

ADMINISTRATION HISTORY APPENDIX
CHAPTER ONE: FISCAL DISCIPLINE

MEDICARE

95-145812

April 30, 1995

MEMORANDUM FOR SECRETARY RUBIN

INFORMATION

FROM: Alan Cohen
Senior Advisor to the Secretary

Glen Rosselli
Deputy Assistant Secretary for Economic Policy

SUBJECT: Medicare and the Budget

SUMMARY: The Republican "strategy" of moving Medicare reform in a separate reconciliation bill creates enormous new difficulties for them. They have two options, either of which is painful. First, they could have a budget resolution that fails to show balance over seven years. Alternatively, they could include a plug of \$250 Billion of Medicare spending cuts in their budget resolution, which will make many of their members extremely skittish.

DISCUSSION:

Speaker Gingrich said on Friday that Medicare "reform" would move separately from Reconciliation. Senator Dole said on television today that there would be two reconciliation bills this year. What do these statements mean for the budget process and what are the implications?

The most likely interpretation of this "strategy" for the budget process is as follows:

The Republicans would try to pass a Budget Resolution that calls for two separate reconciliation bills. They can do this within the rules. One reconciliation bill would order cuts in entitlements other than Medicare. The other reconciliation bill would be for Medicare only. Presumably, for political reasons, the second one would move after the first one; otherwise, why go to the trouble of having two separate bills.

However, if the Budget Resolution calls for two reconciliation bills, how do the numbers in the resolution reflect Medicare? There are two possibilities:

1. The Budget Resolution would call for Medicare reforms in a second reconciliation bill, but the numbers in the Resolution would not include any impact of those reforms on Medicare spending.

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The problem with this approach for the Republicans is that it means that the Budget Resolution and reconciliation would have tremendous difficulty coming close to balancing the budget over seven years. They have failed to meet the objective which they claimed was so crucial. Furthermore, without budget balance, the Republicans will look derelict if they try to include tax cuts in the Budget Resolution and/or reconciliation. Furthermore, they will probably not have enough political cover to put a debt ceiling increase into the reconciliation bill.

2. Not only would the Budget Resolution call for Medicare reforms in a second reconciliation bill, but the numbers in the Resolution would actually show the aggregate impact of those reforms on Medicare spending and on total Federal spending -- and on the Federal deficit. But this means that the Budget Resolution would still be calling for \$250-300 Billion in Medicare cuts over seven years. Republicans who are skittish now about these large cuts would be just about as skittish over this option. Furthermore, under this option, the Republicans would be quite hard-pressed to include tax cuts in the Reconciliation bill because that bill, which will not have any Medicare cuts in it, will not balance the budget in seven years. For the same reason, it would be hard to include a debt ceiling increase in reconciliation. Therefore, this option, which may appear attractive at first, has major liabilities and few benefits to the Republicans.

With either option, the Republicans would have to pass a huge reconciliation bill with painful cuts in programs other than Medicare, without the cover that they would get from budget balance and/or without the sweetener of tax cuts. Their tax cuts would have to be a difficult piece of Medicare reform legislation (part of the reconciliation bill). In short, they are in deep trouble in terms of

Moreover, having staked their position on including Medicare cuts, it appears that the Republican position.

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93-122278



DEPARTMENT OF THE TREASURY
WASHINGTON

INFORMATION

TO: Deputy Secretary Altman
FROM: Marina Weiss
SUBJECT: Impact of Additional Medicare/Medicaid Budget Cuts on Health Care Reform Initiative
DATE: June 4, 1993

SUMMARY: Pursuant to our discussion of yesterday, here are my thoughts on increasing the level of Medicare and Medicaid budget cuts as the Finance Committee marks up its title of the Reconciliation bill.

RECOMMENDATION: In order to deliver on the President's promise to finance at least some of the cost of reforming the national health care system from reductions in Federal spending, it would be preferable to defer further cuts in Medicare and Medicaid until the Administration proposes its health reform initiative. If, however, it is necessary to make additional cuts in Medicare and Medicaid as a way of obtaining Senate support for the Reconciliation bill, then I would recommend a two part strategy:

1. tailor the cuts to complement the contours of what we expect the Administration's plan to be; and
2. reassure Senators, Members of Congress and others who find the cuts excessive that there will be an opportunity to revisit the issue during the House-Senate conference.

ACTION: Not applicable.

DISCUSSION:

Background

Throughout the campaign, the President told the American people that he intended to reform the health care system to make coverage universal and more affordable. He also made it clear that he would phase in universal coverage as savings from reducing current costs became available.

As you know, Medicare and Medicaid are the two largest Federal health care programs accounting for approximately \$130b and \$73b in 1992 outlays.

When it was submitted in April, the President's budget included Medicare and Medicaid cuts amounting to \$2.6b in 1994 and \$46.8b over the 5 year budget period. The Administration then sent up a second set of cuts in Medicare which brought the total proposed

to \$3.0b in 1994 and \$51.2b over the 5 year period.

In its Reconciliation bill, the House Committees with jurisdiction over these programs (Ways and Means and Energy and Commerce) cut a total of \$69.6b over the 5 year period. The total cuts in Medicare and Medicaid exceed the Reconciliation deficit reduction target by more than \$30b. These additional "savings" were used as a way of offsetting the cost of expanding the Earned Income Tax Credit, and to pay for several new initiatives, notably the Administration's immunization proposal and continuation of special subsidies for rural hospitals.

As part of their proposal to eliminate the Btu tax, Senators Boren and Danforth have recommended further cuts in Medicare of nearly \$90b. In fairness, it should be pointed out that the Boren-Danforth Medicare and Medicaid proposals were described as options rather than proposals. Senator Breaux's staff has indicated that he would be more comfortable with a lower target, perhaps \$30b in additional cuts over the 5 year period.

Potential Impact of Cuts on Health Reform Initiative:

As you know from our earlier discussion, these large cuts in Medicare and Medicaid should not be made without a full understanding of the interaction between the economic plan and the health reform initiative.

Specifically, I would recommend that the following points be discussed with the White House:

1. Making deep cuts in Medicare and Medicaid to reduce the deficit will use up on-budget resources that could be applied to the Federal costs of the health reform plan (costs of insuring the uninsured who are not connected to the workforce and costs of subsidizing small businesses who will be mandated to cover their employees).
2. If savings from cutting Federal spending is used in the Reconciliation bill, Federal costs of the health care plan will have to be financed by tax increases or by expanding the scope of the employer mandate.
3. If these cuts are made and the Administration is not willing to raise taxes to pay for health care reform, the cost of the health care plan will have to be reduced by either proposing a more austere benefit package or by phasing in coverage over a longer period of time.
4. Since cutting Medicare and Medicaid payments to providers has the effect of reducing the price government pays for services, providers of care [e.g. hospitals, physicians, etc.] will make up their losses by increasing the cost of medical care to individuals, businesses, and State and local governments. If this phenomenon, known as "cost shift" is substantial, some

individuals and businesses can be expected to reduce or drop their insurance coverage altogether, thereby increasing the numbers of uninsured/underinsured Americans. Others who continue to purchase coverage privately will see an increase in the cost of their premiums.

5. If employers experience significant increases in the cost of providing health coverage, imposing an employer mandate as a part of health care reform may be more difficult.

6. Medicare and Medicaid already pay providers at a discounted rate. While there is no rigorous study showing that Medicare beneficiaries have difficulty in finding physicians who are willing to treat them, there are growing numbers of anecdotal reports to that effect. As you know, there is a very serious problem with Medicaid beneficiaries not being able to find physicians willing to take them as patients. Providers claim that they refuse to treat Medicaid patients because of inadequate reimbursement. If the already discounted payment rates in these programs are reduced even further through budget cuts, beneficiaries may have even more difficulty in obtaining necessary care.

7. On the other hand, if individuals, employers and State and local governments are victims of significant "cost shift," it may increase their incentive to negotiate a reasonable comprehensive health care reform agreement.

8. If the White House is interested in portraying this Administration as willing to make the difficult decisions and to "take on" traditional Democratic constituencies, deep cuts in the fastest growing entitlement programs can be characterized as an example of courage and retrenchment.

TREASURY CLEARANCE SHEET

NO. _____
Date June 4, 1993

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Marina L. Weiss

THROUGH: _____

SUBJECT: Impact of Additional Medicare/Medicaid Budget Cuts on Health Care Reform Initiative

REVIEW OFFICES (Check when office clears)

- Under Secretary for Finance
 - Domestic Finance
 - Economic Policy
 - Fiscal
 - FMS
 - Public Debt

- Under Secretary for International Affairs
 - International Affairs

- Enforcement
 - ATF
 - Customs
 - FLETC
 - Secret Service
 - General Counsel
 - Inspector General
 - IRS
 - Legislative Affairs
 - Management
 - OCC

- Policy Management
 - Scheduling
 - Public Affairs/Liaison
 - Tax Policy
 - Treasurer
 - E & P
 - Mint
 - Savings Bonds

Other _____

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
WEISS, Marina	MW	6/4/93	DAS for Health Policy	2-0090
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date

TREASURY CLEARANCE SHEET

NO. 93-122278
Date June 4, 1993

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

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THROUGH: _____

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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S) WEISS, Marina	<i>MW</i>	6/4/93	DAS for Health Policy	2-0090
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date



DEPARTMENT OF THE TREASURY
WASHINGTON

May 17, 1995

ASSISTANT SECRETARY

DDP
INFORMATION

MEMORANDUM FOR SECRETARY RUBIN

FROM: Alicia Munnell *AM*
SUBJECT: New Medicare Proposals

Congressmen Christopher Shays, Dave Hobson, Dan Miller, and Steve Largent have submitted three separate alternative proposals (referred to as Plans A, B, and C) for improving the Medicare system to Chairman Thomas of the House Subcommittee on Health (copy attached). Under each of the plans, Medicare cost increases would be limited to an average of 5.4 percent per year over seven years, so that total spending would reach \$258.9 billion in FY 2002 (as in the Senate Budget Committee mark). Total claimed savings, based on CBO scoring, are \$288 billion over seven years. Below is a brief summary of each plan.

Plan A: Incentive Based Medicare Reform

This plan would implement 35 proposals for Medicare savings, ranging from increasing beneficiary copayments, premiums, and deductibles to cutting provider payments. The plan would also establish a preferred provider organization, allow beneficiaries to stay in employer plans when they retire, increase incentives for HMOs to contract with Medicare, and further increase the Part B premium for new enrollees who choose fee-for-service plans after 1999.

In addition, Plan A would limit payments to hospital physicians whose costs far exceed the national median, make hospitals responsible for post-acute care decisions, establish payment limits for outpatient services, adjust the Medicare Volume Performance Standard, reduce direct and indirect medical education funds, phase out Medicare disproportionate share payments to hospitals, and apply means testing to the Part B premium.

Plan B: Defined Medicare Contribution

Medicare would be transformed into a defined contribution program for every beneficiary, with Medicare making contributions to a qualifying health plan of the beneficiary's choice and the beneficiary paying extra or receiving a rebate depending on whether the plan is more or less costly than the amount of the contribution. The contribution level would be adjusted based on each beneficiary's age, gender, geographic location, disability status and End Stage Renal Disease status; in 1996, the average contribution amount would be \$5,122. Medicare could continue to offer the traditional Medicare benefit plan and allow beneficiaries to purchase it at its actuarial value.

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Plan C: Incentive Based Medicare Reform with Look Back Sequester

This proposal consists of three "levels." The first level comprises several measures to lower expenditure growth in the current system: establishing home health, skilled nursing, and clinical lab coinsurance, reducing the hospital inflation update and freezing the physician update, increasing and indexing the Part B deductible, and other changes. The second level would expand the scope of Medicare private plans to include Preferred Provider Organizations, Point of Service plans, Medical Savings Accounts, and other options. Enrollees would receive an adjusted contribution toward the cost of the plan, as in Plan B above. The third level, a look back sequester, would be instituted if contributions to private plans are below the projected target, or if government-run Medicare spending is projected higher than the target. The sequester would include unspecified reductions in provider payments and expanded beneficiary cost sharing; HCFA would recommend changes which Congress could adopt or overrule. If Congress failed to act altogether, HCFA's recommendations would be adopted. Payroll tax increases and higher government contributions to Part B could not be recommended.

Attachment



CONGRESS OF THE UNITED STATES

May 11, 1995

The Honorable William M. Thomas
Chairman
House Subcommittee on Health
1136 Longworth HOB
Washington, D.C. 20515

Dear Bill:

Recognizing the challenges your subcommittee faces in the coming months in passing legislation to save the Medicare system, we want to take this opportunity to share with you three separate plans we believe will help protect, preserve and improve the current system, which, as you know, will be bankrupt in seven years.

Congress and the Administration have a historic opportunity to improve the quality of care for seniors, increase choice, reduce waste and inefficiency, and, most importantly, save the program from bankruptcy.

There is no reason why Medicare should not be able to realize the same improvements in health care delivery and reductions in the rate of growth experienced by the private sector during the past few years. Unfortunately as we discovered, part of the problem is that Medicare's current structure is designed to meet the market place of the 1960's, not the market place of the 1990's and beyond.

We have attached information about our three plans. We do not send them to you advocating one plan over another but simply pass them on as different approaches you may want to consider in working to provide more choice, greater effectiveness and a lower rate of growth in the Medicare system, all of which is essential to avoiding bankruptcy. Each plan has been scored by CBO, and while we believe them to be viable, we also know they can be improved.

In short, the three plans are as follows:

A. Incentive Based Medicare Reform

This proposal would implement 35 specific proposals that reform the existing Medicare system to help create more choice and incentives for competition and cost effectiveness.

Congressman
Christopher Shays
Fourth District Connecticut

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Washington, DC 20515-0704

Telephones

Bridgeport 571-5870
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Stamford 357-8277
Washington, DC 202/225-5541

B. Defined Medicare Contribution

This proposal would provide a defined contribution -- adjusted for age, gender, geographic location, disability and ESRD status -- towards the plan of choice for each beneficiary.

C. Incentive Based Medicare Reform with Look Back Sequester

Under this approach, specific proposals would be implemented initially to achieve savings and encourage seniors to choose more cost-effective plans. It would also include a yearly savings target that if not met through private care would trigger additional cost saving measures to meet annual targets.

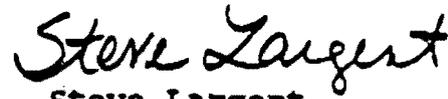
We hope this information will be helpful to your subcommittee and look forward to working with you in your efforts to protect, preserve and improve the Medicare system.

Sincerely,


Christopher Shays
Member of Congress


Dan Miller
Member of Congress


David Hobson
Member of Congress


Steve Largent
Member of Congress

cc: The Honorable Bill Archer

OPTIONS FOR PRESERVING MEDICARE

**Congressmen Christopher Shays, Dave Hobson,
Dan Miller, and Steve Largent**

May 11, 1995

NOTE ON SCORING: All three plans provide for Medicare growing from \$178 billion in 1995 to \$281 billion in 2002. This is an overall growth of 44.9 percent over the seven years and 5.4 percent compounded annually. The resulting slower growth rate achieved from implementation of any one of the plans would save \$288 billion over seven years.

As an integrated plan overall scoring for Plan A will not equal the total of the individual proposals. This is due to the interactive behavior of the proposals when combined into one plan. If taken separately, the 35 proposals save \$302 over seven years. But as an integrated plan the savings, as scored by the Congressional Budget Office (CBO) totals \$288 over seven years. Therefore, the ultimate savings is \$288 billion, not the total of the 35 proposals.

In addition, some of the proposals contained in Plan A are new and had not been previously scored by the CBO. As it has continued to analyze these new proposals, CBO has revised its assumptions, thereby altering savings figures. It is expected CBO will continue to make revisions.

PLAN A: INCENTIVE BASED MEDICARE REFORM

This plan consists of four sets of proposals aimed at accomplishing these goals:

- I. Proposals to *expand choice for seniors*, to introduce incentives for the market to compete, and to convert Medicare to a system similar to the Federal Employees Health Benefits Program.
- II. Proposals to eliminate waste and overpayments and motivate providers to practice more cost effectively by bringing market principles to Medicare.
- III. Proposals to increase cost consciousness and reduce the Medicare subsidy.

IV. Proposals that will end Washington budget gaming by *permanently* extending current law that is set to expire.

Expand Choices for Medicare Beneficiaries

Twelve initiatives are proposed to transform Medicare. These proposals will promote more health care choices for the elderly and are designed to encourage Medicare beneficiaries to choose plans based on cost effectiveness and quality. They also contain incentives to motivate private plans to participate in the Medicare program. These proposals represent the largest reform of the Medicare program since its inception. Although several of the following proposals do not produce direct savings by themselves, they contribute indirectly by improving the overall Medicare program.

1. **Inform Beneficiaries (no outlay savings)**

Many Medicare beneficiaries are not even aware of the HMO option they have now. Under a system where there are many more options, it will be imperative that they be informed of the many advantages these plans have over their current system. This proposal would require that Medicare beneficiaries be supplied with comparable information on all their choices of health plans (including Medicare fee-for-service) similar to what Office of Personnel Management (OPM) now provides during the open enrollment season for federal employees. Included in this information should be report cards on quality of health care plans.

2. **Allow Plans Price Flexibility and Rebates (no outlay savings)**

Currently, Medicare allows HMOs the option to offer extra benefits to Medicare beneficiaries, such as prescription drugs and preventive care. Some HMOs are able to offer these extra benefits because their Medicare payment is far higher than the cost to treat the beneficiary.

This proposal would allow plans to give beneficiaries the option of extra benefits or a cash rebate (not allowed under current law) for the difference between the Medicare payment and the plan's cost to treat the beneficiary. Beneficiaries who choose a less expensive plan should be rewarded for that choice and be allowed to receive a rebate.

3. **Establish a Preferred Provider Option for Both Part A and Part B of Medicare (\$26.3 billion savings over seven years)**

Medicare beneficiaries are uncertain about joining coordinated care plans because it limits their ability to choose a doctor. A Preferred Provider Organization has a combination of advantages over coordinated care plans and indemnity plans: it offers a very broad array of doctors with negotiated discounted rates. Beneficiaries can still choose a doctor outside the health plan if they pay a higher copayment. This proposal

would model a Medicare preferred provider system after those that have emerged as a major way to control the growth in costs in private sector insurance programs. Providers who choose to be on Medicare's preferred provider list would provide fee discounts to Medicare.

4. **Allow Beneficiaries to Remain in Their Employer Plans (no outlay savings)**

Currently, if an individual belongs to an employer sponsored plan that does not participate in Medicare, that individual must leave their plan when they become a Medicare beneficiary. This problem will become more prevalent as the private health care population turns in increasing numbers to coordinated care plans — because most of these plans do not have contracts with Medicare. This proposal would provide a seamless health care transition when employees retire and become Medicare beneficiaries by allowing Medicare payment to employer sponsored plans.

5. **Lift the "50/50" Legislation (no outlay savings)**

This Health Care Financing Administration rule requires HMOs with a Medicare contract to have at least as many commercial customers as it does Medicare customers. Almost all insurance plans cite HCFA's "50/50" rule as the major barrier for starting a Medicare HMO in many areas of the country.

6. **Allow Plans to Sell More Products (no outlay savings)**

Insurers believe they could recruit more beneficiaries, and be more profitable, if they could offer more Medicare products in addition to the very regulated HMO product that the Medicare laws now allow. These include point-of-service plans, preferred provider organizations, medical savings accounts, and partial capitation plans. Payment to these plans would be made through a contribution from Medicare that is based on a revised method of how Medicare currently pays HMOs (see proposal below). Beneficiaries would receive a rebate or pay an additional amount depending on the price of the plan they choose.

7. **Increase Incentive for HMOs to Contract with Medicare by Making Medicare Payments to HMOs More Equitable (\$9.9 billion in savings over seven years)**

Currently, Medicare payment to HMOs vary greatly from county to county because the HMO payment is based on average fee-for-service Medicare costs. For example, Medicare pays HMOs in some counties in California around \$650 per month per beneficiary because Medicare has very high fee-for-service costs in that area. But HMOs in the Minneapolis area are paid only around \$350 per month per beneficiary because Medicare fee-for-service is less costly in this area. For this reason, HMOs with Medicare contracts are concentrated in a few areas around the country, leaving most areas with no Medicare HMOs at all because it would be unprofitable for them. Also, while the HMOs in the high paying areas are able to offer beneficiaries extra benefits, such as prescription drugs, with no monthly premium, HMOs in low paying areas must charge the beneficiary a monthly premium upwards of \$60 and are still

unable to offer any extra benefits. This proposal would unlink HMO payment from Medicare fee-for-service costs by increasing current HMO payments by 5 percent each year (instead of increasing payments by the increase in fee-for-service costs) and would collapse the range of HMO payments by increasing by only 1.5 percent payments to HMOs that are now paid over 120 percent of the national median until those HMO payments fall within 120 percent of the national median.

8. Make Payments and Population More Stable for Managed Care Organizations (no outlay savings)

This proposal would discontinue the 30-day disenrollment policy for HMOs and require beneficiaries to remain in a plan for one year (as does FEHBP). An exception would be made, allowing beneficiaries who are first-time HMO enrollees a 90-day trial period before committing to the full-year enrollment. The proposal would allow plans a three-year payment contract option to eliminate uncertainty in payments that the current year to year contract involves.

9. Eliminate Part B Premium for Coordinated Care (no-outlay savings)

Medicare beneficiaries would be encouraged to join coordinated care plans by eliminating the beneficiary Part B premium of about \$50 per month. This premium, which currently is included in the Federal Government payment to Medicare HMOs, would be excluded from the federal payment. HMOs could then, in the annual premium charge to HMO beneficiaries, raise their current premium rate to make up for some or all of this reduced federal payment. Because HMOs can presumably deliver services more efficiently than Medicare fee-for-service, competition will likely result in a premium of less than \$50 per month. These savings will accrue directly to the beneficiary.

10. Increase Premium for New Beneficiaries Who Choose Medicare Fee-For-Service (\$3.8 billion in savings over seven years)

The Medicare Part B program is highly subsidized out of general revenues (projected to receive transfers of \$59 billion in 1996). Beginning in 1999, all new enrollees choosing Medicare fee-for-service would pay a Part B premium \$20 higher than that of current Medicare beneficiaries. This would help reduce the subsidy while encouraging beneficiaries into more cost effective plans. Current enrollees would be exempt from this proposal.

11. Move Medicare Deductible Toward Average Deductibles in Private Sector Health Care (\$15.2 billion in savings over seven years)

The Medicare Part B deductible has been increased only three times in the history of the program: the original \$50 deductible of 1965 is now \$100. This low deductible provides a major incentive to overuse medical services. This proposal would increase the deductible to \$150 in 1996 then index it to program growth. Beneficiaries will have the option to avoid paying this deductible (or avoid paying an increased premium for

a Medigap policy that covers this deductible) by choosing a private plan, such as an HMO, that does not charge a deductible.

12. **Convert Medicare to an FEHBP-Like System. (savings are realized beyond seven-year period)**

After the above proposals have increased private market capacity for Medicare beneficiaries, and have helped to introduce beneficiaries to the advantages of the new expanded choice system, Medicare will be converted to a capitated voucher system in which the government will make a standard, defined contribution to the plan each beneficiary chooses, similar to the way the government contributes to the plan of each Federal employee's choice under the Federal Employee Health Benefits Plan (FEHBP).

II. Eliminate Waste and Overpayments and Motivate Providers to Practice More Cost Effectively by Bringing Market Principles to Medicare

13. **Allow Medicare Beneficiaries to Share in the Savings When they Detect Inappropriate Medicare Payments (savings undetermined)**

This proposal would allow Medicare beneficiaries to receive 10 percent of the savings if they detect that Medicare was charged for services they did not receive or for medical equipment they did not request or need.

It is almost impossible for HCFA to thoroughly monitor payments to the thousands of Medicare products and services providers. But 37 million beneficiaries ensuring that their bills are correct will help to reduce Medicare waste and abuse.

14. **Limit Payments to Hospital Physicians Whose Costs Far Exceed the National Median (\$6.0 billion in savings over seven years)**

The volume and intensity of physician services per hospital admission varies widely from hospital to hospital even after adjusting for case-mix, geographic price differences, teaching status, and disproportionate share. This proposal would withhold 10 percent to 20 percent of the Medicare payment to physicians in hospitals which exceed 115 percent of the national median. If the physician staff reduces volume and intensity in the year of the withhold, Medicare will pay the physician staff some or all of the withhold at the end of the year. This is the first Medicare fee-for-service proposal ever that provides an organized group of physicians, the hospital medical staff, with the incentive to manage utilization.

15. **Transfer Post-Acute Care Decisions from the Government to the Private Sector by Bundling the Hospital Payment (\$19.3 billion in savings over seven years)**

Home Health Care, Skilled Nursing Facilities (SNF), and rehabilitation care — together known as post-acute care — are some of the fastest growing components of Medicare spending. Since 1985, post-acute spending has grown by over 25 percent annually,

from about \$2 billion in 1985 to \$16 billion in 1994. In the last two years, post-acute spending for SNF and home health services grew at an annual growth rate of 40 percent. Beginning in 1997, this proposal would make a single prospectively determined payment to hospitals that combines (and hospitals would be responsible for) all post hospital SNF and rehabilitation services, along with 60 days of home health services, thereby shifting the responsibility for deciding the appropriateness of post-acute care services from the Federal Government to the private sector. Bundling post-acute care services into the hospital payment would also correct the incentive that hospitals now have to discharge patients more quickly into post acute care settings because payment rates have traditionally been higher in post-acute settings.

16. Require Competitive Bidding on Clinical Labs and Durable Medical Equipment (\$1.6 billion in savings over seven years)

This proposal will require HCFA to run competitive bidding programs throughout the country in 1997 for certain durable medical equipment (oxygen, parenteral and enteral, MRI, and CAT scans) and clinical laboratory tests. Bids are expected to lower average prices by at least 10 percent nationally. If this average price reduction is not obtained, fees for certain durable medical equipment and clinical lab tests would be reduced to obtain an average price reduction of 10 percent nationally.

17. Establish Payment Limits for Outpatient Department Services Not Covered Under Current Cost Limits (\$3.1 billion in savings over seven years)

Nearly 40 percent of outpatient costs are exempt from cost limits or prospective payment rates. These costs have greatly expanded in the past five years. This proposal requires HCFA to set payment limits similar to cost-reimbursed outpatient services.

18. Readjust the Medicare Volume Performance Standard (MVPS) Formula (\$3.4 billion in savings over seven years)

The MVPS is the Medicare annual "growth target" for physician expenditures. If actual physician expenditures fall below this target, physicians are rewarded with an increase in the next year's fees — but then the next year's target is raised — and vice versa. The problem with the current law is that there is an asymmetry in the adjustment formula. That is, the upward adjustment in the target is smaller than the downward adjustment because of the expected behavioral change of increased volume and intensity of services when physician fees are reduced.

The asymmetrical treatment of future MVPSSs, therefore, effectively rewards physicians for exceeding the limit since future target limits are adjusted upwards for expected volume increases. This proposal, which is supported by the Physician Payment Review Commission, would determine future MVPSSs symmetrically by eliminating the behavioral offset assumption from the calculation.

19. Reduce Payments to Physicians for Overhead (\$0.9 billion in savings over seven years)

Medicare physician fees are calculated to include, among other things, physician office overhead costs. This component of the fee is based on historic charges instead of resource costs which are more reliable. This policy moves overhead expenses towards a resource-cost system.

20. Eliminate Formula Error That Causes Outpatient Overpayment (\$16.0 billion in savings over seven years)

The current Medicare payment formula for certain outpatient department services (ambulatory surgery, radiology, and diagnostic tests) contains an anomaly in the payment formula that was not intended by Congress when it was first designed. Beginning in 1998, this proposal would correct the anomaly in the outpatient payment methodology by changing how beneficiary coinsurance is applied in the blended limit formula.

21. Reduce Medicare Payments to Hospitals for Direct Costs of Medical Education (\$6.1 billion in savings over seven years)

Medicare makes a separate payment to hospitals for the direct costs they incur in providing graduate medical education, namely residents' salaries and benefits, teaching costs, and institutional overhead. This proposal would reduce teaching and overhead payments for residents, but continue to pay their salaries and fringe benefits. The overall reduction in the level of subsidy is warranted since market incentives appear to be sufficient to encourage a continuing flow of new physicians.

22. Reduce Medicare Payments to Hospitals for Indirect Costs of Medical Education (\$21.1 billion in savings over seven years)

This proposal would lower Medicare indirect education (ICE) in 1996 from 7.7 percent to 3 percent for each 10 percent increase in the intern and resident-to-be ratio (IRA ratio). The GAO and Prospective Payment Assessment Commission (ProPace) have both found that the 7.7 percent adjustment overcompensates teaching hospitals for these costs.

23. Eliminate Medicare Payments to Hospitals for Medicare Patients' Bad Debts (\$2.7 billion in savings over seven years)

Hospitals are responsible for collecting certain deductibles and co-payments from Medicare beneficiaries for inpatient services. Medicare fully reimburses unpaid balances for hospitals that have collection efforts. There is little incentive for thorough collection activities and bad debt claims have more than doubled since program inception. Hospitals that serve financially needy are already compensated through other Medicare payments. The HHS Office of the Inspector General recommends legislation to modify bad debt payment policy. Eliminating bad debt is included in CBO's spending and revenue options book.

24. Phase Out Medicare Payment to Hospitals for Disproportionate Share (\$28.8

billion in savings over seven years)

Under Medicare's prospective payment system (PPS), higher rates are paid to hospitals with a disproportionately large share of low income patients. In 1985, Congress added this adjustment to account for low income Medicare patients that may be sicker and more expensive to treat. In 1996, disproportionate share (DSH) payments are projected to total \$3.7 billion, more than 5 percent of all PPS payments.

Data on hospital costs, however, provide only limited support for any disproportionate share adjustment. Although more than 1,900 hospitals receive DSH payments, only 8.4 percent of hospitals have high DSH values accounting for one fifth of DSH payments. This proposal would phase out Medicare DSH payments over a two-year period. In addition to Medicare DSH payments, hospitals also receive DSH payments from the Medicaid program.

25. **Bring Surgeon Conversion Factor in Line With Primary Care (\$5.8 billion in savings over 7 years)**

Under the Medicare physician fee schedule, relative value units (RVUs) are allocated for each physician procedure. A physician's payment amount is determined by multiplying the number of units (assigned to the procedure) by a dollar amount called the conversion factor. Currently, this conversion factor is \$35.15 for surgery, \$33.72 for primary care, and \$32.91 for all other physicians. (For example: an appendectomy may be assigned 100 units - this is multiplied by \$35.15 to determine a payment of \$3515.00). Beginning in 1998, this proposal would reduce the surgery conversion factor to the same as the primary care conversion factor. Because surgical procedures are generally assigned more RVUs, this proposal would not necessarily reduce surgeon payments to the level of primary care.

III. **Increase Cost Consciousness and Reduce the Medicare Subsidy**

26. **Reduce the Medicare Subsidy to High-Income Beneficiaries (\$18.0 billion in savings over seven years)**

The current Medicare Part B premium charged to seniors covers 30 percent of total program costs (in 1996 this will go down to just 25 percent because of an OBRA 1993 law). The remaining 70 percent of the cost of providing Medicare Part B services is paid from the Federal Government's general tax revenues (only Medicare Part A is financed by the Medicare payroll tax).

This proposal gradually reduces the Medicare Part B premium subsidy for high income beneficiaries. The subsidy decrease would phase in to adjusted gross income of \$70,000 for individuals and \$90,000 for couples and would be phased out to zero for individuals above \$95,000 and couples above \$115,000 in income. At the zero subsidy level, beneficiaries will pay the full monthly premium amount: \$164 per month.

27. **Expand Medicare Coinsurance to Services Now Provided at No Cost to**

Beneficiaries: Clinical Laboratory and Home Health Services (\$25.8 billion in savings over seven years)

These provider services are the only Medicare services which do not now include a beneficiary co-insurance. Requiring beneficiaries to share the cost of these services would help to discourage over utilization and reduce the Medicare subsidy. Beginning in 1996, beneficiaries would pay 10 percent of all home health visit costs, beginning in 1999, this amount would increase to 20 percent. Beneficiaries would pay 20 percent of all laboratory services beginning in 1997. Beneficiaries below 150 percent of the poverty level would be excluded from paying this coinsurance.

IV. End Washington Budget Gaming by Permanently Extending Current Laws that are Set to Expire

28. Freeze 1996 Physician Payment at the 1995 Level and Reduce Future Updates by 3 Percent (\$2.5 billion in savings over seven years)

This proposal would adjust the annual update component of the Medicare physician fee schedule so that its statutory formula will not continue to award physicians with large updates. In 1994 and 1995, physicians received cumulative overall Medicare rate increases of 15.2 percent (7.0 percent in 1994 and 7.7 percent in 1995).

29. Reduce the Excess Capacity Adjustment for Hospital Inpatient Capital Payments (\$5.4 billion in savings over seven years)

Current Medicare prospective and cost reimbursed payments to PPS hospitals for inpatient capital is based on the assumption that the hospital has a 100-percent occupancy rate. Hospital occupancy, however, has actually been about 60 percent over the last five years and, as a result, Medicare is paying hospitals for empty beds. This proposal would adjust Medicare hospital capital payments for excess capacity. In the late 1980s, these capital payments were reduced by 15 percent. In the 1990s, this reduction was scaled back to 10 percent.

This proposal recaptures the 5 percent in Medicare capital savings given back to hospitals in the 1990s. While this capital proposal addresses Medicare overpayments only for excess capacity.

The capital extender proposal (below), preserves the OBRA 1990 savings that reduced excessive Medicare capital payments resulting primarily from the previous Medicare capital cost reimbursement system that encouraged hospitals to buy the most expensive as opposed to the most efficient types of equipment and buildings.

30. Extend 10-Percent Reduction for Inpatient Capital Related Costs (\$7.0 billion in savings over seven years)

OBRA 1990 included a 10-percent reduction in the amount of payments attributable

to capital related costs that would otherwise be made to hospitals. The Secretary determines the amount of the reduction from prior year data. The OBRA 1990 provision expires in 1995. As Medicare continues to grow at or above 10 percent per year, it is viewed that there is sufficient flexibility to adjust capital payments.

31. **Reduce Hospital Update to Market Basket Minus 2 Percentage Points through 1999 and Minus 1 Percentage Point in 1998 and 1999 (\$25.9 billion in savings over seven years)**

Since the beginning of the hospital prospective payment system, the Medicare payments per hospital admission have been gradually higher than the hospital market basket inflation factor. OBRA 1993 reduced the hospital market basket update by 2.5 percentage points in 1994 and 1995, 2 percentage points in 1996, and 0.5 percentage points in 1997. This proposal reduces the update to market basket minus 2 percentage points through 1999 and market basket minus 1 percentage point thereafter. The market basket reductions are based in part on the Medicare overpayments to hospitals relative to inflation since the beginning of the hospital prospective payment system in 1983. The reduction incorporates the OBRA 1993 reduction of 0.5 percentage points from the market basket, as well as a 1-percentage-point productivity gain, and conforms the hospital update to that of other Medicare updates.

32. **Maintain Savings from Skilled Nursing Facilities Cost Limits (\$2.0 billion in savings over seven years)**

This provision would maintain the savings from the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) that froze for two years the costs limits for Medicare payments to skilled nursing facilities (SNFs). Payments to SNFs are based on average costs subject to cost limits, which are updated each year. The cost limit freeze in OBRA 1993 would expire October 1, 1995. This provision would not continue the freeze, but simply would update the cost limit without including cost increases during the two years of the cost limit freeze. This extender was included in the President's 1996 budget.

33. **Maintain Savings from Home Health Cost Limits (\$3.1 billion in savings over seven years)**

This provision, like the SNF provision, would maintain the savings from the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) that froze for two years the costs limits for Medicare payments to home health agencies (HHAs). Payments to HHAs are based on agency's costs subject to cost limits, which are updated each year. The cost limit freeze in OBRA 93 would expire July 1, 1996. This provision would not continue the freeze, but simply would update the cost limit without including cost increases during the two years of the cost limit freeze. This proposal was included in the President's 1996 budget.

34. **Increase Part B Premium \$5 per Month for 1996-99 and \$7 per Month beginning in 2000 (\$36.3 billion in savings over seven years)**

OBRA 1993 set the Medicare Part B premium at 25 percent of program costs for 1996-98 (as a result of this, beneficiaries' will see their monthly premiums drop from \$46.10 in 1995 to \$43.00 in 1996 because currently the premiums are set to pay for about 30 percent of program costs). For the past three years, the monthly premium has risen about \$5 per year. This proposal would replace the OBRA 1993 25-percent law with a flat increases in the monthly premium of \$5 (i.e. \$60 per year) in the early years and \$7 (i.e. \$84 per year) beginning in 2000.

35. Permanently Extend OBRA 1993 Medicare Secondary Payer Provisions (\$6.4 billion in savings over seven years)

This provision would permanently extend certain Medicare Secondary Payer provisions from OBRA 93. In general, payment for services provided to a Medicare recipient is first required from a private payer, if the recipient has private health coverage. Under current law, MSP for the disabled, End Stage Renal Disease (ESRD) patients, and MSP data match would expire in 1998. These provisions make Medicare the secondary payer for disabled and ESRD beneficiaries, and would authorize data links to obtain information about primary payers for other beneficiaries. This proposal was included in the President's 1996 budget.

PLAN B: DEFINED MEDICARE CONTRIBUTION

Under this option, Medicare is transformed into a defined contribution program for every beneficiary. Medicare will make a contribution to the health plan of each beneficiary's choice. Choices will include a broad range of plans with varying levels of coverage. Beneficiaries will pay extra if the plan they choose is more costly than the amount of the contribution and will receive a rebate if the plan is less than the amount of the contribution.

Private plans can include indemnity plans, HMOs, preferred provider organizations, point-of-service plans, medical savings accounts as well as other innovative insurance products. Any plan available in the market to be purchased with a Medicare contribution *must include catastrophic coverage* for out-of-pocket costs over \$10,000. Plans would be required to meet a minimal set of other eligibility requirements, including quality review, in order to prevent marketing abuses.

The value of the contribution would be determined by setting total Medicare expenditures at an overall 5.4 percent compounded annual growth rate. The contribution would be adjusted based on the beneficiaries' age, gender, geographic location, disability status and ESRD status. Average contribution amounts, along with current 1995 per beneficiary spending, are as follows:

<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
\$4,816	\$5,122	\$5,338	\$5,574	\$5,786	\$5,955	\$6,162	\$6,361

Total spending for Medicare would be as follows:

	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
(billions)	\$178.2	\$192.6	\$203.9	\$215.7	\$226.8	\$237	\$247.7	\$258.9

Medicare could continue to offer the traditional Medicare benefit plan by determining the actuarial value of Medicare and allowing beneficiaries to purchase it with their contribution. Savings would be achieved by limiting total expenditures to a reduced rate of growth.

PLAN C: INCENTIVE BASED MEDICARE REFORM WITH LOOK BACK SEQUESTER

Under this option, reforms to preserve Medicare would be implemented in a two level plan. First, proposals would be adopted to ensure the financial solvency and reduce the irresponsible growth in general revenue payments in the near term. Second and concurrently, Medicare would be expanded to allow market based choices for beneficiaries, promoting cost efficient care and incentives through potential rebates or added benefits. As these reforms improve the Medicare system, the financial solvency will be strengthened.

While market based reforms will be structured to give clear incentives, beneficiaries will not be forced to join the private market plan. They may stay in the government-run fee for service Medicare option if they so choose. It is anticipated that the private plans will sufficiently reduce the rate of growth in Medicare to keep the program on sound footing. However, both the market plans and the government-run Medicare fee for service system will be structured to grow at financially viable rates. Medicare target spending will be established based on assumptions of how many beneficiaries will choose private plans. If an insufficient number of beneficiaries join the private plans and spending targets for the year are exceeded, Congress would implement additional cost saving measures for the government run non-market Medicare plan.

First Level: Immediate Financial Solvency Measures

Upon implementation of this plan, immediate measures would be taken to lower growth rates in the current Medicare system. Present growth rates of 11 percent per year would be reduced to an 5.4 percent compounded annual growth rate over a seven year period. Proposals to achieve this growth rate include:

- Establish home health, skilled nursing, clinical lab coinsurance
- Reduce hospital inflation update by 1.5 Percent
- Bundle Post-Acute Care Services
- Withhold payments to medical staffs above 115 percent of the national median
- Freeze physician update
- Extensions of OBRA 90 and 93
- Increase Part B deductible from \$100 to \$150 then index to program growth

In addition to reducing the spending growth of Medicare, these proposals would help reduce the over utilization of government run Medicare services, and introduce market incentives into the program.

Second Level: Savings from Private Market Plans

Medicare private plans would be expanded from the current limited offering to include Preferred Provider Organizations, Point of Service plans, Medical Savings Accounts, and other types of plans. Currently, nine percent of Medicare beneficiaries are enrolled in HMOs. As these market based reform improve the options available to seniors, it is anticipated that enrollment in private plans will grow steadily (projected enrollment rates are below).

Year	1995	1996	1997	1998	1999	2000	2001	2002
enrollment	9%	15%	25%	35%	45%	50%	55%	59%

Each year, Medicare will conduct an open enrollment period for beneficiaries to choose their coverage option. Enrollees in the private plans will receive a Medicare contribution toward the cost of the plan chosen. The contribution will be adjusted to account for age, gender, medical costs, and health status. Compounded annual growth of the amount contributed will be 5.4 percent. The beneficiary can choose the plan that meets his or her health insurance coverage needs, and select deductibles, benefits, rebates, and other parameters as desired.

The amount of spending in the Medicare market plans and government-run plan is projected to be as follows:

Year	1996	1997	1998	1999	2000	2001	2002
(billions)							
Private	\$28.9	\$50.9	\$75.5	\$102.0	\$118.5	\$132.2	\$153.6
Government	\$163.7	\$153.0	\$140.2	\$124.8	\$118.5	\$115.5	\$105.3
Total	\$192.6	\$203.9	\$215.7	\$226.8	\$237.0	\$247.7	\$258.9

Third Level: Look Back Mechanism

To ensure that spending in both the Medicare market plans and the government-run program achieve financially viable rates of spending, the following procedure is implemented.

I. Determination of Projected Spending:

- a. At the completion of the Medicare open enrollment season, the Health Care Financing Administration shall report on the number of enrollees in market based plans, and shall calculate the total Medicare contribution for the program.

- b. HCFA shall then determine, for the fiscal year, the amount of spending in the government-run Medicare program --given the reduction policies initially implemented in level one and any additional legislation passed in the current fiscal year affecting Medicare.

II. Look Back Sequester:

- a. If the total contributions to private plans are lower than the projected target, or if government-run Medicare spending is projected higher than the target,
- HCFA shall submit to Congress a list of proposals for the government-run Medicare program to meet the total spending target.
 - Congress shall act on these proposals, or meet the target with other proposals before the beginning of the fiscal year.
 - If Congress does not meet the deadline, HCFA shall implement its recommendations to meet the targets.
- b. Order of sequestered savings:
- First order proposals shall be reductions in provider payment updates, such that updates are positive.
 - Second order proposals shall be reductions in add on payments not directly related to providing services, and cost limit changes.
 - Third order savings shall be cost sharing in high growth services.
- c. The ratio of beneficiary savings proposals relative to providers shall not exceed fifty percent.
- Prohibited savings proposals: Congress and HCFA shall not recommend increases to the Hospital Insurance payroll tax, or increase the percentage of Supplementary Medical Insurance program costs covered by government contributions in the base year.

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Alicia Munnell
 THROUGH:
 SUBJECT: Shays' Three Plans for Medicare Reform

- Under Secretary for Finance Enforcement Policy Management
- Domestic Finance ATF Scheduling
- Economic Policy Customs Public
- Affairs/Liaison
- Fiscal FLETC Tax Policy
- FMS Secret Service Treasurer
- Public Debt General Counsel E & P
- Inspector General Mint
- Under Secretary for Int'l Affairs IRS Savings
- International Affairs Legislative Affairs Bonds
- Management Other _____
- OCC

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
James E. Duggan	<i>JD</i>	5-16-95	Office of Economic Policy	622-1513
REVIEWERS				
John S. Greenlees	<i>JG</i>	5/16/95	Office of Economic Policy	622-2020
Alicia H. Munnell			Asst. Sec. (Office of Economic Policy)	622-2200

SPECIAL INSTRUCTIONS:

Review Officer Date: Executive Secretary Date



GENERAL COUNSEL

 DEPARTMENT OF THE TREASURY
 WASHINGTON

May 24, 1995

 J. E. Knight
 P. B. B. B.
INFORMATION

MEMORANDUM FOR SECRETARY RUBIN

 FROM: EDWARD S. KNIGHT *ESK*
 SUBJECT: Medicare Trust Funds Solvency Recommendation

*Please keep in a file
 we can use
 this in such legislation
 process.*

There is currently under consideration in both houses of the Congress, legislation which would require the Board of Trustees of the Medicare trust funds (the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund [herein referred to as "the Trust Funds"]) to report to the Congress by June 30, 1995 with the Trustees' recommendations for legislation to address the Federal Hospital Insurance Trust Fund's (the "HI Fund") financial condition. The Board of Trustees of the Trust Funds includes yourself, the Secretaries of Labor and HHS, the Commissioner of the Social Security Administration and two public trustees (together "the Trustees").

The legislation would require the Trustees to submit a report with recommendations for legislation that would: 1) control medicare hospital insurance program costs generally; 2) address the projected financial imbalance of the HI Fund as recognized by the Trustees in their 1995 Annual Report; and, 3) more effectively control medicare supplementary medical insurance costs. We have been researching the legal consequences, if the legislation passes in its current form, to you or the other Trustees of not providing the report, or of presenting a report without the requisite elements, on or before June 30, 1995.

If the legislation passes both houses of Congress and is signed by the President, there will be a legal requirement to submit the report. A failure to provide the report to the Congress would be a violation of the specific statutory requirement. The legislation, however, does not provide any specific sanctions which are to be brought against the Trustees in the event of an untimely or incomplete report.

Notwithstanding the absence of such sanctions, the Congress does have the ability to bring other actions against the Trustees or their agencies including refusing to approve appropriations requests, not acting on presidential nominations, and issuing subpoenas for the material with a potentially resulting contempt citation if the subpoena is not complied with. These matters would almost certainly be resolved in a political context rather than a legal one. Finally, private citizens or individual members of Congress would probably lack standing to bring suit to enforce the reporting requirement.] ✓

cc: Alicia Munnell

EXECUTIVE SECRETARIAT

June 5, 1995

NOTE TO ED KNIGHT

FROM: Bob Rubin

Please keep in a file so we can use this
if such legislation passes.



ASSISTANT SECRETARY

MAY 24 1995

MEMORANDUM FOR SECRETARY RUBIN

FROM: Alicia Munnell *AM*

SUBJECT: Are the Senate and House Medicare Cuts Too Large?

Summary

Central to the debate surrounding the Medicare cuts in the Senate and House proposals is the question of whether those cuts can be justified as necessary to preserve the financial integrity of Medicare. Based on our current, tentative, understanding of the Senate proposal, the Medicare cuts of \$256 billion over seven years will include about \$165 billion in Part A (Hospital Insurance) and \$91 billion in Part B (Supplementary Medical Insurance). The size of the Part A cuts has apparently been chosen to be the minimum amount necessary to keep the Hospital Insurance Trust Fund at or above 100 percent of annual disbursements. This would be consistent with the Trustees' short-range test of financial soundness. **From the trust fund point of view, therefore, the Senate Part A cuts do not appear "too large."**

The House's proposed Medicare cuts are larger (\$282 billion over seven years) but the breakdown between Parts A and B has not been determined. If the House were to follow the Senate and cut \$165 billion from Part A, the Part B cuts would be \$117 billion compared to \$91 in the Senate plan. Furthermore, Part B spending in FY 2002 would be 24 percent lower than in the Senate proposal, because of the backloading of the House cuts.

The Senate proposal apparently constrains Part A outlay growth to 4.8 percent annually for seven years. The Medicare actuaries report that a 5.3 percent growth rate would be sufficient to achieve long-run solvency if maintained over a 75-year period. A slower growth rate in outlays is required in the short run because disbursements now exceed tax receipts and because of relatively slow projected payroll growth in the near term.

Discussion

Senate HI cuts. In the intermediate actuarial projection, the balance in the

Hospital Insurance (HI, or Part A) Trust Fund is forecasted to fall from \$133 billion at the end of 1994 to a deficit of \$7 billion at the end of calendar year 2002. The trust fund ratio (the ratio of the fund balance to the year's expected outgo) falls from its 1994 level of 122 percent to below 100 percent after 1997, and the fund will be exhausted during 2002.

Thus, the fund currently fails the Trustees' short-range test of financial adequacy. The test requires that if the trust fund ratio is initially above 100 percent, it must be projected to remain at or above 100 percent throughout the 10-year projection period. (If the trust fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within five years and then remain at or above 100 percent throughout the remainder of the 10-year projection period.)

In the Senate Budget Committee proposal, total planned cuts for Medicare as a whole are \$256 billion over seven years, relative to the CBO baseline spending and income projections. The CBO-baseline seven-year annual growth rate for Medicare of 10.2 percent would be reduced to 6.8 percent. In evaluating the proposal's impact on the HI Trust Fund, the crucial issue is how the planned savings are broken down between Part A and Part B of Medicare. The Senate has not presented information on this breakdown, either year-by-year or in the aggregate, but it is generally understood that Part A will account for \$165 billion of the \$256 billion total cuts. This would be consistent with a CBO simulation in which Part A is constrained to a 4.8 percent annual growth rate in each of the seven years from 1996 through 2002. That path yields budget savings of \$165 billion, and results in a smooth movement of the trust fund ratio from 116 percent at the beginning of 1995 to 100 percent seven years later. This trust fund path is displayed in the attached figure. From this perspective, the Senate Part A cuts will not be "too large"; they are approximately the minimum cuts required to satisfy the short-term financial soundness test.

House Cuts. At this point, we have insufficient information about the breakdown of Part A and Part B spending reductions in the House budget proposal. One possibility is that the House contemplates Part A cuts above and beyond those in the Senate plan; i.e., beyond those required to sustain a 100-percent trust fund ratio. On the other hand, if the \$26 billion difference between House and Senate Medicare spending is attributable entirely to Part B cuts, the result will be even more severe impacts on physicians or on beneficiary out-of-pocket payments. The table below compares the impacts on Medicare Part B spending, under the assumptions that both House and Senate Part A cuts follow the \$165 billion pattern discussed above. (A memorandum from Congressmen Shays, Hobson, Miller, and Largent to Chairman

Thomas of the House Subcommittee on Health proposes three "Options to Save Medicare," and provides fragmentary information on the Part A-Part B breakdown of cuts in one option. This information is roughly consistent with Part A cuts in the range of \$165 billion.)

**Medicare Outlays Under Alternative Proposals
(\$billions, net of premium receipts)**

	<i>Total Cuts FY 1996-2002</i>		<i>Average Annual Growth (%) FY 1995-2002</i>	
	<i>Part A</i>	<i>Part B</i>	<i>Part A</i>	<i>Part B</i>
Baseline (CBO)	8.1	14.5
Senate	165	91	4.8	11.1
House	165	117	4.8	6.7

Note: House Part A spending is assumed to equal expected Senate path.

The results in the table are subject to change based on any new information we receive about the Congressional proposals. However, they do demonstrate the greater potential severity of the House cuts. Over seven years, the House would cut \$26 billion more in Part B spending, assuming that Part A spending is the same in both plans. Moreover, because the House cuts are more backloaded, the impact on spending in FY 2002 (and presumably in subsequent years) would be particularly dramatic. At the end of the seven-year budget horizon, Part B spending net of premiums would be \$74 billion in the House plan, about 24 percent below the Senate level of \$98 billion and 39 percent below the \$121 billion baseline level.

Background on Required Medicare Cuts

It may be useful to compare the proposed cuts in Part A to other estimates of the "minimum" cuts required for HI fund adequacy. For example, it may be questioned why a 4.8 percent growth rate is necessary during the seven-year budget period, when the HI actuaries have estimated that a 5.3 percent annual growth would achieve solvency over the 75-year forecast period. The reasons are twofold:

- Tax receipts and other non-interest income are currently at a level about \$6 billion below disbursements. Therefore, even if disbursements grew at only 5.3 percent, they would exceed non-interest income in the near term, causing the trust fund to decline.

- HI revenues are projected to rise relatively slowly during the next few years, because of relatively modest growth in nominal wages.

As an example of this near-term dilemma, the HI actuaries have simulated a 5.0 percent annual growth path of aggregate expenditures, a growth rate tighter than the 5.3 percent required for long-run balance but looser than the 4.8 percent contemplated in the Senate proposal. In that simulation, the trust fund ratio falls below the 100 percent minimum for a period of about two decades beginning in 1999.

Another comparison is between the \$165 billion Senate proposal and the actuaries' estimate that a reduction of \$147 billion in HI spending during 1996-2002 would be sufficient to maintain the trust fund ratio at a level of 100 percent. The primary difference here is that the actuaries' baseline spending path is below the CBO baseline used by the Senate, so smaller cuts are required to meet the short-range test of financial adequacy.

- MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
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FROM: Alicia Munnell
 THROUGH _____
 SUBJECT: Are the Senate and House Medicare Cuts Too Large?

- Under Secretary for Finance Enforcement Policy Management
 Domestic Finance ATF Scheduling
 Economic Policy Customs Public
 Affairs/Liaison
 Fiscal FLETIC Tax Policy
 FMS Secret Service Treasurer
 Public Debt General Counsel E & P
 Inspector General Mint
 Under Secretary for Int'l Affairs IRS Savings
 Bonds
 International Affairs Legislative Affairs
 Management Other _____
 OCC

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
John S. Greenlees James E. Duggan	<i>JG</i> <i>JD</i>	5/24/95 5/24/95	Director, Office of Economic Analysis	622-2020
REVIEWERS				
John S. Greenlees	<i>JG</i>	5/24/95	Director, Office of Economic Analysis	622-2020
Alicia H. Munnell			Asst. Sec. (Economic Policy)	622-2200

SPECIAL INSTRUCTIONS:

Review Officer _____ Date: _____ Executive Secretary _____ Date _____

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
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SPECIAL INSTRUCTIONS:

Review Officer Date: Executive Secretary Date

95-150268



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

September 21, 1995

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

The Honorable Robert Dole
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Speaker and Mr. Majority Leader:

I understand the House Majority is releasing its plan to restructure Medicare today. I am writing to discuss the condition of the Medicare Hospital Trust Fund in the context of these reform plans.

As Managing Trustee of the Medicare Hospital Insurance (HI) Trust Fund, I am concerned by a growing number of statements by Members of Congress which appear to be based on a misunderstanding of what our annual report said. Because votes for significant changes in Medicare should not be cast without Members knowing the facts, I want to recount briefly what the Trustees reported about the funding status of Medicare.

Simply said, no Member of Congress should vote for \$270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare Trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In the annual report to Congress on the financial condition of Medicare, the Trustees concluded that the HI Trust Fund will not be depleted until 2002, seven years from now. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then in the context of health care reform to make long-term changes in the system that would accommodate the influx of "baby-boomer" beneficiaries. At no time did the Trustees call the funding crisis "imminent." Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed.

Nonetheless, the Majority is asking for \$270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance (Part A) Trust Fund for the next ten years. Moreover, I understand that the \$270 billion of cuts proposed by the Majority includes increases in costs to beneficiaries under Part B of the Medicare program, even though increases in Part B do not contribute to the solvency of the Part A Trust Fund. In this context it is clear that more than \$100 billion in Medicare funding reductions are being used to pay for other purposes -- not to shore up the Medicare HI Trust Fund.

By contrast, the President's proposal, by providing ten years of trust fund security, is consistent with actions by prior Congresses and would afford us far more than sufficient time to propose a bipartisan solution to the long-term fiscal needs of Medicare. Such a bipartisan solution will be needed regardless of whether the President's plan or Congress's plan is finally adopted.

To emphasize, the Trustees did not recommend \$270 billion of Medicare cuts at this time nor state that the funding problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I hope this information can be provided to Members of Congress on both sides of the aisle as they review the significant changes in Medicare that are being considered so that Members can have a clear understanding of the facts.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert E. Rubin", with a stylized flourish at the end.

Robert E. Rubin

September 7, 1995

95-150272

To: Al. L. L.
P-: B.S. M.
I agree.

MEMORANDUM FOR SECRETARY RUBIN

FROM: Alan Cohen *ac*
Senior Advisor to the Secretary

SUBJECT: Release of Medicare Plans By Republicans

I. BACKGROUND

While early returns are incomplete, it does not appear that the Congressional Republicans were split during the recess period in their support for \$270 Billion of Medicare cuts. While some members remain squeamish, not enough have peeled off yet to deny the Republicans the votes they need to pass reconciliation. Part of the difficulty in getting members to peel off is that neither chamber has released its plan yet which makes it difficult to focus the public's attention.

Both the House Ways and Means Committee and the Senate Finance Committee are supposed to complete action on Medicare and other cuts by September 22. The press reports that the House will release its plan publicly next week. Senator Packwood could do the same or wait until the following week. The House plan should be released first. There will be only limited time between the release of the House plan and the votes in the Committees.

Attacking the plans when they are released is probably our last best chance to break the Republican coalitions in one or both chambers in support of these cuts. We must turn the public at large against these cuts. The amount of time available will be short. Moreover, it is imperative that we act immediately upon release of the plans because the first impressions formed by the public will be the lasting ones.

II. OPTIONS FOR ACTION

To achieve these objectives, we need a bold, breakthrough event that will focus the public's attention on the issue and will help to galvanize opposition to the cuts. The impact of the event should be akin to the Gore-Perot debate on Nafta. This event should take place as close as possible in time to the release of the House plan.

Several options exist:

1. A Presidential hearing or forum on the cuts and their impact. The President could hold a public meeting in which elderly citizens and experts on Medicare could "testify" to the impacts of the Republican plans. This could be done as a mock hearing or

in a "Little-Rock economic conference type forum."

2. There could be a debate between either the President or the Vice-President and a leading Republican.

3. Other alternative options may exist.

To prepare for release of the House (and Senate) plans, we should have a subset of the Erskine Bowles 9 AM group prepare for an all-fronts response operation. The activities of this group would include but not be limited to:

1. Development of the substantive response to the plans. We know enough about the plans now so that this could begin immediately.

2. Scheduling and preparation for the main event.

3. Preparation of outside validators.



The Secretary of the Treasury

September 21, 1995

NOTE FOR ALAN COHEN

FROM: BOB RUBIN

I agree.

Attachment



95-150723
150513

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

September 28, 1995

**MEMORANDUM FOR SECRETARY RUBIN
DEPUTY SECRETARY SUMMERS**

FROM:

Glen Rosselli *GR*
Deputy Assistant Secretary for Economic Policy

Daniel Sichel *DS*
Deputy Assistant Secretary for Economic Policy

SUBJECT: Medicare Managed Care

The Republican Medicare proposals expect to save a significant amount over seven years by giving beneficiaries the option of choosing managed care or a medical savings account.¹ Managed care as an option may be less expensive than traditional fee-for-service insurance. Medicare currently has a small number of beneficiaries enrolled in managed care. Assuring quality and adverse selection are potential problems in Medicare managed care.

MANAGED CARE OPTIONS

Sixty-five percent of individuals in the non-Medicare population with employer-sponsored health plans were enrolled in managed care in 1994. Fewer than 10 percent of Medicare beneficiaries participate in managed care, however.

Managed care takes three major forms:

- The most common form of managed care is the health maintenance organization (HMO). HMOs attempt to reduce utilization of health services by requiring enrollees to receive referrals from primary-care physicians before seeking specialized care. HMOs give primary-care physicians financial incentives to reduce utilization. Patients are charged a nominal fee for office visits and there are no deductibles.
- Preferred provider organizations (PPOs) do not require referrals, and patients face only nominal copayments if they use providers who have agreed to accept reduced payments from the PPO; individuals who use non-plan providers are required to pay the entire cost out-of-pocket.

Preliminary CBO estimates indicate the Senate's Medicare Choice proposal (which includes both managed care plans and MSAs) will save \$47.5 billion over seven years.

- Point-of-service plans (POSS) are a combination of PPOs and traditional indemnity plans: individuals can use plan providers for a low copayment, or can use non-plan providers subject to a deductible and significant copayment.

MANAGED CARE AND COST SAVINGS

Managed care appears to reduce medical costs, primarily through reduced utilization, although the evidence is not overwhelming. One reason managed care enrollees may have lower average costs than those in fee-for-service is that managed care enrollees tend to be healthier. HMOs appear to be better at reducing costs than either PPO or POS plans. It is unclear if managed care reduces the *rate* of growth in health care costs, or simply the level. If the latter is the case, a move to managed care may result in "one time savings," but may not slow the rate of growth. By increasing competition, managed care may result in lower prices in the fee-for-service sector, although the evidence is weak. Also, any reduced costs may result in reductions in health care services.

The annual Foster Higgins survey of employer costs reported a 1.1 percent drop in per-employee health insurance costs in 1994, compared to an 8 percent increase in 1993. This was not due to a decrease in the cost of any specific type of insurance, but primarily to a move to managed care from more expensive indemnity plans. For employers in 1994 the average price for an HMO policy was \$3500, a PPO \$3400, and a POS \$3600, compared to \$3850 for an indemnity plan. As discussed above, these may be "one time savings": prices of managed care plans increased in 1994 (HMOs by 6 percent, PPOs 2 percent, and POSs 10 percent).

CURRENT MEDICARE MANAGED CARE

In 1994, 7 percent of Medicare beneficiaries were enrolled in health maintenance organizations. Under the current law:

- Plans are required to cover all services offered by Medicare and often provide additional services to attract members.
 - The plans receive a fixed payment for each enrollee that is set at 95 percent of the average cost of fee-for-service enrollees, controlling for certain individual characteristics. There is strong evidence that this payment is too high, however, as Medicare HMO enrollees tend to be healthier than their counterparts in the fee-for-service sector, even after controlling for these factors.
- This payment system provides a strong incentive for plans to attract healthy recipients and discourage the enrollment of sicker individuals.

- The General Accounting Office has found that HCFA does not adequately assure the quality of Medicare HMOs, as it is required to do so.

REPUBLICAN PROPOSALS

The House and Senate proposals on managed care are generally similar. The major provisions include:

- Medicare beneficiaries would have the option of receiving a voucher, adjusted for age, geographic area, and medical condition, to purchase a managed care policy.
- The value of the voucher would originally be tied to average beneficiary costs in the fee-for-service sector; over time, however, the value of the vouchers would be "delinked" from the fee-for-service sector and geographic disparities would be reduced.
- The value of the vouchers would increase over time at a rate that would constrain Medicare spending to meet the Republican conference agreement.
- All plans would have to guarantee a minimum benefit package and meet financial and quality standards. To attract beneficiaries plans could offer additional benefits.
- If the value of the voucher is greater than the cost of the policy, the House proposal would allow plans to refund an amount up to the value of the Part B premium to consumers; the Senate proposal would allow beneficiaries to deposit any difference in a medical savings account or take 75 percent of the difference in cash.
- Beneficiaries would have the option of moving between plans or a plan and traditional Medicare during an annual open enrollment period, after a two year transition in which they would have the option of changing plans once a month.
- The proposals attempt to facilitate the provision of managed care to Medicare recipients by easing restrictions on the ability of hospitals and physicians to form managed care networks.

POTENTIAL PROBLEMS WITH MEDICARE MANAGED CARE PROPOSALS

- The managed care approach may not be able to provide quality health care under the budget limitations in the Republican proposals. Both the House and Senate plans would limit payments to managed care plans to achieve their desired 4.9 percent per capita annual growth rate in Medicare spending. If costs increase more rapidly than payments, plans may cut back on services to beneficiaries and provide lower quality care. HCFA estimates that per capita private health insurance costs will increase at a 7.6 percent annual rate over 1996-2002.
- Expansion of Medicare managed care may lead to adverse selection. There is a strong incentive for plans to adjust their benefit package to attract healthy individuals and discourage sicker individuals from enrolling. This would lead to the sickest individuals staying in traditional fee-for-service Medicare, resulting in higher costs for the government and higher Part B premiums for those beneficiaries who do stay in traditional Medicare.
 - The Republican proposals would attempt to reduce adverse selection by adjusting payments to managed care organizations for age and health status, and prohibiting plans from refusing to enroll individuals.
 - The ability of individuals to move between plans and traditional Medicare increases the potential for adverse selection.

TREASURY CLEARANCE SHEET

NO. _____
Date 9/28/95

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Dan Sichel & Glen Rosselli
 THROUGH: _____
 SUBJECT: Medicare Managed Care

REVIEW OFFICES (Check when office clears)

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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Gus Faucher	MF	9/27/95	Office of Policy Analysis	622-0174
REVIEWERS				
John Hambor	JH	9/27/95	Director, Policy Analysis	622-2350

SPECIAL INSTRUCTIONS

Review Officer _____ Date _____ Executive Secretary _____ Date _____

TREASURY CLEARANCE SHEET

NO. _____

Date 9/28/95

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
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FROM: Dan Sichel & Glen Rosselli

THROUGH: _____

SUBJECT: Medicare Managed Care

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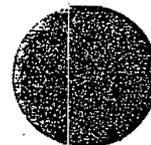
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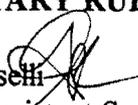


DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220



December 5, 1995

MEMORANDUM FOR SECRETARY RUBIN

FROM: Glen Rossetti 
Deputy Assistant Secretary
(Economic Policy)

SUBJECT: Administration's Medicare Proposal

What follows is a description of the main provisions of the Administration's Medicare reform proposal. It will be released to select reporters tonight or tomorrow AM.

In general, 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 deliver 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

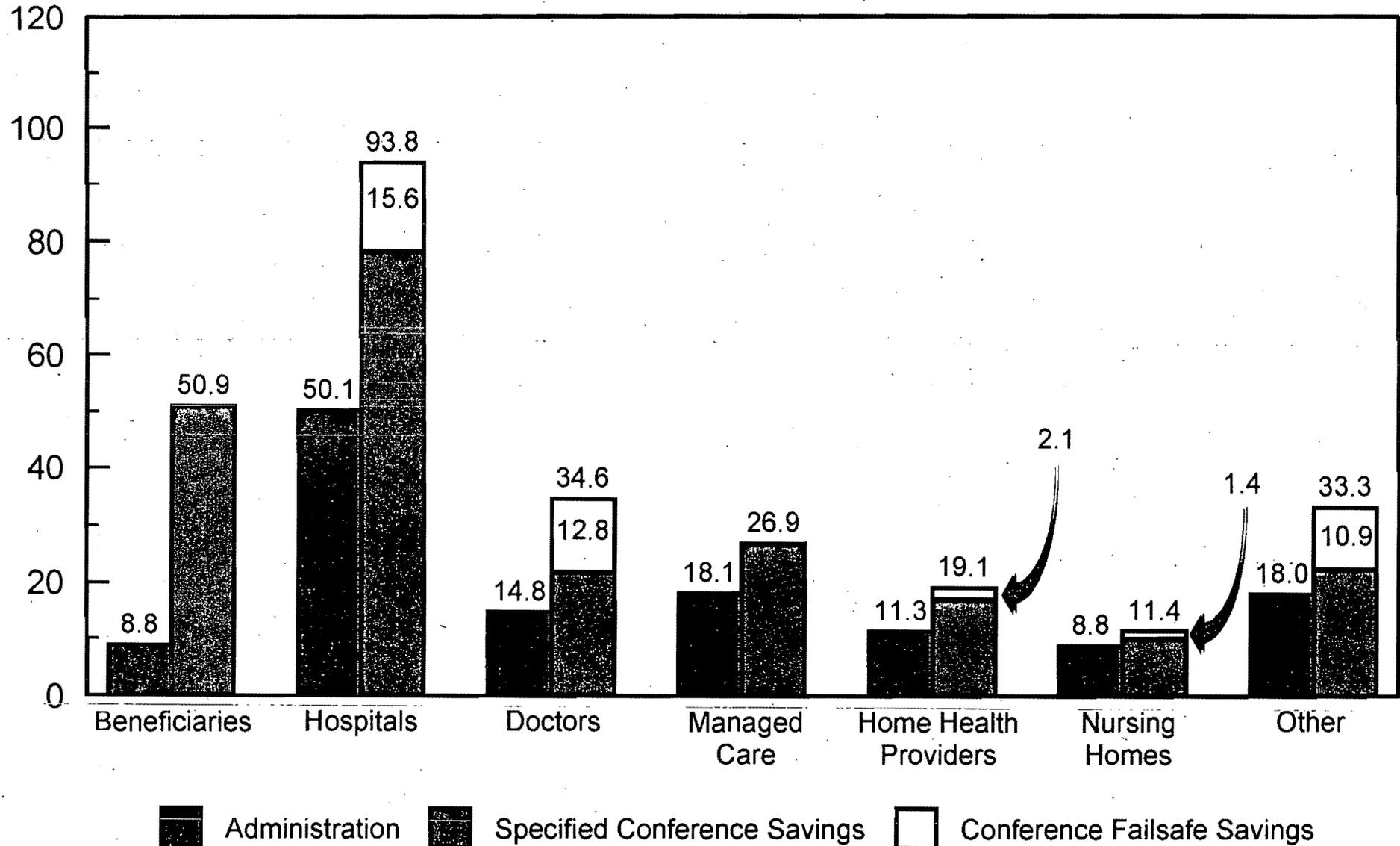
Including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

MEDICARE CUTS BY CATEGORY

ADMINISTRATION VS. REPUBLICAN PLAN

7-YEAR OMB AND CBO PRICING, RESPECTIVELY

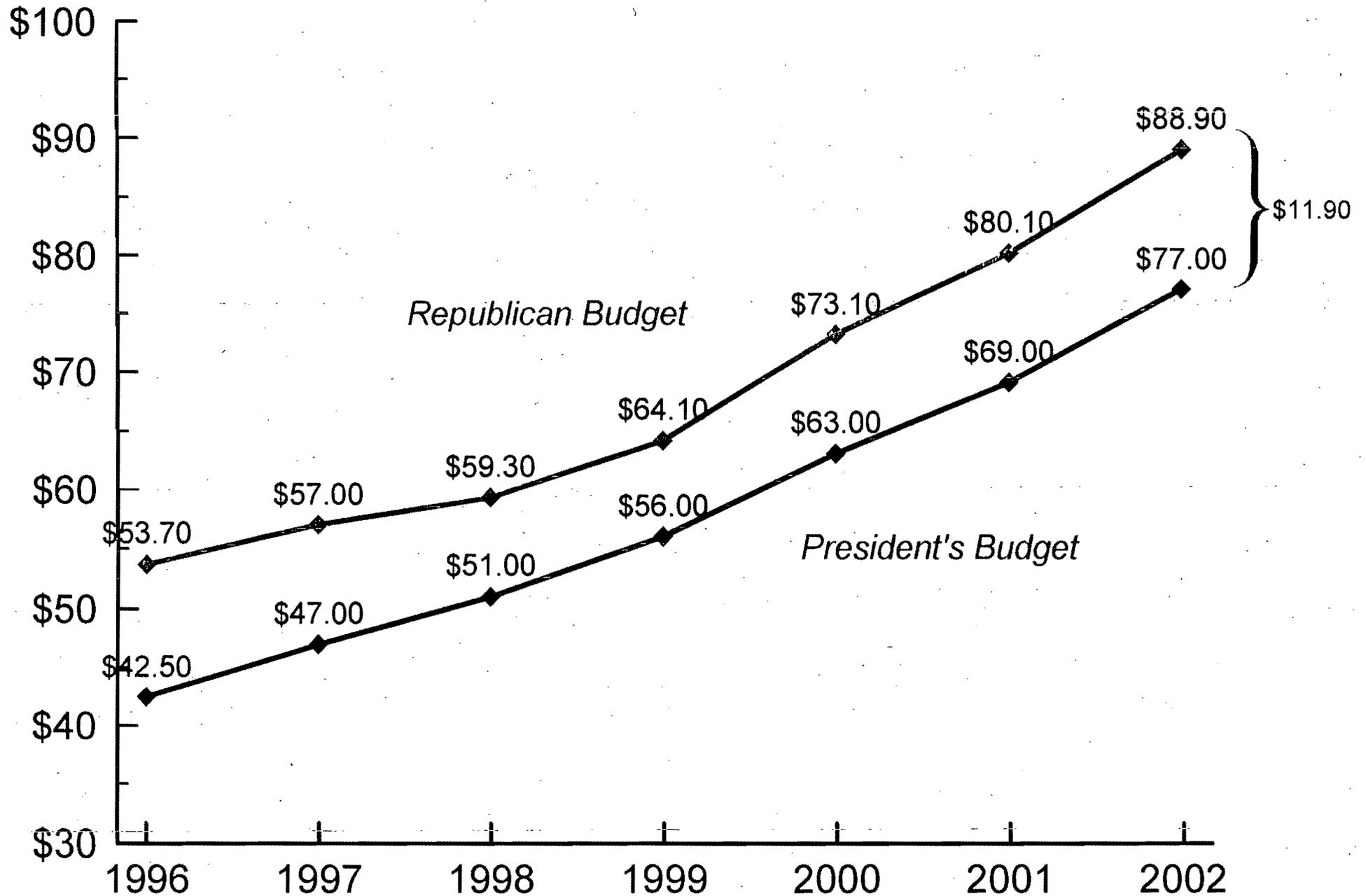
Billions of Dollars



Note: In the attached graph the 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.

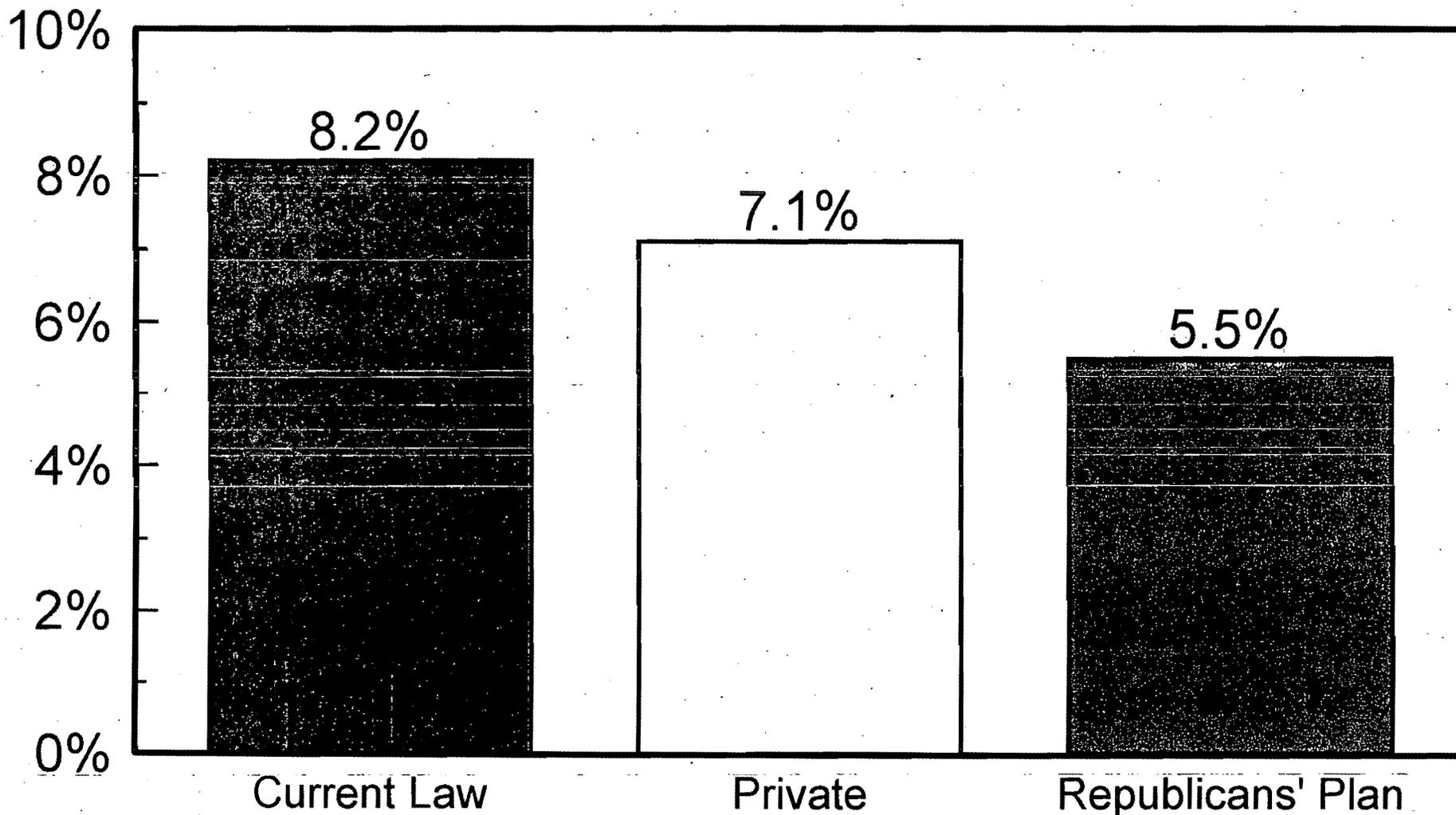
Also the indirect reduction in Part B premiums due to failsafe spending reductions is reflected in the Conference Agreement "Beneficiaries" total.

MEDICARE MONTHLY PREMIUMS



CBO estimates of Republican, as published in the November 16 letter to Senator Domenici; HFCA 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, 6.0%. Source: US DHHS.

TREASURY CLEARANCE SHEET

NO. _____
Date Dec. 5, 1995

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Glen Rosselli
 THROUGH: _____
 SUBJECT: Administration's Medicare Proposal

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TREASURY CLEARANCE SHEET

NO. 95-153016
Date Dec. 5, 1995

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
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FROM: Glen Rosselli

THROUGH: _____

SUBJECT: Administration's Medicare Proposal

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1996-SE-004685



DEPARTMENT OF THE TREASURY
WASHINGTON

June 6, 1996

MEMORANDUM TO THE SECRETARY

THRU: Josh Gotbaum *JG*
FROM: Glen Rossell *GR*
SUBJECT: The President's Medicare Plan

The President's Medicare plan strengthens and improves the program, reducing spending by a net \$124 billion by 2003 and guaranteeing the solvency of the Hospital Insurance (HI) trust fund for about a decade. Specific reforms:

- Give seniors more choices among private health plans.
- Make Medicare more efficient and responsive to beneficiary needs.
- Attack fraud and abuse through programs praised by law enforcement officials.
- Cut the growth rate of provider payments.
- Hold the Part B premium at 25 percent of program costs.

Hospitals: The budget reduces the annual inflation increase or "update" for payment for inpatient care and adjusts payments for capital. It also reforms the payment method for outpatient departments while protecting beneficiaries from increasing charges for those services (saves \$42.4 billion through 2002).

Managed Care: The budget reforms payments by using reasonable rate-of-growth limits on updates for managed care payments and reducing the current geographic variation in payments (saves \$29.8 billion through 2002).

Physicians: The budget reforms physician payments by paying a single update for all physicians and replaces current "volume performance standards" with a reasonable growth rate (saves \$9.0 billion through 2002).

Home health care/skilled nursing facilities: The budget implements a series of interim payment reforms before the planned establishment of separate prospective payment systems for home health care and skilled nursing facilities (saves \$22.4 billion through 2002).

Fraud and Abuse: The budget introduces aggressive and comprehensive policies to stamp out Medicare waste, fraud, and abuse, and extends and enhances Medicare secondary payer policy to ensure that Medicare pays only when it should (saves \$3.3 billion through 2002).

Other Providers: The budget freezes or reduces payments for durable medical equipment and ambulatory surgical centers, reforms Medicare Secondary Payer policy, establishes new preventive benefits, and makes other programmatic changes to control provider payments (saves \$6.5 billion through 2002).

Beneficiaries: The budget maintains the requirement that beneficiaries pay 25 percent of Part B costs (saves \$5.5 billion through 2002).

TREASURY CLEARANCE SHEET

NO. _____
Date 6/07/96

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Glen Rosselli
 THROUGH: Josh Gotbaum
 SUBJECT: The President's Medicare Plan

REVIEW OFFICES (Check when office clears)

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INITIATOR(S)				
Glen Rosselli	<i>GR</i>	6/7/96		
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Review Officer _____ Date _____ Executive Secretary _____ Date _____