A. MAGNITUDE OF SPENDING CUTS

1. GENERAL POINTS

KEY POINT: The magnitude of the Republican cuts are extreme, unnecessary and will have ramifications for the entire health care system. You should be careful not to get into a discussion of specific cuts, lest you find yourself in the midst of a trading match over the details.

OUR POSITION: *The Administration believes that efficiencies in the Medicare system can be achieved, and that the growth in Medicare spending might even be held to slightly below the private sector growth rate. But the Republican plan's assumption -- that federal spending growth can be cut a full 20% below the private sector rate over seven years -- is simply unrealistic. The inadequate expenditures provided under the Republican plan threaten access to quality health care for seniors across the nation.*

- **EXTREME. The Republican cuts are extreme and excessive.**
  - **20% below private sector rate.** The Republican plan cuts the permissible federal growth rate to about 5%, more than 20% below the projected private sector rate of about 7%. Under the President's plan, federal spending grows at 6.4%.
  - **$1,400 below baseline.** By 2002, Republican proposals will provide $1,400 less in spending per beneficiary than what Medicare would have spent. This is a cut of 19% below the 2002 current law spending projection.
- **UNNECESSARY. The cuts are unnecessary to protect the Trust Fund.** The President's plan, which cuts Medicare far less than the Republican proposal, still extends the trust fund solvency date to 2011 -- leaving it as strong as or stronger than it has been in 19 of the last 20 years.
- **THREATEN THE QUALITY OF CARE FOR ALL AMERICANS.**
  - **VHI-Lewin: Cuts will cause a massive cost-shift.** Based on VHI-Lewin's methodology, roughly 20% of the Republican cuts in Medicare and Medicaid will be shifted onto the private sector. With the Republican's Medicare and Medicaid cuts now totalling more than $300 billion, a cost shift of over $60 billion is likely.
  - **Statement of the National Association of Public Hospitals, American College of Physicians, and American Nurses Association: Cuts mean Fewer Choices.** "The effect of these reductions will be to squeeze providers so much that doctors and hospitals are forced to treat far fewer Medicare patients. . . . Patients may find that their only "choices" at that point are cheap managed care plans or medical savings accounts, with the government washing its hands of its responsibility to assure that care is up to acceptable standards." (Statement, October 17, '995)

- **American College of Physicians: Cuts call into question quality of care.** According to Gerald Thomson, President of the College, "We think that cuts of this magnitude [in the reconciliation bill] call into question our ability to provide world class medical care . . . The college is concerned about an approach to Medicare that starts from a target number driven by the demands for a balanced budget and tax cuts, then tries to engineer changes to meet that target." [Testimony to Senate Democratic Leadership, 10/5/95]

- **National Small Business Group: Cuts will increase private sector premiums dramatically.** John Galles, President of the National Small Business United warned that, due to cost-shifting, "we are likely to see health care premiums increase back in the double digits as a result of this legislation."

2. WHY CAN'T WE CUT SPENDING GROWTH FURTHER?

KEY POINT: Additional efficiencies beyond what the President's plan specifies is unrealistic.

- **MEDICARE SPENDING IS UNLIKELY TO AFFORD SIGNIFICANT NEW EFFICIENCIES.**

  - **Expensive population.** The Medicare population -- with significant health needs -- is far harder to manage than private sector populations.

  - **For most services, Medicare spending is already below private sector rates.** For standard medical services, Medicare spending is actually below the private sector rate.

    - The only reason Medicare is growing faster than the private sector now is that it also covers home health care, hospice services, and skilled nursing care -- all are growing quickly.

- **THE PRESIDENT'S PLAN ALREADY CUTS DEEPLY INTO MEDICARE.**

  - **The President's plan cuts far below the current law baseline.** Medicare spending is growing at 8.4%, while the private sector rate is 7.2%. The President's plan cuts the growth rate to 6.4% -- 10% below the private sector rate.

  - **The Republican plan cuts spending to 5.2% -- 20% below the private sector rate and twice the cut of the President's plan.** Even the Administration's 10% cut is at the margin of feasibility. But a cut that is twice as large is simply unrealistic.

  - **Providers will not be able to manage additional cuts.** The only way providers have managed to accept Medicare's low payment rates has been to shift much of the loss onto the private sector. However, with the growth of managed care plans, this kind of cost-shifting is increasingly difficult.

3. SPECIFIC PROVIDER CUTS

KEY POINT: Rather than speaking about specific cuts, we should emphasize that the bulk of the difference between the President's and the Republican's savings are in hospital cuts, premium increases, and cuts associated with the look-back mechanism. The Administration can not compromise on these areas.

- **A $100 BILLION CHASM.** Roughly $100 billion separates the Republican cuts of $200 billion and the President's proposal to cut $98 billion.
    - **$44 billion of the difference comes from hospital cuts**. Further cuts in hospital payments is simply unacceptable. For details see the following page.
    - **$33 billion of the difference comes from premium increases.** The Republican proposal specifies $44 billion in premium increases; we specify $11 billion.
        - $36 billion in Republican cuts are due to the increase in Part B premiums from 25% of program costs to 31.5%.
        - $8 billion in Republican cuts come from income testing Part B premiums. This change will encourage wealthy seniors to leave the traditional fee-for-service system for private plans, further segmenting the Medicare market into separate pools of healthy and sick beneficiaries.
    - **$12-14 billion of the difference comes from unspecified provider cuts imposed through the look-back budget enforcement mechanism.** The President's plan does not rely on unspecified cuts designed to meet budget targets, but detailed policy changes designed to improve the Medicare system.

4. IMPACT ON HOSPITALS

KEY POINT: WE CAN NOT CUT ANY FURTHER FROM HOSPITALS.

- **$40 BILLION DIFFERENCE. Republican proposal cuts $40 billion more from hospital payments than the President's proposal.**

- THERE IS LITTLE MORE THAT CAN BE CUT FROM HOSPITALS.

  - **Medicare has achieved significant efficiencies.** Medicare is currently on the leading edge of improving hospital efficiencies.

    - **Medicare surpasses private sector in controlling costs.** Medicare currently pays hospitals only 89% of cost, while private payers pay 129% of costs (PROPAC, 1993).

  - HOSPITALS ARE PARTICULARLY VULNERABLE TO NEW CUTS.

    - **Hospitals are caught in a bind.** Hospitals have managed to accept Medicare's below cost payments by shifting the loss onto the private sector. However, with the growth of managed care plans, this kind of cost-shifting is no longer possible.

    - **Medicare pays for 25% of all hospital revenues.**

    - **American Hospital Association: 700 Hospitals are particularly vulnerable to cuts.** According to the AHA, nearly 700 hospitals derive two-thirds or more of their net patient revenues from Medicare and Medicaid. Two-thirds of these vulnerable hospitals are already in financial duress, since they have negative patient revenues.

  - MANY HOSPITALS WILL BE FORCED TO CLOSE

    - **American Hospital Association: Cuts jeopardize quality health care.** According to the American Hospital Association and 40 state hospital associations, the cuts envisioned in the reconciliation bill would "jeopardize the ability of hospitals and health care systems to deliver quality health care, not just to Americans who rely on Medicare and Medicaid, but to all Americans,"

    - **American College of Physicians: Cuts put hospitals in financially untenable position.** "The committee package jeopardizes the viability of hospitals, many of which already operate on slim margins. The combination of cuts updating the Prospective Payment System for hospitals and in reimbursement for graduate medical education will push many hospitals into a financially untenable situation." (Testimony, October 5, 1995)

- **Moody's: Hospitals downgraded.** Moody's Investor Service indicated that it "might have to downgrade its ratings of many major hospitals, and that some of them might not survive the ordeal." (*New York Times*, November 3, 1995).

- **Report: Impact on hospitals severe**. "[I]t is likely that many hospitals will not be able to achieve savings well beyond any historical precedent [as required by Republican cuts]. In these cases, hospitals will be faced with the following options: Reduce quality and/or access, seek government relief, or be forced to merge or close." [Council on the Economic Impact of Health Care Reform, November 1995]

MEDICAID KEY POINTS

Issue

1. Savings/Expenditures/Growth Rate
2. Program Structure: Block Grant v. Per Capita Cap
3. Federal Guarantee
4. Enforcement/Private Right of Action
5. Eligibility
6. Benefits
7. Family Financial Protection
8. Nursing Home Standards
9. Vaccines for Children

MEDICAID KEY POINTS

1. SAVINGS/EXPENDITURES/GROWTH RATE

Key Point: The magnitude of the Republican cuts and the way they are distributed over time are unacceptable. Their cuts would force states to deny coverage for millions of people.

- Based on CBO data, their annual growth rate averages less than 2% per person over seven years, which is over 70% below the private sector growth rate. In 2001, spending per person would actually *decrease* by 1.7%.

- The President's Medicaid plan limits the per person growth rate to 5.5% -- already more than 20% below the private sector growth rate of about 7%.

- Republicans will claim that states could reduce their costs if given more flexibility, but they have *never shown how* states could achieve this level of savings without denying eligibility or reducing benefits. Medicaid payments to providers are already low, and there is little evidence that managed care would significantly reduce spending on older and disabled Americans, who account for more than two-thirds of Medicaid spending. CBO already assumes that more than 33% of poor children and their families are already in managed care.

2. PROGRAM STRUCTURE: BLOCK GRANT V. PER CAPITA CAP

Key Point: Under a block grant, states would be liable for 100% of the additional costs caused by circumstances beyond their control (e.g., economic downturn, inflation, changes in population, natural disaster). A per capita cap would allow us to restrain the growth in federal Medicaid outlays, without penalizing states and reducing coverage for people with low-incomes during these circumstances.

- **Rainy Day Fund.** Republicans will say that they can address this issue by creating a "rainy day fund" that will be available to states experiencing downturns or other circumstances beyond their control. While they have not outlined the specifics, we expect that there will be less than $20 billion in this fund.

    - **Insufficient Funds.** No rainy day fund could fully protect states or respond quickly enough to states' needs. If several regions of the country experience a recession at the same time, costs due to enrollment increases could easily be much higher than the amount in the fund. Also, states would have to go through an administrative process that could delay funding.

- **Unfunded Mandates.** They will also argue that our per capita cap is an unfunded mandate.

    - **Protects States Financially.** Our per capita cap is not an unfunded mandate because, under the President's Medicaid plan, federal funding is not fixed but instead responds to state financial needs. In addition, the President's plan offers significantly more funding per beneficiary than the Republican plan.

- **Scoring of Per Capita Cap.** Republicans will say that CBO will not score a per capita cap. CBO has given preliminary estimates of significant savings under a per capita cap to Congressional staff. CBO has said that it did not score the President's per capita cap because the wording was not explicit enough and wrote instructions on how to fix it. We are making changes and anticipate that CBO will score savings.

3. FEDERAL GUARANTEE

Key Point: The Republican plan ends the individual entitlement under Medicaid, eliminating the guarantee of meaningful coverage.

- **Coverage Loss.** According to the Urban Institute, Lewin-VHI, and HHS, millions of people will be denied meaningful coverage under the Republican plan.
    - While Republicans claim to cover poor children under the age of 13, pregnant women, and people with disabilities, states would have nearly complete discretion to determine the level of benefits provided and to define the eligible disabilities. The *only* required benefits would be immunizations and limited family planning. The block grant "set asides", or required spending, cover less than half of state Medicaid spending for these groups.
    - While Republicans claim to cover Medicare premiums under Medicaid for poor Medicare beneficiaries, they eliminate the guarantee and set aside less than half of the amount required to pay premiums alone. (See #6 Benefits for more details.)
- **States will be forced to cut benefits.** States will not be able to save enough through increased use of managed care because CBO already assumes expansion of managed care for poor children and their families and because there is no evidence that managed care produces significant savings for elderly and disabled populations. In addition, provider payments under Medicaid are already low. As a result, states will be forced to cut benefits in order to absorb the federal spending reductions.

4. ENFORCEMENT/PRIVATE RIGHT OF ACTION

Key Point: A key element of maintaining the guarantee under Medicaid is retaining the right of individuals to go to court to enforce their rights.

- The Republicans, like the Republican Governors (and to some extent the Democratic Governors), strongly support eliminating the right of individuals to sue in federal court. Because we are sympathetic to their concerns about lawsuits, the President's plan repeals the Boren Amendment (that requires that payment to providers be "reasonable"), which is one of the primary sources of suits against states in federal courts.

- We have not reached consensus within the Administration on our final position on the *individual* right of action. However, we have conducted meaningful discussions with the Democratic Governors to examine alternatives that would help address their concerns. We anticipate having some substantive options available for internal review by early next week. We therefore believe that discussion should be deferred until that time if at all possible.

5. ELIGIBILITY

Key Point: The Republican plan does not guarantee Medicaid eligibility to older Americans, people with disabilities deemed ineligible by their state, and many children. While we strongly support maintaining current eligibility, you can signal some flexibility.

Our Position: We maintain the current categories of eligibility, and we allow states to cover anyone up to 150% of poverty within the per capita cap. We can signal interest in: (1) simplifying eligibility rules (e.g. simplifying processes for determining eligibility, consolidating small eligibility groups into broader categories); and (2) considering options for states dealing with Medicaid coverage under a new welfare program.

Republican Position:

- **Children.** While Republicans claim to cover children, their bill actually repeals guaranteed coverage for children under age 6 between 100-133% of poverty. In addition, it ends Medicaid's phased-in coverage of children aged 13-18.

- **People with Disabilities.** Under the Republican plan, states would determine which disabilities would make someone eligible, so people with disabilities would not be guaranteed coverage -- meaningful or not.

- **Older Americans.** Republicans eliminate the guarantee of any coverage for older Americans, including nursing home coverage.

- **QMBs and SLMBs: Low-Income Older and Disabled Medicare Beneficiaries.** Republicans eliminate the guarantee of Medicaid coverage of Medicare premiums, deductibles, and copayments for Medicare beneficiaries under 100% of poverty (Qualified Medicare Beneficiaries or QMBs) and of coverage of Medicare premiums for those below 120% of poverty (Specified Low-Income Medicare Beneficiaries or SLMBs). Elimination of this coverage may deny poor elderly and disabled people access to the Medicare Part B program.

6. BENEFITS

Key Point: There must be a guarantee of meaningful benefits. While there is room for some increased flexibility, you should not get into a discussion of specifics now.

Our Position: We maintain the current benefit package. We allow states to set up home and community-based care programs without waivers (as is currently required). You can signal that we are willing to discuss additional flexibility, particularly in the category of optional benefits.

Republican Position:

- **No Minimum Benefits Package.** The Republican plan does not guarantee *anyone* meaningful benefits. The *only* required benefits under the Republican plan are immunizations and limited family planning. States would have nearly complete discretion to set benefits, and the deep federal spending reductions would force states to reduce benefits to save money.

- **Cost Sharing.** The Republican plan removes all restrictions on how large a share of the costs of medical care states could require from eligible individuals other than children and pregnant women. These increased copayments could discourage low-income people from seeking medical care. The President's plan continues current law that requires copayments to be nominal and exempts particularly vulnerable populations from copayments.

- **QMBs: Medicaid Coverage of Poor Older and Disabled Americans' Medicare Premiums, Deductibles and Copayments.** Republicans eliminate the guarantee of Medicaid coverage of poor Medicare beneficiaries' premiums, deductibles, and copayments. Elimination of this coverage may deny poor elderly and disabled people access to the Medicare Part B program.

    - **No Set-Aside for Deductibles and Copayments.** The Republican plan eliminates the guarantee to any coverage of copayments and deductibles, and does not set aside any funding for copayments and deductibles.

    - **Inadequate Set-Aside for Premiums.** While Republicans claim to cover Medicare premiums for poor Medicare beneficiaries, they set aside *less than half* of the amount required to pay premiums. While they set aside 90% of 1993-1995 state spending on *mandated* services for *mandatory* eligibles, this amounts to less than half of current Medicaid spending on premiums.

- **Comparability of Benefits Across Eligibility Groups.** The Republican plan eliminates the current requirement that states provide comparable services to all beneficiaries and provide protections against discrimination. This could lead to a sharp reduction in benefits for certain needy but politically weak populations, such as poor children and people with AIDS, in order to protect other more powerful populations.

- **Statewideness: Comparability of Benefits in All Regions in a State.** The Republican plan eliminates the current requirement that states provide comparable services across geographic areas of the state, which could lead some states to short-change certain needy but politically weak regions and shift benefits to others.

Other Issues:

- **Abortion.** The Administration supports current law, but any discussion of this issue should begin at the staff level before going to the level of advisors or principals.

- **Assisted Suicide.** The Administration does not currently have a position on this issue. Discussion of it should begin at the staff level before going to the level of advisors or principals.

7. FAMILY FINANCIAL PROTECTION

Key Point: The Republican plan ends the guarantee of meaningful coverage, potentially shifting costs of care to families who can ill afford them. It also repeals financial protections that are important not only to the poor, but also to a larger group of middle class families that depend on Medicaid to provide long-term care for their parents. We should insist on current law.

Our Position: The President's plan and all the other Democratic plans retain both the federal guarantee of meaningful benefits and current financial protections.

Republican Position:

- **Loss of Guarantee.** Under the Republican plan, people who no longer qualify for medical assistance would be faced with paying all their medical costs themselves, or seeking help from relatives or charity. In the worst cases, families would have to mortgage or sell their homes to be able to pay for care, or elderly people needing long-term care would have no choice but to turn to their children for help.

- **Spousal Impoverishment.** The Republicans claim that they have retained spousal impoverishment protections -- which require states to protect minimum amounts of a couple's income and assets for the at-home spouse when the other spouse enters a nursing home or other institution for a long-term stay. Despite appearances, the Republican plan fails to adequately protect spouses of persons in nursing homes from being impoverished by the high cost of long-term care because: (1) the infirm spouse may not qualify for benefits in the first place; (2) they repeal procedural safeguards and beneficiaries' rights to judicial redress if the state has acted improperly; and (3) federal tools for enforcing state compliance are severely weakened.

- **Homes, Family Farms, and Liens.** Republicans repeal current federal law that protects the home, family farm, and certain other assets by prohibiting states from counting their value to determine eligibility for Medicaid.

  The Republican plan would give states unlimited license to decide whether and how to: (1) use liens on people's homes and other property; (2) recover before or after a beneficiaries (or spouse's) death; (3) adjust the state's payments for care based on home equity. States could use this flexibility to require a person to sell or mortgage a home and use the proceeds either to repay the state or to finance the cost of their care even while they, a spouse, or child is still living in the home. Under current law, states are restricted from imposing liens on real property of Medicaid beneficiaries under most circumstances.

- **Adult Children of Nursing Home Patients.** The Republicans would also allow states to impose financial costs on the adult children of nursing home patients if they had income above the median state income for the first time under Medicaid.

8. NURSING HOME STANDARDS

Key Point: The Republicans claim to retain the federal nursing home quality standards, but they undermine these standards by repealing federal enforcement and repeal key standards. We should insist on current law, including federal enforcement.

Our Position: The President's plan and all the other Democratic plans retain the 1987 bipartisan standards and enforcement models.

- Since the 1987 reforms were implemented, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31% (Research Triangle Institute; HCFA).

Republican Position: The Republicans claim to maintain these standards, but they undermine them by repealing federal enforcement and some key standards.

- **No Federal Enforcement.** The federal government would have no way to ensure that States enforce the standards. Most recently, *federal surveyors found 14% of nursing homes out of compliance with the federal standards.* (Source: HCFA.)

- **States Could Leave Enforcement to Private Organizations.** States could turn over their survey and enforcement responsibilities to private accreditation organizations with no Federal review, thereby reducing accountability and increasing variations in quality and enforcement.

- **Inadequate Resources to Enforce Standards.** States would have to set and enforce quality standards with significantly less Medicaid funding than they receive under current law. While States may want to maintain nursing home quality, inadequate resources combined with repeal of Federal enforcement could lead them to fail to set and enforce adequate quality standards.

- **Quality May Decline With Payments.** Nursing homes may find it difficult or impossible to maintain the current quality with significantly reduced Medicaid payments. Nursing homes would have to significantly lower their costs, lower services and quality, drop out of the Medicaid program, or shift costs to residents and their families, diminishing Medicaid beneficiaries' access to quality care.

- **Elimination of Key Federal Quality Standards.** The Republican proposal repeals key Federal quality standards, allowing the States to set their own standards within broad Federal guidelines. For example, Federal law would no longer guarantee that nursing homes provide services to "attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident." As a result, residents could be denied skilled nursing and rehabilitative services necessary to improve their ability to function.

9. VACCINES FOR CHILDREN

Key Point: For the purposes of this discussion, it is important only to signal that VFC is important to the Administration but that we are willing to make significant changes to the program.

- **Our Position.** There has been significant opposition to the VFC program. Our strategy is to work with Senators Bumpers and Breaux and Congressmen Dingell and Waxman to change the program so that states are given more flexibility to tailor the program to their needs while *guaranteeing* funding for vaccines for needy children.

- **Republican Position.** The Republicans may suggest that because states are required to cover immunizations, there is no need to continue the VFC program. However:

    - VFC provides guaranteed funding for three groups of children not covered by Medicaid: American Indians, uninsured, and underinsured (at federally qualified health centers).

    - In addition, under the Republican Medicaid plan, states decide which vaccines to cover. There is no guarantee that the range of medically recommended vaccines delivered under VFC will be provided.

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Our Position: The President's plan and all the other Democratic plans retain both the federal guarantee of meaningful benefits and current financial protections.

Republican Position:

- **Loss of Guarantee.** Under the Republican plan, people who no longer qualify for medical assistance would be faced with paying all their medical costs themselves, or seeking help from relatives or charity. In the worst cases, families would have to mortgage or sell their homes to be able to pay for care, or elderly people needing long-term care would have no choice but to turn to their children for help.

- **Spousal Impoverishment.** The Republicans claim that they have retained spousal impoverishment protections -- which require states to protect minimum amounts of a couple's income and assets for the at-home spouse when the other spouse enters a nursing home or other institution for a long-term stay. Despite appearances, the Republican plan fails to adequately protect spouses of persons in nursing homes from being impoverished by the high cost of long-term care because: (1) the infirm spouse may not qualify for benefits in the first place; (2) they repeal procedural safeguards and beneficiaries' rights to judicial redress if the state has acted improperly; and (3) federal tools for enforcing state compliance are severely weakened.

- **Homes, Family Farms, and Liens.** Republicans repeal current federal law that protects the home, family farm, and certain other assets by prohibiting states from counting their value to determine eligibility for Medicaid.

  The Republican plan would give states unlimited license to decide whether and how to: (1) use liens on people's homes and other property; (2) recover before or after a beneficiaries (or spouse's) death; (3) adjust the state's payments for care based on home equity. States could use this flexibility to require a person to sell or mortgage a home and use the proceeds either to repay the state or to finance the cost of their care even while they, a spouse, or child is still living in the home. Under current law, states are restricted from imposing liens on real property of Medicaid beneficiaries under most circumstances.

- **Adult Children of Nursing Home Patients.** The Republicans would also allow states to impose financial costs on the adult children of nursing home patients if they had income above the median state income for the first time under Medicaid.

8. NURSING HOME STANDARDS

Key Point: The Republicans claim to retain the federal nursing home quality standards, but they undermine these standards by repealing federal enforcement and repeal key standards. We should insist on current law, including federal enforcement.

Our Position: The President's plan and all the other Democratic plans retain the 1987 bipartisan standards and enforcement models.

- Since the 1987 reforms were implemented, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31% (Research Triangle Institute; HCFA).

Republican Position: The Republicans claim to maintain these standards, but they undermine them by repealing federal enforcement and some key standards.

- **No Federal Enforcement.** The federal government would have no way to ensure that States enforce the standards. Most recently, *federal surveyors found 14% of nursing homes out of compliance with the federal standards.* (Source: HCFA.)

- **States Could Leave Enforcement to Private Organizations.** States could turn over their survey and enforcement responsibilities to private accreditation organizations with no Federal review, thereby reducing accountability and increasing variations in quality and enforcement.

- **Inadequate Resources to Enforce Standards.** States would have to set and enforce quality standards with significantly less Medicaid funding than they receive under current law. While States may want to maintain nursing home quality, inadequate resources combined with repeal of Federal enforcement could lead them to fail to set and enforce adequate quality standards.

- **Quality May Decline With Payments.** Nursing homes may find it difficult or impossible to maintain the current quality with significantly reduced Medicaid payments. Nursing homes would have to significantly lower their costs, lower services and quality, drop out of the Medicaid program, or shift costs to residents and their families, diminishing Medicaid beneficiaries' access to quality care.

- **Elimination of Key Federal Quality Standards.** The Republican proposal repeals key Federal quality standards, allowing the States to set their own standards within broad Federal guidelines. For example, Federal law would no longer guarantee that nursing homes provide services to "attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident." As a result, residents could be denied skilled nursing and rehabilitative services necessary to improve their ability to function.

9. VACCINES FOR CHILDREN

Key Point: For the purposes of this discussion, it is important only to signal that VFC is important to the Administration but that we are willing to make significant changes to the program.

- **Our Position.** There has been significant opposition to the VFC program. Our strategy is to work with Senators Bumpers and Breaux and Congressmen Dingell and Waxman to change the program so that states are given more flexibility to tailor the program to their needs while *guaranteeing* funding for vaccines for needy children.

- **Republican Position.** The Republicans may suggest that because states are required to cover immunizations, there is no need to continue the VFC program. However:

  - VFC provides guaranteed funding for three groups of children not covered by Medicaid: American Indians, uninsured, and underinsured (at federally qualified health centers).

  - In addition, under the Republican Medicaid plan, states decide which vaccines to cover. There is no guarantee that the range of medically recommended vaccines delivered under VFC will be provided.

MEDICAID KEY POINTS

Issue

1. Savings/Expenditures/Growth Rate
2. Program Structure: Block Grant v. Per Capita Cap
3. Federal Guarantee
4. Enforcement/Private Right of Action
5. Eligibility
6. Benefits
7. Family Financial Protection
8. Nursing Home Standards
9. Vaccines for Children

MEDICAID KEY POINTS

1. SAVINGS/EXPENDITURES/GROWTH RATE

Key Point: The magnitude of the Republican cuts and the way they are distributed over time are unacceptable. Their cuts would force states to deny coverage for millions of people.

- Based on CBO data, their annual growth rate averages less than 2% per person over seven years, which is over 70% below the private sector growth rate. In 2001, spending per person would actually *decrease* by 1.7%.

- The President's Medicaid plan limits the per person growth rate to 5.5% -- already more than 20% below the private sector growth rate of about 7%.

- Republicans will claim that states could reduce their costs if given more flexibility, but they have *never shown how* states could achieve this level of savings without denying eligibility or reducing benefits. Medicaid payments to providers are already low, and there is little evidence that managed care would significantly reduce spending on older and disabled Americans, who account for more than two-thirds of Medicaid spending. CBO already assumes that more than 33% of poor children and their families are already in managed care.

2. PROGRAM STRUCTURE: BLOCK GRANT V. PER CAPITA CAP

Key Point: Under a block grant, states would be liable for 100% of the additional costs caused by circumstances beyond their control (e.g., economic downturn, inflation, changes in population, natural disaster). A per capita cap would allow us to restrain the growth in federal Medicaid outlays, without penalizing states and reducing coverage for people with low-incomes during these circumstances.

- **Rainy Day Fund.** Republicans will say that they can address this issue by creating a "rainy day fund" that will be available to states experiencing downturns or other circumstances beyond their control. While they have not outlined the specifics, we expect that there will be less than $20 billion in this fund.

    - **Insufficient Funds.** No rainy day fund could fully protect states or respond quickly enough to states' needs. If several regions of the country experience a recession at the same time, costs due to enrollment increases could easily be much higher than the amount in the fund. Also, states would have to go through an administrative process that could delay funding.

- **Unfunded Mandates.** They will also argue that our per capita cap is an unfunded mandate.

    - **Protects States Financially.** Our per capita cap is not an unfunded mandate because, under the President's Medicaid plan, federal funding is not fixed but instead responds to state financial needs. In addition, the President's plan offers significantly more funding per beneficiary than the Republican plan.

- **Scoring of Per Capita Cap.** Republicans will say that CBO will not score a per capita cap. CBO has given preliminary estimates of significant savings under a per capita cap to Congressional staff. CBO has said that it did not score the President's per capita cap because the wording was not explicit enough and wrote instructions on how to fix it. We are making changes and anticipate that CBO will score savings.

3. FEDERAL GUARANTEE

Key Point: The Republican plan ends the individual entitlement under Medicaid, eliminating the guarantee of meaningful coverage.

- **Coverage Loss.** According to the Urban Institute, Lewin-VHI, and HHS, millions of people will be denied meaningful coverage under the Republican plan.
    - While Republicans claim to cover poor children under the age of 13, pregnant women, and people with disabilities, states would have nearly complete discretion to determine the level of benefits provided and to define the eligible disabilities. The *only* required benefits would be immunizations and limited family planning. The block grant "set asides", or required spending, cover less than half of state Medicaid spending for these groups.
    - While Republicans claim to cover Medicare premiums under Medicaid for poor Medicare beneficiaries, they eliminate the guarantee and set aside less than half of the amount required to pay premiums alone. (See #6 Benefits for more details.)
- **States will be forced to cut benefits.** States will not be able to save enough through increased use of managed care because CBO already assumes expansion of managed care for poor children and their families and because there is no evidence that managed care produces significant savings for elderly and disabled populations. In addition, provider payments under Medicaid are already low. As a result, states will be forced to cut benefits in order to absorb the federal spending reductions.

4. ENFORCEMENT/PRIVATE RIGHT OF ACTION

Key Point: A key element of maintaining the guarantee under Medicaid is retaining the right of individuals to go to court to enforce their rights.

- The Republicans, like the Republican Governors (and to some extent the Democratic Governors), strongly support eliminating the right of individuals to sue in federal court. Because we are sympathetic to their concerns about lawsuits, the President's plan repeals the Boren Amendment (that requires that payment to providers be "reasonable"), which is one of the primary sources of suits against states in federal courts.

- We have not reached consensus within the Administration on our final position on the *individual* right of action. However, we have conducted meaningful discussions with the Democratic Governors to examine alternatives that would help address their concerns. We anticipate having some substantive options available for internal review by early next week. We therefore believe that discussion should be deferred until that time if at all possible.

5. ELIGIBILITY

Key Point: The Republican plan does not guarantee Medicaid eligibility to older Americans, people with disabilities deemed ineligible by their state, and many children. While we strongly support maintaining current eligibility, you can signal some flexibility.

Our Position: We maintain the current categories of eligibility, and we allow states to cover anyone up to 150% of poverty within the per capita cap. We can signal interest in: (1) simplifying eligibility rules (e.g. simplifying processes for determining eligibility, consolidating small eligibility groups into broader categories); and (2) considering options for states dealing with Medicaid coverage under a new welfare program.

Republican Position:

- **Children.** While Republicans claim to cover children, their bill actually repeals guaranteed coverage for children under age 6 between 100-133% of poverty. In addition, it ends Medicaid's phased-in coverage of children aged 13-18.

- **People with Disabilities.** Under the Republican plan, states would determine which disabilities would make someone eligible, so people with disabilities would not be guaranteed coverage -- meaningful or not.

- **Older Americans.** Republicans eliminate the guarantee of any coverage for older Americans, including nursing home coverage.

- **QMBs and SLMBs: Low-Income Older and Disabled Medicare Beneficiaries.** Republicans eliminate the guarantee of Medicaid coverage of Medicare premiums, deductibles, and copayments for Medicare beneficiaries under 100% of poverty (Qualified Medicare Beneficiaries or QMBs) and of coverage of Medicare premiums for those below 120% of poverty (Specified Low-Income Medicare Beneficiaries or SLMBs). Elimination of this coverage may deny poor elderly and disabled people access to the Medicare Part B program.

6. BENEFITS

Key Point: There must be a guarantee of meaningful benefits. While there is room for some increased flexibility, you should not get into a discussion of specifics now.

Our Position: We maintain the current benefit package. We allow states to set up home and community-based care programs without waivers (as is currently required). You can signal that we are willing to discuss additional flexibility, particularly in the category of optional benefits.

Republican Position:

- **No Minimum Benefits Package.** The Republican plan does not guarantee *anyone* meaningful benefits. The *only* required benefits under the Republican plan are immunizations and limited family planning. States would have nearly complete discretion to set benefits, and the deep federal spending reductions would force states to reduce benefits to save money.

- **Cost Sharing.** The Republican plan removes all restrictions on how large a share of the costs of medical care states could require from eligible individuals other than children and pregnant women. These increased copayments could discourage low-income people from seeking medical care. The President's plan continues current law that requires copayments to be nominal and exempts particularly vulnerable populations from copayments.

- **QMBs: Medicaid Coverage of Poor Older and Disabled Americans' Medicare Premiums, Deductibles and Copayments.** Republicans eliminate the guarantee of Medicaid coverage of poor Medicare beneficiaries' premiums, deductibles, and copayments. Elimination of this coverage may deny poor elderly and disabled people access to the Medicare Part B program.

    - **No Set-Aside for Deductibles and Copayments.** The Republican plan eliminates the guarantee to any coverage of copayments and deductibles, and does not set aside any funding for copayments and deductibles.

    - **Inadequate Set-Aside for Premiums.** While Republicans claim to cover Medicare premiums for poor Medicare beneficiaries, they set aside *less than half* of the amount required to pay premiums. While they set aside 90% of 1993-1995 state spending on *mandated* services for *mandatory* eligibles, this amounts to less than half of current Medicaid spending on premiums.

- **Comparability of Benefits Across Eligibility Groups.** The Republican plan eliminates the current requirement that states provide comparable services to all beneficiaries and provide protections against discrimination. This could lead to a sharp reduction in benefits for certain needy but politically weak populations, such as poor children and people with AIDS, in order to protect other more powerful populations.

- **Statewideness: Comparability of Benefits in All Regions in a State.** The Republican plan eliminates the current requirement that states provide comparable services across geographic areas of the state, which could lead some states to short-change certain needy but politically weak regions and shift benefits to others.

Other Issues:

- **Abortion.** The Administration supports current law, but any discussion of this issue should begin at the staff level before going to the level of advisors or principals.

- **Assisted Suicide.** The Administration does not currently have a position on this issue. Discussion of it should begin at the staff level before going to the level of advisors or principals.

7. FAMILY FINANCIAL PROTECTION

Key Point: The Republican plan ends the guarantee of meaningful coverage, potentially shifting costs of care to families who can ill afford them. It also repeals financial protections that are important not only to the poor, but also to a larger group of middle class families that depend on Medicaid to provide long-term care for their parents. We should insist on current law.

Our Position: The President's plan and all the other Democratic plans retain both the federal guarantee of meaningful benefits and current financial protections.

Republican Position:

- **Loss of Guarantee.** Under the Republican plan, people who no longer qualify for medical assistance would be faced with paying all their medical costs themselves, or seeking help from relatives or charity. In the worst cases, families would have to mortgage or sell their homes to be able to pay for care, or elderly people needing long-term care would have no choice but to turn to their children for help.

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Medicare Issues

- Medicare Restructuring: Medical Savings Accounts
- Medicare Restructuring: Payment Methodology
- Medicare Restructuring: Extra-Billing Protections
- Medicare Restructuring: Enrollment Process
- Medicare Restructuring: Provider Service Networks
- Medicare Restructuring: Anti-Trust Reforms
- Provider Cuts
- Beneficiaries: Basic Part B Premium
- Beneficiaries: Income-related Part B Premium
- Lookback and Failsafe Mechanism
- Extend HI Tax to State and Local Workers
- Trust Fund Transfers
- Regulatory Reform
- Benefit Expansions

Medical Savings Accounts

- **The Conference Agreement** -- Creates the option of a Medical Savings Account for all beneficiaries.

- **The Coalition** -- Proposes 10 MSA demonstration projects to last 7 years.

- **The Administration** -- Has no MSA proposal.

Analysis

- CBO believes that MSAs would attract the more healthy beneficiaries and has scored the provision as a cost.

- MSAs will increase Medicare outlays because Medicare will pay more than it should for healthy beneficiaries. In addition, as healthier beneficiaries opt for an MSA, they leave a disproportionate share of unhealthy (and more costly) beneficiaries in the fee-for-service sector. While the Conference has a cap on fee-for-service expenditures, it may ultimately be unsustainable because fee-for-service must pay for the sickest population (whose costs are most difficult to control).

- The Administration could opt for the Coalition proposal of an MSA demonstration program.

Payment Methodology

- **The Conference Agreement** -- Explicitly delinks managed care payments from fee-for-service payments and grows managed care payments at about 5.5 percent per year.

- **The Coalition** -- Explicitly delinks managed care payments from fee-for-service payments and grows managed care payments at about 6.0 percent from 1996-98 and 5.5 percent per year thereafter. It also removes teaching and disproportionate share payments from HMO payments and redirects much of the savings to teaching hospitals.

- **The Administration** -- [The Administration had only nominal managed care proposals in its original package, but has indicated a willingness to move toward the Coalition. The following summary describes the new compromise managed care proposal.] The Administration preserves a tenuous link to fee-for-service by limiting payment growth to fee-for-service growth minus 0-3 percentage points depending on the year. Like the Coalition, the Administration removes teaching and disproportionate share payments from HMO payments and redirects much of the savings to teaching hospitals.

Analysis

- It could be acceptable to fully delink managed care payments from fee-for-service. Accepting a lower growth rate yields increased managed care savings.

- Removing teaching and DSH payments from HMO payments is strongly endorsed by teaching hospitals and strongly opposed by HMOs.

- While the latest managed care versions of all plans include similar approaches to limit geographic variation, the Conference and Coalition propose higher floors for rural areas than the Administration does. Because there is not much difference between the plans, the Administration could accept either option, but prefers the Conference Agreement.

Extra Billing Protections

- **The Conference Agreement** -- Does not permit extra billing for services in-plan, but allows unlimited balance billing for services received out-of-plan and from private fee-for-service plans. This means that although there is a premium cap (i.e., beneficiaries premiums, coinsurance and deductibles cannot be greater than for traditional fee-for-service Medicare), MedicarePlus beneficiaries' liability can be much greater as a result of extra billing if they receive care out-of-plan.

- **The Coalition** -- Does not permit extra billing for services in-plan and restricts extra billing for out-of-plan services and private fee-for-service plans to the traditional fee-for-service restrictions (i.e., non-participating providers may charge 15% higher than Medicare payment rates). In contrast to the Administration, there are no protections for unauthorized use of service for Medicare managed care enrollees.

- **The Administration** -- Limits the ability of providers to extra bill HMO enrollees for *unauthorized* services to fee-for-service levels (i.e., 15 percent for non-participating physicians). The bill also clarifies that there may not be any extra billing for authorized services, whether provided by in-plan or out-of-plan providers.

Analysis

- The Coalition position could be adopted as it adequately limits beneficiaries' liability. The same extra billing protections should apply to fee-for-service and services received out-of-plan if enrolled in a MedicarePlus plan.

Enrollment Process

- **The Conference Agreement** -- Beneficiary enrollment occurs through health plans rather than through the Secretary of HHS.

- **The Coalition** -- Same as conference.

- **The Administration** -- Requires that enrollment occur through the Secretary.

Analysis

- The Administration proposal should be adopted because it limits the possibility of adverse selection (i.e., only the healthy will enroll in the new plans). Adverse selection is likely to occur if plans have the opportunity to control enrollment (e.g., plans may select certain affluent neighborhoods to enroll beneficiaries). Adverse selection costs Medicare because the HMO payment is determined based on the average beneficiary, yet the HMOs are enrolling more healthy (and less expensive) beneficiaries.

Provider Service Networks (PSNs)

- **The Conference Agreement** -- Allows provider sponsored delivery systems to participate in Medicare. They must be licensed by states consistent with federal solvency guidelines. If the state does not act promptly or fails to follow federal guidelines, the PSN may seek a waiver of state licensure from the Secretary.

- **The Coalition** -- PSOs are exempt from the state licensing requirement unless the state adopted identical standards as the federal government.

- **The Administration** -- Similar to the Conference Agreement in that it establishes federal solvency guidelines, but requires PSNs to be licensed by states. It allows similar conditions for preempting state licensure if federal solvency standards are not applied. The Administration would prohibit a solely physician-owned PSN and prohibits a PSN from offering a point-of-service option.

Analysis

- The hospital industry is strongly in favor of waiving state licensure requirements for PSNs and has therefore endorsed the Coalition proposal. They argue that their capital investments (i.e., bricks and mortar of hospitals) and long-standing role in the community should be considered in meeting solvency requirements.

- The insurance and HMO industry opposes waiving the state licensure requirement. HMOs argue that all providers should adhere to the same requirements. They believe that newly formed PSNs may not be sufficiently experienced in bearing risk.

Anti-Trust

- **Coalition** -- Eases anti-trust laws affecting Medicare Provider Service Networks --PSN contracting activity (establishing fee schedules, choosing which providers to contract with, etc) could not be deemed illegal "per se", but would have to be analyzed in the context of all relevant competitive factors, i.e. based on a "rule of reason".

  -- In any industry, in reviewing "per se" violations--price fixing, boycotts, tying arrangements etc--Justice and FTC only have to show that the behavior exists to bring an anti-trust action. Reviewing violations under the "rule of reason" means that Justice and FTC must undergo a thorough economic analysis of the behavior in the context of other competitive factors before they can bring an action.

- **Conference** -- Similar provision subjected to Byrd rule.

- **Administration** -- No Provision.

Analysis

- Easing anti-trust laws for Medicare PSNs is unnecessary because current anti-trust analysis does not impede the development of cost-effective delivery options. Such changes could actually harm competition for Medicare and non-Medicare services by making it harder to prevent blatant restraints on competition. Possibly keep people out of the market and raise prices.

- The Coalition "per se" language does not completely exempt behavior from DOJ and FTC enforcement action. But DOJ has argued that it makes it harder for DoJ and FTC to bring such enforcement actions.

Provider Cuts

Hospitals

Total Savings: The **Administration's** plan reduces payments to inpatient and outpatient hospitals in the period FY 1996-2002 by $42.9 billion; the **Coalition** would reduce hospital payments by $54.3 billion; and the **Conference** agreement would reduce hospital payments by $82.5 billion.

- While these differences seem large, the inclusion of justifiable outpatient department payment reductions from the Coalition and Conference plans (which may be necessary to score $129 billion) would increase the Administration's hospital savings by $17.8 billion (to $60.7).

The three major issue areas that make up the bulk of the differences in the hospital savings packages are discussed below:

(1) Medical Education -- IME. Over seven years, the **Conference Agreement** saves $11.5 billion, the **Coalition** saves $6.9 billion, and the **Administration** saves $6.5 billion.

- The only difference between the three bills is the size of the IME reduction -- the Conference Agreement reduces IME from 7.7 percent to 5.0 percent by FY 2000; the Administration reduces IME to 6.0 percent by FY 2001; and the Coalition reduces IME to 6.0 percent from FY 1996-1999 and then increases it to 6.8 percent in FY 2000.

(2) Medical Education -- GME. Over seven years, the **Conference** saves $1.4 billion, and the **Administration** proposals save $3.8 billion. The **Coalition** does not contain any provisions regarding direct medical education payments (GME).

- The Conference Agreement makes only minor changes in GME payments, while the Administration proposes a set of provisions ("medical education reform") affecting both GME and IME.

- If more savings are needed from Medicare, the Administration may want to consider adding its GME reform proposal into the Coalition's Medicare package.

(2a) Medical Education -- GME Trust Fund. Savings estimates do not apply.

- The **Conference** and **Coalition** both establish medical education trust funds.

- In addition to Medicare medical education payments, the Conference would also appropriate $13.5 billion (over seven years) from general revenue to their trust fund.

- The Coalition uses its trust fund to return 75 percent of the savings from removing IME, GME and DSH from the AAPCC.

- The Administration's bill does not contain a trust fund (it does, however, return 75 percent of the AAPCC savings to teaching hospitals).

- The Administration would not object to setting up an accounting mechanism similar to the Coalition trust fund for the purpose of returning the AAPCC savings.

(3) Disproportionate Share. The **Administration** saves $1.8 billion by reducing disproportionate share (DSH) payments by 10%; the **Conference** would save $5.3 billion by phasing in a 30% DSH cut; and the **Coalition** does not include a DSH cut in its package.

- DSH payments are made to hospitals to support their uncompensated care for the poor and indigent. Because these payments have been poorly targeted, however, there is a sound rationale for reducing DSH payments.

- Given the absence of a DSH cut in the Coalition plan, if additional savings were to be needed in addition to the Coalition package, the Administration's DSH cut could be added.

Skilled Nursing Facilities

Savings: For SNFs, the **Conference Agreement** ($10.0 billion), **Coalition** ($6.8 billion), and **Administration** ($7.3 billion) generate roughly the same amount of savings.

- While the three bills are close in terms of seven-year savings, significant technical differences (e.g., different treatment of ancillary costs) separate the Administration's SNF plan from that of the Conference and Coalition (which, based on available bill language, are fairly similar although the Coalition does not implement prospective payment).

Home Health

Savings: The **Conference Agreement** produces notably more savings ($17 billion) than either the **Coalition** ($8.7 billion) or **Administration** ($9.1 billion) proposals.

- The Coalition and Administration plans are fairly similar, and the Coalition plan would require only minor changes to make it identical to the Administration's.

- The Conference Agreement, however, takes a significantly different approach on home health, and HCFA states that it would not be possible to implement the Conference home health proposal within the next 2-3 years. Further, the Medicare actuary believes that this proposal may increase Medicare outlays.

- The Administration would prefer to use its set of home health proposals.

Physicians

Savings: The **Administration** and **Coalition** have about $20 billion in savings from reducing physician payments. The **Conference Agreement** saves about $12 billion (this figure would be increased after savings from the "lookback" mechanism).

- The Coalition achieves its savings through one proposal reforming Medicare's system for annually increasing or decreasing physicians' fees. The Conference Agreement has the same policy as the Coalition but different technical details in the policy result in about $8 billion less savings. The Administration also has this proposal, but different technical details in the policy result in about $5 billion less savings than the Coalition.

- The Administration plan has three additional proposals for another $5 billion in savings. These proposals include a proposal to limit growth in the volume of services instead of just reducing fees.

Other Part B Providers (includes laboratories, durable medical equipment, oxygen supplies)

Savings: The Administration is scored by CBO at $2 billion, the Coalition at $6 billion, and the Conference Agreement at $12 billion.

- The Administration prefers competitive bidding for clinical laboratory services and some durable medical equipment (DME), while the Coalition and Conference Agreement prefer payment freezes (i.e., no allowance for inflation). CBO has shown reluctance to score savings from the Administration preferred policies, but these scoring issues may be resolved through legislative language revisions.

- It also appears that the GOP December 15 offer may have changed the Conference Agreement savings from this group of providers. The GOP document could be interpreted to mean that all or most of the savings from payment freezes have been dropped.

Beneficiaries: Basic Part B Premium

- **Administration** -- Premium at 25 percent of program costs in 1996 and after.

- **GOP Offer of December 15** -- Premium at 25 percent of program costs in 1996, 29.5 percent in 1997, phase up to 31.5 percent in 2001.

- **Coalition** -- Premium at about 27 percent of program costs in 1996 (same monthly dollar amount of $46.10 as in 1995). 25 percent of costs in 1997 through 2002.

Analysis

- **Under current law:** The premium is set at 25 percent of program costs in 1996 through 1998. In 1999 and after, premium grows at rate of Social Security COLA, thus declining as a share of program costs to about 18 percent by 2002.

- **Comparison of monthly premiums in dollars:** The **Administration** and **GOP December 15 offer** would maintain the current law premium for 1996, $42.50 per month. The **Coalition** bill would keep the 1996 premium at the same dollar amount as 1995, $46.10 per month. At this point in time, it is not administratively feasible to change the 1996 premium from $42.50, but CBO scoring of the Coalition bill reflects the higher premium.

- Monthly premium amounts for 2002 can only be compared using a consistent package of Part B savings because the Part B premium is a calculated as a percentage of program costs. For example, assuming Part B savings in all plans were the same as in the Coalition bill, monthly premiums in 2002 would be:

  - $66.30 under both the Administration and Coalition plans (they have the same premium policy by 2002), and about $83.50 under the Conference Agreement/GOP December 15 offer.

- **Savings Option -- Increase Premium to Cover New Home Health Costs:** The Administration and Coalition plans would shift certain home health outlays from Part A to Part B. Neither plan would increase the Part B premium to reflect these new Part B program costs. Adding these costs to the calculation of the 25 percent premium would generate roughly $14 billion in new savings over 1996-2002. By 2002, the monthly premium would increase by about $6.30 for all beneficiaries.

Beneficiaries: Income-Related Part B Premium

- **Administration** -- No provision.

- **Conference Agreement** -- Beneficiaries with incomes above $60,000 for single beneficiaries and $90,000 for couples pay a gradually larger share of program costs. Incomes over $110,000 for singles and $150,000 for couples pay premium equal to 100 percent of per capita program costs.

    - Savings: $8 billion over 1996-2002 (assumes Conference Agreement Part B savings).

- **Coalition** -- Beneficiaries with incomes above $50,000 for single beneficiaries and $75,000 for couples pay a gradually larger share of program costs. Incomes over $100,000 for singles and $150,000 for couples pay 100 percent of program costs.

    - Savings: $17 billion over 1996-2002 (assumes Coalition Part B savings).

Analysis

- Both provisions affect a relatively small number of beneficiaries. The **Coalition** proposal -- with the lowest income thresholds (and thus broadest impact) -- affects about 5 percent of single beneficiaries and about 7.5 percent of beneficiaries filing as couples

- By requiring the highest income beneficiaries to pay a premium equal to 100 percent of program costs, the Coalition and **Conference** would give these beneficiaries an incentive to drop out of Medicare Part B altogether. Staff estimate that up to 20 percent of these beneficiaries would rather drop out than pay the full premium. Reducing the maximum premium to 75 percent of costs would cut the drop-out rate in half (to 10 percent).

- As a last resort, the **Administration** might support an income-related premium similar to that proposed in the Health Security Act. That proposal had income thresholds of $90,000 for single beneficiaries and $115,000 for couples. The maximum premium would be limited to 75 percent of program costs rather than 100 percent, to reduce beneficiary dropping Part B coverage. Such a proposal would save up to $7.5 billion, but this savings would be reduced when combined with other Part B savings proposals.

Lookback and Failsafe Mechanism

- **The Conference Agreement** -- Establishes annual fee-for-service expenditure targets for 9 provider sectors (e.g., hospitals, physicians). If the target is expected to be exceeded, the Secretary must adjust payment at the beginning of the fiscal year to ensure that the sector targets are met. The Conference relies on this mechanism to ensure its savings targets are reached.

  In 1999 and thereafter, a lookback mechanism is implemented to determine if actual spending in 1997 (or two years prior to the year of the lookback) exceeded targets. If so, further reductions must be made in payments to the sectors that exceeded the target.

- **The Coalition** -- Does not contain explicit limits on Medicare spending, but sets budgetary goals and establishes a Medicare reform commission to determine if the goals were met. If not, the Commission makes recommendations. The President will then submit legislative proposals to Congress to correct the problems and the Congress will consider the proposals on a fast track, similar to the Defense Base Closure process.

- **The Administration** -- Does not include a lookback or failsafe mechanism.

Analysis

- Specific Medicare savings provisions should be adopted to reach the savings target for Medicare so that failsafe savings are not relied upon to reach the target at the outset.

- The Administration could adopt an approach that establishes either spending or savings targets.

- When conducting a lookback, Medicare should be subject to its own target: If Medicare's target is not achieved, the Secretary of HHS would be required to make across the board payment reductions if Congress did not suggest an alternative. The target could be adjusted to reflect unanticipated changes in enrollment, economic performance, incidence of disease or epidemic, and minor estimation errors.

- Medicare could be subjected to a budget-wide sequester if overall spending exceeds budget-wide targets, but a maximum sequester percentage should be established so that Medicare is not subject to devastating reductions.

Extend HI Tax to State and Local Workers

- **Coalition** -- Requires all state and local employees and governments to contribute to the Medicare Hospital Insurance program through payroll contributions. Previously, only employees hired after 1986 were required to pay into Medicare. $8.2 billion in seven year savings.

- **Conference/Administration** -- No Provision.

Analysis

- The following states have the largest number of employees not currently contributing to Part A: California, Ohio, Texas, Illinois, and Massachusetts. Other states such as Colorado, Alaska, Louisiana and Nevada, as well as the District of Columbia, appear to have a high proportion of workers affected.

- The Administration does not favor this proposal because it would add to the financial and administrative burdens of many government entities, some of which are already facing budgetary strains and may be perceived as an unfunded mandate and an attempt to shift part of the burden of reducing the Federal deficit to State and local governments.

- However, it should be recognized that in some cases states and localities have always had the liability of covering their retirees, but have been relieved of the responsibility by Medicare. Therefore, this provision does not necessarily impose a new requirement or mandate.

- Because HI payroll taxes are credited to the HI Trust Fund, this proposal directly enhances Trust Fund solvency.

Trust Fund Transfers

(1) *Home Health Visit Shift:*

Administration/Coalition -- The Administration and Coalition plans contain similar (though not identical) proposals to shift certain home health visits from Part A to Part B.

Conference Agreement -- The Conference Agreement contains no such proposal.

Analysis

- Home health is one of the fastest growing Medicare benefits, with increases in the number of visits per beneficiary driving this growth.

- Limiting Part A home health visits would recognize that Part A covers only acute care services, and the HI Trust Fund would no longer be forced to support a chronic care benefit. At the same time, moving the remainder of a beneficiary's visits to Part B ensures that no beneficiary would be denied home health care.

- Shifting home health visits from Part A to Part B also significantly improves the solvency of the HI Trust Fund.

(2) *Part B Premium Proposals:*

Administration/Coalition -- The Administration and Coalition do not transfer any Part B premium revenue to the Hospital Insurance (Part A) Trust Fund.

Conference -- The Conference Agreement bill language would transfer two Part B premium income streams to the Part A Trust Fund:

- revenue from the income-related Part B premium; and

- revenue from increasing the basic Part B premium from 25 percent to 31.5 percent of program costs. The amount transferred is equal to the increment between 25 percent and 31.5 percent (i.e., 6.5 percent).

The GOP's December 15 offer changed the basic Part B premium policy and it is unclear how this offer changes the transfer. The new offer would set the premium at 29.5 percent of costs in 1997, phasing up to 31.5 percent of program costs between 1998 and 2001. It is possible that any increment over 25 percent would still be transferred to the Part A Trust Fund.

Regulatory Reform

(1) Clinical Laboratory Regulations

Coalition -- Repeals all requirements applying to physician office labs, except for requirements protecting Pap tests.

Conference Agreement -- Originally included a similar provision, which was subsequently removed via the Byrd rule.

Administration -- No provision.

Analysis

- Repealing these provisions, while attractive to the physician community, could be seen as removing some quality oversight protections for clinical laboratory services.

(2) Physician Self-Referral

Conference Agreement -- Repeals physician ownership referral prohibitions based on compensation arrangements, decreases the list of designated health services subject to ownership referral prohibitions, delays implementation until regulations are promulgated, adds a series of new exceptions (shared office, rural, no alternate providers, ASCs, renal dialysis, hospices)

Coalition -- Similar Provision.

Administration -- No Provision.

Analysis

- The HHS Inspector General and others have found that laboratories and clinics that are owned or invested in by physicians perform 40-50 percent more procedures than non-physician owned facilities.

- Taken together, the Coalition and Conference changes could reduce the protections for beneficiaries and the program against physician self-referral.

- A compromise might be alternative Stark language (H.R. 2173) which appeases physician concerns but retains minimal levels of protections.

Benefit Expansions

- **Coalition** -- The Coalition proposes benefit expansions that cost $2.1 billion. The expansions do not start until 2001. These expansions include covering diabetes screening, prostate cancer screening, colorectal screening, pelvic exams and expanded mammography coverage.

- **Conference Agreement** -- No Provisions.

- **Administration** -- The Administration proposes benefit expansions that cost $13 billion. These expansions include waiving the cost-sharing requirement for mammography services, covering annual screening mammograms for beneficiaries over age 49, covering colorectal screening, increasing payments for preventive injections, and establishing a respite benefit.

Analysis

- Accept Coalition benefit expansions proposal and start date.

MEDICARE

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MEDICARE

I. MAIN AFFIRMATIVE POINTS

Our Medicare plan:

Maintains beneficiary financial protections: the plan keeps the Medicare premium at its traditional level of 25 percent, and protects beneficiaries enrolling in private health plans from being charged extra amounts when they see their physician, and assures (through Medicaid) payment for the premiums, copayments and deductibles for very low income beneficiaries. Median income for older women is only $8,500 and $15,000 for older men over 65.

- **Republican plan would increase out-of-pocket costs in other ways:** As mentioned above, premium percentage will increase from 25% to 31.5%. Furthermore, segmentation could lead to a less healthy pool in the traditional fee-for-service Medicare and more shifting to outpatient coverage, which could drive up Medigap premiums -- already up 30% next year -- for 25 million seniors who use Medigap policies.

- **Protects Medicare From Being Divided Into Two Systems:** Three of the new plan options advocated by the Republicans -- Medical Savings Accounts (MSAs), Association plans (e.g., the elderly tennis players Association), and the Republicans' private fee-for-service option -- would pick off the healthiest and wealthiest, making the "capped" traditional fee-for-service system a more expensive program with higher premiums and reduced quality and services. For example, the Republican private fee-for-service option, by allowing doctors to charge whatever they wish for services (and eliminating current "balance billing" protections for these plans), would effectively select higher income, generally healthier populations away from the traditional fee-for-service plans.

Modernizes Medicare and provides real choice for beneficiaries: The plan provides real choices of managed care and innovative delivery models that operate in a market environment in which plans compete by providing quality, cost effective care -- not by y attracting healthy populations and avoiding the sick as do some of the options outlined by the Republicans. These new plans include: Provider Service Networks, Preferred Provider Organizations (PPOs), HMOs with a point of service option. Unlike the Republican private fee-for-service, these plans cannot balance bill, would have strong quality and consumer protections, and would compete on quality and costs (and not avoiding risk).

Provides savings that secure the Trust Fund without arbitrary caps: the plan includes real savings that secure the Trust Fund through 2011 -- but without arbitrary budget caps that bear no relationship to the projected cost of services for beneficiaries.

II. REPUBLICAN MAIN CHARGES AND OUR RESPONSES:

A. **Republican Claim: They are not cutting Medicare** -- they are increasing it over today's levels.

Response:

The Republican plan does cut Medicare. According to CBO, the $5,900 in federal spending per beneficiary in 2002 is a cut of $1400 per beneficiary below what Medicare would have spent in 2002.

That is a cut of 19 percent below the 2002 current law spending projection.

- **Example of How in Health Care More Funds can still mean a cut:**
  Costs go up by 30%. If this was a service provided by Medicare it would be an example of how a 6% increase would still mean a cut in services and benefits for people.

B. **Republican Claim: Medicare Health Insurance Trust Fund is in crisis** and is expected to go broke in the year 2002. Our plan will save the trust fund.

Response:

This is not a new problem. On nine separate occasions over the past 20 years the Trust Fund was projected to go broke within 7 years.

At the beginning of the Clinton Administration, the Trust Fund was projected to go broke by 1999. The President's 1993 five-year deficit reduction package (OBRA '93) extended the life of the Trust Fund by an additional three years--to 2002.

The President's plan will extend the life of the Trust Fund for 16 years, until 2011 which would give us adequate time to address the larger problem--changing demographics--on a bipartisan basis.

The President's plan leaves the Trust Fund as strong as or stronger than its been in 19 of the last 20 years.

C. **Republican Claim: These Medicare cuts are not severe.**

Response:

According to the American Hospital Association and 40 state hospital associations, these deep cuts will "jeopardize the ability of hospitals and health care systems to deliver quality health care, not just to Americans who rely on Medicare and Medicaid, but to all Americans."

The Republican proposal cuts permissible growth in Medicare spending to about 5% per person in 2002, more than 20% below the projected private sector rate of 6.9%.

The Republican cuts could also lead to a massive cost-shift onto the private sector.

-- A study by Lewin-VHI estimates that when the Republican Medicare and Medicaid cuts were $270 and $163 billion respectively, they could add as much as $85 billion to private sector costs as health care providers hike the bills they charge privately insured individuals to compensate for public program cuts. Even at the new lower levels, a cost shift of $60 billion is likely.

-- Small Business: John Galles, President of the National Small Business United warned that, due to cost-shifting, "we are likely to see health care premiums increase back in the double digits as a result of this legislation."

D. Republican Claim: Mrs. Clinton called for slowing the growth to near 7% and said it was not a cut. Medicare is just an excuse for not balancing the budget.

Response:

• *Clinton Health Care Plan Re-Channelled every penny of Medicare Savings -- Back into increased benefits for older Americans through prescription drugs, preventive care and long-term care.*

> *The Republican plan simply slashes $200 billion away from health care for seniors, and uses it for a tax cut and other priorities.*

• The Clinton Health Care plan sought to control Medicare costs in the context of lowering overall health care costs -- so that seniors needed less growth to achieve the same degree of health care.

> The Republican plan does nothing to bring down private health care costs -- and indeed gives Medicare recipients second-class treatment -- by giving them a growth rate per person that is over 20% less than what is needed to keep up with costs in the private health care market.

• The Clinton health care plan decreased the growth of Medicare spending, controlled costs and prevented cost-shifting. By contrast, according to a study by Lewin-VHI, the reconciliation bill's cuts of over $430 billion in Medicare and Medicaid spending would have added as much as $85 billion to private sector costs as health care providers hike the bills they charge privately insured individuals to compensate for public program cuts. Even at the lower levels, a cost shift of $60 billion is likely.

E. **Republican Claim: The GOP plan modernizes Medicare - expanding choices for seniors -- and introducing competition to control costs.**

Response:

We too want to expand choices of plans. However, we are concerned that some of the plans and structural changes the Republicans advocate will create a situation where the new plans compete through their ability to avoid risks rather than to provide cost-effective care.

The GOP creates an uneven playing field between Medicare Plus plans (private health plans) and traditional fee-for-service Medicare.

-- Private health plans, including MSAs, fee-for-service, and association plans, would pick off the good risks.

-- No major employer allows the degree of risk segmentation that would result from the range of plans proposed under the Republican proposal.

-- These new plans do not protect beneficiaries against extra billing by providers for Medicare.

The Administration's plan would:

-- expand managed care and innovative delivery options in Medicare in order to permit beneficiaries a broader range of choices that promise real reform of the health system; these include preferred provider organizations and HMOs with a point-of-service option.

-- establish provider networks, with appropriate Federal standards.

-- maintain beneficiary protections against balance billing or extra premiums, while revising quality assurance mechanisms to reflect improvements in this area.

F. **Republican Claim: The GOP proposal will not harm traditional Medicare.**

RESPONSE: **The Republican proposal is nothing less than a concerted effort to destroy traditional medicare -- to let it "wither on the vine."**

THE REPUBLICAN PROPOSAL DESTROYS TRADITIONAL MEDICARE BY INCREASING ITS COSTS WHILE CAPPING ITS FUNDING.

1. **HIGHER COSTS. The Republican plan will increase the costs of traditional Medicare by "segmenting" the market.** Medical Savings Accounts (and other GOP health care options) will entice the healthiest beneficiaries from the fee-for-service program, leaving traditional Medicare with only the sickest beneficiaries -- those most expensive to insure.

   - **Medical Savings Accounts.** Medical Savings Accounts (MSAs) allow a beneficiary to withdraw a set amount of money from the Medicare program to buy health insurance with a very high deductible. Any left over money can be deposited into a tax-preferred medical savings account.

   - **A segmented Medicare system.** Experts warn that MSAs and private fee-for-service plans will attract only the healthiest beneficiaries, who expect few medical expenses during the coming year, and thus expect to be able to keep a portion of the funds deposited into their medical savings account. The Republican plan also takes away the full subsidy for higher income older Americans, increasing the chance that they will drop out of the Part B program and further segment the traditional Medicare program.

   - **A more expensive traditional Medicare program.** MSAs will leave the fee-for-service program with a pool of beneficiaries who are sicker than before and more costly to insure.

2. **INSUFFICIENT FUNDING. Even as costs are increasing, the GOP proposal sharply limits the growth in spending on fee-for-service medicine.**

   - **Budget cap limits spending.** The Republican proposal limits spending growth on the fee-for-service program by imposing a highly restrictive "budget cap."

   - **Traditional Medicare will not be able to meet increased costs.** The budget cap breaks the link between Medicare spending and medical needs. Because the traditional Medicare program will be responsible for taking care of the sickest beneficiaries under the GOP proposal, it should have received a significant spending increase. However, the budget cap does not take into account the greater needs of the beneficiaries in the traditional program.

3. FEWER DOCTORS. **The combined effect of higher costs and insufficient funds will force traditional Medicare to cut back on its payments to providers, leading many providers to abandon the traditional program altogether.**

   - **Doctors will be forced out of the program.** According to a spokesperson for the American Association of Physicians and Surgeons, "doctors won't be able to afford to treat Medicare patients, because the rates will be so low, and fee-for-service medicine will just disappear." [*L.A Times*, October 23, 1995]

   - **Doctors will be enticed to join private plans.** With higher payments in the private plan, doctors will inevitably be drawn to these options. But the GOP proposal gives doctors another reason to abandon the fee-for-service program. Providers in private plans, like MSA plans, are permitted to "balance bill" -- to charge patients in private plans more than what Medicare pays for medical services. In contrast, balance billing is not permitted in the traditional Medicare program.

4. HIGHER MEDIGAP PREMIUMS. **Medigap premiums are likely to increase under the Republican plan, even as access to doctors and other providers drops.**

   - **Premium increases will reflect the higher risks in the fee-for-service pool.** Medigap premiums are likely to go up more under the Republican proposal because the traditional Medicare program will be left with only the less healthy beneficiaries -- those most expensive for Medigap to insure.

   - **Premium increases will also reflect hospitals' attempt to cut costs by shifting patients to out-patient care**. Because hospitals have more flexibility to charge co-payments for out-patient services (often over 50% of cost), more providers may be shifting care to out-patient services. Since Medigap typically pays for all or part of this co-payment, the shift to out-patient services makes Medigap more expensive -- leading to a premium increase.

G. **Republican Claim: the Administration is resorting to frightening the elderly to defend their Medicare positions.**

Response:

- We have called the public's attention to the facts about the Republican plan and its impact, and will continue to do so.

- The elderly have good reason to fear plans to raise out-of-pocket costs and shift Medicare to a voucher-like program in which the federal payment is not linked to the value of benefits-- leaving them exposed to the consequences.

III. MAIN SPECIFIC POLICY DIFFERENCES

A. Beneficiary premiums

Objectionable Republican proposal: raise the beneficiary premium to 31.5 percent of program spending, from the President's level of 25 percent.

Republican claim: Republicans' Medicare premium is within dollars of the President's.

Response:

- About $40 billion, nearly one out of every five dollars saved by the Republican Medicare plan comes out of the pockets of Medicare beneficiaries in the form of increased premium payments.

- The Congressional Budget Office (CBO) estimated that the Republican premium would be $84.60 in the year 2002.

- This premium is at least $12 per month higher than the estimated premium under the President's plan. This means that Republicans would force beneficiaries to pay more than $140 more in premiums in 2002 (more than $280 for an elderly couple) compared to the President's plan.

- Seniors already pay more than one fifth of their income on health care. *According to the Bureau of the Census (1993), the median income for women 65 or older is $8,600 a year; for men it's $15,000 a year.*

- The recent reports on Medigap cost increases shows that premium increases are only one way that the Republican budget plan will increase out-of-pocket costs for older Americans. The Republican plan has several aspects that encourage segmentation, which will increase provider shifting to out-patient care, thus raising the demand and costs of Medigap premiums.

- These increases will hit low-income Medicare beneficiaries especially hard since the Republican's Medicaid plan ends guaranteed Medicaid coverage of Medicare premiums.

- The Republican proposal increases premiums without significantly expanding benefits. It adds only one new benefit -- coverage of oral nonsteroidal antiestrogen for the treatment of breast cancer. President Clinton's proposal updates the Medicare benefits package significantly, making it more comparable to private sector packages, including annual screening mammograms, new benefits for preventive injections, and colonoscopy screening. The President also creates a new respite benefit for families with Alzheimer's disease.

B. **Hard budget cap:** the Republican plan includes an arbitrary cap on Medicare spending that is used to limit payments to Medicare health plans and to limit traditional Medicare provider payments if the arbitrary level is not reached.

Republican claim: The cap simply guarantees the savings levels envisioned in the Conference Agreement.

Response:

- An arbitrary cap breaks the link between Medicare funding and guaranteed Medicare benefits, changing the underlying nature of the program.

- The cap takes no account of unanticipated changes -- in inflation, in health care costs, or other factors -- any of which could trigger deep Medicare spending cuts under the plan -- meaning that Medicare would be held hostage to macroeconomic forces.

  For example, the Republican proposal entices healthy beneficiaries to join private plans -- like Medical Savings Accounts -- leaving the sicker and more costly beneficiaries in the fee-for-service program. In a truly fair system, spending on the fee-for-service program would increase to meet the greater needs of these beneficiaries (while spending in the private plans would be reduced somewhat). The rigid budget cap, however, prevents such an adjustment from taking place.

- Over time, benefits could be eroded, beneficiary out-of-pocket payments increased, and/or payment rates to providers reduced -- all threatening benefits, quality, and access.

- Budget caps can discourage proper medical care of patients. The Republican proposal actually divides the Medicare fee-for-service program into nine sectors -- such as home health services and in patient hospital care. These divisions could discourage efficient treatment. For example, technological advances might make it possible to treat illnesses at home rather than the hospital, but home health agencies as a group might nonetheless resist taking these patients for fear of exceeding their spending limit.

C. **Level of cuts:**

Objectionable Republican Proposal: More than $200 billion in Medicare cuts over the next 7 years.

Republican Claim: This level of cuts is needed to preserve Medicare and the HI Trust Fund.

Response:

- The cuts are unnecessarily high. The Administration plan, with only $124 billion in Medicare cuts, preserves the HI Trust Fund until 2011. This leaves us with plenty of time to deal with the longer term demographic changes facing Medicare.

- The magnitude of cuts will force Medicare beneficiaries to pay more through higher premiums and balance billing. The cuts will also result in privately insured, working Americans facing higher charges from providers to make up for cuts in Medicare and Medicaid.

- Moody's Investor Service indicated (New York Times, November 3, 1995) that it "might have to downgrade its ratings of many major hospitals, and that some of them might not survive the financial ordeals ahead."

D. **Medicare reform - real choices**

Objectionable Republican Proposal: The GOP would create new options that could de-stabilize Medicare financing, including medical savings accounts, association plans, and private fee-for-service plans.

Republican Claim: New options will provide beneficiaries more choice and more responsibility for their health care.

Response:

- We agree that beneficiaries need more choices, but the GOP plan moves backward, not forward. Medicare will be seriously undermined. In contrast, the Administration proposal modernizes Medicare through additional choices of managed care and innovative delivery arrangements, but avoids options that are experimental or that threaten the stability of the program or financial protection of beneficiaries.

- The GOP's new options are constructed in a way that would create risk selection problems, leading healthy beneficiaries to leave the program and sick ones to stay. CBO has estimated the costs of MSAs alone at *over* $4 billion. No private employer would permit the degree of risk segmentation allowed in the Republican proposal among health plan options offered to its employees.

- Beneficiaries who elect these new plans will not be adequately protected against high out-of-pocket costs. Providers will be able to balance bill in instances where they cannot in current Medicare. Premiums for supplemental benefits are not constrained in the GOP plan, while they are in current law.

- The new options, combined with lack of balance billing protections and deep provider cuts, give doctors and other providers strong incentives to leave traditional Medicare. The result could be less, rather than more, choice for beneficiaries.

- Beneficiaries electing another option may not be able to return to traditional Medicare easily, because supplemental Medigap coverage may not be available without medical exams. (The Administration proposal addresses this problem.)

E. Beneficiary protections

Objectionable Republican proposal: GOP permits more balance billing under private health plans than under traditional Medicare.

Republican claim: GOP claims that their balance billing rules are adequate and that seniors retain the choice of traditional Medicare with its balance billing rules undisturbed.

Response:

- Hospitals and doctors will have an incentive to move out of traditional Medicare and into private insurance plans -- not managed care arrangements -- where they can balance bill.

- Tight budget cuts fuel this incentive, as providers will want to shift costs to seniors.

F. Fraud and abuse

Objectionable Republican Proposal: Make it easier to defraud Medicare by relaxing anti-kickback and penalties.

Republican Claim: New mandatory funding has been provided to crack down on those who defraud or abuse Medicare and other Federal health care programs.

Response:

- Despite the increased anti-fraud and abuse resources, it will be more difficult to identify and successfully prosecute criminals because new loopholes are created that will encourage more creative ways to abuse and defraud the program.

- Providers could get away with defrauding Medicare by claiming that they did not know that they were filing a false claim against the program. Prosecutors would have to prove that such providers acted in "deliberate ignorance" or "reckless disregard" of the law in order to make charges stick.

- Providers could evade anti-kickback statutes by forming managed care organizations.

- Medicare beneficiaries could be placed at risk by physicians who refer them for care based on compensatory arrangements.

- Providers could use bankruptcy protections to avoid repaying monies that they legitimately owe to the program.

G. Double jeopardy for low income seniors

Objectionable Republican Proposal: Eliminate requirement that states pay Medicare premiums and cost sharing for selected low income elderly.

Republican Claim: Low income elderly will be protected by requirements that States continue to set aside and target a portion of spending, based on 90 percent of their base year spending for Medicare premiums.

Response:

- States' actual set-asides would be significantly lower than current law spending. States would set-aside 90 percent of Medicaid spending for premiums. The Republican plan contains no set-aside for copayments and deductibles.

- At the same time, the Medicare premium is increased under the Republican plan.

- In actuality, the set-asides will cover less than half of Medicaid spending for these groups.

MEDICARE

- **GENERAL ARGUMENTS**
- **TIER 2 and TIER 3 ISSUES**

Revised
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A. MAGNITUDE OF SPENDING CUTS

1. GENERAL POINTS

KEY POINT: The magnitude of the Republican cuts are extreme, unnecessary and will have ramifications for the entire health care system. You should be careful not to get into a discussion of specific cuts, lest you find yourself in the midst of a trading match over the details.

OUR POSITION: *The Administration believes that efficiencies in the Medicare system can be achieved, and that the growth in Medicare spending might be held below the private sector growth rate. But the Republican plan's assumption -- that federal spending growth per beneficiary can be cut a full 20% below the private sector rate over seven years -- is simply unrealistic. The inadequate federal spending under the Republican plan threatens access to quality health care for seniors.*

- **EXTREME. The Republican cuts are extreme and excessive.**
  - **20% below private sector rate.** The Republican plan cuts the permissible federal growth rate to about 5%, more than 20% below the projected private sector rate of about 7%. Under the President's plan, federal spending grows at 6.4%.
  - **$1,400 below baseline.** By 2002, Republican proposals will provide $1,400 less in federal spending per beneficiary than what Medicare would have spent under current law. This is a cut of nearly 20% below the 2002 current law spending projection.

- **UNNECESSARY. The cuts are unnecessary to protect the Trust Fund.** The President's plan, which cuts Medicare far less than the Republican proposal, still extends the trust fund solvency date to 2011 -- leaving it as strong as or stronger than it has been in 19 of the last 20 years.

- **THREATEN THE QUALITY OF CARE FOR ALL AMERICANS.**
  - **Lewin-VHI**: Cuts will cause a massive cost-shift. Based on Lewin-VHI's methodology, roughly 20% of the Republican cuts in Medicare and Medicaid will be shifted onto the private sector. With the Republican's Medicare and Medicaid cuts now totalling more than $300 billion, a cost shift of over $60 billion is likely.

- **Statement of the National Association of Public Hospitals, American College of Physicians, and American Nurses Association: Cuts mean Fewer Choices.** "The effect of these reductions will be to squeeze providers so much that doctors and hospitals are forced to treat far fewer Medicare patients. . . . Patients may find that their only "choices" at that point are cheap managed care plans or medical savings accounts, with the government washing its hands of its responsibility to assure that care is up to acceptable standards." (Statement, October 17, 1995)

- **American College of Physicians: Cuts call into question quality of care.** According to Gerald Thomson, President of the College, "We think that cuts of this magnitude [in the reconciliation bill] call into question our ability to provide world class medical care . . . The college is concerned about an approach to Medicare that starts from a target number driven by the demands for a balanced budget and tax cuts, then tries to engineer changes to meet that target." [Testimony to Senate Democratic Leadership, 10/5/95]

- **National Small Business Group: Cuts will increase private sector premiums dramatically.** John Galles, President of the National Small Business United warned that, due to cost-shifting, "we are likely to see health care premiums increase back in the double digits as a result of this legislation."

2. SPENDING GROWTH

KEY POINT: The President's plan pushes efficiencies to the limit. Additional efficiencies beyond what the President's plan specifies are unrealistic.

- **IT IS UNLIKELY THAT SIGNIFICANT SAVINGS CAN BE WRUNG FROM MEDICARE THROUGH FURTHER EFFICIENCIES.**

  - **For most services, Medicare rates are already below private sector rates.** For standard medical services, Medicare spending is actually below the payments made by private health plans.

  - **The only reason Medicare is growing faster than the private sector now is that it also covers home health care, hospice services, and skilled nursing care -- all are growing quickly.** A recent study by the Urban Institute found that once these additional services are taken into account, Medicare spending growth is comparable to private spending growth.

- **THE PRESIDENT'S PLAN ALREADY CUTS DEEPLY INTO MEDICARE.**

  - **The President's plan cuts far below the current law baseline.** Medicare spending is growing at 8.4% per beneficiary, while the private sector rate is 7.1%. The President's plan cuts the growth rate to 6.4% -- about 10% below the private sector rate (and 20% below the Medicare baseline)..

  - **The Republican plan cuts federal spending to 5.2% per beneficiary -- over 20% below the private sector rate and <u>twice</u> the cut of the President's plan.** Even the Administration's 10% cut is at the margin of feasibility. But a cut that is twice as large is excessive.

  - **Providers will not be able to manage additional cuts.** One way providers have managed to deal with Medicare's low payment rates has been to shift much of the loss onto the private sector. However, with the growth of managed care plans, this kind of cost-shifting is increasingly difficult.

3. SPECIFIC PROVIDER CUTS

KEY POINT: Rather than speaking about specific cuts, we should emphasize that the bulk of the difference between the President's and the Republican's savings are in hospital cuts, premium increases, and cuts associated with the look-back mechanism. The Administration cannot compromise on these areas.

- **A $100 BILLION DIFFERENCE.** Roughly $100 billion separates the Republican cuts of $200 billion and the President's proposal to cut $98 billion (as scored by CBO).
    - **$44 billion of the difference comes from hospital cuts.** Further cuts in hospital payments is simply unacceptable. For details see the following page.
    - **$33 billion of the difference comes from premium increases.** The Republican proposal specifies $44 billion in premium increases; we specify $11 billion.
        - $36 billion in Republican cuts are due to the increase in Part B premiums from 25% of program costs to 31.5%. By 2002, this means that an elderly couple will pay over $340 more per year than under the President's plan.
        - $8 billion in Republican cuts come from income-testing Part B premiums. This change will encourage wealthy seniors to leave the traditional fee-for-service system for private plans, further segmenting the Medicare market into separate pools of healthy and sick beneficiaries.
    - **$12 billion of the difference comes from unspecified provider cuts imposed through the look-back budget enforcement mechanism.** The President's plan does not rely on unspecified cuts designed to meet budget targets, but detailed policy changes designed to improve the Medicare system.

4. IMPACT ON HOSPITALS

KEY POINT: We can not cut any further from hospitals.

- **$40 BILLION DIFFERENCE. Republican proposal cuts over $40 billion more from hospital payments than the President's proposal.**

- **THERE IS LITTLE MORE THAT CAN BE CUT FROM HOSPITALS.**

  - **Medicare has achieved significant efficiencies.** Medicare is currently on the leading edge of improving hospital efficiencies.

  - **Medicare surpasses private sector in controlling costs.** Medicare currently pays hospitals only 89% of cost, while private payers pay 129% of costs (PROPAC, 1993).

- **HOSPITALS ARE PARTICULARLY VULNERABLE TO NEW CUTS.**

  - **Hospitals are caught in a bind.** Hospitals have managed to deal with Medicare's below-cost payments, in part, by shifting the loss onto the private sector. However, with the growth of managed care plans, this kind of cost-shifting is increasingly difficult.

  - **Medicare pays for 25% of all hospital revenues.** A reduction as significant as that proposed by the Republicans will be felt by <u>all</u> hospitals.

  - **American Hospital Association: 700 Hospitals are particularly vulnerable to cuts.** According to the AHA, nearly 700 hospitals derive two-thirds or more of their net patient revenues from Medicare and Medicaid. Two-thirds of these vulnerable hospitals are already in financial duress, since they have negative patient margins.

- **MANY HOSPITALS COULD BE FORCED TO CLOSE**

  - **American Hospital Association: Cuts jeopardize quality health care.** According to the American Hospital Association and 40 state hospital associations, the cuts envisioned in the reconciliation bill would "jeopardize the ability of hospitals and health care systems to deliver quality health care, not just to Americans who rely on Medicare and Medicaid, but to all Americans,"

- **American College of Physicians: Cuts put hospitals in financially untenable position.** "The committee package jeopardizes the viability of hospitals, many of which already operate on slim margins. The combination of cuts updating the Prospective Payment System for hospitals and in reimbursement for graduate medical education will push many hospitals into a financially untenable situation." (Testimony, October 5, 1995)

- **Moody's: Hospitals downgraded.** Moody's Investor Service indicated that it "might have to downgrade its ratings of many major hospitals, and that some of them might not survive the ordeal." (*New York Times*, November 3, 1995).

- **Report: Impact on hospitals severe.** "[I]t is likely that many hospitals will not be able to achieve savings well beyond any historical precedent [as required by Republican cuts]. In these cases, hospitals will be faced with the following options: Reduce quality and/or access, seek government relief, or be forced to merge or close." [Council on the Economic Impact of Health Care Reform, November 1995]

B. WEAKENED FEE-FOR-SERVICE MEDICARE

KEY POINT: The Republican proposal undermines traditional medicare by increasing its costs while capping its funding.

- **RISK SEGMENTATION WILL INCREASE COSTS. The Republican plan draws the healthiest beneficiaries into the private health care plans, leaving the sickest individuals -- those most costly to insure -- in the traditional fee-for-service program.**

  - **Medical Savings Accounts.** Medical Savings Accounts (MSAs) appeal to the healthiest beneficiaries who expect few medical expenses during the coming year, and thus expect to be able to keep a portion of the funds deposited into their medical savings account.

  - **Balance Billing.** The Republican plan allows providers associated with certain private plans to bill patients more than what Medicare pays for medical services. Given this increased risk of liability, only the healthiest beneficiaries -- those who expect to need few medical services -- will join these plans.

  - **Medigap laws.** Medigap laws currently exacerbate the risk segmentation effect. These laws allow Medigap plans to penalize beneficiaries trying to switch from private plans back into the traditional fee-for-service program. By decreasing choice in this way, Medigap "locks-in" risk segmenation.

- **INSUFFICIENT FUNDING. Even as the cost of the fee-for-service program increases, the GOP proposal limits spending on this program.**

  - **Budget cap limits spending.** The Republican proposal limits spending growth on the fee-for-service program by imposing a highly restrictive "budget cap."

  - **Traditional Medicare will not be able to meet increased costs.** To adequately meet the needs of the sicker beneficiaries who will be left in the fee-for-service program under the GOP proposal, spending on the traditional program would have to increase significantly. However, the Republican budget cap does not take into account the increased cost of caring for these beneficiaries. Without sufficient resources, the fee-for-service program will have no choice but to cut back significantly on provider payments.

- **WITHER ON THE VINE. The result will be a dramatically weakened fee-for-service program -- with less access to doctors and higher Medigap premiums.**

  - **Limited access to doctors.** The combined effect of higher costs and insufficient funds will force traditional Medicare to cut back on its payments to providers, leading many providers to abandon the traditional program altogether.

    - **Fee-for-Service will "disappear."** According to a spokesperson for the American Association of Physicians and Surgeons, "doctors won't be able to afford to treat Medicare patients, because the rates will be so low, and fee-for-service medicine will just disappear." [*L.A Times*, October 23, 1995]

    - **Doctors will be enticed into private plans.** The GOP proposal offers another temptation to draw doctors into private health care plans: It allows providers in private plans, like MSA plans, to balance bill, charging patients in private plans more than what Medicare pays for medical services. In contrast, balance billing is not permitted in the traditional Medicare program.

  - **Higher Medigap premiums.** Medigap premiums are likely to increase under the Republican plan, even as access to doctors and other providers drops.

    - **Premium increase will reflect the higher risks in the fee-for-service pool.** Medigap premiums are likely to go up more under the Republican proposal because the traditional Medicare program will be left with only the less healthy beneficiaries -- those most expensive for Medigap to insure.

    - **Premium increases will also reflect hospitals' attempt to cut costs by shifting patients to out-patient care**. Because hospitals have more flexibility to charge co-payments for out-patient services (often over 50% of cost), more providers may be shifting care to out-patient services. Since Medigap typically pays for all or part of this co-payment, the shift to out-patient services makes Medigap more expensive -- leading to a premium increase.

C. HIGHER PREMIUMS

KEY POINT. The republican plan raises premiums significantly.

- **HIGHER PART B PREMIUMS.** The Republican plan raises Part B premiums from the current law rate of 25% of program costs to 31.5% of those costs.

  - **A heavy burden.** The Republican proposal sets premiums $340 above the President's proposal for an elderly couple in 2002. The Congressional Budget Office estimated that about $40 billion --- nearly one out of every five dollars saved by the Republican Medicare plan -- comes out of the pockets of Medicare beneficiaries in the form of increased premium payments.

  - **A vulnerable population.** Seniors already pay one-fifth of their income on health care. The median income for an elderly woman 65 years of age or older is $8,600 per year; for an elderly man, it's $15,000.

- **INCOME-RELATED PART B PREMIUMS.** The Republican proposal increases premiums for high-income beneficiaries, which will encourage many of the wealthiest beneficiaries to leave the traditional Part B fee-for-service program. Because these beneficiaries are often in good health, their disenrollment further undermines the traditional fee-for-service program, leaving it with the sicker, more costly Medicare beneficiaries.

- **PREMIUM PAYMENTS FOR LOW-INCOME BENEFICIARIES.** Republican proposals hit low-income beneficiaries especially hard by eliminating current law's guarantee that Medicaid will cover their Medicare premiums and cost-sharing.

  - **Current law.** Under current law, Medicaid pays premiums for all Medicare beneficiaries falling below 120% of the poverty line, as well as deductibles and copayments for those falling below 100% of the poverty line. The President's proposal maintains this critical protection for low-income beneficiaries.

  - **Republican proposal.** The Republican plan eliminates the safety net for many low-income beneficiaries -- who would no longer be guaranteed coverage of their premiums, deductibles, and copayments. As a result, many would be forced to leave the traditional Medicare program and enroll in managed care plans that require little or no cost-sharing -- assuming one exists in their area. The President's proposal preserves financial safeguards for low-income beneficiaries.

- **HIGHER MEDIGAP PREMIUMS.** The Republican proposal has several provisions that will segment the Medicare market, driving healthy beneficiaries into private plans -- like Medical Savings Account plans -- and leaving the sickest seniors to fend for themselves in a weakened fee-for-service program. That will drive up Medigap premiums in the fee-for-service program, since less healthy beneficiaries are most expensive to insure.

D. FALSE CHOICES/REAL CHOICES

KEY POINT: The Republican plan does not extend critical beneficiary safeguards to the new private plan options.

- **BALANCE BILLING**. The Republican plan allows doctors to "balance bill," to overcharge beneficiaries in their new private health care plans, even though this practice is prohibited in the traditional Medicare program.

    - The President's proposal prohibits balance billing in private plans and traditional Medicare.

- **SUPPLEMENTAL PREMIUMS.** The Republican plan contains no limits on what a private health care plan can charge for supplemental benefits, even though existing laws limit the permissible amount in private plans that currently enroll Medicare beneficiaries.

    - The President's plan retains current law provisions that prohibit plans from charging beneficiaries excessive premiums for supplemental benefits.

- **QUALITY STANDARDS.** The Republican proposal weakens the enforcement of quality standards, eliminating the requirement of independent and external oversight.

    - The President's plan extends existing quality standards to the private plan options, ensuring that these plans offer fair and effective medical coverage.

- **MEDIGAP REFORM.** The Republican proposal gives no guarantee that beneficiaries who switch to the fee-for-service program from private plans will be able to obtain Medigap coverage. As a result, beneficiaries who might otherwise switch will be discouraged from doing so.

    - The President's proposal enacts Medigap reforms, ensuring that beneficiaries in private health care plans will not be penalized in obtaining Medigap coverage should they ever decide to transfer back into the fee-for-service program.

    - The President's proposal would also prohibit Medigap plans from adjusting premiums in a way that discriminates against beneficiaries on the basis of age. Rather, the proposal requires Medigap plans to offer all beneficiaries in a given area the same premium rate, a practice called "community rating."

1. HEALTH CARE OPTIONS

a. MEDICAL SAVINGS ACCOUNTS.

KEY POINT: Medical Savings Accounts segment the Medicare population by encouraging health beneficiaries to join private health care plans -- leaving the traditional fee-for-service program with sicker, most costly beneficiaries.

OUR POSITION: *While we strenuously oppose MSAs in the Medicare system, this concept is virtually a matter of faith with conservative Republicans. If this issue becomes a sticking point, you might opt for the Coalition proposal of an MSA Demonstration project.*

- **CURRENT PROPOSALS.**
  - **Republican proposal establishes MSAs.** The Republican Medicare plan allows beneficiaries to withdraw a set amount of money from the Medicare program to buy a health insurance policy with a very high deductible. Individuals may deposit any money left over after the purchase into a tax-preferred medical savings account, an MSA.
  - **The Administration opposes MSAs.**
  - **The Coalition proposes 10 MSA demonstration projects to last 7 years.**
- **SEGMENTS THE MARKET.** MSAs tend to attract only the healthiest beneficiaries, who expect few medical expenses during the coming year, and thus expect to be able to keep a portion of the funds deposited into their medical savings account.
- **UNDERMINES TRADITIONAL MEDICARE. By segmenting the Medicare system, MSAs increase overall costs and undermine the traditional program.**
  - **Higher costs.** Under CBO projections, vouchers provided to healthy MSA enrollees will exceed what these beneficiaries would have cost the current Medicare system. As a result, CBO projects that MSAs will increase Medicare costs by more than $4 billion over seven years. And Lewin-VHI projects that MSAs will cost $15-20 billion over the same period.
  - **Weaker fee-for-service program.** Because healthy beneficiaries will enroll in MSAs, the traditional fee-for-service program will be left with a pool of beneficiaries who are sicker on average and more costly to insure. However, due to the Republican budget cap, spending on the fee-for-service program can not rise a corresponding amount. Facing higher costs and tight funds, the traditional program has no choice but to reduce provider payments.
- **BALANCE BILLING.** The Republican plan allows health care providers to "balance bill"; that is, to charge beneficiaries enrolled in MSA plans more than Medicare allows. This change means that beneficiaries who join MSAs will be vulnerable to higher and unexpected medical costs. Current law prohibits balance billing in most cases.

b. PRIVATE FEE-FOR-SERVICE PLANS

KEY POINT: These plans provide little additional value and leave beneficiaries vulnerable to balance billing.

- **CURRENT PROPOSALS.**
  - **The Republican plan establish private fee-for-service plans.** These plans, as their name implies, are simply private plans that offer fee-for-service coverage, just like the traditional Medicare program.
  - **The President's proposal does not include a private fee-for-service option.**
- **MANAGING RISK, NOT MEDICAL CARE.** The typical managed care entity is profitable by efficiently organizing the care provided to its enrollees -- they manage medical care. By contrast, fee-for-service plans are not organized to manage care; rather, they try to reduce costs by managing their risk. That is, they are typically geared to benefit from the reality of risk segmentation in health care spending by enrolling a group that is healthier on average.
- **BALANCE BILLING INCREASES BENEFICIARY COSTS.** The Republican plan allows health care providers to "balance bill" in the private fee-for-service plans. As a result, beneficiaries who join these plans will be vulnerable to higher and unexpected medical costs.
  - In addition, by permitting providers to over-charge in private fee-for-service plans, the Republican Medicare proposal increases the level of risk segmentation. Only healthy beneficiaries -- who expect few medical needs during the year -- will risk joining plans that allow balance billing.

c. LIMITED ENROLLMENT/ASSOCIATION PLANS

KEY POINT: **Limited enrollment/association plans, by their very nature, increase the risk segmentation in the Medicare system.**

- CURRENT PROPOSALS.
  - **The Republican plan establishes limited enrollment plans.** These health care plans are affiliated directly with a union or association; e.g. a community organization or local club.
  - **The President's proposal does not permit limited enrollment plans in the Medicare program.**
- THE REPUBLICAN PLAN INCREASES SEGMENTATION AND WEAKENS FEE-FOR-SERVICE.
  - Organizations that establish limited enrollment plans typically have information on the health care costs of their members. This will allow them to determine whether they will make or lose money under Medicare payment rates.
  - Organizations that will make money, because their enrollment is healthier than average, will likely establish a plan. However, organizations whose enrollment is sicker that average, and therefore more costly, will not establish plans.
  - Thus, organizations with healthier members will remove their members from traditional Medicare, leaving the program with a pool of beneficiaries who are sicker and more costly to insure.

2. MEDIGAP REFORMS

KEY POINT: Medigap reform is a critical step in ensuring that beneficiaries have a real choice in choosing between private plans and the traditional fee-for-service program.

- **CURRENT LAW:**

  - **Limited Open Enrollment.** Current law requires Medigap plans to hold an open enrollment period for six months after a beneficiary reaches the age of 65 or older and enrolls in Part B Medicare. During this period only, a Medigap insurer cannot refuse to issue a policy, place conditions on the policy, or discriminate in the price of the policy because of health status, claims experience, receipt of health care, or medical condition.

  - **Premium pricing.** While a Medigap insurer may not discriminate on the basis of health status during the open enrollment period, it may use whatever other pricing methodology it prefers, including adjusting premiums based on the age of a beneficiary.

- **PRESIDENT'S PROPOSAL REFORMS AND IMPROVES MEDIGAP.**

  - **Annual Open Enrollment.** Current law, which requires open enrollment only once in a lifetime, discourages beneficiary choice, because a beneficiary who joins a private plan can not be assured of obtaining coverage upon switching back to the fee-for-service plan.

    - The President's proposal expands choice by requiring Medigap plans to hold an open enrollment period annually, not just once in a lifetime. This puts Medigap plans on an equal footing with other Medicare plans.

  - **Comunity-rated Premiums.** Medigap plans are currently allowed to offer premiums that increase as the subscriber ages, which discourages seniors in private health care plans from switching from private health care plans to the fee-for-service program, since they face higher Medigap premiums as they get older.

    - The President's proposal expands choice by prohibiting Medigap plans from adjusting premiums based on the age. Instead, it requires Medigap plans to offer all subscribers in a given area the same Medigap rates, regardless of age, a practice called "community rating."

3. BALANCE BILLING

KEY POINT: The Republican proposal exempts certain private plan options from balance billing protection, increasing risk segmentation and exposing beneficiaries to unexpected costs.

- CURRENT LAW AND PROPOSALS.
  - **Current Law.** In the fee-for-service program, providers are generally prohibited from balance billing --- charging beneficiaries more than what Medicare provides as payment. Providers in private health care plans are also generally prohibited from balance billing for services authorized by a Medicare HMO. However, no such restriction applies to non-authorized services.
  - **The President's proposal** extends balance billing protection to all of the new private health care options for authorized services. In addition, the President's proposal broadens existing protections by limiting balance billing for non-authorized services as well.
  - **The Republican proposal** would allow balance billing for high deductible MSA plans and for private fee-for-service plans. Balance billing would also be allowed in network plans when subscribers seek services from providers who are not under contract with the health care plan.
- REPUBLICAN PROPOSAL WOULD INCREASE COSTS AND WEAKEN THE TRADITIONAL PROGRAM
  - **Higher costs.** By failing to extend balance billing prohibitions to the new health care options, beneficiaries who enroll in private plans could face unexpected costs. Physicians and other providers would be permitted to bill them for amounts in addition to the plans' premiums and cost-sharing.
  - **Weaker fee-for-service program.** By relaxing the balance billing protections for private plans, the Republican proposal gives doctors another reason to abandon the traditional fee-for-service program.
    - Doctors may see the opportunity to balance bill in these private plans as a way to compensate for reduced Medicare payments under the Republican plan.
    - If doctors drop out of the traditional program, the GOP proposal could actually reduce -- rather than increase -- access and choice for beneficiaries who wish to stay in the fee-for-service program. Beneficiaries might be forced, as a practical matter, to follow their providers into Medicare Plus plans, losing balance billing protections in the process.

4. LIMITS ON PREMIUMS FOR SUPPLEMENTAL BENEFITS

KEY POINT: The Republican plan repeals protections against overcharging for supplemental benefits.

- **CURRENT LAW AND PROPOSALS.**
  - **Current law.** Supplemental benefits are benefits that are not part of the standard Medicare benefit package and need not otherwise be provided by law. Virtually all managed care plans offer supplemental benefits of some sort, such as routine physicals and prescriptions. *Under current law, a health care plan must set premiums for its supplemental benefits at levels consistent with the premiums a plan charges its commercial (non-Medicare) enrollees*
  - **The Republican proposal repeals supplemental benefit protections.**
  - **The President's proposal retains current law protections.**
- **REPUBLICAN PROPOSAL HAS NO LIMIT ON PREMIUMS FOR SUPPLEMENTAL BENEFITS.** As a result, their plan could result in excessive premiums for supplemental benefits. Because most beneficiaries purchase supplemental benefits of one sort or another, this change could have a wide-ranging effect on the Medicare population.

5. BUDGET CAP

KEY POINT: The Republican plan includes an arbitrary cap on spending on both the traditional fee-for-service program and the private health care plans. This cap constrains spending on both programs, regardless of the cost of medical care, the need for treatment, or the kind of beneficiary who enrolls in each program.

- **Holds Medicare payments hostage to macroeconomic events.** An arbitrary cap breaks the link between Medicare funding and the need for medical care, changing the basic nature of the program.

    - The cap takes no account of unanticipated changes -- in inflation, in health care costs, or other factors -- which could trigger deep Medicare spending cuts under the plan. *Medicare, in short, would be held hostage to macroeconomic forces.* Over time, benefits could be eroded, beneficiary out-of-pocket payments increased, and/or payment rates to providers reduced -- all threatening benefits, quality, and access.

- **Will harm the fee-for-service program.** The Republican proposal essentially establishes separate budget caps for the private health care plans and for the fee-for-service program. These caps do not take into account many factors. Most importantly, they do not account for the fact that, under the GOP plan, the healthiest beneficiaries will be drawn into the private plans, leaving the sickest, most costly beneficiaries behind in the traditional program. Since the budget caps do not adjust for this risk segmentation, the traditional program will be forced to ration its provider and hospital payments to meet its overly-restrictive budget target.

- **Arbitrary caps may discourage proper medical care.** The budget cap imposed on the fee-for-service program is divided into nine "mini-caps," constraining the spending growth in nine separate medical sectors -- such as home health services and in patient hospital care. These divisions could delay or discourage proper treatment. For example, technological advances might make it possible to treat illnesses at home rather than the hospital, but home health agencies as a group might nonetheless resist taking these patients for fear of exceeding their spending limit.

- **Calls for $12 billion in unspecified savings.** The Republican budget caps are set so tights that they require the GOP to make $12 billion in additional cuts, beyond the already severe policy changes listed in their proposals. The Administration's proposal achieves its savings from specific policy changes designed to achieve necessary and measured reform.

HOW THE REPUBLICAN BUDGET CAP WORKS

The budget cap operates according to a five-step process:

- First, the overall spending allocation is set in statute for the Medicare system as a whole.

- Second, the spending allocation for the private health care plans (MedicarePlus plans) is calculated. This allocation is determined, in part, by the per capita growth rate permitted for the MedicarePlus plans. This number is set by statute. Since the MedicarePlus growth rate represents a per capita (per person) growth rate, the actual allocation for the MedicarePlus plans depends also on the number of beneficiaries who choose the private plans; the greater the participation in these plans, the greater the spending allocation on the MedicarePlus system.

- Third, the allocation for the fee-for-service program is calculated by subtracting the allocation for the MedicarePlus plans from the total spending allocation for the Medicare system as a whole. The fee-for-service allocation is subdivided into nine smaller allocations according to a legislatively-created formula. These allocations impose spending limits on the nine separate fee-for-service sectors identified in the Republican proposal: inpatient hospital, home health, extended care, hospice, physicians, hospital outpatient, DME, diagnostic tests, and other.

- Fourth, projected spending in each of the nine fee-for-service sectors is compared to the sector's allocation. If spending is projected to be greater than a sector's allocation, the Republican proposal reduces payments to that sector by an appropriate amount.

- Fifth, after the year has ended, the actual spending on the total fee-for-service program is compared to the program's allocation. If the allocation is exceeded, a "look-back" provision is triggered, reducing spending in subsequent years for those sectors that exceeded their suballocations. This "look-back" mechanism starts in fiscal year 1999, and looks back to spending in fiscal year 1997.

Example of look-back adjustment. In FY 1997, assume that the total spending on the fee-for-service program exceeds its budgetary cap by $1 billion. Assume, too, that this amount reflects overspending of $2 billion by two sectors -- physician services and home health services -- and underspending of $1 billion in the other seven sectors.

- Specifically, physician services exceeded its cap by $1.2 billion and home health services exceeded its cap by $800 million -- for a total of $2 billion -- while the other seven sectors achieved below-budget spending of $1 billion.

- In this scenario, physician services and home health services would be required to make up the $1 billion fee-for-service excess. The specific amount each sector would contribute would be determined as follows.

- The excess spending by physician services and home health services excess would be multiplied by the ratio of (1) the total amount the fee-for-service program exceeded its allocation and (2) the sum of the excess spending of the two sectors that exceeded their suballocation. Thus, for physician services, the sector's excess spending ($1.2 billion) would be multiplied by the ratio of total fee-for-service spending ($1 billion) to the sum of the excess spending by both physician services and home health services ($2 billion). The result is that physician payments would be lowered by $600 million in the following year. A similar analysis demonstrates that payments to home health services would drop by $400 million in the following year.

6. CASH REBATES

KEY POINT: Cash rebates are prone to abuse and can be used by private plans to entice the healthiest beneficiaries out of the fee-for-service program.

- CURRENT LAW AND PROPOSALS.
  - **Current law prohibits private health care plans from offering cash rebates to attract enrollees.** An HMO is permitted to offer enrollees additional benefits or it can reduce the out-of-pocket expenses charged beneficiaries. Once a plan reduces its out-of-pocket fees to zero, however, it can only offer additional benefits. Cash rebates are not permitted.
  - **The Republican proposal repeals current law, permitting plans to offer cash rebates.**
  - **The President's proposal retains current prohibitions on cash rebates.**
- **CASH REBATES CAN BE USED BY PRIVATE PLANS TO DRAW HEALTHY BENEFICIARIES OUT OF THE FEE-FOR-SERVICE PROGRAM.** Cash rebates are prone to abuse, since they can be used as a marketing tool to attract ("cherry pick") the healthiest, low-cost beneficiaries from the pool of Medicare beneficiaries. In this way, the Republican proposal could exacerbate risk segmentation in the Medicare system.

7. DISENROLLMENT

KEY POINT: Republican provision could "lock" beneficiaries into unsatisfactory private plans for up to a year.

- **FLEXIBLE ENROLLMENT CURRENTLY PERMITTED.** Under current law, beneficiaries are permitted to terminate enrollment at any time -- with termination effective on the first of the first month following the request for termination. The President's proposal retains that flexibility.

- **REPUBLICAN PROPOSAL "LOCKS-IN" SENIORS FOR UP TO A YEAR.** Under the GOP plan, beneficiaries may terminate enrollment only during a specified annual enrollment period. As a result, after enrolling, a beneficiary would be "locked-in" to a plan for up to a year.

- **THEIR PLAN ALSO MAKES OVERSIGHT OF PLANS MORE DIFFICULT.** A significant increase in the rate of disenrollment for a given health care plan is a good indicator of management or quality problems and typically triggers an independent review of the plan. Under the Republican proposal, HHS would have to wait a year to get comparable disenrollment information. This delay would disadvantage enrollees receiving poor quality care.

8. REVIEW OF QUALITY STANDARDS

KEY POINT: The Republican proposal essentially eliminates external and independent oversight over the quality of private health care plans.

- **CURRENT LAW AND COMPETING PROPOSALS.**

  - **Current law requires HMOs to establish internal quality assurance programs and comply with external quality reviews.**

    - **Internal review** ensures that the HMO has the appropriate processes in place to ensure quality (e.g., the HMO has a quality assurance team that meets regularly, develops quality improvement programs and reports to the senior HMO executives).

    - **External review** is generally conducted by independent peer review groups under contract with HHS, which monitor and evaluate the HMO to ensure that it is actually providing medically necessary, appropriate, and effective health care services for its enrolled population.

  - **The President's plan.** The Administration's proposal allows a private plan to satisfy the internal review requirement by seeking and receiving accreditation from a qualified private organization. However, external review by an independent body is still required.

  - **The Republican plan.** Under the Republican proposal, private plan can satisfy both internal and external review requirements by obtaining accreditation from a private organization -- essentially making such plans exempt from independent oversight of quality standards. Moreover, the Republican plan repeals quality review requirements altogether for high deductible MSA plans and private fee-for-service plans.

- **REPUBLICAN PROPOSAL ELIMINATE ALL REQUIREMENT FOR INDEPENDENT REVIEW.** By exempting high deductible and private fee-for-service plans from quality review requirements, the Republican proposal puts enrollees at risk. For other private plans, the Republican proposal relies entirely on private accreditation to meet quality standards, ignoring the need for some independent external verification of the quality of care.

9. PREMIUM PROTECTION FOR LOW-INCOME BENEFICIARIES (QMBs/SLMBs)

KEY POINT: We must maintain the guarantee of Medicaid coverage for the premiums and other medical expenses of low-income beneficiaries.

- **GUARANTEE OF COVERAGE ELIMINATED**. Republicans eliminate the guarantee of Medicaid coverage of Medicare premiums, deductibles, and copayments for Medicare beneficiaries under 100% of poverty (Qualified Medicare Beneficiaries or QMBs) and of coverage of Medicare premiums for those below 120% of poverty (Specified Low-Income Medicare beneficiaries or SLMBs). Elimination of this coverage may deny poor elderly and disabled people access to the Medicare Part B program.

    - **No set-aside for deductibles and copayments.** The Republican plan eliminates guarantee to any coverage of copayments and deductibles, and does not set aside any funding for copayments and deductibles.

    - **Inadequate set-aside for premiums.** While Republicans claim to cover Medicare premiums for poor Medicare beneficiaries, they set aside *less than half* of the amount required to pay premiums. While they set aside 90% of 1993-1995 state spending on "mandated" eligibles, this amounts to less than half of the projected Medicaid spending on premiums.

- **DOUBLE JEOPARDY FOR LOW-INCOME SENIORS.** At the same time that the Republican plan eliminates the guarantee of coverage of premiums, the plan increases Part B premiums.