MARKERS FOR THE BUDGET NEGOTIATIONS ON MEDICAID

The President's Medicaid/budget proposal assumes a saving of $54 billion during the next seven fiscal years (predicated on the OMB baseline) while the Congressional proposals assume a reduction of $182 billion (predicated on the CBO baseline). As significant as these differences are, they are no more important than the structural changes envisioned by the competing proposals.

The most crucial structural issue is the retention of the guarantee (in Beltway parlance, the "entitlement") to specific groups of vulnerable people and families that they will receive Medicaid coverage. Current law, and the President's proposed revision, provide guarantees of Medicaid coverage directly to people while the Congressional proposals merely provide guarantees of a specific amount of money to the states. The loss of this Medicaid coverage guarantee will jeopardize coverage for millions of children, seniors and people with disabilities; will result in growing numbers of uninsured people, especially as employer-provided coverage continues to decline and when economic downturns occur; and, as experienced with previous block grant programs, will inevitably erode public support for the underlying programmatic purpose (here, the provision of health care coverage) as federal funding becomes more attenuated from specific, discernable public benefits.

The other important structural issues, especially those that breathe life into the coverage guarantee, include:

- **Scope of Coverage Guarantee:** Specific vulnerable groups are explicitly included in the coverage guarantee under existing law and need to be similarly protected in the revised program. These groups are pregnant mothers and children (to 133 percent of poverty for pregnant mothers and children up to age six; and to 100 percent of poverty for children between six and 12 years of age, with the same standard phased in for children through 18 years of age), as well as specific groups of parents of dependent children, seniors and people with disabilities. States should also have optional authority to include coverage for other people without private insurance.

- **Covered Benefits:** A coverage guarantee is meaningless unless it is linked with a clear description of needed benefits included in such coverage. (As Senator Chafee observed -- after his amendment to include children in the coverage guarantee succeeded but his amendment to specify covered benefits failed -- a state could decide that a covered group's benefits "will be one aspirin a year.") To achieve such needed protection, either current law must be retained with its list of mandatory and optional benefits, or a more generic standard must be established (such as covered benefits must be commensurate with benefits provided to that state's public employees).

- **Out-of-Pocket Costs:** For low-income beneficiaries of the Medicaid program, anything beyond nominal out-of-pocket costs (including premiums, deductibles and copayments) is unaffordable and would preclude their ability to get the health care they need. As with current law, there needs to be a prohibition against the imposition of anything beyond

OK to give discretion to states to charge for ones above poverty line.

nominal out-of-pocket costs as well as a prohibition against balanced billing.

- **Quality Standards:** Since the Medicaid program's delivery system is moving rapidly towards managed care and will undoubtedly continue to do so, national quality care standards must be implemented. Those standards should include, but not be limited to, standards on solvency, accessibility, services, marketing, appeals, choice of plans, data collection and ombudsman assistance.

- **Enforcement of Enumerated Rights**: The rights to guaranteed, meaningful coverage will be ineffective without a realistic enforcement mechanism. A private right of action, therefore, needs to be retained.

- **Long-Term Care:** A number of current program features need to be retained: (1) the right to nursing home coverage after income and resources have been spent down; (2) protection against spousal impoverishment; (3) protection against recovering the costs of long-term care from adult children; (4) national quality care nursing home standards; (5) mandatory coverage of home health care; and (6) state options to offer personal care and home and community-based coverage as an alternative to nursing home care.

- **Medicare-Related Cost-Sharing Protections for Low-Income Seniors:** Current law protects low-income seniors from unaffordable and fast-rising cost-sharing requirements (premiums, deductibles and copayments) of the Medicare program. (Medicaid now covers Medicare's premiums, deductibles and copayments for seniors under the poverty line and the premiums for seniors up to 120 percent of poverty.) Low-income seniors would lose their ability to access the Medicare program if these protections are eliminated, especially as Medicare premiums are scheduled to escalate in the future. Since governors have a legitimate concern about picking up these Medicare-related costs, it would be far preferable to transfer this guaranteed protection from the Medicaid program to the Medicare program -- and reductions in the Medicare cutback numbers should include this transfer of responsibility.

- **State Contributions:** Currently, in order to draw down federal Medicaid dollars, states must contribute 17 to 50 percent of program costs. Also, some restrictions on what constitutes the state share apply. For example, restrictions on voluntary contributions were enacted in response to abuses by the states. As with current law, the restrictions should remain in place and states should match federal funds at a rate no lower than their current match rate. Failure to establish such rules would result in far greater Medicaid cutbacks than the dollars cut from current federal commitments.

MEMORANDUM

November 21, 1995

TO: Distribution

FR: Chris Jennings

RE: Democratic Coalition Proposal

Attached is an analysis of the Democratic Coalition's balanced budget proposal comparing it with the Republican proposal and the House Democratic proposal. Congressman L.F. Payne sent it over to me for our review.

SOURCES OF SAVINGS BY SECTOR/MEDICARE[1]

Group	Republican w/ Fail Safe[2]	House Democrats	Coalition
Hospitals Total	$95.4	$57.3	$65.2
All hospitals	$86.4	$49.6	$60.6
Teaching Hospitals	$ 9.0	$ 7.7	$ 4.6
Skilled Nursing	$ 13.0	$6.1	$6.9
Doctors	$ 31.6	$25.2	$25.2
Home Health	$ 21.0	$7.7	$9.0
Providers, other (Labs, durables)	$ 17.2	$2.6	$6.5
Total Provider	$178.2	$98.9	$112.8
Beneficiaries	$57.3	(COSTS $21.0[3])	$26.3
Managed Care	$28.9	$-0-	$34.0
Other Savings (Fraud, Secondary Payor etc).	$10.5	$7.9	$18.4
COSTS (preventive benefits medical ed. trust fund etc).	$2.4	$8.3	$20.1
TOTAL SAVINGS after costs/interactions	$270.0	$89.5	$168.0

[1]Due to rounding and interactions, numbers do not add up to 100%

[2]Estimates, based upon CBO score of $36.6 billion failsafe in Conference agreement.

[3] $15.9 billion in Formula Driven Overpayment cuts returned to beneficiaries and $5.1 billion from premiums lower than current law. CBO did not subtract the $15.9 FDO provision from its calculations of total savings.

McKinnon/ DRAFT 11.19.95

MEDICARE COMPARISON			
	Republican	**House Democrat**	**Coalition**
BENEFICIARIES	***TOTAL:$57.3 billion***	***TOTAL: COST of $21 billion***	***TOTAL:$26.3 billion***
Part B Premium	Saves $48.8 billion at 31.5%.	COSTS $5.1 billion	Saves $ 7.5 billion by freezing premium at $46.10 in 1996 and keeping at 25% until 2002.
Means Testing	Saves $8.5 billion by means testing at $60,000 (ind) and $90,000 (couple)	No provision	Saves $18.8 billion by means testing at 50,000 (ind) and 75,000 (couple)
Coinsurance	No provision	COSTS $15.9 billion: Hospital Formula Driven Overpayment savings are given to beneficiaries in the form of lowered coinsurance rates.	No provision
Growth Rate/Per Capita/ Managed Care *(CBO also considers Provider Service Network language as a factor in scoring)*	***TOTAL: $28.9 billion***[1] Per-capita growth: 1996- 8% 1997- 3.4% 1998- 4.6% 1999- 4.3% 2000- 3.8% 2001- 5.5% 2002- 5.6%	*No savings*	***TOTAL: $34 billion*** Per-capita growth: 1996- 6.0% 1997- 6.0% 1998- 6.0% 1999- 5.5% 2000- 5.5% 2001- 5.5% 2002- 5.5%

[1]**Original House-Senate savings were about $32 billion - CBO's score of the Conference Agreement includes losses due to Medical Savings Account provisions under this estimate. Thus MSAs likely cost the Republicans about $3 billion.**

1. McKinnon/ DRAFT/ 11.19.95

MEDICARE COMPARISON			
	Republican	**House Democrats**	**Coalition**
HOME HEATH	***TOTAL: $21.0 b***	***TOTAL: $7.7 b***	***TOTAL: $9 b***
Transfer coverage	no provision	Revenue neutral - transfers to Part B after 120 days	Revenue neutral - transfers to Part B after 150 days
PPS for Home Health	Saves $17.0 billion	Saves $7.7 billion	Saves $9 billion
Fail Safe	Saves $4 billion (preliminary estimate, pending CBO score)	No provision	No provision

2. McKinnon/ **DRAFT**/ **11.19.95**

MEDICARE COMPARISON			
	Republican	House Democrat	Coalition
HOSPITALS **Part A**	*TOTAL PARTS A & B: $86.4 b*	*TOTAL PARTS A & B: $49.6 b*	*TOTAL PARTS A & B: $60.6 b*
Market Basket Update/ PPS	Saves $29.1 billion with updates of -2.5 in 1996 and -2.0 until 2002.	Saves $14.4 billion with updates of MB - 1.0 until 2002.	Saves $26.5 billion/ one-year freeze and MB -1.5 (urban) and MB-.5(rural).
Market Basket Update/non-PPS	Saves $2.0 billion/ updates same as PPS	Saves $500 million/ updates same as PPS	Saves $1.2 billion from one year freeze/ updates same as PPS
Rehab. & long-term care hospitals	Saves $2.7 billion/ update reductions	No provision	No provision
Capital Payments-PPS	Saves $9 billion, reduces by 15%	Saves $6.9 billion, reduces by 10%	Saves $6.3 billion, reduces by 10%
Capital Payments, non-PPS	Saves $900 million, reduces by 10%	Saves $1.5 billion, reduces by 10%	Saves $1.4 billion, reduces by 10%.
Rebase Capital Payments, PPS	Saves $2.7 billion	No provision	No provision
Disproportionate Share Payments	Saves $5.4 billion by reducing by 30% over seven years.	Saves $4.1 billion from eliminating DSH/IME outlier payments.	No provision
Hospital Bad Debt Payments	Saves $1.1 billion by cutting payments 50% by 2002	No provision	No provision
Moratorium of PPS exemption for long-term care hospitals.	No provision	No provision	Saves $1.4 billion
Clarify transfers for Long term care	No provision	Saves $5.7 billion	Saves $5.7 billion

MEDICARE COMPARISON			
	Republican	**House Democrat**	**Coalition**
HOSPITALS, PART B			
Formula Driven Overpayment	Saves $15.9 billion by eliminating	Eliminates; $15.9 billion in savings returned to beneficiaries.	Saves $15.9 billion by eliminating
Outpatient Capital reduction/	Saves $600 million by extending	Saves $600 million by extending	No provision
Extend Outpatient Payment reduction	Saves $1.4 billion	no provision	no provision
PPS for Outpatient Services	No provision	No provision	Saves $2.2 billion
PARTS A & B	Saves about $15.6 billion (pending CBO final estimate).	No provision	No provision
Fail Safe			

MEDICARE COMPARISON			
	Republicans	**House Democrats**	**Coalition**
Teaching Hospitals	***TOTAL: $9.0 b***	***TOTAL: $7.7 b***	***TOTAL: $4.6 b***
Indirect Medical Education	Saves $7.6 billion from cutting IME from 6.7% in 96 to 5% in 2002.	Saves $1.2 billion from IME resident freeze	Saves $4.6 billion from cutting IME to 6.8% thru 98 and 6.0% thru 2002.
Direct Graduate Medical Education	Saves $1.4 billion from reducing GME payments.	Saves $3.1 billion for 50% weight for post-initial residency. Saves $1.4 billion for other GME reforms.	No provision
	Trust fund created by appropriation. Cost of appropriation NOT included in CBO score.	Saves $2 billion from keeping 25% of amount removed from AAPCC and not placed in trust fund.	All savings from removing from AAPCC placed in trust fund.
Graduate Medical Education 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 COST[2]: $12.5 billion***	Expenditures from removing from AAPCC/75% 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 COST: $6.2 billion***	Expenditures 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 COST: $11.8 billion***

[2]COST NOT INCLUDED BY CBO IN ITS ESTIMATE.

MEDICARE COMPARISON			
	Republican	**House Democrats**	**Coalition**
PHYSICIANS	***TOTAL: $31.6 b***	***TOTAL: $25.2 b***	***TOTAL: $25.2 b***
Update	Update: $35.42	Update: $34.60	Update: $36.40
MEI Floor/Ceiling	Floor is +3/-7	Floor is +3/-7.5	Floor is +3/-8.25
Adjustments	Adjustments to updates are GDP +2	Adjustments to updates are GDP +2	Update is at GDP.
Antitrust	Has provisions	No provisions	No provisions
Self referral	Has provisions	No provisions	No provisions
Shared Facilities	Has provisions	Has provisions	Has provisions
Fail Safe	Saves $9 billion (estimate, pending CBO score of total)	No provisions	No provisions

MEDICARE COMPARISON			
	Republican	House Democrats	Coalition
PROVIDERS/ OTHER	*TOTAL: $17.2 b*	*TOTAL: $2.6 b*	*TOTAL: $6.5 b*
Ambulances	Saves $800 million from 7 year freeze	No provision	No provision
Ambulatory Surgery Centers	Saves $1.3 billion from 7 year freeze	No provision	No provision
Durable Medical Equipment	Saves $ 4.1 billion from 7 year freeze	Saves $1 billion from two year freeze	Saves $3.1 billion from 7 year freeze
Labs	Saves $6 billion from seven year freeze	Saves $1.6 billion from two year freeze	Saves $3.4 billion from 7 year freeze
Oxygen	Cuts 20%, to 30% by 2002 (savings included in DME).		Cuts 10% for 1996 (savings included in Durable)
Fail Safe	Saves $5 billion (pending CBO estimate).		
SKILLED NURSING FACILITIES	*TOTAL: $13 billion*	*TOTAL: $6.1 billion*	*TOTAL: $6.9 billion*
Implement PPS	$10.0 billion	$6.1billion	$6.9 billion
Fail Safe	Saves $3.0 billion (estimate, pending CBO score)	No provision	No provision

MEDICARE COMPARISON			
	Republicans	House Democrats	Coalition
OTHER SAVINGS	***TOTAL: $10.5 b***	***TOTAL: $7.9 b***	***TOTAL: $18.4 b***
Fraud & Abuse	Saves $3.5 billion	Saves $2.0 billion	Saves $2.4 billion
Medicare Secondary Payor	Saves $6.5 billion	Saves $5.9 billion	Saves $6.2 billion
Extend Hospital Insurance to State/Local workers	No provision	No provision	Saves $9.8 billion
Hospice	Saves $500 million by reducing payment	No provision	No provision

MEDICARE COMPARISON			
	Republican	House Democrats	Coalition
OTHER COSTS	**TOTAL COST: $2.4 b**	**TOTAL COST:$8.3 b**	**TOTAL COST: $20.1 b**
Preventive Benefits	Costs $100 million to cover oral cancer drugs in 1996 only.	Costs $2.1 billion to expand coverage for mammography in FY 2001 and 2002 and, colo rectal screening, pap smear, diabetes for all 7 years.	Costs $2.1 billion to expand coverage for mammogram, prostate cancer, colo rectal cancer, pap smears and diabetes.
Rural Health	Costs $700 million to continue rural health initiatives	no provision	Costs $1.4 billion to continue rural health initiatives
Investigative Devices	no provision	no provision	costs $200 million
Direct Payment to PAs and Nurse Practitioners	Costs $800 million	no provision	Included in rural health savings
Preferential update/Medicare dependent hospitals	Costs $800 million	no provision	no provision
Payments for military retirees	no provision	no provision	costs $4.6 billion
GME Trust Fund	Appropriation- cost not included in CBO score	costs $6.2 billion	costs $11.8 billion
Lower Part B Premium	no provision	costs $5.1 billion (cost included on p.1)	No provision

CBO SCORE - REPUBLICAN CONFERENCE/MEDICARE

Premium Cost Year	1996 Month/Year	1997 Month/Year	1998 Month/Year	1999 Month/Year	2000 Month/Year	2001 Month/Year	2002 Month/Year	7 Year Cost	Cost over Current Law
Current law	$42.50/$510	$46.20/$554	$53.20/$638	$55.00/$660	$56.80/$681	$58.60/$703	$60.50/$726	$4,472	$-0-
Coalition	$46.10/$553	$46.00/$552	$49.50/$594	$53.80/$645	$60.50/$726	$66.10/$793	$73.10/$877	$4,740	$268
Republican	$53.70/$644	$57.00/$684	$59.30/$711	$64.10/$769	$73.10/$877	$80.10/$961	$88.90/$1,066	$5,712	$1,240

:	0.0	0.0	-6.2	-10.8	-7.1	-7.0	-6.6	TOTAL: $36.6 billion

DEPARTMENT of HEALTH & HUMAN SERVICES

ASSISTANT SECRETARY for PLANNING & EVALUATION

OFFICE of HUMAN SERVICES POLICY

Phone: 202-690-7409 FAX: 202-690-6562

From: Emil Parker

Division: ASPE

City & State:

Office Number: 690-1808

Fax Number: 690-6562

To: Jennifer Klein

Division: Office of the First Lady/ DPC

City & State:

Office Number:

Fax Number: 456-2878

Number of Pages: 4

Remarks:

TO: Jennifer
FROM: Emil EP
RE: Cost shifting fact sheet and other
DATE: November 14, 1995

Thank you for your comments on the cost shifting piece. Attached is a draft that attempts to incorporate your suggestions.

Also, thanks for the update on the logistical situation. If there's anything I can do, e.g., following up with people in White House administration, please let me know.

I'm out of here in a few minutes, but you can reach me at home (202-547-4918) at any time. I hope to talk to you soon.

REPUBLICAN REDUCTIONS IN MEDICARE AND MEDICAID WILL SHIFT COSTS TO PRIVATE PATIENTS

November 14, 1995

Republican cuts in Medicare and Medicaid would force hospitals and physicians to charge privately insured patients $90 billion more. Employees would absorb $72 billion of that shift in higher premiums and lost wages.

- A study by Lewin-VHI, a nonpartisan health care research firm, estimates that if Medicare and Medicaid are cut by $450 billion--as called for in the Republican budget resolution--employers, employees and the self-insured would see their health care bills rise by $92 billion.

When Medicare and Medicaid payments are not sufficient to cover the cost of services to beneficiaries, hospitals and other health care providers raise prices for private sector patients. The Lewin study, cited in both *The New York Times* and *The Washington Post*, found that as a result of Medicare and Medicaid cuts, employer spending on health insurance would rise by $75 billion over the period from 1996 through 2002, while employee contributions for employer-provided coverage would increase by $6.4 billion and the self-insured would pay an additional $10.2 billion. According to the study, however, employers would pass on almost all of their increased health care costs--$66 billion of the $75 billion--to workers in the form of lower wages.

- The Medicare and Medicaid reductions would consequently cost employees a total of $72 billion in lost wages and increased premiums--almost $1,000 per worker over the period.

The costs would be shifted primarily to middle-income workers.

According to the Lewin study, much of the cost shift would fall on middle-income workers, who are more likely than low-wage workers to have employer-provided health insurance. Families with annual incomes between $20,000 and $75,000 per year would absorb 60 percent of the cost shift--$43 billion over seven years. Low-wage workers with insurance, however, would be the most severely affected, because health benefits represent a greater percentage of their total compensation. While the cost shift would slow wage growth by 2.7 percent for all workers with insurance coverage, those earning less than $6.00 per hour would see their wage growth fall by 10.1 percent.

Over 500,000 persons would lose private insurance coverage as a result of the cost shifting.

The Lewin study predicts that the increased premiums resulting from cost shifting will force some firms to drop health insurance coverage for their employees. According to the study, by 2002, 523,000 fewer persons will have private insurance coverage, strictly due to cost shifting. This is in addition to the over eight million Americans who will be denied Medicaid coverage as a direct result of program cuts.

Costs will be shifted to small businesses in particular.

Larger firms, due to their greater bargaining power, will be relatively well-equipped to avoid cost shifts. This will leave small businesses--which already pay higher health insurance premiums--to bear the brunt of the impact. The American Hospital Association notes that "...large employers and insurers may be able to avoid this implicit tax [the cost shift] through negotiated discounts;

but many employers, particularly smaller employers, will not be able to do so." (*Unsponsored Care and Medicaid Shortfalls, 1980-1991*, American Hospital Association)

Small business advocates agree that cost shifting will drive up health care bills for smaller firms. John Galles, president of National Small Business United, warned that "we are likely to see health care premium increases back in the double digits as a result of this legislation." (*The New York Times*, November 4, 1995)

Executives from larger businesses are also expressing concern about the potential impact of the Medicare and Medicaid cuts on employers' health care costs. Michael Rourke, senior vice president of A & P, a grocery chain with 92,000 employees, predicted that "the costs now being paid by the Medicare system are going to creep right back into the insurance system. Just cutting Medicare isn't going to solve a problem that needs a far more comprehensive approach." (*The Washington Post*, November 5, 1995)

There is ample evidence of cost shifting. When Medicare or Medicaid payments are cut, hospitals raise prices for privately insured patients.

The Prospective Payment Assessment Commission (ProPAC) has documented the relationship between Medicare/Medicaid payments to hospitals and the prices charged to private payers. In 1986, Medicare payments fully covered the cost of services; hospitals marked up prices for private patients by 16 percent. By 1993, the most recent year for which data was available, Medicare payments covered only 89 percent of the cost of services, and the mark-up for private patients had risen to 29 percent. (*Medicare and the American Health Care System: Report to the Congress*, Prospective Payment Assessment Commission, June 1995)

- The Congressional Budget Office concurs with these findings, observing that "hospitals offset most of the rise in unreimbursed costs during the 1980s by generating higher revenues from private payers...in the current multiple-payer health care system, actions taken by one payer to control health spending can have a significant impact on spending by other payers...As a consequence, in the absence of other changes, further attempts to control public-sector spending would probably produce additional cost shifting to the private sector..." (*Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals 'Cost Shift'?* Congressional Budget Office, May 1993; italics added)

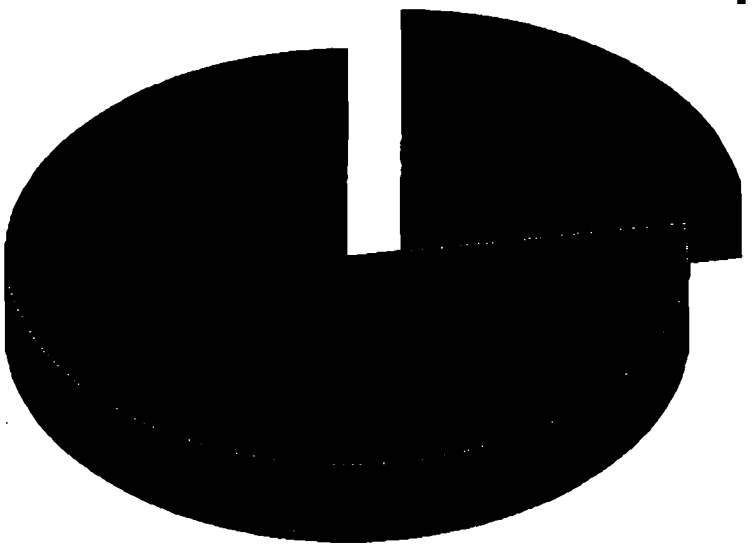
The Lewin study, based on a survey of existing research, estimates that about 40 percent of reductions in Medicare and Medicaid payments to hospitals would be passed on to privately insured patients in the form of higher mark-ups. The research suggests that physicians, however, would be able to pass on only 20 percent of Medicare/Medicaid payment reductions. The study takes into account the extent to which increased enrollment in managed care plans, and the bargaining power of these plans, constrains the ability of providers to transfer cuts in public programs to private payers.

NOTE TO JENNIFER: John Sheils, first author on the Lewin study, told me that they will be revising the numbers as soon as the reconciliation bill conference report is completed (and available). He expects a rapid turnaround. I would suggest waiting for the revised numbers rather than attempting to calculate them ourselves. During my conversation with him, he indicated that he would not be comfortable with any extrapolating using the Lewin methodology; i.e., he might undercut such an attempt in the press.

Republican Reduction in Medicare
Spending Per Beneficiary, 2002

Republican Spending: $5,900

Republican Reduction: $1,700



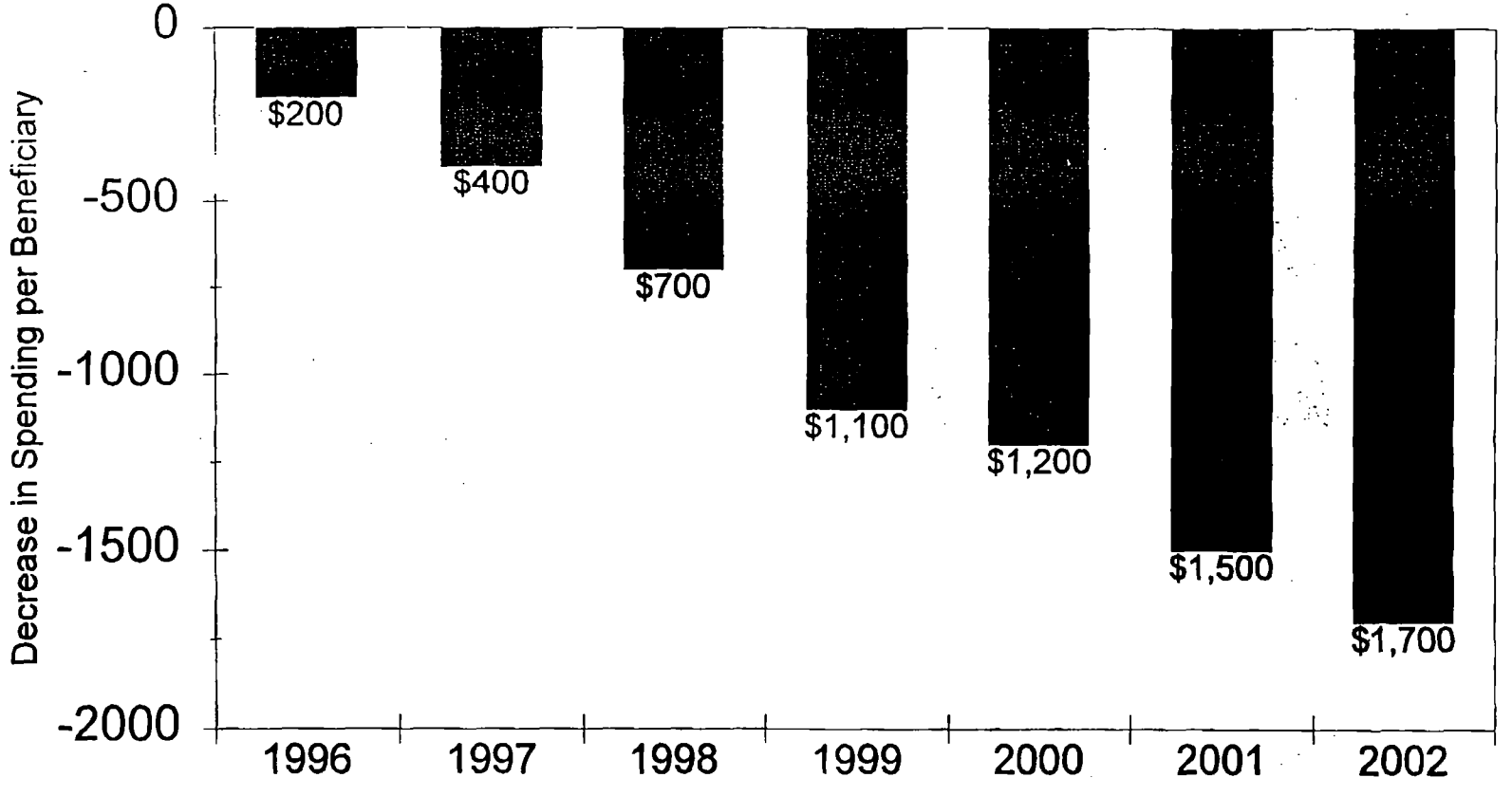
Current Law Spending: $7,600

CBO baseline Medicare spending divided by projected number of beneficiaries; fiscal year 2002.
Source: U.S. Department of Health and Human Services.

DRAFT

Decreases in Federal Medicare Spending Per Beneficiary in the Republican Plan

Compared to Current Law

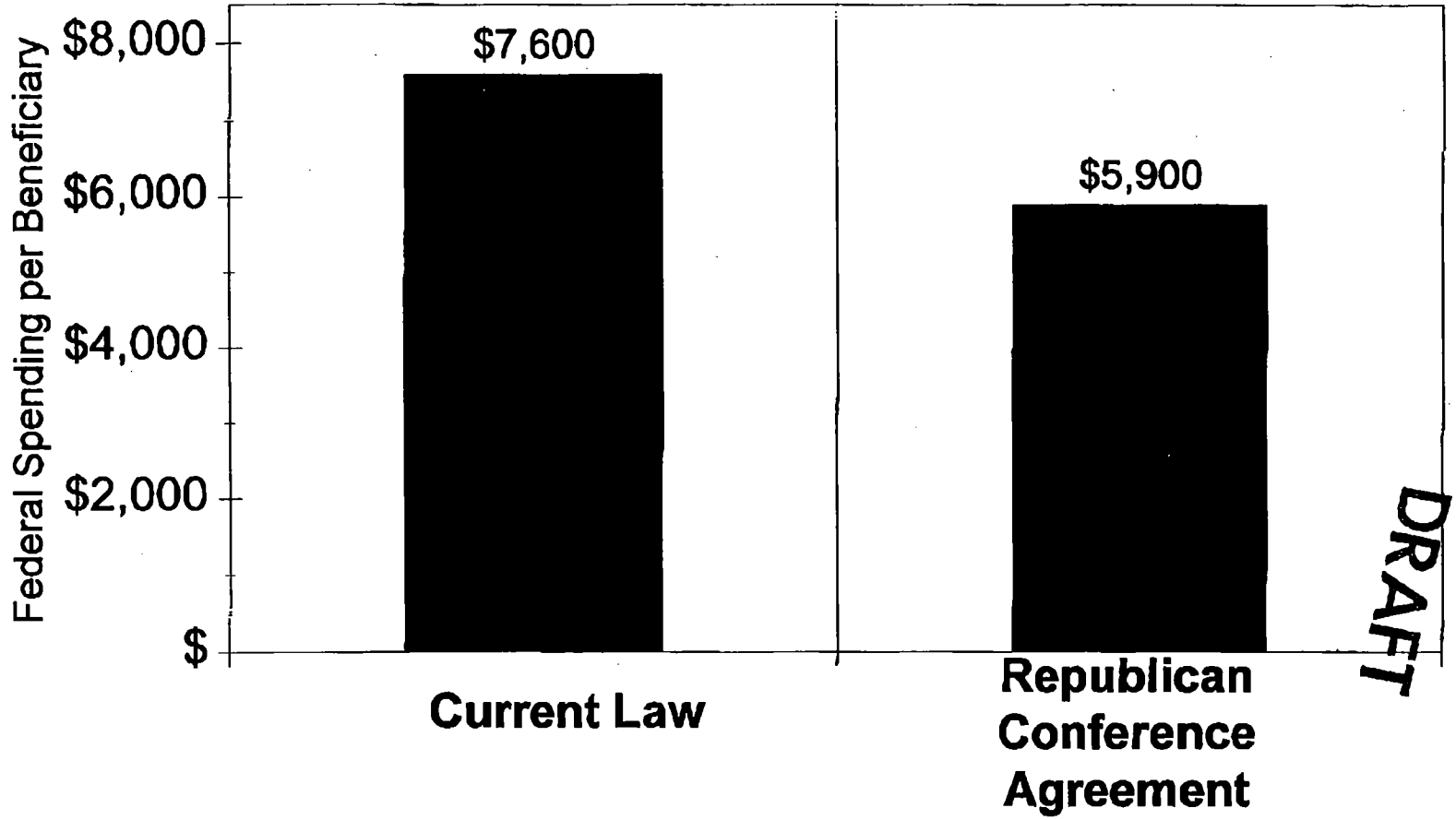


DRAFT

CBO estimates of the Conference Agreement, 11/16/95, using CBO baseline plus CPI adjustment; Administration projections of unduplicated beneficiaries. Source: US DHHS

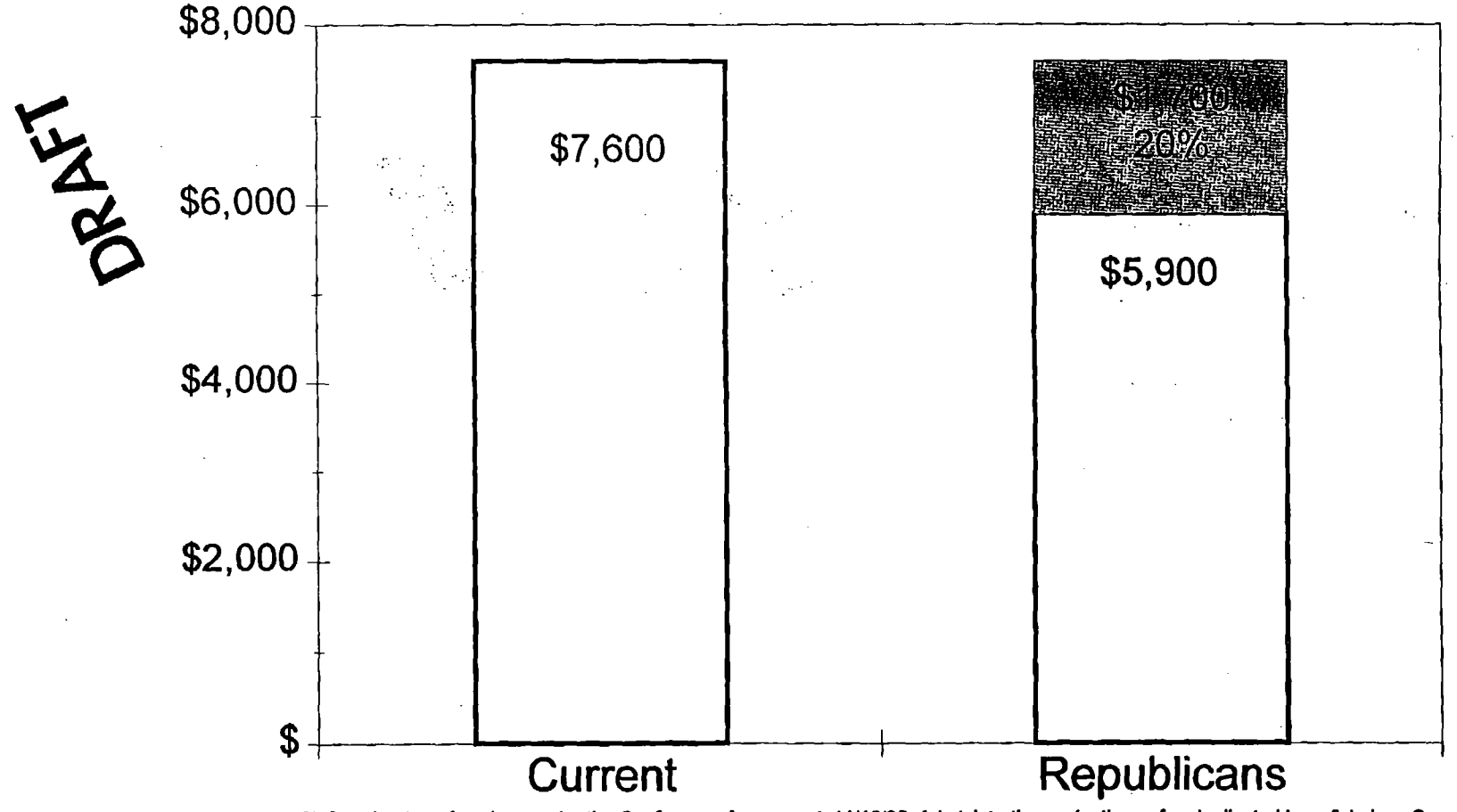
Federal Medicare Spending in 2002

Current Law versus Republican Proposal



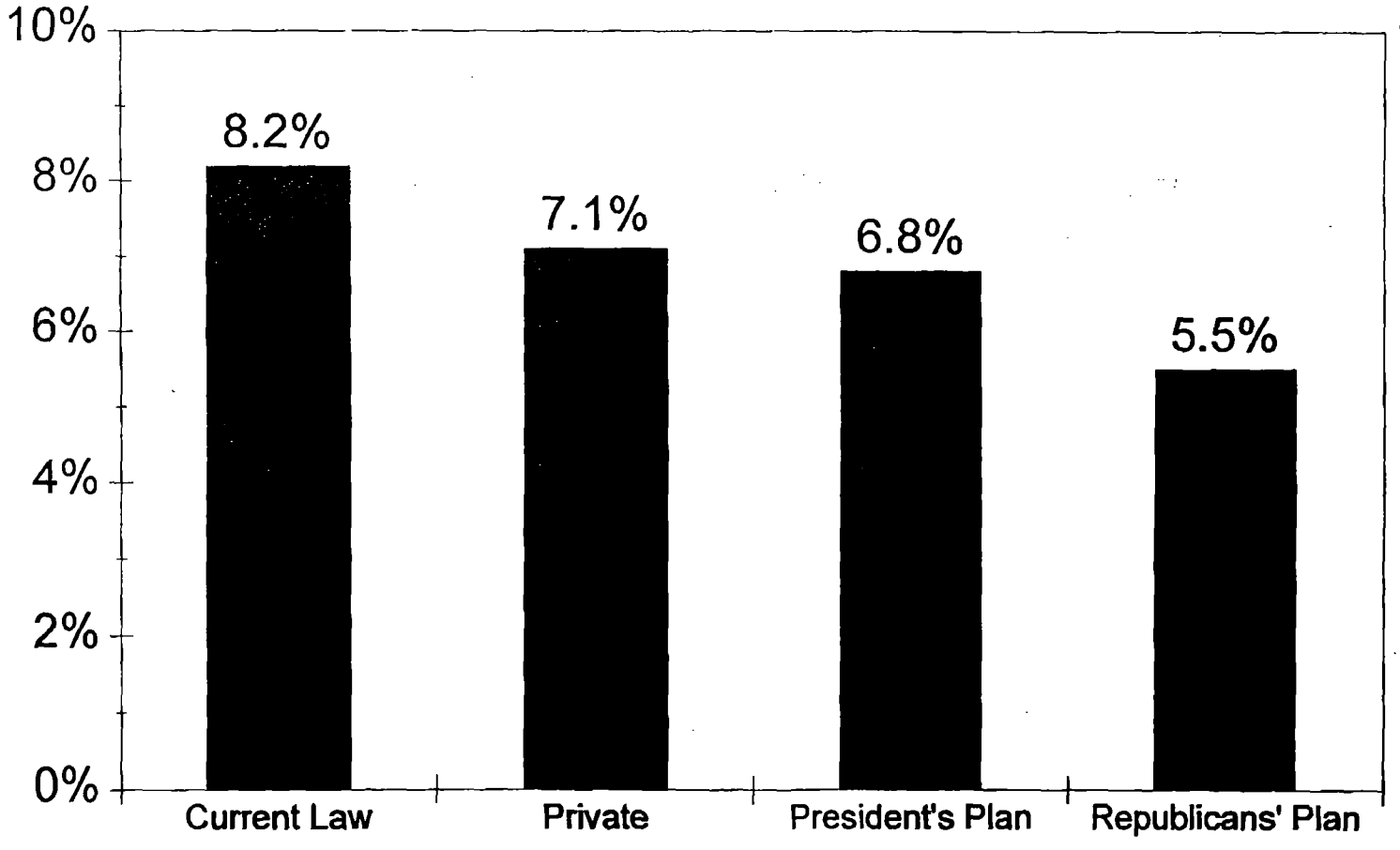
CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. The President's proposal would produce Federal spending of $6,700 in 2002. Source: US DHHS

Republican Medicare Plan v Current Law
Federal Spending per Beneficiary
2002



CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. Source: US DHHS

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

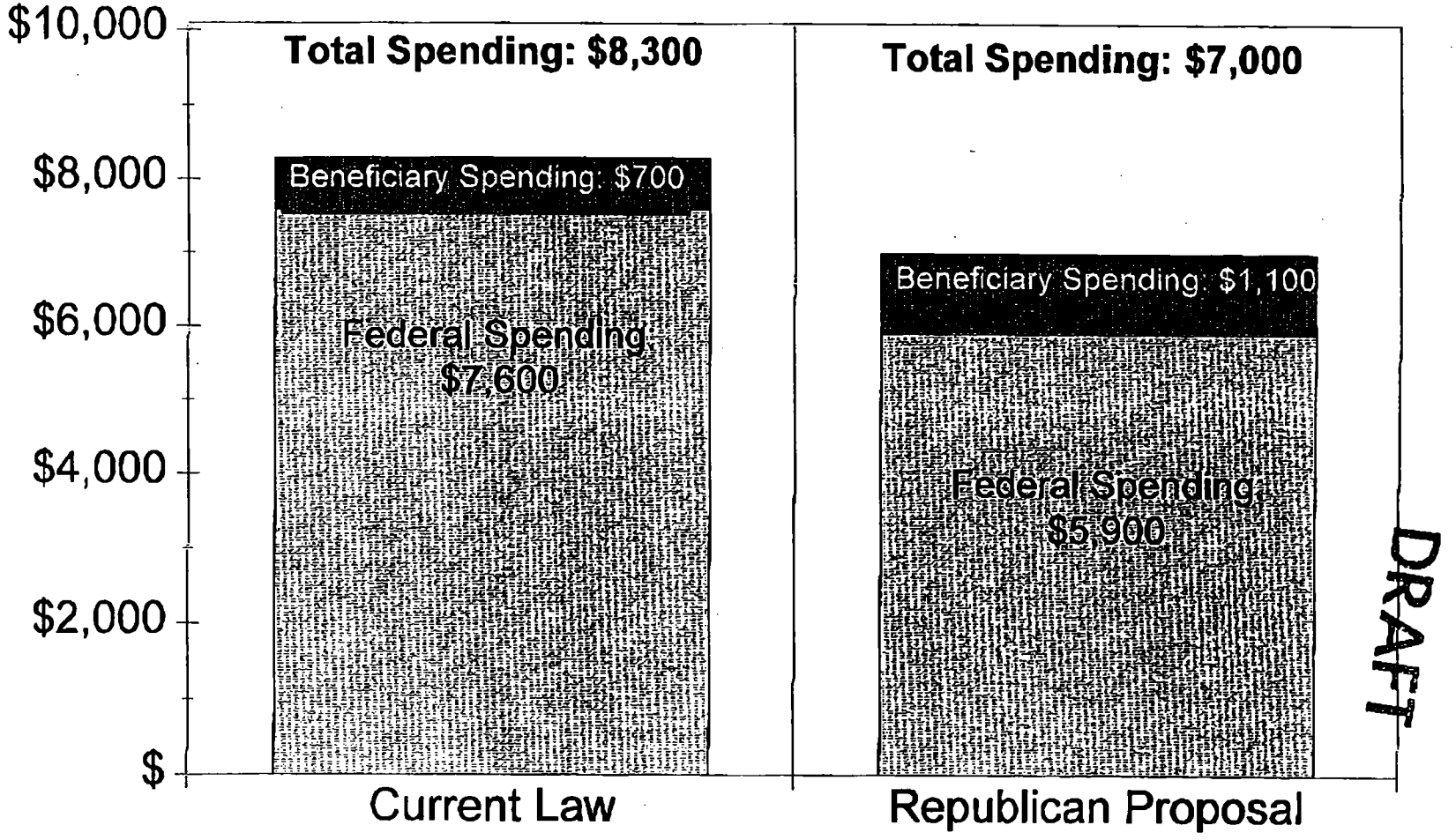


DRAFT

CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. Administration estimates of private health spending per insured person, using CBO data. Source: US DHHS

Republican Medicare Cost-Shift:

Medicare Spending per Beneficiary 2002

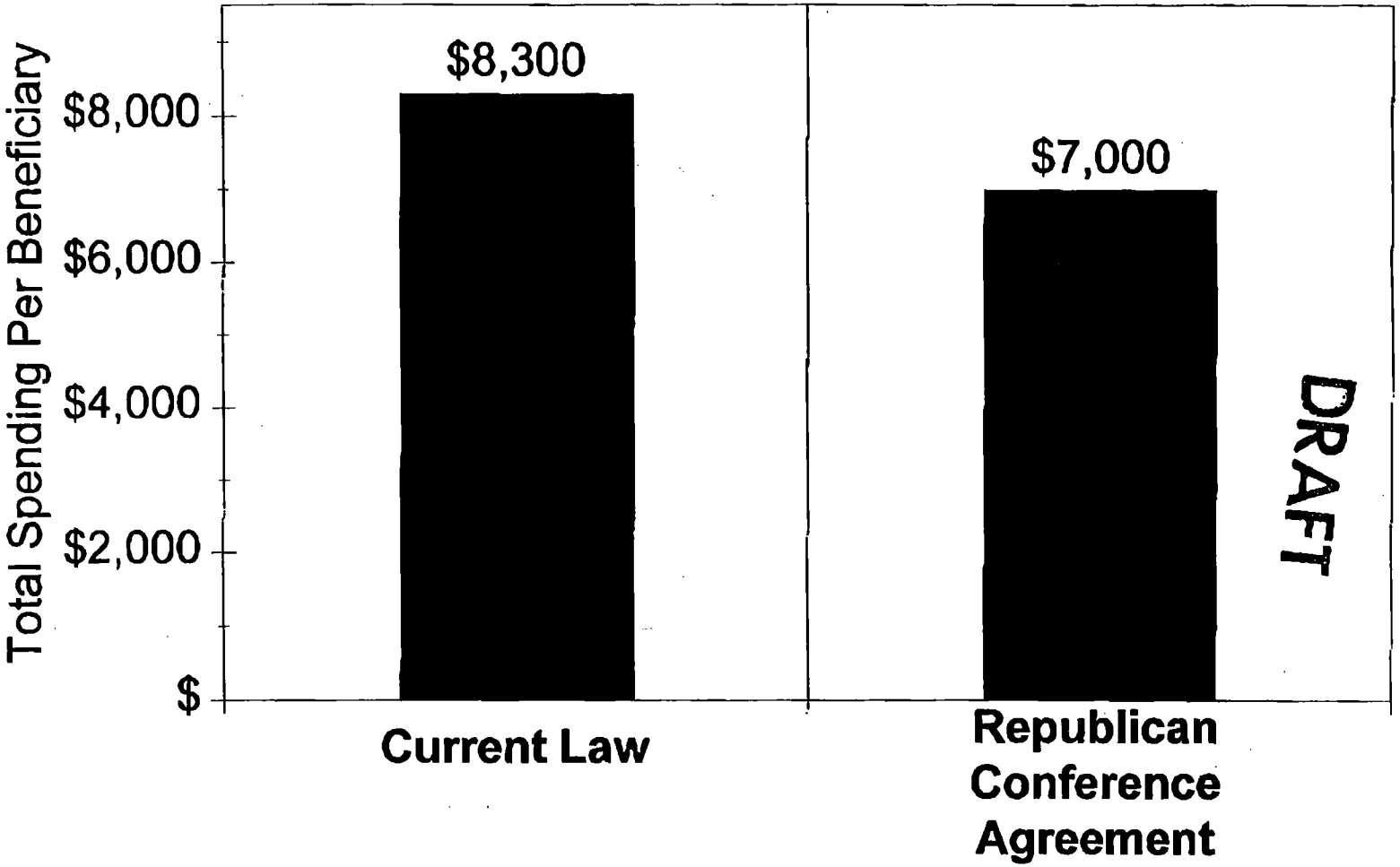


CBO baseline, including CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16; Administration projections of unduplicated beneficiares. Source: US DHHS

Confusing

Total Medicare Spending in 2002

Current Law versus Republican Proposal



CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. The President's proposal would produce total spending of $7,600 in 2002. Source: US DHHS

Republican Reduction in Medicare
Spending Per Beneficiary, 2002

Republican Spending: $5,900

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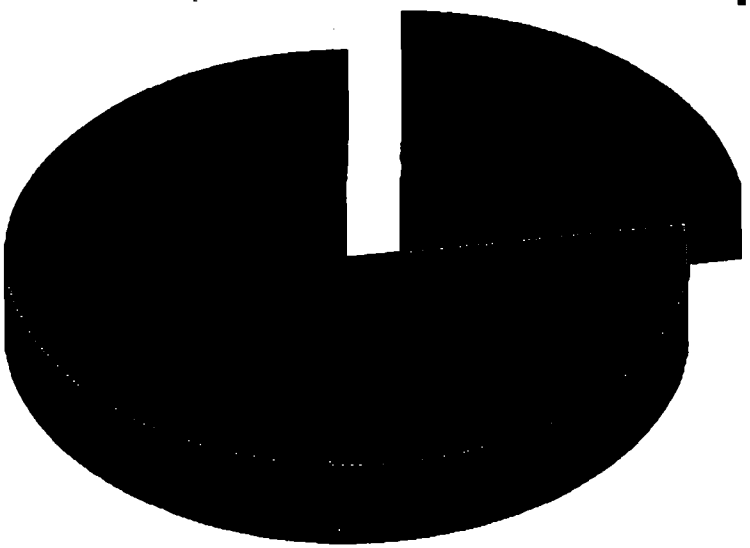


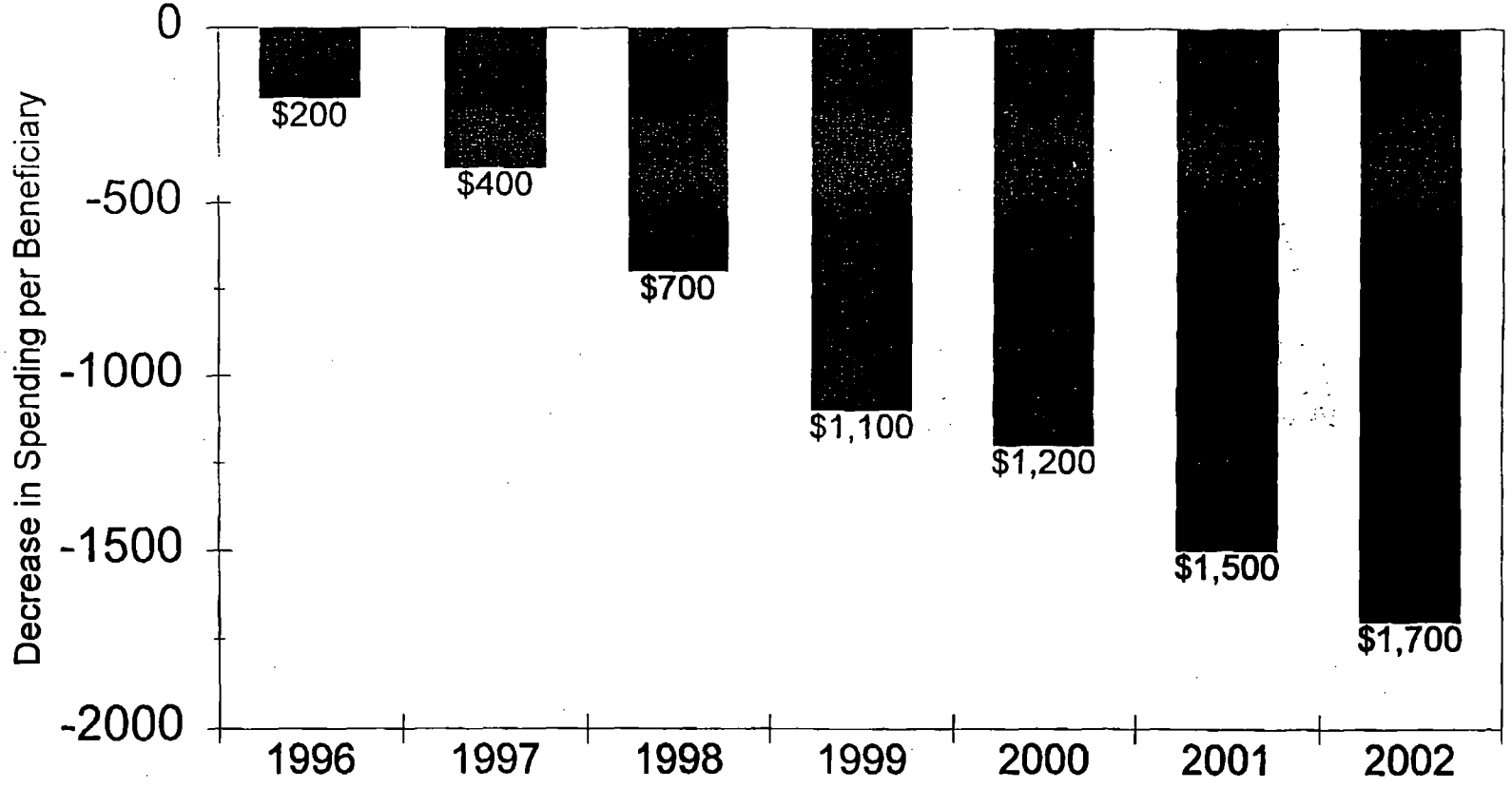
Current Law Spending: $7,600

CBO baseline Medicare spending divided by projected number of beneficiaries; fiscal year 2002.
Source: U.S. Department of Health and Human Services.

DRAFT

Decreases in Federal Medicare Spending Per Beneficiary in the Republican Plan

Compared to Current Law

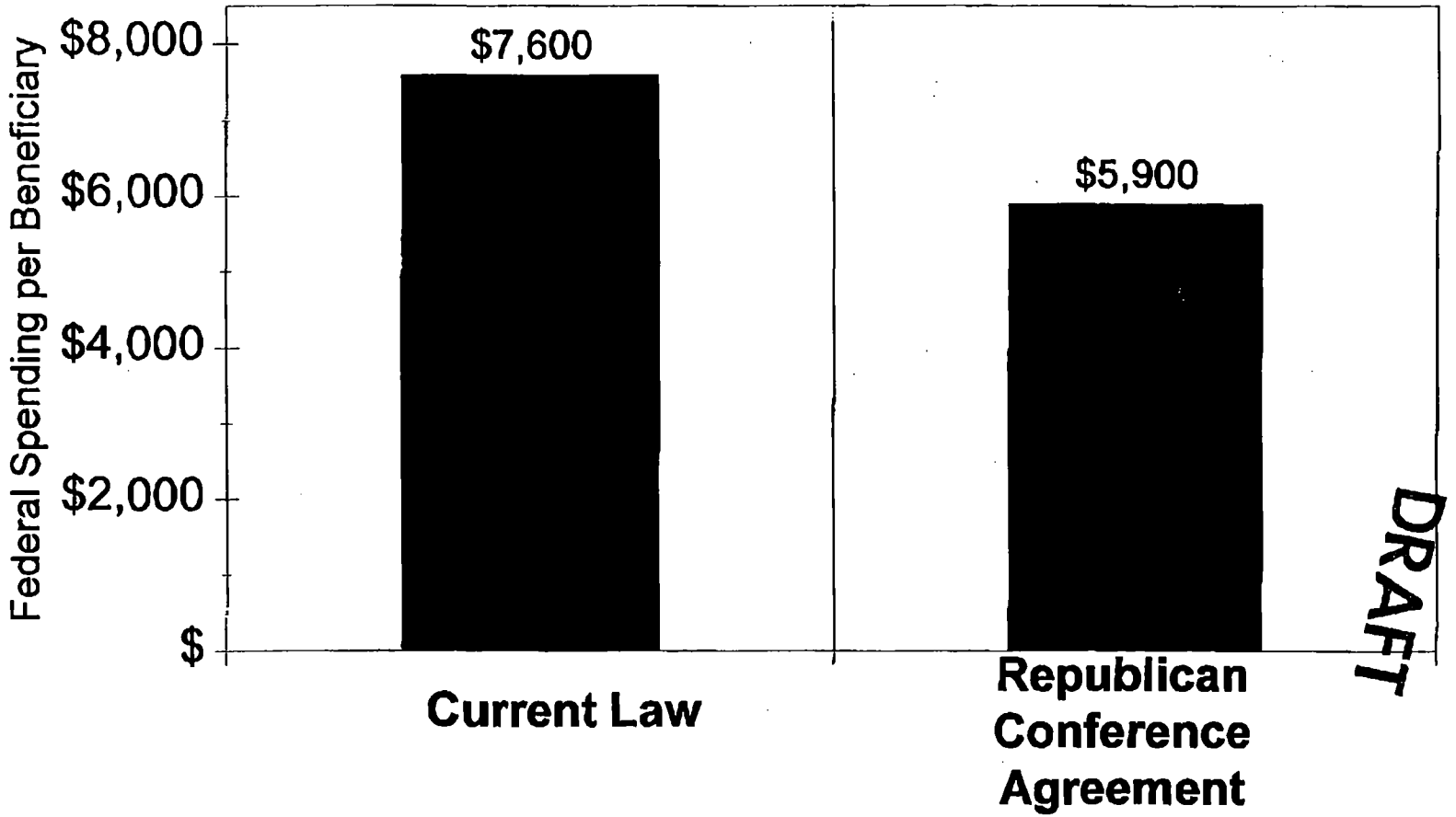


CBO estimates of the Conference Agreement, 11/16/95, using CBO baseline plus CPI adjustment; Administration projections of unduplicated beneficiaries. Source: US DHHS

DRAFT

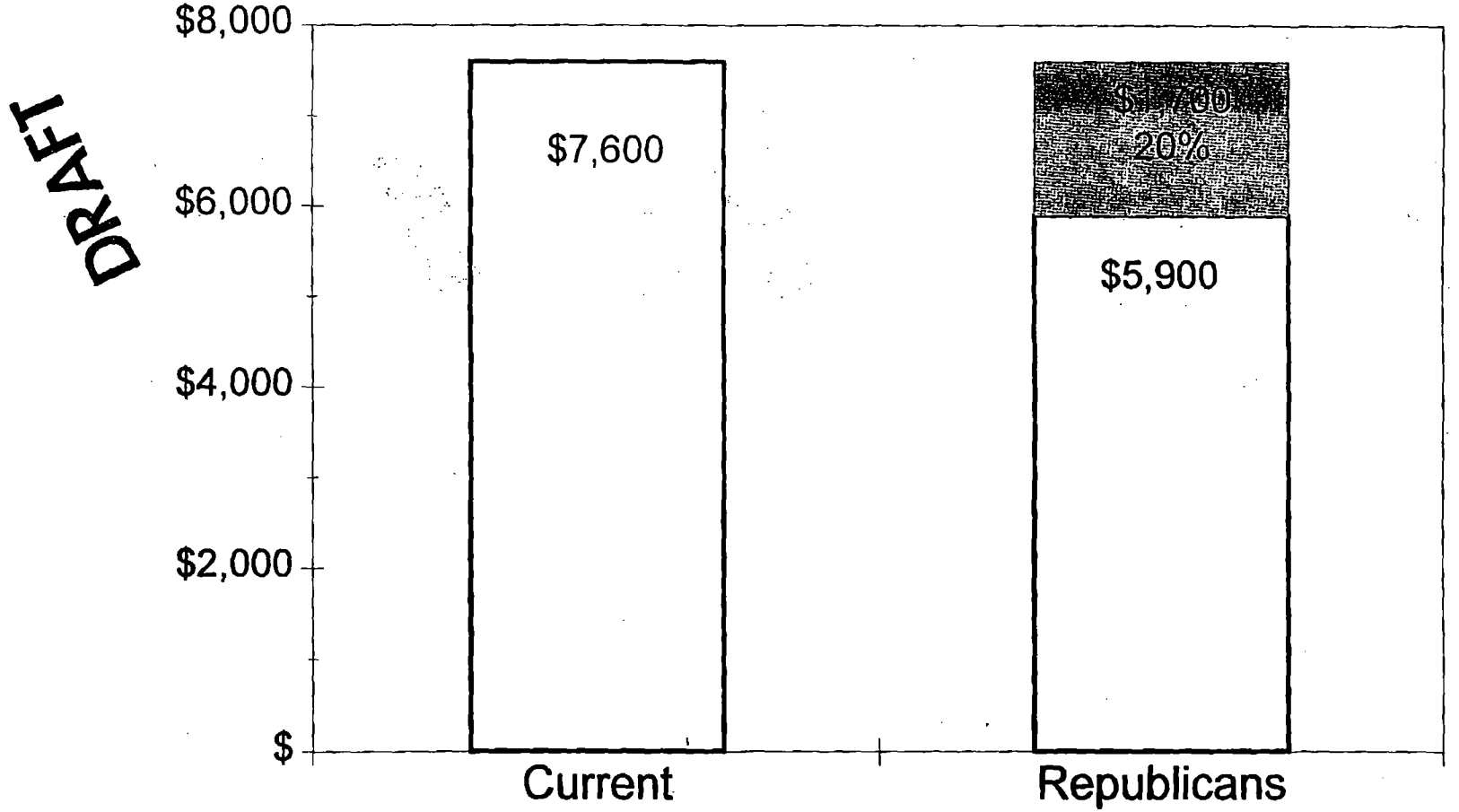
Federal Medicare Spending in 2002

Current Law versus Republican Proposal



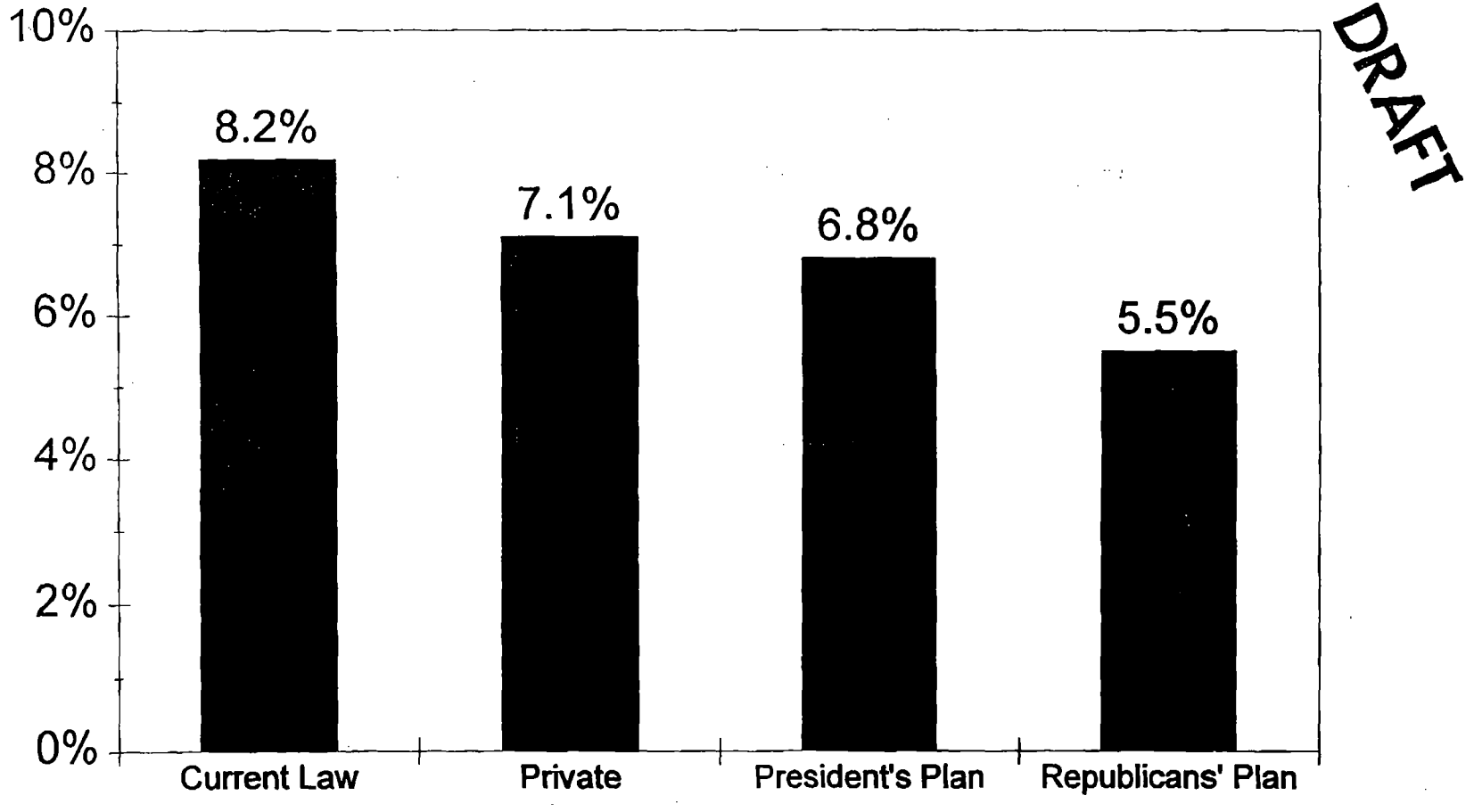
CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. The President's proposal would produce Federal spending of $6,700 in 2002. Source: US DHHS

Republican Medicare Plan v Current Law
Federal Spending per Beneficiary
2002



CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. Source: US DHHS

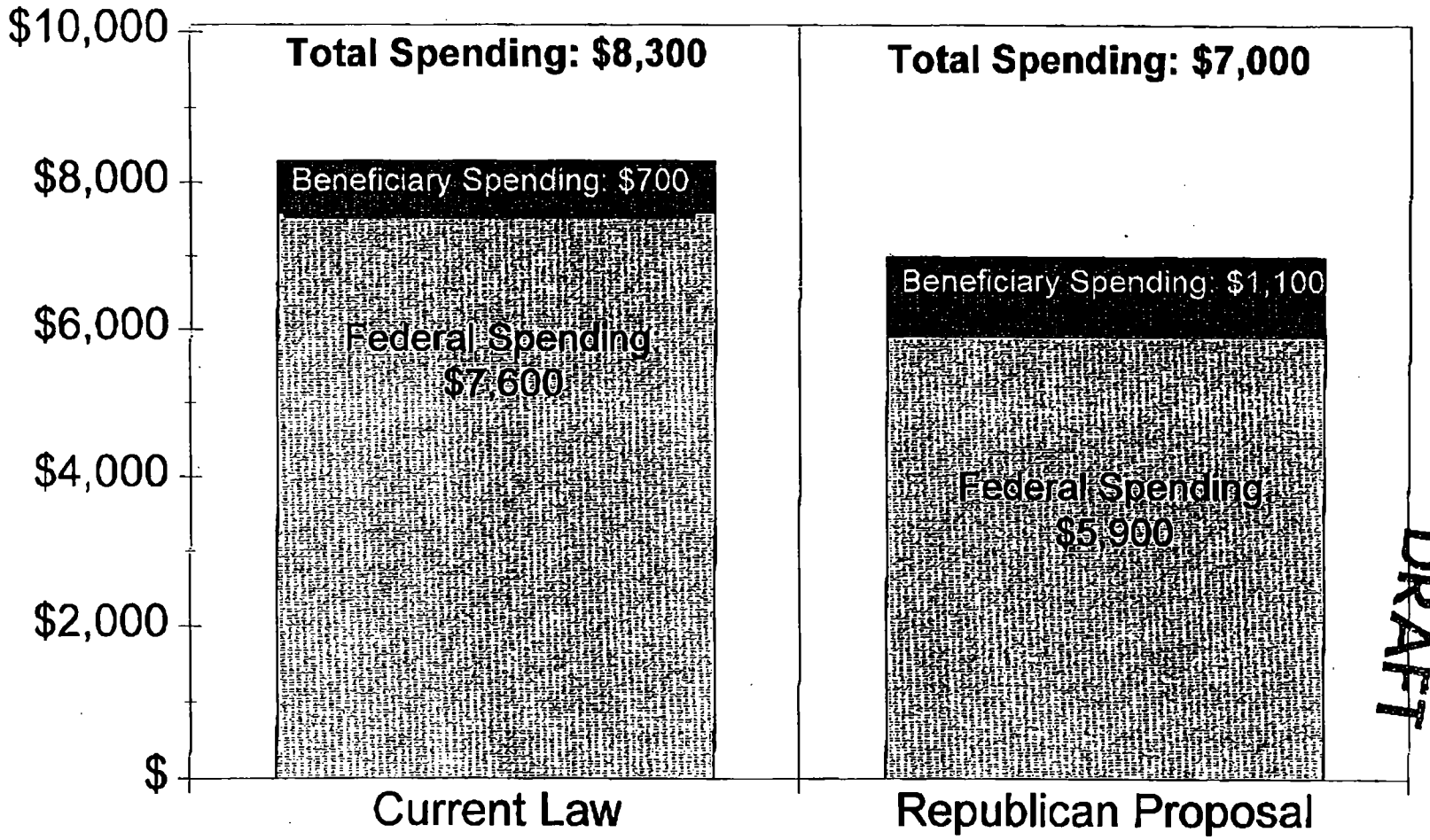
Comparison of Growth in Total Medicare Spending Per Beneficiary, 1996-2002



CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. Administration estimates of private health spending per insured person, using CBO data. Source: US DHHS

Republican Medicare Cost-Shift:

Medicare Spending per Beneficiary 2002



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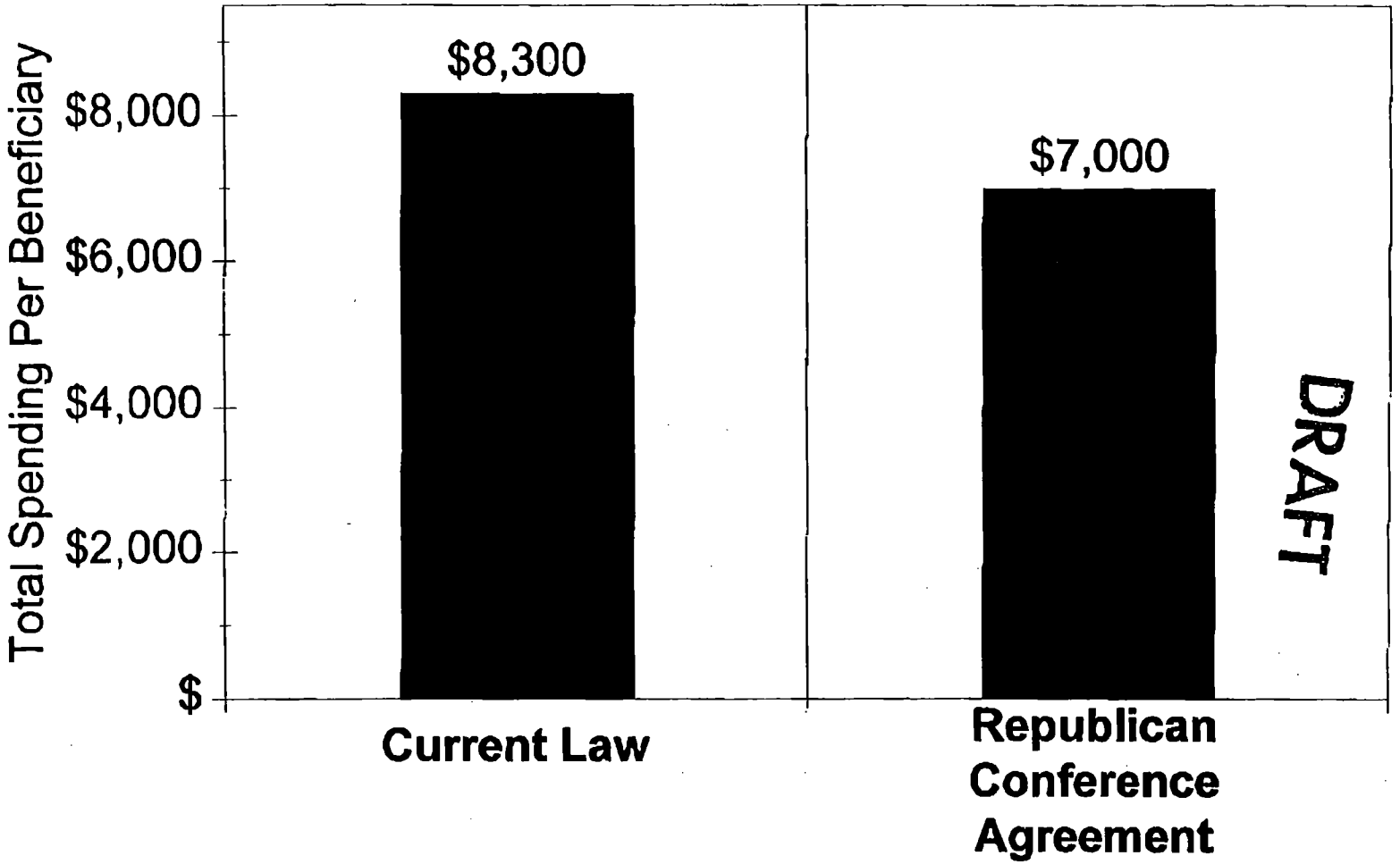
CBO baseline, including CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16; Administration projections of unduplicated beneficiares. Source: US DHHS

Total Medicare Spending in 2002

Current Law versus Republican Proposal



CBO baseline plus CPI adjustment; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of unduplicated beneficiaries. The President's proposal would produce total spending of $7,600 in 2002. Source: US DHHS

MEDICAID STATE FLEXIBILITY

The Alternative Medicaid Reform Proposal dramatically increases State flexibility in Medicaid program administration. At the same time, it achieves Federal Medicaid savings through the use of per capita caps which provide States with substantial protections against eligible population growth due to demographic changes, economic downturns, and other uncontrollable events. Finally, the level of savings proposed by the alternative is substantially less than a third of what the Republicans are seeking. Thus, States would have the flexibility to tailor their Medicaid programs to meet their local needs without the substantial funding losses and financial risks inherent in the Republican block grant proposals.

The State flexibility of the alternative plan is illustrated by the fact that many of the Medicaid flexibility proposals requested by the States over the past several years are included explicitly in the plan. The following chart reflects items requested by the NGA in its 1993 summary of State Recommendations for Statutory Change and its Medicaid Policy adopted in January 1995.

November 20, 1995

Flexibility Proposals Contained in the Alternative Medicaid Proposal

NGA Medicaid Proposals	Alternative Proposal
1. Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
• States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95)	Included.
• Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95,)	Included.
• Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93)	Included.
2. OBRA '87 Nursing home reform modifications:	Addressed.
• Eliminate restrictions on training sites for nurse aides. (NGA '93)	Eliminates prohibition on providing nurse-aide training in rural nursing homes.
• Eliminate PASARR. (NGA '93, NGA '95)	Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.
3. States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers (subject to CBO scoring).
4. Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs.

5. Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95)	Addressed. Boren amendment is repealed for hospitals and nursing homes. Process options, such as hearings and public comment -- to be determined.
6. Provider Qualifications	Addressed.
• Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93)	Included.
• Repeal the annual reporting requirements for OB and pediatric care. (NGA '93)	Included.
7. Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)	Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.
8. Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)	Addressed. Managed care and home and community-based care no longer require waivers.
9. Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)	Addressed. To allow for some eligibility simplification, continued State innovation, and some eligibility expansions; States would have the option of covering individuals up to 150 percent of poverty if "budget neutral" (subject to CBO scoring). Current coverage would be maintained.
10. Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)	Affirms current law that personal care services can be delivered by providers other than home health agencies.

11. OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93)	Affirms current law to allow the targeting of state enforcement resources.
12. Impose no unilateral caps for federal spending on Medicaid entitlement.	Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. The DSH definition would be expanded to include FQHCs/RHCs.

politicization, but we argue this trigger is necessary to protect against groundless, political charges (e.g., vs. U.S. military, or for "Israeli war crimes"). Tony says we will find appropriate opportunities to reinforce your support for the Court.

(D) **Stiglitz memo on household debt.** Household debt has grown rapidly this year, which could lead to decreased spending as consumers face paying off their debt. So far, households are managing without much strain -- delinquency rates on home mortgages, consumer loans and credit card loans are up a bit, but well below peaks of 1980s and early '90s. However, the following developments warrant monitoring: debt service as a percentage of income is up sharply; personal bankruptcy filings rose in the first half of this year, after going down for three years; 1994 mortgages are delinquent at 1.5 times the rate of 1993 mortgages; OCC believes banks have lowered their standards for making consumer loans; banks appear to have lowered their lending standards in the intensely competitive credit card business -- the credit available to consumers on bank-issued credit cards is way up this year.

(E) **John Young (PCAST) letter on academic health centers.** Young emphasizes great importance of academic health centers (AHCs) for research, education and care of the indigent and uninsured. Very worried that proposed cuts in Medicare, Medicaid and Disproportionate Share expenditures, plus erosion of clinical revenues resulting from shift toward managed care could have devastating impact. *A PCAST health panel has concluded*: (i) responsibility for supporting the mission of AHCs rests too much on federal government and should be shared more broadly; (ii) AHCs' disproportionate responsibility for indigent/uninsured will increase given current trends in medical marketplace; (iii) current climate of heated debate is not conducive to resolving these issues. *Thus PCAST recommends:* (a) appoint expert commission to make recommendations for preserving research and educational capacity of AHCs; (b) in interim, resist disproportionate decrease in Graduate Medical Education accounts; (c) provide adequate resources for AHCs to care for indigent/uninsured.

Jennifer Klein

John Young (PCAST) letter on 4th plenary session. Reviews PCAST activities in its first year: reports on U.S.-Russian cooperation re protecting nuclear materials, U.S. Fusion Energy R&D program, Statement of principles on Science and Technology policy; op-eds and letters to editor; meetings with Hill; informal consultations with Administration. Two key questions guide Committee for future: (i) how can federal government protect and enhance nation's research enterprise, especially university network; (ii) how can federal government best manage its R&D programs in face of shrinking budgets. Young urges you to continue stressing importance of investing in science/technology and education and to embrace PCAST's Science and Technology principles. Young says direct contacts with you and VP have been very helpful and hopes to meet with you again, perhaps at March 7-8 PCAST meeting. I have sent a copy of this letter to Stephanie and Ann.

(F) **McGinty note on Superfund and dry cleaners.** Response to your note on *Newsweek* article by woman whose mother was hurt by costs of cleaning up toxic wastes generated by her dry cleaning business. Katie points out that this cleanup was required under Oregon, not federal, law. Your Superfund bill would have ensured that small businesses either wouldn't be liable or could settle quickly. EPA has

THE PRESIDENT HAS SEEN
11-20-95

EXECUTIVE OFFICE OF THE PRESIDENT
PRESIDENT'S COMMITTEE OF ADVISORS ON SCIENCE AND TECHNOLOGY
WASHINGTON, D.C. 20500

95 NOV 14 P12:28

November 8, 1995

Big item - we need to discuss options

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

The significant accomplishments in American biomedical research and our innovations in medical care are widely respected throughout the country and, indeed, the world. These achievements have occurred primarily at our Nation's academic health centers. Since World War II, the Federal government has played a vital role in the support of academic health centers and has done so on a bipartisan basis.

Your Administration's 1994 health care reform plan acknowledged the important contribution to our quality of life made by academic health centers and provided a mechanism to mitigate the loss of significant revenue that these institutions are now experiencing. In the absence of comprehensive health care reform, academic health centers are beginning to show signs of serious stress. Although they represent only six percent of the Nation's non-Federal acute care hospitals, these institutions provide more than half of the care for the indigent and uninsured populations. The prospect of sharp reductions in Medicare, Medicaid, and Disproportionate Share (DSH) expenditures, coupled with the erosion of clinical revenues resulting from the emergence of managed care, could have a devastating impact on the Nation's capacity to support medical research and education and the system that provides medical care to its most vulnerable citizens.

Academic health centers develop the biomedical knowledge and clinical techniques needed for new and improved treatments, train the Nation's physicians and provide unique patient care resources. In the long term, biomedical research conducted in these centers offers our citizens the best potential to enhance their quality of life and control medical expenditures with cost-effective methods for disease prevention and management.

Historically, the Federal government has assumed responsibility for a majority of the support for fundamental biomedical research and graduate medical education as a public investment that contributes broadly to the health of Americans. In 1995, the Federal investment in academic health centers for biomedical research and education was about one percent of total health care expenditures. Measured by any standard, this very modest rate of investment in an area of extraordinarily rapid advancement in knowledge and technology has had a remarkable yield. In addition, the Federal government provides, through the Medicaid and DSH programs, significant support for low-income patient care delivered in academic health centers.

Clinical revenues derived from medical practice programs conducted by the faculty of academic health centers have been another very significant source of funds for these programs of research, education and indigent care. Current changes in the health care system, including Medicare and Medicaid reform, driven by Federal and State fiscal concerns and the emergence of managed care, also threaten to eliminate this critical support for biomedical research and medical education.

We recognize the need to slow the rate of growth in health care costs and endorse efforts to address this need. Both public and private elements of the health care system need to be carefully examined and restructured to enhance medical efficacy and cost-effectiveness. However, it is also essential that in this process, the crucial public benefits that are contributed uniquely by academic health centers be recognized, and that their continued strength remain an important priority in the ongoing health care debate.

A panel of your Committee of Advisors on Science and Technology (PCAST) examined these issues and reached the following conclusions:

- **Sharing the Responsibility** -- The education of competent physicians and scientists, and the production of new biomedical knowledge and technologies, represent vital public necessities. To date, only the Federal government has supported these functions explicitly through the Graduate Medical Education (GME) mechanisms of the Medicare program. With a few notable exceptions, other payers do not contribute to this support. We affirm the principle that responsibility for supporting the missions of academic health centers and their contributions to the well-being of society should be broadly shared by all who benefit.

- **Care for the Indigent and Uninsured** -- Historically, academic health centers have provided care for a disproportionate share of the indigent and uninsured populations and have received a Medicare payment adjustment for this service. It is likely that this responsibility can only increase in the developing private and public medical care marketplaces. With the trend toward managed care, others are even less likely to provide this service because of its resource-intensive nature.

- **Current Debate** -- A satisfactory disposition of these critically important and complex issues is unlikely to emerge from the heat of the current public debate, with its intense and narrow focus on budgetary concerns.

To support and sustain the Nation's academic health centers in the immediate future and over the longer term, PCAST therefore respectfully suggests that you consider the following recommendations:

- **Expert Commission** -- We recommend that an expert commission, credible to the President, the Congress and the public, be established to develop and recommend specific policies to address the preservation of the research and educational capacity of the Nation's academic health centers, and the supply, composition and support of the future health care work force. The commission should carefully consider the implementation of an equitable mechanism to achieve these objectives. The commission should also determine the most effective way to allocate training funds in furthering the goals of a rational workforce policy to ensure that the numbers and competencies of health care professionals are responsive to the Nation's needs. We believe that such an approach can best ensure the future vitality of our biomedical research enterprise and the highest quality of our Nation's medical care.

- **Graduate Medical Education (GME)** -- In the interim, in revising the Medicare program, the Administration should continue to resist disproportionate decreases in the GME accounts. Further, the funds for GME that are currently melded into the premiums paid to all Medicare managed care providers (the Average Adjusted Per Capita Cost formula) should be redirected to accomplish their intended objectives. This may entail developing a process that provides these payments directly to caregivers and institutions that are involved in graduate medical education.

- **Disproportionate Share** -- If academic health centers are to continue their role of disproportionately caring for the indigent and uninsured populations, then appropriate resources must be provided. This will almost certainly remain a responsibility of the government.

PCAST believes that the academic health centers are a national resource that, together with our research universities, must be sustained for the good of the Nation. We hope that you will find these recommendations helpful.

Sincerely,

John A. Young
Co-Chair
President's Committee of Advisors
on Science and Technology

To: Jen Klein
Fr: Chris Jennings
Per your request

DRAFT HHS 11/17

SUMMARY OF MAJOR PROVISIONS

"MEDICARE PRESERVATION ACT OF 1995"

Caps and Failsafe [Follows structure of House provision, with some changes in dollar totals and growth rates.]

- Failsafe sets overall annual spending limits for Medicare at: $194.2 billion in FY96, $206.3 billion in FY97, $217.8 billion in FY98, $229.2 billion in FY99, $247.2 billion in FY2000, $266.4 billion in FY01, and $289.0 billion in FY02. For each subsequent year, spending limit increases 5 percent (after taking into account the annual percentage increase in the average number of beneficiaries).

- Annual projected spending for MedicarePlus would be subtracted out of the overall spending limit.

  Growth Rates for MedicarePlus Plans - Payments to plans would vary by geographic area. A national payment floor is established at $300 per beneficiary per month in 1996 and $350 in 1997. No plan would ever experience an increase smaller than 2 percent of the previous year's rate. Overall, payments would increase as follows: 1996 - 8.0 percent; 1997 - 3.8 percent, 1998 - 4.6 percent, 1999 - 4.3 percent; 2000 - 3.8 percent; 2001 - 5.5 percent; 2002 - 5.6 percent; and subsequent years 5.0 percent. [Mixture of House & Senate.] (CBO estimates private sector cost per person will grow 7.1 percent per year on average from 1996 to 2002.)

- Distinct allotments would be set for different fee-for-service sectors: inpatient hospital, home health, extended care, hospice care, physicians' services, outpatient hospital services and ambulatory facility services, durable medical equipment and supplies, diagnostic tests, and other items and services. Established in statute are baseline projections of annual growth rates in spending for each of these sectors for each fiscal year. Each sector's allotment for a fiscal year is determined by calculating that sector's portion of total baseline spending in that year, and then multiplying that portion (percentage) times the total fee-for-service (FFS) budget for Medicare that year.

- In order to maintain spending at the specified levels, a prospective adjustment and a look-back mechanism are provided. Under the prospective adjustment, beginning with FY 1998 the Secretary compares projected FFS expenditures by sector for the coming year with the allotment for that sector. If projected expenditures exceed the sector's budget allotment, the Secretary adjusts payment rates for that sector downward so that spending is within the allowed amount. Initial determinations and prospective adjustments must be published by May 15, and final ones must be published by September 1.

- o Look-back provision:

  - + If a sector's actual expenditures two years previously exceeded its estimated allotment, the Secretary would reduce that sector's allotment for the coming fiscal year by **133 1/3 percent** of the excess. Once an allotment is reduced, the reduction can never be recaptured.

  - + If actual spending were less than the allotment for that sector, the Secretary would increase that sector's allotment for the coming fiscal year by the amount of the shortfall.

  - + Under this system, each sector's gain or loss must come from or contribute to the other sector's allotments: the overall budget is not changed by this process. The look-back would start in FY 1999: first look-back is to FY 1997, which will not be subject to prospective adjustment.

MedicarePlus

Uneven rules: In general, beneficiaries have less protection under MedicarePlus than under traditional Medicare. Also, in general, provider and plans have more opportunities to escape budget cuts by shifting costs onto beneficiaries under MedicarePlus that under traditional Medicare. Over time, this will lead Medicare to "wither on the vine."

Voucher/defined contribution: Medicare pays MedicarePlus plans a pre-set amount, unrelated to the cost of health care. If the amount exceeds health care cost, a MedicarePlus plan may rebate 75 percent of the difference to the enrollee. However, if the amount is insufficient to cover the cost of health care -- a more likely occurrence because the Agreement does not permit Medicare spending to grow as fast as private sector health care costs -- beneficiaries can be charged more through balance billing and other means.

Lock-in: Once beneficiaries sign up for a MedicarePlus plan, they are locked in for one year. (A special 90-day trial period is allowed for people making their first MedicarePlus plan election, but never again after the first election.) By contrast, under current law, beneficiaries may disenroll from Medicare managed care plans at any time if they are dissatisfied.

High Deductible/Medical Savings Account Plans: Would be allowed under the agreement. [In House bill.] The deductible in 1996 could not exceed $6,000. [The House provision had a maximum of $10,000.] MSAs will attract healthier wealthier beneficiaries, leaving a sicker group in Medicare, driving up Medicare costs, triggering further automatic budget cuts in traditional Medicare under the failsafe.

Private fee-for-service plans: Would be allowed under the Agreement. [In both bills.]

Medigap: The Agreement includes House provisions liberalizing restrictions on the sale of

Medigap products that duplicate Medicare, with a modification: Medigap products sold to MedicarePlus enrollees would not have to meet any Medigap standards (including loss ratio and standardization requirements). Enrollees leaving MedicarePlus to return to traditional Medicare may find themselves locked out of Medigap plans. The Agreement did not conform current law rules to permit beneficiaries to move back and forth between Medicare and MedicarePlus. As a result, Medigap plans will only be required to offer open enrollment and community rated premiums to beneficiaries when they first become eligible for Medicare.

Payment: Payment would be blend of local and input-price adjusted national rate (90/10 in 1996 -- 70/30 in 2000 and thereafter). Rates would still be county-based, but States could obtain MSA-based rates or a single statewide rate. These provisions are designed to gradually increase plan payments to rural areas (at the expense of urban areas where most of the current Medicare risk enrollees are concentrated). (See other information above under **Caps** section.) [Mixture of Senate and House provisions.]

Provider Sponsored Organizations: PSOs would have special process to develop standards for fiscal solvency. Enforcement of these Federal standards could be delegated to States if the Secretary determined that the State certification process applied standards identical to the Federal standards. PSOs could get a temporary waiver of the requirement for State licensure if (1) the State was not timely in completing action on the entity's application or (2) if States applied other standards to PSOs that were not generally applicable to other similar plans. [Mixture of House and Senate provisions.]

HCFA's Status: The MedicarePlus program would be administered by an agency separate from HCFA. [House provision]

Beneficiary Impact

Part B Premium: For 1996 through 2002, the Part B premium would bet set to cover 31.5 percent of program costs. [House provision.]

Income Related Premium: Individuals with annual adjusted gross income (AGI) over $60,000 and couples with annual adjusted gross income over $90,000 would pay an increased premium, with the subsidy being completely phased out at $110,000 for individuals and $150,000 for couples. HCFA would administer this premium. [Provisions in both bills; amounts are in the middle.]

Part B Deductible: The Agreement does not include the Senate provision to raise the deductible.

Balance Billing/Premium Limits in MedicarePlus: [Same as House provision.] Beneficiaries enrolling in MedicarePlus plans would have less protection than beneficiaries enrolling in a Medicare managed care plan today:

- Under current law, beneficiaries enrolling in private plans can be no worse off financially than if they stayed in fee-for-service. There is no similar guarantee under the House bill since extra-billing is allowed (as described below) and is excluded from limits on out-of-pocket costs for MedicarePlus enrollees.

- Beneficiaries have no extra-billing protections for physician, hospital and skilled nursing facility services in private fee-for-service plans, high deductible/medical savings account plans, and coordinated care plans (for authorized non-network services).

Transfer to Part A

For calendar years 1996 through 2002, the savings from setting the Part B premium at 31.5 percent of program costs versus 25 percent would be transferred into the HI Trust Fund. [From the Senate provision. House "lockbox" provision does not appear.]

GME/Academic Health Centers/ME

- Cuts Medicare payments for indirect medical education (ME) by $ 9 - 10 billion over 7 years. Reduces payment add-on for ME to 6.7 percent from 10/1/95 to 10/1/96, to 6.0 percent until 10/1/98, to 5.6 percent until 10/1/99, to 5.3 percent until, and to 5.0 percent thereafter. [Basically the Senate provision, with a slower phase-in.]

- Counts residents beyond their initial residency period at 0.25 for direct graduate medical education (DGME) purposes, effective 10/1/97. [Mixture of Senate and House provisions.]

- Does not include a phase-down of reimbursement for graduates of foreign medical schools.

- Caps the number of residents on a hospital-specific basis for FY96 through FY02 at the number an approved medical residency program had on August 1, 1995. [House provision.]

- Establishes a Teaching Hospital and GME Trust Fund, to include the following appropriations from the general fund of the Treasury: $1.1 billion in FY97, $1.3 billion in FY98, $2.0 billion in FY99, $2.6 billion in FY2000, $3.1 billion in FY01, $3.4 billion in FY02. The appropriation over 7 years totals $13.5 billion. [Same as House proposal, but with lower appropriations.]

Home Health [Similar provisions in both bills.]

- Establishes a prospective payment system for home health services. HHAs would be paid a national average, per visit, prospective payment rate for each of the six HHA disciplines (skilled nursing, home health aide, PT, OT, speech pathology or medical social services). The amount of per visit rate payments would be limited by an agency-specific, case-mix adjusted per episode cap, a dollar threshold that approximates those covered services that would be

furnished to beneficiaries over a period of **120 days**. This 120-day dollar cap would be applied to **165 days** worth of actual services, however.

- Home health agencies (HHAs) that keep total payments for the year below the annual episodic cap would be allowed to retain 50 percent of the savings; shared savings could not exceed 5 percent of the HHA's aggregate Medicare payments in a year.

- Payments made for services extending beyond 165 days (outlier) would be paid on a per visit basis, not subject to any cap. Outlier must be approved and certified as medically necessary.

- The episodic cap is purportedly devised to control costs. In reality, it is nothing more than an arbitrary budget ceiling that will provide incentives to agencies to avoid long-term heavy care patients.

- There would be no shift in coverage and financing from Part A to Part B, as in the House bill.

- The conference agreement envisions 10/1/96 implementation of PPS, which would not be possible given the lack of reliable data and systems to collect them. It would take at least two to three years to develop a viable new payment system and a valid case-mix adjuster.

- Provides that the maximum interval between recertification surveys be not greater than 36 months. Permits the Secretary to establish a frequency for surveys within this 36-month interval commensurate with the need to ensure the delivery of quality HHA services. [House provision; similar to proposal in President's.]

- Savings generated by the OBRA 1993 freeze on cost limit adjustments, but not the freeze itself, would be extended indefinitely in setting future HHA limits by not allowing for the inflation that occurred during the two freeze years. [In President's February budget.]

Skilled Nursing Facilities

- Effective 10/1/97, establishes a per episode prospective payment system for all cost categories (routine, non-routine and capital) except physician services. There would be a 10 percent reduction in payments under this system. [Senate provision.]

- SNFs would be required to bill for all services that its Medicare patients receive [House and Senate provisions were the same] EXCEPT the following services: physicians services, and portable x-ray or EKG, which are treated as a physician's service.

- Extends the savings from the OBRA93 freeze on SNF cost limits. [House and Senate provisions were the same; President's proposal.] Reduces payment for capital-related costs by 10 percent. (House and Senate provisions were both at 15 percent)

o The House provision to weaken Federal quality oversight of Medicare SNFs was not included.

Part B

Payments for Physicians' Services. [Senate provision.]

(1) Creates a single physician conversion factor, instead of the current three different factors, effective 1/1/96,
(2) Sets the 1996 conversion factor at $35.42, and
(3) Establishes a revised target/update system which sets cumulative expenditure targets, bases them on real GDP per capita rather than historical physician volume/intensity, eliminates the behavioral offset for update changes from the target and increases the maximum reduction in updates due to performance from 5 to 7 percentage points and sets limits on annual bonuses at 3 percentage points.

Oxygen: 20 percent reduction in 1996, increased to a 30 percent reduction by 2002 (may preclude reduction greater than 30 percent by Secretary). [Mixture of House and Senate.]

Fraud and Abuse Provisions

o Establishes Health Care Fraud and Abuse Control Account, controlled by the Secretary of HHS and the Attorney General. In addition to criminal fines, civil monetary penalties, forfeitures, and penalties and damages, includes the following amounts appropriated from the HI Trust Fund: $104 million in FY96, and that amount increased by 15 percent each year.

o The OIG/HHS shall have at her disposal the following portion of the Account: between $60 and 70 million for FY96, between $80 and 90 million for FY97, between $90 and 100 million for FY 98, between $110 and 120 million for FY 99, between $120 and 130 million for FY2000, between $140 and 150 million for FY 2001, and between $150 and 160 million for each successive year. [More than in House bill.]

o The following amounts shall be appropriated from the general fund of the Treasury to the Account for the use of the FBI: FY96 $47 million, FY97 $56 million, FY98 $66 million, FY99 $76 million, FY2000 $88 million, FY01 $101 million, and $114 million for each subsequent year.

o Establishes the Medicare Integrity Program, under which the Secretary may enter into contracts to carry out the following activities: review of activities of providers (including medical review and fraud review), audits, payment determinations, provider and beneficiary education, developing and periodically updating a list of items of DME which are subject to prior authorization. Current contractors may not duplicate efforts under the Medicare Integrity Program. The following amounts from the Trust Funds are transferred into the program account: FY96 between $430 and 440 million, FY 97 between $490 and 500 million,

FY 98 between $550 and 560 million, FY99 between $620 and 630 million, FY2000 between $670 and 680 million, FY01 between $690 and 700 million, between $710 and 720 for each successive year. [House provision.]

- Creates beneficiary incentive programs, including requiring an "explanation of Medicare benefits" (EOMB) notice be sent to beneficiaries for each service provided (at present, these notices are sent for all services except laboratory and home health services), a program to collect information on fraud and abuse and pay a portion of amounts collected to the informant, and a program to collect information to improve the efficiency of Medicare and pay a portion of program savings to the suggester. [In both bills.]

- Expands sanctions for Medicare or State health programs to all Federal health care programs.

- Requires HHS to issue additional safe harbors, modifications to safe harbors, and interpretive rulings.

- Adds new permissive exclusion from Medicare and Medicaid for individuals controlling a sanctioned entity. [Senate provision.]

- Creates intermediate sanctions for HMOs. [Similar provisions in both bills.]

- Adds an exception to anti-kickback penalties allowing any remuneration between an organization and persons providing services under a written agreement if the organization is a Medicare Plus organization or the written agreement places the services providers at substantial financial risk. [House provision.]

- Establishes a Health Care Fraud and Abuse Data Collection program for the reporting information on final adverse actions, including the taxpayer identification numbers (TIN) of those involved. [Senate provision.]

- Extends civil monetary penalties (CMPs) to all Federal health care programs.

- Persons excluded from Medicare or a State health care program and maintaining a direct or indirect ownership or control interest in an entity or is an officer or managing employee of a Medicare or State health care entity shall be subject to CMPs. [Senate provision.]

- Allows CMPs to be imposed for incorrect coding or medically unnecessary services and persons offering inducements to enrollees. [Senate provision.]

- Makes CMP provisions for fraudulent claims more lenient by redefining the term "should know" so that providers would only be liable if they act with "deliberate ignorance" or "reckless disregard" of false claims. [House provision.]

- Creates new CMP for false certification by physicians of the need for HH services. [House provision.]

- Incorporates "Amendments to Criminal Law" from Senate bill.

- Expands authority of State Fraud Control Units. [Senate provision.]

Other Provisions

CLIA: The Agreement includes the House provision to eliminate CLIA for physician office labs.

Physician Self-Referral: Same as House provision, with the exception that a provision overriding State laws that are more restrictive than Federal law was not included in the agreement. The agreement would: repeal prohibitions based on compensation arrangements; exclude six currently covered medical services from the list to which the self-referral provisions apply; expand the list of exceptions; and delay implementation of the self-referral provisions until regulations are published.

Malpractice Reform: [Unable to find any provision, but the House provision to reform malpractice may be in another title.]

draft

11/17/95

Issues Summary
"Medicaid Transformation Act of 1995"
Conference Agreement
November 1995

OVERVIEW

Repeals Title XIX and replaces it with Title XXI, "Medigrant Program for Low-Income Individuals and Families"

ELIGIBILITY

[Largely the same as the Senate version, although States may define disability for purposes of mandatory coverage.]

♦Individual entitlement would be eliminated. Current Medicaid enrollees -- including children, the elderly, individuals with disabilities and dually-eligible Medicare beneficiaries -- could, at a State's option, lose eligibility for certain Medicaid-covered services.

- States are required to cover pregnant women, children age 12 and under, and the disabled (as defined by the State) with income below the poverty level. However, other provisions in the bill undermine this guarantee. States can vary coverage across geographic areas and can vary duration and scope of services across enrollees. Enrollees have no guarantee of any particular service or any level of covered services.

♦ Current spousal impoverishment protections are retained.

♦ Individuals would not be able to sue a State in Federal court for the State's failure to comply with Federal Medigrant requirements. Therefore, guaranteed coverage for pregnant women, children and the disabled and spousal impoverishment protections -- as well as any other individual rights within this bill -- are effectively nullified. Only the Federal government could attempt to enforce these statutory provisions through an administrative compliance process.

♦ Current restrictions on liens and estate recoveries are eliminated.

♦ States could not deny coverage of services based on a pre-existing condition.

♦ States cannot require an adult child whose income is below the State median income level to

contribute to the cost of nursing home care for a parent.

- States may cover individuals with incomes below 275 percent of poverty. [Midpoint between House and Senate.]

SERVICES

[Largely similar to both the House and Senate.]

- Required services -- even for hospital or physician services -- would be eliminated.
  - Immunization services and pre-pregnancy family planning services would remain as the only required services in this bill. However, the VFC program would be repealed, causing immunization costs to increase.[Same as Senate.]

♦Comparability of services within States would be eliminated; therefore, covered services would vary from State to State. No standard services (e.g., current mandatory services) would be required to be covered in every State.

- States would be able to vary duration and scope of services from enrollee to enrollee. Therefore, equitable coverage for eligible beneficiaries would not be assured. States would be able to discriminate against certain enrollees (e.g., due to age, sex, or race) by providing different levels of coverage for the same service.

♦The requirement for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) of children would be eliminated.

- Abortion services would be limited to situations involving rape, incest, and protecting the life of the mother.

PAYMENT TO STATES - ALLOCATION FORMULA

[Similar methodology to both House and Senate provisions, but with significant differences.]

- Savings total approximately $164 billion over seven years.
- For each fiscal year, the Secretary would calculate both a Federal obligation and an outlay allotment for each State.
  - The obligation allotments would be slightly higher than the actual amount of Federal funds States can draw down -- the outlay allotment. The rationale for this provision may be that States often incur greater costs than they are able to draw down Federal matching payments in a given fiscal year.

- No special treatment for disproportionate share hospitals (DSH). DSH payments are included in the base.

- All States' outlay allotments would be adjusted (using a scalar factor) so that the total does not exceed the available pool of Federal funds. The pool of Federal funds would be $96.4 billion in 1996, $103.2 billion in 1997, $107.9 billion in 1998, $112.6 billion in 1999, $117.4 billion in 2000, $122.3 billion in 2001 and $127.4 billion in 2002. The available pool of Federal funds would increase the lower of 4.2 percent or GDP for years after 2002.

- Outlay allotments for 1996 would be established in statute. [New provision.]

- A State's outlay allotment for 1997 and subsequent fiscal years would be equivalent to a calculated needs-based amount, subject to a scalar (to make State allotments sum to the total pool) and growth limits:

  Floors

  - Annual growth in States' outlay allotments would not fall below 3.5 percent in 1997; this increase is reduced to 3 percent in 1998 and 2 percent for subsequent years;

  - All States' computed allotments would be at least 0.24 percent of the Federal pool beginning in 1998.

  - Beginning in 1998, if a State's annual allotment growth exceeds the national growth percentage, annual allotment growth would be limited to 4 percent.

  Ceilings

  - The growth in States' outlay allotments cannot exceed 9 percent for 1997 and 5.3 percent for subsequent years;

  - Outlay allotments for the ten States with the lowest Federal Medigrant spending per resident in poverty would grow at 7 percent;

- The needs-based amount for each State is generated using measures of State's relative number of residents in poverty, a case-mix index, an input cost index, and national spending per person in poverty.

- New Hampshire and Louisiana would have outlay allotments fixed through fiscal year 2000. The two States would incrementally increase their financial participation. Both States would be required to contribute 20 percent of the amount that would be necessary to draw down their full outlay allotments in 1996 -- $203 million and $355 million respectively. Their obligations would increase by 20 percent increments in order that by fiscal year 2000, they would be meeting their full obligations. [Same as Senate.]

- Louisiana and Nebraska would have pre-determined allotment increases of $37 million and $106 million, respectively, for 1997; Nevada's allotment would be increased by $90 million annually for 1996, 1997 and 1998. [New provision.]

- A supplemental allotment for emergency services to undocumented immigrants would be provided to the fifteen States with the highest number of undocumented immigrants. This allotment would be allocated based on the proportion of undocumented immigrants in each State compared to the total for all States receiving the supplemental allotment. $3.5 billion from 1996 to 2000.

- The Federal Medicaid assistance percentage (FMAP) would be either the result of the current formula (based on States' relative per capita incomes), 60 percent, or the lower of the new FMAP (based on total taxable resources and aggregate expenditure need) or the current FMAP plus 10 percent. States would be able to choose between these three options. [Combination of Senate and House provisions.]

LIMITATIONS

[Mostly similar to House provisions.]

- States would not receive Federal match for payments made for non-emergency services provided by excluded providers or provided to illegal aliens, payments eligible for third-party coverage, or payments for medically-related costs in excess of five percent of total expenditures. [Similar to House and Senate.]

- No Federal funding would be available for administrative expenses greater than $20 million plus 10 percent of total program spending in a given year.

- No Federal funds would be available for purchase of outpatient drugs from a manufacturer who was not participating in the drug rebate program.

SET-ASIDES

[Combination of House, Senate and new provisions.]

- States would be required to devote a minimum proportion of their total program spending on low-income families, low-income elderly, low-income disabled individuals, and services provided by Federally-qualified health centers and rural health centers.

    - This minimum percentage would be based on 85 percent of the average percentage of State spending on mandatory eligibles within these groups for mandatory services from 1992 to 1994. Spending for all elderly in nursing homes would be included in the

elderly set-aside. The Medicare cost sharing set-aside would be based on 90 percent of the average percentage of State spending on Medicare premiums from 1993 to 1995. [Same as House and Senate.]

- The minimum percentage for FQHC and RHC services would be based on 85 percent of the average annual Medicaid expenditures from 1992 through 1994 on services provided by these entities. [New provision.]

- States will be permitted to spend <u>less</u> than the minimum set-asides if they can determine that the health needs of the population can be "reasonably met" without the required expenditure amount. [Same as House.]

- States would also be permitted to spend less than the minimum set-asides if an independent actuary certifies that, under the State plan, the State will be spending at least 95 percent of the minimum set-aside for any of these categories. [New provision.]

PROVIDER PAYMENTS

[Largely the same as House and Senate provisions.]

The bill removes all Federal provider payment requirements, including the Boren amendment and payment requirements for Federally-qualified health centers and rural health centers.

- States would be required to set capitation rates in accordance with actuarial principles.

- DSH payments are not explicitly retained. However, States must include a description of how these hospitals will be paid in their State plan. [Same as Senate].

COST-SHARING

- States may impose cost-sharing requirements -- including coinsurance, copayments, deductibles and other charges -- on Medicaid enrollees, except:

  - States would be prohibited from imposing premiums on families with incomes below the Federal poverty level with a pregnant woman or a child (under age 19).

  - Copayments for primary and preventive services (as defined by the State) must be nominal for pregnant women and children in families with income below the Federal poverty level.

- States would have broad flexibility to develop premium and cost-sharing schedules. States could choose to develop premium and cost-sharing requirements that discourage inappropriate use of emergency services; encourage the use of primary and preventive care,

are related to economic factors, employment status, and family size; reflect the availability of other insurance coverage; or are tied to participation in programs that promote personal responsibility (i.e., drug treatment or employment training).

DELIVERY SYSTEMS

[Same as House and Senate.]

- Access standards for health plans and other providers would be eliminated.
- Freedom of choice requirements would be eliminated. Beneficiaries would not be guaranteed a choice of plan or delivery system.
- States' ability to contract with managed care plans for services, case management, or coordination would be unfettered.

NURSING HOME QUALITY ASSURANCE

Maintains much of the current statutory structure from the OBRA 87 nursing home reforms, but States will be responsible for setting and enforcing quality standards.

- States could turn over their standard setting and enforcement responsibilities to private organizations (allows "deemed status"), with no Federal review;
- Maintains Federal look-behind of State surveys, but changes look-behind to a three-year cycle;
- Requires States, rather than the Federal government, to establish requirements for nurse aide training, pre-admission screening and annual resident review (PASARR) and administrator qualifications;
- Eliminates the annual review component of PASARR;
- Reduces statutory specificity on the level of services and activities that must be provided to nursing home residents;
- Eliminates current protections that prohibit nursing homes from requiring potential residents to forgo Medicaid coverage at the point of admission or in the future or from requiring additional payments;
- Modifies residents' rights with regard to transfers; and
- Eliminates uniform data requirements.

MEDICAID DRUG REBATE PROGRAM

[Largely similar to House and Senate.]

- Federal payment for outpatient prescription drugs would be available only if the manufacturer has entered into a Medicaid drug rebate agreement with the Secretary.

- States are not required to participate in the drug rebate program, but they cannot pay for drugs unless they do.

- Supplemental rebates (beyond those agreed to by the Secretary) are prohibited. [Same as Senate.]

MEDICARE COST-SHARING

[Same as House and Senate.]

Low-income Medicare beneficiaries would not be assured of continuing to receive State-financed assistance with Medicare costs. States could eliminate payments for premiums, coinsurance, and deductibles or reduce the scope of assistance -- e.g., covering only a proportion of the Medicare premium.

NATIVE AMERICANS

[Same as House and Senate.]

- One hundred percent Federal matching would be extended to services provided by tribal providers as well as Indian Health Service facilities. However, one hundred percent Federal matching for these services would not increase the State's base. This requirement therefore would effectively reduce available Federal funds for other Medicaid populations.

- State Medigrant plans would be required to include a description of how (or whether) Indian Health Service facilities will be included as Medigrant providers and how eligible Indians will receive medical assistance.

- States will be required to consult with Indian tribes and tribal organizations as they develop their Medigrant plans.

DEMONSTRATION PROGRAMS

[Same as House.]

No provisions for section 1115 demonstration programs. States with 1115 statewide demonstrations would be treated on par with other States.

ACCOUNTABILITY

[Similar to House and Senate.]

- The bill does not require States to be accountable for how they spend Federal funds.
- Limitations on the use of provider taxes and donations, contained in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 are eliminated. [Same as House.]
- The State-share limit on inter-governmental transfers is retained. [Same as Senate].
- The Secretary's authority and ability to enforce compliance would be severely constrained by procedural requirements.
- Goals, objectives and performance measures in State Medicaid plans are unenforceable. State accountability for State Medicaid plans -- and amendments to these plans -- would be minimal.
- Current Federal disallowance authority would be compromised. The Federal government would be prohibited from collecting pending disallowances.

MEDICARE/MEDICAID DEMONSTRATIONS

[Similar to Senate provision.]

Requires the Secretary to conduct State demonstration projects (no specific number) integrating Medicare and Medicaid delivery systems, financed through a combination of Medicare and Medicaid funds. These projects would focus on coordinated services for chronically ill elderly and disabled individuals who are eligible for both programs. Beneficiaries would not be required to participate in these programs.

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