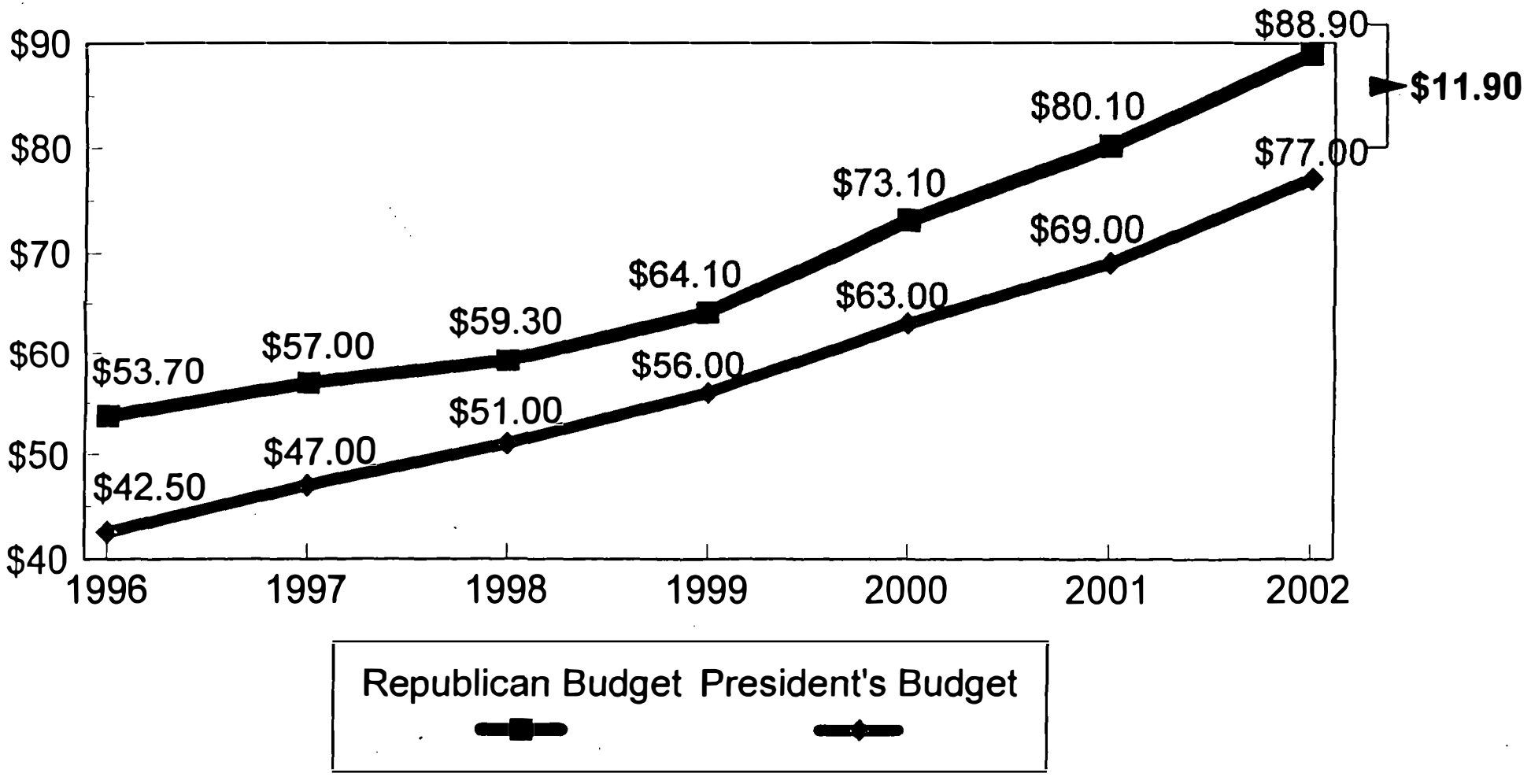
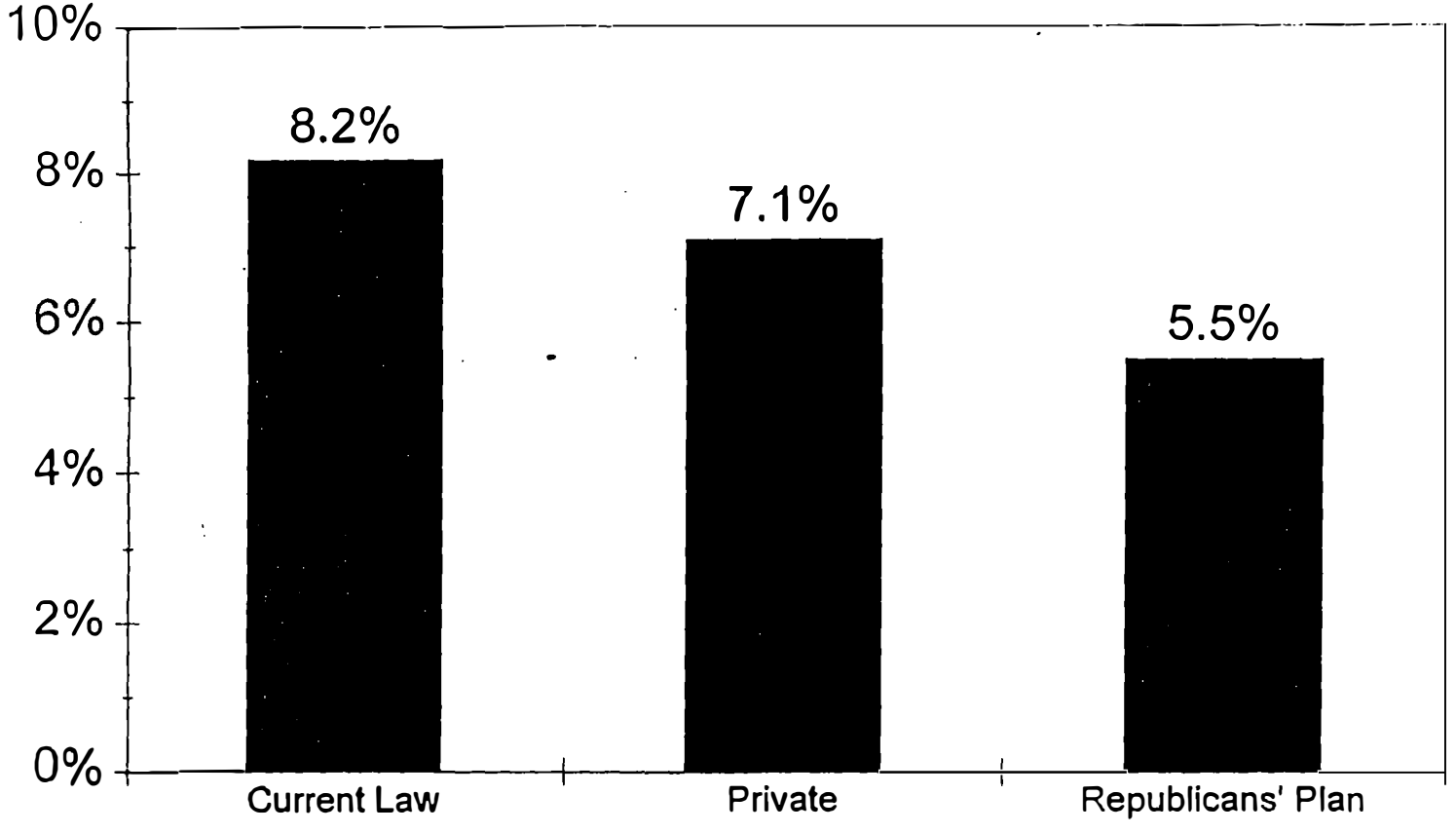
Medicare Monthly Premiums



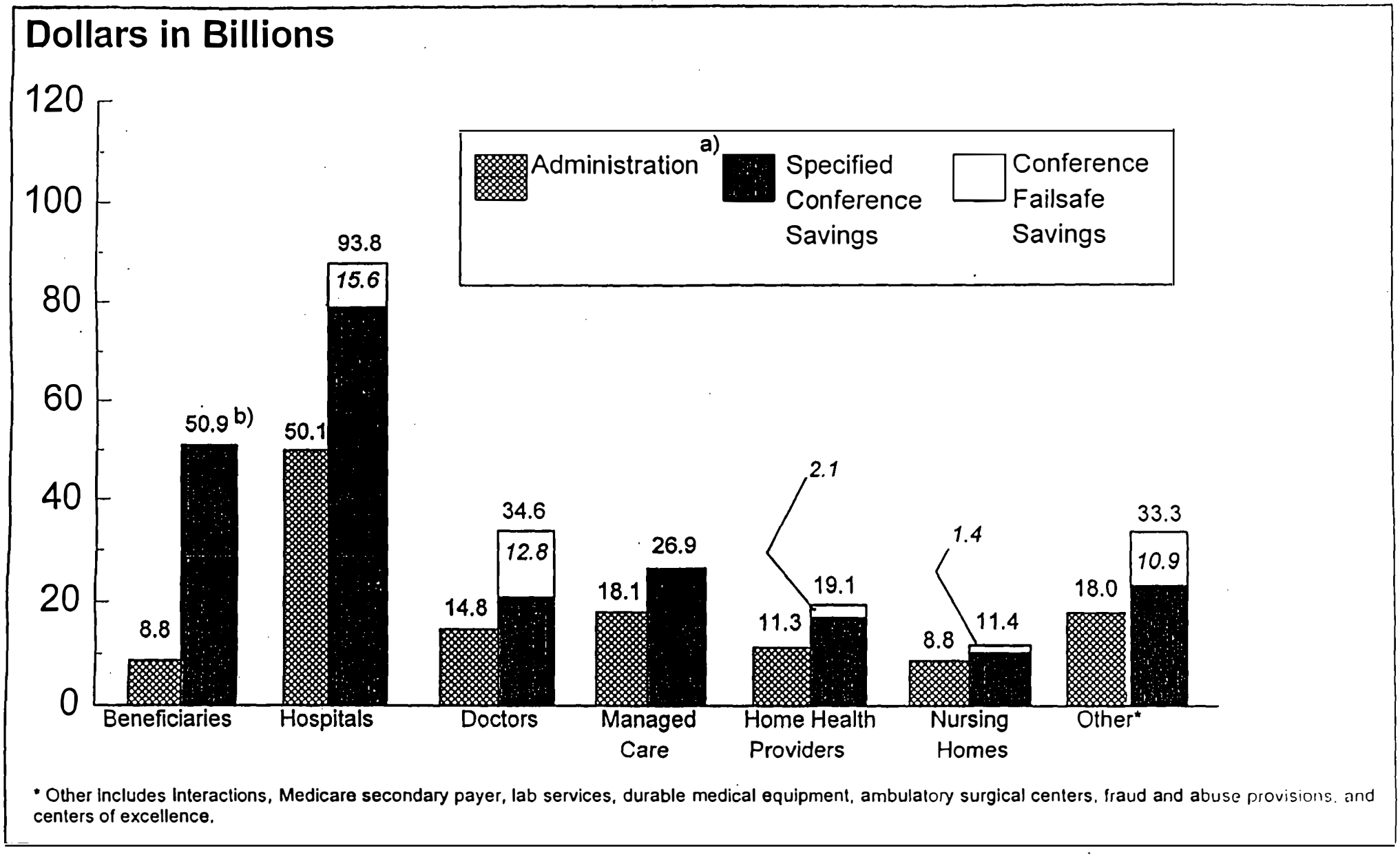
CBO estimates of Republican premiums, as published in the November 16 letter to Senate Domenici; HCFA's estimates of premiums under the President's proposal. SOURCE: US DHHS.

Comparison of Growth in Total Medicare Spending Per Beneficiary, 1996-2002



CBO baseline as of October 1995; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of beneficiaries. Administration estimates of private health spending per insured person, using CBO data. DHHS estimates of the President's proposed rate of growth in spending per beneficiary: 6.8%. Source: US DHHS

Administration vs. Republican Conference Agreement Medicare Cuts By Category (7-yr. OMB and CBO Pricing, respectively)



* Other includes Interactions, Medicare secondary payer, lab services, durable medical equipment, ambulatory surgical centers, fraud and abuse provisions, and centers of excellence.

a) Administration managed care savings include both direct managed care payment reductions and the indirect effect of fee for service cuts on managed care. All Conference managed care savings are direct because the link between fee for service expenditures and managed care payments is severed. Administration savings do not include $5.3 billion cost of additional preventive benefits

b) The indirect reduction in Part B premiums due to failsafe spending reductions is reflected in the Conference Agreement "Beneficiaries" total.

12/11/95

NOTE TO: Gene Sperling
Jennifer Klein
Chris Jennings
Ginny Terzano
Lorrie McHugh

FROM: Melissa Skolfield

Two quick bulletins on Medicare and Medicaid.

1) The Secretary is concerned that the congressional leadership is now pushing a line that our proposals are similar to theirs, and she'd like to be sure that we're stressing the policy differences between our plans as well as just the numbers. I've attached some internal talking points that she uses here -- the focus is on choice, nursing home standards, and consumer protections like balanced billing. I think this is an important message this week, and plan to make it the centerpiece of her Wednesday speech to the National Health Council. (Text to come over tomorrow for approval to some of you.)

2) Please be aware that the Social Security trustees meet on Wednesday to discuss the status of the Social Security and Medicare trust fund. We're developing talking points for any media inquiries here.

If we can provide any further assistance, please call me or Richard Sorian.

cc: Richard Sorian
Victor Zonana

DRAFT

TOP LINE MEDICARE

OVERVIEW

In Medicare, our plan calls for $124 billion in savings, in contrast with their $270 billion plan. The following are the key priorities.

- ***Maintain beneficiary financial protection:*** The average Medicare beneficiary must not be subject to a premium in excess of 25 percent of Part B spending.

- ***Oppose arbitrary budget caps***: Program savings must come from specific policy changes designed to achieve required savings levels and meet the target of 10 year trust fund solvency. Arbitrary budget-driven caps on Medicare spending and "lookbacks" that bear no relationship to the projected cost of health services for Medicare beneficiaries are unacceptable.

- ***Support real choice:*** Beneficiaries must be provided real choices of managed care arrangements and delivery models -- under Medicare health plans and through supplemental Medigap policies -- that do not lead to a system in which insurers discriminate against less healthy and poorer beneficiaries. Medicare reform must be implemented in a responsible manner, and not result in significant segmentation of the Medicare population and financing base by private insurers.

HIGHLIGHTS OF THE PRESIDENT'S PLAN

- ***Expanded choice of plans under Medicare:*** Maintain strong traditional Medicare, while increasing choice of alternative health plans and delivery systems.

- ***A more cost-effective Medicare program:*** The $124 billion in savings included in the plan is based on sound reforms that make the program more efficient, constraining growth rates to just below private sector rates -- while keeping the Part B premium at 25 percent of costs.

- ***An improved Medicare program:*** Improves Medicare by investing in better preventive benefits (covering colorectoral screening; making mammography an annual benefit starting at age 50, and eliminating cost-sharing for the benefit); and by adding a new, limited respite care benefit for families of those with Alzheimer's disease.

KEY MEDICARE ISSUES

SAVINGS

Our plan - $124 billion

Republican plan - $270 billion

Key points

They cut too much too fast. Our per capita growth rate (6.8 percent) is just below CBO's estimate of private sector growth (7 percent); they cut per capita growth by 20 percent below private sector, to 5.5 percent.

They cut federal Medicare spending below the baseline by $1700 per person by 2002; we have more moderate reduction of $900.

PART B PREMIUM

Our plan - 25 percent

Republican plan - 31.5 percent

Key points

Beneficiaries will pay $10-$11 per month more under the Republican plan in 1996 and 1997 - and $12 in the year 2000.

TRUST FUND

Our plan extends Part A Trust Fund to 2011 (2006 with "savers"; 2011, with home health shift).

Republican plan - we think extends till about 2016.

Key points

We extend Trust Fund until 2011 -- more than 15 years from now -- when we all recognize that the demographic changes of retiring baby-boomers will call for further changes.

CAP

Our plan - we have no arbitrary cap - reach $124 billion with real savings proposals

Republican plan - arbitrary cap on Medicare - payment to plans; and FFS "lookback"

Key points

An arbitrary cap on Medicare breaks the link between funding and benefit costs -- erodes funding, and ultimately access to care and benefits. Lets be honest about our savings proposals.

RESTRUCTURING

Our plan

-- Expanded choice of responsible managed care plans and delivery systems

-- Standards for all plans - including limits on balance billing

-- Medigap reforms to assure beneficiaries choices of health plans or of Medigap

Republican plan

-- Include plans that have no ability to control costs - FFS plans and MSAs -- will simply risk select -- and/or allow balance billing of beneficiaries within the plan

-- No Medigap reforms -- beneficiary may not have choice to go back to traditional Medicare plus Medigap -- because Medigap plan could underwrite them.

Key points

We want to move to a responsible, pragmatic reform of Medicare for the 21st century.

-- we want to include those plans that can help coordinate the delivery of care and help reform the health system -- that does not include FFS plans and MSAs which simply will segment the market and the Medicare risk pool.

-- we want plans to assure beneficiary protections -- and not simply be vehicles to allow balance billing;

-- we need real choice for beneficiaries -- that requires coordinated annual open enrollment that includes both Medicare health plans and Medigap plans.

TOP LINE MEDICAID

OVERVIEW

The President is gaining credit for a principled stand in support of the Medicaid entitlement and opposition to the block grant and deep budget cuts in the Republican plan. This is by far the most important health care issue in the debate. We have to stick as close as we can to the President's $54 billion maximum Medicaid savings target. The following are four specific points in support of the principles that have been articulated.

- ***Maintain entitlement:*** Medicaid must remain a federal entitlement that guarantees coverage with meaningful benefits for children, pregnant women, seniors, and individuals with disabilities.

- ***Oppose block grant, deep cuts***: Federal Medicaid funding cannot be fixed and block-granted -- we cannot breach a thirty-year partnership with the states in financing benefits for low income Americans and their families. The President's per capita cap limits the rate of increase in spending per person while maintaining the federal financial commitment to states if they have to expand coverage to meet needs in their state.

- ***Enhance state flexibility***: States should be granted increased flexibility in how to operate their Medicaid programs, through more use of managed care arrangements, and changes in and elimination of many administrative and payment requirements.

- ***Maintain nursing home quality:*** High quality and enforceable federal standards for nursing home residents, including individuals with disabilities, must be maintained.

Key negotiating point: use the current Medicaid statute (title XIX of the Social Security Act) as the basis for negotiations and amendments.

HIGHLIGHTS OF THE PRESIDENT'S PLAN

- ***Guaranteed Coverage***: People currently eligible for Medicaid services would retain their Federal guarantee of health care coverage.

- ***Financial Partnership with States:*** Constrain the rate of increase in federal Medicaid spending by through a per capita limit that supports state needs in the event of economic downturns leading to increases in the number of Medicaid beneficiaries. Specifically:

  - DSH payments tightened, coupled with state flexibility to target payments
  - 15 states with largest number of undocumented persons to receive special grants
  - 10 states with disproportionately large uncompensated care population will receive additional funds
  - pools created to assist states in FY 1996 and 1997 for transition to the new system

- ***Enhanced State Flexibility:*** States are given much greater flexibility to change how they pay for services, so they can reduce costs not coverage--including repeal of the Boren Amendment, requirements for beneficiaries to choose among managed care plans, and provision of home and community based care without the need for federal waivers.

- ***Quality is Protected:*** Maintains existing federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities. Also, quality standards for managed care systems would be enhanced.

- ***Financial Protection for Beneficiaries and Their Families:*** Spousal impoverishment protections are maintained, as are guarantees for payment of Medicare premiums and cost sharing.

KEY MEDICAID ISSUES

SAVINGS

Our plan - $54 billion

Republican plan - $163 billion

Key points

They cut too much. Because states will be unable to absorb the deep cuts through efficiency alone, they will be forced to reduce coverage for their most vulnerable citizens, shift costs to providers, or increase their state spending.

GUARANTEED COVERAGE

Our plan - Preserves the existing guarantee of health care coverage for low-income elderly, nursing home residents, pregnant women, children, and people with disabilities.

Republican plan - Eliminates guaranteed eligibility and benefits for the 36 million Americans currently covered by Medicaid. Gives states almost complete discretion to decide who is eligible and for what benefits.

Key points

Under their plan, severe cuts in Federal financial support, combined with virtually complete state flexibility to define eligibility and benefits, could result in loss of health care coverage for nearly 8 million children, seniors, and people with disabilities by 2002.

STATE FINANCIAL PROTECTION

Our plan - Continues to match state spending for every single Medicaid enrollee, capping only the annual rate of growth in Federal payments per capita. Annual growth in Federal payments per beneficiary is limited to 5.5% on average over 1996-2002.

Republican plan - Replaces Medicaid with fixed Federal block grants to states. The block grants reflect average annual growth in per beneficiary spending of only 1.6% over 1996-2002 -- compared to 7% in the current Medicaid program and 7.1% in the private sector.

Key points

Because it is enrollment-based, our policy preserves the Federal commitment to share in the risks associated with recession, the aging of the population, and the rising number of uninsured children. By contrast, their fixed block grants leave states at full risk for the unexpected costs associated with such dynamics.

All states receive more Federal funding under the President's plan than under the Republican plan. Moreover, while the President's plan cuts most states by similar percentages, the Republican plan takes up to 45% from some states and gives money to others.

STATE FLEXIBILITY

Our plan - Signficantly enhances state flexibility by repealing the Boren Amendment and other provider payment requirements, and by permitting states to mandate managed care and provide home and community-based services without Federal waivers.

Republican plan - Provides states with almost unfettered flexibility -- in benefit and eligibility decisions, as well as payment and administration.

Key points

The Republican plan gives states much broader flexibility. However, states will pay for this flexibility with Federal funding cuts over $100 billion deeper than ours, and the poor will pay with loss of health care coverage.

DSH SPENDING

Our plan - Reduces and retargets DSH payments. Creates supplemental pools for states with high numbers of undocumented persons and states with high levels of uncompensated care and Medicaid shortfalls.

Republican plan - Terminates the DSH program and includes it within the block grant. Creates supplemental pool for states with high numbers of undocumented persons.

Key points

Our plan makes targeted changes in federal DSH spending.

Their plan will exacerbate the critical financial problems facing inner-city, public, and rural hospitals that care for Medicaid and uninsured patients.

DRAFT

The President's Plan is not an Aggregate Cap

A "per capita cap" is a policy that limits Federal Medicaid spending growth on a per person basis. The Federal payments under this policy adjust to a state's enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in the costs for that population. This shared responsibility distinguishes the per capita cap from an aggregate cap.

- Under the President's plan, per person spending levels are estimated using a base year of 1995.
- The base year spending per person (estimated separately for non-disabled children, non-disabled adults, disabled and elderly), is projected to future years using an index.
- States would receive Federal matching funds up to this indexed spending per person.
- Therefore, the President's plan is not an "aggregate cap" because the states will receive different amounts of federal matching, depending on the number of people in the program.
- Recognizing that the economic assumptions regarding the CBO baseline are still in flux, the legislation was drafted to meet the $54 billion savings over 7 years. That is why the levels of savings were specified and these were merely part of a mechanism to determine the appropriate index.
- In fact, the legislation specifies that the Secretary shall determine the index for the seven-year period within 2 months of enactment of legislation. The index is a combination of the growth in the average nominal gross domestic product (GDP) plus an "adjuster."
- It is envisioned that the Congress will set in law the values of the index for each of the seven years once a common baseline is established.

ADMINISTRATION/COALITION - MEDICARE

Overall Target/Savers

- President: $124 billion
- Coalition: $!68 billion

Option/rationale: could reach Coalition number at <u>end</u> of negotiating process with Republicans -- not yet.

Cap

- President: No hard cap, lookback
- Coalition: Targets, commission, President report/recommendations (base closure model).

Options/rationale: could accept Coalition view as interim step in negotiations toward some type of "insurance" mechanism.

Premium

- President: 25 percent; no higher premium on upper income
- Coalition: 25 percent; higher premium on upper income → $16 B
  Rs = $8-9 B

Options/rationale: at some point, could accept higher premium on upper income beneficiaries -- so long as they don't pay more than 50 percent of costs; issue is whether that is part of negotiations with coalition or final negotiations.

↳ Collected by IRS

Home health transfer

- President: Maintain 100 post hospital visits in Part A; shift rest to Part B
- Coalition: shifts HH costs beyond 150 visits to Part B; excluded from Part B premium.

Options/rationale: try to gain Coalition support for our policy rationale.

Work w/ coalition - helps w/ Trust Fund solvency

Health plan structure

- President: increased use of PPO, POS, provider networks; maintain federal standards, with state licensure; special licensure provisions of provider networks
- Coalition: structure similar to Conference agreement in general; <u>include FFS insurers, MSA demonstrations</u>; special treatment of provider networks that is more acceptable to AHA, <u>Taft-Hartley</u>, <u>Associations</u>

Accept at end of day

Option/rationale: consider moving to Coalition on federal/state, PSN issues.

HI Tax
- In Coalition
- Not in Republican plan

Problem w/ coalition plan

What about balance billing?

ADMINISTRATION/COALITION - MEDICAID

Overall target

- President: $54 billion → 4.5 - 5% cap
- Coalition: $82 billion → 3% cap + deeper DSH cuts
  ↳ Below medical inflation

Option/rationale: maintain our number until final negotiations with Republicans.

Structure

- President: Per capita cap; retain entitlement; work off of title XIX
- Coalition: Per capita cap; retain entitlement; work off of title XIX

Option/rationale: consistent positions

Eligibility

- President: maintains entitlement
- Coalition: maintains entitlement

Option/rationale: consistent position; will have to work with Democratic governors

Asset/income protection

- President: maintains current law protections
- Coalition: maintains current law protections

Option/rationale: consistent position; will have to work with Democratic governors

Services

- President: maintains current law provisions
- Coalition: maintains current law provisions; for EPSDT treatment services, requires Secretary to define treatments that must be covered by state; provides options for higher cost sharing on those subject to cost sharing

Option/rationale: will need to deal with EPSDT treatment services, and cost sharing issues, other mandatory services, at some point in negotiations - with Democratic governors and then with Republicans.

Flexibility/contracting, payment, administration

- President: new flexibility in managed care contracting without waivers, provider payment, administration
- Coalition: less flexibility, especially as regards providers (retain Boren, cost payment for FQHCs)

Option/rationale: subject to negotiations with Democratic governors.

DSH

- President: phase in DSH reductions - differential reductions for high/low DSH states; options for states to pay additional providers, including FQHC, RHC; Secretary to develop standards for allocations; 2/3 "pools"
- Coalition: DSH cut, with variant of NAPH retargetting

Option/rationale: can move to more directed targetting of DSH funds, including special payments for FQHC/RHC, subject to politics of state-by-state allocations, need to fund special transition monies.

AMOUNT OF FUNDING CUT FROM EACH SECTOR
MEDICARE

Group	Republican with FAIL SAFE[2]	COALITION	Ways and Means Dems[1],
Hospitals	$97.9	$59.4	$49.5
SNF/hospice	$ 19.0	$ 6.9	$8.5
Doctors	$ 37.5	$25.5	$24.7
Home Health	$ 19.3	$ 9.8	$11.8
Labs, durables	$ 15.7	$ 6.5	$1.0
Total Provider	$189.4	$107.9	$98.1
Managed Care Savings	$30.7	$34.0	-0-
Fraud	$2.0	$2.4	$3.0
Secondary Payor	$6.0	$6.2	$7.7
Beneficiaries	$42.9	$26.1	+17.9[3]
Extend HI	-0-	$9.8	-0-

[1] Some differences in scoring exist between Coalition proposals and Ways and Means proposals, even though the provisions are virtually identical, because of the Coalition's lower projected rate of growth and the fact that some items scored as 'home health' and SNF in the Ways and Means bill were scored elsewhere in the Coalition bill.

[2] ESTIMATES - based upon existing House - Senate CBO scores.

[3] Includes $15.9 billion in Formula Driven Overpayments returned to beneficiaries and $2 billion in new preventive benefits.

SECTOR	Republican Conference	Democrats/ Ways and Means	Coalition
Beneficiaries	*Saves $57 billion (estimate)* Premium at 31.5% until 2002. **Premium in 2002 is $87.00** Means testing at $50,000 and $90,000.	*Loses $15.9 billion in savings due to Formula Driven Overpayment* Premium at $46.10 for 1996, then reverts to current law. **Premium in 2002 is about $61.00** No means testing	*Saves $26.1 billion* Premium at $46.10 for 1996, then reverts to 25%. **Premium in 2002 is $73.10** Means testing at $50,000 and $75,000
GME Trust Fund	Mandatory Expenditures of FY 97- $1.1 billion FY 98- $1.3 billion FY 99- $2 billion FY 00- $2.6 billion FY 01- $3.1 billion FY 02- $2.4 billion TOTAL: $12.5	Expenditures from removing from AAPCC FY 96: $.5 billion FY 97: $.6 billion FY 98: $.7 billion FY 99: $.8 billion FY 00: $1.0 billion FY 01: $1.2 billion FY 02: $1.4 billion TOTAL: $6.2 billion	Expenditures from removing from AAPCC (includes DSH) FY 96: $.5 billion FY 97: $.8 billion FY 98: $1.4 billion FY 99: $1.8 billion FY 00: $ 2.1 billion FY 01: $2.4 billion FY 02: $2.9 billion TOTAL:$11.8 billion
GME	Cuts IME from 6.7% in 96 to 5% in 2002 (Other cuts unclear at this point).	No cuts to IME Freezes # of new residents, 50% weight for post residencies Extends OBRA '93 freeze for nonprimary care residents.	Cuts IME to 6.8% thru 98 and 6.0% thru 2002.

	Republican Conference	Democrats/ Ways and Means	Coalition
Home Health Care	*Cuts $19.3 billion* Establishes PPS for home health effective in FY 1997. A per-visit rate and a national per-visit rate is established. A market basket - 2 update is imposed. National per-visit payment rates are rebased in 1999 and every five years thereafter. Per-episode limits are established, with an aggregate limit and a per-episode limit. A case mix adjustment factor is established. A case mix factor is that established by HCFA's demonstration projects. No payments after 165 days. Agencies get a bonus payment - 50% of difference - it may not exceed 5% of total payments that year. Expands OBRA 93 freeze on updates.	*Cuts $11.8 billion* Establishes PPS for home health effective in FY 2000 with the following steps - a)Impose Interim Cost Limits equal to 112% through FY 1996 and 105% effective Oct. 1, 1996. The Secretary establishes a TEFRA-type system under which each home health agency would be subject to a total dollar cap for each beneficiary per year. b) expand, through FY 96, the OBRA '93 freeze on updates c). Modify payment rules d). Establish prospective payment in FY 2000 e). Transfer home health to Part B after 120 days.	*Cuts $9.8 billion* Same as WM Dems, with PPS in effect FY 1999. Same as WM Dems Same as WM Dems Same as WM Dems Same as WM Dems Same as WM Dems, but transfer after 150 days.

SECTOR	Republican Conference	Ways & Means Democrats	Coalition
Hospitals	*Saves $97.9 billion.*	*Saves $49.5 billion*	*Saves $59.4 billion*
	MB - 2.5 in 1996 MB - 2.0 96-2002	MB - 1	MB - 1.5 Urban MB - 0.5 rural
	Reduces DSH : 1996: 5% 1997: 10% 1998: 17.5% 1999: 25% 2000- 2002: 30%	no provision	no provision
	No provision	Reduces DSH/IME outlier payments	No provision
	Reduces Capital payments by 15%	Reduces capital payments by 10%	Reduces capital payments by 10%
	Reduces Bad Debt payments: 1996: to 75% 1997: to 60% 1998 to 2002: 50%	no provision	no provision
	Increases updates for Medicare dependent hospitals	no provision	no provision
	Eliminates formula driven overpayment and keeps savings	Eliminates formula driven overpayment and returns savings to beneficiaries	Eliminates formula driven overpayment and keeps savings
	Rebase capital rates	No provision	No provision

SECTOR	Republican Conference	Ways & Means Democrats	Coalition
	Saves $15.7	*Saves $1.0*	*Saves $6.5*
Labs/	Seven year freeze	two year freeze	seven year freeze
Durables/	Seven year freeze	two year freeze	seven year freeze
Oxygen	Cuts 20%, to 30% by 2002	No cut	Cuts 10%
Physicians	*Saves $37.5 billion*	*Saves $24.7 billion*	*Saves $25.5 billion*
	Update: $35.42	Update: $34.60, with three separate expenditure targets.	Update: $36.40
	Floor is +3/-7	Floor is +3/-7.5	Floor is +5/-6.25
	Adjustments to updates are GDP +2	Adjustments to updates are GDP +2	Update is at GDP.
	Antitrust provisions	No provisions	No provisions
	CLIA exemption provisions	No provisions	No provisions
	Self-referral provisions	No provisions	Some provisions
Preventive Benefits	Includes coverage of oral anti-cancer drugs	Includes benefits for Colo-rectal screening, diabetes self-testing, etc. beginning in 2001.	Same as WM Dems

SECTOR	Republican Conference	Ways & Means Democrats	Coalition
Provider Networks	National Association of Insurance Commissioners to develop standards within one year; Secretary to review for 90 days and promulgate. Interim rules would be developed by the Secretary. The Secretary establishes solvency standards for PSOs on an expedited basis. Factors to consider are delivery system assets and alternative means of protecting against insolvency. Target date: October, 1996. States develop certification processes; the Secretary certifies.	Includes language to promote state-certified organizations but no statutory change to current law.	Under discussion; current language is a modified version of House Republican proposal. Secretary would develop federal standards; states could choose to certify. State standards not to pre-empt federal standards. Objective is to avoid too-stringent state regulation while ensuring patient protection.

	Republican Conference	Democrats/Ways & Means	Coalition
SNF/Hospice	*Saves $19 billion* *Hospice at MB - 2* Establishes PPS in FY 1997 for SNFs. Payment levels will be 90% of current payment. A new payment method for covered non-routine services is begun in FY 96; SNFs must manage billing. Limits are placed on per stay amounts paid and number of stays. SNF market basked is set at MB - 2	*Saves $11.8 billion* a). Extends SNF cost limits b). Establishes PPS in FY 1997 c). Reforms SNF transfer/gaming	*Saves $9.8 billion* Language was patterned after House Republican with payment levels at 100% of current. Current discussion has focused upon modifying language to address HCFA concerns.
National Average Per-Capita Growth Percentage	*Savings $34 billion (estimate of conference)* 1996- 8% 1997: 3.4% 1998: 4.6% 1999: 4.3% 2000: 3.8% 2001: 5.5% 2002: 5.6%	*No scorable savings* No provision	*Savings $34 billion* 1996: 6.0% 1997: 6.0% 1998: 6.0% 1999: 5.5% 2000: 5.5% 2001: 5.5% 2002: 5.5%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

PHONE: (202)690-8794 FAX: (202)690-6518

Date: _____

From: Jeanne

To: JENNIFER + Pauline

Division: _____

Division: _____

City & State: _____

City & State: _____

Office Number: _____

Office Number: _____

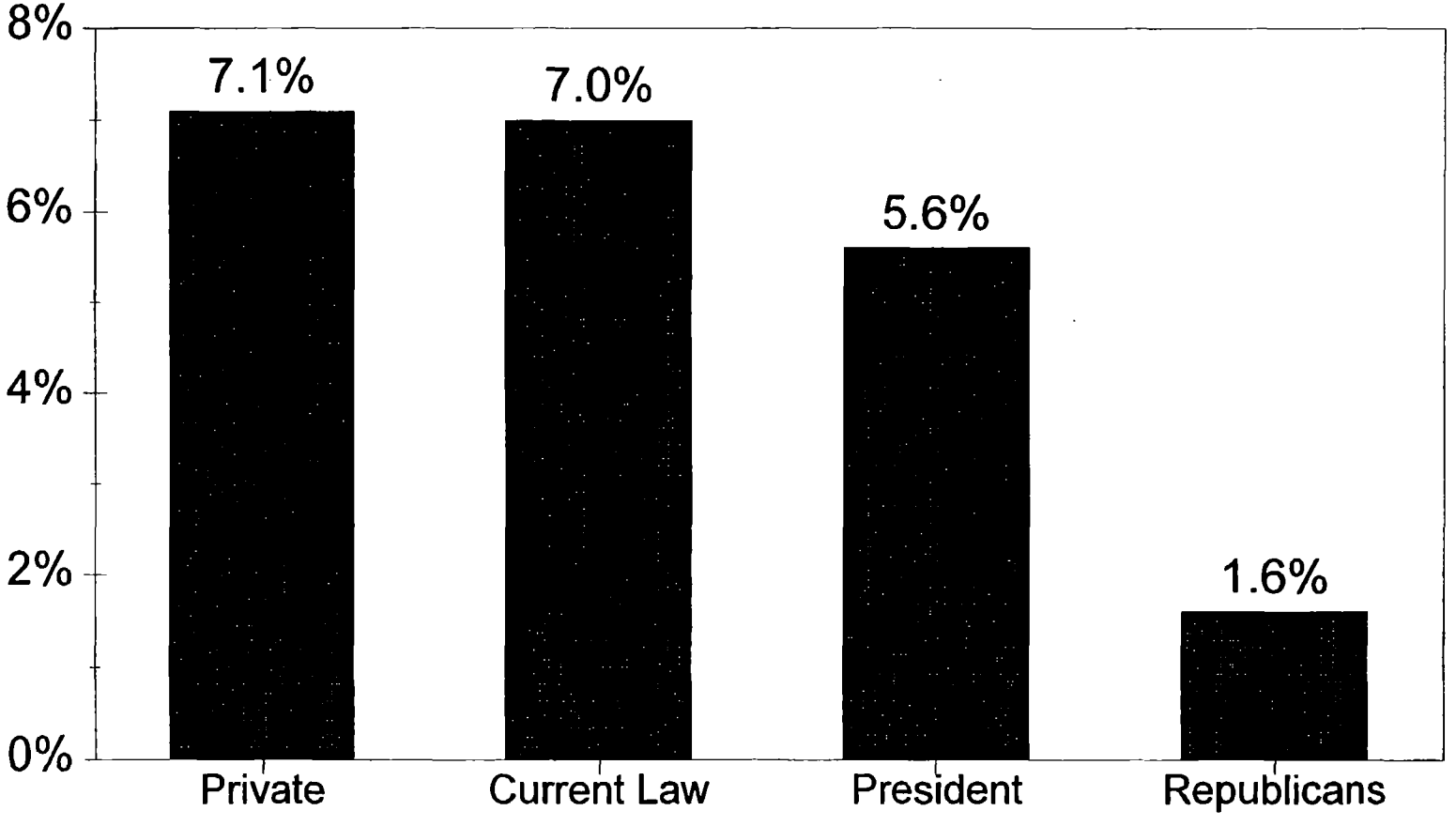
Fax Number: _____

Fax Number: _____

Number of Pages + cover _____

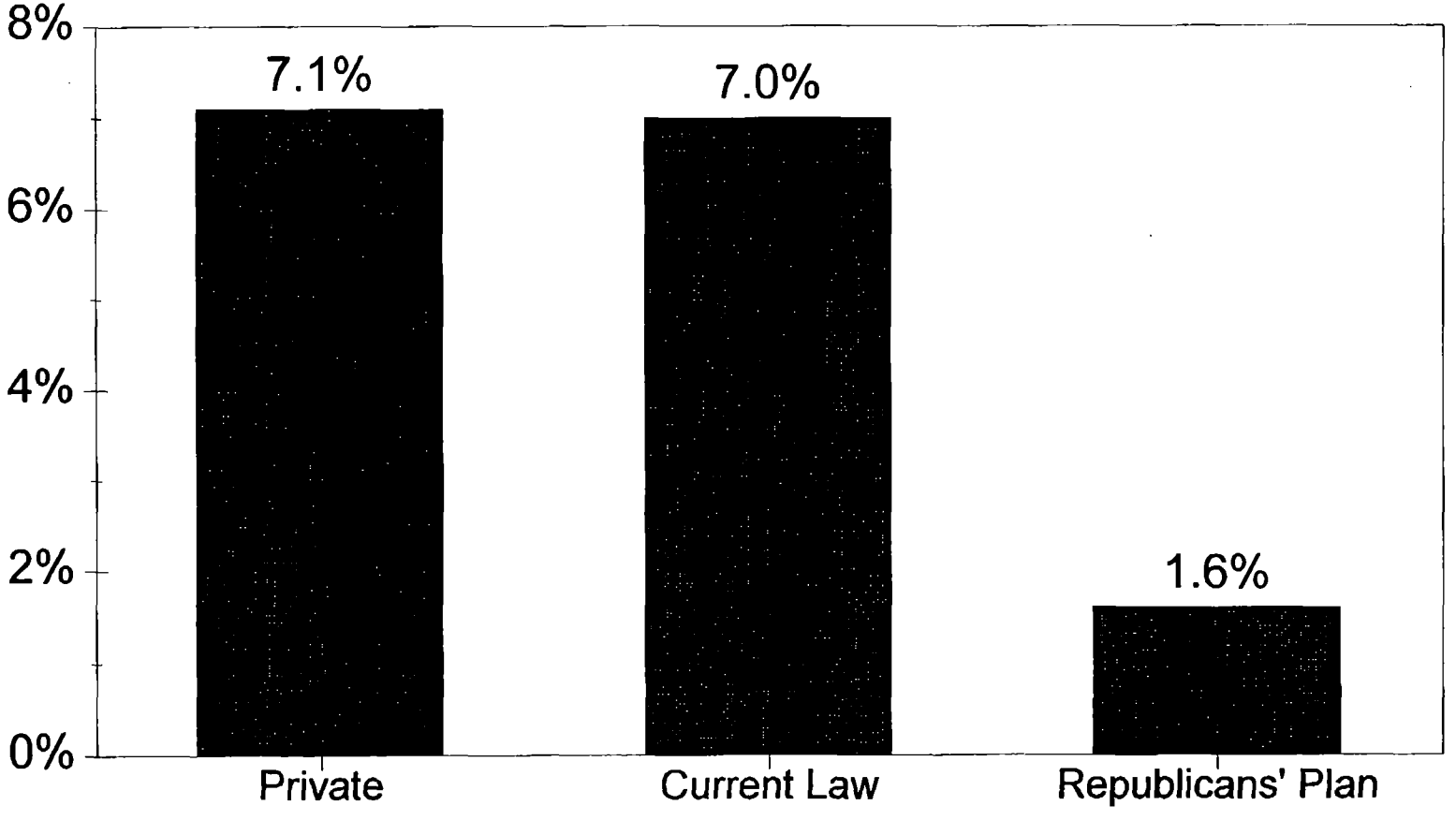
REMARKS: Please hold until we get OMB Clearance
Thanks.

Comparison of Growth in Total Medicaid Spending Per Beneficiary: 1996-2002



CBO February baseline; CBO estimates of savings under the Conference Agreement; Administration estimates of private health spending growth per insured person, using CBO data; DHHS estimates that the President's proposal using CBO baseline. US DHHS

Comparison of Growth in Total Medicaid Spending Per Beneficiary: 1996-2002



CBO baseline; CBO estimates of savings under the Conference Agreement; Administration estimates of private health spending growth per insured person, using CBO data; DHHS estimates that the President's proposal would produce Federal spending growth per beneficiary of approximately 5.6% over the period. US DHHS

Medicaid Per Capita Cap Savings Under the President's Proposal

(Dollars in billions)

	1996	1997	1998	1999	2000	2001	2002	Seven-year Growth
CBO Baseline	99.3	110.0	122.0	134.8	148.1	162.6	177.8	
New Spending	97.7	107.0	116.6	128.1	139.2	149.7	162.0	8.8%
Spending Per Beneficiary	2,546	2,677	2,831	3,021	3,187	3,337	3,527	5.6%
Savings	(1.6)	(3.0)	(5.4)	(6.7)	(8.9)	(12.9)	(15.8)	(54.4)
Beneficiaries (millions)	0.0384	0.0400	0.0412	0.0424	0.0437	0.0449	0.0459	

Savings estimates from HCFA's Office of the Actuary (December 5); savings subtracted from CBO February baseline to yield new spending.

Beneficiaries from CBO's February baseline.

5-Dec

MEMORANDUM

December 8, 1995

TO: Distribution Jen Klein

FR: Chris Jennings

RE: Updated Medicare/Medicaid Information

Attached are the latest materials we have produced on the President's health care initiative. Included you will find:

A Side-by-Side summary Table Comparison of key Medicare/Medicaid issues;

A one-page talking point document on Medicare with accompanying charts;

An analysis of the effect of the President's Medicaid plan on cities; and

An Executive Summary of the President's health care initiative.

We hope this information is useful. Please feel free to call 456-5660 with any questions.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
MEDICARE	• **Size of Cuts.** Cuts Medicare by an unprecedented $270 billion, more than twice the President's cuts, and three times greater than any previous cuts in history. Cuts spending per person more than 20% below the private sector growth rate.	• **Size of Cuts.** Cuts Medicare by $124 billion over the next seven years, less than half of the Republican cuts, while ensuring the fiscal integrity of the Trust Fund through 2011.
	• **Premiums.** Raises premiums to 31.5% of program costs -- hiking premiums by $264 for an elderly couple in 1996 alone.	• **Premiums.** Maintains premiums at the current policy level of 25% of program costs.
	• **Spending Per Person.** Medicare beneficiaries will pay more and get less. In 2002, couples will pay $286 more per year than under the President's budget while spending per couple will be $1,600 less.	• **Spending Per Person.** Spending per person keeps pace with the private sector while adding new preventive benefits, respite care for families of people with Alzheimer's, and annual mammograms.
	• **Traditional Fee-For-Service Plans.** Undermines traditional Medicare by initially cutting spending in the fee-for-service program far more than in the new plan options. Gives doctors additional incentives to leave the program by allowing them to overcharge in the new plan options.	• **Traditional Fee-For-Service Plans.** Protects the traditional fee-for-service program by providing sufficient funds and not allowing doctors to overcharge in the new plan options.
	• **Choice.** Offers new options such Medical Savings Accounts that will undermine the traditional Medicare fee-for-service program by drawing the healthiest beneficiaries away.	• **Choice.** Expands choice without undermining the traditional Medicare fee-for-service program and without forcing any beneficiaries to change their doctor.
	• **Beneficiary Costs.** Allows doctors in the new plan options to overcharge by repealing "Balance Billing" protections.	• **Beneficiary Costs.** Extends current protections against extra charges to the new plan options.
	• **Lock-in.** Generally, locks beneficiaries into new plans for a year -- even if they are dissatisfied and want to change back.	• **Lock-in.** Retains current law and allows beneficiaries to leave a plan at any time.
	• **Fraud and Abuse.** Reduces penalties for defrauding Medicare and puts obstacles in the way of enforcing fraud and abuse laws.	• **Fraud and Abuse.** Provides additional tools and resources to crack down on fraud and abuse in the Medicare program.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
MEDICAID	• **Guarantee.** Replaces Medicaid guarantee with a deeply underfunded "block grant" which will deny meaningful health benefits for older Americans needing nursing home care, pregnant women, individuals with disabilities, and poor children and their families.	• **Guarantee.** Retains Medicaid guarantee of meaningful health benefits for older Americans needing nursing home care, pregnant women, individuals with disabilities, and low-income children and their families.
	• **Coverage.** Could deny coverage for nearly 8 million people in 2002 alone, including: - 3.8 million children - 1.3 million disabled persons - 850,00 elderly - 330,000 nursing home residents - 150,000 veterans	• **Coverage.** Ensures Medicaid health benefits for each of the 36 million people currently receiving coverage.
	• **Size of Cuts.** Cuts $163 billion by limiting annual per capita growth to 1.6% -- 70% less than the private sector (7.1%).	• **Size of Cuts.** Cuts Medicaid $54 billion -- one third as much as Republicans -- while ensuring through a per capita cap that no current Medicaid recipient is denied coverage in the future.
	• **States.** Block grant will leave states vulnerable to economic downturns. Total state and federal Medicaid cuts could more than double if states do not spend more than required to receive their full block grant.	• **States.** Maintains 30-year federal partnership with the states, protecting states during economic downturns and increasing state flexibility.
	• **Nursing Homes.** Denies nursing home coverage for as many as 330,000 persons in 2002 -- 75% of whom are likely to be women. Repeals enforcement measures that protect nursing home residents from abuses and inadequate treatment.	• **Nursing Homes.** Maintains current guarantee of nursing home coverage. Maintains current nursing home protections.
	• **Homes and Family Farms.** Could force the sick to sell their homes and family farms to qualify for Medicaid.	• **Homes and Family Farms.** Maintains law that protects beneficiaries from having to sell their homes and family farms to qualify for the program.
	• **Poor Elderly and Disabled.** Eliminates guarantee that ensures that 5.4 million elderly and disabled people can afford Medicare physician services.	• **Poor Elderly and Disabled.** Retains current guarantee of assistance for poor elderly and disabled Medicare beneficiaries.
	• **Spousal Impoverishment.** Weakens spousal impoverishment protections.	• **Spousal Impoverishment.** Maintains current spousal impoverishment protections.

PRESIDENT'S MEDICARE PROPOSAL

The Medicare savings and structural reforms included in the President's balanced budget proposal have been carefully designed to strengthen the Medicare Trust Fund, expand health plan options for beneficiaries and assure that Medicare benefits continue to be affordable for the 37 million elderly and people with disabilities the program serves.

The Medicare Trust Fund is Strengthened through 2011. The savings and structural changes assure the financial health of the Medicare Trust Fund through 2011 -- placing the Fund in a better position than it has been in 18 out of the last 20 years.

Savings Achieved Without Any New Beneficiary Cost Increases or Arbitrarily Imposed Budget Caps. The Administration's proposal has specific and scorable policy changes that assure program efficiency and produce $124 billion in savings. This is achieved without undermining the structural integrity of the program, imposing new costs on beneficiaries, or arbitrarily capping the program's growth to an index that has nothing to do with health costs.

The Cuts are Significantly Smaller than the Republican Conference Agreement. The Administration proposes smaller cuts for all major categories of the Medicare program (i.e., beneficiaries, hospitals, physicians, home health care providers and nursing homes). The differences in beneficiary and hospital cuts are particularly significant. The Administration has $42 billion less in beneficiary cuts and $44 billion less in hospital cuts than the Republican conference agreement. (See attached charts.)

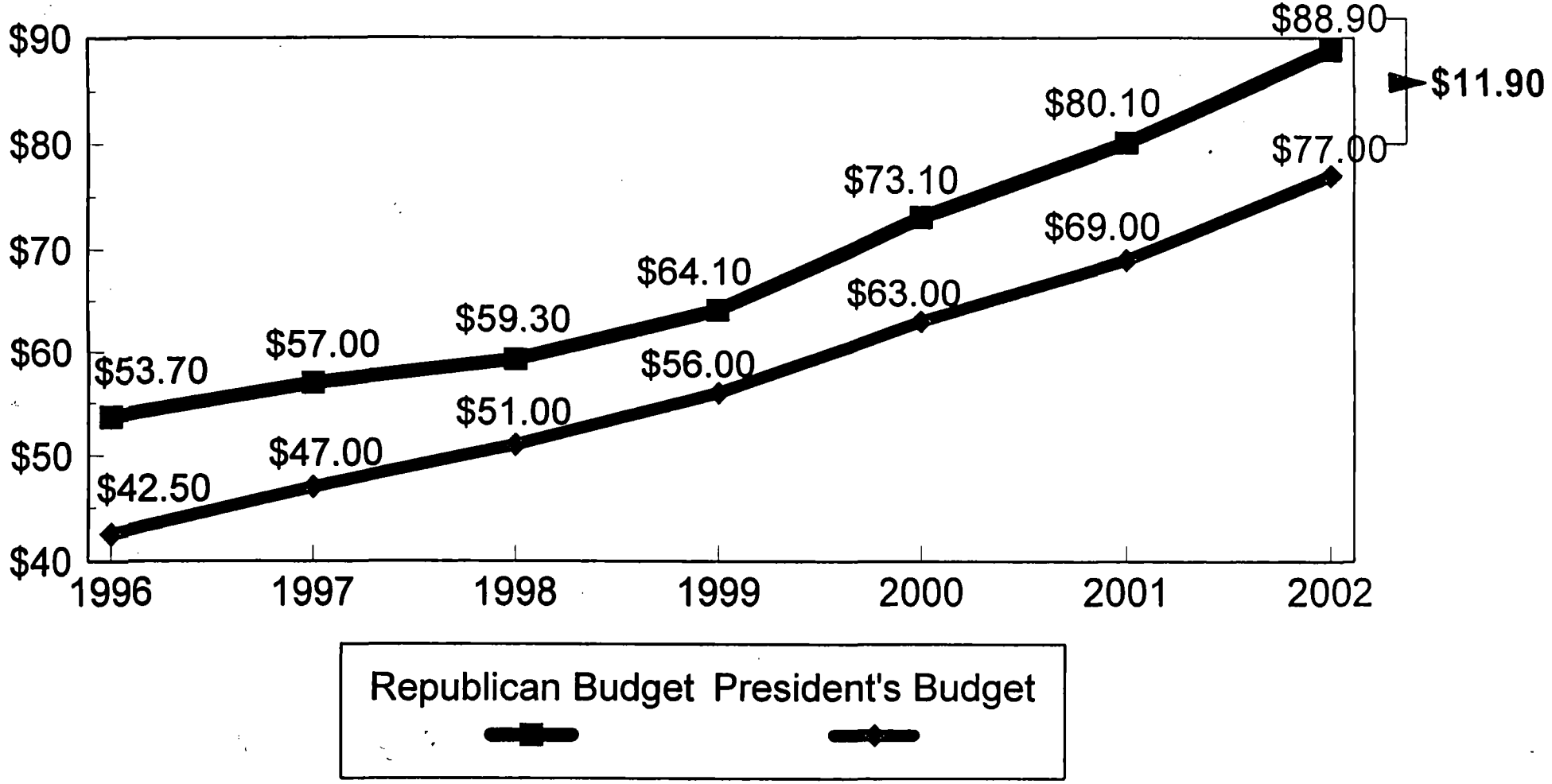
The Reforms Hold the Medicare Per Beneficiary Program Growth Rate to Approximately that of the Private Sector. On a per person level, the President's proposal holds the Medicare program to a growth rate that is slightly lower than the 7.1 percent per person private sector growth rate as estimated by the Congressional Budget Office. In contrast, the Republican Conference Medicare cuts would constrain Medicare growth per beneficiary to over 20 percent below the private sector per person growth rate. (See attached chart.)

Republican Cuts Will Lead to Cost Shifting or Access and Quality Problems. The Administration believes that cuts of the magnitude advocated by the Republicans would result in significant cost-shifting ($84.7 billion according to the bipartisan National Leadership Coalition on Health Care) or reduced quality and access to needed health care providers. This is why the American Hospital Association has stated: "the reductions in the conference report will jeopardize the ability of hospitals and health systems to delivery quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

Choices of Plans are Expanded Under Medicare in a Pragmatic, Responsible Way. The President's plan retains a strong Medicare fee-for-service program and significantly increases choices of alternative health plans, including new managed care options (PPOs and HMOs with point of service options) as well as provider networks. In contrast, the Republican approach -- which includes Medical Savings Accounts and other options that tend to manage risk rather than manage costs -- will fragment the Medicare risk pool.

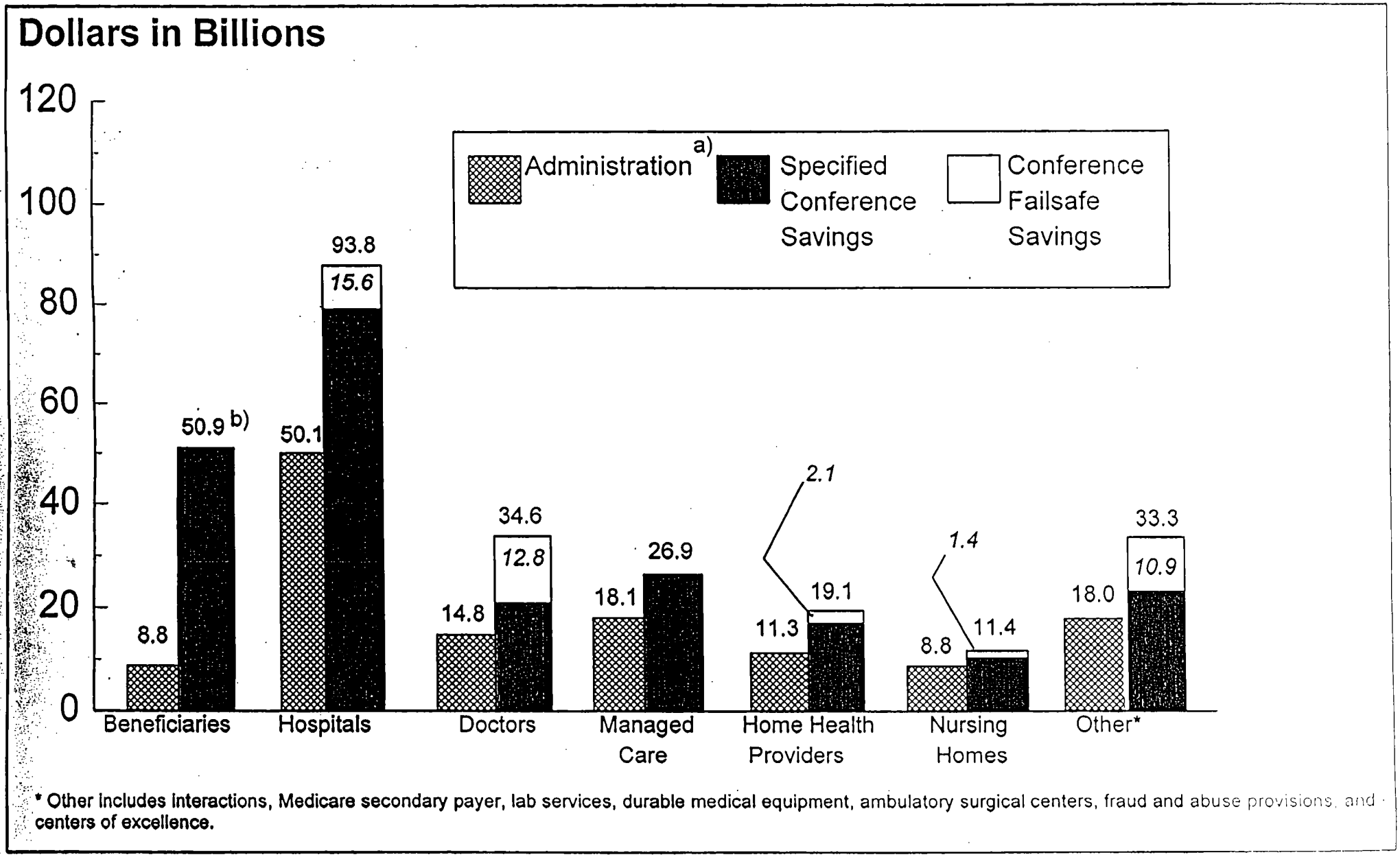
Medicare is Improved by Expanding Preventive Programs, including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

Medicare Monthly Premiums



CBO estimates of Republican premiums, as published in the November 16 letter to Senate Domenici; HCFA's estimates of premiums under the President's proposal. SOURCE: US DHHS.

Administration vs. Republican Conference Agreement Medicare Cuts By Category
(7-yr. OMB and CBO Pricing, respectively)

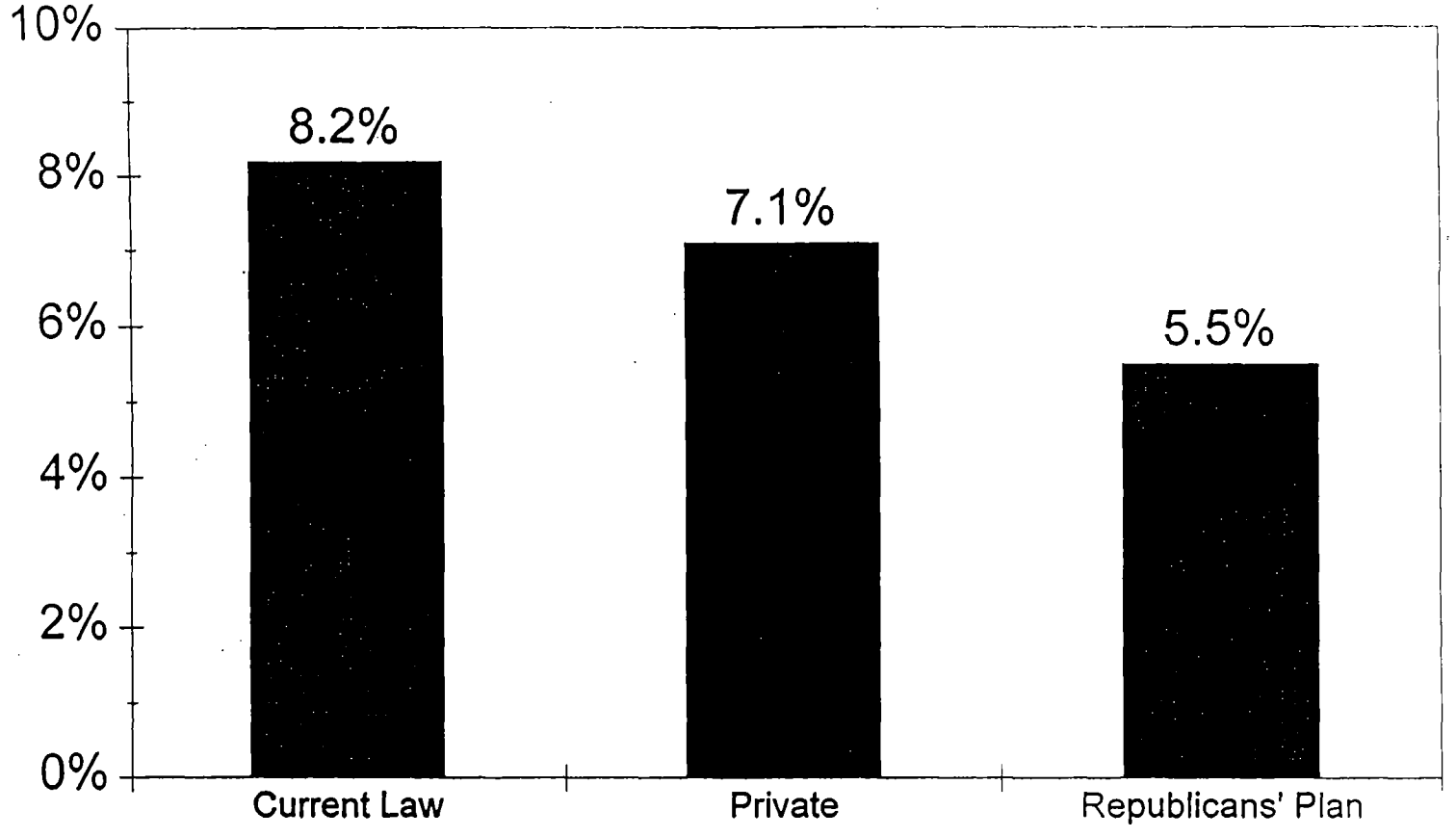


* Other includes interactions, Medicare secondary payer, lab services, durable medical equipment, ambulatory surgical centers, fraud and abuse provisions, and centers of excellence.

a) Administration managed care savings include both direct managed care payment reductions and the indirect effect of fee for service cuts on managed care. All Conference managed care savings are direct because the link between fee for service expenditures and managed care payments is severed. Administration savings do not include $5.3 billion cost of additional preventive benefits

b) The indirect reduction in Part B premiums due to failsafe spending reductions is reflected in the Conference Agreement "Beneficiaries" total.

Comparison of Growth in Total Medicare Spending Per Beneficiary, 1996-2002



CBO baseline as of October 1995; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of beneficiaries. Administration estimates of private health spending per insured person, using CBO data. DHHS estimates of the President's proposed rate of growth in spending per beneficiary: 6.8%. Source: US DHHS

The President's Medicaid Plan: Effect on States

- **Guarantees Coverage:** The President's plan ensures that the low-income elderly, nursing home residents, pregnant women, children, and people with disabilities continue to receive health coverage.

  The Republican plan would end guaranteed coverage for the 36 million Americans currently insured by Medicaid. By 2002, nearly 8 million children, elderly and people with disabilities could be without the health care coverage now provided by Medicaid.

- **Provides for Increased State Flexibility:** States are given significantly greater flexibility in the administration of their Medicaid programs. The President's plan is extremely responsive to the flexibility objectives put forth by the National Governor's Association in January of 1995. The Boren Amendment would be repealed. States would be permitted to establish managed care plans as well as home- and community-based care options without Federal waivers.

  While the Republican block grant would allow states to administer their program without virtually any national minimum standards, it comes at a cost -- a loss of over $100 billion relative to the President's plan over seven years.

- **Controls Medicaid Spending without Putting States at Financial Risk:** The President proposes a "per capita cap". This policy limits spending without ending the Federal commitment to share in the risk of an economic downturn or other unexpected events that increase costs because of additional enrollment. The Federal government will match state spending up to a limit that is adjusted for enrollment. When spending growth per person increases at a rate higher than the proposed index, Federal payments are limited.

  The Republican plan ends the Federal role as a partner in states' health care spending for seniors, children and people with disabilities. States would be 100 percent at risk for unexpected increases in costs associated with recessions or an aging population.

- **Reduces Disproportionate Share Payments but Increases State Control:** The President's plan changes the current Disproportionate Share (DSH) program in two ways. First, Federal DSH payments are gradually reduced and then frozen at their levels in 1998 for subsequent years. Supplemental pools for states with high numbers of undocumented persons and with high levels of uncompensated care and Medicaid shortfalls, along with a transitional funding pool, will ease the impact. Second, states are given more latitude in choosing which providers are eligible for DSH payments, and the Secretary will develop standards for appropriate allocation among providers. States will submit annual reports to the Secretary on who gets the funds, how much the providers receive, and how the funding is easing the problems in their states.

  The Republicans end the DSH program, increasing the already-severe financing problems of inner city, public and rural hospitals which care for uninsured and large numbers of Medicaid patients.

Why States Benefit from the President's Plan:

- **Federal Spending Reductions Are Not Excessive:** The President' s plan reduces Federal Medicaid spending by $54 billion over seven years -- a responsible reduction that can be managed by states.

  The Republicans' plan takes $163 billion in Federal Medicaid funding from the states, leaving them with the same health care problems but less support in addressing them. In fact, the $163 billion cut translates into a per recipient growth rate that is 70 percent below the private sector per person growth rate as estimated by the Congressional Budget Office. Since the cut is too large to be absorbed through efficiency alone, states will be forced to shift the costs onto providers, reduce coverage for their citizens or increase their state spending.

- **All States Fare Better Under the President's Plan than the Republican Plan:** Every single state gets more Federal funding under the President's plan than under the Republican plan. More importantly, Federal spending to states would increase if states were faced with a recession or some other unforeseen event that causes enrollment to increase.

  The Republicans cannot reduce Federal spending by $163 billion without hurting states -- and hurting some states more than others. In fact, while most states get similar percentage reductions under the President's plan, the Republican plan takes up to 45 percent from some states and actually gives money to others.

PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET VS. THE REPUBLICAN 7 YEAR BUDGET

ANALYSIS OF KEY PRIORITIES

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
BALANCING THE BUDGET	• **Method Of Balancing The Budget.** Balances the budget in 7 years with deep cuts in Medicare and Medicaid (4 times greater than any health cuts in history), deep cuts in education, a rollback in environmental protection, and a tax increase on working families.	• **Method of Balancing the Budget.** Balances the budget in 7 years while protecting Medicare, Medicaid, education, and the environment, and targeting tax relief to the middle class -- without any new tax increase on working families. *In each of the priority areas, the President's investments are the same as in his June balanced budget.*

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
MEDICARE	• **Size of Cuts.** Cuts Medicare by an unprecedented $270 billion, more than twice the President's cuts, and three times greater than any previous cuts in history.	• **Size of Cuts.** Cuts Medicare by $124 billion over the next seven years, less than half of the Republican cuts, while ensuring the fiscal integrity of the Trust Fund through 2011.
	• **Premiums.** Raises premiums to 31.5 percent of program costs -- hiking premiums by $264 for an elderly couple in 1996 alone and nearly doubling premiums by 2002.	• **Premiums.** Maintains premiums at the current policy level of 25 percent of program costs.
	• **Traditional Fee-For-Service Plans.** Undermines the traditional fee-for-service program by initially cutting spending in the fee-for-service program far more than in the new plan options, and gives doctors additional incentives to leave the program by allowing them to overcharge in the new plan options.	• **Traditional Fee-For-Service Plans.** Protects the traditional fee-for-service program by providing sufficient funds and not allowing doctors to overcharge in the new plan options.
	• **Choice.** Offers new options such Medical Savings Accounts that will undermine the traditional Medicare fee-for-service program by drawing the healthiest beneficiaries away.	• **Choice.** Expands choice without undermining the traditional Medicare fee-for-service program and without forcing any beneficiaries to change their doctor.
	• **Beneficiary Costs.** Allows doctors in the new plan options to overcharge by repealing "Balance Billing" protections.	• **Beneficiary Costs.** Extends current protections against extra charges to the new plan options.
	• **Lock-in.** Generally, locks beneficiaries into new plans for a year.	• **Lock-in.** Retains current law and allows beneficiaries to leave a plan at any time.
	• **New Benefits.** Increases beneficiary costs while only adding one new benefit.	• **New Benefits.** Adds new preventive benefits, respite care for people with Alzheimer's, annual mammograms, and eliminates cost-sharing for mammograms.
	• **Fraud and Abuse.** Reduces penalties for defrauding Medicare and puts obstacles in the way of enforcing fraud and abuse laws.	• **Fraud and Abuse.** Provides additional tools and resources to crack down on fraud and abuse in the Medicare program.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
MEDICAID	• **Guarantee.** Replaces Medicaid guarantee with an underfunded "block grant" which will deny meaningful health benefits for poor elderly, low-income children and their families, pregnant women, and individuals with disabilities.	• **Guarantee.** Retains Medicaid guarantee of meaningful health benefits for poor elderly, low-income children and their families, pregnant women, and individuals with disabilities.
	• **Coverage.** Could deny coverage for nearly 8 million people by 2002, including 3.8 million children and 1.3 million disabled persons.	• **Coverage.** Ensures Medicaid health benefits for each of the 37 million people currently receiving coverage.
	• **Size of Cuts.** Cuts Medicaid by $163 billion by limiting annual per capita growth to 1.6%, compared to 7.1% for the private sector -- 70% less than the private sector.	• **Size of Cuts.** Cuts Medicaid by $54 billion by capping per capita spending growth.
	• **States.** Block grant will leave states vulnerable to economic downturns. Total state and federal Medicaid cuts could more than double if states do not spend more than required to receive their full block grant.	• **States.** Maintains 30-year federal partnership with the states, protecting states during economic downturns and increasing state flexibility.
	• **Nursing Homes.** Will eliminate the guarantee of nursing home coverage for as many as 300,000 persons. Repeals key enforcement measures that protect nursing home residents from abuses and inadequate treatment.	• **Nursing Homes.** Maintains current guarantee of nursing home coverage. Maintains current nursing home protections.
	• **Spousal Impoverishment.** Weakens spousal impoverishment protections.	• **Spousal Impoverishment.** Maintains current spousal impoverishment protections.
	• **Homes and Family Farms.** Could force the sick to sell their homes and family farms to qualify for Medicaid.	• **Homes and Family Farms.** Maintains law that protects beneficiaries from having to sell their homes to qualify for the program.
	• **Poor Elderly and Disabled.** Eliminates guarantee of assistance for poor Medicare beneficiaries and sets aside less than half of what is needed to cover their premiums in 2002 alone.	• **Poor Elderly and Disabled.** Retains current guarantee of assistance for poor Medicare beneficiaries.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
EDUCATION AND TRAINING	• **Overall Education and Training.** Cuts education and training investments by $31 billion to pay for a huge tax cut for the wealthy.	• **Overall Education and Training.** Builds on our nation's traditional commitment to education by increasing investments in education and training by $40 billion over 7 years to help Americans succeed in the new economy.
	• **Student Loans.** Provides a gift to special interests by dropping Direct Lending student loan opportunities for 2.5 million students in 1,350 colleges and universities in 1996.	• **Student Loans.** Maintains the Direct Lending student loan program, giving colleges the opportunity to choose the loan program that best fits their needs.
	• **Critical Investments.** Cuts would deny opportunities to millions of young Americans. Includes cuts in Head Start, Safe and Drug-Free Schools, basic and advanced skills for needy students, Pell Grant scholarships, and training for dislocated workers. Eliminates Goals 2000 reforms, and the AmeriCorps community service program, summer jobs opportunities for needy youth, and education programs that promote educational equity for women and girls.	• **Critical Investments.** Maintains key educational opportunities for millions of young Americans. Invests in critical programs such as Head Start, Safe and Drug-Free Schools, basic and advanced skills for needy students, Pell Grant scholarships, and training for dislocated workers. Expands Goals 2000 reforms and the AmeriCorps community service program. Maintains summer jobs opportunities for needy youth and education programs that promote educational equity for women and girls.
ENVIRONMENT	• **Enforcement.** Cuts EPA's enforcement budget by 25% from the President's request, increasing health risks from PCBs and other toxins and allowing polluters to violate the law without fear of being caught.	• **Enforcement.** Strengthens enforcement of laws and safeguards for clean air, clean water, and toxic waste.
	• **Clean Water**. Cuts funding that goes to states for clean water (30 percent cut from the President's request for 1996) and safe drinking water (45 percent cut).	• **Clean Water.** Maintains the national commitment to ensuring clean water and safe drinking water funding.
	• **Natural Resources.** Provides natural resource give-aways to special interests, including opening the rare, pristine Arctic National Wildlife Refuge to oil drilling.	• **Natural Resources.** Increases funding for national parks and protects public lands, including the Arctic National Wildlife Refuge.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
TAXES	• **Size of Tax Cut.** Provides $245 billion in tax cuts, targeted at the wealthiest Americans -- a figure that explodes outside the seven year window to $400 billion by 2005.	• **Size of Tax Cut.** Cuts taxes by $98 billion to help middle class families raise their children, pay for an education and save for the future.
	• **Working Families Tax Credit.** Raises taxes on millions of working Americans. Repeal of the Earned Income Tax Credit hits 12.6 million working families (14.5 million children) with an average $332 tax increase in 1996. And 7.7 families who earn under $30,000 a year would face a net tax increase of $318 in 1996.	• **Working Families Tax Credit.** Continues expansion of the Earned Income Tax Credit [EITC] -- providing tax relief for the working poor and incentives for low income families to move from welfare to work.
	• **Distribution.** According to the Treasury Department, families in the lowest 20% of the income distribution as a group (and those with incomes under $30,000, according to the Joint Tax Committee), face a net tax increase. Nearly half of the tax cuts go to the top 12% -- those with incomes above $100,000. The top 1% -- those with incomes over $349,000 -- would receive an $8,500 a year tax cut.	• **Distribution.** No tax increases for working families. 85 percent of the tax cuts go to families with incomes below $100,000.
	• **Pensions.** Permits corporations to raid pension funds, risking pensions for millions of workers.	• **Pensions.** Maintains current laws restricting corporations from raiding their employees' pensions.
	• **Special Interest Loopholes.** Contains dozens of special interest tax breaks costing taxpayers more than $3 billion.	• **Special Interest Loopholes.** No special tax breaks for special interests.
	• **Corporate Taxes.** Allows many profitable corporations to pay no income tax by weakening the corporate alternative minimum tax.	• **Corporate Taxes.** Maintains current laws that ensure that profitable corporations cannot avoid income taxes.

President Clinton's Health Care Initiative

The President's health care initiative will strengthen and protect Medicare and Medicaid, and will increase access to and the affordability of health care. It will:

Preserve our commitment to the elderly, individuals with disabilities, women, children and families as we make Medicare and Medicaid more efficient.

- Improve Medicare by offering new choices of high-quality health plans and delivery systems, and by providing new preventive benefits and a new respite care benefit for families coping with Alzheimer's Disease.

- Assure the financial integrity of the Medicare Hospital Insurance Trust Fund through 2011 without imposing substantial new costs on Medicare beneficiaries.

- Protect the federal guarantee of coverage under Medicaid, while providing new flexibility for states to administer their programs within a targeted growth rate for spending per beneficiary.

- Establish strong new protections against fraud and abuse in the health care system.

- Create a new grant program to states to provide home and community-based care for people with disabilities of all ages.

Increase the availability and affordability of private health care coverage for working Americans.

- Reform the insurance system to ensure that workers don't lose their insurance when they lose a job or change jobs, limit the use of pre-existing condition exclusions, and establish voluntary purchasing cooperatives so that small businesses can obtain more affordable health insurance coverage.

- Provide assistance for workers who are temporarily unemployed and need short-term financial support to help them keep health insurance coverage.

- Make health benefits more affordable for individuals who are self-employed by increasing the tax deductibility of health benefits.

- Simplify the administration of the health system so that fewer dollars are spent on overhead, and health professionals are freed from unnecessary paperwork.

Preserving and Strengthening Medicare

Medicare provides health care benefits to 37 million elderly Americans and individuals with disabilities. The President's plan maintains the 30-year national commitment to this program and makes it more efficient.

The President's balanced budget proposal builds on the 1993 deficit reduction package, which strengthened the Medicare Hospital Insurance (Part A) Trust Fund, with additional Medicare reforms. It includes $124 billion in savings over the next seven years and would assure the fiscal integrity of the Trust Fund through 2011, while imposing no new cost increases on Medicare beneficiaries.

Key elements of the President's Medicare proposal are:

- **Continued Expanded Choice of Plans Under Medicare**: The President's plan would retain a strong, traditional Medicare fee-for-service program while increasing choices of alternative health plans or delivery systems. It would:

  -- Expand beneficiary choice among health plans and delivery system options that guarantee high quality care for reasonable costs, including preferred provider organizations (PPOs), provider networks, and point-of-service HMOs;

  -- Provide beneficiaries with detailed information about the providers and health plan choices available in their area, thereby facilitating the enrollment process;

  -- Improve Medicare's method for paying health plans and delivery systems;

  -- Foster improvement in the quality of care provided by health plans; and

  -- Enhance choice/portability through Medigap reforms.

- **A More Cost-Effective Medicare Program**: The $124 billion in savings included in the President's plan is based on sound, responsible reforms that would make the program more efficient, constraining it to growth rates that are at or just below private sector per person growth rates.

  These changes will protect the Medicare Hospital Insurance Part A Trust Fund and keep the Part B premium at 25 percent of program costs. The plan would:

  -- Significantly moderate the Republican Medicare cuts so that payments to hospitals, physicians, and other providers are reduced while ensuring that high quality health care providers continue to serve Medicare beneficiaries;

  -- Reform Medicare financing for graduate medical education and training provided by the nation's academic health centers and teaching hospitals;

-- Create savings and structured reforms that assure that the Medicare Trust Fund will be sound through 2011 -- a stronger position than it has been in 18 out of the last 20 years.

- **An Improved Medicare Program:** The President's plan improves Medicare program. It would:

-- Invest limited resources to expand preventive benefits;

-- Establish a respite care for families of victims of Alzheimer's Disease;

-- Initiate a new funding pool for medical teaching and research institutions.

Preserving and Strengthening Medicaid

Medicaid provides acute and long-term health care services to 36 million low-income women, children, families, older Americans, and individuals with disabilities. Nearly half of Medicaid beneficiaries are children but approximately two-thirds of Medicaid expenditures are for care for the elderly and individuals with disabilities.

The President's proposal maintains the 30-year collaboration with the states to provide health services to low-income families, children, older Americans, and individuals with disabilities, while making Medicaid more effective and efficient. It would reduce federal Medicaid spending by $54 billion over seven years.

Key elements of the President's Medicaid proposal are:

- **Guarantee of Coverage**: People currently eligible for Medicaid services would retain their Federal guarantee of health care coverage.

- **Cost Effectiveness**: To limit the growth in federal Medicaid expenditures, a per capita limit would be established to constrain the rate of increase in federal matching payments per beneficiary. These limits maintain the federal financial commitment to states in the event of an economic downturn that could require states to add beneficiaries. Federal payments for disproportionate share hospitals would also be tightened and states would have the flexibility to target these payments to a range of essential community providers, including federally qualified health centers and rural health centers. The 15 states with the largest number of undocumented persons would receive special grants, and the 10 states with the institutions that serve disproportionately large numbers of uncompensated care patients would also receive additional funds. Finally, a funding pool would be established to assist states with transition in FY 1996 and FY 1997.

- **Unprecedented State Flexibility**: States would be given much greater flexibility to change how they deliver and pay for services, so that they can reduce costs, not coverage. For example, the Boren Amendment would be repealed. In addition, states would be permitted to require beneficiaries to choose among certain types of managed care plans. States could also provide home and community-based care at their option without a federal waiver.

- **Quality Protection**: Existing federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities would be maintained. Quality standards for managed care systems would be updated and enhanced.

- **Financial Protection**: Protections against impoverishment for spouses of nursing home residents would be retained as would the guarantee that Medicare premiums and cost-sharing be paid for by Medicaid.

Operation Restore Trust: Combating Fraud and Abuse

The Clinton Administration stepped up efforts to combat fraud and abuse with remarkable results. Key to this success has been Operation Restore Trust -- a pilot program launched earlier this year in New York, Florida, Illinois, Texas, and California. The President's plan would take Operation Restore Trust nationwide.

The President's plan would also give law enforcement officials additional authorities and resources to investigate, prosecute, and sanction those who defraud federal health programs; ensure adequate and dependable sources of funds to support program integrity activities; and change reimbursement policies that inadvertently may have contributed to abuse and fraud.

Long-Term Care

Frail elderly Americans and younger persons with disabilities frequently require home and community-based long-term care to assist them in carrying out the routine activities of daily life. The President's plan would improve access to such services in the following ways:

- **Home and Community-Based Care**: A new grant program to states would provide funding for home and community-based care and personal assistance services for individuals of all ages with disabilities.

- **Respite Care**: Family members of persons with Alzheimer's disease would be eligible for up to 32 hours of respite care each year under a new Medicare benefit.

- **Insurance Reforms**: Private long-term care insurance standards would be implemented to ensure that consumers purchasing such policies are protected against substandard policies and unacceptable insurance practices.

Protecting Working Americans

Today, a majority of working Americans receive their health care insurance coverage through their employer, but the security of that coverage often depends on economic conditions and on insurance rules that can exclude coverage for some people. There has been strong, bipartisan support for reform of the group health benefits market to preserve and protect the coverage of working Americans.

The President's plan includes the following insurance reforms and programs to protect workers:

- **Pre-existing Medical Conditions**: Insurers and group health plans would be restricted in how long they could exclude individuals from coverage because of pre-existing medical conditions. Insurers in the small group market would be required to sell coverage to small businesses regardless of the health status of the workers employed by those companies.

- **Portability of Coverage**: Under the President's plan, "job lock" would be eliminated by ensuring that workers who change jobs don't lose their health care coverage.

- **Enhanced Portability Protections for Temporarily Uninsured Workers**: Grants would be made available to the States to provide for a six-month period of private health benefits for laid-off workers who lose their coverage when they lose their job and receive unemployment benefits.

- **Small Business Assistance**: Grants would be provided to states to help them create voluntary small group insurance purchasing cooperatives to encourage competition and affordability in the small group market. Upon request of the state, the Federal Employees Health Benefits Program could require its participating health plans that serve the small group market to make themselves available through purchasing cooperatives established by the state.

- **Tax Deduction for the Self-Employed**: Self-employed individuals, including farmers, would be allowed to deduct 50 percent of the cost of their health insurance premiums from their taxable income.

Administrative Simplification and Security of Health Information

The health care system includes a tremendous amount of red tape and paperwork that often gets in the way of providing care to patients. The President remains committed to reducing these burdens. Standards would be adopted to simplify the use of electronic health information transactions. New federal standards would be developed to assure the security and privacy of individual medical information contained in electronically conducted health care transactions.

HEALTH PROGRAMS SUMMARY

Subtitle A - Medicare Savings

This subtitle enacts $124 billion in Medicare savings during FYs 1996-2002. These program changes will ensure HI trust fund solvency until the middle of FY 2011.

Part I (Provisions Relating to Part A - Hospital) makes a number of changes in Medicare payments to hospitals. For example, it will reduce the hospital market basket update index by one percentage point for FYs 1997-2000 and by 1.5 percentage points for FYs 2001-2002. In addition, Part I: (1) reduces the disproportionate share hospital adjustment by 10 percent; (2) gradually reduces the indirect medical education adjustment to 6 percent by January 1, 2001; (3) reforms the manner in which Medicare payments are made for graduate medical education; (4) makes certain long-term care hospitals subject to Medicare's prospective payment system (PPS); (5) permanently captures the savings from the (a) OBRA 1990 provision for hospital capital payments and (b) OBRA 1993 freeze on updates to the cost limits for skilled nursing facilities; and (6) provides that Medicare pay 85 percent of capital costs for PPS-exempt hospitals and units for FYs 1996-2005.

Part I also establishes (1) a Medicare respite benefit for beneficiaries with Alzheimer's disease or other cognitive impairment, effective through FY 2005, and (2) a Commission on Medical Education and Workforce Priorities to assist in developing policies affecting the Nation's medical education and training, research, and healthcare workforce needs.

Part II (Provisions Relating to Part B - Physician) makes a number of changes affecting Medicare payments for physician services. It replaces the current three "conversion factors" with one, and sets the conversion factor for 1996 at $35.42. It also changes the manner in which the formula used to update physician payments annually is calculated. The most significant change is that annual physician expenditure targets will be based on real GDP per capita plus one percentage point rather than on an historical trend in volume and intensity of physician services. Among other things, Part II also: (1) establishes a single fee for surgery -- regardless of whether the primary surgeon used one or more assistants at surgery; (2) limits payments to groups of physicians practicing in hospitals where the volume and intensity of services per admission exceed certain specified levels, effective on January 1, 1999; and (3) extends the OBRA 1993 practice expense (overhead) payment reduction through CY 1997.

Part II also includes several preventive benefit expansions. It: (1) waives the Medicare copayment and deductible for women seeking preventive mammograms, and establishes coverage of annual

mammograms for all beneficiaries over age 49, effective on January 1, 1997; (2) provides coverage of colorectal screening tests, effective January 1, 1996; and (3) provides increased payments for providers of flu shots and elimination of coinsurance and deductible for hepatitis B vaccination.

Part III (Provisions Relating to Parts A and B) expands the "Centers of Excellence" demonstration to all urban areas by allowing Medicare to pay select facilities a single rate for all services associated with cataract, coronary artery by-pass surgery, and other services as the Secretary of Health and Human Services determines appropriate. Part III also maintains the savings from the OBRA 1993 freeze on updates to the cost limits for home health services and establishes a prospective payment system for home health services. In addition, Part III establishes a post-hospitalization home health benefit under Part A and transfers all other home health services to Part B.

Part IV (Medicare Part B Premium) permanently sets the Part B premium at 25 percent of program costs.

Subtitle B - Expanded Medicare Choice

This subtitle expands access to managed care plans and encourages new provider groups to participate in the Medicare program. In particular, the subtitle: (1) reforms current risk contract eligibility rules to encourage Preferred Provider Organizations (PPOs) and provider-sponsored organizations to participate in the Medicare program; (2) revises certain requirements to allow HMOs to more easily expand Medicare enrollment in rural areas and in States with growing Medicaid managed care enrollment; and (3) requires Medigap insurers to offer policies to beneficiaries annually, ensuring that those who opt for Medicare managed care still have the option to move back to fee-for-service without the loss of wrap-around insurance.

This subtitle also protects beneficiaries in managed care plans by (1) allowing the Health Care Financing Administration (HCFA) to terminate more swiftly contracts with HMOs that fail to comply with HCFA standards and (2) limiting the amount that managed care enrollees can be charged when obtaining out-of-plan services. Moreover, this subtitle makes a number of changes designed to improve Medicare managed care payment policies, including a Competitive Bidding Demonstration to test a market-based alternative payment methodology.

Subtitle C - Medicaid

Subtitle D - Fraud and Abuse

This subtitle contains a number of initiatives designed to combat fraud and abuse in the Medicare program.

Part I makes a number of changes to statutory authorities currently available to combat fraud and abuse. Among other things, Part I: (1) authorizes administrative sanctions, i.e., civil monetary penalties, assessments, and program exclusions, where fraud or abuse is identified in other Federal health care programs; and (2) extends the current anti-kickback statute from Medicare and State health care programs to all Federal health care plans and to the private sector. It also creates a national data base containing information on (1) individuals convicted of health care fraud; (2) individuals against whom a health care related civil judgment has been rendered; (3) individuals excluded from Medicare; and (4) providers, suppliers, and practitioners whose licenses have been revoked.

Part II establishes the Medicare Trust Fund as a source of funds for all Medicare anti-fraud and abuse activities conducted by the HHS Inspector General. Part II also includes the Medicare Benefit Integrity System (MBIS). The MBIS provides a source of funding for Medicare payment safeguard activities by supporting them as a mandatory program under the trust funds. MBIS will allow the Department of Health and Human Services to pursue strategies designed to ensure that more health insurance claims are paid correctly the first time. In addition, Part II creates a $10 million per year Government-wide, anti-fraud reinvestment fund into which recoveries from those who defraud Federal and joint Federal/State government health care programs will be deposited. All Federal government agencies could use this account to fund their health care anti-fraud activities.

Part III makes a number of changes to the criminal statutes affecting health care fraud. The most significant changes; (1) increase criminal penalties for health care fraud violations; (2) require courts to order persons convicted of a Federal health care offense to forfeit property that is derived from the offense; (3) permit disclosure of certain grand jury information for use in health care fraud investigations; and (4) grant the Attorney General increased subpoena authority regarding health care records.

Part IV makes changes to various aspects of the Medicare program. For example, Part IV: (1) clarifies time and filing limitations, liability, and payments amounts to Medicare by an individual's primary plan; (2) permits Medicare to contract competitively with any entity (not just insurance companies) to perform the administrative functions of the Medicare program, including fraud and abuse prevention activities; and

(3) establishes fee schedules for those Part B services now paid based on reasonable charges (such as ambulance and oxygen).

Subtitle E - Long-Term Care

This subtitle establishes a new program of grants to States to expand home and community-based care for the aged and disabled. It will authorize appropriations of $1.5 billion for each of FYs 1997-2006 to carry out this new program.

Grants will be used for such activities as (1) expanding the availability of personal assistance and attendant services; (2) developing and implementing new service delivery approaches including managed care, methods of integrating acute and long-term care, and new consumer directed service models; (3) providing new forms of residential services, such as assisted living; and (4) providing mechanisms that enable individuals receiving services under the program, or their personal representatives, to choose the persons providing their personal care and assistance.

Subtitle F - Health Insurance Reform

This subtitle includes a number of health insurance reforms designed to make health care coverage more accessible, portable, and affordable.

Part I affects the group market which includes self-employed individuals. It limits pre-existing condition exclusions to 12 months and stipulates that exclusions can only be imposed for conditions diagnosed or treated within six months of health plan enrollment. Part I also (1) prohibits health plans from imposing new pre-existing condition exclusions for new enrollees; (2) requires insurers to make coverage available to all eligible groups, regardless of the health status of any of the group's members; and (3) requires insurers to renew coverage to employer groups regardless of any group member's health status.

Part I also affects insurers in the individual market by requiring them to offer coverage to persons who (1) were insured over the previous 12 months; (2) lost previous coverage under certain circumstances (e.g., loss of employment, divorce, change of residence); and (3) apply for individual coverage within 60 days of losing their previous coverage.

Part II authorizes the States to enforce the requirements of this subtitle affecting insurance carriers. Requirements affecting self-insured plans will be enforced by the Secretary of Labor; plans that fail to comply will be subject to civil penalties under the Employee Retirement Income Security Act (ERISA).

Part III authorizes the Secretary of Health and Human Services to establish a new grant program designed to facilitate the development and creation of purchasing cooperatives. Part III authorizes annual appropriations of $25 million for FYs 1997-2001 to carry out the new program.

Part IV gradually increases the tax deduction for self-employed individuals from 30 percent to 50 percent by the year 2000. The tax deduction will increase to 35 percent for CYs 1996-1997; to 40 percent for CY 1998; to 45 percent for CY 1999; and to 50 percent for CY 2000 and each year thereafter.

Subtitle G - Health Care for the Temporarily Unemployed

This subtitle establishes a new capped entitlement program of health insurance for the temporarily unemployed. Grants will be made to States to finance up to six months of coverage for certain unemployed workers and their families. The new program will be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have incomes below certain thresholds.

Participating States will receive grants annually to carry out the new program. Under certain circumstances, the Department of Health and Human Services will operate the program in States that choose not to participate. The initial allocation to States will be based on their respective unemployment rates. The formula for subsequent allocations will be revised based on additional data. States will have substantial flexibility in administering the new program, including the option of extending eligibility periods or providing a more generous package using State funds.

Subtitle H - Administrative Simplification

This subtitle requires the Secretary of Health and Human Services to adopt standards and data elements for electronic health information transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. The Secretary is required to consult with affected parties prior to adoption of standards. Where feasible, the standards will come from those already approved by private standards developing organizations or standards in common use. The Secretary is also required to establish standards for the security and privacy of electronic transmission and storage of health information. Health plans will be required to use the approved standards if requested to do so by another party, such as a provider, an employer, or another plan. Health plans can meet this requirement either directly or through a "health information network service" -- an entity that processes nonstandard data elements of health information into standard data elements.