The Health Security Act of 1993

Documentation of Federal Budget Effects

December 1993

Table of Contents

BACKUP DOCUMENTATION

This document provides a description of policies in the Health Security Act which involve Federal costs or savings, the line-by-line numerical estimates, and a brief description of key assumptions or methodologies used to derive the estimates. The estimates are consistent with the Congressional testimony presented by the Director and Deputy Director of OMB. A few minor variances with the final bill language remain. Revised estimates will be provided with the President's FY 1995 Budget.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Providing Coverage for Medicaid Non-Cash Recipients through Alliances

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Guaranteed benefit package	0	-1,900	-6,500	-18,500	-24,700	-27,900	-79,500
Wrap: non-cash	0	-100	-600	-1,600	-2,300	-2,600	-7,200
Wrap: cash kids	0	-100	-300	-900	-1,200	-1,300	-3,800
Emergency svcs for undocumented persons	0	100	200	400	500	600	1,800
Net Medicaid savings	0	-2,000	-7,200	-20,600	-27,700	-31,200	-88,700

POLICY DESCRIPTION

Current non-cash recipients of Medicaid (individuals under age 65 who do not receive AFDC or SSI payments) will receive a comprehensive package of benefits through the health alliances, like everyone else. Medicaid will not pay their premiums. In addition, Medicaid will no longer pay for wraparound benefits on behalf of non-cash recipients integrated into alliances or cash recipient children. (Cash and non-cash children will receive wraparound benefits through a new Federal program, as described in a separate backup document.)

KEY TECHNICAL ASSUMPTIONS

Estimates are based on projected Medicaid acute care spending for services covered in the guaranteed benefit package as well as Medicaid wraparound benefits. Pricing based on August 1993 Medicaid estimates. The percentage of aggregate acute care spending allocated to non-cash recipients is based on data from HCFA-64 and 2082 forms. DSH spending is not included in the estimates. Assumes that states with 15% of Medicaid spending implement by FY 1996, 40% by FY 1997, and 100% by FY 1998. Estimate includes discount due to payment lag liability for non-cash recipients. Cash kids wrap estimates based on assumption that new Federal program is created to cover wrap benefits for both cash and non-cash children. Net Medicaid savings includes estimate for continued Medicaid coverage of emergency services for undocumented persons.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Long-term care: Medicaid offset from new community LTC program

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
community LTC offset	0	-1,500	-2,200	-2,700	-3,100	-3,600	-13,100

POLICY DESCRIPTION

The new community LTC program for people with severe disabilities will serve eligible individuals who were previously covered under Medicaid.

KEY TECHNICAL ASSUMPTIONS

Estimates are from ASPE/ Lewin-VHI (see "New Programs/Long-Term Care"), based on the assumption that roughly 50% of baseline Medicaid home and community-based spending will be offset by the new program. Data from the National Medical Expenditures Survey and the Medicaid program support an estimate that 50% of Medicaid home and community-based expenditures are for individuals meeting the severely disabled criteria of the new community LTC program. ASPE assumed that States will move these individuals to the new LTC program, where a higher Federal matching rate and increased program flexibility will be available. Medicaid baseline spending projected by Lewin-VHI.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicaid: Effect of Capitated Payment for Cash Recipients

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-300	-1,200	-3,900	-6,700	-10,200	-22,300

POLICY DESCRIPTION

Under the Health Security Act, a comprehensive benefits package will be provided to cash AFDC recipients through the Alliances. States will contribute to the Alliances a premium for cash recipients equal to 95% of baseline spending on benefits for cash recipients in the year prior to implementation of reform. Baseline spending in the year prior to implementation is computed by trending forward spending in FY 1993 by the projected national average Medicaid growth rate for benefits for cash recipients. Beginning with the first year of implementation, premiums grow at the budgeted premium growth rate for the private sector. Separate premiums will be computed for AFDC and SSI recipients. States are to vary premiums across Alliances within a State so that the weighted average premium across all Alliances is equal to the premium as calculated on a uniform, Statewide basis.

OACT'S KEY TECHNICAL ASSUMPTIONS

To calculate the premium, actuaries used annual growth rates derived from historical and baseline data. States were assumed to implement health reform on a Federal fiscal year basis in 1996 (15%), 1997 (25%), and 1998 (60%). It was assumed that full-year cash recipients would total roughly 18 million by FY 1996. The baseline data used to calculate the savings listed above incorporates State spending estimates from August, 1993.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ hundreds of millions)

BUDGET CATEGORY

Medicaid: Disproportionate Share Hospital Payments and Vulnerable Populations Adjustment

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000	
Disprop Share	0.0	-1.4	-4.7	-13.0	-16.8	-18.6	-54.6	*
Vulnerable Pop Adj	0.0	0.2	0.4	1.0	1.0	1.0	3.6	*
Net	0.0	-1.2	-4.3	-12.0	-15.8	-17.6	-51.1	*

* Totals do not add due to rounding.

POLICY DESCRIPTION

Medicaid disproportionate share hospital (DSH) payments are supplemental payments for hospitals that serve large numbers of low-income, undercompensated, or non-paying patients. The Federal share of DSH payments totalled about $9 billion in FY 1993, over 12% of medical assistance payments. Hospitals that currently serve a disproportion share of Medicaid and uncompensated patients will receive large inflows of new revenue when universal coverage is phased in with health reform. Providers will be compensated for all patients and rates for current and former Medicaid recipients will be determined through negotiations with health plans. As a result, Medicaid DSH payments are to be eliminated as States implement health care reform in CY 1996 (15%), CY 1997 (25%), and CY 1998 (60%). New Federal payments of $3.55 billion will be targeted to hospitals serving a high percentage of low-income individuals through the Vulnerable Populations Adjustment.

OACT's KEY TECHNICAL ASSUMPTIONS

The baseline data used to calculate the savings listed above incorporates State spending estimates from August, 1993. August State estimates were not included in HCFA's mid-session review (MSR) estimates. HCFA actuaries estimated that Federal DSH outlays in FY 1994 will total roughly $10.3 billion -- up from an MSR estimate of $9.5 billion. Actuaries

assumed that a three-month payment lag would lower potential first-year savings in each State by 25%. Savings were calculated assuming that States would implement health reform on a Federal fiscal year basis as follows: FY 1996 (15%), FY 1997 (25%), and FY 1998 (60%).

BACKUP DOCUMENTATION

(savings negative, costs positive)

BUDGET CATEGORY (outlays in $ millions)

Long-term care: Liberalized LTC eligibility

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Liberalized LTC elig.	0	500	500	500	500	500	2,500

POLICY DESCRIPTION

Under the Health Security Act, States will establish a medically needy program for all residents of nursing homes and intermediate care facilities (ICFs-MR). The personal needs allowance (PNA) for nursing home residents may be raised to $50 per month. (Current PNA levels vary across States, but the national average is $35 per month.) The costs of raising the PNA are financed with 100% Federal dollars. States have the option to allow unmarried nursing home and ICF-MR residents to retain up to $12,000 in assets (up from the current $2,000) in determining Medicaid eligibility.

KEY TECHNICAL ASSUMPTIONS

Approximately 1.2 million residents of nursing homes and ICFs-MR are Medicaid recipients. PNA levels would increase for these individuals in 45 States. 5 States already have PNAs at or above $50 per month.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Cost-Sharing Discounts Provided in Some Alliances

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	100	200	600	700	700	2,300

POLICY DESCRIPTION
If a low-cost sharing plan is not available at or below the weighted average premium, AFDC and SSI recipients (as well as other low-income beneficiaries) will receive discounts to reduce their cost-sharing to the level they would have incurred if they had enrolled in a low cost-sharing plan. Medicaid pays for these cost-sharing (out-of-pocket) discounts as part of payments to the alliances.

KEY TECHNICAL ASSUMPTIONS
The total number of Medicaid cash enrollees (non-aged and disabled) was estimated by HCFA at 18.4 million in FY 96 and grows to 20.2 million in FY 2000.
The percentage of Medicaid cash enrollees eligible for low cost-sharing discounts is estimated at 5.0%, yielding 990,000 enrollees receiving discounts in FY 1999. The average discount cost was estimated at $1050 in FY 96, 57% of which is Federal, yielding an average Federal discount cost of $599. Average discount costs were assumed to increase by 5% per year.
State phase-in schedule assumes States with 15% of Medicaid spending implement 10/1/95; States with 25% implement 10/1/96; and States with the remaining 60% of spending implement 10/1/97. Estimate of cost-sharing discounts calculated on fiscal year basis.
Act provides Medicaid premium (in addition to out-of-pocket) discounts to AFDC and SSI recipients (§1371 (c) (1)) who reside in alliance areas in which a health plan at or below the average weighted premium is not available.
This estimate only reflects costs associated with these out-of-pocket (not premium) discounts.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicaid: Costs associated with paying unpaid Medicaid claims for cash recipients ("Payment lag").

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	1,040	1,960	5,310	0	0	8,310

POLICY DESCRIPTION

States generally pay Medicaid costs (claims) retrospectively. Thus, in the year of implementation, States will be responsible for "lagged" claims from the previous year in addition to prepaid capitation payments to plans.

KEY TECHNICAL ASSUMPTIONS

States are, on average, a quarter behind in payments. In the year in which a State implements reform, the State (and the Federal government) must make up for this lag, which constitutes 25% of spending for cash recipients for services in the standard benefit package. The costs are incurred in FY96 through FY98 due to staggered State implementation of 15%/25%/60%. States are assumed to phase-in on fiscal year basis.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicaid: Administrative Savings Due to Program Reduction and Simplification

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-100	-300	-800	-1,100	-1,400	-3,700

POLICY DESCRIPTION

Under the Health Security Act, as under current law, State expenditures for administering the Medicaid program will be matched by the Federal government. State Medicaid programs will include far fewer enrollees, however. Payment for services included in the comprehensive benefits package will be made via a fixed, pre-paid monthly premium, rather than through direct, fee-for-service provider reimbursements -- significantly reducing the volume of claims and the need for provider contracts, reimbursement specialists, and other State oversight personnel. Thus, with enactment of the Health Security Act, States will have an opportunity to reduce Medicaid administrative expenses substantially.

KEY TECHNICAL ASSUMPTIONS

It is assumed that States would be able to reduce administrative expenses by about one-third in response to reduced responsibilities in enrollment, oversight, rate-setting, and claims processing. Because administrative savings depend on discretionary State action, potential savings were discounted by 25%. Savings totals assume that States implement health reform on a Federal fiscal year basis in FY1996 (first 15%), FY97 (next 25%) and FY98 (last 60%), and that full administrative savings are reached 2 years after implementation.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicaid: Impact of Medicare Drug Benefit on Medicaid Spending

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-700	-1,000	-1,200	-1,300	-1,500	-5,700

POLICY DESCRIPTION

The Health Security Act extends a drug benefit to Medicare Part B beneficiaries. Low-income beneficiaries will receive the same out-of-pocket discounts for the drug benefit as they do for other Medicare services. Individuals eligible for both Medicaid and Medicare who currently receive Medicaid drug benefits will now be served by the Medicare drug benefit when reform is implemented. Federal and State Medicaid expenditures will be reduced by the portion of the Medicare drug benefit financed through Federal Medicare revenues.

OACT'S KEY TECHNICAL ASSUMPTIONS

OACT assumed that the net Federal per-beneficiary cost of the Medicare drug benefit, together with beneficiary premiums and cost-sharing, would be equivalent to net Federal per-beneficiary costs for prescriptions drugs under Medicaid. Actuaries also assumed that Federal outlays from the Medicare drug benefit would reduce current Medicaid spending on dual eligibles (approximately 3.5 million beneficiaries) by 50%, since Medicaid will continue to pay the premium and cost sharing. Conversely, in a shorthand way, the actuaries assumed that Medicaid would incur additional costs equal to 50% of the net Federal per-beneficiary cost of the Medicaid drug benefit for Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs), for whom Medicaid pays Part B premiums (approximately 1.5 million beneficiaries). The baseline data used to calculate the offset savings listed above incoporates State spending estimates from August, 1993.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ hundreds of millions)

BUDGET CATEGORY

Medicare/Medicaid: Effect on Qualified Medicare Beneficiary (QMB)/Selected Low-Income Medicare Beneficiary (SLMB) participation and Medicaid payments

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Net effects on Medicaid of Medicare savings proposals	0.0	0.1	0.1	0.1	0.2	0.3	0.8

(Drug benefit cost-sharing and premiums assumed in Medicare drug estimates.)

POLICY DESCRIPTION

Under the Health Security Act, working individuals of Medicare-eligible age and their spouses will receive health coverage by enrolling in Alliances, with the employer as primary payor in those cases when a Medicare enrollee works at least 40 hours in each of the last two months of each year. Those eligible for Medicare and Medicaid coverage of cost-sharing and/or benefits will retain Medicaid benefits. Medicare is primary payor for all Medicare services under current law, including drugs for non-working dual eligibles, with Medicaid paying Part B premiums and, in some cases, cost-sharing for poor Medicare Part B enrollees.

KEY TECHNICAL ASSUMPTIONS

Full FY 1996 implementation of relevant policies; approximately 3.5 million QMBs and 750,000 SLMBs in 1996, extrapolated from HCFA data reports for 1993. Assumed no QMBs/SLMBs are working aged. Medicare is primary payor of drugs for dual eligibles. Drug cost-sharing for QMBs is not in the MOE calculation, but will be required of States. QMBs and dual eligibles who work would receive coverage

through the Alliance and may continue to receive Medicaid wrap-around coverage. Medicaid cost-sharing for drugs assumed in Medicare estimates. Assumed 57% of total additional Medicaid costs would be borne by Federal government. Effect of package on Part A premium is not calculated and, as a result, effects on qualified working disabled individuals (QDWIs) are not included in the estimates.
This calculation is, therefore, sensitive to the following variables: Percentage of QMBs working; whether Medicaid pays the 20% premium for working QMBs/SLMBs; whether Medicaid pays QDWIs' 20% premium in Alliance; effect on Part A premium for QDWIs of Medicare savings package; effect of final Medicare savings package on coinsurance liabilities (Medicaid pays the Part A premium for QDWIs).

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicare: Part B Prescription Drug Benefit

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Drug Benefit	0	6,600	13,500	14,200	15,200	16,200	65,800

POLICY DESCRIPTION
Under the Health Security Act, Medicare Part B will be expanded for all beneficiaries to include a prescription drug benefit on January 1, 1996. Beneficiaries will pay for their prescriptions out-of-pocket up to $250 each year and 20% of drug cos between $250 and $1000, and will not incur out-of-pocket costs for prescriptions above $1000 each year. Manufacturers will be required to pay a rebate for each non-generic prescription sold to a beneficiary equal to at least 17% of the average manufacturer's price to the retail class of trade. The Part B premium is calculated to equal 25% of the Federal costs of the drug benefit (net of rebate revenue). Reimbursement to pharmacists will be capped at 93% of the average wholesale price for ingredient costs plus $5 per script for the dispensing fee (indexed to inflation). Pharmacists will be expected to answer questions from beneficiaries on recommended usage, side-effects, interactions, etc. The HHS Secretary is authorized to require those administering the benefit to operate a utilization review program for pharmacists and physicians similar to that required under Medicaid.

OACT'S KEY TECHNICAL ASSUMPTIONS
Listed costs are net of rebate revenue. It was assumed that each dollar of the new Medicare drug benefit would induce an additional 60 cents of drug spending by beneficiaries. Induced demand is estimated to be about $10 billion annually. Administrative costs account for about $1 billion per year of gross Federal expenditures. Monthly Part B premiums would rise between $10 and $11 in CY 1996 to cover 25% of Federal program costs. It was assumed that, after implementation

of the drug benefit in 1996, over 36 million Part B beneficiaries would obtain a total of about about 1 billion prescriptions per year. It was also assumed that 500,000 high-income beneficiaries would disenroll from Part B due to the combined effect on the Part B premium of the drug benefit and the proposal in the Health Security Act to income-relate the Medicare Part B premium. Working beneficiaries in the Alliance (see separate description of working policy) were included in the beneficiary population used to estimate the costs listed above. An offset for working beneficiaries for all Medicare expenditures, including Part B drug costs, is listed separately.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicare: Part B Prescription Drug Benefit Administrative Costs (non-add)

Administrative costs are displayed separately for illustrative purposes only and are included in the cost estimate of the Part B prescription drug benefit.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Drug Benefit	13	600	900	1,000	1,000	1,100	4,613

POLICY DESCRIPTION

Under the Health Security Act, Medicare Part B will be expanded for all beneficiaries to include a prescription drug benefit on January 1, 1996. Beneficiaries will pay for all prescriptions out-of-pocket up to $250 each year, 20% of drug costs between $250 and $1000, and will not incur out-of-pocket costs for prescriptions above $1000 each year. Manufacturers will be required to pay a rebate for each non-generic prescription sold to a beneficiary equal to at least 17% of the average manufacturer's price to the retail class of trade. Pharmacists will be expected to answer questions from beneficiaries on recommended usage, side-effects, interactions, etc. The Secretary is authorized to require those administering the benefit to operate a utilization review program for pharmacists and physicians similar to that required under Medicaid.

OACT's KEY TECHNICAL ASSUMPTIONS

Actuaries assumed that, beginning in 1996, over 36 million Part B beneficiaries would obtain a total of about 1 billion prescriptions per year. It was assumed that electronic claims would account for 90% of all prescriptions and would cost 73 cents each in 1993. Remaining claims would be filed on paper, averaging 1.5 prescriptions per claim, and would cost about $1.00 each to administer. It was assumed that the weighted average cost per prescription, 72.4 cents, would increase 3% annually through FY 2000. Fixed costs of $100 million annually were also included in the cost estimates.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicare payments to VA health plans

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Medicare payments to VA health plans				200	300	300	800

POLICY DESCRIPTION
Under the Health Security Act, Medicare will reimburse VA health plans for services to higher-income veterans for non-service-connected conditions, as defined in 38 USC 1722 (b), eligible for Medicare. VA and HHS will negotiate application of rules and payment rates.

KEY TECHNICAL ASSUMPTIONS
VA estimates approximately 55,000 veterans that are enrolled in Medicare and that are above the "higher-income" threshold received VA care in FY 1992. Assumes 1/1/98 start-up date. VA health facilities must meet Medicare conditions of participation and reporting requirements.
This calculation is sensitive to the following variables: which Medicare payment methodology will be used if VA health plans are considered Medicare HMOs; interaction with working aged policy; whether VA health plans will also cover spouses of veterans; rate of increase/decrease in eligible population; whether Medicare pays for a spouse who enrolls in a VA plan; phase-in schedule used in pricing; whether premiums have been netted out of Medicare expenditures, including drug premium add-on; whether Medicare will be primary payor for prescription drugs purchased by the VA; the date for commencement of Medicare payments to VA health plans; additional administrative costs, if any.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY
Medicare payments to DoD health plans

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Medicare payments to DoD health plans		200	500	1,300	1,400	1,400	4,800

POLICY DESCRIPTION
Under the Health Security Act, the Secretary of HHS has the discretion to disregard the exclusion in the Social Security Act on Medicare payments to DoD health facilities. Medicare will pay a capitated amount to military health plans for services equivalent to SMI benefits for those Medicare beneficiaries who enroll in military plans. The payment will equal the payment to an organization with a risk-sharing contract under Section 1876 of the Social Security Act.

KEY TECHNICAL ASSUMPTIONS
DoD estimates it will provide $1.268 billion in services to individuals over 65 in 1993. Assumes revised phase-in schedule of 15% in FY 1996, 40% in FY 1997, and 100% FY 1998. Estimate only accounts for currently projected services to over-65 population and assumes no induced utilization for inpatient or outpatient services. DoD used the DRG workload for the over-65 population to calculate total services provided Medicare beneficiaries. Assumes Medicare paid for 90% of costs. Used the CPI-U to inflate estimates in the out-years.
This calculation is sensitive to the following variables: method of calculation of the capitated amount; inpatient induced utilization would appear to be negligible, but there may be an inducement effect on the outpatient (Part B) side; effective date for Medicare payment -- phase-in schedule for such payments not specifically outlined.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY

Medicare: New liabilities for ex-FEHB retiree beneficiaries

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
New Medicare costs, net of premium penalty		0	0	300	300	300	900
Medicare offsetting receipts from monthly premium		0	0	-100	-100	-100	-300

POLICY DESCRIPTION

Under the Health Security Act, retiree health benefits for Federal retirees are covered by Medicare as primary payor. Federal retirees could then have first-dollar coverage, with OPM filling in the cost-sharing as the secondary payor. OPM is assumed to be responsible for payments to cover late enrollment fees assessed against the Part B premium. OPM will offer a Medigap-like policy to protect Federal retirees from cost- sharing.

KEY TECHNICAL ASSUMPTIONS

Assume all Federal employees and annuitants join beginning January 1, 1998. Assume cohort equals 115,000 individuals (OPM estimates). New enrollment is only under Part B, since almost all have Part A coverage now. Assumed average Part B benefits for aged Part B enrollees. Assumed OPM pays 100% of the Part B late enrollment penalty, including new drug premium (Beneficiaries who do not enroll in Medicare during their initial enrollment period are subject to a penalty in the monthly premium). Assumes all new enrollees pay Part B premium of 25%, including new drug premium. Assumes no drop-outs as the result of the working aged policy or the income-related Part B premium. Assumes no

balance billing; assumes drug rebate amounts (15%) into net new Medicare outlays.
This calculation is sensitive to the following variables: Effect of wrap-around coverage on utilization; whether wrap-around policies will cover the Part B deductible; how many will opt to purchase FEHB supplemental coverage; average number of years subject to penalty; relative health status of this cohort of individuals; PAYGO consequences; what effect the final policy on working aged will have on these estimates; interaction effect with income-related Part B premium; design of OPM's supplemental policies; receipts from drug add-on amount to Part B premium (Estimates do not account for working aged, long-term care policies).

BACKUP DOCUMENTATION

(savings negative, costs positive)

BUDGET CATEGORY Medicare Working Policy. Offset for Medicare-Eligible Employed Beneficiaries, and Medicare-Eligible Spouses and Dependents of Working Individuals

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
		-1,000	-3,000	-8,000	-8,000	-8,000	-28,000

POLICY DESCRIPTION

Policy is described in detail in the attached specifications.

KEY TECHNICAL ASSUMPTIONS

HCFA actuarial estimate is based upon the attached specifications. The Office of the Actuary assumes the Medicare working policy would result in about 5.4 million beneficiaries obtaining primary coverage in FY 1996 through their employment (or as a dependent or spouse of an employee) -- up from about 2.2 million who would have primary coverage from group health insurance under current law. All 5.4 million would retain Medicare Part A for secondary coverage; about 5 million out of the 5.4 million beneficiaries are projected to retain Medicare Part B secondary coverage. The remaining 400,000 who would not enroll in Part B are largely high-income beneficiaries who would be required to pay a higher, income-related premium to receive Part B wrap-around coverage.

Pricing assumes 15% phased into alliances in FY 96, 40% in FY97, and fully phased-in in FY98.
Includes Medicare as Secondary Payer (MSP) savings associated with the drug benefit. Does not include savings from the MSP proposals in the $124 billion Medicare savings package. Interactions with the income-related Part B premium and savings proposals in the $124 billion Medicare savings package are taken into account within the $124 billion package.

MSP POLICY

- Medicare beneficiaries who are working or have a spouse that is working or who are a dependent of someone who is working would be required to enroll in the alliance if the individual working worked forty or more hours in each of the previous two calendar months and would be working in the third month. (An exception would be provided in the case of a person who retired in the month prior to the month in which Medicare coverage begins.) Coverage in the alliance would begin on the first day of the third month.

  This policy is a variation on the coverage rules for non-Medicare beneficiaries under which the employer is required to make a payment on behalf of an individual if the individual worked more than 40 hours in a month.

- Medicare would make the following payments on behalf of beneficiaries enrolled in alliances:

  + Medicare would fill in all cost sharing if the individual was enrolled in Part B or cost sharing only for Part A covered services if the individual did not enroll in Part B.

  + Medicare would pay the remainder of the employer share that would otherwise be the responsibility of the worker, if the employment was for less than 30 hours per week. (Discounts that would otherwise apply if the individual was paying part of the employer share would not apply.)

- If the tie to employment is terminated prior to the end of the year, the individual would stay in the alliance and Medicare would pay the entire employer share for the remaining months. At the end of the year, the individual would have the option of Medicare coverage or opting to remain in the alliance under the opt-in rules.

- Existing limitations on the working aged provisions to firms with at least 20 employees and on the disabled provisions to large group health plans would be eliminated. The ESRD MSP provisions would be conformed to the revised aged and disabled provisions. The existing limitation of 18 months for ESRD MSP would be eliminated. (Savings from extension of the authority for the disability provision, reduction of the employer threshold from 100 to 20, and extension of the 18-month provision for ESRD are included as part of the Medicare savings, rather than under this proposal.)

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY

Medicare. Reimbursements to physician assistants, nurse practitioners, and clinical nurse specialists (Sec. 4022)

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	250	450	500	600	650	2,450

POLICY DESCRIPTION

Sec. 4022 of HR 3600 would expand the sites and areas in which services from Medicare's physician fee schedule could be furnished by physician assistants, nurse practitioners, and clinical nurse specialists. Separate billing for these services (i.e., fee-for-service payment) would be more widely available to these non-physician practitioners or their employers.

Effective January 1, 1996, services furnished by the specified non-physician practitioners would be separately reimbursable as follows: physician assistants -- services furnished in all settings and all areas; nurse practitioners -- services furnished in all settings except to inpatients of hospitals located in urban areas; clinical nurse specialists -- services furnished in all settings except to inpatients of hospitals, nursing facilities, and skilled nursing facilities located in urban areas.

KEY TECHNICAL ASSUMPTIONS

HCFA actuary pricing assumes that outlays would increase because of greater beneficiary access to these non-physician practitioners' services (predominantly primary care) in more settings and more areas of the country. The actuary also assumes that some substitution for higher-cost physician-furnished services would occur, reducing the net costs of the provision.

Interactions with other relevant provisions of the Health Security Act, e.g., Medicare savings provisions, Medicare incentives for provision of primary care services, and between Health Alliances and the Medicare beneficiary population still being considered.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY
Medicare savings proposals

BUDGET PROJECTIONS

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-2000
Medicare savings proposals	-150	-2,480	-9,875	-14,373	-22,815	-33,000	-41,721	-124,414

POLICY DESCRIPTION
HR 3600 contains a package of provisions to reduce the rate of growth of Medicare program costs that will result in seven-year savings of over $124 billion. The provisions include changes to payment rates, enrollee cost-sharing, and and other changes to current law. These changes will be made in the context of both universal coverage and slower growth in private sector health costs, reducing the likelihood of cost-shifting and adverse effects on beneficiaries. A significant portion of these savings would come from reducing payments originally intended to ease financial pressures created by uncompensated care, the rationale for which is virtually eliminated under the universal coverage ensured by the Health Security Act. The provisions will also strengthen the Medicare Trust Funds and ease upward pressure on beneficiary cost-sharing.

KEY TECHNICAL ASSUMPTIONS
Provides back-up documentation for estimates in the 1994-2000 window. See attached document.
Estimates are sensitive to interaction with other provisions affecting Medicare; effect and magnitude of Medicare enrollees opting into managed care plans; net effect of all relevant provisions on Medicare spending.

MEDICARE SAVINGS PROPOSALS for HEALTH REFORM
($ in millions)

PART A PROPOSALS

Reduce the Hospital Market Basket Index (HMBI) Update by 2% in FY 1997-2000. Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input cost changes and Congressional direction. OBRA 93 reduced the HMBI in FYs 94 - 97 by 2.5, 2.5, 2, and 0.5 percentage points respectively, to reflect greater efficiencies in hospitals. This proposal would reduce the market basket updates by 2% for FY 1997 - FY 2000. Since the market basket is projected to increase 5% annually, and case mix is projected to increase 2% per year, hospitals can still expect an overall 5% increase per year.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	930	2,870	5,610	8,750	$18,160

Reduce Indirect Medical Education (IME) Adjustment to 3.0% in FY 1996. A portion of the IME is intended to compensate hospitals for uncompensated care. Universal coverage, however, will ensure payment for all patients and essentially eliminate uncompensated care. In 1996, the IME adjustment will be lowered to 3.0% under this proposal. Beginning in FY 1997, the aggregate amount of IME payments will be increased by the projected national average increase in premiums for the under-65 population for those States that opt into the reformed system; by 1998, all Medicare IME payments will be made in this fashion. These payments will be appropriated to a national pool to finance the higher costs of academic health centers. The cash flow effect for IME payments is built into these estimates.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$2,470	3,110	3,470	4,130	4,660	$17,840

Adjust Inpatient Capital Payments to Reflect Better Cost Data. This proposal combines three inpatient capital payment adjustments to reflect more accurate base year data and cost projections. The first piece would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system (PPS) by 15% for FY 1996 - 2000. PPS-excluded hospitals, currently paid at full costs, do not have an incentive for efficiency. The second piece would reduce PPS Federal capital payments by 7.31 percent and hospital-specific amount by 10.41 percent to reflect new data on the FY 1989 capital cost per discharge and the increase in Medicare inpatient costs from FY 1990 to FY 1992. The last piece would reduce payments for hospital inpatient capital through a 22.1% reduction to the FY 1996 - 2000 updates of the capital rates. Current data indicate that Medicare inpatient capital cost per discharge increased 77.5% during the years immediately before the introduction of prospective payment for capital-related costs (FY 1986 - FY 1991). The identifiable variables for capital costs only increased 38.2% over the same period. This proposal would reduce the update to the capital rates by 4.9% each year during FY 1996-2000 to recover excess capital spending.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$995	1,400	2,005	2,610	3,315	$10,325

Revise the Disproportionate Share Hospital (DSH) Adjustment. Hospitals that treat a disproportionate share of low-income patients receive an additional payment. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income Medicare patients. In the reformed system with universal coverage, DSH can be reduced. This proposal would replace the current DSH program with a new program as States come into the new system. The new program would assist hospitals serving the largest share of low-income patients.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$430	1,330	3,670	4,390	4,810	$14,630

Moratorium on PPS-Exempt Long-Term Care Hospitals. Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to a rate-of-increase limit. This proposal would pay new long-term care hospitals under the PPS system. Alternatively, these hospitals could seek reclassification as psychiatric or rehabilitation hospitals, or become certified as skilled nursing facilities (SNFs), for example, and be paid under the SNF cost limit structure.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$20	40	70	100	130	170	$530

Extend OBRA 93 Provision: Eliminate Catch-Up after SNF Freeze Expires. OBRA 93 established a two-year freeze on updates to the cost limits for skilled nursing facilities (SNFs). A "catch-up," however, is allowed after the SNF freeze expires on October 1, 1995; new cost limits would be established that do not reflect the effects of the freeze. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$80	160	180	200	210	$830

Graduate Medical Education: Effect of National Pool. Under the legislation, Medicare would pay into two national pools: one for direct medical education, and one for academic health centers. The projected Medicare spending for direct and indirect medical education would be transferred to the Secretary for those States that have opted into the reformed system; by 1998, all States will be folded into the new system. These funds will be transferred out of the Trust Funds faster than they are currently paid to hospitals. This will result in a slight cost to Medicare. The costs displayed here are the cash flow effect for direct graduate medical education.

Costs

	1996	1997	1998	1999	2000	1996 - 2000
	($30)	(60)	(150)	(20)	(20)	($280)

Interaction Costs

PART A INTERACTION	($0)	(110)	(300)	(510)	(730)	($1,650)

PART A REVENUE PROPOSAL

Subject All State and Local Employees to Hospital Insurance Tax. State and local jurisdictions can opt to pay the HI payroll tax for State and local workers hired before April 1, 1986, but are not required to do so. The proposal would extend the payroll tax to all remaining exempt State and local workers, who would thus be treated like all other covered workers. Additional revenues would exceed benefit payments for a long time, since 90% of retired State and local workers already receive Medicare benefits through other covered jobs or spousal employment; only about 70%, however, worked in State or local government jobs on which HI taxes were paid.

Savings

1996	1997	1998	1999	2000	1996-2000
$1,535	1,518	1,470	1,420	1,366	$7,309

(Estimates for this proposal were calculated by Treasury Department staff.)

PART B PROPOSALS

Base MVPS on Real GDP Per Capita. This proposal would change the statutory formula that is used to determine the Medicare Volume Performance Standard (MVPS), a target for the rate of growth in Medicare physician expenditures. Currently, the MVPS is based on the average annual growth in the volume and intensity of physicians' services over the preceding five fiscal years. This proposal would substitute the five-year average of growth in real GDP per capita for this volume and intensity factor and the performance standard factor. This change would directly connect the MVPS to the growth rate of the nation's economy. The MVPS for all three categories of physician services (surgical, primary care, and all other) would continue to be adjusted for projected increases in physicians' fees, beneficiary enrollment, and changes resulting from regulatory and legislative activity. The MVPS for primary care services would be given an additional 1-1/2 percentage point upward adjustment. Under current law, there is no upper limit on physician fee increases, but fees cannot decrease by more than five percentage points. This proposal would eliminate the floor on physician fee reductions.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	275	1,075	1,975	2,775	$6,100

Establish Cumulative Growth Targets for Physician Services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays, without regard to the prior year's target rate of growth in outlays. This process weakens the ability of the MVPS to serve as a meaningful target for sustainable growth in Medicare physician spending. Under this proposal, the MVPS for each category of physician services would be built upon a designated base-year MVPS (FY 1995). This initial target would be updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above or below the target. Essentially, physician fee changes in any one year would no longer distort the MVPS for the following years. The annual process for calculating physician fee updates would not change from current law.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	(85)	1,825	2,475	1,600	$5,815

Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services. The conversion factor is a dollar amount that converts the fee schedule's relative value units (RVUs) into a payment amount for each physician service. This proposal would reduce the conversion factor by 3% in CY 1995 to account for the excessively high FY 1992 target and 1994 update that is anticipated, except that primary care services would not be reduced.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$250	475	525	550	575	600	$2,975

Eliminate Formula-Driven Overpayment in Hospital Outpatient Departments. Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal would eliminate the flaw in the payment methodology and the resulting overpayment, effective July 1, 1994. In addition, the current payment method gives hospitals strong incentives to increase charges for these services, thus raising beneficiary coinsurance liabilities. Fixing the formula-driven overpayment would mitigate the hospital incentive to raise the charges to Medicare enrollees.

Savings

1994	1995	1996	1997	1998	1999	2000	1994 - 2000
$150	1,050	1,300	1,690	2,190	2,750	3,480	$12,610

Contract Competitively for All Part B Laboratory Services. The Secretary would be required to establish the same kind of competitive acquisition system for Medicare laboratory services as for other selected Part B items and services beginning January 1, 1995. Pricing assumes that competitive contracting will reduce the price of laboratory services by 10%. Medicare laboratory payments currently are projected to grow by 15% to 18% per year. This proposal seeks to curtail the growth rate by lowering the price of tests and reducing the profit incentive for physicians to order unnecessary tests. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$140	220	260	290	320	360	$1,590

Competitively Bid Selected Medicare Part B Items and Services. This proposal would require the HHS Secretary to contract competitively for Medicare services and supplies, based on quality and other standards. The initially planned items for competitive procurement are MRIs, CAT scans, oxygen services, and enteral nutrients. Pricing assumes a 10% reduction in price for these services and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$110	190	210	240	270	300	$1,320

Income-Related Part B Premium, Fully Phased-in to 75%. Currently, all Medicare enrollees pay the same Part B premium, regardless of income. This premium is set at approximately 25% of program costs, beginning in 1996; the balance is paid by general revenues. This proposal would charge high-income enrollees a premium up to 75% of program costs. The increase in the premium for single individuals would begin at modified adjusted gross incomes (plus taxable Social Security benefits) of $90,000 and phase up to 75% for those individuals with incomes equal to or above $105,000. The increase for couples would begin at $115,000, with the maximum 75% premium being paid by couples in which both are eligible for Medicare with a combined income of over $130,000.

Savings (includes interaction)

1996	1997	1998	1999	2000	1996 - 2000
$350	935	900	985	1,070	$4,240

Re-establish 20% Coinsurance for Laboratory Services. This proposal would re-establish a 20% coinsurance on all physician office, outpatient, and independent laboratory tests under Medicare Part B, effective January 1, 1995. Congress eliminated the required coinsurance on laboratory services for independent labs and those in hospital outpatient departments in 1984. In 1985, Congress eliminated the coinsurance for physician office laboratory services. Clinical laboratory services are the only services provided under Medicare Part B for which no coinsurance is now required.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$650	1,070	1,230	1,380	1,540	1,720	$7,590

Extend OBRA 93 Provision: 25% SMI Premium. OBRA 93 established the Part B premium collections at 25% of program costs for 1996-1998. This proposal would extend the OBRA 93 provision requiring that Part B premium collections cover an estimated 25% of program costs.

Savings

	1996	1997	1998	1999	2000	1996-2000
	$0	0	0	1,770	4,310	$6,080
Interaction	($710)	(1,090)	(2,140)	(2,770)	(3,180)	($9,890)
NET	($710)	(1,090)	(2,140)	(1,000)	1,130	($3,810)

Limit Payments to High-Cost Medical Staffs. This proposal would establish limits on Medicare physician payments per inpatient hospital admission, similar to limits used in other parts of Medicare. The proposal would take effect in 1998. Payment limits would be established based on the median of hospital-specific case-mix adjusted relative value units per admission. For urban hospitals, the limit would be 125% of the national median in 1998 and 1999, and 120% in 2000 and thereafter. For rural hospitals, the limit would be 140% of the national median in 1998 and thereafter. Annually, a hospital-specific per admission relative value would be projected for the upcoming year for each hospital. This projection would be adjusted for each hospital's teaching status and disproportionate share. At the beginning of each year, Medicare would establish a 15% withhold for medical staffs projected to be over the national limit. After the end of each year, Medicare would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. For medical staffs below the limit, the entire withhold would be returned.

Savings

1995	1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	500	780	1,040	$2,320

Prohibition on Balance Billing. Physicians and other providers of Part B services are said to "accept assignment" on Medicare claims when they accept the Medicare approved amount as payment in full for covered services. Balance-billing (also called extra-billing) occurs when providers charge more than the Medicare approved amount -- Medicare pays 80% of the approved amount and the beneficiary or other payor (e.g., Medigap insurance) is responsible for paying the balance. Balance-billing is prohibited under current law for most Part A and B services. Physicians may not charge more than 15% over the Medicare approved amount for their services, and only about 6% of all physician dollars are billed on an unassigned basis. Elimination of balance-billing remaining in Medicare will make for consistent treatment of all services within Medicare and between Medicare and the health alliance-approved plans serving the under-65 population. It will also reduce beneficiary confusion, enhance beneficiaries' financial protection, and simplify carrier administration. This proposal will mandate assignment and prohibit all balance-billing by providers of Part B services effective January 1, 1996. The costs from this proposal arise largely from elimination of the participating physician payment differential.

Costs

1996	1997	1998	1999	2000	1996 - 2000
($130)	(250)	(260)	(270)	(290)	($1,200)

PARTS A AND B PROPOSALS

Extend OBRA 93 Provision: Eliminate Catch-Up after Home Health Freeze Expires. OBRA 93 eliminated the inflation adjustment to the home health limits for two years, FY 1994-1995. This proposal would eliminate the inflation "catch-up" -- currently allowed after the freeze expires on July 1, 1996 -- by recalculating the percent of the mean that would produce the same amount of savings as if the freeze continued. HCFA actuaries estimate this to be 100% of the mean.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	480	600	650	690	$2,420

Lower Home Health Limits to 100% of Median. Home health is projected to rise over 10% a year through 1998, including 33% growth in 1994. This proposal would lower the cost limits to 100% of the median for cost reporting periods beginning on or after July 1, 1997. In other words, Medicare would reimburse home health agencies at a rate no higher than the costs encountered by half of the agencies.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	10	160	230	250	$650

Require a 10% Copayment on All Home Health Visits for Visits other than Those Occurring 30 Days after a Hospital Discharge. Home health is one of the fastest growing benefits in Medicare, with a projected increase in home health outlays of nearly 33% in 1994. Medicare enrollees do not currently pay cost-sharing on home health care. This provision would charge a copayment on all home health visits except those received within 30 days of an inpatient hospital discharge; these visits are less discretionary and more intensively rehabilitative. Enrollees who receive home health without an inpatient stay would pay the 10% copayment on all services. The copayment would be equal to 10% of the average cost per visit.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$230	1,400	1,560	1,680	1,800	1,920	$8,590

Expand Centers of Excellence. HCFA has initiated two bundled payment demonstration projects that show potential for Medicare savings. These projects involve contracting with "Centers of Excellence" that perform coronary artery bypass graft (CABG) surgery and cataract surgery. By expanding this concept to all urban areas, contracting with individual centers using a flat payment rate for all services associated with the cataract or CABG surgery, Medicare would be able to reduce costs. The Secretary also would be granted the authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so through rebates representing 10% of the government's savings from the center. Pricing assumes a 10% discount in the price of services for the 20 percent of beneficiaries who are assumed to use the centers.

Savings

	1996	1997	1998	1999	2000	1996 - 2000
Part A	$60	70	70	70	70	$340
Part B	$40	40	40	40	40	$200

Extend OBRA 93 Provision; Medicare Secondary Payor (MSP) Data Match with SSA and IRS. OBRA 93 included an extension of the data match between HCFA, IRS, and the Social Security Administration to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare. This proposal would extend that provision beyond its scheduled expiration date of 1998.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	195	330	$525

Establish a Threshold of 20 Employees for MSP for the Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled enrollees with employer-based health insurance. The provision is applicable to all employers with 100 or more employees. This proposal would lower the employee threshold from 100 to 20 employees beginning on January 1, 1998. With community rating under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would eliminate the employee threshold. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	150	240	260	$650

Extend OBRA 93 Provision: MSP for Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. This proposal would extend this provision permanently.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	990	1,340	$2,330

Extend OBRA 93 Provision: Medicare Secondary Payor Provisions for ESRD Patients. OBRA 93 extended through FY 1998 a provision that makes Medicare the secondary payor for individuals with end stage renal disease (ESRD) enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. This provision permanently extends the MSP provision for individuals with ESRD. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would provide for coverage of individuals with end stage renal disease for as long as the individual requires care. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996 - 2000
$0	0	0	75	105	$180

HMO Payment Improvement. Medicare pays 95% of the average adjusted per capita cost (AAPCC) for Medicare enrollees in Medicare-contracted HMOs. This proposal would establish a range around the Part A and Part B components of the AAPCC that would presumably encourage HMOs to participate in Medicare while establishing reasonable limits on reimbursement for high-cost counties. The ceiling would be 150% of the national average Part B component of the AAPCC and 170% for the Part A component of the AAPCC, with a floor established at 80%. The range would be phased-in over a four-year period, beginning in 1995.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
$30	90	165	250	350	400	$1,285

TOTAL SAVINGS

1994	1995	1996	1997	1998	1999	2000	1994-2000
$150	2,480	9,875	14,373	22,815	33,000	41,721	$124,414

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Department of Veterans Affairs: Third Party Receipts

BUDGET PROJECTIONS

Fiscal Year	1995	1996	1997	1998	1999	2000	1995-2000
Third Party Receipts	0	-600	-1,700	-4,300	-4,500	-4,700	-15,800

POLICY DESCRIPTION

Under reform, VA will collect receipts from a variety of sources, including premium payments from Health Alliances.

KEY TECHNICAL ASSUMPTIONS

The number of veterans currently using VA medical care will not change under reform. Receipt estimates are based on average premium and copayments projected under health care reform that VA is expected to receive. Based on the phase-in of health care reform, reimbursements are estimated at 15 percent in 1996, 40 percent in 1997, and 100 percent in 1998 and later years. Detailed VA data on current users relies on a 1987 survey.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Department of Veterans Affairs: Reimbursement from Medicare

BUDGET PROJECTIONS

Fiscal Year	1995	1996	1997	1998	1999	2000	1995-2000
Medicare Collections	0	0	0	-225	-300	-300	-825

POLICY DESCRIPTION

Under reform, VA health plans will collect reimbursement from Medicare when VA care is provided to a Medicare eligible, non-service connected, higher-income veteran.

KEY TECHNICAL ASSUMPTIONS

The number of veterans currently using VA medical care will not change under reform. Medicare reimbursements to VA are equal to the average actual cost per Medicare beneficiary. Based on the phase-in of health care reform, collections are estimated at 75 percent in 1998 and 100 percent in 1999. Detailed VA data on current users relies on a 1987 survey.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Veterans Health Care Investment Fund

BUDGET PROJECTIONS

Fiscal Year	1995	1996	1997	1998	1999	2000	1995-2000
Health Care Investment Fund	1,000	600	1,700	0	0	0	3,300

POLICY DESCRIPTION

These resources will help VA implement and operate under the President's national health care reform.

KEY TECHNICAL ASSUMPTIONS

n/a

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Department of Defense health care for dependents and retirees.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category	0	-100	-200	-500	-500	-500	-1800

POLICY DESCRIPTION

Assumes DoD pays all costs for dependents of active duty personnel, retirees and dependents of retirees who enroll in the DoD medical plan. DoD will pay 80 percent of the premium cost for non-working beneficiaries who enroll in other health plans. Employers of DoD dependents and retirees are assumed to pay the normal employer payment. This payment will go to DoD for beneficiaries who choose a military plan.

KEY TECHNICAL ASSUMPTIONS

Average cost per capita for the DoD health plan was determined using data provided by RAND and the DoD. We have assumed that the same proportion of beneficiaries who choose the DoD system today will enroll in the DoD health plan in the future.

During the transition, savings are estimated at 15 percent in 1996, 40 percent in 1997, and 100 percent in 1998 and later years.

The cost estimates assume that in areas where there are no military facilities, DoD will use health alliance plans if running DoD's own plan in those areas would be more costly.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Savings to the Department of Defense resulting from Medicare paying DoD for care now provided by DoD to eligible beneficiaries.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category BA	0	-200	-500	-1300	-1400	-1400	-4800

POLICY DESCRIPTION

Beginning Oct. 1, 1995, DoD will be reimbursed by Medicare for care provided to Medicare eligible DoD beneficiaries who choose DoD health plans.

KEY TECHNICAL ASSUMPTIONS

DoD estimates that it will provide $1.268 billion in medical services to persons over age 65 in FY 1993. Medicare estimates it pays 90 percent of costs. Payments are assumed to phase in at the rate of 15 % in FY 1996, 40% in FY 1997 and 100% thereafter.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Savings to the Department of Defense resulting from payments to DoD for health care of non-working retirees between the age of 55 and 65.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category	0	0	0	-200	-300	-300	-800

POLICY DESCRIPTION

The Government will assume 80 percent of the cost of health care for non-working early retirees.

KEY TECHNICAL ASSUMPTIONS

DoD currently pays the cost of health care provided to its non-working retired beneficiaries. This estimate assumes that DoD will continue paying twenty percent of the cost of the care. The funds shown are an estimate of 80 percent of the cost of health care for non-working beneficiaries who would choose to use DoD health care under national reform. The estimate assumes the same percentage of non-working retirees who choose DoD health care today would choose DoD health care under national reform.

Payments are assumed to begin Jan. 1, 1998.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY

Federal Employees Health -- coverage for Federal annuitants age 55-65, not yet medicare-eligible.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	-1.1	-1.7	-1.9	-4.8*

POLICY DESCRIPTION

Annuitants without Medicare coverage obtain coverage through the alliances. Annuitants in this group would be eligible for a Government discount for the employer share of premiums. Savings above result from shifting the employer-share of premiums away from the Government as an employer (from the OPM "Government Payment for Annuitants" account) and onto the broader Government early retiree discount program.

KEY TECHNICAL ASSUMPTIONS

-- After January 1998, Government, as an employer, makes no contributions to premiums for Federal annuitants in this group until they become Medicare-eligible (i.e., Government subsidy program pays 80% of the alliance premium and Federal annuitants pay the remaining 20%).
-- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service would accrue to the U.S. Postal Service; savings for pre-1971 creditable service would accrue to the Federal Government).

OUTSTANDING ISSUES

-- Cost sharing and benefit assumptions for supplemental plans.
-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

**Row does not total due to rounding.*

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY

Federal Employees Health -- coverage for Federal annuitants age 65 or older, not Medicare-eligible*, or under age 55, not yet Medicare-eligible.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	-0.1	-0.2	-0.3	-0.6

POLICY DESCRIPTION

Annuitants without Medicare coverage obtain coverage through the alliances. The Federal Government, as an employer, makes a contribution toward premium costs.

*In general, the group of annuitants age 65 or older, not Medicare-eligible, is comprised of Federal employees who retired before January 1, 1983 and did not have enough employment outside Government to qualify for Medicare.

KEY TECHNICAL ASSUMPTIONS

-- Annuitants under age 55 (not yet Medicare-eligible) or age 65 or older (not Medicare-eligible) are not eligible for the Government subsidy program. An employer contribution for the alliance premiums would be paid out of the OPM "Government Payment for Annuitants" account.
-- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service accrue to the U.S. Postal Service; savings for pre-1971 creditable service accrue to the Federal Government).

OUTSTANDING ISSUES

-- Cost sharing and benefit assumptions for supplemental plans.
-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY

Federal Employees Health -- coverage for Medicare-eligible Federal annuitants.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	-0.0	-0.0	-0.0	-1.6	-1.8	-2.1	-5.5

POLICY DESCRIPTION

Annuitants with Medicare obtain additional coverage through an OPM-administered supplemental Medicare wrap-around plan ("medigap"). The Federal Government, as an employer, makes a contribution toward the premium costs.

KEY TECHNICAL ASSUMPTIONS

- -- Annual premium cost for comprehensive medigap (1994 preliminary estimate): $1,273 single; $2,545 family.
- -- Government pays an employer-share of the medigap premium of approximately 72% (the rate in use today under FEHB; paid via the OPM "Government Payment for Annuitants" account). Annuitants pay the remaining 28%. (Note: because the "medigap" premiums are estimated to be much lower than current FEHBP premiums, annuitants are still likely to be better off than they are today.)
- -- All Medicare-eligible annuitants enroll in Medicare Parts A and B, and elect to be covered by the OPM medigap.
- -- Assumes the same benefit levels for current and future annuitants.
- -- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service accrue to the U.S. Postal Service; savings for pre-1971 creditable service accrue to the Federal Government).

OUTSTANDING ISSUES

- -- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY

Federal Employees Health -- Payments to Medicare

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	0.1	0.1	0.1	0.3

POLICY DESCRIPTION

Approximately 115,000 Medicare-eligible annuitants under FEHBP have declined the optional Part B coverage available from Medicare. Without FEHBP (or another insurer), these annuitants would lack insurance coverage for physician services. Annuitants in this group who wanted to be covered by Part B after FEHBP terminated, would have to pay a late enrollment penalty. This policy assumes that the Government, as an employer, would pay the late enrollment penalty amount on behalf of these annuitants.

KEY TECHNICAL ASSUMPTIONS

-- Average penalty is 10 years (based on each year the individual could have elected coverage but did not).
-- OPM would pay the late enrollment penalty amount on an annual basis. The payments would be funded out of the OPM "Government Payment for Annuitants" account.
-- Medicare has additional costs for benefit amounts incurred by these annuitants once they enroll in Part B. These costs are absorbed by Medicare (they are not a liability for OPM). The increased costs to Medicare for the benefit amounts are estimated at: 1994-1997: $0; 1998: $0.3; 1999: $0.3; 2000: $0.3.
-- Note: to the extent that annuitants without Part B coverage decided to elect coverage through the alliances rather than through Medicare, the estimated penalty and benefit payment costs would be reduced.

OUTSTANDING ISSUES

-- Although for estimating purposes it was assumed OPM would pay the penalty amount on an annual basis, no decision has been made regarding whether the penalty would be paid annually or in a lump sum.
-- Cost sharing arrangements for the U.S. Postal Service and the Federal Government for penalty amounts for Postal Service annuitants.

HEALTH SECURITY ACT

PUBLIC HEALTH INITIATIVE

BACKUP DOCUMENTATION

BUDGET CATEGORY

Public Health Service

BUDGET PROJECTIONS:

(billions of dollars)

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Authority	1.1	3.0	3.8	4.2	4.1	3.7	19.9
Total Outlays	0.4	1.5	2.6	3.3	3.7	3.8	15.3

Details of the Public Health Service initiatives planned as part of health reform are shown in the following tables in this section. These budget estimates are presented in terms of proposed Budget Authority. Actual outlays will differ somewhat from the BA because of differences of timing. Total outlays for the PHS initiatives are shown above.

PUBLIC HEALTH SERVICE
Health Care Reform Budget
Public Health Initiative
(Dollars in Millions)

Program/Activity	FY 1995 Increment	FY 1996 Increment	FY 1997 Increment	FY 1998 Increment	FY 1999 Increment	FY 2000 Increment	Six Year Total
Capacity Expansion/Enabling							
Community/Migrant Health Centers	$100	$100	$100	$100	$100	$100	600
Capacity Expansion	200	500	600	700	500	200	2,700
Enabling Services	0	200	300	300	300	100	1,200
Subtotal	300	800	1,000	1,100	900	400	4,500
Workforce							
National Health Service Corps	50	100	200	200	200	200	950
Health Professions 1/	20	200	200	200	100	100	820
Academic Health Centers	3	4	5	5	5	5	27
Subtotal	73	304	405	405	305	305	1,797
School-Based Health							
School Related Health Services	0	100	275	350	400	400	1,525
School Health Education	50	50	50	50	50	50	300
Subtotal	50	150	325	400	450	450	1,825
Health Research Initiatives							
Prevention Research (Section 3201)	400	500	500	500	500	500	2,900
Health Services Research (Section 3202)	150	400	500	600	600	600	2,850
Subtotal	550	900	1,000	1,100	1,100	1,100	5,750
Indian Health Supplemental Services	40	180	200	200	200	200	1,020
Mental Health & Substance Abuse	100	150	250	250	250	250	1,250
Public Health Services							
Core	12	325	450	550	650	750	2,737
Priority	0	175	200	200	200	200	975
Subtotal	12	500	650	750	850	950	3,712
TOTAL	**$1,125**	**$2,984**	**$3,830**	**$4,205**	**$4,055**	**$3,655**	**$19,854**

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SECURITY ACT
Public Health Initiatives

The President's Health Security Act includes a $20 billion initiative over the next 6 years to expand Public Health Service activities that are essential to successful implementation. This initiative begins with $1.125 billion in FY 95, $2.98 billion in FY 1996, grows to $4.2 billion in FY 1998, and levels off at $3.6 billion in FY 2000. The additional resources in FY 1995 and FY 1996 represent an increase of 5 percent and 14 percent respectively over the resources available to PHS in appropriations bills (conference action) for FY 1994.

These PHS initiatives are central to achieving the prevention, access, quality, and cost effectiveness goals articulated in the President's plan. These initiatives, included in Title III and Title VIII of the Health Security Act, are divided into seven major elements:

- Workforce Priorities - A new national council on graduate medical education (GME) is established to allocate speciality positions in a manner that: expands training capacity to support a shift to training 55 percent of new physicians in primary care; expands recruitment and financial assistance programs to increase the number of minority students in the health professions; and supports expansion of priority nurse training initiatives including advanced practice nursing, faculty development, school nurse training, and development of data systems. (The AHC and GME funds established in the Health Security Act are not included in PHS authorizations cited above but are a separate entitlement.)

- Health Research Initiatives - are expanded to:

  -- Provide research on prevention and high-cost/debilitating diseases (e.g., Alzheimer's disease) and areas such as children's health, breast cancer, and reproductive health and translate advancements into the health delivery system to help control health care costs and improve the quality of life.
  -- To accelerate health services research including quality measurement and improvement, efficiency, and effectiveness of the health care delivery system.

- Core Functions of Public Health Programs and Preventive Health - support for public health agencies and community-based organizations to improve the health of populations and to control health care costs through:

- -- Core Public Health - to reduce preventable disease and disability and their attendant costs to the personal health care delivery system by supporting states to strengthening their state and local health departments' capacity to carry out core public health functions that protect whole communities from infectious diseases, environmental hazards, and preventable injury and provide population-based prevention education and community mobilization regarding behavioral and environmental risks.
- -- National Initiatives Regarding Preventive Health - to achieve measurable reductions in preventable disease, disability, and death by supporting public and private non-profit agencies at the community level to address priorities defined through the *Healthy People 2000* process with community-based, innovative interventions affecting special population groups and involving regional and state variations in level of need.

- Health Services for Medically Underserved Populations - Capacity expansion and enabling initiatives are essential to ensure that underserved populations have access to the services to which they are entitled under the Health Security Act. Activities include support for:

  - -- the development of practice networks and community-based health plans;
  - -- information systems and telecommunications linkages
  - -- acquisition, construction, or renovation of delivery sites; major equipment purchases; establishing financial reserves; and other capital needs of health care providers;
  - -- expansion of Community and Migrant Health Centers (C/MHCs); and
  - -- the provision of outreach and enabling services to ensure that low-income, hard-to-reach, and culturally diverse populations are able to use the health care system effectively.
  - -- expand from 1,600 to 8,000 by 2005 (when full effects are felt) the number of National Health Service Corps (NHSC) providers available to serve underserved populations;

- Mental Health and Substance Abuse - support is expanded for wrap-around services for the most vulnerable populations of our society, which includes over 2.5 million persons in poverty who are homeless, seriously mentally ill, or diagnosed to have mental health and/or substance abuse problems.

- Comprehensive School-related health activities - by FY 1999 provide health services for 3.2 million students in 3,500 schools with a high proportion of low-income populations. Also, a $50 million health education program will be implemented for children in grades Kindergarten through 12.

- Indian Health - expand enabling services to help raise the health status of American Indian and Alaskan populations to that of the rest of the United States population covered under the Health Security Act.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 1 - Community and Migrant Health Centers

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$100	$100	$100	$100	$100	$100	$600

The Community and Migrant Health Center program is a successful program that currently provides a range of primary care, specialty care, and enabling services to 6.8 million Americans living in Federally-designated underserved areas. Twice as many projects are approved in this program than can currently be funded. An additional investment of $100 million annually over six years will expand the reach of this program to an additional 2 million individuals, meeting 7% of the current unmet capacity needs in underserved areas.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 2 - Initiatives for Access to Health Care
Subparts A, B, and C

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$200	$500	$600	$700	$500	$200	$2,700

This transitional program supports capacity expansion in underserved areas in ways that build on existing resources in each community and that are responsive to local circumstances and needs. With a $2.7 billion investment over six years, the program will fully address the estimated need for information systems and telecommunications (exclusive of highway costs) in underserved areas; provide all federally-funded and other practitioners in underserved areas with the skills and support they need to form practice networks or health plans; meet most of the need for new practice sites in underserved areas; support renovations to improve the practice environment for 3800 practitioners working in C/MHCs and other existing sites in underserved areas; and address much of the capital needs of rural and public hospitals.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations
Part 2 - Subpart D: Enabling Services

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$0	$200	$300	$300	$300	$100	$1,200

This program ensures that low-income, hard-to-reach, culturally diverse populations have access to the services to which they are entitled under reform by providing them with the supplemental services they need to use the health care system effectively. With a $1.2 billion investment over six years, the program will support the provision of transportation, translation, outreach, follow-up, and child-care services to 6 million individuals not served by other programs.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 3 - National Health Service Corps

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$50	$100	$200	$200	$200	$200	$950

The National Health Service Corps assures the availability of physicians and other health professionals in severely underserved rural and urban communities. Of the 72 million Americans who live in underserved areas, 33 million currently lack a regular source of care. The NHSC provides scholarships and repayment of student loans to health professionals who agree to serve at least two years in these areas.

The NHSC would be expanded by increasing the number of NHSC scholarships and loan repayments from approximately 800 in 1994 to 1,800 in 1996 and to 2,800 in 1998 and subsequent years.

The NHSC field strength would grow from its level of 1,600 providers in 1993 to 5,300 providers serving over 8 million people in 1998. NHSC field strength would plateau at about 8,000 providers by the year 2005. Placements are prioritized by severity of need and these providers would serve the most difficult to reach one-third of underserved communities with providers distributed fairly evenly between rural and urban sites.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle A - Workforce Priorities Under Federal Payments
Institutional Costs of Graduate Medical Education; Workforce Priorities

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$20	$200	$200	$200	$200	$100	$820

The nation currently trains far too many physicians in specialties and too few in primary care. This distortion of the workforce contributes to the high costs of care. There are also too few mid-level professionals trained and the workforce lacks diversity to assure adequate access to care for all groups in the population.

In a new system with more limited specialty training, the number of new medical school graduates who choose primary care training programs needs to increase from present levels of 4,000 per year to 9,000, or 55 percent of all new graduates. Similarly, estimates indicate that the number of mid-level providers should increase from the current 2,500 per year to 5,000 per year. Finally, an estimated 23,000 minority students could benefit from expanded recruitment programs, with about 8,500 students in such programs now.

Funds support the transition of physician training to primary care by increasing Federal assistance for primary care programs by 50%. These funds help meet the need for more graduates who choose primary care by supporting faculty and curricula development and expansion of 2,500 additional positions. Mid-level providers will increase to about 4,000 graduates per year to meet 80 percent of the projected need. Minority recruitment programs will expand to reach about 12,500 students each year, about 50% of the projected goal. Support for physician retraining programs will begin an effort to redirect physicians currently trained as specialists into primary care. Expanded support will be provided for a range of nursing programs, including school nurse training, geriatric nursing, development of innovative education and practice models, and other priority nursing projects. Public health training support will also increase.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle B - Academic Health Centers

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
*	*	*	*	*	*	*

The Health Security Act establishes formula payments to Academic Health Centers (AHCs) to assist eligible institutions with costs incurred by virtue of their training function. These funds will help cover such costs as:

- -- reduced rate of productivity of faculty due to teaching responsibilities;
- -- uncompensated costs of clinical research; and
- -- exceptional costs including treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care.

The President's Health Security Act contemplates stronger ties between academic health centers and providers in urban and rural areas. The Act authorizes grants to assist academic health centers to establish referral networks and educational alliances in such areas.

* A new Academic Health Center account is established (outside the PHS initiative) to fund these activities as follows: 1996, $3,100 million; 1997 and 1998, $3,200 million; 1999, $3,700 million; and 2000, $3,800 million.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle G - Comprehensive School Health Education; School Related Health Services

Part 5 - School Related Health Services

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$0	$100	$275	$350	$400	$400	$1,525

Only 500,000 children in America's middle and high schools have access to school based or school-linked clinics. Yet, according to a 1992 Department of Education survey, 5.4 million students age 10 - 19 in 9,411 middle and high schools with a high prevalence of poverty and other risk factors (schools where at least thirty percent of the students are eligible for subsidized meals) are estimated to be in need of these services. These young people, who frequently engage in high risk behaviors, experience multiple non-financial barriers to health care. These barriers include reluctance to seek help, lack of parental availability, and lack of knowledge about what help may be available and how to get it. This initiative will improve access to health and psycho-social services to up to 3.2 million children in over 3,500 schools (priority will be given to schools with the highest percentage of children in need) by providing health services where they spend most of their time. As a result of targeting services in high-need areas, there will be a reduction in the preventable morbidity and mortality that children and adolescents experience. Grants to states and local consortia will support the provision of services at sites throughout the country in areas of greatest need.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle G - Comprehensive School Health Education; School Related Health Services
Parts 2, 3 and 4

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$50	$50	$50	$50	$50	$50	$300

The health problems that plague our children and adolescents, and the adults they become, are caused primarily by behavioral patterns usually established during youth. Research has shown that initiation of these behaviors can be delayed, reduced, or prevented through school based health education programs. Yet U.S. Department of Education data show only 12 percent of 10th graders and 2 percent each of 11th and 12th graders received any health education credits in school. This initiative will provide grants to every state as well as 20 of the largest Local Education Agencies to enable them to implement comprehensive school health education programs. It contains waiver authority to leverage existing health education monies. State education and health agencies will be expected to collaborate in developing plans targeted to students at highest risk while integrating new funding with existing categorical funding to provide comprehensive health education services.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle C: Health Research Initiatives

Prevention Research

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$400	$500	$500	$500	$500	$500	$2,900

Prevention research is the foundation for clinical preventive services and public health interventions which are integral components of efforts to reduce the burden of avoidable disease, disability, and death. A renewed emphasis on prevention research is necessary to ensure the availability of effective preventive measures against existing diseases, as well as new and emerging threats to the health of Americans. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly.

NIH is the Federal Government's lead agency for biomedical and behavioral research and has the expertise to plan, coordinate, and implement a prevention research agenda to support health care reform. Prevention research findings will be translated into, or appropriately integrated with personal health services and public health programs to maximize the impact of prevention research on disease reduction and improved health status.

The Prevention Initiative will contribute to more effective and efficient measures to prevent the onset of diseases and disabilities that now affect tens of millions of Americans. For example, delaying the onset of Alzheimer's disease by an average of five years would cut in half the costs associated with this disease, currently estimated at $90 billion annually.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle C: Health Research Initiatives
Health Services Research

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$150	$400	$500	$600	$600	$600	$2,850

The DHHS supports a broad based program of investigator-initiated and directed research on cost, quality and access issues in health care delivery. This research will inform practitioners, managers, purchasers, providers, and consumers under the Health Security Act. The basic principle underlying the President's Health Security Act is that we can provide *better quality* of care to *more* people at *less* cost. To support the achievement of these objectives, DHHS will expand its research program to: 1) develop the science base on what works best in medical care to identify practice variations with unnecessarily high costs and no added clinical benefit; 2) develop quality and performance measures and related information to assist consumers, practitioners, and plans in making good health care decisions; 3) significantly expand medical effectiveness research and practice guidelines development, dissemination and evaluation to improve the treatment decisions made by physicians, thereby contributing to cost-containment by reducing unnecessary care; 4) design and test clinical and administrative data systems and technologies to expedite administrative simplification and lower administrative costs; 5) investigate and assess the organizational, clinical, and financial alternatives adopted by states during initial reform to refine and improve subsequent implementation; 6) develop approaches for improving the efficiency and equity of reimbursement and provider payment systems; and 7) determine the impact of improved primary care on access to care.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title VIII, Subtitle D - Indian Health Service

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$40	$180	$200	$200	$200	$200	$1,020

The IHS provides comprehensive medical and public health services to the 1.3 million American Indians living on reservations. American Indians have among the poorest health status of all Americans: 40%reduction in years of productive life; tuberculosis rate 6 times higher than other Americans; and infant mortality 1.5 times higher than whites. Isolated living conditions, poverty, lack of available public health services, and inadequate access to care all contribute to poorer health status.

Historic legal and ethical obligations require that the Federal Government provide health care and public health services to American Indians and Alaskan Natives. These obligations continue under the Health Security Act. But, health insurance alone will not improve the health of American Indians. Given existing resources only 45% of American Indians receive the necessary personal, community and environmental-based public health services. Only about half of American Indians receive necessary enabling services such as outreach, transportation and translation services.

Additional funding will improve the health status of American Indians to a level closer to other Americans. Funds will increase enabling services by 2.7 million additional home and other visits, one-half million nursing visits and additional transportation and interpretive services to an additional 240,000 American Indians by FY 1998. Improved services will be targeted to lower rates of diabetes, alcoholism, injuries, and to improve immunization coverage.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle F - Mental Health; Substance Abuse

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$100	$150	$250	$250	$250	$250	$1,250

While health insurance will cover most direct acute mental health and substance abuse treatment costs, it will not ensure access to services. Research clearly shows that enabling services, such as outreach, transportation, child care and translation services are necessary to get persons with serious substance abuse and chronic mental health conditions into treatment. Beneficiaries will include over 2.5 million persons in poverty who are homeless, seriously mentally ill, or diagnosed to have both mental health and substance abuse problems. This would meet approximately one-quarter of the need nationwide. Funds would be distributed to States using the existing formula for mental health and substance abuse block grants.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle D - Core Functions of Public Health Programs;
National Initiatives Regarding Preventive Health
Part 2 - Core Functions of Public Health Programs

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$12	$325	$450	$550	$650	$750	$2,737

The Health Security Act cannot meet its national cost containment targets if full advantage is not taken of opportunities to prevent unnecessary disease--opportunities largely accessible through public health programs. These functions are necessary to protect whole communities from infectious diseases, environmental hazards, and preventable injury and to provide population-based prevention education and community mobilization regarding behavioral and environmental health risks. Yet the resources available to support the core functions of public health are only about half the level necessary to meet basic responsibilities. Between 1981 and 1993, support for the basic public health functions fell from 1.2% to 0.9% of national health care expenditures. Concurrently, additional demands were imposed on public health agencies by problems such as HIV infection, childhood vaccine-preventable diseases, tuberculosis, violence, and the health and social service needs of young, single mothers and their children. There is a vital need to assist state and local health agencies to rebuild and strengthen their capacity to carry out their basic responsibilities for population-based programs, which have the potential to prevent diseases that otherwise drive up personal health care service utilization and cost billions of dollars to treat. Through this grant program, the Health Security Act will support states and communities to meet approximately 8% of estimated need to repair the eroded infrastructure by the year 2000. The returns to this program in terms of cost savings from reduced disease incidence--even using conservative assumptions--will substantially exceed the investment.

HEALTH SECURITY ACT

Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle D - Core Functions of Public Health Programs;
National Initiatives Regarding Preventive Health
Part 3 - National Initiatives Regarding Health Promotion and Disease Prevention

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-FY 2000
$0	$175	$200	$200	$200	$200	$975

Prevention opportunities related to behavioral risks, physical and social environment, and appropriate use of clinical preventive services have been defined and quantified in the national prevention agenda contained in *Healthy People 2000*. Through community-based prevention approaches, it is possible to dramatically reduce premature mortality and chronic disease and disability. The need is to support public and not-for-profit agencies in devising approaches that mobilize communities to improve health of whole populations, thus effecting savings to the overall health care system. A competitive grants program will support large-scale, multi-site community-based prevention innovations, with findings from these projects disseminated through public health information networks to other communities across the Nation. Examples of priorities of this program and prevention of the initiation of Smoking by Children and Youth, prevention and violence, and reduction of behavioral risks contributing to chronic diseases such as heart disease, cancer, stroke, and adult-onset diabetes.

Public Health Service Off-sets

Many current Public Health Service (PHS) programs provide 'gap-filler' health services to uninsured individuals. Some PHS programs provide direct health services to selected uninsured populations, while others support disease-specific or treatment-specific medical services. For example, PHS grants support State immunization programs.

The Health Security Act assurance of universal coverage and a comprehensive benefits package directly addresses many of the 'gaps' that PHS fills. The services currently provided piece-meal through public health programs will be covered uniformly under the comprehensive benefits package, such as immunizations. Preventive, mental health and substance abuse services, and many disease-specific services, are covered under the benefits package.

As health reform progresses, there will be an opportunity to redirect PHS resources to higher priority programs.

PHS Off-sets
(outlays in $ billions)

		FY95	FY96	FY97	FY98	FY99	FY00		FY95-00
Offset/Redirection	**OL**	0.0	(0.3)	(0.9)	(1.8)	(2.4)	(2.6)		(8.0)

BUDGET CATEGORY

Special Supplemental Food Program for Women, Infants, and Children (WIC)

BUDGET PROJECTIONS (OUTLAYS IN BILLIONS)

Fiscal Years	1995	1996	1997	1998	1999	2000	2001
Increase in regular appropriations	0	.2	.2	.2	.3	.3	.3
Special fund	0	.2	.4	.4	.4	.4	.4
Total	0	.5*	.6	.6	.7	.7	.7

*Total does not add due to rounding.

POLICY DESCRIPTION

The Special Supplemental Food Program for Women, Infants, and Children (WIC) has been proven to play a key role in health promotion by providing nutritional supplements to pregnant women and young children. WIC services to pregnant women have been found to reduce medical costs the first 60 days after birth. WIC also increases micronutrient intake among infants and children, thus reducing conditions such as iron deficiency anemia. Fully funding WIC is a strong priority of the President's and builds on our commitment to preventative and primary care. The bill seeks to guarantee full funding for WIC by the end of FY 1996 by creating a special fund to supplement annual appropriations. The amounts in the fund will automatically become available for WIC if appropriations bills include the amounts shown in the first line in the table below.

	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000
	(BA in millions)				
Regular appropriation HCR anticipates	3,660	3,759	3,861	3,996	4,136
Special fund	254	407	384	398	411
Full funding level	3,914	4,166	4,245	4,394	4,547

KEY TECHNICAL ASSUMPTIONS

The cost estimate for the WIC provision in the bill is the difference between current services and full funding.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(Outlays in $ billions)

BUDGET CATEGORY
Academic Health Centers and Graduate Medical Education

BUDGET PROJECTIONS

FY	1995	1996	1997	1998	1999	2000	'95-00
Gross	5.93	6.3	6.75	8.0	9.5	9.6	46.08
Medicare Offset	-5.9	-3.6	-3.6	-3.6	-4.0	-3.9	-24.6
Net New Spending	0.03	2.7	3.15	4.4	5.5	5.7	21.48

POLICY DESCRIPTION
The "Gross" spending line represents the policy commitment to Academic Health Centers and Graduate Medical Education support for physicians, nurses, and other health professionals. The Medicare Offset represents proposed law IME and current law DME payments for physicians (DME for nonphysicians is assumed to continue to flow to Academic Health Centers).

KEY TECHNICAL ASSUMPTIONS
The projections of IME/DME dollars are made by OACT consistent with their appraisal of overall health reform and the Medicare savings package in general.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Program for Poverty-Level Children with Special Needs

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	264	869	2,453	3,025	3,157	9,768

POLICY DESCRIPTION
A new Federally-funded program will provide certain medically necessary and appropriate items and services (that are not in the comprehensive benefit package and are not Medicaid long-term care services) to qualified low-income children.

KEY TECHNICAL ASSUMPTIONS
The estimate assumes that Federal expenditures would be limited to total (Federal and State) Medicaid spending for these services in FY 1993 in participating States, trended forward through the year of implementation for each State by the appropriate growth rates in §9003 (a). Thereafter, the annual Federal expenditure limit is trended forward by the growth rates in §9003 (b).

This estimate includes administrative costs, which are not explicitly accounted for in the legislation.
The estimate also differs from the legislation in the calculation of the annual Federal expenditure limit: (1) The estimate trends FY1993 expenditures for wrap-around services by projected spending growth for these services for children; (2) §1934 (d) (2) (A) (i) requires that FY1993 spending also be adjusted to take into account annual increases or decreases in the number of qualified children; (3) the legislation requires that FY93 spending for these wrap-around services be trended forward according to a schedule that does not take into account when States become participating States. This estimate applies the trend factors noted in §9003 (b) for spending in each State in the year following the year in which it becomes a participating State.

BACKUP DOCUMENTATION

(savings negative, costs positive)

BUDGET CATEGORY (outlays in $ millions)

Long-term care: New Federal spending for community-based program

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
community LTC program	0	4,500	7,800	11,000	14,700	18,700	56,700

POLICY DESCRIPTION

The new community-based LTC program is a capped entitlement to States to finance community-based care for the severely disabled (i.e., disability with at least 3 ADLs) . The program is not means-tested but includes an income-scaled coinsurance schedule. The Federal matching rate for the program is approximately 28% higher than current Medicaid FMAP in each State.

KEY TECHNICAL ASSUMPTIONS

Estimates are from ASPE/Lewin-VHI long-term care model, the key components of which are outlined in the attached document. Figures reflect phased-in funding of total program costs according to the following schedule: 20% in 1996, 30% in 1997, 40% in 1998, 50% in 1999, 60% in 2000, 80% in 2001, and 100% in 2002. Thereafter, the capped amounts are trended forward by CPI and the percentage change in the severely disabled population. Absolute capped amounts are derived from the following assumptions (per Lewin-VHI): 3.1 million individuals are eligible for the program; 80% of eligibles participate in the program; elderly participants receive approximately 120 visits per year; physically disabled adults and children receive approximately 122 visits per year; mentally retarded participants receive care 365 days per year. Costs per visit are assumed to be $56 for elderly and physically disabled patients, $85 for mentally retarded (in 1993 dollars). Per ASPE, the capped amounts now include the Federal share of

administrative costs. No Medicaid offset dollars are included in these capped amounts.

KEY COMPONENTS OF HOME AND COMMUNITY-BASED CARE PROPOSAL

NUMBER OF ELIGIBLES

1993 estimates in thousands
total -- 3,090
children -- 150
adult physical -- 420
MR/DD -- 270
elderly -- 2,250

The estimates are based on a number of different data sources used for different age groups in an attempt to use the best available data source.

- Children -- For persons under age 18, both the 1989 National Health Interview Survey (NHIS) and the 1987 National Medical Expenditure Survey (NMES) were used to estimate the number of children with at least three of five ADLs.

- Working-Age Adults -- For persons age 18 to 64, the 1990 Survey of Income and Program Participation (SIPP) was relied upon to estimate the number of persons who required help with at least three of five ADLs. SIPP was also used to estimate the number of persons who have severe or profound mental retardation or developmental disabilities (MR/DD). Because SIPP does not have data on levels of MR/DD, we used data from Charles Lakin at the University of Minnesota to estimate the total number of community-dwelling persons with severe or profound MR/DD (approximately 220,000 in 1990).

- Elderly -- The 1989 National Long Term Care Survey (NLTCS) was used to estimate the number of elderly who would be eligible. The NLTCS provides a large sample of elderly Medicare beneficiaries with disabilities that have or are expected to last at least three months. The data were used to estimate the number of persons with at least three of five ADLs or a similar level of cognitive impairment. A similar level of cognitive impairment was defined as: 1) missing four of ten questions on the Short Portable Mini-Mental Status Questionnaire (SPMSQ); and 2) demonstrating one of the following: disability in at least one of the cognitive Instrumental Activities of Daily Living (IADLs) of medication management, money management, or telephoning; evidence of a behavior problem; or disability in one or more ADLs.

PARTICIPATION RATE

total -- 77%
children -- 60%
adult physical -- 65%
MR/DD -- 77%
elderly -- 80%

AVERAGE EXPENDITURES

1993 estimates of average expenditures under fully phased-in program

	Average Annual **Total** Expenditures		Average Annual **Public** Expenditures	
	Per Eligible	Per User	Per Eligible	Per User
TOTAL	$9,320	$12,150	$8,415	$10,970
Children	$4,100	$6,830	$4,100	$6,830
Adult Physical	$4,440	$6,830	$3,900	$6,000
MR/DD	$24,095	$31,290	$24,095	$31,290
Elderly	$8,840	$11,100	$7,950	$9,940

CURRENT LAW PROGRAMS AFTER REFORM

Medicare -- assumed unchanged

Other Federal Sources (OAA & VA) -- assumed unchanged

State Supported Programs --

expenditures estimated for severely disabled are incorporated into match rate on an aggregate basis

$1.7 billion current law state-only spending in 1993 for the eligible population has been distributed among the states according to the estimated distribution of MR/DD state-only spending by state

state spending for other populations assumed to remain unchanged

Medicaid --

In 1993, we estimate $7.1 billion for Medicaid home and community-based care expenditures; this is less than HCFA actuaries $8.8 billion and more than the annualized first three

quarters of HCFA 64 data at $6.5 billion

One-half of current Medicaid home and community-based care spending ($3.55 billion) is assumed to be for persons eligible for the program.

The estimate of one-half of current Medicaid home and community-based care expenditures for the eligible population is based on NMES data and HCFA form 64 and 372 data. For Home Health, Personal Care, and Home and Community-Based Waivers, the distribution among all elderly, adult disabled and children who are Medicaid home and community-based care recipients and the subset that would be eligible for the program is based on 1987 NMES data. These data indicate that approximately 50 percent of Medicaid expenditures are for those meeting the severely disabled criteria. The split between MR/DD Medicaid Home and Community-Based Waiver recipients and others is based on a Congressional Research Service paper by Richard Price ("Medicaid Home and Community-Based Care Program," 92-902 EPW). This report indicated that approximately 65 percent of Home and Community-Based Care Waiver expenditures in 1991 were for persons with MR/DD. Based on data from the 1987 NMES Institutional sample for residents of small (beds less than 16) MR facilities, we assumed that 47 percent of these expenditures were for persons with severe or profound MR/DD (those eligible for the program).

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Net Federal Discount Payments to Alliances (Capped Entitlement)

BUDGET PROJECTIONS

FY	1995	1996	1997	1998	1999	2000	'95-00
Gross Discounts	**0**	**12.8**	**35.7**	**96.3**	**100.6**	**103.6**	**349.0**
State Maintenance of Effort	**0**	**-2.5**	**-7.4**	**-20.6**	**-21.7**	**-22.6**	**-74.9**
Net Discounts	**0**	**10.3**	**28.3**	**75.7**	**78.9**	**81.0**	**274.1**

POLICY DESCRIPTION
Although all Americans will be asked to contribute to the cost of their health care, there are some groups that will not be able to meet their full contribution: low income families, individuals who have lost their jobs, and small businesses. Low income households and all firms in regional alliances are eligible for premium discounts. Low income households without access to low cost-sharing plans are also eligible for discounts on their out-of-pocket expenses. There are special discounts for early retirees as well. No firm in the regional alliance will pay more than 7.9% of payroll, and small, low-wage firms will pay less, according to a specified schedule. These numbers also reflect a direct grant program for state and local governments as employers ($2B over the period). State maintenance of effort payments (detailed documentation follows this page) to alliances offset Federal discount payments. The Federal liability is capped at the Net Discounts amount, to ensure fiscal responsibility.

Discount eligibility summary:

20% share:	households with AGI less than 150% of poverty, no household pays more than 3.9% of AGI for this portion;
80% share:	households with less than at least one full-time worker which have AGI - wages - unemployment compensation + tax exempt interest less than 250% of poverty;
out-of-pocket:	households with AGI less than 150% of poverty without access to an HMO;
7.9% payroll cap:	all firms in the regional alliance;
small-firm schedule:	firms with fewer than 75 employees and average wages less than $24,000. The self-employed are treated as a firm of size one for the 80% share.

KEY TECHNICAL ASSUMPTIONS

Discount estimates came from a collaborative estimation process involving HCFA/OACT, AHCPR, Treasury, and the Urban Institute models. The actual numbers used were from the HCFA/OACT model. An additional 15% contingency was added to the point estimate of the premium discounts. This 15% is an allowance or "cushion" to cover potential behavioral responses that are difficult to model.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Medicaid: State maintenance-of-effort payments to alliances.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Non-DSH							
Alliance-covered services		-1,890	-5,570	-15,590	-16,270	-16,970	-56,290
State share of new wrap-around program		-70	-230	-640	-790	-820	-2,550
Less ER svcs for undocumented persons		70	180	470	490	510	1,720
DSH		-630	-1,800	-4,880	-5,100	-5,320	-17,730
TOTAL		-2,520	-7,420	-20,640	-21,670	-22,600	-74,850

POLICY DESCRIPTION

Each State contributes a maintenance-of-effort (MOE) payment to alliances that is equal to the level previously spent for services in the standard benefit package for non-cash Medicaid recipients and for wrap-around services for children who receive AFDC or SSI benefits. Medicaid will continue to provide emergency services to undocumented persons and current State spending for these services is netted out of the MOE computation.

KEY TECHNICAL ASSUMPTIONS

State phase-in schedule assumes States with 15% of Medicaid spending implement 10/1/95; States with 25% implement 10/1/96; and States with the remaining 60% of spending implement 10/1/97.

KEY TECHNICAL ASSUMPTIONS (cont.)

The State contribution is based on the State share of spending for non-cash recipients (comprehensive benefits package only); cash children (wrap-around services only); and DSH spending attributable to non-cash recipients in FY 93, trended forward according to national projected growth rates for Medicaid through the first year of implementation. Projected annual growth rates will be those included in §9003 of the Health Security Act. Following the first year of implementation, the MOE is trended forward according to the 1 + general health care inflation factor (§6001) multiplied by 1 + the annual percentage increase in the U.S. population that is under age 65. States assumed to phase-in on fiscal year basis.

BACKUP DOCUMENTATION

(savings negative, costs positive)

(outlays in $ millions)

BUDGET CATEGORY

Information Systems and Quality Assurance

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total FY95-00
Estimated Cost	891	248	248	250	250	260	2,147

POLICY DESCRIPTION

The Health Security Act specifies that the Federal government would help develop and maintain the new health information systems and would perform quality assurance activities in the new system.

KEY TECHNICAL ASSUMPTIONS

The estimate includes pricing for the following major administrative functions: support of information systems , support of the National Quality Management Program, and technical assistance to alliances, plans and states. The estimate assumes that, in addition to new resources, existing resources could be used to help support the quality assurance and information collection activities of the National Quality Management Program.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Monitoring of Alliances and States

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total FY95-00
Estimated Cost	63	120	205	240	250	262	1,140

POLICY DESCRIPTION

The Health Security Act specifies that the Federal government would be responsible for overseeing certain state and alliance functions. Major monitoring activities would include: overseeing the financial operations of alliances, ensuring that plans and alliances adhere to applicable regulatory requirements, and overseeing the premium targets.

KEY TECHNICAL ASSUMPTIONS

The estimate assumes a number of Federal auditing functions, and includes costs associated with the hiring and contracting of auditors needed to carry out these activities.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Program Oversight and Financial Management

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total FY95-00
Estimated Cost	301	218	242	293	300	300	1,654

POLICY DESCRIPTION

As reflected in the Health Security Act, the Federal government would be responsible for developing rules/standards for the new system, and managing existing Federal programs within the new system.

KEY TECHNICAL ASSUMPTIONS

The estimate includes several oversight functions of the National Health Board, including: updating the comprehensive benefits package, monitoring new drug prices for consumers, development of enrollment rules for plans, monitoring of alliance grievance procedures, development and management of a risk adjustment factor for premiums in the alliances. The estimate also includes the cost of Federal support for antitrust reform, and fraud and abuse activities.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Transition to the New System

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total FY95-00
Estimated Cost	419	360	393	783	39	39	2,033

POLICY DESCRIPTION

As reflected in the Health Security Act, the Federal government would be responsible for helping states make the transition to the new sytem. The Federal government would help administer planning and implementation grants, issue standards, provide technical assistance and approve state plans. The Federal government would also administer a national risk pool for the uninsured during the period before universal coverage fully phased-in.

KEY TECHNICAL ASSUMPTIONS

The estimate reflects the costs of organizing and maintaining a new National Transitional Health Insurance Risk Pool for uninsured individuals. The cost of administering the risk pool would phase-down as universal coverage is phased-in. The estimate also reflects the administrative costs of processing approvals of state plans and waivers for states opting to implement single payer systems, as well as the cost of state planning and start up grants.

Glossary of Acronyms

AAPCC	Average Adjusted Per Capita Cost
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
ASPE	Assistant Secretary for Planning and Evaluation (HHS)
CABG	Coronary Artery Bypass Graft
CBO	Congressional Budget Office
CEA	Council of Economic Advisers
C/MHC	Community/Migrant Health Centers
CPI-U	Consumer Price Index -- Urban Area
CY	Calendar Year
DME	Durable Medical Equipment
DoD	Department of Defense
DSH	Disproportionate Share Payments to Hospitals
ESRD	End Stage Renal Disease
FEHBP	Federal Employees Health Benefits Program
FMAP	Federal Matching Percentage (Medicaid)
FY	Fiscal Year
GDP	Gross Domestic Product
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCR	Health Care Reform
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIV	Human Immuno-Deficiency Virus
HMO	Health Maintenance Organization
IADL	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facility/Mentally Retarded (facilities)
IME	Indirect Medical Education
LTC	Long-Term Care
MOE	Maintenance of Effort
MR/DD	Mentally Retarded/Developmentally Disabled
MRI	Magnetic Resonance Imaging
MSP	Medicare Secondary Payer
MVPS	Medicare Volume Performance Standard
NHSC	National Health Service Corps
NLTCS	National Long Term Care Survey
NMES	National Medical Expenditures Survey
OACT	Office of the Actuary, Health Care Financing Administration
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPM	Office of Personnel Management
PHS	Public Health Service
PNA	Personal Needs Allowance
QMBs	Qualified Medicare Beneficiaries
QDWI	Qualified Disabled Working Individual
PPS	Prospective Payment System
RVS	Relative Value Scale
RVU	Relative Value Unit
SIPP	Survey of Income and Program Participation

(continued)

SLMB	Specified Low-Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SSI	Social Security Income
VA	Veterans Administration
VPA	Vulnerable Population Adjustment
WIC	Women, Infants, and Children