PRESERVING AND STRENGTHENING MEDICARE

The President's plan saves $124 billion over seven years, extends the solvency of the Medicare Hospital Insurance Trust Fund, and does not impose new costs on beneficiaries. The plan also expands health plan choices for beneficiaries, provides new benefits, improves Medicare's health plan payment methodology, fosters continuous improvement in health plan quality, helps beneficiaries become more informed about their choices, and levels the playing field for Medicare managed care plans and Medicare supplemental coverage.

I. EXPANDING MEDICARE MANAGED CARE OPTIONS

The President's plan further expands Medicare managed care options by statutorily authorizing the participation of a range of health delivery plan options, including preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and other alternative delivery systems that meet strong consumer protection standards. These health delivery plans would qualify for designation as "participating" plans if they met the following criteria:

- Benefits. At a minimum, benefits under the plan should be the benefits available under fee-for-service Medicare.

- Quality. Beneficiaries should receive high quality care that increases the likelihood of needed and desired health outcomes.

- Access. Beneficiaries should have timely access to all medically necessary and appropriate covered care.

- Financial Liability. Out-of-pocket expenditures under the plan should not be greater than the cost sharing that beneficiaries would experience if they stayed in fee-for-service Medicare. This includes provisions to preclude extra balance billing for authorized plan services and to provide the same protections afforded under Medicare fee-for-service for non-authorized services. In addition, plan premiums should not vary based on health status or age.

- Financial Soundness. Beneficiaries should be protected from the risk of interruptions to their care that could result from the insolvency of a plan or its providers.

- Appeals, Complaints, and Grievances. Beneficiaries should have access to timely and fair resolution of any appeals, complaints, or grievances.

- Information. Beneficiaries should have timely access to comprehensive, understandable information about plans, including: basic policies and procedures, consumer satisfaction, and plan performance.

- Marketing and Enrollment. Beneficiaries should not be coerced to enroll in a plan, prevented from enrolling in a plan of their choice due to health status, or encouraged to disenroll from a plan.

- Accountability. Beneficiaries should be assured that those purchasing services on their behalf will establish, monitor, and enforce beneficiary protections.

II. IMPROVING MEDICARE'S MANAGED CARE PAYMENT METHODOLOGY

The plan phases in a series of improvements in Medicare payment methods, while testing alternatives. Under the plan, the Administration would:

- Reduce extreme regional variation in the capitated payments to plans contracting with Medicare and immediately increase rates in rural areas by: delinking payments to plans from fee-for-service expenditures at the local level; adopting a blended payment methodology; and creating a minimum payment amount.

- Maintain linkage and equity with the fee-for-service program at the national level by updating payment rates based on projected growth in per capita Medicare spending.

- Test new risk adjusters for capitated payments in order to improve the accuracy of rates and to reduce the impact of selection on Medicare payments.

- Conduct demonstrations on a competitive pricing methodology, under which Medicare's payments to plans would be based on plan bids.

- Create a partial-risk payment alternative to the current inefficient cost payment option. Under the partial-risk payment methodology, plans would be paid on a fee-for-service basis subject to an annual limit. Plans would share in savings achieved below the limit.

Specific savings proposals are discussed in Section VII under "Medicare Managed Care."

III. FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

The plan would enhance quality assurance by building on existing mechanisms and cooperative efforts with national organizations. Under the plan, the Administration would:

- Create partnerships with public and private purchasers, consumer groups, and managed care plans to focus on developing population-based outcome measures and encounter data systems that could assure quality of care.

- Collaborate with national quality assurance organizations to develop plan performance indicators relevant to the Medicare population.

- Expedite the process for terminating non-compliant plans and expand authority for intermediate sanctions (e.g., freezing new enrollment).

- Develop a proposed regulation (to be released in August 1997) establishing consistent standards for quality assurance and performance measurement. These standards, when implemented, would replace the "50/50" rule, which requires Medicare and Medicaid membership not to exceed 50 percent of total plan enrollment. As an interim measure, they would give the HHS Secretary authority to waive the "50/50" rule in specified circumstances.

- Give plans the option of contracting with an independent organization, approved by the HHS Secretary, to certify that the plan has met internal quality assurance requirements.

IV. BENEFICIARY INFORMATION/LEVEL PLAYING FIELD

The plan would develop information to help Medicare beneficiaries become more informed about their choices, and level the playing field for Medicare managed care plans and Medicare supplemental coverage. The plan would:

- Authorize the HHS Secretary to (1) develop standardized comparative materials for beneficiaries about managed care and Medigap plans, and (2) contract out to a third-party to provide enrollment and disenrollment activities for Medicare managed care plans. To assure adequate funding, all plans would contribute to the costs of these activities.

- Work with the National Association of Insurance Commissioners to develop an approach to standardize additional benefits offered by managed care plans and to move to community rating of Medigap policies.

- Eliminate barriers to beneficiaries enrolling in the managed care or Medigap plan of their choice by: (1) establishing an annual 30-day simultaneous open enrollment period for all managed care and Medigap plans; (2) giving newly-entitled beneficiaries a special open enrollment period; and (3) allowing beneficiaries leaving managed care to re-enroll in Medigap plans, without prejudice.

- Strengthen current safeguards for managed care enrollees by protecting enrollees who go outside their plans to receive services without plan authorization.

V. EXPANDED BENEFITS

The plan strengthens the Medicare benefit package by expanding coverage for important preventive care, and it takes steps to encourage families to keep beneficiaries in the community and simultaneously avoid institutional costs for Medicare and Medicaid. The new preventive benefits include: annual mammograms for beneficiaries age 50 and over; waiver of cost-sharing for mammography; several procedures for the early detection of colorectal cancer (including barium enemas); blood glucose monitors and associated supplies and professional assistance for managing diabetes; and increasing Medicare payments for preventive injections.

The plan also establishes a new respite care benefit for beneficiaries with Alzheimer's disease or other irreversible dementia. Under this benefit, Medicare beneficiaries with cognitive impairment would be eligible to receive up to 32 hours per year of non-medical care, giving the beneficiary's informal care givers (e.g., children, spouse) a break from the constant demands of caring for these beneficiaries.

VI. STRENGTHENING MEDICARE

The President's plan saves $124 billion over seven years (FY 1996-2002)[1] and ensures the solvency of the Hospital Insurance, or Part A, Trust Fund through at least the next decade.

To achieve these savings, the plan modifies Medicare payments in a number of ways. The plan ensures that Medicare acts as a prudent purchaser and provides incentives to hospitals for efficiency by constraining updates for hospital operating costs, reimbursing reasonable levels for capital costs, reforming medical education payments, reforming add-on payments for extremely costly (i.e., outlier) cases, and reforming the rules governing transfers from a hospital to a post-acute care facility.

[1]All savings and cost estimates for Medicare are from preliminary CBO scoring dated February 28, 1996.

The plan also changes Medicare physician payments by (1) tying allowable volume growth, which in turn affects fee increases, to the growth in real gross domestic product (GDP) per capita (plus an additional factor), and (2) implementing proposals that create incentives for physicians to deliver quality care efficiently. In addition, the plan reforms payments to home health agencies and skilled nursing facilities by establishing interim payment systems in preparation for rapid implementation of a new prospective payment system.

The plan achieves savings from managed care by tying growth in managed care payments to overall Medicare growth per person. It also removes payments for graduate medical education and disproportionate share hospitals from the AAPCC and redistributes all of the savings to ensure that teaching hospitals caring for Medicare managed care enrollees are compensated directly for the cost of training physicians. Finally, the plan maintains the Part B premium at 25 percent of program costs, reduces payments for durable medical equipment and ambulatory service center services, ensures that Medicare pays for services only after a beneficiary's primary insurance has paid appropriately, reduces the regulatory burden on clinical labs under the Clinical Laboratory Amendments Act (CLIA), and employs a wide variety of strong new initiatives to combat fraud and abuse.

VII. MEDICARE SAVINGS PROPOSALS

Part A -- Hospital Insurance Trust Fund

Medicare Part A provides insurance coverage for hospital, home health, skilled nursing facility (SNF), and hospice care. Most Americans age 65 or older are entitled to Part A coverage. This coverage is financed primarily through a payroll tax of 2.9 percent, paid equally by the individual and employer. Reductions in Part A expenditures, combined with reform of the home health benefit, will extend the solvency of the Part A Trust Fund through at least the next decade.

Under Medicare, hospitals are paid in one of two ways. Most are paid under a prospective payment system (PPS), under which fixed hospital payments per admission are established based on a patient's diagnosis before services are provided. Certain specialty hospitals (i.e., rehabilitation, childrens, long-term care, and psychiatric care hospitals) are paid based on their costs in a base year.

Hospital Proposals

- Reduce the "Market Basket" Payment Update for Inpatient Hospital Services. Under current law, inpatient hospital prospective payment rates are updated annually by a "market basket index" that reflects inflation in the prices of operating an inpatient facility. The update has often been reduced in past budget reconciliation acts -- in OBRA 1993, it was reduced by between 0.5 and 2.5 percentage points in FY 1994-1997. An update of

less than the full market basket is given to reflect anticipated productivity gains and provide an incentive for hospitals to increase efficiency. **This proposal would reduce the hospital market basket index update for prospectively paid hospitals by 1.5 percentage points for each year between FY 1997 and FY 2002.** For 1997, a hospital paid under the prospective payment system would receive about a 2.1 percent increase rather than about a 3.1 percent increase (which reflects the current law reduction of .5 percentage point for that year). The proposal would continue the OBRA 1993 reductions, thereby eliminating a sudden increase in baseline spending that would occur under current law. The Prospective Payment Assessment Commission (ProPAC), created by Congress to offer advice on policies affecting Medicare payments to hospitals and other facilities, recommends a market basket reduction of 1.5 to 2.0 percentage points for the short term.

This proposal also would reduce the update by 1.5 percentage points in FY 1997-2002 for hospitals that are exempt from Medicare's hospital prospective payment system (i.e., psychiatric, rehabilitation, long-term care, cancer, and children's hospitals). This proposal also would reform the methodology for paying PPS-exempt facilities. Exempt hospitals would continue to be reimbursed based on their costs in a base year, subject to limits, but the base year would be updated to use more recent data. Cost limits would be subject to a ceiling of 150 percent of the national average and a floor of 70 percent of the national average (specific to each type of facility). Facilities still would be eligible for payments above their limits under certain conditions, but incentive payments for facilities whose costs are below their targets would be ended.

Seven-year savings from reducing the hospital market basket index update are $19.7 billion. Seven-year savings from reducing the PPS-exempt hospital market basket index update are $1.1 billion.

- Extend OBRA 1990 Reductions for Hospital Capital Payments. Hospitals receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. **This proposal would set future hospital capital payments by updating 1995 capital rates for inflation. In effect, this proposal permanently captures the savings from the OBRA 1990 capital provision, which limited payments for capital under PPS to 90 percent of what they would have been under a reasonable cost system.** Without this extension, capital payments to hospitals increased about 16 percent in FY 1996. This proposal could be considered an efficiency adjustment to recoup excessive Medicare capital reimbursement of the late 1980s. In addition, the current base amount reflects overestimated capital costs, and should be modified to reflect more accurate data. The Office of Inspector General recommends that capital payments be reduced to prevent overpayment to hospitals.

  In addition, this proposal would pay 85 percent of capital costs for PPS-exempt hospitals and units for FY 1997-2002.

  Seven-year savings from limiting capital payments to prospective payment hospitals are $6.1 billion. Seven-year savings from limiting capital payments for non-prospective payment hospitals are $1.4 billion.

- Reform of Long-term Care Hospital Reimbursement. Hospitals with average stays of more than 25 days by all patients are considered long-term care hospitals. These hospitals are currently exempt from the prospective payment system. **This proposal would make new long-term care hospitals subject to the PPS, effective upon enactment.** PPS has proven to be an effective mechanism for increasing efficiency and controlling costs in other inpatient hospitals.

  Seven-year savings are $0.7 billion.

- Graduate Medical Education (GME) Reform. Medicare pays teaching hospitals for a share of the direct (i.e., resident salaries and fringe benefits, teaching costs, and institutional overhead) and indirect costs they incur in providing graduate medical education. The indirect costs are reimbursed through the IME adjustment to the diagnosis related groups (DRGs). But direct costs are based on Medicare's share of hospital-specific, per resident amounts that reflect a hospital's 1984 cost per resident, indexed for increases in the level of consumer prices.

This proposal actually contains three individual proposals, including two program expansions.[2] Most experts agree that the current GME and IME payment methodology is flawed. ProPAC analysis suggests that teaching hospitals are overcompensated, especially in terms of the IME adjustment, and there is general consensus (e.g., Council of Graduate Medical Education, the Physician Payment Review Commission) that GME/IME payments encourage hospital-based specialty training at the expense of primary care training. This proposal is designed to slow the growth in Medicare spending on graduate medical education while encouraging more primary care training.

Seven-year savings are $7.4 billion.

- Establish National Commission on Medical Education and Workforce Priorities. **This proposal would establish the National Commission on Medical Education and Workforce Priorities within the Department of Health and Human Services.** The Commission would: (1) develop and recommend policies to address the preservation of academic health centers' research and educational capacity and the supply, composition, and support of the future health care workforce; and (2) make recommendations concerning the most effective allocation of training resources to ensure that the numbers and competencies of health care professionals are responsive to national needs.

There are no Medicare savings or costs associated with this proposal.

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[2]The three proposals would: (1) cap the total number and the number of non-primary care residency positions reimbursed under Medicare at the current level; (2) count work in non-hospital settings for IME; and (3) allow GME payments to non-hospitals (e.g., Federally Qualified Health Centers) for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting.

- Telemedicine. Telemedicine uses telecommunications technology to provide patients with real-time interactive examination and consultation from medical professionals who are at a remote site. **This proposal would establish a grant program to support the development of telemedicine networks in rural areas.**

- Rural Health Outreach Grant Program. This proposal would establish a grant program to demonstrate the effectiveness of outreach to populations in rural areas that do not normally seek, or have access to, health or mental health services.

  Seven-year investment for both telemedicine and the rural health outreach grant program is $0.2 billion.

- Medicare Dependent Hospitals. OBRA 1989 established a Medicare Dependent Hospitals classification, which allowed small rural hospitals with more than 60 percent of their utilization from Medicare patients to receive higher payments based on the method Sole Community Hospitals. **This classification was discontinued as of FY 1995. This provision would once again reinstate the classification and allow Medicare Dependent Hospitals to receive higher payments.**

  Seven-year investment is $0.1 billion.

- Rural Primary Care Hospitals (RPCH). The RPCH program seeks to preserve rural residents' access to hospital care by allowing certain hospitals to convert to limited service, short-stay hospitals and receive reasonable cost reimbursement. The program is currently authorized in only seven states. **This proposal would make several improvements to the RPCH program, including: extending the program to all states, expanding the allowable number of beds, extending the allowable length of stay and establishing a minimum separation distance between RPCHs. This proposal also would eliminate the Essential Access Community Hospital (EACH) designation for new hospitals, while allowing existing EACHs to continue to be paid on a reasonable cost basis.**

  Seven-year investment is $0.2 billion.

Home Health Agencies

- Extend Savings from OBRA 1993 Home Health Cost Limits Freeze. Medicare pays for covered home health services on a cost basis, subject to limits that are updated annually. OBRA 1993 eliminated the update for home health cost limits from July 1, 1994 to July 1, 1996. **Although this proposal would not extend the freeze, it would permanently**

extend the savings realized from setting future home health limits by not allowing for the inflation that occurred during the freeze. Without new legislation, spending would revert to pre-freeze levels.

- Reform Home Health Payment: Home health services are one of the fastest growing areas of Medicare expenditures, and there is widespread consensus that the high rate of growth in home health expenditures must be addressed. This proposal combines three individual proposals designed to reform the reimbursement system for home health services, improve financial management, and control fraud and abuse:

  1. Establish a Prospective Payment System (PPS) for Home Health Services -- Medicare reimburses home health agencies on a cost basis, subject to limits. However, Medicare's retrospective reimbursement rates often contribute to increased expenditures by failing to control volume. **This proposal would constrain growth in expenditures through lower cost limits over the short run and implement a per-episode PPS for home health in 1999.** Budget-neutral rates under the PPS would be calculated after first reducing, by 15 percent, expenditures that exist on the last day prior to implementation. HCFA is currently running a demonstration to test a per-episode home health PPS.

  This proposal would take the following interim steps to help reduce home health costs and control volume:

  - **Beginning October 1, 1996, reduce the current cost limits from 112 percent of the mean to 105 percent of the median.**

  - **Beginning October 1, 1996, implement an additional limit, based upon aggregate per beneficiary costs in a base year.** Payment would be the lesser of: (1) the actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) the per visit cost limits; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs. Effective January 1, 1997, or as soon as feasible, the agency-specific per beneficiary limit would be modified to provide for regional or national variations in utilization by calculating the limit through a blend of 75 percent of the agency-specific cost or utilization in 1994 with 25 percent of the national or regional cost or utilization in 1994.

    Home health agencies (HHAs) with costs or utilization experience less than 125 percent of the mean national or regional aggregate per beneficiary cost or utilization experience for 1994, and with year-end costs below the agency-specific per beneficiary limit, would share 50 percent of the savings for FYs 1997-1999. The shared savings, however, could not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year. The interim reimbursement mechanism

- Reduce Indirect Medical Education (IME) Adjustment to 6 percent. Through the IME adjustment, Medicare recognizes the higher indirect costs that teaching hospitals incur in running a teaching program (e.g., additional tests and procedures that residents may order as part of their training). Currently, the IME adjustment is based on a teaching hospital's ratio of interns and residents to beds (IRB), with payments increasing by about 7.7 percent for each 10 percent increase in a hospital's IRB. ProPAC analysis suggests that the current IME adjustment overcompensates hospitals. It recommends initially reducing the adjustment to 7 percent and, in the future, further reducing it to a level that corresponds more closely with the actual relationship between teaching intensity and costs. Health Care Financing Administration (HCFA) data also suggest that a lower IME adjustment would more accurately reflect what teaching hospitals actually experience. **This proposal would reduce the IME adjustment to 6.5 percent in FY 1997, 6.3 percent in FY 1998, and 6 percent in FY 1999 and thereafter.**

  Seven-year savings are $6.3 billion.

- Refine Outlier Payment Methodology. Currently, hospitals are eligible for additional payments, called outlier payments, when they serve long-term patients or those who require exceptionally costly care. When the outlier amount is paid, teaching and disproportionate share (DSH) hospitals also receive additional IME and DSH payments added to the outlier payments. **This proposal would eliminate increased IME and DSH payments that are attributable to the outlier payments, but would allow hospitals to count IME and DSH as part of costs that trigger outlier payments, effective FY 1997.** Consequently, teaching and DSH hospitals would receive a greater portion of outlier payments. ProPAC supports this change as being consistent with the intent of the PPS.

  Seven-year savings are $3.2 billion.

- Redefine Hospital "Transfer." Currently, hospitals that move patients to PPS-exempt facilities and SNFs "discharge" the patient and receive a full DRG payment. This policy overpays hospitals and contributes to higher post-acute expenditure growth rates, because these sites end up caring for more acutely ill patients. **Under this proposal, moving a patient from a PPS hospital to a non-PPS hospital or SNF would be considered a hospital "transfer" rather than a discharge. Reimbursement for each transfer reimbursements would be made on a per diem basis, subject to a cap equivalent to the DRG payment.**

  Seven-year savings are $5 billion.

- Expand "Centers of Excellence" Demonstration. Currently, HCFA is conducting a demonstration that pays 10 facilities, considered "centers of excellence," a flat fee to provide cataract or coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. **This proposal would expand centers of excellence demonstrations to all urban areas by allowing Medicare to pay select facilities a single rate for all services associated with CABG surgery or other heart procedures, knee surgery, hip surgery, and other procedures that the HHS Secretary determines appropriate.** This approach gives hospitals incentives to provide high quality care more efficiently. Beneficiaries would not be required to receive services at these centers.

  Seven-year savings are $0.2 billion.

- Sole Community Hospitals (SCH). SCHs are the sole source of inpatient services reasonably available in a geographic area. Payments for SCH services are currently based on FY 1982 or FY 1987 costs (updated annually) or a standard federal amount. **This proposal would base SCH payments on FY 1992 and 1993 costs, although SCHs could still be paid based on updated 1982 or 1987 costs or the federal rate if it would yield higher payments.**

  Seven-year investment is $0.3 billion.

- Rural Referral Centers. The Rural Referral Center designation is a special classification for large rural hospitals that provide a large amount of specialized hospital services. **This proposal would allow hospitals designated as rural referral centers as of FY 1994 to continue to be treated as rural referral centers. This proposal also would increase the wage adjustment for rural referral centers whose wages are between 100 percent and 108 percent of the average wage in their area.**

  Seven-year investment is $0.1 billion.

would be in effect until a full per-episode home health PPS is implemented in 1999.

2. Eliminate Periodic Interim Payments (PIP) for HHAs -- PIP was established to help simplify cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, PIP is reconciled with actual expenditures. But, with about 100 new HHAs joining Medicare each month, access to home health care is no longer a problem, and new providers no longer need PIP to encourage them to participate in Medicare. Further, the Office of Inspector General has found that Medicare tends to overpay providers who receive PIP, and has a hard time recovering the money. **This proposal would eliminate PIP for home health agencies simultaneous with PPS implementation.**

3. Base Payments on Location of Service Delivery -- HHAs are often established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, payment is based on the higher wage rate for the urban area, even though the service delivery occurred in a rural area. **Under this proposal, payments would be based on the location where the services are *rendered*, not where the services are *billed*, beginning January 1, 1997.**

Total seven-year savings from home health reforms are $9.1 billion.

- Shift Financing of a Part of the Home Health Benefit to Part B. **This proposal divides the financing of the Medicare home health benefit between Part A and Part B -- without changing general coverage and eligibility rules or imposing any beneficiary cost sharing.** Under this proposal, effective in FY 1997, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. (Part B visits would not be subject to the Part B coinsurance or deductible; this shift also would not impact the Part B premium.) For those beneficiaries who are eligible for only Part A or Part B, the benefit would be financed completely by the part for which they are eligible. This proposal also would clarify current policy on the definitions of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services. By creating a post-hospital home health benefit under Part A, this proposal would recognize that Part A covers only acute care services. It allows Part B to finance the longer-term, and more expensive, portion of home health services. And by restructuring the home health benefit so that Part B bears more of the costs, this proposal would extend the solvency of the Part A Trust Fund.

Medicare spending shifted from Part A to Part B over seven years is $62.1 billion.

Skilled Nursing Facilities

- Extend Savings from OBRA 1993 SNF Cost Limits Freeze. Payments for SNF routine services are made on a reasonable cost basis, subject to certain SNF cost limits that are updated annually. OBRA 1993 eliminated the update for FY 1994 and FY 1995. Beginning in FY 1997, SNF routine payments would not reflect the effects of the freeze. **Although this proposal would not extend the freeze, it would permanently extend the savings realized from setting future limits by not allowing for the inflation that occurred during the freeze.**

- Reform the SNF Reimbursement System. Within Medicare, the SNF program is one of the fastest growing benefits, with both increased volume and costs driving the overall increase in SNF expenditures. SNFs provide daily skilled nursing care to Medicare beneficiaries for conditions related to a prior hospitalization. Medicare reimburses SNFs on a cost basis, subject to certain limits. For SNFs, limits are applied only to the routine services (i.e., room and board, nursing, administration, and other overhead); ancillary (e.g., drugs, physical therapy, speech therapy) and capital-related costs are not subject to any limits. Medicare's current retrospective reimbursement rates contribute to rising expenditures by providing incentives to increase costs.

  This proposal would make the following changes in SNF reimbursement:

  - **Establish an interim prospective rate for routine costs, beginning in FY 1997. These rates would be based on facility-specific costs, subject to regional limits.** The regional limits would be based on data from freestanding SNFs only. Freestanding SNFs tend to have lower costs than hospital-based SNFs. SNFs would be reimbursed under this system until a full SNF PPS is implemented in FY 1998.

  - **Eliminate new provider exemptions and new exceptions to the cost limits, beginning in FY 1997.** Currently, new Medicare SNF providers are exempted from the cost limits for three to four years. These exemptions allow SNFs to be reimbursed for inflated costs for several years. An exception currently is provided for SNFs that provide atypical care (e.g., sub-acute care) or are forced to operate under extraordinary circumstances (e.g., earthquakes, hurricanes). In the case of exceptions, an upward adjustment to the cost limit is determined. Exceptions effectively allow SNFs to fully bill Medicare for more costly sub-acute care services, which Medicare reimbursement would not completely cover. SNFs that had exceptions in the base year would be protected under a hold harmless provision, because the limit plus the exception amount would be included in the

base year cost. The HHS Secretary may also make future adjustments, based on case mix, to the routine payment rates.

- **Establish limits on ancillary services.** Ancillary services would be subject to limits based on amounts payable for similar services on a fee-for-service basis under Part B.

- **Require consolidated billing, beginning in FY 1997.** The HHS Office of Inspector General and others have reported that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. **This proposal would require SNFs to bill Medicare for all services its residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered inpatients. SNFs also would be required to include HCFA Common Procedure Codes on their Part B bills.** This proposal will reduce double billing for some supplies and services and reduce beneficiary Part B copayments for services covered under Part A. It also will provide data necessary to construct a SNF PPS rate that covers ancillary services. (This proposal is discussed in the "Eliminating Waste, Fraud, and Abuse" section.)

- **Establish a full SNF PPS, beginning in FY 1998.** The prospective rate would be designed to cover all three (i.e., routine, ancillary, and capital-related) SNF costs. Budget-neutral rates under the new system would be calculated after first reducing, by 7 percent, rates that exist on the last day of FY 1997.

- Establish Therapy Guidelines. As part of their SNF care, Medicare beneficiaries are eligible for occupational (OT), physical (PT), speech, and respiratory therapies. While some SNFs employ their own therapists, many use contractors to provide these services. In the latter case, either the SNF or the contractors can bill Medicare. Medicare spending on therapy services has risen significantly over the last several years, and Medicare has established salary equivalency guidelines for PT and respiratory therapy. These guidelines determine the maximum Medicare payment for this service. However, similar guidelines have not been developed for OT and speech-language pathology. In a March 1995 General Accounting Office (GAO) report, GAO found that Medicare needs tighter rules to curtail overcharges for nursing home therapy and recommended that HCFA set limits to ensure that Medicare does not pay more for therapy services than other health care purchasers. **This proposal would apply salary equivalency guidelines for OT and speech language therapy and update the existing PT and respiratory therapy guidelines, effective October 1, 1996.**

  Total seven-year savings from SNF reforms are $8.3 billion. (Note: Some savings from the consolidated billing and therapy guidelines provisions are attributable to Part B.)

Medicare Managed Care

- Reform Medicare Managed Care. While managed care appears to have reduced private health care costs, studies indicate that it does not reduce Medicare costs, due to a flawed payment methodology and favorable selection. Under current law, Medicare is required to pay HMOs a capitated rate equal to 95 percent of fee-for-service costs.

  This proposal includes several policies to improve the current payment methodology. It would:

  - **Reduce current geographic variations in managed care payment rates.** This proposal would raise payment levels for certain counties, encouraging HMOs to enter new markets and provide more beneficiaries with a choice of plans. It also would limit payments for counties whose rates have been inflated by high service utilization in the fee-for-service sector.

  - **Tie managed care payment growth to overall Medicare expenditure growth per person.** This growth rate allows for a fair and reasonable increase in managed care payments.

  - **Eliminate the GME, IME and DSH payments included in HMO rates; redistribute these funds to teaching hospitals and managed care plans with teaching programs.** These payments would be distributed directly to academic

medical centers, and to HMOs that run their own residency programs (i.e., incur most of the costs of an approved residency program).

- **Conduct a competitive pricing demonstration to test a market-based alternative payment methodology.** Under the demonstration, rates to all HMOs in an area would be established using a competitive pricing methodology. It is part of a long-range strategy to improve the payment methodology for managed care products.

Seven-year savings from revising the Medicare managed care payment methodology are $23.7 billion. (Note: Some savings from this provision are attributable to Part B.)

Part B -- Supplementary Medical Insurance Trust Fund

Medicare Part B provides insurance coverage for physician services, hospital outpatient services (including diagnostic testing and ambulatory surgery), clinical laboratory services, durable medical equipment (e.g, wheelchairs, oxygen services, medical supplies), and other medical services. Payments for physician fees, clinical laboratory services, and durable medical equipment are based on fee schedules. Payments for other services reasonable costs or reasonable charges. The program provides for annual updates of based on payment amounts to reflect inflation and other factors.

Part B coverage is voluntary; almost all of those who are eligible for Part A coverage choose to buy Part B coverage. Part B is financed through (1) beneficiaries' monthly premiums which will continue to cover 25 percent of program costs under the Administration's proposal, and (2) general Federal revenue.

Physicians

- Establish Single Conversion Factor and Reform Method for Updating Physician Fees. Each year, the fees paid to doctors who serve Medicare beneficiaries are updated to account for medical inflation. In addition, the update is adjusted according to a formula that compares actual spending on physicians' services to a spending "standard" established each year according to a complex statutory formula. For purposes of updating fees, Medicare divides doctors' services into three categories: surgical services, primary care, and all other services (e.g., diagnostic tests). Because of different growth rates and spending standards, the three categories have received different updates each year since 1992, when a major payment reform was implemented.

Between 1992 and 1995, the basic payments increased as follows: 29.7 percent for surgical services, 19.6 percent for primary care services, and 13.8 percent for medical services. The Physician Payment Review Commission (PPRC) has stated repeatedly that these different rates of increase are inconsistent with the basic principle of physician payment reform -- i.e., physician fees should vary only according to the relative amount of resources used to provide services.

This proposal would implement several PPRC recommendations to improve the physician payment system. First, a single conversion factor would go into effect in 1997 (the conversion factors for 1996 will be at the levels established by the HHS Secretary under current law). Second, the single conversion factor for 1997 will be based on the 1996 conversion factor for primary care services ($35.42), updated for 1997 based on performance relative to the overall Medicare Volume Performance Standards (MVPS) for FY 1995. Third, to set spending growth targets beginning with FY 1996, the MVPS would be replaced with a sustainable growth rate based on growth in real GDP per capita plus one percentage point (rather than historical volume and intensity growth). This policy would affect updates to the single conversion factor beginning in 1998. Fourth, an upper limit on fee increases of 3 percentage points above medical inflation would be set. And fifth, the lower limit on fee increases would be increased from 5 percentage points to 8.25 percentage points.

Seven-year savings are $13.5 billion.

- Make Single Payment for Surgery. Under certain conditions, Medicare will make an extra payment for each physician or other practitioner who assists the primary surgeon during an operation. These "assistants-at-surgery" are paid a percentage of the fee paid to the primary surgeon. Both the Rand Corporation and the PPRC have reported that there is substantial geographic variation in the use of assistants for the same surgical procedure. This evidence suggests a lack of medical consensus on the use of assistants, which suggests that, in some cases, the use of an assistant-at-surgery may not meet the criteria for medical necessity.

  This proposal would make the same payment to primary surgeons, regardless of whether they use an assistant-at-surgery for whom Medicare makes a separate payment. In effect, Medicare's payment to the primary surgeon would be reduced by the amount of the payment for the surgeon's assistant-at-surgery. The HHS Secretary would specify exceptions for specific procedures or special situations.

  Seven-year savings are $0.6 billion.

- Extend OBRA 1993 Reduction in Payments for Physician Overhead Expenses. Medicare's fee schedule payment for each physician service is made up of three parts: payment for the physician's work, payment for overhead costs or "practice expenses" (e.g., office rent, employee wages), and payment for malpractice insurance costs. On average, about 41 percent of each payment is for overhead costs. Unlike the payment for the physician's work, which is based on an estimate of the actual resources involved in providing a service, practice expense payments are based on historical charges. In some cases, this distorts the fee schedule, because the resulting practice expense payment is inappropriately large relative to the work payment.

  In 1993, Congress considered legislation to implement a permanent, resource-based payment system for practice expenses. To address the existing payment distortion and begin the transition to the new system, OBRA 1993 reduced practice expense payments for certain services. For services meeting certain conditions, the excess practice expense payment is reduced by 25 percent of the difference in 1994, 1995, and 1996, subject to a limit on the total reduction. Because it intended to have a permanent solution to the payment distortions in place by 1997, Congress limited the cut to three years (through 1996). However, legislation mandating the permanent solution was not passed until late 1994, delaying the new payment system until 1998. **This proposal would extend the OBRA 1993 practice expense payment cut for one more year (i.e., through 1997) and reduce the limit on the reduction from 128 percent to 115 percent of the physician work payment.**

  Seven-year savings are $0.7 billion.

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. Given a limited consensus on clinical practice guidelines and regional differences in practice styles, some amount of variation in volume and intensity is inevitable. But this variation in the volume of physician services suggests there is room for efficiency improvements. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient.

  This proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 120 percent of the national median for urban hospitals (125 percent in 1999 and 2000) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate in order to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. The policy would not be implemented until 1999, to give physicians

time to organize themselves to control volume and intensity while maintaining the delivery of high-quality care.

Seven-year savings are $2.3 billion.

- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). **This proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged.** Further, these providers would have the option of billing Medicare directly for covered services (as opposed to receiving the payments through their employer).

  Seven-year investment is $0.7 billion.

Hospital Outpatient Departments (OPDs)

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments Made on a "Reasonable Cost" Basis. Although there are several payment methodologies for services delivered in the hospital outpatient setting, some outpatient department services are still made on a reasonable cost basis. OBRA 1990 reduced payment for these services by 5.8 percent for FY 1991-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 5.8 percent reduction.**

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments for Capital Costs. Hospital outpatient departments receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. OBRA 1990 reduced payments for outpatient department capital costs by 10 percent for FY 1992-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 10 percent reduction.**

- Correct the "Formula-Driven Overpayment." Current law requires Medicare to use a flawed formula to calculate payments for most ambulatory surgeries, radiology procedures, and diagnostic services performed in hospital outpatient departments. For these services, Medicare's payments are not reduced by the full amount of beneficiary coinsurance. Thus, the Medicare payment is higher than it should be, and hospitals have an incentive to increase charges, which also increases costs to beneficiaries. **This proposal would correct this so-called "formula-driven overpayment" by allowing**

Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments.

Seven-year savings from the three OPD proposals are $15.0 billion.

- Establish a Prospective Payment System for Outpatient Department Services. Medicare's current outpatient payment methodologies do not create incentives for providers to operate efficiently, and allow beneficiary coinsurance to grow as a percentage of total outpatient payments. **This proposal would implement a PPS for outpatient department services, starting in 2002. The new PPS would be designed to limit growth in Medicare outpatient expenditures by providing incentives for providers to operate efficiently, and gradually reduce beneficiary coinsurance as a percentage of total outpatient payments.**

  This proposal would be implemented in a budget-neutral manner.

Medicare Managed Care

- Reform Medicare Managed Care Payments. See discussion on page 16.

Other Providers

- Freeze Durable Medical Payments and Reduce Oxygen Payments. Durable medical equipment covered by Medicare includes items ranging from electric heat pads and wheelchairs to oxygen equipment and hospital beds. Medicare also covers artificial limbs and other prosthetic and orthotic devices. Medicare's fees for these items are based on fee schedules that are updated annually by the consumer price index for urban consumers (CPI-U). Durable medical equipment is one of the fastest growing areas of Medicare spending; CBO's most recent projections (December 1995) show Medicare spending for these medical items growing by over 13 percent per year from 1996-2002. **This proposal would freeze updates for durable medical equipment, and orthotics, and prosthetics from 1997-2002. It would also reduce overpriced payments for oxygen and oxygen equipment by 10 percent beginning in 1997.**

  Seven-year savings are $2.3 billion.

- Reduce Updates for Ambulatory Surgical Center Fees Through 2002. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY 1994 and FY 1995. Utilization of ASC services has escalated rapidly since the mid-1980s. In addition, the number of ASC facilities has increased

dramatically over the same period, suggesting that Medicare's payment rates are more than adequate to cover facility costs. In 1984, there were 155 ASCs participating in Medicare; by 1993, over 1,600 ASCs were participating.

This proposal would reduce the annual CPI update for ASC fees by 2 percentage points for each year between FY 1997 and 2002.

Seven-year savings are $0.8 billion.

- Expand Centers of Excellence. See description on page 10.

- Extend Part B Premium at 25 percent of Program Costs. Premiums for 1991-1995 under the Supplementary Medical Insurance (SMI) program are specified in the Medicare law. OBRA 1993 set the Part B premium at 25 percent of SMI program costs for 1996-1998. Beginning in 1999, the percentage increase in the premium will be limited to the Social Security cost of living adjustment (COLA). **This provision would permanently set Part B premiums at 25 percent of SMI program costs.** The monthly premium in calendar year 2002 under this proposal would be $67.50 (preliminary CBO estimate).

  Seven-year savings (net of interactions with Part B program savings) are $6.9 billion.

Preventive Services Benefit Expansions (all in Part B)

- Waive Cost-Sharing for Mammography Services. Although Medicare's coverage of mammography services began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the benefit. One factor is the required 20 percent coinsurance. To remove financial barriers to women seeking preventive mammograms, **this proposal waives the Medicare coinsurance and the deductible, effective January 1, 1998.**

- Cover Annual Screening Mammograms for Beneficiaries Age 50 and Over. OBRA 1990 mandated coverage of biannual screening mammography for Medicare beneficiaries over age 65. **This proposal would cover annual screening mammograms for beneficiaries age 50 and over, without coinsurance or a deductible, effective January 1, 1998.**

  Seven-year investment for both mammography benefits is $4.8 billion.

- Cover Colorectal Screening. **Effective January 1, 1998, this proposal would cover four common preventive screening procedures -- barium enema, colonoscopy, sigmoidoscopy, fecal-occult blood test -- for detection of colorectal cancers.** Current law provides for these procedures only as diagnostic services.

  Seven-year investment is $0.8 billion.

- Increase Payments to Providers for Preventive Injections. **Effective January 1, 1998, this proposal would increase the payment for administration of Medicare-covered preventive injections, which include pneumonia, influenza, and hepatitis B vaccines.** It is expected that enhanced payment will increase utilization of these vital preventive services. The proposal would waive the Part B deductible and coinsurance for all of these injections.

  Seven-year investment is $0.5 billion.

- Establish Diabetes Self-Management Benefit. **Effective January 1, 1998, this proposal would provide Medicare coverage of diabetes outpatient self-management training services rendered by a certified provider in an outpatient setting.** The proposal would also allow Medicare to cover blood-glucose monitors and associated testing strips as durable medical equipment for both Type II and Type I diabetics.

  Seven-year investment is $0.5 billion.

- Establish Respite Benefit. **This proposal would establish a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia, beginning in FY 2002. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. The benefit would apply to home-based services as well.**

  Seven-year investment is $1.1 billion.

Medicare Parts A and B (proposals that affect outlays from both the HI and SMI Trust Funds)

Medicare as Secondary Payer (MSP)

Some Medicare beneficiaries have health coverage through an employer group health plan, workers' compensation, or automobile and liability insurance. In these cases, Medicare pays after a beneficiary's primary insurer, subject to certain restrictions and conditions.

- Extend Medicare as Secondary Payer (MSP) Provisions from OBRA 1993. Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. To identify primary payers, OBRA 1993 extended, through FY 1998, the data match among HCFA, the Social Security Administration (SSA), and the Internal Revenue Service (IRS). In addition, OBRA 1993 extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for ESRD beneficiaries who are enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. Finally, OBRA 1993 also extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. **This proposal would permanently extend these three MSP provisions.**

  Seven-year savings (Part A and B combined) are $5.6 billion.

- Establish Better Coordination of Insurance Coverage. **This proposal would require a beneficiary's other insurance plan to tell Medicare when that beneficiary is covered.** Currently, Medicare has problems getting this information, resulting in billions of dollars in Medicare payments made on behalf of beneficiaries whose private insurance should have covered the service.

- Clarify Medicare Secondary Payer Authority. The Supreme Court recently invalidated long-standing Medicare rules on MSP, limiting Medicare's ability to make collections in certain situations. **This proposal would clarify Medicare's authority.**

- Eliminate Fraud and Abuse. **This proposal (described in the following section entitled "Combating Fraud and Abuse") would eliminate fraud and abuse in the Medicare by: providing Medicare with modern administrative tools to detect fraud, ensuring that individuals and entities who defraud Medicare are penalized or banned from the program; preventing participation by individuals and entities seeking to defraud the program; and by maintaining necessary resources for eliminating fraud and waste in Medicare.**

  Seven-year savings from the three proposals (Part A and B combined) are $3.4 billion.

- **Physician Self-Referral Prohibitions.** Medicare law prohibits physicians from making referrals to medical facilities in which they have a financial interest. This "self-referral" ban covers certain "designated health services" (e.g., laboratory tests, MRI procedures) that are specified in the law. Some general exceptions to the ban are provided in current law. **This proposal would expand the current exceptions to include services that are furnished in a "shared facility" (defined in the legislation), in ambulatory surgical**

centers, and by hospice programs. The proposal also clarifies the requirements for permissible compensation arrangements.

Seven-year cost is $0.3 billion.

Note: Because of rounding, savings estimates for individual proposals may not equal the total savings.

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

07-Oct-1996 09:56pm

TO: Christopher C. Jennings
TO: Jennifer L. Klein
TO: William White

FROM: Pauline M. Abernathy
National Economic Council

SUBJECT: RNC'S BARBOUR: CLINTON DEBATE STRATEGY? WHEN CORNERED, ...

Date: 10/07/96 Time: 17:47
bRNC's Barbour: Clinton Debate Strategy? When Cornered, Don't Tell

To: National Desk, Political Writer
Contact: Virginia Hume of the Republican National Committee, 202-863-8550

WASHINGTON, Oct. 7 /U.S. Newswire/ -- Following is a statement by Republican National Committee Chairman Haley Barbour:

After watching the debate last night, it's clear why polls show the American people don't trust Bill Clinton. Time and again, Clinton tried to deceive the voters with charges that were just plain false. Here are two examples:

Clinton claimed Dole and Speaker Gingrich had ''cut'' Medicare when, in fact, even the AARP (American Association of Retired Persons) says that's not true. In a letter to Clinton dated 12/19/95, the AARP wrote that the balanced budget Congress passed and Clinton vetoed ''would reduce the average annual rate of growth of Medicare benefits to 7.0 percent.'' The letter went on to state ''the president's plan would reduce Medicare's growth rate to 7.8 percent.'' For Bill Clinton to claim that a 7 percent increase in Medicare is a devastating ''cut,'' while a 7.8 percent increase in Medicare spending allows him to ''protect'' the program is not only absurd, it shows Clinton has no regard for the truth.

Yet it's not enough for Clinton to scare seniors with his falsehoods. He went on to claim Bob Dole had ''voted against student loans.'' Wrong again. The balanced budget Congress passed and Clinton vetoed increased funding for student loans from $24 billion today to $36 billion in 2002 -- a 50 percent increase. According to the Congressional Budget Office, these are the exact same levels that would occur under President Clinton's student loan policies.

Somehow Bill Clinton seems to get away with these deliberate deceptions. As Sen. Bob Kerrey (D-Neb.) has said, ''Clinton's an unusually good liar. Unusually good'' (Esquire, Jan., 1996). But the American people are a lot smarter than Bill Clinton gives them credit for. The truth will come out, and come this election day,

Nov. 5, the American people will choose a leader whom even Democrats describe as a ''man of his word'' -- that man is Bob Dole.

-0-

/U.S. Newswire 202-347-2770/

APNP-10-07-96 1758EDT

SIMILAR LETTER DELIVERED TO ENTIRE CONGRESS

AARP

Bringing lifetimes of experience and leadership to serve all generations.

December 19, 1995

The President
The White House
Washington, DC 20500

Dear Mr. President:

Throughout 1995 one of the most perplexing problems confronting policymakers and the public has been the need to reform and constrain the cost growth in Medicare, and at the same time maintain the program's commitment to provide affordable, quality health care to older and disabled Americans. The dual challenge of constraining cost and continuing to provide quality care has led to a continuing debate over the appropriate growth rate for the Medicare program.

The Medicare reductions proposed in the budget reconciliation conference agreement and in the President's proposal are without precedent in their magnitude and potential effects on the program. In an attempt to understand what a fair and appropriate growth rate for Medicare would be, AARP has compared the Medicare growth rates in the budget reconciliation conference agreement and in the President's December 7, 1995 package to growth rates in the private sector and in current-law Medicare (see enclosed chart). If done accurately, comparisons to the private sector can provide a useful benchmark against which to assess alternative Medicare spending proposals. Unless a proposal permits Medicare spending to grow at least in tandem with growth in the private sector, it seems unlikely that the program will be able to hold its own -- either in payments to providers or in quality of care -- when compared to the coverage available through other payers.

Under current law, the average annual rate of growth in the cost of Medicare benefits is projected to be 9.2 percent over the next seven years, while the average annual rate of growth in health care benefit costs for those under 65 in the private insurance market is estimated to be 7.4 percent. Under the conference agreement, Congress would reduce the average annual rate of growth of Medicare benefits to 7.0 percent. The President's plan would reduce Medicare's growth rate to 7.6 percent. However, looking at these aggregate growth rates can be misleading, and could lead to very serious mistakes.

American Association of Retired Persons 601 E Street, N.W. Washington, D.C. 20049 (202) 434-2277
Horace B. Deets Executive Director

It is only when one looks at the components of health spending that it is possible to accurately assess whether reductions of the magnitude being proposed will sustain basic benefits and quality health care for Medicare enrollees now and in the future.

Health spending increases are composed of several factors:

1. general price inflation as measured by the Consumer Price Index (CPI);
2. population growth;
3. aging of the population; and
4. "health-specific costs," including
   - medical-specific price inflation over the CPI, such as the hospital market basket or the Medicare Economic Index (MEI),
   - medical technology,
   - medical research, and
   - the increased use and complexity of services.

To understand the impact of spending reductions in Medicare as compared to the private sector, we need to focus on the reductions in the only area -- health-specific costs -- where these cost reductions could fall.

The enclosed chart -- which is based upon projections by the Congressional Budget Office (CBO) using the new economic assumptions -- shows that general price inflation applies consistently across all populations. Increases in population and aging of the population are different for those under and over 65, but nonetheless, are determined by demographics; they will not change as the result of any budget legislation.

Health-specific costs, however, are different for those over and under 65. This category can be viewed as the projected *need* for the increased use of health care services, the complexity of these services, and advances in technology. For example, as people grow older they often need a greater number of health care services and more complex types of services than those under 65.

Thus, the reductions in Medicare's rate of growth will not come from general price inflation[1], or from the categories that reflect the growth and aging of the population. These categories reflect factors that are beyond our control and cannot be "legislated away." Rather, changes will come from health-specific costs. In this category, the chart shows that both the Congressional proposal and the President's proposal reduce Medicare's growth rate substantially below the private sector.

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[1] Even if Congress and the President make a change -- or assume one -- in the CPI, it will apply equally across all populations and programs.

Health-specific costs are currently projected to account for 4.1 percent of spending growth in the Medicare program, and 4.0 percent of spending growth for those under 65. However, Congress would dramatically reduce Medicare's rate of growth in this area to 3.0 percent, and the President's proposal only permits 2.8 percent growth.

It is essential that Medicare's cost growth -- and health cost growth, in general -- be cut back. In fact, the current growth rate is unsustainable. Efficiencies can and must be found, and ways to provide quality health care for less must be identified and put into practice. But, if Medicare is to continue to provide an acceptable level of quality care, it cannot be constrained significantly more tightly than private-sector health care. If the disparity between the two is too large, then we risk turning Medicare into a second class health program. Medicare's future growth in health-specific costs should be at least comparable to private sector growth, especially as technology improves, the population ages, and people live longer.

Older Americans and their families look to the Medicare program to provide reliable, affordable health insurance and financial security against the cost of health care. Deep reductions in Medicare spending over 7 years will place tremendous pressure on the program and on the beneficiaries who depend on it. If costs in the overall health care system continue to grow -- as they inevitably will -- but the rate of growth in Medicare is held down, who will pay the difference? Will Congress begin cutting benefits from Medicare to keep costs low? Will health care plans and providers "cut corners" to reduce costs? Will beneficiaries pay more out-of-pocket (e.g., balance billing)? Will individuals in the private sector pay more due to cost-shifting by providers? Will quality suffer?

AARP is concerned about the answers to these questions. If you would like to discuss this further, please do not hesitate to call me, or have your staff call Marty Corry (434-3750) or Tricia Smith (434-3770) of our Federal Affairs Department.

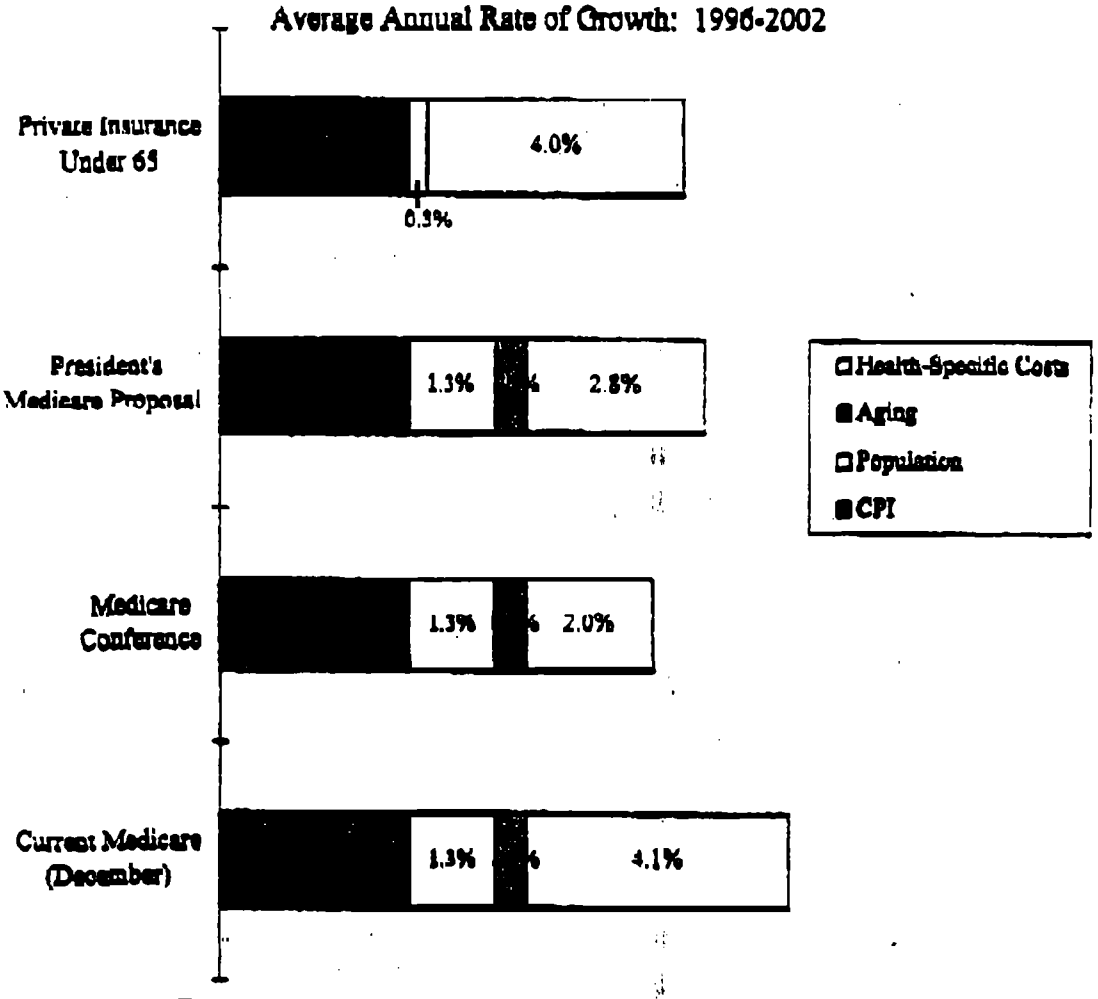
Sincerely,

Horace B. Deets

Enclosure

Components of Health Spending Growth

Average Annual Rate of Growth: 1996-2002



Note: The percentages do not add to the total growth rates. To get to the total growth rates, add "1" and multiply. For example, current Medicare = (1.030)x(1.013)x(1.006)x(1.041)=(1.092)=9.2%.

Source: Based on CBO preliminary December projections, except for the private insurance forecast, which was based on earlier CBO projections.

Congressman Pete Stark's
MEDICARE MONITOR Vol.I, Issue 10

May 12, 1995

IS ARMEY ACCUSING FELLOW REPUBLICANS OF LYING?

Dear Colleague:

"In a blistering attack delivered to an American Enterprise Institute forum on the politics of Medicare," the *National Journal* reported this week, "**[Majority Leader Dick] Armey insisted 'anyone claiming we are cutting Medicare is simply lying,'** since the program will continue to grow, only at a slower rate."

Is Mr. Armey saying that Republicans on the Ways and Means Committee lied last year during consideration of health care reform? It seems a reasonable conclusion to reach.

After all, Republicans in 1994 called a proposed $168 billion reduction in Medicare spending a "cut." Why less than a year later a $283 billion "cut" in Medicare should not be considered one would be a mystery.

[See the reverse side for Republicans' 1994 portrayal of reductions in Medicare expenditures.]

Remember, the level of cuts (or reductions in growth, or whatever one prefers to call it) proposed last year is *one half* the level passed by Budget Committee Republicans this year.

You decide what's a cut.

If federal policy is changed so that services now fully covered by Medicare are only partially covered, and charges currently paid by Medicare are pushed on to beneficiaries, wouldn't you call this a cut? (See page 10 of the "House Republican Budget Committee Recommendations" for three such examples.)

And if the funds not spent on Medicare beneficiaries create room in the budget to cut taxes for wealthy Americans, isn't it accurate to describe the Medicare cuts as financing tax cuts for well-to-do Americans?

I've never had difficulty accepting that reductions in projected expenditures can be considered cuts. And *this year*, because of the drastic nature of the Republican desire to shove

Every Republican on the Ways and Means Committee last year, eleven of which are on the panel this year as well, were signatories to the following statement --

> ***"...the additional massive CUTS in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."***

The current Ways and Means Chairman made the following charge last year –

> ***"I just don't believe that quality of care and availability of care can survive these additional CUTS. And that is the price that is going to have to be paid to pay for these CUTS."***

Current Subcommittee Chairman Clay made the following indictment –

> ***"The Medicare CUTS proposed by the President would devastate the Medicare program... The committee must not approve these destructive Medicare CUTS."***

A Republican Member of the Health Subcommittee this year and last year commented --

> ***"I would love to believe that we could achieve the level of CUTS you have in this bill... But history tells us that isn't possible."***

NOTE: The 1994 Ways and Means Committee health reform bill would have achieved $168 billion in Medicare savings over seven years, all of which would have been re-directed to expand health care coverage, as compared to 1995 Republican proposals to reduce Medicare spending by $283 billion over seven years, none of which would be reinvested to cover uninsured Americans.

Sincerely,

Pete Stark

Pete Stark
Member of Congress

239 Cannon House Office Building, Washington, DC 20515 202-225-5065

YES, THEY WERE CUTS

Experts Confirm That The GOP Medicare Cuts Would Have Had A Devasting Impact

Representatives of hospitals, doctors, and older Americans all concluded that Medicare and Medicaid cuts of the magnitude in the Republican budget threatened accessibility, quality and the level of health care provided:

- **American College of Physicians:** *"We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many...."* [American College of Physicians, October 5, 1995]

- **American College of Physicians, the American Nurses Association and the National Association of Public Hospitals:** "Weighing all the elements of this bill [House and Senate Republican Medicare proposals], the American College of Physicians, the American Nurses Association and the National Association of Public Hospitals, believe that the total package will be harmful to patients, physicians, hospitals, and the health care system as a whole....*This legislation will reverse the gains in the health status of the elderly that Medicare has achieved in its 30 year history....The budget cuts in this package....do not save or preserve Medicare, they simply shift costs from government to patients and providers.*" [American College of Physicians, 10/17/95]

- **Hospitals:** "This legislation...is not in the best interest of patients, communities, and the men and women who care for them....the reductions in the conference report will jeopardize the ability of hospitals and health systems to deliver quality care, not just to those who rely on Medicare and Medicaid, but to all Americans." [America Hospital Association, Catholic Health Association, and Voluntary Hospitals of America, and State Hospital Associations from 47 states, November 17, 1995]

- **American Hospital Association:** The Senate Republicans budget "would result not in a reduction in the rate of growth, but in a *real cut*. That means per beneficiary spending for hospital care grows less than the rate of inflation....[these] reductions will seriously jeopardize the ability of the hospital community to continue to provide high quality care, not only to seniors, but to all our citizens." [American Hospital Association, letter to Senator Dole, 10/16/95]

- **AARP:** "Four hundred billion dollars in *cuts* from these two major health care programs that serve older and low-income Americans do not meet the fairness test. Reductions in Medicare called for in the conference report are much more than is necessary to keep the program solvent into the next decade." [American Association of Retired Persons (AARP), November 16, 1995.]

- **National Council of Senior Citizens:** "No matter how you spin the dial, you can't cut $270 billion out of Medicare and $180 billion out of Medicaid without giving America's elderly, disabled and poor dramatically less health care or dramatically higher out-of-pocket costs." [NCSC News Release, 9/15/95]

- **American Society of Internal Medicine:** "If health-care costs rose faster than the GOP budget allots, doctors, hospitals, and other providers would have to absorb the losses. That, in turn, could come back to bite the beneficiaries. *If doctors, for example, see their Medicare payments cut deeply, they might stop seeing Medicare patients,* explains Robert Doherty of the American Society of Internal Medicine, which represents physicians. *'The rate of reductions is too steep under the Republican plan,'* he says." [*WSJ*, 12/27/95]

- **Corporate Health Care Coalition:** "The basic intent of the GOP plans 'is to push everyone into managed care, drying up the old fee-for-service system,' said Lawrence Atkins, spokesman for a coalition of major corporate employers involved in health benefits issues [The Corporate Health Care Coalition]." [*LA Times*, 10/23/95]

- **American Association of Physicians and Surgeons:** "Doctors won't be able to afford to treat Medicare patients because the rates will be so low, and fee-for-service medicine will just disappear." [LA Times, 10/23/95]

- ***Los Angeles Times:*** "Even the affluent, who could afford to pay doctors more, might find their ability to choose their doctors under today's fee-for-service system would disappear as virtually all physicians shifted into HMOs and other managed-care networks....If only the relatively young and healthy Medicare beneficiaries migrate to HMOs, that would leave the oldest and sickest in more expensive fee-for-service medicine. Medicare would once again face financial catastrophe." [*LA Times*, 10/23/95]

MORE THAN DOLLARS ARE AT STAKE -- THEIR DAMAGING STRUCTURAL CHANGES WOULD FORCE MEDICARE TO "WITHER ON THE VINE."
Republicans continue to insist not just on excessive cuts, but on damaging structural changes that would segment the Medicare population, leaving the traditional program with fewer dollars and sicker beneficiaries.

- **MEDICAL SAVINGS ACCOUNTS (MSAs).** Republicans insist on the immediate adoption of untested changes to the Medicare program, such as MSAs, that appeal to the healthiest and wealthiest beneficiaries, leaving the sickest and most costly beneficiaries in a weakened fee-for-service program. CBO projects that MSAs will *increase* Medicare costs by more than $4 billion over seven years.

  ***New York Times*:** "A hallmark of the [Republican] Medicare legislation is the encouragement of private health plans....But many experts fear a balkanization of healthy and sick....If some experts worry that managed care plans would skim healthy recipients from the conventional Medicare program, many of the large plans are *concerned that the healthy would be skimmed from them by medical savings accounts.*" [11/18/95]

- **OVER-CHARGING IN PRIVATE PLANS.** Republican proposals permit physicians to charge beneficiaries extra -- through "balance billing" -- in private Medicare plans, increasing out-of-pocket costs for beneficiaries and slowly draining the fee-for-service system of both doctors and dollars.

- **HARD SPENDING CAP.** Republicans impose a hard cap on Medicare spending. For the first time in history, the Medicare program would no longer adjust for changes in demographics, general inflation, and costs due to new technology.

  Wall Street Journal: "Republicans also would apply a cap to these services. If health-care costs rose faster than the GOP budget allots, doctors, hospitals and other providers would have to absorb the losses. *That, in turn, could come back to bite the beneficiaries.*" [12/27/95]

PRESIDENT CLINTON'S BALANCED BUDGET SHOWS THAT THE REPUBLICAN DEEP CUTS, PREMIUM HIKES, AND DAMAGING STRUCTURAL CHANGES ARE <u>NOT NECESSARY</u> TO BALANCE THE BUDGET AND GUARANTEE THE LIFE OF THE MEDICARE TRUST FUND FOR 10 YEARS.
The President's budget would guarantee the life of the Trust Fund for a decade from now. [HCFA Chief Actuary 6/4/96]. It builds on his 1993 deficit reduction package, which extended the life of the Trust Fund by 3 years -- without a single Republican vote.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date June 4, 1996

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for HI Trust Fund under Administration's Balanced Budget Proposal

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare provisions in the Administration's balanced budget proposal. Based on the intermediate set of assumptions in the 1996 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in mid-calendar year 2006 under the Administration's proposal.

In the absence of corrective legislation, trust fund depletion would occur early in calendar year 2001 under the intermediate assumptions. Thus, the Administration's proposal would postpone the year of exhaustion by roughly 5½ years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Administration's balanced budget proposal is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Administration's Medicare proposals, we would be happy to provide it.

Richard S. Foster, F.S.A.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date June 4, 1996

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for HI Trust Fund under Senate Budget Resolution

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare savings targets specified in the Senate Budget Resolution. It is our understanding that the resolution would require Medicare expenditure reductions of the following amounts (in billions, by fiscal year):

	1997	1998	1999	2000	2001	2002	Total
HI	$5	$10	$16	$23	$30	$39	$123
SMI	$2	$2	$6	$9	$12	$14	$45
Total	$7	$12	$22	$32	$42	$53	$168

Based on the intermediate set of assumptions in the 1996 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in the first half of calendar year 2004 if the specified savings targets were implemented. Under present law, trust fund depletion would occur early in calendar year 2001 (based on the same assumptions). Thus, the savings proposed under the Senate Budget Resolution would postpone the year of exhaustion by roughly 3 to 3½ years.

This estimate of the year of depletion under the Senate Budget Resolution is subject to several important limitations. First, it is our understanding that the specified savings amounts represent targets, as opposed to the estimated financial effects of a specific package of legislative provisions. Our estimates of the effects of such a package, once it is developed, could differ from the savings amounts shown above.

Second, we believe the savings targets are consistent with the assumptions and estimates developed by the Congressional Budget Office. We have made a rough adjustment to these amounts to place them on a basis consistent with the intermediate assumptions from the 1996 Trustees Report. Actual savings amounts, estimated directly on the basis of the intermediate assumptions, could differ somewhat.

Third, the savings targets were available only through fiscal year 2002. We extrapolated this series by assuming that the savings in later years would represent the same percentage reduction from present-law expenditures as in 2002. In practice, subsequent savings could be either larger or smaller than the extrapolated amounts.

Finally, the financial operations of the HI trust fund will depend heavily on future economic and demographic trends. The estimated year of depletion under the Senate Budget Resolution is very sensitive to the underlying assumptions and could vary significantly if actual future economic and demographic trends differ from these assumptions.

For these reasons, the estimated year of depletion presented in this memorandum represents only a crude estimate of the effects of Senate Budget Resolution's Medicare savings on the HI trust fund. As additional information becomes available on the specific provisions underlying these budget targets, we will be able to prepare more refined estimates. Please let us know if we can provide additional information in the meantime.

Richard S. Foster, F.S.A.

most sensitive aspect of the operation, the pollster said, would be to "get seniors on board" and make them feel that they had a say in the new-fangled Medicare system while gently moving them toward managed care and health maintenance organizations—a direction that gave Republicans the long-term savings they needed to balance the budget. "Our job," DiVall said, "is to get them to choose the option we want them to choose."

Several words were important to that strategy. "Do not say *changing* Medicare," DiVall stressed. Her research showed that seniors were nervous about change and likely to resist it. At a focus group in Cincinnati on March 6, when seniors were asked what words they preferred, one man offered "preserve." It had a comforting ring to it. DiVall promoted the suggestion of another respondent that they call their legislation "the Medicare Preservation Act." There were other words that should be edited out of the Republican dictionary in discussions of Medicare, DiVall said. She advised the group to be "leery" of the words "cut," "cap," and "freeze"—they would bring nothing but trouble and help Democrats define the process in negative terms.

To underscore "the magnitude of the task" ahead, DiVall showed Gingrich and his team the sardonic answer from a focus group that had been asked to predict the newspaper headline on the day Republican congressional leaders announced they would work on Medicare reform. It read: CONGRESS ENFORCES TERM LIMITS.

DiVall's presentation informed most of the people in the room, but it did little to calm their nerves. Leadership aide Barry Jackson felt as if the entire Republican team was "jumping into the unknown and hoping the ripcords worked." At one point the bell rang signaling a vote on the House floor and all the members left except Gingrich, who rarely votes. He seemed fascinated by DiVall's findings. Alone with the pollster and aides, he became "totally engaged in picking up the nuances." By the time the others returned, he seemed convinced that they could find the right words. The voluble speaker was preparing himself for his version of war.

* * *

THE first word on Medicare already had come from Haley Barbour, chairman of the Republican National Committee (RNC). It was one word that he uttered back in February in four private meetings with Gingrich and John Kasich, and with their counterparts in the Senate, Bob Dole and Pete Domenici.

"Don't," Barbour had said.

A gregarious Mississippian known for his southern aphorisms and colorfully mixed metaphors, Barbour viewed the balanced budget as his party's "soft underbelly" and Medicare as its "Achilles' heel." He urged Gingrich and the others to "take it off the table" for at least two years. Public opinion experts had told him that it took two years to educate and prepare the public for change of that sort. The Democrats wanted the Republicans to go after Medicare "like the Pope hates sin," he said. They had been frustrated when the Republicans declared Social Security off-limits during the 1994 election campaigns and were looking for a chance to push their most potent political issue—the argument that Republicans care more about numbers than people.

Don't touch Medicare for two years, Barbour urged the congressional leaders. They could make up for lost time then, and still reach the seven-year balanced budget goal, by attaining the same amount of savings in five years instead of seven. It was not incidental to Barbour's thinking that a two-year delay would carry the Republicans beyond the 1996 elections. "They all understood that I was right politically. God damn, that ain't rocket science," Barbour recalled. But they rejected his advice. "To a man, they said, if you wait two years, the degree of change required is so much more difficult and drastic than if we start now that it'll end up being much worse."

Once Barbour realized his argument had lost, he became a crucial field general in the rhetorical war, devoting himself and his staff to the Medicare cause. His credo was "Information is our ally." His communications policy, as described by one of his aides, was "to continually flood the faxes, flood the technology, with as much information as you can of what you are doing and why. Fax to the world!" Once you find a theme, Barbour said, "the biggest

thing is to get everybody saying the same thing. The only way you can get market penetration is through repetition, repetition, repetition." Over at the RNC headquarters one block from the Capitol, his staff used a more evocative Barbourism: "Repeat it until you vomit."

But there was a problem with the Medicare "account" during those early days of February and March. The public, according to Republican pollsters, did not think there was anything broken in the Medicare system that needed fixing. It appeared that the Republicans were merely tapping into it for their own purposes, to balance the budget and release a similar amount of money for tax cuts for the wealthy. Rank-and-file House members were constantly asking why they had to deal with an issue that they could not easily explain. Gingrich's CommStrat team of press flacks in the Capitol was struggling with the same problem. The speaker kept telling them to "walk people through the moral imperative," but they were uncertain what that meant.

Barbour likened his party's situation to "the country dog that comes to the city: If you stand still, they screw you, and if you run, they bite you on the ass—that's why you've got to be going forward." But he was nervous about going forward without a more compelling theme that could separate Medicare from the numbers game. Linda DiVall's focus groups had started them thinking about what words they should use in talking about Medicare, but they still had no larger rhetorical plan. "We were groping around for a strategy," Barbour recalled.

Then, in the first week of April, the Medicare board of trustees issued its annual report. Word that this document was about to be released had been spreading around Capitol Hill for a few weeks. It was mentioned at a CommStrat meeting, but no one thought it was a big deal. The report came out every year and said essentially the same thing, that Medicare faced long-term financial troubles. No one seemed to pay any attention to it. Barbour had "no idea there was a goddamn Medicare report" until he received a tip from a friendly lobbyist that it would be published earlier than usual. That made him suspicious. "We were out smelling a rat," he said.

"We thought they were going to try to make it look like it was in better condition than it was."

Instead, the report warned that Medicare's trust fund faced bankruptcy by the year 2002. The system's financial condition was deemed "very unfavorable." The report was signed by three cabinet officials in the Clinton administration. Barbour took one look at it and declared, "This is manna from heaven!"

The Republicans had stumbled onto another word they could use effectively in the rhetorical battle over Medicare: "bankruptcy." Barbour carried the news to Gingrich, who considered the report providential. Now they could separate Medicare from the balanced budget. They could say that it needed to be fixed anyway. Gingrich had found his moral framework. The Republicans would repeat it over and over for the rest of the spring and all through the summer. They were saving Medicare from bankruptcy.

Democrats, however, saw a hollow promise in the Republican strategy. The GOP notion of saving Medicare, thought White House aide George Stephanopoulos, "sounded like the old Vietnam argument that they had to destroy the village to save it."

EVERY morning at eight, the press secretaries of CommStrat would participate in a conference call to discuss their message for the day. They would go over what the party office would say in its faxes, what the press secretaries would emphasize in their chats with reporters, what House members on a special Theme Team were planning for the one-minute speeches and longer special orders that begin and end the day on the floor, and what the House Republican Conference was doing to provide cover for members back in their home districts.

It was all part of what Gingrich called the "unified approach" to communications, which gave him tighter control of the message. During his long years as a backbencher when the Democrats controlled Capitol Hill, Gingrich had become obsessed with

FOUR

John Kasich's Dream Machine

THE ABIDING OBSESSION of John Richard Kasich grew ever more intense until it finally seeped into his subconscious. He began dreaming about the federal budget. His budget dreams were invariably ugly. When he fell asleep, his restless mind encountered the same nocturnal furies—fellow members of Congress who appeared before him red-faced and screaming: "How could you do this to us! We didn't know about this!"

As chairman of the House Budget Committee, which undertook the historic but precarious task of attempting to slash programs to balance the federal books by the year 2002, Kasich's confrontations, real and imagined, were getting nastier day by day in May 1995. He had reached a critical moment in his congressional career, a time when his obsession, his dreams, and the fate of his party became inextricably linked. The high-profile House votes on the Contract with America were over by then. Every point in that conservative agenda except term limits had passed the House, but many of them were stalling in the Senate and the early momentum was dissipating. It was obvious to Speaker Gingrich that to bring about significant legislative change, he would have to rely

heavily on the balanced budget bill. That also meant relying more on John Kasich. The fate of the revolution would depend on how the irrepressible mailman's son and Gingrich protégé handled the pressures, the degree to which he lived up to his reputation as an honest broker willing to take on turf-conscious colleagues and special interests traditionally aligned with the Republicans.

Kasich was anything but the green eyeshade sort, more of a human bottle rocket than a patient numbers nerd, but he had a peculiar attraction to the arcane art of the budget. He had been drafting budgets aimed at eliminating the federal deficit since 1989, though those earlier efforts had been brushed aside by the White House or congressional leadership or both. This time he had the strength of the House Republican Revolution behind him. Gingrich had not only supported Kasich's effort but gave it a crucial kickstart. At a news briefing on Valentine's Day, during a period when the Contract with America's provision calling for a constitutional amendment to balance the budget seemed endangered in the Senate, the speaker issued an unequivocal declaration: The House would move forward no matter what happened, pass a bill that balanced the budget in seven years, and push it through Congress.

The declaration of seven years made Kasich and his budget aides nervous. It was one thing to put that number in the constitutional amendment, a document without real numbers in it, but another to have to deal with it in reality. At that point Kasich and his staff were working on a five-year budget—the traditional time span for federal budget projections—that would get them on what was called a "glide path" to balance in seven years. But they were not yet comfortable with the substantial amount of program cuts they would have to make in the sixth and seventh years to reach zero. At a leadership meeting over dinner in Gingrich's office on February 15, Kasich and his aides expressed concern that a seven-year balanced budget would require Medicare cuts "unlike any this town has ever seen before." Kasich was hoping to have more flexibility. "Who said we have to do seven years?" he asked.

Gingrich remained adamant. This was a critical point for the

revolution, he said. They could go forward with what they really believed, or "start accommodating to Washington realities." There was no choice: Go forward. Kasich pressed the question one last time at a leadership meeting on February 21. "Is this etched in stone?" he asked. Gingrich, exasperated, put it to a vote. "All in favor of having it etched in stone raise your hands." Every hand went up *except* the budget chairman's.

But from that moment on, no member of the House was more committed to seven years than Kasich. In March and April he pushed his staff and his budget committee to find a way to get to zero in seven years. By the night of May 2, he had crafted a plan that had the unanimous approval of the Republicans on his committee. The next day he was ready to take it to the full House Republican membership. At three o'clock that afternoon, he bounced out of his congressional office in the Longworth Building and slipped into the front passenger seat of Ohio colleague Dave Hobson's Olds 88 for a *fifty*-minute drive through the northern Virginia countryside to Leesburg, Virginia, where Gingrich and his troops were staging a retreat, regrouping after their first vacation break of the year. The central mission of the retreat was to coalesce around a master plan for the tough budget fights that loomed ahead. Kasich was his usual bundle of nervous energy on the trip to Leesburg, a condition only exacerbated by questions from a backseat passenger, moderate Nancy Johnson of Connecticut, who worried about the budget plan's treatment of Medicare and Medicaid, foreshadowing problems to come.

The *gathering* was Kasich's coming-out party of sorts. The morning after his arrival at the retreat, he took the floor to describe his budget plan. But as he roamed the aisles, praising and cajoling his brothers and sisters in a style that reminded one witness of "Brother John's Traveling Salvation Show," it did not take long for him to notice the first sign of trouble: The Aggies were missing. House Republicans from rural districts, known on Capitol Hill as "Aggies," had essentially boycotted the opening of Kasich's presentation to caucus among themselves in another part of the conference center. Earlier that morning, they had found out from their

leader, Pat Roberts of Kansas, chairman of the House Agriculture Committee, that the Budget Committee proposal cut farm subsidies by $11.7 billion. It was too much, said Roberts, a fellow so attached to the farm constituency that he maintained a vote board on the wall of his Capitol Hill office recording the ups and downs of wheat, corn, milo, and cattle on the Dodge City Daily Markets. Roberts wanted the number cut to single digits.

The shadowplay with the Aggies marked the opening of an important two-week stretch for Kasich that culminated in the House's historic vote approving a measure intended to balance the federal books by the year 2002. On the surface, the budget enterprise seemed to benefit from a remarkable display of party unity. Kasich's plan sailed through the committee and the House floor with only one dissenting vote. But behind the scenes, the boyish budget chairman's we-can-work-it-out motto was stretched to the limit by several powerful factions: the Aggies; a competing group of urban members known as "the Road Gang"; as well as defense hawks and corporate tax break defenders, all of whom threatened to withhold support until their needs were met.

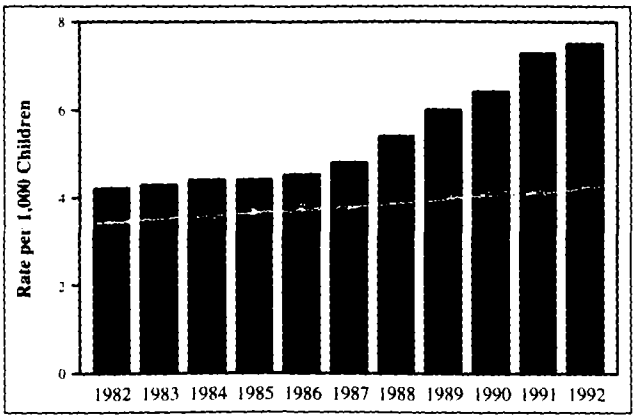
The money in dispute—a relatively few tens of billions of dollars amid $1.4 trillion in savings—seemed almost marginal in comparison with massive cuts in Medicare, job training, science, and education that would become the fields of battle months later when the balanced budget fight turned into a fierce partisan contest with President Clinton. But the internal political considerations at play in May went to the heart of the Republican Party's relationships with key constituencies and its ability to survive as a congressional majority. Relenting here and bargaining there, Kasich attempted to ensure that no faction would suffer or benefit out of proportion to the rest. It was a process that reminded him of a sensitive moment in his own life, after his elderly parents were killed in a traffic accident. "It's kind of like when Mom and Dad go, and you've got to go into the house and figure out who gets what," he said. "You don't want to send an appraiser in there to appraise everything and divide it up, if you're going to do things in a humane and decent way. But you kind of get a

PF 2.3 CHILDREN LIVING IN FOSTER CARE

Placement of a child in foster care occurs when a state protective services worker (under supervision of the state judicial system) determines that a child's family cannot provide a minimally safe environment for the child. Most commonly, placement occurs either because a member of the household has physically or sexually abused the child or because the child's caretaker(s) has severely neglected the child. In some cases, children with severe emotional disturbances may also be put into foster care. Since both federal and state law strongly discourage removal of children from their families, placement in foster care is an extreme step that protective services workers take only when a child is in immediate danger or when attempts to help the family function better have failed. Thus, the frequency of placements in foster care is an indicator of serious family dysfunction and serious damage to the welfare of children.

As shown in Figure PF 2.3, the rate of children living in foster care per thousand children under age 18 has risen dramatically from 4.2 per thousand in 1982 to 7.5 per thousand in 1992—an increase of nearly 80 percent. Nearly all of this increase was concentrated in the five years between 1986 and 1991. The number of children in foster care has risen steadily from 262,000 in 1982 to 442,000 in 1992.

Figure PF 2.3 CHILDREN LIVING IN FOSTER CARE: 1982 - 1992 (Rate per thousand)



Note: Estimate of total is the number of children in foster care on the last day of the fiscal year. Estimate of Race/Ethnicity and Age percentages based on children entering the system.

Source: American Public Welfare Association, *Characteristics of Children in Substitute and Adoptive Care: A Statistical Summary of the VCIS National Child Welfare Data Base*. Public Welfare Association, October 1993.

Table PF 2.3 NUMBER OF CHILDREN LIVING IN FOSTER CARE: 1982 - 1992

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Total											
Number	262,000	269,000	276,000	276,000	280,000	300,000	340,000	383,000	407,000	429,000	442,000
Rate per thousand	4.2	4.3	4.4	4.4	4.5	4.8	5.4	6.0	6.4	7.3	7.5

Note: Estimate of total is the number of children in foster care on the last day of the fiscal year.

Source: Tatara, Toshio. *Characteristics of Children in Substitute and Adoptive care: A Statistical Summary of the VCRS National Child Welfare Data Base*. Washington, DC: October 1993. U.S. Bureau of Census Statistical Abstract of the United States, 1994 (Washington, DC: U.S. Government Printing Office, 1994).

Medicare Premiums: GOP vs. President's Proposal

	1996	1997	1998	1999	2000	2001	2002	7 year total
1995 GOP Budget (CBO, 12/13/95, December CBO baseline)	$51.40	$54.90	$58.60	$62.80	$70.70	$77.20	$84.60	$5,522.40
President's 7-Year Balanced Budget 12/7/95 (CBO, 12/13/95, December CBO baseline)	$42.50	$45.50	$49.50	$53.40	$59.50	$64.60	$70.40	$4,624.80
Monthly Difference from President:	$8.90	$9.40	$9.10	$9.40	$11.20	$12.60	$14.20	
Yearly Difference from President:	$106.80	$112.80	$109.20	$112.80	$134.40	$151.20	$170.40	**$897.60**
Yearly Difference per couple:	$213.60	$225.60	$218.40	$225.60	$268.80	$302.40	$340.80	**$1,795.20**
Vetoed GOP Budget on March 1995 baseline (CBO 11/16/95, CBO didn't score President on March baseline)	$53.70	$57.00	$59.30	$64.10	$73.10	$80.10	$88.90	$5,714.40
Monthly Difference from President:	$11.20	$11.50	$9.80	$10.70	$13.60	$15.50	$18.50	
Yearly Difference from President:	$134.40	$138.00	$117.60	$128.40	$163.20	$186.00	$222.00	$1,089.60
Yearly Difference per couple:	$268.80	$276.00	$235.20	$256.80	$326.40	$372.00	$444.00	$2,179.20

DOC-GINGRICH
BUDGET: MEDICARE
RAISED PREMIUMS
$1000 MORE/COUPLE

VETOED GOP BUDGET (CBO 11/16/95 Mock Backing)

ubtitle H--Rural Areas:								
Medicare-Dependent Payment Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Critical Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Establish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Classification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Expand Access to Nurse Aide Training 3/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal, Subtitle H	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
hange in Net Mandatory Medicare Outlays before Failsafe	-6.8	-14.3	-21.1	-31.2	-42.0	-52.8	-65.3	-233.5
\dditional Outlay Reductions Required by Failsafe, Net of Premiums	0.0	0.0	-6.2	-10.8	-7.1	-7.0	-5.6	-36.6
tal, Medicare	-6.8	-14.3	-27.2	-42.0	-49.0	-59.8	-70.9	-270.0

EMORANDUM: Monthly Part B Premium (By calendar year)

timated premium under proposal	$53.70	$57.00	$59.30	$64.10	$73.10	$80.10	$88.90
timated premium under current law	$42.50	$48.20	$53.20	$55.00	$56.80	$58.60	$60.50

OTNOTES:

Estimate includes medical savings accounts provision.
These items are included in Subtitle H (Rural Areas)
CBO estimates that this provision would cost less than $50 million over seven years.

TES:

tails may not sum to totals because of rounding.
e estimates assume an enactment date of November 15, 1995.
e estimates do not incorporate changes in discretionary spending for administration.

...le VIII, Medicare, as reestimated under December 1995 baseline

13-Dec-95

...fiscal year, in billions of dollars	1996	1997	1998	1999	2000	2001	2002	Total
...bilite H--Rural Areas:								
...ledicare-Dependent Payment Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
...cal Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
...stablish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
...lassification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
...xpand Access to Nurse Aide Training 3/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
...ubtotal, Subtitle H	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
...ange in Net Mandatory Medicare Outlays before Failsafe	-6.4	-13.8	-20.1	-29.6	-39.2	-48.8	-57.8	-215.2
...dditional Outlay Reductions Required by Failsafe, Net of Premiums	0.0	0.0	-2.7	-4.6	-2.6	-1.7	0.0	-11.5
...otal, Medicare	-6.4	-13.8	-22.8	-34.2	-41.8	-50.6	-57.8	-226.7

...EMORANDUM: Monthly Part B Premium (By calendar year)

...stimated premium under proposal	$51.40	$54.90	$58.80	$62.80	$70.70	$77.20	$84.80
...stimated premium under current law	$42.50	$45.80	$50.70	$52.20	$53.70	$55.30	$56.90

...OOTNOTES:

- ... Estimate includes medical savings accounts provision.
- ... These items are included in Subtitle H (Rural Areas)
- ... CBO estimates that this provision would cost less than $50 million over seven years.
- ... CBO assumes that the freeze on reasonable costs or charges would apply to all ambulance services.

...OTES:

- ...otals may not sum to totals because of rounding.
- ...he estimates assume an enactment date of November 15, 1995.
- ...he estimates do not incorporate changes in discretionary spending for administration.
- ...stim... as reflect minor revisions made subsequent to those shown in the Economic and Budget Outlook.

Reestimate of President's Medicare Proposal under April 1996 Baseline

By fiscal year, in billions of dollars	1996	1997	1998	1999	2000	2001	2002	'97-02
Optional Policy: Outpatient Hospital Formula-Driven Overpayment (FDO) /10	0.0	-1.2	-1.5	-1.9	-2.3	-2.8	-3.4	-13.1
Total (with optional policy)	0.5	-6.2	-9.0	-15.9	-22.4	-28.9	-34.2	-116.1

MEMORANDA:

Monthly Part B Premium (By calendar year)							
Estimated premium under proposal	$42.50	$44.00	$47.50	$50.40	$54.20	$58.20	$63.60
Estimated premium under current law	$42.50	$44.40	$48.70	$50.20	$51.70	$53.20	$54.70

FOOTNOTES:

/ Interacted with PPS update (MB-1.5), and with resident freeze in section 11104a.
/ Effect of resident freeze on Direct GME only, effect on IME included in section 11103.
/ Removal of Special Payments Included in Subtitle B, Medicare Choice;
/ Physician policy includes growth rate of GDP+1 percentage point, 1997 single conversion factor of 35.84, and limit on downward adjustments to MEI of 8.25%
/ This is an optional policy whose effects are shown separately below.
/ This provision has an effective date of January 1, 1998.
/ After accounting for changes in policy, Part B outlays would be increased by $55.1 billion over 7 years; Part A outlays be reduced by $67.6 billion.
/ All secondary payer estimates consolidated under Section 11148.
/ Reduction in Part A premium revenue due to lower Part A outlays.
0/ The net change here includes the effect of the policy on Medicare Choice savings and Part B premium receipts.

NOTES:

Details may not sum to totals because of rounding.
The estimates do not incorporate changes in discretionary spending for administration.

Medicare Premiums: GOP vs. President's Proposal

	1996	1997	1998	1999	2000	2001	2002	7 year total
1995 GOP Budget (CBO, 12/13/95, December CBO baseline)	$51.40	$54.90	$58.60	$62.80	$70.70	$77.20	$84.60	$5,522.40
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Monthly Difference from President:	$11.20	$11.50	$9.80	$10.70	$13.60	$15.50	$18.50	
Yearly Difference from President:	$134.40	$138.00	$117.60	$128.40	$163.20	$186.00	$222.00	$1,089.60
Yearly Difference per couple:	$268.80	$276.00	$235.20	$256.80	$326.40	$372.00	$444.00	$2,179.20

Pres t's Proposal Title XI--Health C re, estimated er December 1995 baseline

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle G--Health Insurance for the Temporarily Uninsured	0.0	1.5	2.2	2.3	2.6	2.9	3.1	14.4
Subtitle H--Administrative Simplification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total, Title XI Health Care	-3.5	-1.3	-5.6	-14.0	-20.7	-26.9	-35.0	-107.3

MEMORANDUM: Monthly Part B Premium (By calendar year)

		45.50	49.50	53.40	59.50	64.60	70.40	
Estimated premium under proposal	$42.50	$46.50	$49.50	$53.40	$59.50	$64.60	$70.40	←
Estimated premium under current law	$42.50	$46.80	$50.70	$52.20	$53.70	$55.30	$56.90	
		45.80	50.70			55.30	56.90	

MEMORANDUM: Change in Spending by Medicare, Medicaid, and Other

					18.7		30.9	97.5
Total Medicare	-1.2	-3.2	-8.4	6.4 -12.4	-16.7	-24.4	-30.9	-97.6
Total Medicaid	-2.3	-3.4	-6.1	-8.7	-8.3	-7.9	-7.7	-37.8
Total Other	0.0	5.3	8.9	4.1	4.3	6.5	3.6	22.7
Total, Title XI	-3.5	-1.3	-5.6	-14.0	-20.7	-26.9	-35.0	-107.3

$620

FOOTNOTES:

1/ Included in Subtitle B, Medicare Choice.
2/ For this discretionary provision, the proposal authorizes $3.5 billion for 1997 - 1998, $1.5 billion for 1999 - 2001 and $500 million for 2002 - 2005.
3/ Proposal would transfer $62.1 billion to Part B over 7 years
4/ Includes discretionary grant programs, but not the expansion of self-employed tax deduction.
5/ Most of these are to be made budget neutral; other provisions not sufficiently specified to estimate savings.
6/ Probably no significant revenue impacts from repeal of excise tax for non-qualified large group plans etc.
7/ Probably no significant revenue impacts from ERISA provisions.
Assumes the insurance reforms are identical to S. 1028--additional provisions could have cost/revenue implications.

NOTES:

Details may not sum to totals because of rounding.
The estimates assume an enactment date of February 1, 1996.
The estimates do not incorporate changes in discretionary spending for administration.

CBO: THIS GOP BUDGET on DECEMBER BASELINE....

itle VIII, Medicare, as reestimated under December 1995 baseline

13-Dec-95

by fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
ubtitle H--Rural Areas:								
Medicare-Dependent Payment Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Critical Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Establish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Cl sification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Expand Access to Nurse Aide Training 3/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal, Subtitle H	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
hange in Net Mandatory Medicare Outlays before Failsafe	-6.4	-13.8	-20.1	-29.6	-39.2	-48.8	-57.8	-215.2
Additional Outlay Reductions Required by Failsafe, Net of Premiums	0.0	0.0	-2.7	-4.6	-2.8	-9.7	0.0	-11.8
Total, Medicare	-6.4	-13.8	-22.8	-34.2	-41.6	-60.0	-57.8	-226.7

MEMORANDUM: Monthly Part B Premium (By calendar year)

Estimated premium under proposal	$51.40	$54.90	$58.60	$62.80	$70.70	$77.20	$84.60
Estimated premium under current law	$42.50	$45.80	$50.70	$52.20	$53.70	$55.30	$56.90

FOOTNOTES:

1/ Estimate includes medical savings accounts provision.
2/ These items are included in Subtitle H (Rural Areas)
3/ CBO estimates that this provision would cost less than $50 million over seven years.
4/ CBO assumes that the freeze on reasonable costs or charges would apply to all ambulance services.

NOTES:

Details may not sum to totals because of rounding.
The estimates assume an enactment date of November 15, 1995.
The estimates do not incorporate changes in discretionary spending for administration.
Estimates reflect r evisions made subsequent to those shown in the Economic and et Outlook.

SEP 29 '95 08:39PM HCRP

1 ETOED GOP BUDGET (C) 11/16/95 Mock Backing

Subtitle H–Rural Areas:								
Medicare-Dependent Payment Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Critical Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Establish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Classification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Expand Access to Nurse Aide Training 3/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal, Subtitle H	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Change in Net Mandatory Medicare Outlays before Failsafe	-6.8	-14.3	-21.1	-31.2	-42.0	-52.8	-65.3	-233.5
Additional Outlay Reductions Required by Failsafe, Net of Premiums	0.0	0.0	-6.2	-10.8	-7.1	-7.0	-5.6	-36.6
Total, Medicare	-6.8	-14.3	-27.2	-42.0	-49.0	-59.8	-70.9	-270.0

MEMORANDUM: Monthly Part B Premium (By calendar year)

Estimated premium under proposal	$53.70	$57.00	$59.30	$64.10	$73.10	$80.10	$88.90
Estimated premium under current law	$42.50	$48.20	$53.20	$55.00	$58.60	$58.60	$60.50

FOOTNOTES:

1/ Estimate includes medical savings accounts provision.
2/ These items are included in Subtitle H (Rural Areas)
3/ CBO estimates that this provision would cost less than $50 million over seven years.

NOTES:

Details may not sum to totals because of rounding.
The estimates assume an enactment date of November 15, 1995.
The estimates do not incorporate changes in discretionary spending for administration.

Vendor payment program -
Aid to Dependent
Children

→ one reason to
qualify was
medical need

→ auth. to pay medicals. bills for kids

- no min. benefits $
stds - no insurance

Amendments of 1991 (P.L. 102-234) prohibit the use of provider donations after 1992 (or mid-1993, in certain States) and limit the use of provider-specific taxes.

G. Medicaid and the Federal Budget

From a Federal budget perspective, Medicaid is viewed as an entitlement program. Entitlement programs provide benefits to all people or jurisdictions who are eligible and receive benefits. Spending levels for entitlements are determined, not by the annual appropriation process, but by the number of persons who participate in the program and program benefit levels. However, Medicaid spending is still drawn from Federal general funds. There is no trust fund like that established for some other entitlement programs (such as Social Security and Part A of Medicare).

Under the Budget Enforcement Act of 1990 (Title XIII of OBRA 90, P.L. 101-508), Medicaid spending falls into the "pay-as-you-go" category with other entitlement programs. The budget law requires that for fiscal years 1991 through 1995 any legislation affecting these programs should be deficit neutral for the whole class of entitlement programs. That is, any legislative change in one of these programs that would increase spending over current law levels must by offset by changes in the same program or other "pay-as-you-go" programs, in order to avoid increasing the size of the Federal deficit.

II. MEDICAID PROGRAM HISTORY

A. Predecessor Programs and Enactment of Medicaid

Medicaid was enacted in 1965, in the same legislation that created the Medicare program, the Social Security Amendments of 1965 (P.L. 89-97). It grew out of and replaced two earlier programs of Federal grants to States to provide medical care to low-income persons. The first was the vendor payment program for welfare recipients, enacted in 1950. The second was the Kerr-Mills medical assistance program for the aged, enacted in 1960.

TABLE I-2. Major Medicaid Legislation, 1965 to 1991

- **1965** — Social Security Amendments of 1965 (P.L. 89-97)
  - Established the Medicaid program
- **1967** — Social Security Amendments of 1967 (P.L. 90-248)
  - Limited financial standards for the medically needy
  - Established the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to improve child health
  - Permitted Medicaid beneficiaries to sue providers of their choice
- **1971** — Act of December 14, 1971 (P.L. 92-223)
  - Allowed States to cover services in intermediate care facilities (ICFs) and ICFs for the mentally retarded (ICFs/MR)
- **1972** — Social Security Amendments of 1972 (P.L. 92-603)
  - Repealed 1965 provision requiring States to move toward comprehensive Medicaid coverage
  - Allowed States to cover care for beneficiaries under age 22 in psychiatric hospitals
- **1977** — Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142)
  - Established Medicaid Fraud Control Units
- **1980** — Mental Health Systems Act (P.L. 96-398)
  - Required most States to develop a computerized Medicaid Management Information System (MMIS)
- **1981** — Omnibus Reconciliation Act of 1980 (P.L. 96-499)
  - Broad amendment permitted States to establish payment systems for nursing home care in lieu of Medicare's rule
- Omnibus Budget Reconciliation Act of 1981 (OBRA 81, P.L. 97-35)
  - Enacted 3-year reductions in Federal matching percentages for States whose spending exceeded growth targets
  - Established section 1915(b) and 1915(c) waiver programs (freedom-of-choice and home and community-based services)
  - Extended the Boren amendment to inpatient hospital services
  - Eliminated special penalties for noncompliance with EPSDT requirements and gave States with medically needy programs broader authority to limit coverage
- **1984** — Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369)
  - Eliminated categorical tests for certain pregnant women and young children

Continued on next page.

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

04-Oct-1996 01:15pm

TO: klein_j

FROM: Timothy Westmoreland

SUBJECT: Still checking, but I have been reminded that the Maternal a

Still checking, but I have been reminded that the Maternal and Child Health program goes back to 1935; it was, however, not an individual assistance program. We're checking on the welfare "vendor payment" program pre-1960.

TMW

103d Congress 1st Session	COMMITTEE PRINT	Committee Print 103-A

MEDICAID SOURCE BOOK:
BACKGROUND DATA AND ANALYSIS
(A 1993 Update)

A REPORT

PREPARED BY THE

CONGRESSIONAL RESEARCH SERVICE

FOR THE USE OF THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

JANUARY 1993

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To J Kleine	From S Rosenbaum	
Co./Dept.	Co.	
Phone #	Phone #	
Fax #	Fax #	

Welfare Medicine in America

by Stevens, R
and Stevens, R.

THE FREE PRESS

2

Public and Political Concern with Medical Care

The Philosophies Congeal

While the Social Security Act of 1935 sidestepped the issue of medical care, the question of national health insurance by no means disappeared. For both the working population and the poor, some type of coverage of medical bills was becoming imperative. High medical bills were already a feature of modern specialized medicine. There was still no direct federal provision for medical care for those on welfare, a situation which continued until 1950. For the middle class, the alternative to a federal program was reliance on the private insurance sector. From 1935 to 1950, however, national health insurance continued to be actively debated.

Private health insurance schemes for the working population grew to fill the vacuum caused by the failure to implement public insurance or to offer a viable alternative. Both Blue Cross (for hospitals) and Blue Shield (for physician bills) were products of the late 1930s. The first fullfledged example of the latter was the California Physicians Service, started in 1939. By the end of 1946 this plan had over 419,000 subscribers.[1] These voluntary, nonprofit insurance plans filled a pressing need, by spreading the risk of large medical bills among the middle-class population. The programs were to expand rapidly in the 1940s, in large part through collective bargaining agreements negotiated after World War II.[2]

By 1940, however, only 9 percent of the civilian population were covered for any kind of hospital benefits through private health insurance. Only 4 percent were covered for surgical benefits and 2 percent for in-hospital medical benefits. Nevertheless the gap was closing. By 1950 these figures had grown dramatically to 51 percent, 36 percent, and 14 percent respectively.[3] So fast was the increase, indeed, that the private health insurance movement was used by some in the late 1940s as evidence that a govern-

ment-supported health insurance scheme for the whole population was unnecessary.

During the 1940s innumerable bills proposing a government subsidy, organization, or provision of a socially inclusive health insurance system died in Congress.[4] President Truman's plea that every member of the population had a "right to adequate medical care and the opportunity to achieve and enjoy good health," as well as the "right to adequate protection from the economic fears of . . . sickness"[5] was apparently unpersuasive. The Congress was in favor of a new program to subsidize construction of hospitals and related facilities in rural areas, enacted as the Hill-Burton Act in 1946[6]—another government excursion along the same philosophical road of "gap-plugging" with respect to services for the socially deprived. But prepayment of medical costs for all was consistently defeated.

Compulsory government prepayment for health services for the working population fell once more under the stigma of political clichés. Whereas the earliest health insurance movement of 1915–20 had suffered the indignity of the times by being labelled "German," the health insurance movement of the 1940s found itself castigated as "socialized medicine" by the major lobbying groups against it (notably by the American Medical Association). Senator Wagner, one of the major proponents of compulsory national health insurance in the 1940s, insisted in vain that a system of insurance was not socialized medicine. No hospitals would be taken over, no physicians would be employed by the state; the scheme would primarily have guaranteed certain medical services to all those eligible when they needed it. Yet by 1949 the movement toward national health insurance for the whole population was moribund. It was to remain moribund until the 1970s.

If Congress or the states had enacted a comprehensive system of health insurance or service for the whole or a substantial sector of the population, health services and income-maintenance programs would have been long ago divorced in the United States, as they are in the United Kingdom and many other western European countries. Health services would have been made available to the poor and to other beneficiaries as an entitlement quite apart from programs of cash assistance and other supporting services. But the defeat of the Wagner-Murray-Dingell bills of the 1940s, like the earlier exclusion of health insurance from social security legislation, denied that there was a need for a separate system of health protection. Instead, government intervention in health services continued to focus on the health needs of specific groups and continued to be viewed as a subsidiary aspect of income protection.[7]

This philosophy of providing medical services only to those in approved financial need permeated a host of alternative proposals to the Wagner-Murray-Dingell bills. Although the provision of health services to essential personnel (and their dependents) in wartime clearly represented a different social goal from the provision of health services to those on public assis-

tance, the same selective principle operated. There was tacit agreement that publicly organized health services were not necessary to the normal operation of a private enterprise system. Publicly supported medical care would be made available only to those who could not afford to purchase it privately. For those on public assistance (and for veterans in the expanding World War II veterans program, with respect to non-service-connected health conditions), this meant access to free health services only on passing a means test.

By 1950 the proponents of comprehensive national health insurance and those in favor of providing medical care only to those in proven need formed two distinct political camps. The two philosophies were once again in conflict. National health insurance, like other aspects of the contributory social security program, would provide specific benefits as a right for all beneficiaries. The public assistance approach, supported by Senator Robert Taft and others, regarded the need for government-sponsored health care as an aberrant necessity rather than being in any sense generally desirable and saw eligibility and benefits in terms of discretionary actions rather than clear-cut rights.

Senator Taft outlined this latter philosophy in a nutshell, in presenting his own proposed National Health Program of 1949:

> *It has always been assumed in this country that those able to pay for medical care would buy their own medical service, just as under any system, except a socialistic system, they buy their own food, their own housing, their own clothing, and their own automobiles. . . . Undoubtedly, in that system there are gaps, particularly in rural districts and poorer districts in the cities, and we have a very definite interest in trying to fill up those gaps.*[8]

It was in this context that "welfare medicine" was defined. Medical services to the poor were viewed as a reflection of unavoidable—but peripheral—breakdowns in the economic system, rather than as a pointer toward national health service benefits.

Vendor Payments Become the Order of the Day

The philosophical arguments could, however, have been made much more clearly if public assistance benefits had been both broader and more effective. But public assistance, too, was in a state of confusion and disarray. The structure of categorical federal grants to the states for public assistance was one drawback. Even with the inclusion of a new program of Aid to the Permanently and Totally Disabled (APTD) in 1950, under the same formula as OAA and AB, and even with the extension under the same legislation of ADC to cover a needy adult caring for a child, thus translating the

program into the current Aid to Families with Dependent Children (AFDC), there were obvious gaps in the categorical system. The child of an unemployed father was not covered (a situation later somewhat alleviated by the development of the Aid to Families with Dependent Children-Unemployed Parent [AFDC-UP] program); the child of a father who had deserted his family was covered under AFDC.[9] The destitute person aged 64 was not covered; the person of 65 was eligible for OAA. Yet categorical assistance became the order of the day. Between 1940 and 1966 the number of individuals receiving cash payments under general assistance declined from four million to less than 600,000, while the number receiving categorical assistance rose from some three million to over seven million persons.[10]

Even within the categories the amounts of assistance were barely adequate. At the time the 1950 Amendments were being discussed the maximum possible federal contribution for OAA and AB was $30 of the first $50 a month spent by the state. For ADC the maximum was $16.50 of the first $27 a month spent by the state for the first child in a family, with a similar percentage of a lesser amount for other children. (States could, of course, choose to pay a sum lower than the federal maximum, thereby receiving less by way of matching funds). There was marked concern in some states over the inadequacy of these arrangements. A referendum in the California state elections of 1949 approved a constitutional amendment guaranteeing every old person a minimum of $75 a month. Similar pressures in Louisiana led to a doubling of old-age assistance grants and a definition of need so liberal that in 1949 as many as 79 percent of the elderly population were receiving relief.[11] But in many other states assistance provisions continued to be minimal. Thus, even where reasonably comprehensive health services were provided by the states and localities to those on assistance, in many states, including New York, there were large numbers of "deserving poor" who were not eligible.

The lack of separate provisions in the 1935 Act for federal cost-sharing of any health care provided to public assistance recipients proved another obvious deficiency in public assistance programs. Federal grants to the states applied only to payments made directly to welfare recipients. Although part of such payment could be earmarked by the state for medical care paid for out of the recipients' pocket, the existence of the relatively low federal ceilings on reimbursement made this possibility unlikely.

A survey of 20 states undertaken by the Bureau of Public Assistance in the late 1940s noted the absence of any provision for medical care as the major problem of public assistance. Even where there were programs, there were problems of administration. Especially where large amounts of money were involved, it was not surprising that the agencies preferred dealing directly with doctors, nurses or clinics rather than attempting to pay for services through the welfare recipient.[12] There was an implied possibility that the recipient might abscond with the funds, or at least use them for

other purposes, and serious concern by welfare administrators about the provision of good medical care.

The debates over social security and public assistance roles, purposes, and levels in the 1940s (and after) formed an essential backdrop to concurrent discussions of health insurance. If the basic working population were to rely increasingly (as seemed likely) on private health insurance as a means of paying their medical bills, protection of the marginal worker and the nonworking population could be seen as a vital foundation for the remainder of the population. Indeed, if the poor were receiving adequate medical care from public sources and the main working population were covered by private insurance, there would be no obvious call for setting up compulsory state-run national health insurance. Providing better health services to the poor through available public assistance schemes thus offered a viable political alternative to national health insurance in the 1940s.

The Social Security Amendments of 1950 provided an important watershed in these debates, and a temporary victory for those opposing national health insurance. By expanding the federal public assistance categorical grants-in-aid to include federal cost-sharing with respect to charges for hospital and other medical care paid directly to providers by state welfare agencies, the amendments enlarged the potential scope of welfare medical care. State welfare administrators were mollified because states would henceforth be able to reimburse the providers of care directly—hence the coining of a new term, *vendor payments*. Opponents of national health insurance were also gratified in that—while funding continued to be low—the new arrangement opened the door for expanded health services for the poor and thus lessened the need for more draconian federal measures.

These hopes were not unfounded. With the availability of federal grants-in-aid for vendor payments, the states began providing medical services on a much larger scale. By 1960, medical vendor payments under all public-assistance programs had reached a total of $514 million, well over half of which was for hospital and nursing-home care.[13] These payments were, however, still limited to persons on the welfare rolls, for almost all of whom the states were also recovering part of their cash benefits from the federal government through one of the categorical assistance programs.

At the same time, the implementation of federally-subsidized vendor payments marked the end of serious discussions of comprehensive national health insurance by the Congress for 20 years. Yet it was clear from the beginning of the vendor payments scheme that the level of health care provided was likely to remain inadequate, at least for those receiving old-age pensions and old-age assistance, as well as for certain other groups.

Opinion polls late in the Depression had indicated widespread support for government disbursements to the aged needy; such concern continued in the 1940s.[14] Indeed, as already noted, some states were making assistance payments substantially above federally subsidized levels. Yet health needs

and income needs could not be separated. The provision of medical care to the elderly was an essential part of their income protection; the aged, more than any other categorical group, were likely to fall sick, need hospitalization and nursing-home care, and incur major, long-term medical expenses without concomitant earning powers. But besides having increasingly evident medical needs—and medical bills—the elderly were becoming a potent force in American politics. In Massachusetts, for example, the demands of the old-age lobby affected health care services to the extent of a state policy amending the OAA state law as early as 1945, requiring old-age assistance to "provide for adequate medical care for every recipient of assistance. . . ." Under this, recipients were to have free choice of physician, subject to departmental rules and regulations.[15]

The availability of federal vendor payments after 1950, by providing state responsibility for reimbursement to providers, accelerated the movement toward the provision of standard medical benefits within each state. In Massachusetts, for instance, the movement led in 1954 to a state plan that set out liberal provisions for medical care for old-age assistance recipients, reimbursable under fee schedules negotiated with medical organizations. Yet the relatively low amounts provided by federal grants-in-aid (including vendor payments) meant that a state such as Massachusetts, with relatively liberal medical provisions, spent far more for the medical care of its OAA recipients than the sums received from the federal government under the vendor-payment formula. In many other states, however, medical care for the aged poor remained minimal or nonexistent, with considerable variations even within the states.

Medical Care and Geriatric Politics

During the 1950s there was a growing groundswell of concern from and about the increasing number of the aged who were not on public assistance but who, becoming sick through no fault of their own, frequently lacked adequate private insurance, with the result that their life's savings too often vanished in a spate of medical bills. In 1935 one of the major foci for welfare provision had been children. But while children remained an important sector of the welfare population, their assistance and health needs were (probably wrongly) assumed to be relatively well met in comparison with the conditions of the elderly. By the 1950s, moreover, the aged represented a special group of "deserving poor," with special needs with respect to medical bills. The very successes of modern medicine in preventing and controlling diseases meant that an increasing proportion of the population lived to reach the age of 65 and thus became susceptible to chronic and crippling conditions. Almost four out of five aged persons, it was reported, were afflicted with one or more chronic conditions. Few were able to buy

private health insurance; as a result, almost three fourths of all health bills for the elderly had to be met by the aged themselves, from savings or by assuming debts or by their relatives—at the very moment that family structure was changing, and the social responsibility of children for their parents was being questioned. Moreover, the medical bills themselves were high. Because of their great need, the average health bill for those over 65 was twice that for the remainder of the population.[10]

Although the early years of the Eisenhower administration reflected a certain amount of complacency, a series of hearings in the late 1950s brought these demands into focus through poignant vignettes.[17] The political pressures were growing. In terms of policy, there were three ways in which the needs of such elderly persons, unable to pay their medical bills out of Social Security benefits (which had not kept pace with the cost of living) or from other funds, could be met. First, efforts could be made to remove the stigma of public assistance, making a minimum income a guaranteed right and with it providing basic health protection. The idea of a minimum income, while it had a period of popularity in the Townsend plan of the 1930s, was alien to the burgeoning prosperity of the 1950s; indeed, it has reappeared as a serious possibility only in the last few years. The second possibility was to provide health benefits as a part of the existing social security provisions for the elderly, regardless of their means. The third and most traditional approach was to create a new category of those to be recognized as deserving and poor, who would be clearly distinguished from others on public assistance. These last two possibilities, based on the very different insurance and assistance philosophies, formed the context of debate over welfare medicine in the 1950s.

The medical needs of the elderly had become a focus of attention for both Republicans and Democrats. In 1951, on the advice of Oscar Ewing, the Federal Security Administrator, President Truman's administration withdrew from its previous position as an advocate of national health insurance for the whole population. Instead, the administration focused its efforts on proposals for a subsidized hospital insurance scheme limited to the elderly.[18] This move defused the health insurance issue from the emotionalism caused by its apparent (if erroneous) kinship to "socialized medicine," in favor of building services on to the existing social security pension system. Between 1957 and 1965 (in which latter year the present Medicare program was passed) health insurance proposals instituted by both Republicans and Democrats were geared toward the special needs of the aged.[19]

There were both political as well as humanitarian reasons for taking this tack. Politically, the aged were becoming both more numerous and more articulate. By 1960, there were 16.5 million people 65 years of age and over, representing 15.4 percent of the population over 21. This sizable proportion of potential voters could not be ignored politically. While proposals for health insurance remained dormant during the first Eisenhower term,

Health Insurance for the Aged, the forerunner of hospital benefits under Medicare, appeared forcefully in 1957 under the sponsorship of Senator Aimé Forand.[20] His bill proposed that Social Security contributions should be raised to provide up to 120 combined days of hospital and skilled nursing home care, together with necessary surgery, for those receiving Social Security benefits. This proposal was thus much more limited in scope, as well as in coverage, than the earlier proposals for national health insurance. Nevertheless, the underlying principle was similar: Health benefits would be provided as a right to all eligible members of the population regardless of any means test. Such a health insurance system could, moreover, be extended in the future to other age groups and to other types of health care. As such the Forand bill and its successors were the thin end of a wedge of national health insurance. Meanwhile others were pressing for expanded medical care through the categorical forms of public assistance. From this latter pressure the Kerr-Mills compromise was to emerge.

Kerr-Mills

By 1960 health insurance for the aged had become a major political issue.[21] In part this was a reflection of inadequate levels of retirement benefits under Social Security; in part it was a reflection of the inadequate services made available under public assistance vendor payments to the two million persons on old-age assistance. In 1960 there were still 10 states and jurisdictions that made no vendor payments at all to provide medical care for those receiving public assistance. And in those states with a federal-state vendor-payments program, there were wide variations. Under OAA, the average monthly amount paid for medical care per recipient varied from 19 cents (Montana) to $43.93 (Wisconsin). Services covered under the programs also varied widely, some states covering hospitalization but not physician services, some excluding hospitalization, and so on; moreover there were often variations from county to county.[22]

The voluntary nature of the assistance grants programs encouraged such differences. States were not required to offer health programs or services under the vendor-payments scheme, although the federal government stood ready to provide matching funds when the states spent their share. Entitlements for care were rarely generous or open-ended. In Missouri recipients of old-age assistance were entitled to hospital care only for medical emergencies or acute serious illness, and care was limited to 14 days per admission. However, nursing-home care was also available, but only up to a maximum of $65 a month, or $100 a month if the patient was completely bedridden. Mississippi paid up to 15 days of acute hospital care for an OAA recipient in any one year at rates not to exceed $15 a day, at a time when the average daily cost of voluntary hospitals in the state was more than $25.

The state did, however, maintain three state charity hospitals for provision of care to the indigent (at a daily cost of well below $15). Louisiana had a unique state network of charity hospitals. Begun in 1814, and substantially developed by Huey Long, they comprised nine hospitals, two of which acted as specialist referral centers. Free ambulance and bus service was also provided.

Iowa made vendor payments for virtually all types of care except hospital care, but the latter was provided by the State University Hospital at Iowa City or locally, with the expense borne by the county poor fund. Delaware also left hospital care to the counties, which paid for ward care at the extremely low rates of between $2 and $4 a day; it was estimated that the hospitals themselves subsidized the poor to the extent of a quarter of a million dollars a year. Nationwide, the medical profession was expected to give free care: it was alleged, for instance, that physicians donated $658 million in services in 1960 alone.[23] Of course, relatives were expected to help finance their poor relations. In Texas it was estimated that in 1961 private charity contributed between $10 and $11 million to medical care of the indigent. Much of this was contributed (often under pressure from welfare departments) by the children of aged recipients. These patterns and their variations were duplicated from state to state and from place to place.

The combination of vendor-payment schemes and services provided by state, county, and city authorities created a web of enormous complexity. But it was clear that New York and California were providing substantial programs compared with most other states. New York, in particular, with its $80 million public health service expenditures (in 1959) and a total of $69 million in vendor medical payments, was providing a vast social service with respect to medical assistance. Yet even there, the payments made to providers of care were far lower than the standard prevailing fees. While there appeared to be general agreement in the states about the inevitability of low payments for the care of the poor, the expectation of charity by providers—hospitals, nursing homes, physicians and others—gave not only a continuing piquancy to the welfare stigma but also a direct incentive for the providers to welcome more generous public assistance reimbursement schemes.

The question of costs was to reverberate throughout all subsequent debates about welfare medicine. In 1960, however, it was largely as an aspect of consumer hardship rather than provider concern that costs were of vital political importance. The rising costs of medical care, especially as far as the elderly were concerned, were pricing vital health services out of reach. Hospital room rates more than tripled in cost between 1945 and 1958. While in retrospect the costs appear nostalgically low even in the latter year (an average of $28 a day), the price spiral of medical costs was already causing general concern.[24] For the elderly, rising costs were of special

concern, or at least of special interest in view of the fact that they frequently had fixed incomes. The average annual medical bill per OAA recipient in New York in 1960 was $700.[25] This was not only higher than the average cash benefits provided to the elderly in that state, but it was appreciably more than many of those not on public assistance could afford for medical services.

That persons 65 and over were reportedly twice as likely as other members of the population to need medical care, and at the same time held significantly less private health insurance,[26] meant a continuing prominence for medical care costs in Congressional hearings and in the press. Concern with the problems of the aged was reinforced, in turn, by 1960 House and Senate hearings on the Forand bill, by then under the sponsorship of Senators Clinton Anderson and John Kennedy. Although the House Ways and Means Committee defeated the Forand proposals by a vote of 17–8, the mail continued so strongly in favor of the proposals that the Committee took up the proposals a second time. While its second vote, in June, was similar to the first, the proposals could not be lightly dismissed.

It was clear to the political realist that, if the movement for health insurance for the aged as part of the Social Security system were to be slowed down (if not stopped), there had to be a viable, or at least plausible, alternative. While the health insurance principle was vigorously opposed, there was thus a willingness to consider benefits for the elderly under an expanded form of welfare system. One form of expansion was already available. As a countermeasure to the proposals for hospital insurance for the aged, the Eisenhower Administration had proposed earlier in 1960 a new federal-state program to protect the low-income aged against the cost of long-term illness. This proposal would have established a national means-test eligibility level for medical assistance, with specified physician, hospital, and nursing benefits.[27] But a national means test was still unacceptable; this, too, was rejected by the House Ways and Means Committee.

This left as a third possibility the expansion of the existing system. Sponsored by Representative Wilbur Mills of Arkansas, and by Senator Robert Kerr of Oklahoma, the Kerr-Mills proposal was born. Added to the omnibus Social Security Bill of 1960 (H.R. 12580) the new proposals, representing the triumph of the welfare approach, were enacted into law as the Kerr-Mills Act of that year.[28]

The Kerr-Mills legislation rocked no boats. This, indeed, was the essence of its political success. Other proposals at the time for subsidizing health bills for the elderly would have required substantial administrative changes in the manner of paying medical bills as well as the acceptance of new concepts of entitlement to medical care. The Forand proposals, for example, would have demanded substantial expansion in the social security system, an expansion eventually achieved under Medicare in 1965. Proposals supported by the Administration in 1960 would have set an important prece-

dent in providing federal subsidy of private insurance for the elderly. The Kerr-Mills legislation provided temporary relief to opponents of both philosophies, by accepting neither principle. Instead Kerr-Mills extended the existing system of vendor payments, turning an expedient blind eye to that system's deficiencies.

Social legislation is too often accompanied by hyperbole. As was later to be true of Medicaid, wide claims were made for the new legislation. According to Senator Kerr the plan was "to provide a program, in every State of the Union in which the individual State has or wants a medical-care program for its aged, whereby every aged person in each individual State can, under the provisions of a medical-care program approved by each state, have an adequate medical-care program." Two underlying themes were evident. The first was a strong commitment to continuing state responsibility for welfare medicine; the second, a kind of hopeful expectation that each state would indeed provide adequate care so that a national problem would be avoided. The legislation thus contained a built-in inconsistency. Senator Forand remarked:

> *It will not do any harm, but it will not do any good. Personally I think it is a shame, I think it is a mirage that we are holding up to the old folks to look at and think they are going to get something. I am sure all of you know enough about legislative bodies to realize that the list of items the States could provide under the plan just would never be realized.*[29]

The potential of Kerr-Mills was, however, substantial. The Act not only provided more generous federal matching grants for vendor medical payments for medical care provided to welfare recipients under old-age assistance;[30] it also—much more significantly—included a new category of vendor payments that would apply to elderly persons who were poor but not receiving cash assistance. To accomplish this, a separate program of federal grants to the states, Medical Assistance to the Aged (MAA), was established to pay for services with respect to the "medically needy" aged; after 1962 the blind and disabled were included under a similar category (Title XVI). These new beneficiaries were defined as elderly or blind persons or totally disabled persons over 21 who were not on public assistance and whose income might be above state eligibility levels for cash assistance but who nevertheless had incomes insufficient to meet their medical bills. Here, then, was a new assistance category, "medical indigence," for the deserving poor, primarily for those 65 years of age and over. The new program provided matching grants to participating states of 50 to 80 percent of the cost of vendor payments.

The structure, to be followed later by Medicaid, was one of open-ended federal cost-sharing, without limitations on individual payments or on total state expenditures; cost control was left to the states. The matching formula

favored lower-income states, including incidentally those of Representative Mills and Senator Kerr, but state participation was optional, as with other public assistance categorical titles. Unlike the Eisenhower proposal, each state would set its own definition of the limits and scope of medical indigence. In other respects, too, most of the initiative was left to the states, although one important precedent was set with respect to future legislation. While the Act only suggested a broad range of hospital, nursing-home, physician, and other services that might be provided in the state plan, it required each plan to include both institutional and noninstitutional care as a condition of federal sharing.

Thus while the new program was left in the hands of state administrators, it included as an important precedent the concept of federal standard-setting: the provisions that a recipient could not receive medical care under both OAA and MAA,[31] that the states were not to set up enrollment fees for participation, and that (as with other categorical public assistance programs) the program had to be in effect in all administrative subdivisions of a state. Two innovations set the new MAA apart from other public assistance programs: States were not to impose residency requirements on participants except for current residence, nor were they to impose liens on the recipient's property during his lifetime or that of a surviving spouse.[32] The Department of Health, Education, and Welfare was made responsible for approving state plans, issuing guidelines, and receiving reports on their operation; the program was set to begin on October 1, 1960.[33]

In theory the new program could have provided extensive services to a substantial proportion of the elderly population and to the other two adult groups included in at least some of its provisions. It could have met a considerable share of the needs of those who fell into the gap between adequate coverage of their medical bills through private health insurance schemes and those receiving cash payments under public assistance.[34] But in fact the nature of Kerr-Mills was predetermined by its heritage as a political compromise in Congress, and by its formulation as a supplement to existing forms of public assistance.

Kerr-Mills was perhaps less a means of increasing aid to the elderly than it was a means for shifting the burden of that aid from others to the federal government. The many counties in the United States subsidizing medical relief could look upon Kerr-Mills as a golden egg of additional state support;[35] hospitals and doctors could view it as a means of reducing their own private charitable contributions to medical care to the indigent by its introduction of more realistic fees for welfare patients who were elderly; and the states had the pleasant prospect of expanded federal funding. The rhetoric of health was thus even more firmly wedded to the economic realities of the welfare system.

Insofar as it increased aid to the elderly, Kerr-Mills was predicated on

a welfare, means-oriented, not a social security insurance oriented, theory. Thus the program was administered by the Bureau of Public Assistance, not by the Public Health Service. Here was a clear indication of its welfare image. Moreover, without exception, the states in implementing their programs designed means tests for the medically indigent under MAA, which, while more liberal than the means test for both cash and health programs under OAA, were similar in administration and intent.[36] Nor were the benefits much more generous than those available under the previous programs.[37] In terms of vendor payments, Kerr-Mills extended OAA at a somewhat higher income level. The atmosphere of welfare was all-pervasive.

No one seriously pretended that Kerr-Mills was the final answer to meeting the health needs of the elderly. Nevertheless the program was disappointing to conservatives and liberals alike. It did not vindicate those who saw the long-term answer to health care financing as a mix of private health insurance backed by public assistance, rather than comprehensive national health insurance; nor did it begin to meet the concern of those who looked for a full range of preventive as well as curative services for the elderly as a means to forestall possible indigence.

Indeed, perhaps the program's most serious flaw was this failure to act until sickness had struck and medical indigency was achieved. Under MAA, the elderly were forced to spend down to the relatively low income-eligibility limits of the program before receiving any benefits. As Secretary Celebrezze pointed out in the 1963 hearings on hospital insurance for the aged, Kerr-Mills did not prevent dependency but only dealt with it after it happened.[38] Like other welfare programs, moreover, its effect was often subtly punitive. A later report from the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging was to catch this flavor of the program:

> *If the objective of a public program designed to assist with the expenses accompanying illness is the preservation of the financial independence of older persons, then any program employing means tests —such as MAA—cannot achieve that goal. For, such programs afford some help only after the older individual has depleted his irreplaceable assets to the point of semidependency or total dependency. . . . It is impossible to divorce consideration of how the aged person will manage after he is well from consideration of when and what benefits are available to him during illness.*[39]

Kerr-Mills Is Implemented

The implementation of Kerr-Mills in the states was similar in approach to the later implementation of Medicaid. The Secretary of Health, Education, and Welfare wrote to all the state governors recommending that each

state take necessary action to implement the new law. The Bureau of Public Assistance of the Social Security Administration was renamed the Bureau of Family Services of the Welfare Administration, a name reflecting its increasing social role. The Bureau issued a series of State Letters summarizing the provisions of the legislation and reflecting the department's view that both the extended OAA vendor-payment provisions and the new MAA program would improve health care for the elderly. While the role of the Federal agency was limited, as in any other state-federal grant-in-aid program, the Bureau offered exhortation and advice. Its staff prepared information leaflets, met with state directors of public assistance, appointed a group of consultants on medical matters, prepared a guide and a handbook of regulations, published statistics, and assisted the states through technical medical consultation.[40] As a voluntary program of grants-in-aid, however, MAA imposed little responsibility on the Department of Health, Education, and Welfare. Success or failure rested with the states.

This degree of state responsibility could be regarded by proponents of states' rights as a natural development of state responsibility. On the other hand, it represented some buck-passing. Decisions made in Washington as a political alternative to expanded social security were thrown squarely into the laps of legislators in Sacramento and Albany. Each state could decide whether to join the program or not, with no penalty for not doing so. Each could set its own limits for defining the "medically needy," provided they were over 65; and aside from having to provide some institutional and some noninstitutional care, each state could choose the services to be covered and any limits on those services. Far from being taken over by the federal government, state medical services were given expanded responsibility. Indeed, the lack of guidance from Washington was soon to become a point of criticism, as it was even more strongly in respect to Medicaid. At the hearings on Kerr-Mills in 1963, Representatives Burns and Curtis in the House publicly asserted that HEW administrators were dragging their feet on approving programs and not giving even the guidance provided for in the Act.[41]

In fact, the states responded slowly to the new program. Twenty-eight states had Kerr-Mills programs by the end of 1962. Generally these were states which already had substantial vendor-payment programs, states such as Massachusetts, Michigan, Illinois, New York, California, Connecticut, and Pennsylvania. The federal cost-sharing provision was designed to encourage the poorer states to enter, but it was the richer states that saw the potential of the new programs as an extension of existing welfare programs and as a new source of federal budgetary assistance. Because of the higher federal sharing provisions under MAA there was an immediate incentive, particularly in the states with large vendor-payment programs, to shift part of their existing programs into the new category. This was

also encouraged by the provision that a recipient could receive medical care through OAA or MAA, but not both.

Massachusetts, for example, began its Kerr-Mills program in October 1960 by transferring 14,000 persons—recipients needing and receiving long-term nursing home care—from other public assistance programs; these persons represented 89 percent of the initial recipients under MAA.[42] A study of MAA in Connecticut found that in its first month of operation (April 1962) 3887 of the total 3929 individuals on MAA were already receiving assistance through the OAA: and the transfers continued.[43] Altogether, it was estimated that nearly 100,000 persons then on other welfare programs in the states were moved to the new program.[44] There was nothing illegal about such transfers; indeed, from the state point of view, they were perfectly reasonable measures to protect their taxpayers against greater costs. But, at the same time, the transfers frustrated the alleged intention of the Kerr-Mills legislation to provide a major new source of services to the elderly and to serve an entirely new group of recipients. Indeed, one report in 1963 estimated that nationwide the combined percentage of old people who were covered for medical care under OAA and MAA had actually declined after the adoption of the new program, from 14 to 13 percent.[45]

Quite clearly, the rhetoric of federal policy did not jibe with the reality of state concerns. Since the states were given primary responsibility, their concerns predominated. An important by-product of the funding arrangement was that, instead of encouraging services where they were most needed through higher federal matching grants to the low-income states, Kerr-Mills provided substantial additional subsidies to states which already had large vendor programs. By 1965, the five states of New York, California, Massachusetts, Minnesota, and Pennsylvania, which together included 31 percent of the aged in the country, were receiving about 62 percent of federal MAA funds.[46] Forty-four of the 54 jurisdictions had some program in effect by 1965, but in many cases programs were minimal and there were wide and confusing variations. Only five jurisdictions were judged to provide comprehensive medical services.[47] Of the 29 jurisdictions with programs in effect in 1963, only 19 provided drugs (which on average accounted for one fourth of all per-capita health payments of the elderly); and, despite the importance of teeth to the elderly, only 17 states provided dental care.[48] Eligibility levels varied widely; indeed, in 14 states the MAA income levels were found in 1963 to be more rigidly interpreted and often lower than those for OAA.[49]

One major difficulty—which was to be transported lock, stock and barrel into Medicaid—was the financial inability and thus unwillingness of low-income states to afford a medical assistance program even when the federal matching grant was up to 80 percent of the total cost. Georgia, for example, authorized MAA in 1961 and Mississippi in 1964, but no state

TABLE I–2. Major Medicaid Legislation, 1965 to 1991--Continued

1986	• Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272) Extended coverage to all pregnant women meeting AFDC financial standards
	• Omnibus Budget Reconciliation Act of 1986 (OBRA 86, P.L. 99–509) Allowed coverage of pregnant women and young children to 100 percent of poverty Established a new optional category of "qualified Medicare beneficiaries" (QMBs)
1987	• Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100–93) Strengthened authorities to sanction and exclude providers
	• Omnibus Budget Reconciliation Act of 1987 (OBRA 87, P.L. 100–203) Allowed coverage of pregnant women and infants to 185 percent of poverty Strengthened quality of care standards and monitoring of nursing homes Strengthened OBRA 81 requirements that States provide additional payments to hospitals treating a disproportionate share of low–income patients
1988	• Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100–360) Mandated coverage of pregnant women and infants to 100 percent of poverty Expanded coverage of low–income Medicare beneficiaries Established special eligibility rules for institutionalized persons whose spouse remained in the community, to prevent "spousal impoverishment"
	• Family Support Act of 1988 (P.L. 100–485) Extended certain Medicaid coverage for families losing AFDC because of increased earnings and expanded coverage for two–parent families whose principal earner was unemployed
1989	• Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101–239) Mandated coverage of pregnant women and children under age 6 to 133 percent of poverty Expanded EPSDT program requirements Mandated coverage and full–cost reimbursement of federally qualified health centers (FQHCs)
1990	• Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101–508) Phased in coverage of children ages 6 through 18 to 100 percent of poverty Expanded coverage of low–income Medicare beneficiaries Established Medicaid prescription drug rebate program
1991	• Medicaid Voluntary Contribution and Provider–Specific Tax Amendments of 1991 (P.L. 102–234) Restricted use of provider donations and taxes as state share of Medicaid spending; limited disproportionate share hospital payments

Source: Table prepared by the Congressional Research Service.

Before 1950, welfare payments might include a small amount nominally earmarked for medical expenses, but the payments were made to the recipient and could be used for any purpose the recipient chose. The Social Security Amendments of 1950 provided Federal matching funds for direct State payments to medical care providers (or "vendors") on behalf of recipients of public assistance. Total spending under these programs reached $0.5 billion by 1960. In that year, the Kerr-Mills Act created a new program, Medical Assistance for the Aged. This program provided Federal matching funds to States that chose to cover the "medically needy" aged, persons whose incomes were above cash assistance levels but who needed help with medical bills. As of 1965, 40 States and the District of Columbia, along with Puerto Rico, the Virgin Islands, and Guam, had implemented Kerr-Mills programs. Combined spending under the vendor payment and Kerr-Mills programs had reached $1.3 billion.[15]

By 1965, improving medical coverage for the elderly had become a major congressional priority. Congress considered a number of approaches, including a universal system based on Social Security, a voluntary program supported in part by beneficiary premiums, and an expansion of the means-tested Kerr-Mills program for the low-income elderly only. What was adopted in the Social Security Amendments of 1965 represented a combination of all three approaches. Medicare hospital insurance (Part A) was a social insurance program covering nearly all of the elderly, while Medicare's supplementary medical insurance program (Part B) was a voluntary program. However, both programs could leave some elderly beneficiaries exposed to substantial costs for premiums, deductibles, and coinsurance payments, as well as costs for uncovered services. A third component, an expansion of Kerr-Mills to be called Medicaid, was included in order to help the low-income elderly meet these costs. At the same time the new program would consolidate and simplify the other existing Federal efforts to provide medical assistance to the poor, the vendor payment programs for cash assistance recipients. It would also extend the Kerr-Mills concept of medical need to other populations, including families with children, the blind, and the disabled.

The new Medicaid program carried over two key features of its predecessors. First, States were given substantial latitude to design their own programs, so long as they met minimum Federal standards. (States were required, as a condition of continued funding, to make steady progress towards development of a "comprehensive" program by raising eligibility levels and expanding services; this requirement was repealed in 1972.) Second, coverage was largely confined to the populations traditionally eligible for welfare--certain families with children (chiefly single-parent families) and the aged, blind, and disabled. One exception was created by the Ribicoff amendment--States could choose to cover children who met the financial standards for welfare eligibility but not the categorical standards (because, for example, they were in two-parent families with a working parent). As passed by the Senate, the Ribicoff amendment would also have allowed coverage of the children's caretakers, in

[15]U.S. Congress. Senate. Committee on Finance. *Medicare and Medicaid: Problems, Issues, and Alternatives*. Unnumbered Committee Print, 91st Cong., 2d Sess., Feb. 9, 1970. Washington, GPO, 1970.

effect opening the program to all types of low-income families. This provision was dropped in conference, and two-parent families with a working parent are excluded from the program to this day, as are single adults and childless couples who are not aged or disabled.[17]

On the other hand, the law specified no upper income limits for program eligibility, and States were free to provide medically needy coverage for higher income persons in the traditional welfare categories. Despite this flexibility, Medicaid was not expected to result in a dramatic expansion of coverage. Maximum new Federal expenditures, even if all States took full advantage of the new program, were projected to be $238 million per year above those under the vendor payment/Kerr-Mills programs.[18] In fact this level was reached in the first year, although only six States had implemented programs.

B. Medicaid in the 1960s and 1970s

Twenty-six States implemented Medicaid programs in 1966, and another 11 in 1967. Program spending grew much more rapidly than had been anticipated. Combined Federal and State spending under Medicaid and its predecessors (which were not fully phased out until 1970) was $1.7 billion in FY 1966, but rose 43 percent, to $2.4 billion in FY 1967. Spending grew even faster in FY 1968, rising 57 percent, to $3.7 billion.

One factor in the unexpected early growth in the program was liberal eligibility standards for the medically needy. New York in particular established a very high protected income level, $6,000 per year for a family of four in 1966. (By July 1991, 25 years later, 13 States with medically needy programs had not reached this level.) It was projected that up to 45 percent of the State's population in 1966 could have potentially qualified for Medicaid coverage.[19]

Congress responded in 1967 by limiting medically needy eligibility. States that chose to cover the medically needy were required to set upper income limits no greater than 133 1/3 percent of the maximum payment for a family of the same size under AFDC. This meant that States could not expand Medicaid eligibility without expanding their cash assistance programs as well.

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[17]The OBRA 89 established a demonstration project under which up to four States are permitted to extend Medicaid to low-income individuals and families not meeting categorical requirements.

[18]U.S. Congress. Senate. Committee on Finance. *Social Security Amendments of 1965.* (Report to accompany H.R. 6675.) Senate Report No. 404, 89th Cong., 1st Sess., June 30, 1965. Washington, GPO, 1965. p. 85.

[19]Stevens, Robert, and Rosemary Stevens. *Welfare Medicine in America.* New York, Free Press, 1974. p. 86, 92. The protected income level is the amount of countable income a medically needy family may retain after spending any excess on medical bills.

The Social Security Amendments of 1967 (P.L. 90-248) included two other key changes in Medicaid. First, the law established the EPSDT program in conjunction with other, non-Medicaid initiatives to improve child health. Second, the law provided that Medicaid beneficiaries had to be permitted to obtain covered services from any qualified provider "who undertakes to provide [the beneficiary] such services." Under the pre-Medicaid vendor payment programs, a State could contract with specific providers, such as clinics or hospitals, to serve as the sources of care for public assistance recipients. As enacted in 1965, Medicaid continued to allow States the option of making direct arrangements for beneficiaries' care. The new "freedom-of-choice" requirement meant that States could no longer establish separate systems of care for Medicaid beneficiaries. Instead, Medicaid would allow low-income citizens to use providers of their choice, to enter the mainstream of American health care. (Whether they could actually do so depended on whether providers were prepared to participate in the program, an issue to be discussed further below.)

Even in the earliest years of the program, some States were already finding Medicaid a strain on State budgets and began to consider restrictions in eligibility or benefits. They were briefly prevented from doing so by a Secretarial ruling that States could not reduce coverage under an already approved State plan. This ruling was reversed by Congress in 1969. Congress also delayed, and in 1972 repealed, the provision of the original 1965 legislation requiring States to progress steadily towards comprehensive Medicaid coverage. Early expectations for the program had been lowered, and States undertook a variety of cost containment efforts, including benefit limitations, requirements for prior authorization of services, and reductions in payment levels. Some States also began contracting with HMOs or similar entities to provide coverage on a prepaid basis to beneficiaries who agreed to obtain all services through the organization.

Congress also took steps in the early 1970s to control spending under both Medicare and Medicaid; many of these measures were joint initiatives affecting both programs. Professional Standards Review Organizations (PSROs, the predecessors of today's peer review organizations, or PROs) were established to monitor inpatient utilization, and States were required to develop their own systems for monitoring nursing home care. In response to the view that growth in the supply of medical facilities was fueling health care demand, States were required to develop health planning programs, which were supposed to limit unnecessary expansion of hospitals and NFs. Start-up funds were authorized for new HMOs, in the hope of achieving savings for both private purchasers and public programs. These early cost control efforts had mixed results. PSROs had little impact on utilization, while State health planning programs had some success in controlling the growth in nursing home beds. Federal funding promoted rapid growth in the HMO industry, but few of the new entities were prepared to accept Medicaid beneficiaries.

Even as it undertook these early cost containment initiatives, Congress added new optional Medicaid services that were to have a significant impact on program spending in the years ahead. Amendments in 1971 and 1972 allowed States to cover care in ICFs, ICFs/MR and, for beneficiaries under age 22, in