Home Health Copay (60 visits)	-$7		
Indexing Part B Deductible	-$5		
25% of Medicare's Surplus	-$85		
33% of Medicare's Surplus	-$115		
$0.45 Tobacco Tax (above budget)	-$41		
Other Revenues			

OPTION 1: FULLY FINANCED BY SAVINGS

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$343**

OPTIONS:

Prescription Drug Benefit	***+$115-20??***
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start	
$29 Premium in 2002 (50%), Covers 50% of Costs up to $5,000	
State and employer maintenance of effort	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Add Capped Home Health Copay	**-$7**
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (modified BBA extenders)	-$45
Income-Related Premium ($80/100,000)	-$25
Budget Neutral / Paid for Policies (see base package)	
TOTAL:	**+$x**

OPTION 2: ADDITIONAL NON-SURPLUS FINANCING

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$343**
OPTIONS:	
Prescription Drug Benefit	**+$160**
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start $19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000, ***20% after State and employer maintenance of effort; income-related premium***	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Add Capped Home Health Copay	**-$7**
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (**full** BBA extenders)	**-$57**
Income-Related Premium ($80/100,000)	-$25
Tobacco Tax: $0.45 on top of budget	**-$41**
TOTAL:	**+$0 BILLION**

OPTION 3: SURPLUS FINANCING

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$258**
OPTIONS:	
Prescription Drug Benefit	**+$180**
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, ***2001 start*** $19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000, ***20% after State and employer maintenance of effort; income-related premium***	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (modified BBA extenders)	-$45
Balanced Budget Act Fixes	**+$10**
Income-Related Premium ($80/100,000)	-$25
25 Percent of Medicare's Dedicated Surplus	**-$85**
TOTAL:	**-$5**

MEDICARE PRINCIPALS' MEETING

MAY 28,1999

I. **PROVIDER SAVINGS**:

- **Spending: BBA Administrative / Legislative Fixes: 2000-2002**
- **Savings: Extending Certain BBA Policies: 2003-2009**
- **Strategy**

II. **COMPETITION**

III. **DISCUSSION OF PRESENTATION FOR 6/1/99 MEETING**

I. MEDICARE PROVIDER PAYMENTS: BALANCED BUDGET ACT: NEAR-TERM SPENDING (2000-2002)

	ADMINISTRATIVE OPTIONS (COSTS FOR FY 2000-09, $ IN BILLIONS)		LEGISLATIVE OPTIONS (COSTS FOR FY 2000-09, $ IN BILLIONS)	
HOSPITALS	Delay transfer policy 2 yrs (or delay forever) [1,2]	+1.6 (+8.9)	IME at 6.5% in 00[1]	+0.1
			IME at 6.5% 00-01[1]	+1.5
	Daschle Rural Options	*Modest*	Changing outpatient policy on multiple procedures	+4.0
	Outpatient (transition, delay)[1,2]	*Modest*	DSH carve-out	+x
NURSING HOMES	Delay implementation of therapy caps	*Modest*	No Update Cut in 00	+3.4
			Therapy caps to $2,200	+2.8
			Repeal therapy caps	+6.0
			Option of full national rates	+0.5
			Increase top RUGS	+1.0
HOME HEALTH	Extend time period for overpayment to 3 yrs	*Modest*	Repeal Fall '99 cuts	+3.3
	Change surety bond	*Modest*	Reduce halve payment cut	+9.7
MANAGED CARE	None recommended		Increase payment rates	+10
			DSH carve-out	-x

1. Helps Academic Health Centers. Also DSH carve-out
2. Helps Rural Hospitals

BALANCED BUDGET ACT: LONG-TERM SAVINGS 2003-2009

POLICY	BBA 2002 POLICY (SAVINGS FOR FY 2000-09, $ BILLIONS)		ALTERNATIVE (COSTS FOR FY 2000-09, $ IN BILLIONS)		
Hospital					Change
PPS Update	Update – 1.1	-35.4	Update – 1.0 Rural Update – 0.5	-29.9	+3.9 +2.1
PPS Exempt Update	Proportional Update	-4.7	*Same*	-4.7	--
PPS Capital	2.1% Reduction	-1.8	1.0% Reduction	-0.9	+0.9
PPS Exempt Capital	15% Reduction	-0.7	*Same*	-0.7	--
DSH Reduction	Up to 5% cut	-1.4*	*No extender*	--	+1.4*
Outpatient Update	Update – 1.0	-8.0	*Same* Rural Update – 0.5	-7.5	+0.5
Nursing Home	Update – 1.0	-2.1	*No extender*	--	+2.1
Home Health	Update x	na	*No extender*	--	--
Hospice	Update – 1.0	-1.2	*Same*	-1.2	--
Lab	Freeze	-3.5	Update – 1	-1.1	+2.5
Ambulatory Surg Cnt	Update – 2	-0.3	Update – 1	-0.2	+0.1
Ambulance	Update – 1	-0.4	*Same*	-0.4	--
DME, PEN, Prosthetics & Orthotics:	Freeze for DME, PEN P & O: Update - 1	-2.4	Update – 1 for DME, PEN, P & O	-1.1	+1.3
Interactions		+3.6		+3.6	0
TOTAL	**TOTAL**	**-57.5**	**TOTAL**	**-44.1**	**+13.4**

NOTE: Option to extend permanently rather than 2009. Estimates preliminary /not all from actuaries

OPTIONS FOR SETTING GOVERNMENT AND BENEFICIARY CONTRIBUTIONS FOR PRIVATE PLANS

- **Option 1: Based on Average Premium of All Plans**: As under current law, the beneficiary premium for traditional Medicare would be set at 12 percent of traditional program costs. The government contribution for private plans would be based on the enrollment-weighted average of all plan bids (including traditional Medicare), with payments capped at 96 percent of traditional Medicare costs.

- **Option 2: Based on Traditional Program Costs:** As under current law, the beneficiary premium for traditional Medicare would be set at 12 percent of traditional program costs. The government contribution for private plans would also be based on traditional Medicare costs, with a "discount" (i.e., lower government payment) for private plans consistent with current law.

II. COMPETITION

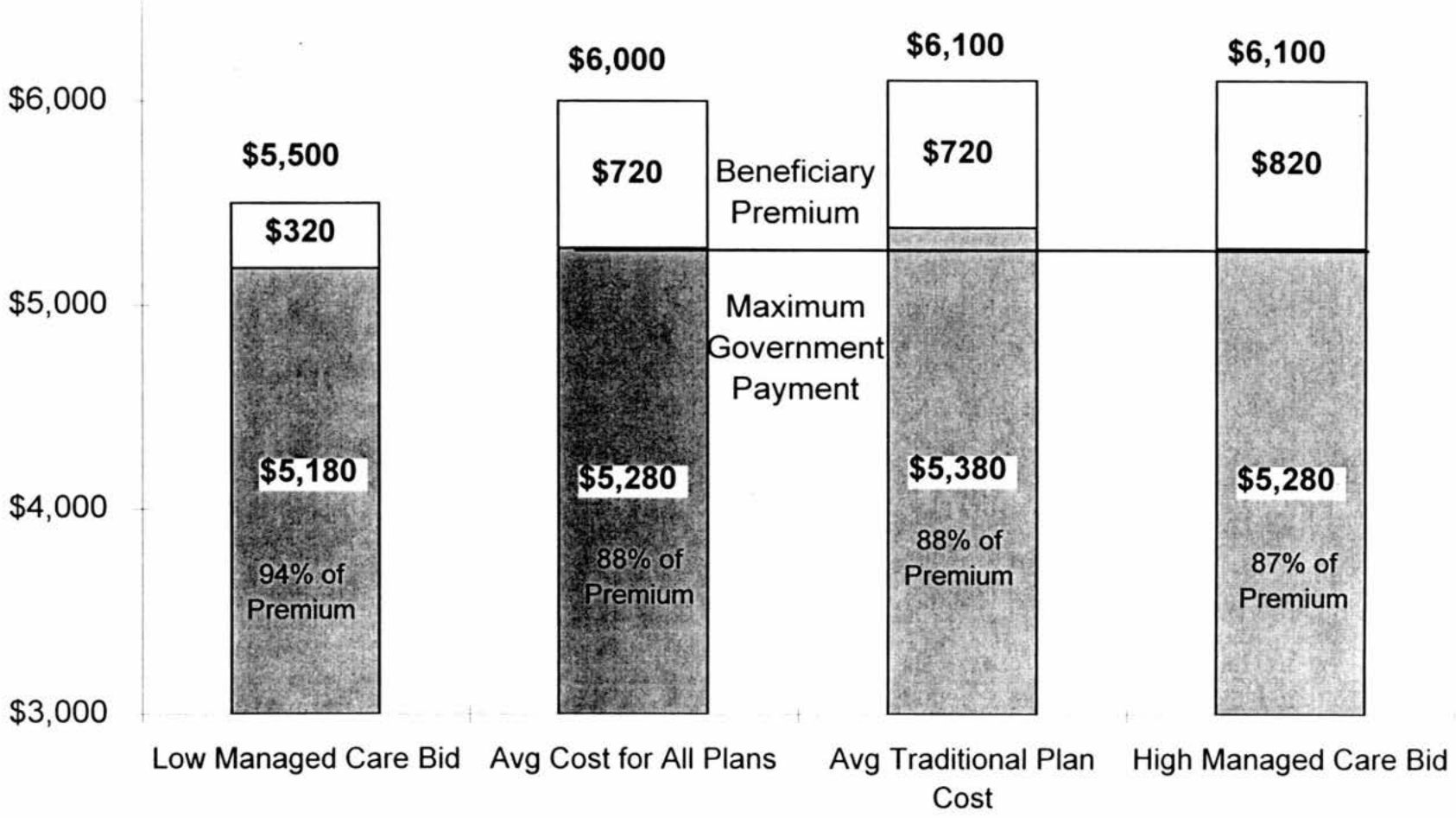
- **Goal**: Improve competition and efficiency without achieving savings through traditional plan premium increases
- **Assumption in all options**:
  - No premium increases for traditional Medicare
  - Guarantees defined set of benefits, including prescription drug benefit
  - Replaces competition on extra benefits with price competition (as under all competitive options, including Breaux-Thomas)
  - Implemented in 2004 with full risk & geographic adjustment
- **Issues with all options**:
  - Could be perceived as a double standard – traditional program is the basis of payments, but traditional program premium is protected.
  - Little savings: $10 billion from 2004-09 (Begins in 2004)

Option 1: Payments Based on Average of All Plans

- **Pros**
  - For conservative Democrats, resembles Breaux-Thomas proposal without the major problem – increasing traditional Medicare premium.
  - Saves from both reduced payments to private plans and increased enrollment, which lowers the average and thus the private plan payment schedule.
- **Cons**
  - Because it is closer to the original Breaux-Thomas model, it is more vulnerable to being modified into an unacceptable premium support plan.
  - Differs from Option 2 if private plan enrollment is high and bids are low, in which case government payments to private plans would be lower. Although this might produce greater savings, it would also distort price competition by making the traditional program a better deal relative to a private plan with the same costs, reducing private plan enrollment.

Option 1: Payments Based on <u>All Plans' Average</u>

Traditional Medicare Premium Protected / Private Plans Not



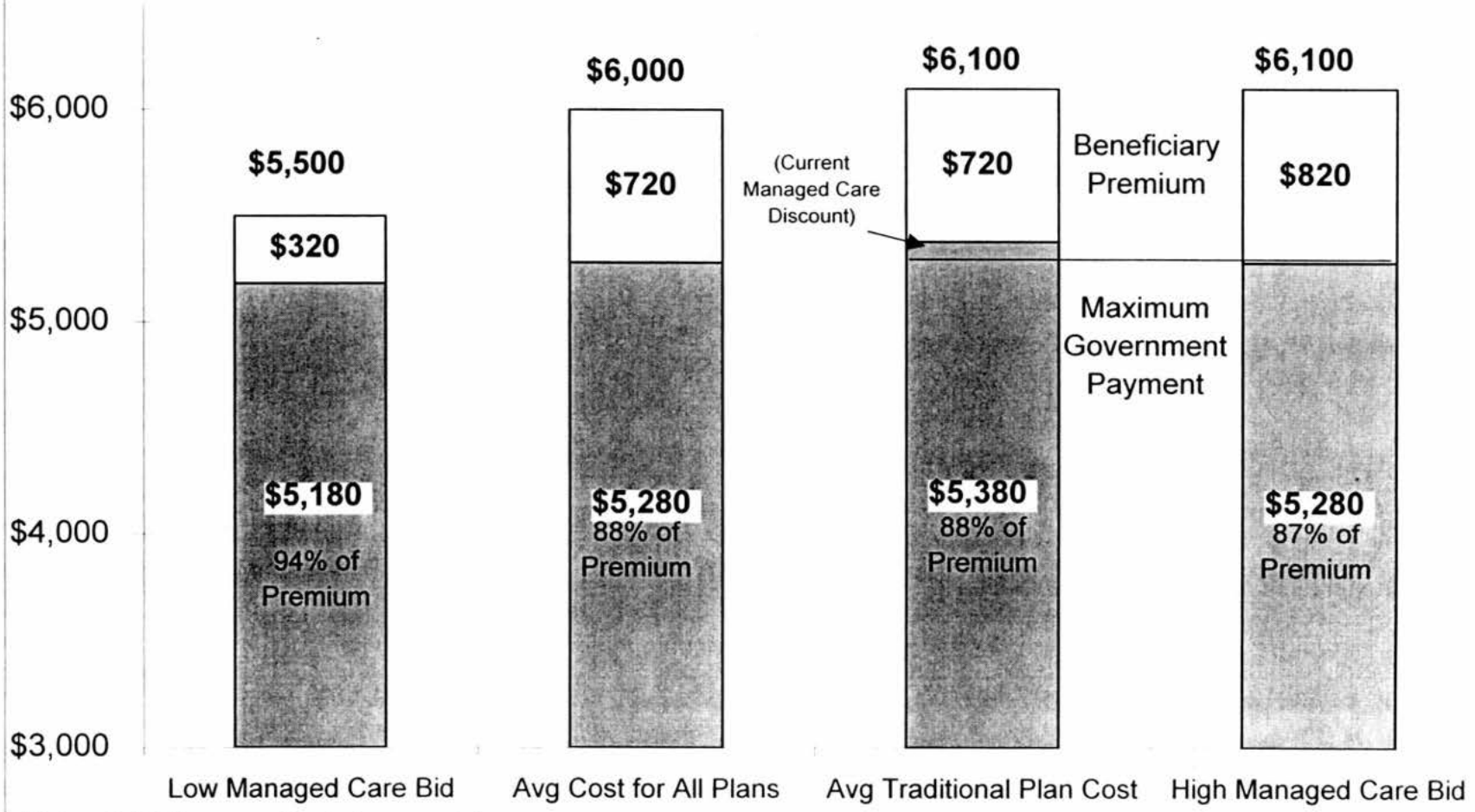
Note: $720 is approximately current law

Option 2: Payments Based on Traditional Program Only

- **Pros**
  - Price competition among all plans, including traditional Medicare, limiting the criticism that the traditional program is getting a special deal.
  - Requires no special rules to protect the traditional premium, making it less vulnerable to movement towards the Breaux-Thomas proposal. At the same time, it leaves Option 1 available if compromise towards Breaux-Thomas is necessary.
- **Cons**
  - Could be viewed as too incremental relative to Breaux-Thomas.
  - Private plan payment schedule is more linked to the traditional program costs than Option 1. This provides more incentives for beneficiaries to switch to a private plan if traditional program costs rise (leading to government and beneficiary savings from greater price competition) but also means higher payments to private plans in this case.

Option 2: Payments Based on Traditional Medicare

Traditional Medicare Premium Automatically Protected



Note: $720 is approximately current law.

Under current law, managed care plans are paid a discounted amount based on the local traditional fee-for-service plan costs

THE PRESIDENT'S FRAMEWORK FOR MEDICARE:
HOW IT WORKS IN THE BUDGET, DRAFT: April 14, 1999

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- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).

- **Step 3 -- Lock-Box Protections:** Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

Like a Thrifty Family: The President's framework is like a family that pays off credit card debt now so that they will not have monthly bills to pay later. When its children get ready for college, the family can take the money that they would have been spending each month on the credit cards and use it to help with college. In contrast, the Republican budget, with its expanding tax cuts, is like a family that goes on a spending spree on credit that comes due just when their children reach college age.

WHAT WOULD HAPPEN IF THE SURPLUS IS USED FOR A TAX CUT RATHER THAN FOR MEDICARE

- **Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases and/or tax increases to extend the life of the Trust Fund.**

- **The Republican Budget Neglects Medicare:** The Republican budget fails to extend the life of Medicare by one day, fails to set aside even one penny of the surplus to strengthen Medicare, fails to guarantee any specific allocation for Medicare, and fails to make a rock-solid commitment to debt reduction. While it ignores Medicare, the Republican budget also fails to strengthen and extend the life of the Social Security Trust Fund; undermines key investments in our children, the environment, and law enforcement -- forcing cuts of 10 percent in 2000 and more than 20 percent in 2004; and chooses instead large tax breaks targeted to the wealthy.

- **Using the surplus for tax cuts would have the following effects**:

  - **Effect # 1:** It would create permanent and growing federal government obligations.

  - **Effect # 2:** It would allow federal debt and interest costs to continue at high levels.

  - **Effect # 3:** It would yield no extension of the life of the Medicare Trust Fund.

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

MYTH: The President's framework increases the future obligations of the government.

FACT: We already have a commitment to pay benefits to current workers when they retire. The President's framework does not increase these benefits. Instead, it pays down debt and frees up resources so that we can better meet our existing obligations.

MYTH: By providing additional funds to the Medicare Trust Fund, the framework creates a commitment to pay benefits after 2015.

FACT: We now have both the commitment and the fiscal resources to pay benefits through 2015; after that we have resources to pay part of the benefits for many years to come. The President's framework provides the additional resources to pay benefits for roughly another decade after that.

MYTH: The bonds in the Medicare Trust Fund will be merely IOUs, just an unenforceable paper promise.

FACT: Treasury bonds convey the soundest promise in the world -- the full faith and credit of the United States. The federal government has never failed to honor Treasury bonds. One can imagine no better guarantee of paying a debt. As well, the framework creates the fiscal soundness and additional resources that will help make it easier to honor those obligations when they come due.

MYTH: The President's framework will have no effect on the unified budget surpluses or the on-budget surpluses and therefore have no effect on the debt held by the public.

FACT: The President's framework would lock in $686 billion from the unified surplus for debt reduction that, under the Republican plan, would go for tax cuts, not debt reduction or Medicare. Merrill Lynch praised the President's overall strategy: "Allocating a portion of the budget surpluses to debt reduction, as the President proposes, is a conservative strategy that makes sense. Reduced debt will result in increased national savings, lower interest rates, and stronger long-term economic growth than would otherwise be the case." (Merrill Lynch, February 10, 1999).

MYTH: Because the President's framework gives a dollar in bonds to the Trust Fund for every dollar of debt reduction, it does not really pay down the total government debt.

FACT: The President's framework pays down debt held by the public exactly as much as paying down the debt without crediting the trust fund. Thus, it creates the same economic

benefits of lower net interest payments, higher savings, higher incomes, and additional revenue. The difference is that the President's framework guarantees Social Security and Medicare the benefits of debt reduction. The President believes we must meet our existing commitments to these programs before we think of allocating the benefits of debt reduction to other purposes.

MYTH: The money devoted to Medicare is already committed to the Social Security Trust Fund.

FACT: The money devoted to Medicare is in addition to the funds devoted to Social Security. Over the next 15 years, the President's framework devotes to Social Security an amount equivalent to the Social Security surplus over that period. By 2014, the President's framework would just about double the balances that the Social Security Trust Funds would have under current law. The 15 percent that the framework devotes to Medicare represents funds in addition to those.

MYTH: The President's framework does not devote 15 percent of the budget surpluses to the Medicare program, as the federal budget process does not provide a mechanism for setting aside current surpluses for future obligations.

FACT: We propose changes in the budget rules to lock in the transfer of 15 percent of the surplus to Medicare. The President's framework would dedicate $686 billion to debt reduction and the Medicare Trust Fund. The independent career Medicare actuary -- repeatedly cited by Republicans in 1995 -- confirmed that this proposal would extend the life of the Trust Fund by roughly a decade. Paying off debt and reducing future interest costs is a real way to create the resources we will need to pay Medicare benefits in the future. For example, even in 2020, net interest savings under the President's framework will more than offset the anticipated increase in Social Security and Medicare payments.

MYTH: Transferring IOUs will require raising taxes, cutting benefits, or increased gross debt to pay for Medicare in the future.

FACT: OMB projects that there will be a surplus well into the middle of the next century even after making full payment of currently promised Social Security and Medicare benefits. By paying down the publicly held debt, the President's framework reduces net interest costs to the federal government and increases economic growth. Thus, even after using the surplus to pay for Medicare and Social Security, there will still be a budget surplus. In contrast, if the nation were to use the surplus for tax cuts and still meet our future obligations to Medicare, then we would be forced to raise the payroll tax, make tough benefit cuts, or take other difficult measures.

- Breast - drop eligibility age
- extend extended 10 yrs
- 15%
- Competition
- Drug

"We need more Dems

- Get money out of Campaign: - Lose Citizens United Ruling
  - Rx drug 25% subsidy
  - no ↑ eligibility age
  - entitlement growth at 8%
  - House Republicans vote Democrats or / Blue Dog Dems (10)
  - Good policy =/ good politics
  - WANT Medicare Buy. ESSENTIAL
  - Knock out GME
  - Underestimate pension ↑
  - Bond / Test place it in

Sarah Bianchi →

DRAFT: MEDICARE PROVIDER POLICIES (Dollars in Billions, FY 2000-09)

PROVIDER	EXTENDERS		LEGISLATIVE FIX		ADMINISTRATIVE FIX	
Inpatient Hospitals	Commission: MB – 1.1 for 03-09:	-$35.4	IME: 6.5% in 00 (cl: 6.0%):	$0.1	Delay expansion of transfer policy from 10/1/00 to 03:	$1.6
	MB – 1.0 for 03-09:	-$31.5	IME: 6.5% in 00-01	$1.5	Delay forever:	$8.9
	MB – 1.0 for 03-09: Rural of –0.5:	-$29.4				
	PPS capital reduction of 2.1	-$1.8	DSH: Eliminate BBA DSH reduction for last 6 months of '00, FY 01 (4%) and FY 02 (5%):	$0.6	Rural: ease restrictions for reclassification	
	PPS-exempt update: BBA mix	-$4.7			Rural: study occupational mix in wage index	
	PPS-exempt capital reduction	-$4.7				
OPD	MB –1	-$8.0	Non-budget neutral transition to full national rates:	$0.8	Budget-neutral transition to full national rates	
					Delay implementation of volume control system	
					Rural: use inpatient wage index*	
Home Health			Repeal most update reductions:	$3.3	Increase time period for repayment of overpayments*	
			IPS: 7.5% reduction:	$9.7	Change surety bond provisions*	
SNF	MB – 1	-$2.1	Raise therapy caps:		Delay implementation of per bene caps (note: helps independent facilities more than SNFs)	
			To $2200:	$2.8		
			To $3000:	$6.0		
			Add third, $1500:	$2.0		
			Increase update in early years			
			Allow SNF to go to nat'l rates			
			Increase top 9 RUGS			
Hospice	MB – 1	-$1.2				
ASC	CPI – 2	-$0.3				
Ambulance	CPI – 1	-$0.4				
DME, PEN, Prosthetics & Orthotics	MB – 1	-$2.4				
Lab	Frozen	-$3.5				

* Already planning to do / in progress

MEDICARE PROPOSALS: ESTIMATES

(Trustees' 1999 Baseline, Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
TRADITIONAL PROGRAM SAVINGS												
Commission Package	0.0	0.0	-0.1	-1.7	-3.4	-5.5	-7.6	-10.0	-10.7	-11.4	**-5.2**	**-50.4**
Commission Package to 2009	0.0	0.0	-0.1	-1.7	-3.4	-5.5	-7.6	-10.1	-13.0	-16.0	**-5.2**	**-57.4**
Breakout of Package to 2009												
PPS Update	0.0	0.0	-0.1	-1.0	-2.1	-3.4	-4.7	-6.3	-8.0	-9.8	**-3.2**	**-35.4**
PPS Exempt Update	0.0	0.0	0.0	-0.1	-0.3	-0.5	-0.6	-0.8	-1.1	-1.3	**-0.4**	**-4.7**
PPS Capital	0.0	0.0	0.0	-0.2	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	**-0.4**	**-1.8**
PPS Exempt Capital	0.0	0.0	0.0	-0.1	-0.3	-0.5	-0.6	-0.8	-1.1	-1.3	**-0.9**	**-4.7**
SNF Update	0.0	0.0	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	**-0.1**	**-2.1**
Hospice Update	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	**-0.1**	**-1.2**
OPD Update	0.0	0.0	0.0	-0.1	-0.4	-0.7	-1.0	-1.4	-1.9	-2.5	**-0.5**	**-8.0**
Lab Update	0.0	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.6	-0.8	-1.1	**-0.3**	**-3.5**
ASC Update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	**0.0**	**-0.3**
Ambulance Update	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	**0.0**	**-0.4**
DME, PEN, P&O Update	0.0	0.0	0.0	0.0	-0.1	-0.2	-0.3	-0.4	-0.6	-0.8	**-0.1**	**-2.4**
Premium offset	0.0	0.0	0.0	0.1	0.2	0.3	0.5	0.7	0.9	1.2	**0.3**	**3.9**
Modifications												
Hosp MB -1 for 2003-09	0.0	0.0	0.1	0.2	0.2	0.4	0.6	0.6	0.8	1.0	**0.5**	**3.9**
Hosp MB -1, -0.5 rural for 2003-09	0.0	0.0	0.2	0.3	0.4	0.7	0.8	1.0	1.2	1.4	**0.9**	**6.0**
Hosp IME: 6.5% in 2000	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.3**	**0.3**
Hosp IME: 6.25% in 2000	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.1**	**0.1**
Hosp IME: 6.5% in 2000,01	0.2	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**1.5**	**1.5**
Hosp DSH: Repeal reductions	0.1	0.2	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	**0.7**	**0.7**
Hosp OPD: Add-on	0.0	0.3	0.3	0.2	0.0	0.0	0.0	0.0	0.0	0.0	**0.8**	**0.8**
Hosp Transfer: 3 year delay	0.0	0.7	0.8	0.1	0.0	0.0	0.0	0.0	0.0	0.0	**1.6**	**1.6**
Hosp Transfer: Delay forever	0.0	0.7	0.8	0.9	0.9	1.0	1.0	1.1	1.2	1.3	**3.3**	**8.9**
Therapy Caps: To $2,200	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.4	**1.0**	**2.8**
Therapy Caps: To $3,000	0.3	0.4	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	**2.3**	**6.0**
Therapy Caps: 3 caps $1,500	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	**0.8**	**2.0**
Home Health: Repeal '98 cuts	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.5	0.5	**1.1**	**3.3**
Home Health: 7.5% (not 15%) IPS	0.0	0.7	0.9	0.9	1.0	1.1	1.2	1.2	1.3	1.4	**3.5**	**9.7**
Modernizing Traditional Program	0.0	-0.6	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.6	**-3.9**	**-14.0**

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Potential Medicare Ideas Under Existing Authorities

(1) Inpatient Hospitals

(a) Delay implementation of discretionary authority to extend the transfer policy to additional DRGs, from 10/1/00 to a future time.

Note: This is a cost of roughly $4 to $5 billion over 5-years since both OACT and CBO scored savings from extension of the transfer to all DRGs, effective 10/1/00, though OACT had much larger savings than CBO.

(b) Encourage managed care plans to make DSH payment to hospitals when a managed care enrollee receives services in a DSH hospital. Make it easier for managed care plans to make the DSH payment by giving managed care plans the formula to determine the DSH add-on for specific hospitals.

Note: This is as far as we could go under existing authorities. GC has indicated that we cannot require managed care plans to make a DSH payment to a hospital. It is unclear whether a letter of encouragement from the intermediary would actually motivate managed care plans to make a DSH payment to a hospital.

(2) OPDs

(a) Reduce the impact of the OPD PPS on hospitals from 5.7% to 4.4% by changing the policy on multiple procedures. Beneficiaries would pay the full amount of coinsurance while Medicare would pay only half of the Medicare payment for the second procedure.

Note: This does not affect Medicare outlays; it only affects hospital revenues by increasing beneficiary coinsurance. Our ability to make this change is still being examined.

(b) Implement a time-limited transition to full OPD PPS at the same time that system is implemented. Two potential options are under development.

Note: Any transition policy under current law would need to be budget-neutral which would cause redistributions.

(c) Delay implementation of OPD PPS system provision to develop a method for controlling unnecessary increases in the volume of OPD services.

Note: While the statute requires that a volume control method be developed under the OPD PPS that is to be implemented beginning with 1999, it does not require implementation of a volume control mechanism.

(3) Home Health

(a) Increase the time period for repayment of HH-IPS overpayments from the recently established 1 year period to 3 years, with accrual of interest.

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(b) Decline to collect interest accrued, in whole or in part, on HH-IPS overpayments, on a case-by-case basis.

Note: A loose policy on collection of interest on overpayments would encourage as many home health agencies as possible to take advantage of perceived interest free loans.

(c) Use a national demonstration to reimburse home health agencies one-time costs for OASIS.

Note: We are still trying to figure out what would actually be demonstrated. If we cannot develop an actual demonstration, we would be mis-using the statutory demonstration authority as a back-door way to funnel money to home health agencies, a troublesome precedent since there would be few criteria to hold back other requests for demonstrations.

It is not clear how quickly home health agencies would receive any money for two reasons. First, a demonstration would need to go through Department and OMB clearances. Second, it is not clear that payment could be made before cost report settlement, unless a fixed payment were made to all agencies, including the approximately 30 percent of agencies with costs below the limits (which would result in double payments). A payment other than actual costs would likely be disputed by the industry as insufficient.

(d) Surety bonds would not be required until 10/1/00 when HH PPS is implemented (i.e., IPS overpayments will not be an obstacle to agencies obtaining surety bonds). In addition, when they are required, the surety bond would be $50,000 per agency (i.e., the requirement of a bond equal to 15 percent of Medicare revenues would not be applicable).

Note: This policy change has not been cleared by HHS.

(4) SNFs

(a) Change the update index from the SNF market basket to the SNF/ICF Producer Price Index (PPI). Do not change the hospital, home health or physician update indices from market baskets to PPIs.

Note: The motivation behind this idea is that the SNF/ICF PPI was higher than the SNF market basket by 3.6 percentage points in 1996, 1.9 percentage points in 1997 and 1.4 percentage points in 1998. However, PPIs are not projected so we cannot now determine if it would be higher than the SNF market basket for 2000 or 2001.

PPIs are relatively new indices and there is no guarantee that the SNF/ICF PPI

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would continue to be higher. The hospital, home health and physician PPIs were lower than the market baskets for hospitals (1997 and 1998), home health services (1998) and physicians (1996, 1997 and 1998). The hospital PPI was lower than the hospital market basket by 1.1 percentage points in 1997 and 2.3 percentage points in 1998. It is entirely plausible that the same reasons that these PPIs were lower than the market baskets will also bring the SNF/ICF PPIs lower than the SNF market basket.

Swapping the SNF/ICF PPI for the SNF market basket would require justifying the change from a long established index to one which has been in existence for only three years and one reflect "list" prices, rather than actual transaction prices SNF inputs. Use of the PPI involves a circularity: SNFs would have incentives to increase prices because the PPI reflects "list" prices.

Unless this change were effective by 7/1/99 (interim final rule published by 7/1/99), it would not be possible to incorporate it into the 10/1/99 SNF update. We would have to develop PPI projections for 2000 as well as draft a rule. The next cycle for implementation would be the SNF update for 10/1/00. However, it is possible to make a change, effective 4/1/00, in the SNF pricer, if a policy were to be specified by 1/1/00.

(5) Therapy Caps

(a) Delay implementation of per beneficiary caps from 7/1/00 until 1/1/01. The caps would apply on a per provider basis, as currently, for the remaining six-months of 2000.

(6) Managed Care:

(a) Change the share in the risk adjustment for 2001 to delay the next step in the transition until 2002, and/or stretch out the transition for the inpatient only portion and/or the comprehensive adjustment.

Note: No change would be made for 2000 as the rates are already final and managed care plans ACRs are dependent upon the already published rates. Any increases in spending for fee-for-service Medicare that would otherwise increase 2000 managed care rates would be factored into managed care rate updates for beginning with 2001.

(7) Rural Health

(a) Use the inpatient wage index for OPD PPS (Daschle bill section 109).

Note: This proposal would be finalized as part of the OPD PPS final rule.

(b) Ease the restrictions for hospital reclassification by lowering the average hourly threshold percents (84 and 108) needed for reclassification (different approach than

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Daschle bill section 109).

Note: This would be done through notice and comment, effective 10/1/00. It should be noted that these type of reclassifications are budget neutral, thus other hospitals will pay for any additional reclassifications.

(c) With BLS, study and, if feasible, collect data on occupational mix that would allow standardization for occupational mix in the wage index. (Daschle bill section 110).

Note: This is likely to be a huge data collection effort that would benefit only a limited number of hospitals.

MassHealth Senior Care Options:
A Medicare-Medicaid Partnership

Overview

Through MassHealth Senior Care Options, the Massachusetts Division of Medical Assistance ("the Division") and the U.S. Health Care Financing Administration (HCFA) will work in partnership to offer seniors eligible for both Medicare and Medicaid (the "dually eligible") and seniors eligible for Medicaid-only the option of enrolling in a comprehensive network of health and social service providers responsible for delivering and coordinating all components of Medicare- and Medicaid-covered services. These networks, which will be called Senior Care Organizations (SCOs), will operate under Medicare §222 waivers and Medicare+Choice variances to be granted by HCFA. No Medicaid waivers are necessary to operate this initiative.

Enrollment in SCOs will be voluntary. All SCO enrollments will be conducted by an independent, third party enrollment broker that will explain enrollment options to seniors in a clear, objective manner. Outreach and education regarding this new enrollment option will be comprehensive and include consumers, family members, providers, and community agencies. The Division is working with staff from the Executive Office of Elder Affairs (EOEA) to incorporate the network of Serving the Health Information Needs of Elders (SHINE) volunteers as part of this outreach effort.

Key objectives of the initiative are to improve the quality and coordination of care provided to low-income seniors, to expand their access to covered services, to maximize their satisfaction with services provided, and to increase the cost-effectiveness of care. Clinical, functional, social, and psychosocial needs of enrollees will be addressed through the application of an interdisciplinary geriatric model of care. Care planning will focus on maintaining or improving functional and health status, and expansion of community long-term care options will be encouraged. Enrollees and/or their authorized representatives, as appropriate, will participate in care choices and care planning, and will be represented in the governance of the SCO. Creativity and flexibility of service options will be encouraged and evaluated to identify best practices for the senior population.

The State and HCFA will jointly select qualified SCOs through a selective contracting process. SCO bidders will be required to demonstrate their ability to provide, either directly, or through subcontracts, all Medicare and Medicaid covered services. In addition, SCOs will be required to contract with Aging Services Access Points (ASAPs)[1]. ASAPs will employ Geriatric Support Services Coordinators who will serve as the social work resource on SCOs' Primary Care Teams and be responsible for managing community long-term care services. Stringent contract requirements will specify access, care integration, quality and financial solvency standards. The contract management and oversight process, to be conducted jointly by the Division and HCFA, will demand continuous quality improvement.

[1] "ASAP" is the name used to refer to the Aging Network entities in Massachusetts. As such, they are the designated Area Agencies on Aging (AAAs). In addition, ASAPs have conducted community long-term care screening functions for Medicaid for the past 8 years.

The Division aims to implement this initiative statewide, assuming there are qualified bidders for every area of the state. SCOs will be able to bid for any size service area. For example, some may bid to serve the entire state or large portions of the state, while others may bid to serve a small area covering a few towns. The Division is currently holding a series of technical assistance sessions for potential SCO bidders. The sessions cover such topics as the establishing clinical guidelines according to the geriatric model of care, developing centralized enrollee records, performance reporting requirements, enrollee rights and responsibilities, financing and administration. Twenty-five (25) organizations have expressed interest in bidding to be a SCO. They include hospital networks, long term care management companies, community health agencies and health maintenance organizations (HMOs).

Funding for this initiative will include Medicare capitation payments paid by HCFA and Medicaid capitation payments paid by the Division. These payments will be integrated at the level of the SCO in order to eliminate cost-shifting between Medicare and Medicaid, and to provide SCOs with maximum flexibility to design a care plan tailored for each individual. The Medicare capitation rates will be risk adjusted to reflect the health and functional status of enrollees. SCOs wanting to reduce their level of financial risk may have the option of being partially capitated for Medicare services. If partially capitated, SCOs would receive Medicare payments based on a blend of fee-for-service and capitation rates. The Medicaid capitation rates will be based on an Upper Payment Limit methodology that ensures that Medicaid payments to SCOs would not exceed the cost of serving the enrolled population in the fee-for-service system. Separate Medicaid rating categories will be developed for each of three populations: the community well, the community frail, and those who are institutionalized.

Comparison to PACE Program

In designing MassHealth Senior Care Option, the Division is building on its 8 years of experience with the Program of All-inclusive Care for the Elderly (PACE), a program which has improved the lives of many frail, Massachusetts seniors. The two programs differ in a few key ways. For example, while PACE serves only the community frail population, SCOs will be offered to virtually all MassHealth seniors regardless of health or residential status. As a result, SCOs will develop an array of care delivery models to meet a wide range of health and long term care needs. This differs from PACE, which follows nationally developed guidelines in which the majority of care is delivered through an adult day health center, with care managed by an extensive, interdisciplinary team. SCO enrollees with complex care needs will select a Primary Care Team to oversee their care needs, consisting of a physician, a nurse or nurse practitioner, and a Geriatric Support Services Coordinator. SCO enrollees without complex care needs will have a Primary Care Physician oversee their care needs. Other important ways in which the PACE and SCO model differ are that SCOs will be required to contract with ASAPs, as noted above, and the quality measurement and management system for SCOs will be more comprehensive and stress continuous quality improvement. In addition, the level of federal-state partnership in the SCO initiative, which will involve a three-way contract, is more extensive than under the PACE program, which involves two contracts administered separately by the state and federal governments.

Estimated Implementation Timeframe

The Division is working with HCFA toward the goal of implementation on July 1, 2000.

Enrollment Projections

The Division has estimated that up to 4,000 seniors will enroll in SCOs during the first year of the five-year demonstration, and that by the end of the fifth year, as many as 35,000 seniors will be enrolled in a SCO. The majority of this enrollment is expected to occur towards the latter years of the demonstration as it is anticipated that the number of referrals for enrollment will increase as the positive results of the initiative are demonstrated and communicated to seniors and their family members.

Public Development Process

The Division of Medical Assistance has been working on this initiative for the past three years, and has involved interested parties throughout the state. Four open public meetings have been held and written public comments have been received in response to a draft waiver application and draft SCO purchasing specifications. Three public advisory groups -- one each for consumers, advocates and providers -- have been meeting regularly for the past two and a half years. In addition, the Division has formed topic-specific workgroups, which have been meeting for the past year and a half, focused on integrated care delivery and outreach and education approaches.

For More Information

For more information, please contact Kate Willrich, Director of Program Development, at (617) 210-5466.

MEDICARE PRINCIPALS' MEETING

MAY 5, 1999

I. Update on Drug Estimates

II. Baseline Changes in Medicare

III. Cost Sharing

PHOTOCOPY
PRESERVATION

I. UPDATED DRUG ESTIMATES

OPTIONS:	2001 Premium	2000-04	2000-09
• **$0 Deductible, 50% copay up to $4,000 in spending** ($2,000 cap)			
° 50% Premium Subsidy	$32/mo	$42 b	$136 b
° 75% Premium Subsidy	$16/mo	$64 b	$204 b
• **$0 Deductible, 50% copay up to $10,000 in spending** ($5,000 cap)			
° 50% Premium Subsidy	$33/mo	$45 b	$154 b
° 75% Premium Subsidy	$17/mo	$70 b	$232 b
• **$0 Deductible, 50% copay phasing up to $10,000 in spending** ($5,000 cap)*			
° 50% Premium Subsidy	$29/mo	$42 b	$147 b
° 75% Premium Subsidy	$15/mo*	$64 b	$222 b
• **$100 Deductible, 20% copay up to $1,350 in spending** ($1,000 cap)			
° 50% Premium Subsidy	$37/mo	$40 b	$124 b
° 75% Premium Subsidy	$18/mo	$61 b	$185 b
• **$200 Deductible, phasing in 20% copay up to $1,700 in spending** ($1,200 cap)**			
° 50% Premium Subsidy	$23/mo**	$35 b	$124 b
° 75% Premium Subsidy	$11/mo	$54 b	$185 b
• **$200 Deductible, 20% copay up to $1,700 in spending, catastrophic** ($1,200 cap, coverage > $4200)***			
° 50% Premium Subsidy	$36/mo	$49 b	$170 b
° 75% Premium Subsidy	$18/mo	$75 b	$257 b

Assume start of July 1, 2001. Premiums based on all beneficiaries. Assume that Medicaid will cover premiums for beneficiaries up to 120% of poverty and cost sharing up to 100% of poverty. Fiscal years, cash basis, dollars in billions.
* Phases in cap: $1000 in 2001; $2000 in 2002-03; $3000 in 2004-05; $4000 in 2006-07; $5000 in 2008; indexed to inflation in subsequent years. Premium when fully phased in in 2008: $25/mo for 75% subsidy.
** Phases in copay: 50% in 2001; 40% in 2002; 30% in 2003; 20% in 2002 and subsequent years.
*** Excludes Medicaid wrap around in Kennedy-Rockefeller package.

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II. MEDICARE BASELINE CHANGES

	CHANGE IN PROJECTED FEDERAL MEDICARE SPENDING: FROM 1997 TO 1999	
	1998-2002 / 1998-2007	2000-04 / 2000-09
CBO BASELINE		
From Jan. 97 to BBA	-$115 / -386 billion	-$180 / (na) billion
From BBA to 1999	-$81 / -238 billion	-$106 / (na) billion
From Jan. 97 to 1999	-$196 / -624 billion	-$286 / (na) billion
MEDICARE TRUSTEES		
From 1997 to 1998	-$156 / -$540 billion	-$254 / (na) billlion
From 1998 to 1999	-$36 / -166 billion	-$55 / -241 billion
From 1997 to 1999	-$192 / -706 billion	-$309 / (na) billion
MEDICARE TRUSTEES **HI Trust Fund Spending Only**		
From 1997 to 1998	-$134 / -$474 billion	-$228 / (na) billlion
From 1998 to 1999	-$20 / -67 billion	-$24 / -89 billion
From 1997 to 1999	-$154 / -541 billion	-$252 / (na) billion

NOTE: The baseline changes cannot be attributed solely to the BBA. Other factors include:

- Reduced spending due to Medicare fraud reduction efforts
- Lower general and health inflation
- Slower claims processing time
- Lower than expected utilization

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III. MEDICARE COST SHARING CHANGES

(FY 2000-2009 costs/savings, dollars in billions)

MEDICARE COMMISSION		BUDGET-NEUTRAL RATIONALIZATION		SAVINGS FOR PRESCRIPTION DRUGS	
Increases:		***Increases:***		***Increases:***	
10% uncapped home health	-22	$5 home health copay w/ cap	-11	$5 home health copay w/ cap	-11
20% lab copay	-8	20% lab copay	-8	20% lab copay	-8
20% nursing facility copay	-17	10% nursing facility copay	-8	10% nursing facility copay	-8
	-47		-27		-27
Decreases:		***Decreases***:		***Decreases***:	
Eliminate preventive cost sharing	+2	Eliminate preventive cost sharing	+2	Eliminate preventive cost sharing	+2
Eliminate hospital limits & copays	+10	Eliminate hospital limits & copays and/or combine deductible of $350**	+25		
Combined deductible: $400*	+4				
	+16		+27		
Medigap Changes:		***Medigap Changes:***		***Medigap Changes:***	
Prohibits deductible coverage	-11	Dropped		Dropped	
TOTAL*	-42	**TOTAL**	0	**TOTAL**	-25

NOTE: All estimates are preliminary and draft / subject to change. Not from HCFA actuary.

*The Commission's policy is to index the deductible to program growth, but the Actuaries assumed that the policy did not increase the deductible over time. As such, the Commission staff did not know that they were savings this much.

**Deductible would be set as low as possible given available funds. This is a very rough approximation

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MAJOR OPTIONS FOR COST SHARING

- **DO NOTHING**

Pros:

- Avoids potential controversy with some beneficiary and provider groups that could distract from our primary goal of dedicating the surplus and adding a prescription drug benefit to Medicare.

- Proposing our own package could open the door to more and/or unacceptable options.

Cons:

- Cost sharing rationalization was recommended by the Commission and our appointees. Not including it makes the plan more vulnerable to validators' criticism that this is not real reform.

- Bypasses source of financing that will likely be needed for prescription drugs – whose relief to beneficiaries will far exceed the effects of cost sharing changes for most beneficiaries.

- **RESTRUCTURING IN A BUDGET-NEUTRAL PACKAGE:**

Pros:

- Avoids criticism of imposing cost sharing for revenues.

- Experts like Reischauer, Moon, Tyson, Altman all recommend making Medicare cost sharing more like private cost sharing thus reducing the demand for expensive and inefficient Medigap.

Cons:

- If Medigap reform or catastrophic coverage aren't included, may not be validated as reform.

- Reduced cost sharing may not be worth the disruption or cost.

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- **REINVESTING IN PRESCRIPTION DRUGS**

  Pros:

  - Helps provide permanent revenue source to offset part of the costs of the drug benefit.
  - Direct link to drugs may enhance both conservative support for drugs and aging advocates' support for cost sharing changes.

  Cons:

  - Would result in close to half of total savings coming from beneficiaries (including income-related premium).
  - Vulnerable to Republican critique of Democratic hypocrisy – Democrats support cutting benefit, but only in their own plan.

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