

# Withdrawal/Redaction Sheet

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	John Hilley & Chris Jennings to POTUS re: Suggested telephone call to Congressman Bill Thomas (2 pages)	5/5/97	P5, P6/b(6)
002. talking points	POTUS conversation with Congressman Thomas (2 pages)	5/97	P5

**COLLECTION:**

Clinton Presidential Records  
 Domestic Policy Council  
 Bruce Reed (Subject File)  
 OA/Box Number: 21204

**FOLDER TITLE:**

Health Care-Medicare | 1 |

rs42

**RESTRICTION CODES**

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

March 8, 2000

**MEDICARE PRINCIPLES DEPARTURE STATEMENT**

**DATE:** March 9, 2000  
**LOCATION:** Behind the Oval Office  
**BRIEFING TIME:** 11:10am – 11:25am  
**EVENT TIME:** 11:30am – 11:45am  
**FROM:** Bruce Reed  
Chuck Brain  
Chris Jennings

**I. PURPOSE**

To accept and endorse a set of "Prescription Drug Principles" from the Senate Democratic Caucus, which will be used to evaluate any Medicare prescription drug proposals developed in the Congress.

**II. BACKGROUND**

**MILLIONS OF MEDICARE BENEFICIARIES NEED PRESCRIPTION DRUG COVERAGE.** Approximately three out of five Medicare beneficiaries lack decent, dependable prescription drug coverage.

- **Millions of beneficiaries have no prescription drug coverage and millions more are at risk of losing coverage.** Thirteen million Medicare beneficiaries have no prescription drug coverage. Millions more are at risk of losing coverage or have inadequate, expensive benefits. Nearly half of rural beneficiaries, and a disproportionate number of seniors over 85, do not have prescription drug coverage.
- **Current drug coverage is unstable and declining.** Only about one in four beneficiaries has retiree health insurance – and the proportion of firms offering such coverage has dropped 25 percent in the last four years. Even fewer beneficiaries have Medigap insurance for prescription drugs. This coverage is often expensive, and many insurers "age rate" (increase premiums as people get older), making it more expensive when seniors can least afford it.

- **Most seniors are middle-income and would not benefit from a low-income prescription drug benefit.** About 15.6 million, or 49 percent, of all elderly Americans have incomes between \$15,000 and \$50,000. And over half of beneficiaries without drug coverage have incomes above 150 percent of poverty (\$12,750 for a single earner, \$15,000 for a couple). Thus, a benefit targeted to the low-income will simply not help most seniors.
- **Only about half of all seniors have high enough income to benefit from a tax scheme.** Not only is it impossible to target needy Medicare beneficiaries through a tax deduction, but studies have repeatedly concluded that the tax code is an extremely expensive and inefficient way to expand insurance coverage for anyone, let alone seniors.

**SENATE DEMOCRATS AGREE ON PRINCIPLES FOR A NEW MEDICARE PRESCRIPTION DRUG BENEFIT.** Senator Daschle and the Senate Democratic Caucus released a set of "Prescription Drug Principles" that will guide the current Congressional debate over the provision of a new Medicare prescription drug benefit to millions of seniors. These principles state that any new benefit should be:

- **Voluntary.** Medicare beneficiaries who now have dependable, affordable coverage should have the option of keeping that coverage.
- **Accessible to all beneficiaries.** All seniors and individuals with disabilities, including those in traditional Medicare, should have access to a reliable benefit.
- **Designed to give beneficiaries meaningful protection and bargaining power.** A Medicare drug benefit should help seniors and the disabled with the high cost of prescription drugs and protect against excessive out-of-pocket costs. It should give beneficiaries bargaining power they lack today and include a defined benefit assuring access to medically necessary drugs.
- **Affordable to all beneficiaries and the program.** Medicare should contribute enough towards the prescription drug premium to make it affordable for all beneficiaries. While subsidies should be provided to all to assure the benefit is affordable, low-income beneficiaries should receive extra help with the cost of premiums and cost sharing.
- **Administered using private sector entities and competitive purchasing techniques.** Discounts should be achieved through competition, not regulation or price controls, and should mirror practices employed by private insurers in delivering prescription drugs. Private organizations should negotiate prices with drug manufacturers and handle the day-to-day administrative responsibilities of the benefit.

- **Consistent with broader reform.** The addition of a Medicare drug benefit should be considered as part of an overall plan to strengthen and modernize Medicare. Medicare will face the same demographic strain as Social Security when the baby boom generation retires. Improving benefits is only one step in preparing Medicare for this new century's challenges.

**YOU URGE CONGRESS TO ACT NOW.** You will urge Congress to act this year to strengthen and improve Medicare. Your FY 2001 budget includes a comprehensive plan that makes Medicare more competitive and efficient and dedicates part of the surplus to improve Medicare solvency and to add a long-overdue prescription drug benefit. This plan:

- **Establishes a new voluntary Medicare drug benefit that is affordable – to all beneficiaries and to the program.** The benefit, at \$160 billion over 10 years, would be:
  - Accessible and voluntary. Optional for all beneficiaries. Provides financial incentives for employers to develop and retain their retiree health coverage.
  - Affordable for beneficiaries and the program. Premiums of \$26 per month in the first year with lower or no premiums for low-income beneficiaries. Provides privately-negotiated discounts, gained by pooling beneficiaries' purchasing power, for all drug expenses. Has no deductible and pays for half of each beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending when fully phased in.
  - Competitively and efficiently administered. Competitively selects private benefit manager to deliver benefit to enrollees in traditional program. No price controls, no new bureaucracy. Integrated into current eligibility and enrollment systems.
  - High-quality and provide necessary medications. Private entities that use formularies must ensure access to medications off formulary if physician deems medically necessary. Requires use of state-of-the-art quality improvement tools.
- **Creates a Medicare reserve fund to add protections for catastrophic drug costs.** To build on your prescription drug benefit, the budget also includes a reserve fund of \$35 billion, available to offer protections for beneficiaries with extremely high drug spending. This reserve will permit the Administration to work in collaboration with Congress to design such an enhanced prescription drug benefit. If no consensus emerges, the reserve would be used for debt reduction.

### III. PARTICIPANTS

#### Briefing Participants:

Secretary Donna Shalala  
Bruce Reed  
Chuck Brain  
Chris Jennings  
Karen Robb  
Jeff Shesol

#### Statement Participants:

**YOU**  
Secretary Donna Shalala

#### *Senators Confirmed to Attend:*

Sen. Joseph Biden, Jr. (D-DE)  
Sen. Richard Bryan (D-NV)  
Sen. Thomas Daschle (D-SD)  
Sen. Byron Dorgan (D-ND)  
Sen. Richard Durbin (D-IL)  
Sen. Russell Feingold (D-WI)  
Sen. Edward Kennedy (D-MA)  
Sen. Carl Levin (D-MI)  
Sen. John Rockefeller, IV (D-WV)  
Sen. Paul Sarbanes (D-MD)  
Sen. Ron Wyden (D-OR)

#### *Senators Pending:*

Sen. Joseph Lieberman (D-CT)  
Sen. Barbara Mikulski (D-MD)  
Sen. Daniel Akaka (D-HI)  
Sen. John Breaux (D-LA)  
Sen. Robert Byrd (D-WV)  
Sen. Dianne Feinstein (D-CA)  
Sen. Bob Graham (D-FL)  
Sen. Tim Johnson (D-SD)  
Sen. Harry Reid (D-NV)  
Sen. Charles Schumer (D-NY)

#### Program Participants:

**YOU**  
Senator Tom Daschle

#### IV. PRESS PLAN

Open Press.

#### V. SEQUENCE OF EVENTS

- YOU greet Members of Congress in the Oval Office.
- YOU proceed with the Members of Congress to the podium positioned behind the Oval Office.
- Senator Tom Daschle makes remarks and introduces YOU.
- YOU make remarks and depart.

#### VI. REMARKS

To be provided by speechwriting.

THE WHITE HOUSE  
WASHINGTON

November 8, 1999

*copied  
Jennings  
Reed  
Spertling  
Podesta*

*Page 1 of 2  
HCFA  
Reed  
Spertling*

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings  
SUBJECT: Proposal to Create a Medicare Board  
CC: Bruce Reed, Gene Spertling

Secretary Shalala has drafted the attached memorandum to respond to a proposal by Senator Breaux and Congressman Thomas to create an independent board to supervise the Health Care Financing Administration's (HCFA) administration of the Medicare fee for service system, as well as to separately oversee operation of private plans participating in the Medicare program. Although it appears that proposals for a Medicare board will not be passed by this Congress, the ongoing frustration of the Congress and its constituents regarding HCFA's role in administering the Medicare program are certain to lead to future discussions about this issue.

Recognizing this, we have been strongly encouraging the Department to integrate a series of private sector practices that would hopefully lead to better coordination and administration of the agency's substantial responsibilities. Nancy-Ann Min DeParle has indicated her willingness to advocate for and implement these initiatives because she thinks that they will improve the agency's operational status and credibility, making it possible to fend off unconstructive initiatives that undermine the agency's ability to manage the program effectively.

**BACKGROUND**

HCFA remains one of the most passionately reviled agencies in the Federal government. This is logical, as it is responsible for denying reimbursement for desired claims from providers and state and local agencies alike. In addition, HCFA's numerous responsibilities makes it difficult for it to effectively manage, and there tends to be little time available for anything other than crisis management. Long-term planning is rare and frequently altered substantially by Congress and other outside entities, making stable and predictable management impossible.

Congressman Thomas and Senator Breaux believe that an independent board would help facilitate better management and utilize the best private sector management techniques. They believe the agency is inherently biased against private insurance plans participating in the program, causing the frustration and problems HMOs participating in the Medicare program have experienced. They also view this board as a possible vehicle to develop and implement benefit coverage and policy changes in a process independent of political intervention from the Congress and other outside sources.

THE PRESIDENT HAS SEEN

11-9-89

*Handwritten: 11/9/89*  
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*Handwritten: 11/9/89*  
In the memo from the Secretary, she counters that a Medicare board would reduce beneficiary protections, dilute Presidential authority, and provide the infrastructure to end the Medicare entitlement. The Department also argues that such a structure would lead to limited accountability by the Medicare program to both the White House and the Congress, and create extreme difficulties in managing program integrity initiatives, including anti-fraud and abuse efforts, within all aspects of the agency. While these are valid arguments and should be taken seriously, the same effort that was exerted to make these arguments should also be applied to the Department's commitment to reform the agency.

While we concur with the Secretary's memo that proposals such as those developed by Congressman Thomas and Senator Breaux would be detrimental to the Medicare program and the beneficiaries it serves, this type of proposal should serve as a warning to the agency to be more efficient and responsive to both the White House, the Congress, and the various advocacy, provider, and insurer communities it deals with.

*Handwritten: 11/9/89*  
We believe that we should use this opportunity as a means to strengthen the Medicare program and push HCFA to ensure that it is more prudently managed. In so doing, the agency will have the additional benefit of strengthening its credibility when opposing harmful and poorly thought out reform proposals.



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

OCT 25 1999

**MEMORANDUM FOR THE PRESIDENT**

I am writing to express my deep concern over discussions occurring in Congress that could result in creation of a new, independent Medicare board. As envisioned by its proponents, this board would operate as an independent entity designed to oversee the Medicare+Choice program, including the competition among private plans and between private plans and fee-for-service Medicare. The creation of such a board seriously undermines your authority over Medicare, the beneficiary protections that you have worked hard to establish for this program, and the significantly improved refocused management which has reduced the Medicare error rate by over fifty percent. This new board also sets the stage for capping government expenditures for Medicare, threatening Medicare beneficiaries' entitlement to first-class medical care.

The board's advocates say they want to bring private-sector expertise into the administration of the program and say they want to avoid conflicts of interest in running a competitive system. Their first goal is being accomplished without undermining the current strengths of Medicare and their second contention is a false promise. Not only will their proposals not achieve their goals, but, for the reasons stated below, they would substantially undercut our ability to serve beneficiaries and efficiently administer the program. At the end of this memorandum, I will describe the activities that we have already undertaken to garner additional private sector expertise in administering Medicare.

**Medicare Board Leads to Reduced Beneficiary Protections.** Under your leadership and through the hard work of this Department, we have ensured that Medicare includes the beneficiary protections outlined in your Patients' Bill of Rights. Medicare was one of the first programs in the country to incorporate these protections and remains a model program. This would not have been possible if the Medicare+Choice program were administered by an independent board.

Given the hostility we have seen in the private sector to even the modest proposals in the Patients' Bill of Rights, I do not believe that a board comprised of private sector health officials would have taken a strong, pro-beneficiary stance. It is not surprising that the strongest proponents of a Medicare board, including managed care interests, are among the most active opponents of strong patient rights legislation. I believe that we must maintain our ability to keep Medicare in the forefront of beneficiary protection. Creation of an independent Medicare board is not consistent with that imperative.

**Medicare Board Dilutes Presidential Authority.** Placing the Medicare+Choice program under the control of an independent board splits accountability for the program and substantially dilutes your authority over a substantial portion of Medicare. This is a significant loss given that Medicare serves 39 million beneficiaries and makes up 11 percent of the Federal budget.

The Administration's ability to make changes to Medicare in the context of the President's Budget would be limited. This is especially true since proposals for treating traditional fee-for-service Medicare as a health plan under the structure of Medicare+Choice would allow a new board to exercise substantial authority over the entire program. In particular, a board could be given substantial authority over what private health plans would be paid by Medicare. It could also be given authority to oversee aspects of traditional Medicare, including benefits and, under some proposals, total spending by traditional Medicare.

As a result, the presence of a board would have hampered our ability to exert strong budget discipline, such as the steps we have taken to extend the life of the Medicare Part A Trust Fund to 2015. Similarly, it would not have been possible to use Medicare changes to help finance key domestic initiatives to improve the health of the nation, such as the Children's Health Insurance Program.

Furthermore, creation of a board would limit the Administration's authority to make key program changes to address Medicare problems identified by beneficiaries, providers, or other segments of the American public.

**Medicare Board Diffuses Accountability for Medicare.** Authority over certain key functions would be unnecessarily complicated by bifurcating control of Medicare between a board and the Health Care Financing Administration (HCFA).

For example, Administration efforts to reduce fraud and abuse in Medicare have been successful because we have provided clear, consistent policy guidance and because we have been willing to take the political heat generated by our aggressive stance. I do not believe that an independent board (especially one that includes private sector health care executives, as would be likely with any congressionally created board) would have initiated or sustained such a controversial, yet productive, program. Specifically, the HCFA actuaries credit aggressive fraud control efforts with bringing down the Medicare baseline through reducing either the rate of growth or the actual level of spending on inpatient hospital services, home health, and lab services. Our efforts have also led to the first-ever decline in hospital upcoding since the inception of a prospective payment system in 1984. The bifurcation of authority under a board would threaten the significant advances made by this Administration by complicating the relationship between the program and the HHS Inspector General and between Medicare and the Department of Justice.

Similarly, this Administration has taken significant steps to measure and hold health plans and providers accountable for quality of care for seniors and other vulnerable populations. The diffusion of accountability threatens our ability to move aggressively in this area as we have on the Patients' Bill of Rights.

**Medicare Board Creates Potential Confusion of Authority That Would Be Detrimental to Beneficiaries.** HCFA is currently responsible for a wide range of activities that might become the responsibility of either the board or HCFA, or both. These functions include beneficiary education, procedures for appeals and grievances, provider enrollment, survey and certification of providers, and quality assurance. If these functions were assigned to HCFA, their applicability to private plans would become uncertain; if assigned to the board, more functions would be removed from the lines of public accountability. If assigned to both, there would be confusion and uncertainty among all parties involved.

**A Medicare Board Provides the Infrastructure for Ending the Medicare Entitlement.**

Although the proponents of a board deny that they intend to fundamentally change Medicare, it is clear that creation of an independent board would establish the administrative framework for a defined contribution plan, which specifies the government's financial contribution toward beneficiaries' health care but does not specify the benefits to which beneficiaries are entitled. Creating an independent board is an ideal first step toward capping government contributions for Medicare, and beneficiary advocates will see it as such. It is not surprising that some of the strongest advocates in Congress for a board are the same Members who tried to cap Medicare spending in the 1995 budget bill that you vetoed.

**Claims About Current Conflicts of Interest in Managing Medicare Are Not Legitimate.**

Advocates for a board argue that HCFA has an inherent conflict of interest in both managing the competition among private health plans and fee-for-service Medicare and operating the fee-for-service Medicare program. In fact, the risk of conflict of interest could be greater if managed care executives, hospital administrators, physicians, durable medical equipment suppliers, or any other individual who benefits from Medicare payments were given statutory powers through participation on the board.

Today, HCFA manages both original Medicare and Medicare+Choice, having successfully supervised the growth of Medicare+Choice to a program that enrolls about one of every six beneficiaries. HCFA's role is not unique – conflicts of interest are successfully avoided by CalPERS and many private employers that run self-insured plans while contracting with competing health plans.

The assertion that HCFA's dual role creates a conflict of interest may stem from certain decisions that private plans may find onerous, such as those in setting standards for consumer protection and quality assurance. Such decisions stem directly from HCFA's primary concern for serving the needs of beneficiaries, not from any desire to bias the competition. If a Medicare board also places serving the needs of beneficiaries as its core mission, it will inevitably make similar decisions. Thus, it will also be subject to the same charges of conflict of interest.

Under your proposal for a competitive defined benefit, traditional Medicare and private health plans would compete on an equal footing, allowing both Medicare and beneficiaries to save when beneficiaries choose efficient health plans. As discussed above, I believe that many board proponents are using the conflict of interest accusation as an excuse to take the first step toward ending the entitlement.

**Private Sector Involvement Can be Achieved Without a Medicare Board.** While I am deeply concerned about the proposals to create an independent board to administer a portion of Medicare, I am committed to expanding the program's access to private sector expertise. In September, we chartered a Management Advisory Committee for HCFA. This step was part of HCFA management modernizations contained in your budget. The committee allows HCFA to get expert advice from individuals in the public and private sector regarding innovations in management practices. It also will allow HCFA to maintain critical relationships with public and private sector experts in management, leadership, and purchasing strategies. The committee will address issues including how HCFA can better manage its private sector contractors and how it can be a more prudent purchaser of fee-for-service Medicare services. The committee need not make recommendations regarding payment or coverage policy, because the Medicare Payment Advisory Commission (MedPAC) and the recently established Medicare Coverage Advisory Committee already fulfill these functions.

I will chair the committee, which will include up to 11 additional members that I will appoint. The members will be selected from among nationally recognized authorities in academia, private consulting, public and private sector health purchasing entities, and private companies. The committee would not include provider or beneficiary representatives since they are already represented in many advisory committees to the Congress and the Department.

If Medicare reform is successful, this committee could also easily be adapted to serve as an advisory body for the implementation of the fee-for-service modernization reforms included in your Medicare plan. Experts from private and public sector organizations that purchase health care for their employees and beneficiaries, as well as experts in public administration, would provide recommendations to the Secretary on how to implement these reforms to purchase services more competitively. HCFA would benefit from the advice of these experts in a forum open to public participation.

**In Conclusion, Creation of a Medicare Board to Oversee a Portion of the Program Would Be a Grave Mistake.** It would be a disservice to our successors and to future generations of beneficiaries if we were to weaken the executive management of Medicare, not only because it is a substantial and growing proportion of federal outlays, but because older and disabled Americans are particularly vulnerable and need government protection. This Administration has strengthened Medicare in innumerable ways: extending solvency, increasing benefits, advancing new beneficiary protections, and strengthening program integrity. The Medicare program would most likely not be experiencing the benefits of the Administration's improvements had the Medicare board, as proposed, been in existence.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', written in a cursive style.

Donna E. Shalala

THE WHITE HOUSE  
WASHINGTON

Medicare

November 9, 1999

MEMORANDUM ON BREAU-FRIST MEDICARE REFORM PLAN

TO: John Podesta, Steve Ricchetti, Karen Tramotoano, Gene Sperling, Bruce ✓  
Reed, Larry Stein, Chuck Brain, Jack Lew, Joel Johnson, Charles Burson,  
Melanne Verveer, Dan Mendelson

FROM: Chris Jennings and Jeanne Lambrew

Senator Breau called yesterday to let us know that he is introducing his Medicare reform plan with Senator Frist and possibly Senator Kerrey today. The proposal is notably improved but still has fundamental flaws. The improvements include a drug benefit that provides premium assistance for all beneficiaries and the lack of a proposal to raise the age eligibility for Medicare. The plan also drops the Breau-Thomas home health and nursing home copays and BBA payment reduction extenders. It still does not dedicate any resources to extend trust fund solvency. We will provide a more detailed analysis once we get the proposal. The major elements apparently include:

- **Premium support:** This appears to be the same as the Breau-Thomas plan, and thus will have the same effect of raising the premiums for the traditional Medicare program by 10 to 30 percent, depending on the other proposals in the plan.
- **Prescription drugs:** Unlike the original plan, this one includes a premium subsidy for all beneficiaries. Premiums are free for those with income up to 135 percent of poverty, subsidized at 50 percent for those with income between 135 and 150 percent of poverty, and subsidized at 25 percent for those with income above 150 percent of poverty. However, this subsidy is too low, according to our actuaries, to attract enough beneficiaries to make the plan affordable. Moreover, private plans, apparently, can offer any array of deductibles and copays, so long as the total value of the package does not exceed \$800. Not only is this value low, but allowing this variation will further exacerbate the risk selection problem. The Senator said that he does not yet have CBO estimates – and we imagine that they will be high.
- **Merging the Part A and B trust fund:** Although this is not troubling in theory, in practice it means that we would be capping the amount of general revenues going to Medicare. This would increase, not decrease, Medicare's financial future shortfall.

- **Medicare Board:** The proposal would create a new board in charge of both the traditional program and managed care plans. Depending on its details, it could seriously undermine the Administration's oversight of Medicare.
- **Medicare modernization proposals:** It appears that, in the context of premium support and the Medicare board, the Senators support the traditional program modernization proposals. It also seems like this is on the only other source of savings.

It is worth noting that the drug industry published a full-page ad in the *Washington Post* supporting this proposal. This suggests that this plan may be designed to immunize the Republicans from not having an explicit prescription drug benefit or reforms in general.

We recommend that we publicly acknowledge the Senators' attempt to address the challenges facing Medicare and support for a Medicare prescription drug benefit with premium assistance for all beneficiaries. We should also praise them for dropping controversial policies like raising the age eligibility for Medicare. However, we should also reiterate our problems with premium support; our questions about how the drug benefit would work; and our disappointment that the Senator's plan does not dedicate resources to Medicare to address its inevitable financing shortfall.

FINAL  
MEDICARE  
LETTER

THE WHITE HOUSE  
WASHINGTON

October 19, 1999

The Honorable William V. Roth, Jr.  
Chairman  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

It was a pleasure to meet with you and Senator Moynihan earlier this month to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

With regards to managed care, we share your commitment to expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support my Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slowdown of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. The Department of Health and Human Services (HHS) has since concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

Sincerely,

*Ben Clinton*

**ADMINISTRATIVE ACTIONS BY THE  
CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE  
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

ISSUE	STATUS
<b>HOSPITALS: GENERAL</b>	
✓ Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓ Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
<b>HOSPITALS: OUTPATIENT</b>	
** Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓ Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓ Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓ Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓ Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓ Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓ Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs)	Planned for regulation early next year*
✓ Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓ Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓ Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
<b>SKILLED NURSING FACILITIES</b>	
✓ Increase payment for high acuity patients	Will be implemented
✓ Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
<b>HOME HEALTH</b>	
✓ Delay tracking patients and pro-rating payments	Now being implemented
✓ Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓ Postpone the requirement for surety bonds until October 1, 2000	Now being implemented
✓ Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

ISSUE		STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
<b>PHYSICIANS</b>		
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
<b>RURAL PROVIDERS</b>		
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	Planned for regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
<b>AMBULATORY SURGICAL CENTERS</b>		
X	Postpone implementation based on 1999 survey	
<b>MANAGED CARE</b>		
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

\*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

\*\*Under review.



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas  
Chairman, Subcommittee on Health  
Committee on Ways and Means  
United States House of Representatives  
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of \$7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

Jacob J. Lew  
Director

SEC. \_\_\_\_ INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.--With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

**DESCRIPTION OF ADMINISTRATIVE ACTIONS BY THE  
CLINTON ADMINISTRATION TO MODERATE THE IMPACT OF THE  
BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS**

**HOSPITALS: GENERAL**

*Capping hospital transfer policy at 10 DRGs for 2 years, through 2002.* We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

*Stop administrative recoupment of DSH payments based on unclear guidance.* We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

**HOSPITAL OUTPATIENT PAYMENTS**

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

*Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions.* We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

***Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS).*** We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

***Delay implementation of prospective payment system for cancer hospitals until additional data are collected.*** The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

***Make technical refinements to the Ambulatory Payment Classification (APC) system.*** We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

***Allow for temporary cost-based APCs for certain new technologies.*** Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

***Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs).*** Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

*Create separate APCs to pay for blood and blood products.* Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

*Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery.* Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

*Eliminate use of diagnostic codes in payments for medical visits and reassess use in future.* The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

#### **SKILLED NURSING FACILITIES (SNF) PAYMENTS**

*Increase payment for high acuity patients.* We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

*Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy.* Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

## **HOME HEALTH PAYMENTS**

***Delay tracking patients and pro-rating payments.*** Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

***Provide for extended interim payment system repayment schedules for agencies.*** As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

***Postponing the requirement for surety bonds until October 1, 2000.*** We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

***Change surety bond requirement to \$50,000, not 15 percent of annual agency Medicare revenues.*** We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

***Eliminate the sequential billing rule.*** As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

***Phase in reporting of services in 15-minute increments.*** We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

## **PHYSICIAN PAYMENTS**

*Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions.* As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

## **RURAL PROVIDER PAYMENTS**

*Change the average wage threshold percentages so more rural hospitals can reclassify.* We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

*Use same wage index for inpatient and outpatient PPS.* In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

*Modify Health Professional Shortage Area designations.* We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

## **AMBULATORY SURGICAL CENTER (ASC) PAYMENTS**

*Postpone implementation based on 1999 survey.* We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

## **MEDICARE +CHOICE PAYMENTS**

***Phase in risk adjustment over a 5-year period.*** In March, we announced a five-year transition to comprehensive risk adjustment for Medicare+Choice plans to minimize the disruption to plans. We plan to begin the transition in 2000 with a 90/10 blend of demographically and risk adjusted rates. This blend will be gradually increased over five years so that in 2004, rates will be fully risk adjusted using a comprehensive adjustment system that takes into account all care settings.

We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds \$4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

***Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension.*** For EverCare managed care plans that provide specialized services to the frail elderly, we are extending this demonstration project for an additional year through December 31, 2001. We also will continue the exemption from risk adjustment during this extension. This will provide additional time to complete our evaluation of this project. It also will allow EverCare to submit additional data on the special population it serves, which we can analyze for possible use in refinement of our risk adjustment methodology.

***Improve beneficiary protections and access to administration.*** We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information. For example, we clarified that any beneficiary who is enrolled in a Medicare+Choice plan that withdraws from the program is entitled to immediate enrollment in any other remaining Medicare+Choice plan serving the enrollee's area.

***Ease provider participation rules.*** We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.

THE WHITE HOUSE

WASHINGTON

June 29, 1999

**MODERNIZING MEDICARE EVENT**

**DATE:** June 30, 1999  
**LOCATION:** Grand Army of the Republic Memorial Hall  
Chicago Cultural Center  
Chicago, IL  
**EVENT TIME:** 10:45am - 11:45am  
**FROM:** Bruce Reed, Gene Sperling, Chris Jennings

**I. PURPOSE**

To highlight your new plan to strengthen and reform the Medicare program, with a special emphasis on the proposals that modernize the Medicare benefit package, including the creation of a new prescription drug benefit for all beneficiaries and cost sharing protections for preventive benefits.

**II. BACKGROUND**

You will address an audience of approximately 350 people, including local government officials, representatives of senior citizen organizations, and senior citizens from across the Chicago area. Many of the seniors in attendance participate in programs sponsored by the Chicago Department on Aging, including classes and activities at the Renaissance Court, a senior center in the Chicago Cultural Center which offers a variety of educational, health, and fitness programs for adults age 55 and above.

Today you will discuss the importance of modernizing the Medicare benefit package to include a long-overdue prescription drug benefit and eliminate all cost sharing barriers for preventive care. As you summarize your plan to strengthen and modernize the Medicare program, you will emphasize that affordable prescription drug and preventive services have become essential elements of high-quality medicine. You will also hear firsthand about the difficult choices and financial burdens seniors face when they do not have prescription drug coverage.

**MEDICARE'S BENEFITS NEED TO BE MODERNIZED.** Prescription drugs and preventive care have become central to modern medicine.

- **Millions of beneficiaries have no prescription drug coverage and millions more are at risk of losing coverage.** Nearly 15 million Medicare beneficiaries have no prescription drug coverage. And, millions more are at risk of losing coverage or have inadequate, expensive coverage. Lack of drug coverage is not just a problem for low-income beneficiaries; about 40 percent of beneficiaries without drug coverage have incomes above 200 percent of the poverty level (about \$16,000 for a single, \$22,000 for a couple). Nearly one in three of non-elderly Medicare beneficiaries, almost half of rural beneficiaries, and about 41 percent of beneficiaries older than the age of 85 do not have coverage for prescription drugs.
- **Current prescription drug coverage is unstable and declining.** About 37 percent of Medicare beneficiaries had private employer-based or Medigap insurance for drug coverage in 1995. Both sources of coverage have been declining as the cost of coverage rises. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1997, and Medigap premiums have been rising at double-digit inflation.
- **Medicare managed care plans have limited coverage and are not accessible to millions of the elderly.** While Medicare managed care plans usually offer some drug coverage, it is typically limited (e.g., \$1,000 cap). In addition, 11 million beneficiaries, who disproportionately reside in rural areas, have no access to managed care plans.
- **Opponents' arguments against a prescription drug benefit that is available to all beneficiaries resembles the opposition to the enactment of Medicare.** Although 56 percent of the elderly had insurance before Medicare, this coverage was expensive, inadequate, and unreliable – much like drug coverage today. Medicare would not have been created if this “coverage” was considered acceptable.
- **Preventive benefits are a necessary part of modern health care.** According to recent studies, Medicare preventive services are underutilized. For example, studies indicated that only one in four women in their sixties are tested as recommended for breast cancer. In the first two years that Medicare covered screening mammographies, only 14 percent of eligible women without supplemental insurance received a mammogram.

Your plan to modernize Medicare's benefit package addresses these critical issues by:

**MODERNIZING MEDICARE'S BENEFITS TO INCLUDE A NEW**

**PRESCRIPTION DRUG BENEFIT.** Your plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high quality prescription drug coverage beginning in 2002. This new benefit would provide:

- **Meaningful coverage that is available to all beneficiaries.** Medicare would cover half of drug costs from the first prescription up to \$5,000 in spending per year (\$2,500 in plan payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers. For the nearly 15 million beneficiaries who have absolutely no coverage, it would provide significant financial relief. For the several million beneficiaries who rely on Medigap or Medicare managed care, this benefit would ensure that their coverage will always be there, without excessive rate increases or reductions in the generosity of the benefit.
- **Affordable premiums.** Beneficiaries would pay a separate premium for Medicare Part D – an estimated \$24 per month in 2002, and \$44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded.
- **Low income protections.** Beneficiaries with incomes up to 135 percent of poverty (\$11,000 for singles, \$15,000 for couples) would pay no premiums or cost sharing, with the premium subsidy phased out from 135 to 150 percent of poverty. The Federal government would pay for all of the costs associated with beneficiaries with incomes above poverty.
- **Private management.** Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities to manage the benefit. This partnership would provide beneficiaries with the same high quality benefits they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used.

#### **IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST SHARING.**

This proposal, which costs \$3 billion over 10 years, would take a number of steps to make preventive services more affordable as well as to raise awareness of services. It would:

- **Eliminate all existing preventive services cost sharing.** Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including hepatitis B, colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
- **Launch a smoking cessation demonstration project.** Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.
- **Create a new health promotion education campaign.** This new, nationwide health promotion education campaign would be targeted to all Americans over the age of 50.

### III. PARTICIPANTS

#### Stage Participants:

Anne Thomas, Oak Park, IL

*Anne is a 68-year-old, single woman with osteoporosis and asthma. Currently, her out of pocket costs on prescription drugs to treat her osteoporosis are over \$100 a month (about 1/6 of her income). She is not able to afford the extremely expensive medication to treat her asthma, and when she has a severe asthma attack she often uses the medication prescribed for her children and grandchildren, who also have asthma.*

Leigh Hamilton, daughter of Anne Thomas

Laura Peterson, daughter of Anne Thomas

#### Event Participants:

Anna Willis, Commissioner, Chicago Department on Aging

Linda Esposito, Cicero, Illinois

*Linda has been a geriatric pharmacist in the Chicago area for 15 years. She has seen first-hand the struggles and tough choices faced by seniors without prescription drug coverage.*

Hanna Bratman, Chicago, Illinois

*Hanna is a 79-year-old widow whose high out-of-pocket costs for her required prescription medications relative to her fixed income have forced her to make difficult lifestyle changes. In order to obtain the appropriate medication to treat her asthma and heart condition, Hanna spends nearly \$3,000 annually.*

### IV. PRESS PLAN

Open Press.

### V. SEQUENCE OF EVENTS

- **YOU** will greet the stage participants and leaders from senior citizen organizations.
- **YOU** will be announced, accompanied by Anna Willis, Linda Esposito, and Hanna Bratman, onto the stage.
- Anna Willis, Commissioner of the Chicago Department on Aging, will make brief remarks and introduce Linda Esposito.
- Linda Esposito will make brief remarks and introduce Hanna Bratman.
- Hanna Bratman will make brief remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline, and depart.

### VI. REMARKS

To be provided by speechwriting.

EDWARD M. KENNEDY  
MASSACHUSETTS

## United States Senate

WASHINGTON, DC 20510-2101

cc: KT  
Larry Stein  
Spending  
Reed

May 14, 1998

Medicare

The Honorable John D. Podesta  
Chief of Staff to the President  
The White House  
Washington, D.C. 20500

Dear John:

It was good to talk with you yesterday. This letter is to follow up on our conversation. I'll be dropping the President a note on this next week, as well.

As you develop a Medicare prescription drug proposal, I wanted to share my thinking on some key concepts:

(1) I hope you will be able to stay as close to the bill that Jay Rockefeller and I introduced as possible. All the elderly groups are supporting it. It would be unfortunate if the Administration's proposals look very different. We need to speak with one voice on this issue, and we need the elderly to be solidly behind us.

(2) The elderly need a sound benefit package if we are to keep their support. That means we need basic coverage that will offer something to those with only moderate drug costs, as well as a catastrophic benefit to guarantee that those who need expensive drugs will be protected. If we don't have both components, our plan will be difficult to defend. When Jay and I developed our bill, we found that most of the cost is in the basic benefit. The catastrophic benefit raised the overall cost by only about 20%, but it means critical protection for those who need help the most.

(3) I know that you have concerns about how to finance the cost. I see a number of possible sources of funds:

The biggest potential source is the surplus that is already allocated to Medicare under the President's budget. I do not see any conflict in using a portion of these funds for financing a prescription drug benefit. Medicare cuts were the biggest single source of spending reductions creating the surplus. The solvency of Medicare has improved dramatically since the President made his proposal. The President said that the surplus was to be used to improve and strengthen Medicare. There is nothing more important to improve and strengthen Medicare than coverage of prescription drugs. If one-half of the portion of the surplus designated for Medicare is used to pay part of the drug benefit, it would raise \$172 billion over the next 10 years--and still make it possible to extend the solvency of the Trust

Page 2

Fund to 2020, the President's original target.

- We should preserve the option of using tobacco taxes to finance part of the benefit. We could propose an additional tobacco tax, or reallocate the tax already included in the Administration's budget. A tax of 55 cents a pack would raise about \$70 billion over ten years.
- In making choices on the benefit package, the elderly are willing to pay more in premiums for greater security. Retaining the 25% share in Part B today is important, but I wouldn't be too concerned the difference between a \$15 and \$25 additional monthly premium, or something of that magnitude. In Massachusetts, 50% of the senior citizens in the Harvard Community Health Plan voluntarily chose to pay more than \$70 a month for drug coverage. Of course, we would need additional protection for the low income elderly.
- Any program savings from the President's reform package should be dedicated to prescription drug coverage.
- The elderly organizations were all very comfortable with the relatively high \$200 dollar deductible included in our bill. It largely financed the cost of the catastrophic benefit.

(4) Strategically, the most important step is to launch a benefit that the elderly will rally around. If we get this program enacted, in the end it will be part of some overall agreement with the Republicans, and not necessarily tied to any specific financing source.

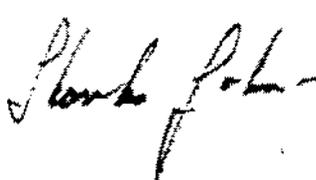
In our March 4 meeting with the President, he emphasized that he wanted a plan that Jay and I and Jim McDermott and John Dingell agree on. We're all grateful for that, and we look forward to working closely with you.

I hope these thoughts are helpful. The President's leadership on this critical health issue has been inspiring, and there are reasonable prospects for success this year.

With thanks and appreciation,

As ever,

Edward M. Kennedy



Bruce

Medicare

THE WHITE HOUSE  
WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

**Modernizing Traditional Medicare.** One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated \$14 billion over 10 years.

**Competitive Managed Care Payments.** A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model (\$10 versus \$50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

**Income-Related Premium.** An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. All of your advisors recommend that it begin at \$80,000 for singles, \$100,000 for couples, which produces about \$25 billion over 10 years and affects about 2 million beneficiaries. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

**Cost Sharing.** Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost \$3 billion over 10 years and is unanimously recommended by your advisors.
- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about \$5-10). It would save about \$9 billion over 10 years and is supported by your advisors.
- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly \$100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about \$60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves \$4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.
- Index the Part B deductible to inflation: The \$100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be \$135) and save about \$2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to \$150) if it would avoid the need for surplus spending.
- Add \$5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves \$7 billion over 10 years).

**Provider Payment Reductions.** Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about \$40 billion over 10 years (more or less depending on the degree of fixes).

**PRESCRIPTION DRUG BENEFIT.** The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent \$4,200 on drugs. This bill costs over \$300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS (\$ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
<b>\$5,000 LIMIT</b>	<u>Cap:</u>	<u>\$2,000</u>	<u>\$2,000</u>	<u>\$3,000</u>	<u>\$4,000</u>	<u>\$5,000</u>	<u>indexed</u>			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	123.0
Premiums		\$24	\$25	\$31	\$36	\$41	\$43	\$45	\$48	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	164.1
Premiums		\$16	\$17	\$21	\$24	\$27	\$29	\$30	\$32	
<b>\$10,000 LIMIT *</b>	<u>Cap:</u>	<u>\$4,000</u>	<u>\$4,000</u>	<u>\$6,000</u>	<u>\$6,000</u>	<u>\$8,000</u>	<u>\$8,000</u>	<u>\$10,000</u>	<u>indexed</u>	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.6	22.9	25.1	141.6
Premiums		\$31	\$33	\$38	\$40	\$45	\$47	\$51	\$55	
67% Premium	0	9.6	16.4	20.8	22.9	25.4	27.8	30.5	33.5	188.8
Premiums		\$21	\$22	\$25	\$27	\$30	\$31	\$34	\$36	
<b>NO LIMIT:</b>	<u>Cap:</u>	<u>\$2,000</u>	<u>\$3,000</u>	<u>\$3,000</u>	<u>\$4,000</u>	<u>\$5,000</u>	<u>None</u>			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	134.8
Premiums		\$24	\$30	\$31	\$36	\$41	\$51	\$54	\$58	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	179.9
Premiums		\$16	\$20	\$21	\$24	\$27	\$34	\$36	\$39	

\* Note: The policy with the \$10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 05); the catastrophic option is more expensive in the out-years

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least \$5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to \$5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under \$20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

**FINANCING GAP.** If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about \$100 billion over 10 years. This is about \$30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly \$10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.
- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.
- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A \$0.50 tax (on top of your budget's \$0.55 tax) would generate about \$45 billion in revenue from 2000-09.

- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline (\$240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

**ILLUSTRATIVE PACKAGES.** On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

<b>OPTION 1: No Additional Financing</b>	<b>OPTION 2: Additional Tobacco Tax</b>	<b>OPTION 3: Surplus</b>
<b>Base:</b>	<b>Base:</b>	<b>Base:</b>
Competition -10	Competition -10	Competition -10
Modernize Medicare -14	Modernize Medicare -14	Modernize Medicare -14
Income-Related	Income-Related	Income-Related
Premium (\$80/100) -25	Premium (\$80/100) -25	Premium (\$80/100) -25
Cost Sharing	Cost Sharing	Cost Sharing
Preventive buy-down +3	Preventive buy-down +3	Preventive buy-down +3
Lab 20% coinsurance -9	Lab 20% coinsurance -9	Lab 20% coinsurance -9
Nursing home 20% -5	Nursing home 20% -5	Nursing home 20% -5
Indexing Deductible -1	Indexing Deductible -1	Indexing Deductible -1
Provider Savings -40	Provider Savings -40	Provider Savings -40
<b>Subtotal: -100</b>	<b>Subtotal: -100</b>	<b>Subtotal: -100</b>
<b>Additions:</b>	<b>Additions:</b>	<b>Additions:</b>
Income-Related	Tobacco Tax -45	Surplus -90
Premium (\$60/90) -7	Income-Related	
More Provider Cuts -7	Premium (\$60/90) -7	
Raise Deductible to \$150 and index -10		
<b>Subtotal: -24</b>	<b>Subtotal: -52</b>	
<b>Drug Benefit:</b>	<b>Drug Benefit:</b>	<b>Drug Benefit:</b>
\$5,000 Limit +123	\$5,000 Limit +164	\$5,000 Limit +164
50% Premium: \$24/\$48*	67% Premium: \$16/\$32*	67% Premium: \$16/\$32*
	\$10,000 Limit +142	\$10,000 Limit +189
	50% Premium: \$31/\$55*	67% Premium: \$21/\$36*
	No Dollar Limit +135	No Dollar Limit +180
	50% Premium: \$24/\$58*	67% Premium: \$16/\$39*
State MOE -5	State MOE -5	State MOE -5
<b>TOTAL** -6</b>	<b>TOTAL** +7-22</b>	<b>TOTAL** -6-31</b>

\*Monthly premiums in 2002 and 2009. Part B premium is \$57 / \$95 in 2002 / 2009.

\*\* This amount is a necessary "cushion" pending final cost estimates.

Drug estimates assume about \$5 billion in savings from state maintenance of effort.

NOTE: The policy with the \$10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

Bruce: FUI, the supposed secret documents (given to the Hill & internally) at least 1 month old

Medicare

## DRAFT: BACKGROUND ON PRESCRIPTION DRUGS

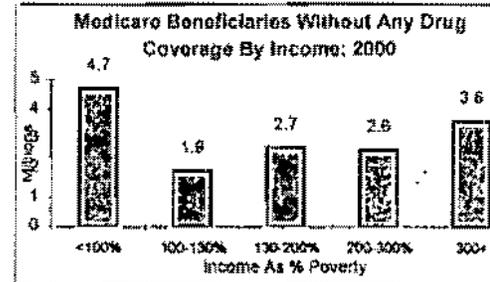
*Medicare does not pay for outpatient prescription drugs. The number of Medicare beneficiaries with some other source of insurance for drugs is decreasing, primarily because private sources are becoming less accessible and more expensive. Fewer employers are offering retiree health coverage, and Medigap is increasingly scarce and expensive. Even those with coverage are finding that the extent of their coverage is declining (especially in Medicare HMOs). This occurs at a time when prescription drugs are becoming a central component of medical care.*

### PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

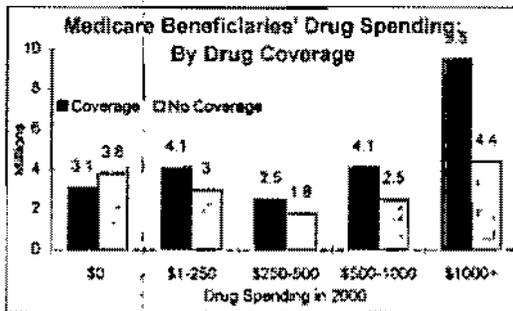
- **Increasing reliance on drugs.** Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g., drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.
- **Elderly and people with disabilities rely more on prescription drugs.** Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.
- **Drugs may reduce need for and cost of other services.** Some studies have found that elderly Medicare beneficiaries whose Medicaid drug coverage is limited are twice as likely to enter nursing homes, whose costs are 20 times higher than the savings from the limitation. Stroke patients treated promptly with drugs to thin clots have lower health care costs. And, all experts agree that drug management can reduce complications that lead to costly hospital care. At the same time, drug coverage could add potential new costs due to increases in utilization and possible extension of lives.

## BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- Beneficiaries across the income spectrum lack drug coverage.** About 16 million beneficiaries are projected to have no drug coverage in 2000. Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about \$17,000 for a single, \$23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



- Many beneficiaries need drugs but do not use them because they are uninsured.** Most research has found that lack of coverage reduces needed drug utilization. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodilators) when their Medicaid drug coverage was limited. And while some do not receive the drugs they need, nearly half of all beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of \$500 or more.



- Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that are at least 15-30 percent higher than large HMOs, employers and the Veterans' Administration. One study found that, for the 10 most prescribed drugs, seniors are charged twice as other payers. A recent General Accounting Office study found that pharmaceutical benefit managers in the Federal Employees' Health Benefits Plan reduced costs by 20 to 27 percent.
- Larger financial burden.** Elderly with private insurance for drugs have about half the financial burden (out-of-pocket drug spending as a percent of income) as those without drug coverage. The financial burden of drug costs for rural elderly is on average 35 percent higher than urban elderly since they are less likely to have insurance covering drugs. Women have, on average, out-of-pocket costs as a percent of income that are 20 percent higher than men, primarily because many are widowed and have lower income. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed \$3,000 - which more than 20 percent of income for at least half of these beneficiaries.
- Difficult to help only beneficiaries without drug coverage.** The diversity of beneficiaries without drug coverage, along with the instability of coverage for those who have it, makes it difficult and inequitable to target a new drug option only those who are uninsured. Such a policy would either require people paying for expensive Medigap or who joined an HMO only for drug coverage to maintain that coverage or result in substitution.

## DRUG COVERAGE AMONG MEDICARE BENEFICIARIES

- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private employer-based or Medigap insurance for drug coverage in 2000 according to the Medicare actuary -- down significantly from 1995. Both sources of coverage have been declining as the cost of coverage rises. Therefore, they cannot be relied upon to provide coverage in the future.
  - **Retiree health insurance:** Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage.
  - **Medigap:** Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a \$250 deductible, 50 percent coinsurance, and a cap on benefits spending of \$1,250 or \$3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. Beneficiaries can be denied coverage if they do not enroll immediately when they are age 65. The premium for a plan with drug coverage is about \$1,100 more than a plan without drug coverage (\$2,073 v \$913 in 1998). Medigap premiums have been rising at double-digit inflation, and coverage has been declining. About 6 percent of beneficiaries are expected to have Medigap drug coverage in 2000.
- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that the potential for "crowding out" private spending are exaggerated.
  - **Medicare managed care:** The vast majority of beneficiaries in Medicare HMOs have some type of drug coverage. While they typically have no deductibles and relatively low copayments, Medicare managed care plans usually limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to \$1,000 or less. Trends and industry reports suggest that benefits are likely to be reduced or dropped in the future.
  - **Medicaid:** Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.

OMB Document

## Medicare Prescription Drug Benefit

**Potential Savings to the Program.** Numerous studies have evaluated the possible savings realized by the Medicare program with the implementation of a monitored (i.e., including drug utilization review and physician education) outpatient prescription drug benefit. Studies have reported savings from reductions in inpatient volume, reductions in nursing home, home health and partial hospitalization services, and savings from the avoidance of hospitalizations and readmissions due to adverse drug reactions.

A report done in 1994 by the Lewin-VHI, Inc. estimated that the use of cost-effective pharmaceuticals, the more appropriate use of pharmaceutical products and diffusion of advanced pharmacy services would save the Medicare program an estimated \$29.2 billion between 1996 and 2000.<sup>1</sup>

**Reductions in Inpatient Volume.** Offering a drug benefit may decrease the volume of services, specifically inpatient admissions. One study reports that Medicare policy prohibiting coverage of outpatient, self-administered drugs has severely limited access of Medicare patients to ambulatory intravenous antibiotic therapy, thus forcing them to rely on more costly inpatient hospital care. This study tested the hypothesis that a new Medicare benefit providing coverage for ambulatory intravenous antibiotic therapy could significantly reduce the program's expenditures for the treatment of infectious diseases. The authors reported a cumulative 5-year savings of nearly \$1.5 billion<sup>2</sup> associated with the new Medicare benefit.<sup>3</sup>

A study in *Health Economics* found that an increase of 100 prescriptions is associated with 16.3 fewer hospital days. A \$1 increase in pharmaceutical expenditure is associated with a \$3.65 reduction in hospital care expenditure (ignoring any indirect cost of hospitalization), but it may also be associated with a \$1.54 increase in expenditure on ambulatory care.<sup>4</sup> Because outpatient costs are more often borne by the patients than are inpatient costs, this effect may result in costs for the patient and savings for the Medicare program.

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<sup>1</sup>Lewin-VHI (1994) *Savings from a Medicare Pharmaceutical Benefit*, pg. i

<sup>2</sup>Model results are predicted on the March 1997 CBO estimates of projected Medicare growth.

<sup>3</sup>Tice, AD., Poretz, D., Cook, F., Zinner, D., Strauss, MJ.: *Medicare Coverage of Outpatient Ambulatory Intravenous Antibiotic Therapy: A Program That Pays for Itself*. Clinical Infectious Diseases, 1998; 27(6): 1415-21.

<sup>4</sup>Lichtenberg, FR.: *Do (More and Better) Drugs Keep People Out of Hospitals*. Health Economics.

Case studies of a number of specific drugs have shown that these drugs reduced the demand for hospital care. According to the Boston Consulting Group, operations for peptic ulcers decreased from 97,000 in 1977, when H2 antagonists were introduced, to 19,000 in 1987; this is estimated to have saved \$224 million in annual inpatient medical costs.<sup>5</sup> The recent Scandinavian Simvastatin Survival Study indicated that giving the drug simvastatin to heart patients reduced their hospital admissions by a third during five years of treatment. It also reduced the number of days that they had to spend in the hospital when they were admitted, and reduced their need for bypass surgery and angioplasty.<sup>6</sup>

Another study used clinical, economic, and epidemiologic data to compare the costs of conventional inpatient care of osteomyelitis, or inflammation of the bone, with the costs of early-discharge treatment using a once daily parenteral antibiotic at home. Osteomyelitis was the cause of 16,578 Medicare-reimbursed admissions in 1995, with a mean length of stay of 15.7 days.<sup>7</sup> Osteomyelitis was selected for study because a new once-daily cephalosporin antibiotic, cefonicid sodium, has been shown to be effective in treating osteomyelitis in the outpatient setting. The authors found that early-discharge treatment was associated with lower medical direct, non-medical direct, and indirect expenses than conventional inpatient treatment. Estimated savings per patient ranged from \$510 to \$22,232 (the wide differences in estimated savings are a result of the use of different sources of data on hospital costs).<sup>8</sup>

In a retrospective study of health care use among Medicare beneficiaries in New Jersey and eastern Pennsylvania, one study examined the impact of New Jersey's Pharmaceutical Assistance for the Aged (PAA) program on health care costs. This study found that New Jersey Medicare recipients used, on average, \$238.50 less in inpatient hospital care under the PAA program than did their counterparts in eastern Pennsylvania, which did not have a drug payment assistance program in place. Although administrative costs may have reduced overall savings, the study concludes that the PAA program resulted in no overall health care cost increases.<sup>9</sup> In other words, the cost of the drugs and administering the benefit did not exceed the savings from reductions in inpatient utilization.

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<sup>5</sup>Boston Consulting Group.: *The Contribution of Pharmaceutical Companies: What's at Stake for America. Executive Summary.* Unpublished report, Boston Consulting Group, Inc., 1993.

<sup>6</sup>New York Times.: *Cholesterol Pill Linked to Lower Hospital Bills.* 27 March 1995a, p. A11.

<sup>7</sup>From the Medicare Provider Analysis and Review (MEDPAR) file of 1995, which contains hospital discharge data for all Medicare beneficiaries using inpatient hospital services.

<sup>8</sup>Eisenberg, JM., Kitz, DS.: *Savings from Outpatient Antibiotic Therapy for Osteomyelitis. Economic Analysis of a Therapeutic Strategy.* JAMA, 1986; 255(12): 1584-1588.

<sup>9</sup>Lingle, EW., Kirk, KW., Kelly WR.: *The Impact of Outpatient Drug Benefits on the Use and Cost of Health Care Services for the Elderly.* Inquiry, 1987; 24(3): 203-11.

Reductions in Nursing Home, Home Health and Partial Hospitalization Volume. The National Institute on Aging estimates that effective treatment for Alzheimer's victims, including the drug Tacrine, could keep 10 percent of patients out of nursing homes, thus savings billions of dollars.<sup>10</sup> One study examined the effects of limits on Medicaid payments for drug treatment and found that restrictions on access to anti-psychotic drugs, the most effective treatment for acute episodes or exacerbations of schizophrenic illness, caused a significant increase in visits to Community Mental Health Centers (CMHCs) and increases in the use of emergency mental health services, and partial hospitalizations.<sup>11</sup> Another study examined the effect of one state's limit of three Medicaid-reimbursed prescriptions per month and found that limiting reimbursement for effective drugs puts frail, low-income, elderly patients at increased risk of institutionalization in nursing homes (relative risk of admission to a nursing home of 2.2 and of admission to a hospital of 1.2 when access to drugs was restricted) and may increase Medicaid costs.<sup>12</sup>

Savings From More Appropriate Use of Pharmaceuticals. Pharmaceuticals sometimes lead to drug-induced disease and drug-related hospital admissions. Drug related hospitalizations (DRH) occur primarily as a result of adverse drug reactions (ADR), an unintended effect of a drug, and therapeutic failure, a failure of a drug due to non-compliance, dose reduction/discontinuation, interaction, improper prescribing, inadequate monitoring, etc. A managed Medicare drug benefit would use drug utilization review, along with other tools, to coordinate the benefit and decrease adverse drug reactions.

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<sup>10</sup>Rice, DP., Fox, PJ., Max, W., et. al.: *Economic Burden of Alzheimer's Disease Care.* Health Affairs, 1993; 12(2): 164-76.

<sup>11</sup>Soumerai, SB., McLaughlin, TJ., Ross-Degnan, D., Casteris, CS., Bollini, P.: *Effects of Limited Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia.* The New England Journal of Medicine, 1994; 331: 650.

<sup>12</sup>Soumerai, SB., Ross-Degnan, D., Avorn, J., McLaughlin, TJ., Choodnovskiy, J., : *Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes.* The New England Journal of Medicine, 1991; 325: 1072-1077.

A number of studies have attempted to assess the number of DRHs that occur and the percentage which are avoidable with increased drug management. One study which classified the geriatric admissions to a community hospital found that DRH accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.<sup>13</sup> A similar study which examined admissions to six medical wards found that the prevalence of drug related hospital admissions caused by ADRs was 8.4 percent and 47 percent were deemed avoidable.<sup>14</sup> A third study which reported on interviews with 315 consecutive elderly patients admitted to acute care hospitals found that 16.8 percent of elderly admissions were due to ADRs.<sup>15</sup> A final study, with the objective of determining the excess length of stay, extra costs, and mortality attributable to ADRs in hospitalized patients, concluded that the attributable lengths of stay and costs of hospitalization for ADRs are substantial and that an ADR is associated with a significantly prolonged length of stay, increased economic burden, and an almost 2-fold increased risk of death.<sup>16</sup>

Hospital readmissions are another source of cost to the Medicare program. Approximately 22 percent to 36 percent of elderly patients are readmitted to the hospital within 6 months of their initial discharge. In addition, rehospitalizations account for 24 percent of all inpatient Medicare expenditures.<sup>17</sup> The findings of one study suggest that in half of the cases drug-related problems precipitated the readmission of the patient and that prevention of the problem could have precluded the readmission. Although the prevention of contributory drug-related problems might not eliminate a hospital readmission, it might decrease the length of stay and costs of the readmission, or improve the patient's discharge prognosis.<sup>18</sup>

### **Possible Management Tools.**

Pharmacy Benefit Manager (PBMs). PBMs administer the prescription drug part of health insurance plans on behalf of plan sponsors, such as self-insured employers, insurance companies,

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<sup>13</sup>Bero, LA., Lipton, HL. and Bird, JA.: *Characterization of Geriatric Drug-Related Hospital Readmissions.* Med Care, 1991; 29 (10): 989-1003.

<sup>14</sup>Hallas, J., Gram, LF., Grodum, E., et. al.: *Drug Related Admissions to Medical Wards: A Population Based Survey.* British Journal of Clinical Pharmacology, 1992; 33(1): 61-68.

<sup>15</sup>Nananda, Col., Fanale, JE., Kronholm, P.: *The Role of Medication Noncompliance and Adverse Drug Reactions in Hospitalizations of the Elderly.* Arch Internal Medicine, 1990; 150: 841-845.

<sup>16</sup>Classen, DC., Pestotnik, SL., Evans, RS., Llyod, JF., Burke, JP.: *Adverse Drug Events in Hospitalized Patients. Excess Length of Stay, Extra Costs, and Attributable Mortality.* JAMA, 1997; 277(4): 301-306.

<sup>17</sup>ibid

<sup>18</sup>Bero, LA., Lipton, HL. and Bird, JA.: *Characterization of Geriatric Drug-Related Hospital Readmissions.* Med Care, 1991; 29 (10): 989-1003.

and health maintenance organizations. In their interviews, Grabowski and Mullins obtained estimates from the leading PBMs of the potential savings to the drug budget to payors, relative to an unmanaged plan, from PBM interventions designed to affect drug product selection. These activities (generic substitution, formularies, drug utilization review and prior authorization) can produce estimated savings between 14 and 31 percent in the health plans total expenditures<sup>19</sup>. The GAO studied three FEHBP plans that contracted with PBMs to control rapidly rising pharmacy benefit payments. The plans estimated that PBMs saved them over \$600 million in 1995 by obtaining manufacturer and pharmacy discounts and managing drug utilization. These savings reduced the pharmacy benefit costs each plan believes it would have paid without using a PBM by between 20 and 27 percent.<sup>20</sup> Note that by using current spending levels in the MCBS data, utilization controls used by employers and other insurers were assumed in the last estimate. Therefore, these savings estimates may be higher than what Medicare could achieve.

Medicare would establish a process whereby PBMs in each region competitively bid to provide Medicare services. Once a contract is awarded, the winning PBM in each region would be the sole-source benefits manager for a beneficiary in that area.

The PBM could use any or all of the following techniques to manage the benefit plus selective contracting and competitive bidding.

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<sup>19</sup>Grabowski, H. and Mullins, D.: *Pharmacy Benefit Management, Cost-Effectiveness Analysis and Drug Formulary Decisions*. Social Science Medicine, 1997; 45 (4): 535-543.

<sup>20</sup>U.S. General Accounting Office : *FEHBP Plans Satisfied With Savings and Services, but Retail Pharmacies Have Concerns*. GAO/HEHS-97-47.

1) *Drug Utilization Review (DUR)*. DUR programs analyze patterns of drug use to prevent contraindications and adverse interactions. PBMs use this information to make prescription substitution recommendations to physicians and inform plans and physicians about physicians' prescribing patterns. DUR can be considered a cost control measure. Grabowski and Mullins estimate that the use of concurrent DUR can produce estimated savings between 2-4 percent in a health plans total expenditures.<sup>21</sup>

2) *Generic Substitution*. Generic substitution interventions switch medications from brand-name drugs to chemically equivalent generic drugs. The Medicare benefit could include incentives for physicians to utilize generic substitutions. These incentives could also extend to the beneficiary by requiring additional copayments for the use of brand name drugs. "Generic substitution can save payors up to 10 percent of their total drug costs. In this regard, a managed care plan can achieve generic utilization rates of 35-45 percent, compared to rates of 15-20 percent for unmanaged plans".<sup>22</sup>

3) *Disease management*. Disease management programs try to improve the care delivered to specific group of patients, such as those with diabetes, by recommending particular therapies or patient self-management techniques. PBMs use physician and patient education materials to emphasize shared responsibility and cost-effective approaches. The Medicare benefit could require disease management by PBMs. We are still looking for savings estimates for this activity.

4) *Mail-Order Pharmacy Benefit*. PBMs operate mail order pharmacies that allow enrollees to obtain prescriptions, particularly maintenance prescriptions, by mail which are more cost-effective than retail pharmacies. Medicare could provide a financial incentive for beneficiaries to utilize mail-order benefits. We are still looking for savings estimates for this activity.

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<sup>21</sup>Grabowski, H. and Mullins, D. *Pharmacy Benefit Management, Cost-Effectiveness Analysis and Drug Formulary Decisions*, Social Science Medicine, 1997; 45 (4), 535-543.

<sup>22</sup>*Ibid*

5) *Formularies*. A formulary is a list of prescription drugs, grouped by therapeutic class, that are preferred by a health plan sponsor. Drugs are included on a formulary not only for reasons of medical value but also on the basis of price. PBMs use formularies to help control drug costs by (1) encouraging the use of formulary drugs through compliance programs that inform physicians and enrollees about which drugs are on the formularies; (2) limiting the number of drugs a plan will cover; or (3) developing financial incentives to encourage the use of formulary products. Grabowski and Mullins estimate that the use of formularies can produce estimated savings between 5-15 percent in a health plans total expenditures.<sup>23</sup>

Formularies can be open, incentive-based, or closed.

Open formularies are often referred to as "voluntary" because enrollees are not penalized if their physicians prescribe nonformulary drugs. Thus, under an open formulary, a health plan sponsor provides coverage for both formulary and nonformulary drugs.

Incentive based formularies provide enrollees financial benefits if their physicians prescribe formulary drugs. Under this arrangement, the health plan sponsor still reimburses enrollees for nonformulary drugs but requires them to make higher co-payments than for formulary drugs.

Closed formularies take financial incentives one step further by limiting coverage to formulary drugs only. Therefore, if a enrollee's physician prescribes a nonformulary drug, the enrollee may have to pay full cost of that prescription. However, the health plans cover nonformulary products when physicians determine that they are medically necessary for their patients.

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<sup>23</sup>Grabowski, H. and Mullins, D. *Pharmacy Benefit Management, Cost-Effectiveness Analysis and Drug Formulary Decisions*, Social Science Medicine, 1997; 45 (4), 535-543.

*Health Care -  
Medicare*



**PROGRESSIVE POLICY INSTITUTE**

**Facsimile Cover Sheet**

**To:** *Bruce Reed*

**From:** Debbie Boylan

**Pages to follow:** *2*

**Problems?** **Contact:** 202/608-1219

*FYI*

**NEW ADDRESS:**

**600 Pennsylvania Avenue, SE, Washington, DC 20003**

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## A Setback to Bipartisan Medicare Reform

*David B. Kendall*

The Bipartisan Commission on the Future of Medicare came tantalizingly close—one vote—to endorsing a breakthrough reform proposal designed largely by its chairman, Senator John Breaux (D-LA). The commission ended in deadlock this week as President Clinton announced his opposition to the plan crafted by a key New Democrat ally.

The commission's work nonetheless will advance the debate. Senator Breaux and the commission's Administrative Chairman Rep. Bill Thomas (R-CA) will introduce legislation based on the proposal that garnered a majority of commission members' support (a super majority was needed to make a formal recommendation). This proposal would reform Medicare using the Federal Employees Health Benefits Program (FEHBP) as a model. (See the Progressive Policy Institute's (PPI) report, *Medicare Breakthrough: Senator Breaux's Reform Proposal*, on our Web site at [www.dlcppi.org](http://www.dlcppi.org)).

Meanwhile, the task of rekindling momentum toward a bipartisan consensus on how to modernize Medicare now falls on the President, who promised to produce his own plan shortly. In announcing his decision, which delighted liberals and disappointed New Democrats, the President cited four objections to the Breaux-Thomas approach:

**1. The Breaux-Thomas proposal "has the potential to increase premiums for those in the traditional Medicare program."** This criticism appears to pit the President against the concept of using competition to restrain Medicare costs. Yet competition between Medicare's traditional fee-for-service program and private health plans represents a third way to control costs that does not require punishing tax hikes or across-the-board benefit cuts. The whole idea of competition is that premiums will rise for the least efficient health plans and fall for those that are most efficient. The Breaux-Thomas proposal would keep Medicare's guaranteed benefits package, but competition between traditional Medicare and private health plans would determine how much Medicare would pay for those benefits.

**2. The Breaux-Thomas proposal "would raise the age of eligibility for Medicare from 65 to 67, without a policy to guard against increasing numbers of uninsured Americans."** Raising the eligibility age, even gradually as Breaux and Thomas propose, would mean that the near-elderly who are already uninsured would remain so for a longer period. But the President's objection ignores a simple truth: *Not* restraining Medicare's cost growth will consume the resources we need to cover all the uninsured, not just those near retirement. Moreover, the Breaux-Thomas plan would continue to cover people ages 65 to 67 who are too disabled to

work and would let everyone else who is affected buy into Medicare with their own money. To achieve universal coverage, the Progressive Policy Institute (PPI) has called for refundable tax credits for all Americans who cannot afford health insurance. Given increases in life expectancy, raising the retirement age for Medicare—as we have already done for Social Security—is a progressive way to curb the program's costs and free resources we need to expand coverage.

3. *"It does not provide for an adequate, affordable prescription drug benefit."* In fact, the Breaux-Thomas proposal does provide a free drug benefit for all Medicare beneficiaries living below 135 percent of the poverty level and expand access to coverage for all others by requiring both traditional and private plans to offer drug coverage through "high option." Furthermore, Senator Breaux has offered to include subsidies for drug coverage higher up on the income ladder, but the White House has yet to offer a specific definition of what it considers "adequate and affordable." Some limits are essential, if only to ensure that low-wage workers with no health care coverage at all are not subsidizing free drug benefits for wealthy retirees!

4. *The Breaux-Thomas proposal "fails to make a solid commitment of 15 percent of the surplus to the Medicare trust fund" for hospital care.* Here the President has a point; by itself, the Breaux-Thomas proposal does not close the long-term funding gap in Medicare. But the same is true of his call for reserving 15 percent of projected budget surpluses for the program. Fixing Medicare's problems requires both steps: finding additional revenues to meet future commitments and restructuring the program to prevent it from consuming a rapidly growing share of the nation's budget.

As the President crafts his own proposal, he faces a choice just as he did six years ago during health care reform. He must build political support either from the "center-out" by using the bipartisan Breaux-Thomas plan as the foundation, or adopt a "left-in" approach which would preserve Medicare's current structure. The left-in strategy is no more likely to succeed now than it did during the great health care debate of 1994. PPI urges the President not to repeat the mistakes of the past.

*David Kendall is the Senior Analyst for Health Policy at PPI.*

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For further information about PPI publications, please call the publications department at 202-547-0001, write: Progressive Policy Institute, 600 Pennsylvania Ave., SE, Suite 4000, Washington, DC 20003, or visit PPI's site on the World Wide Web at: <http://www.dlcppl.org/>.

Medicare

Medicare Commission / Budget / Social Security Issues  
November 19, 1998

**BUDGET**

Dec 2/3

- Adopting private sector, competitive purchasing practices
- Program integrity (fraud and abuse) *> \$1.5B/5 yrs.*
- Medicare HMO withdrawals
  - Risk adjustment - by 2000 - repeat costs 800m - \$1.5B in 1st yr. Let Cong. do it, but can be done administratively (it paid for)
  - Rate reform
  - Medigap reform
- Medicare buy-in for 55 to 65 year olds - too close to Med. Comm? *FBSB not credible. \$1.5/5 yrs.*
- Fixing premium assistance program for low-income beneficiaries / outreach

**OVERLAPS WITH SOCIAL SECURITY REFORM**

2009 vs 2032

- Funding issues:
  - Use of the surplus
  - Effects of change in payroll tax
  - Implications of privatization of Trust Fund on Medicare debate
- Eligibility changes:
  - Age eligibility for Medicare, Social Security / effects on retirement age
- Benefit / payment changes:
  - Implications of Social Security defined contribution on Medicare debate
  - Interaction between Medicare premiums, Medicaid and Social Security
  - Allocation of responsibility between government & beneficiaries (long-term care) *SS check - Med premium - net benefit*
- Population groups:
  - Disability - *Coelho report*
  - Women and minorities

**LARGE ISSUES IN THE MEDICARE COMMISSION**

- Prescription drug coverage and modernizing Medicare cost sharing *- reimburses Medigap mkt costs \$*
- FEHBP model of "premium support" *- income-related premium - 1/2 of 190*
- Graduate medical education

DRAFT

PRINCIPALS TO GUIDE THE MEDICARE COMMISSION RECOMMENDATIONS

**Any Medicare proposal should:**

- **Adopt private sector, competitive practices:** Historical, statutory, and regulatory barriers prevent Medicare from adopting some of the successful payment policies used by private health plans to control health costs. Any proposal should allow and encourage the Health Care Financing Administration to adopt such practices to better contain costs.
- **Align Medicare per capita cost growth with the private sector rate:** The rate of growth of private sector health care costs takes into account both the unique effects of technology on health costs and the cost control achieved through innovative practices. Even though Medicare beneficiaries are sicker and more difficult to manage than privately insured people, private health spending growth should be a goal of any Medicare reform proposal.
- **Guarantee a minimum, modernized benefits package:** Today's Medicare benefits are more similar to private plans in the 1960s rather than the 1990s. For example, while most private plans today offer prescription drug coverage, Medicare does not. Additionally, Medicare has high cost sharing for certain benefits and does not offer protection against catastrophic health care costs. As a result, the majority of beneficiaries rely on other types of coverage (e.g., Medigap, employer plans, Medicaid), resulting in inefficiency and high out-of-pocket costs. Any reform proposal should both guarantee a basic set of health benefits and modernize those benefits to lessen the need for secondary health coverage.
- **Assure access to Medicare fee-for-service coverage:** While over 80 percent of privately insured people are enrolled in managed care, only 16 percent of Medicare beneficiaries are so enrolled. In part, this is because Medicare beneficiaries are older and more likely to be sick -- thus less likely to benefit from managed care. It may also reflect the lack of plan choices for beneficiaries; one in four beneficiaries today lives in a place with no private managed care option, and only about half have more than one plan to choose from: This year, Medicare is allowing a greater variety of plans to offer coverage, but to date, it has not resulted in a greater number of beneficiaries with choices. Thus, to ensure that Medicare beneficiaries have access to needed health care services, strong, modernized, more efficient Medicare fee-for-service coverage is essential to any reform proposal.
- **Protect low-income beneficiaries:** Nearly two-thirds of elderly households have income under \$20,000. Already, these elderly pay about one-third of their incomes on out-of-pocket health care costs. Thus, any proposal should assure that such beneficiaries pay no more -- and possibly less -- than they do under current law.

THE WHITE HOUSE

WASHINGTON

October 7, 1998

MEDICARE STATEMENT

**DATE:** October 8, 1998  
**LOCATION:** Oval Office  
**BRIEFING TIME:** 10:45 am - 11:15 am  
**EVENT TIME:** 11:15 am - 11:45 am  
**FROM:** Bruce Reed/Chris Jennings

I. PURPOSE

To respond to HMOs' decisions to withdraw from the Medicare program by assisting affected beneficiaries and preventing such withdrawals from occurring in the future.

II. BACKGROUND

This is an opportunity to respond to decisions by some HMOs to drop out of selected markets in the Medicare program. HHS estimates that, because of these withdrawals, a relatively small number of Medicare beneficiaries currently in HMOs -- 50,000 enrollees, or less than one percent of the 6.5 million beneficiaries in managed care plans -- will have no managed care alternative in their area. You will address these withdrawals by:

- **Criticizing health plans for demanding the ability to raise costs and reduce benefits as a precondition for staying in the Medicare program.** You should underscore that Medicare should not -- and will not -- be held hostage to threats by HMOs to leave the program unless they can increase and reduce benefits to Medicare beneficiaries.
- **Announcing a new policy to expedite the approval of health plans applying to enter markets without HMOs.** HHS will expedite its review and approval of HMOs seeking to enter markets that have been left without a managed care option. HHS will give these applications first priority for review and will expedite their entrance into the market so long as they meet the solvency, quality, and other standards necessary to protect beneficiaries.
- **Initiating a new campaign to help Medicare beneficiaries understand their rights and options.** To inform Medicare beneficiaries affected by HMO withdrawals that they are automatically eligible for traditional fee-for-service Medicare and that they have guaranteed access to Medigap policies that help fill coverage gaps, HHS will enlist public and private partners representing tens of

millions of older Americans to provide their members with needed information through newsletters, conferences, and targeted information campaigns. These partners include the AFL-CIO, American Association of Health Plans, American Association of Retired Persons, Leadership Council of Aging Organizations, National Council of Senior Citizens, and National Rural Health Association, as well as the Social Security Administration, HCFA Regional Offices, and State Health Insurance Assistance Programs. In addition, HHS will post new information about plan withdrawals on the Medicare Internet site, so that beneficiaries in every local area have the most up-to-date information on available coverage options.

- **Directing Secretary Shalala to develop new legislation to protect Medicare beneficiaries from HMO withdrawals.** You will state your determination to work with Congress to ensure an adequate range of health plan options for beneficiaries and reduce the likelihood that beneficiaries will face this kind of turmoil in the future. To that end, you will ask the Secretary to recommend specific legislation, to be included in your next budget, to enhance HMO participation in the Medicare program and protect beneficiaries from precipitous plan withdrawals and beneficiary protections.
- **Highlighting the need for Congress to reauthorize the Older Americans Act.** One of the most important ways for older Americans to get critical information and counseling about health-care options is through the programs provided by the Older Americans Act. You will announce that you have sent a letter to Senator Lott and Speaker Gingrich urging them to reauthorize the Older Americans Act before Congress adjourns. You should emphasize that failure to do so would call into question our nation's commitment to the vital services this Act provides to millions of older Americans.

### III. PARTICIPANTS

The Vice President  
Secretary Shalala  
HCFA Administrator Nancy Ann Min DeParle  
Members of Congress  
Representatives of senior citizen advocacy organizations

### IV. PRESS PLAN

Open Press.

### V. SEQUENCE OF EVENTS

- YOU will be announced into the Oval Office accompanied by the Vice President, Secretary Shalala, and Nancy Ann Min DeParle.

- YOU will make remarks.
- YOU will greet Members of Congress and senior citizens present, and then depart.

**VI. REMARKS**

Provided by Speechwriting.

**PRESIDENT CLINTON ANNOUNCES NEW INITIATIVE TO HELP MEDICARE BENEFICIARIES DROPPED BY THEIR HMOs AND TAKES STEPS TO PREVENT IT FROM HAPPENING AGAIN**

**October 8, 1998**

Today, the President unveiled an initiative to respond to decisions by some Health Maintenance Organizations (HMOs) to drop out of selected markets in the Medicare program. The Department of Health and Human Services' preliminary analysis indicates that because of these withdrawals a relatively small number of Medicare beneficiaries currently in HMOs (less than one percent of the 6.5 million beneficiaries in managed care plans -- 50,000 beneficiaries) will have no managed care alternative in their area. In response, the President:

- **Criticized health plans for demanding the ability to raise costs and reduce benefits as a precondition for staying in the Medicare program.** The President underscored that Medicare should not -- and will not -- be held hostage to threats by HMOs to leave the program unless they can increase and reduce benefits to Medicare beneficiaries.
- **Announced a new policy to expedite the approval of health plans applying to enter markets without HMOs.** HHS will expedite its review and approval of HMOs seeking to enter markets that have been left without a managed care option. HHS will give these applications first priority for review and will expedite their entrance into the market so long as they meet the solvency, quality, and other standards necessary to protect beneficiaries.
- **Initiated a new campaign to help Medicare beneficiaries understand their rights and options.** To inform Medicare beneficiaries affected by HMO withdrawals of all of their rights and options, including the fact that they are automatically eligible for traditional fee-for-service Medicare and that they have guaranteed access to Medigap policies that help fill coverage gaps, HHS will enlist public and private partners representing tens of millions of older Americans to provide their members with needed information through newsletters, conferences, and targeted information campaigns. These partners include the Leadership Council of Aging Organizations, American Association of Health Plans, American Association of Retired Persons, National Council of Senior Citizens, and National Rural Health Association, National Committee to Preserve Social Security, National Council on Aging, National Council of Senior Citizens, National Hispanic Council on Aging, the National Caucus and Center on Black Aged, Older Women's League, as well as the Social Security Administration, HCFA Regional Offices, and State Health Insurance Assistance Programs. In addition, HHS will post new information about plan withdrawals on the Medicare Internet site (Medicare.gov), so that beneficiaries in every local area have the most up-to-date information on available coverage options.
- **Directed Secretary Shalala to develop new legislation to protect Medicare beneficiaries from HMO withdrawals.** The President stated his determination to work with Congress, health plans, and advocates of older Americans to ensure an adequate range of health plan options for beneficiaries and reduce the likelihood that beneficiaries will face this kind of turmoil in the future. To that end, he asked the Secretary to recommend specific legislation, to be included in his next budget, to enhance HMO participation in the Medicare program and protect beneficiaries from precipitous plan withdrawals and beneficiary protections.

**Highlighted the need for Congress to reauthorize the Older Americans Act.** One of the most important ways for older Americans to get critical information and counseling about health-care options is through the programs provided by the Older Americans Act. Today, the President sent a letter to Senator Lott and Speaker Gingrich urging them to pass legislation that has broad-based bipartisan support to reauthorize the Older Americans Act before Congress adjourns. He emphasized that failure to do so would call into question our nation's commitment to the vital services this Act provides to millions of older Americans.

THE WHITE HOUSE

WASHINGTON

June 16, 1998

THE PRESIDENT HAS SEEN

6-16-98

Copied  
Reed  
Ruff  
COG

MEMORANDUM FROM THE PRESIDENT

FROM: SEAN MALONEY *SM*  
SUBJECT: Medicare Coverage of Abortions

The attached Reed/Ruff memo asks you to decide whether the Hyde Amendment's abortion-funding prohibitions should apply to Medicare.

**Background.** Medicare covers about 500 abortions/year; about the same as during the Reagan/Bush Administrations. (Some 2 million non-elderly women qualify for Medicare through SSDI.) In 1991, HCFA issued a reimbursement directive, tracking the Hyde Amendment, which stated that Medicare would cover abortions only where the mother's life was endangered. Congress later expanded the Hyde exception to encompass rape/incest, but the HCFA directive did not change, leaving it more restrictive than Hyde. Some Medicare carrier medical directors, however, may be covering abortions in cases of rape, incest, deformed fetuses, or mentally impaired mothers. This may explain why pro-choice groups have never complained about the HCFA directive. Recently, the Catholic Health Association (CHA) complained to us and to Senator Nickles about a HCFA regional-office ruling that a Catholic-run Provider Sponsored Organization (PSO) could participate in Medicare only if it agreed to cover qualified abortions for disabled women. Senator Nickles then wrote Secretary Shalala asking whether the Hyde Amendment applies to Medicare, and whether religion-based health plans that do not offer abortion services can qualify as PSOs under Medicare.

**Options/Views.** All of your advisers agree (i) that we should offer the CHA a new administrative option that lets Catholic plans participate in Medicare without covering abortions; and (ii) that we should broaden the 1991 HCFA directive to track Hyde and permit funding in cases of rape/incest. HHS disagrees with the rest of your advisers, however, over whether Medicare might also cover other types of abortions. Two options are presented:

**Option 1: Rule that Hyde applies to Medicare** -- say all Medicare expenditures must abide by the Hyde restrictions because some Hyde-covered appropriated funds are deposited into the Medicare Trust Fund; would avoid a showdown with Congress; covers more abortions than the current HCFA directive; helps a possible agreement with Catholic plans. *DPC, OMB, Podesta, Sylvia, Maria, and Audrey Haynes support Option 1; Sylvia expresses some concern about angering women's groups when Nickles may do little more than reaffirm Hyde's applicability.*

**Option 2: Rule that Medicare can cover abortions necessary to protect a woman's health** -- could segregate appropriated funds (covered by Hyde) from non-appropriated funds (e.g., payroll taxes, premiums) in the Medicare Trust Fund; could use non-appropriated funds to cover health-related abortions; would permit abortion coverage for vulnerable and disabled women; would please women's groups; *HHS supports this option.*

Approve Option 1

Approve Option 2

Discuss

98 JUN 12 08:37

THE WHITE HOUSE  
WASHINGTON

THE ATTORNEY GENERAL HAS SEEN  
6-16-98

June 12, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed  
Charles F.C. Ruff

SUBJECT: Hyde Amendment Application to Medicare and Abortion Coverage Requirements for Catholic Provider Sponsored Organizations

As you know, some women of child-bearing age qualify for Medicare because they receive Social Security Disability Insurance (SSDI). Senator Nickles has asked HHS whether the Hyde Amendment's restrictions on government funding of abortion apply to the Medicare program. He also has asked whether health plans that refuse, on religious grounds, to provide abortion services can still become Provider Sponsored Organizations (PSOs) eligible for Medicare payments.

We believe that we must respond quickly to Senator Nickles to have any chance of avoiding another legislative confrontation over abortion policy. This memo provides background information and policy options for your consideration.

**Background**

Earlier this year, the Catholic Health Association (CHA) contacted HHS and the White House about a ruling by a HCFA regional office that a Catholic-run PSO could participate in Medicare only if it agreed to cover qualified abortions for women with disabilities. The CHA vehemently objected to this ruling and asked if we could intervene administratively. At the same time, the CHA contacted Senator Nickles' office. The CHA discussed with Nickles both whether the Hyde Amendment applies to Medicare and whether Catholic PSOs can decline to provide all abortions (even those permitted under Hyde) because of their religious objections. The Senator, clearly sensing another abortion wedge issue, wrote to Donna Shalala to obtain the Department's formal position on both of these issues.

*Medicare and Abortion coverage.* Five million non-elderly disabled Americans -- including two million women -- receive Medicare coverage by virtue of their SSDI eligibility. The Medicare program currently covers about 500 abortions each year, while denying claims in another 100-200 cases. These figures are consistent with those from the Reagan and Bush Administrations.

In 1991, HCFA issued a reimbursement directive stating that Medicare would cover abortion services only in cases where the life of the mother was endangered. (Prior to this

time, there was no clear guidance on the subject.) This directive, which comported with the then-existing Hyde Amendment, is actually more restrictive than the current Hyde amendment, because it fails to cover abortions arising from rape and incest. The directive, however, has not been modified, and remains the only policy guidance on abortion coverage under the Medicare program.

Although we believe that most Medicare carrier medical directors have largely complied with this directive, some may have covered other kinds of abortions -- e.g., abortions arising from rape or incest, abortions involving deformed fetuses, or other medically necessary abortions. In particular, carriers may have decided to cover some very difficult cases involving the one-third of women on Medicare disability who have some serious mental impairment (about 700,000 women). Such individual coverage decisions may help explain why no one on the pro-choice side of the abortion debate has ever complained about our coverage policy.

*Legislative and Political Environment.* The Nickles' letter has started yet another controversial abortion debate. The CHA is working with Senator Nickles and others on drafting legislation to make clear that Hyde applies to Medicare, as well as to exempt organizations with ethical or religious objections from any abortion coverage requirements. (CHA and Nickles have gotten the impression from HHS that Hyde does not apply to Medicare and that the religious convictions of Catholic PSOs cannot be fully accommodated.) Absent administrative action, there is no doubt that we will see this issue raised on some appropriations bill. At the same time, the womens' groups have become aware of this issue and are urging the Administration to adopt a generous Medicare abortion coverage policy.

In the next few months, the Administration will have to deal with several other controversial abortion issues. Most notably, the Republicans will bring up the partial-birth abortion legislation sometime prior to the November elections. In addition, Republicans in both the House and Senate will attempt to pass a bill, which most in the Administration strongly oppose, to prohibit transferring a minor across state lines to bypass parental consent requirements. Finally, we can expect the usual abortion riders to appear on appropriations bills.

## Options

All of your advisors (HHS, OMB, and DPC) agree that we should offer the CHA a new administrative option that allows Catholic health plans to participate in Medicare without covering any abortions, so long as they accept a slightly reduced capitated payment. We do not know whether CHA will accept this offer, but we think it may do so, particularly if the offer is combined with CHA's preferred outcome on the Hyde issue.

The outstanding question is whether Hyde applies to Medicare. We all agree that we should inform Nickles that current Medicare policy, as set out in the 1991 directive, is to

cover only abortions necessary to protect the life of the mother. We also all agree that because this “life of the mother” standard is more restrictive than the current Hyde amendment, we should modify the directive to cover at least abortions arising from rape and incest. We have not reached consensus, however, on whether we also should cover any other abortions (i.e., abortions that Hyde generally prevents the federal government from funding). We see two viable options:

**Option 1: Rule that the current Hyde Amendment (allowing funding where the life of the woman is in danger or in cases of rape and incest) applies to Medicare.** Under this option, we would take the position that since some Hyde-covered appropriated funds are deposited into the Medicare Trust Fund, all Medicare expenditures must abide by the Hyde restrictions. We then would update our Medicare coverage policy to reflect the current, comparatively expansive Hyde Amendment. DPC and OMB support this option.

Pros:

- This option is most likely to avoid a legislative showdown on abortion funding that we are unlikely to win.
- This option is consistent with our current position on Medicaid funding, and will cover more abortions than the current policy allows.
- This option will enhance our ability to reach an agreement with the CHA on the PSO abortion coverage issue.

Cons:

- This option may expose us to criticism about non-coverage of extremely sympathetic cases involving vulnerable and disabled women.
- This option will anger womens’ groups, which would prefer us to provide Medicare coverage of the widest possible range of abortions, even if doing so would provoke the Republicans to enact contrary legislation.

**Option 2: Rule that Medicare can cover abortions necessary to protect the health of the woman (in addition to abortions allowed by Hyde).** Under this option, we would segregate appropriated funds from non-appropriated funds (payroll taxes, premiums, etc.) in the Medicare Trust Fund and use the non-appropriated (and hence unrestricted) funds to pay for the health-related abortions. HHS supports this option.

Pros:

- This option will ensure that all abortions necessary to protect a woman’s health are

covered, and will allow us to avoid criticism arising from non-coverage of highly sympathetic cases involving vulnerable and disabled women.

- This option will assuage the womens' groups by providing for Medicare coverage of a larger class of abortions.

#### Cons:

- This option will virtually guarantee a legislative battle with Nickles and his allies on the appropriateness of using public funds to pay for abortions. We should expect to lose this battle and to have to veto a bill over government funding of abortion.
- This option diverges from this Administration's past practice on government funding of abortions.
- This option might well undermine our ability to reach agreement with the CHA on the PSO abortion coverage issue.

#### Recommendations

As noted, DPC (Bruce, Chris, and Elena) and OMB support Option 1, because (1) it is most consistent with this Administration's prior practice on government funding of abortions and (2) it stands the best chance of avoiding a high-profile legislative battle -- on both the Hyde and PSO issues -- that we are unlikely to win. HHS supports Option (2) because of the special vulnerability of the population seeking abortion services under the Medicare program. Counsel's Office takes no position as between the two options.



Medicare

THE WHITE HOUSE  
WASHINGTON

March 4, 1998

**DROP-BY MEETING WITH ADMINISTRATION APPOINTEES TO THE  
MEDICARE COMMISSION**

**DATE:** March 5, 1998  
**LOCATION:** Map Room  
**BRIEFING TIME:** 10:00 am - 10:10 am  
**EVENT TIME:** 10:15 am - 10:30 am  
**FROM:** Bruce Reed/Gene Sperling

**I. PURPOSE**

To meet privately with your appointees to the Medicare Commission, before your meeting with the full Commission later in the day. (*See separate briefing memo.*)

**II. BACKGROUND**

This will be the first opportunity for you to meet with your appointees to the Medicare Commission as a group and to offer them the full support and assistance of the Administration. You can take this time to introduce them to the members of your staff and assure them they will have access to the Administration. This is also an opportunity to thank them for their willingness to take on this important responsibility and for the thoughtful comments they have already been making publicly.

**III. PARTICIPANTS**

Briefing Participants:

Gene Sperling

Bruce Reed

Chris Jennings

Event Participants:

Secretary Shalala

Secretary Herman

Bruce Reed

Chris Jennings

Gene Sperling

Frank Raines

Janet Yellen

Presidential Appointees to the Medicare Commission:

Dr. Stuart Altman, Professor of Health Policy at Brandeis University, Waltham, MA

Dr. Laura D'Andrea Tyson, Former Economic Advisor now serving at the University of California-Berkeley

Dr. Bruce Vladeck, Former Head of the Health Care Financing Administration

Mr. Anthony L. Watson, President and CEO of HIP Health Care Corporation

**IV. PRESS PLAN**

Open Press.

**V. SEQUENCE OF EVENTS**

- YOU will enter the Map Room, greet the guests, and take your seat.
- YOU will briefly make informal remarks and then depart.

**VI. REMARKS**

Remarks Provided by Jordan Tamagni in Speechwriting.

**THE WHITE HOUSE**

WASHINGTON

March 4, 1998

**MEDICARE COMMISSION MEETING**

**DATE:** March 5, 1998  
**LOCATION:** Cabinet Room  
**BRIEFING TIME:** 11:50 - 12:15 pm  
**EVENT TIME:** 12:15 pm - 1:15 pm  
**FROM:** Bruce Reed/Gene Sperling

**I. PURPOSE**

To demonstrate your commitment to the work of the Medicare Commission.

**II. BACKGROUND**

You will be meeting with the 17 members of the National Bipartisan Commission on the Future of Medicare Commission, the Staff Director Bobby Jindal, and members of the Administration. The Commission is having their first meeting on Friday, and you have invited them to the White House to call attention to their important work and offer the support and assistance of the Administration to help them succeed in their efforts.

In the Balanced Budget Act, you preserved Medicare in the short term by providing for the extension of the Medicare Trust Fund for at least a decade with new structural reforms. You also made a commitment to secure the financial integrity of Medicare well into the 21st century by the formation of this bipartisan commission.

In the last 30 years, Medicare has provided essential high-quality health care to millions of Americans. Since its introduction the rate of uninsured elderly has dropped from 46% to 1%. Without Medicare, half of the elderly -- 15 million people -- could lack health insurance.

But as you know, Medicare faces great challenges. As the baby boom generation retires, the number of elderly will increase by 45% in the next 20 years, and by 2030 one in five Americans will be elderly. In addition, seniors will be living longer lives, and the higher costs of this larger Medicare population will be borne by a smaller workforce.

The goal of the Medicare Commission must be to meet the new challenges facing Medicare while preserving the basic tenets of the program: providing basic health care protections for older and disabled Americans.

### III. PARTICIPANTS

#### Briefing Participants:

The Vice President  
Gene Sperling  
Bruce Reed  
Chris Jennings  
Larry Stein

#### Event Participants:

The Vice President  
Secretary Shalala  
Secretary Herman  
Bruce Reed  
Chris Jennings  
Gene Sperling  
Larry Stein  
Frank Raines

#### Medicare Commission Members and Staff:

Dr. Stuart Altman  
Dr. Laura D'Andrea Tyson  
Dr. Bruce Vladeck  
Mr. Anthony L. Watson  
Senator John Breaux  
Congressman Bill Thomas  
Congressman Michael Bilirakis  
Congressman John Dingell  
Congressman Greg Ganske  
Congressman James McDermott  
Senator Bill Frist  
Ms. Ilene Gordon, Assistant to Trent Lott  
Senator Phil Gramm  
Samuel Howard, President and CEO of Phoenix Health Care Corporation, Tennessee  
Senator Robert Kerrey  
Senator John Rockefeller  
Ms. Deborah Steellman, Esq., Washington Lawyer who is a health policy specialist.  
Bobby Jindal, Staff Director for the Commission

### IV. PRESS PLAN

Open Press.

### V. SEQUENCE OF EVENTS

- You and the Vice President will enter the Cabinet Room, greet guests, and take your

seats.

- The Press Pool will enter.
- **YOU** will make opening remarks.
- The Vice President will make brief remarks.
- Senator Breaux will make brief remarks.
- Congressman Thomas will make brief remarks.
- The Press Pool will depart.
- The meeting will proceed at your direction. You could begin by calling on Senator Breaux, and then select members.

## **VI. REMARKS**

Remarks Provided by Jordan Tamagni in Speechwriting.

## DRAFT Q&AS FOR MEDICARE COMMISSION EVENT

**Q: IF YOU THINK MEDICARE IS SUCH A PRIORITY, WHY DIDN'T YOUR BUDGET DEDICATE REVENUES FROM THE ASSUMED TOBACCO LEGISLATION TO STRENGTHEN THE TRUST FUND -- LIKE SENATOR DOMENICI IS PROPOSING?**

**A:** First, I welcome Senator Domenici's comments because they, of course, assume a shared goal -- the passage of national, bipartisan tobacco legislation. There is no doubt that the Congress, the states and many others will have a spirited debate over how exactly to use any revenue associated with tobacco legislation. Many thoughtful ideas, such as Senator Domenici's Medicare option, will no doubt emerge and we look forward to that discussion.

**Our investment priorities for the tobacco legislation are aimed at helping children and the victims or potential victims of smoking.** The budget dedicates almost all of any tobacco revenues towards initiatives designed to reduce smoking, help find treatments and cures for diseases associated with tobacco, and invest in our children through health care coverage, needed child care, and education. *We believe that these investments have a natural link to tobacco revenue and will make a major contribution toward preparing the nation for the 21st century.*

**I certainly share the Senator's concern about the Medicare program.** Two of the provisions of last year's Balanced Budget Act that I am most proud of relate to the Medicare program. The first was the package of reforms and savings that extended the life of the Medicare Trust Fund for over a decade. The second was the establishment of the Medicare Commission to begin addressing the long-term financing challenges facing the program.

**But before we get in a big debate about how we invest dollars from a tobacco bill, we should work to do the heavy lifting of developing legislation that will help stop our nation's children from taking up smoking in the first place.** After it is clear that we will succeed in accomplishing this long overdue goal, we can and we should have a thorough debate about the best way to invest tobacco revenues.

**Q: ISN'T IT DISAPPOINTING THAT YOUR OWN CHAIRMAN OF THE MEDICARE COMMISSION HAS DECLARED THAT YOUR MEDICARE BUY-IN PROPOSAL IS DEAD FOR THIS YEAR?**

**A: I do not believe that is what Senator Breaux has said, but I am not going to speak for him. I will say that Senator Breaux has accurately stated that the Medicare Commission will look into this issue as well as a wide range of other issues.**

**I do not believe he or most other Members of Congress would needlessly delay providing a targeted expansion of health coverage for a vulnerable population if we are successful at achieving a consensus to move forward this year. It is my job to work with the Congress to achieve that consensus and I intend to just that. With Senator Moynihan's help, I think we will succeed.**

**As CBO confirmed yesterday, the Medicare buy-in proposal is a financially responsible and targeted policy that addresses a vulnerable population that the private insurance market has failed to serve. CBO concluded that the policy is paid for and would not harm the Medicare Trust Fund in any way.**

**Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. We cannot continue to come up with excuses to not address this problem.**

**While the work of the Medicare Commission is extremely important, I do not believe that the American public would sanction holding up a targeted, important proposal that would help hundreds of thousands of Americans with access to health insurance. I am confident that as Congress examines the needs of this population and the proposal to address it, the necessary consensus to move this legislation forward will be achieved.**

**Q: ISN'T THIS EXACTLY THE WRONG TIME TO PROPOSE EXPANDING MEDICARE – JUST WHEN THE COMMISSION IS GOING TO MAKE RECOMMENDATIONS ABOUT THE OVERALL FINANCING OF THE PROGRAM?**

**A: Once again, this is a targeted proposal that is paid for within the Medicare program and therefore does not add any new burdens to the program. As such, it does not conflict with the Commission's work in this area.**

**Q: YOU HAVE INDICATED YOUR SUPPORT FOR MEANS-TESTING BY INCOME. SHOULDN'T THERE BE AN INCOME-RELATED PREMIUM FOR MEDICARE?**

**A:** Ever since I took office, I have supported the concept of an income-related premium for Medicare as long it was done in a thoughtful workable manner and that it was done in the context of broader reforms that make the program stronger. I included in my first health care reform proposal in 1993 and I indicated my support for it last year during the Balance Budget discussions. I am certain the Commission will review options in this area and I look forward to its recommendations.

**Q: WHAT DO YOU THINK OF GINGRICH'S "NO TAX PLEDGE" THAT HE HAS ASKED ALL HIS APPOINTEES TO THE COMMISSION TO TAKE?**

**A:** I don't know that any additional revenues will be necessary. That is the Commission's job to tell us. Having said this, I of course do not believe that any preconditions should be placed on anyone to participate on any Commission. I hope this Commission will look at a range of options before making any final determinations. It is certainly worth noting that Senator Domenici has proposed using tobacco taxes to fund the Medicare program. But again, I do not think we should preclude anything at this point.

**PRESIDENT WELCOMES MEDICARE COMMISSION AND MAKES STRONG  
COMMITMENT TO PREPARE MEDICARE FOR THE RETIREMENT  
OF THE BABY BOOMERS**

**March 4, 1998**

Today, meeting with the newly appointed Medicare Commission, the President stated his strong commitment to work with Chairman Breaux, Congressman Thomas, and the rest of the Commission to develop a bipartisan consensus for future reforms to the Medicare program that prepare it for the retirement of the baby boom population. In so doing, he highlighted the great achievements of Medicare and the important contributions that the Balanced Budget Act (BBA) made to strengthening and improving the program. The President indicated that he is confident the Commission can build on the successes of last year's Medicare reforms and take the next steps to prepare the program for the unprecedented demographic challenges it faces. He also urged the Commission to never forget that Medicare is more than just a program of policies and numbers; it is a national commitment that serves almost 40 million of our most vulnerable Americans.

**MEDICARE HAS BEEN ONE OF THIS CENTURY'S GREATEST ACHIEVEMENTS -- IMPROVING THE HEALTH OF MILLIONS OF AMERICANS.** In the last 30 years, the Medicare program has provided high-quality health care to millions of older Americans and people with disabilities. Since the program was signed into law:

- **The rate of uninsured elderly has dropped from 46 percent to 1 percent.** Today, about 15 million Americans could go uninsured without Medicare's guarantee of coverage.
- **Older Americans are living 20 percent longer.** A 65 year old today can expect to live until the age of 82; whereas in 1960, a 65 year old lived on average until the age of 79. This is partly attributable to Medicare's expansion of needed health care coverage to older American.
- **The poverty rate has dropped by over half.** Medicare has contributed to decreasing poverty among older Americans. Today, about 11% of people ages 65 and older are poor, compared to 29% in 1966.

**THE BIPARTISAN BALANCED BUDGET ACT INCLUDED UNPRECEDENTED MEDICARE REFORMS.** One of the most important achievements of the Balanced Budget Act the President signed into law last summer was its unprecedented reforms to the Medicare program. This bipartisan effort strengthened the life of the Medicare Trust Fund for at least a decade from now, included new health plan choices, and added coverage of preventive benefits. It:

- **Extended the life of the Medicare Trust Fund for at least a decade.** Through a series of payment and structural reforms, the BBA extended the life of the Medicare Trust Fund for at least a decade from today. This achievement built on the President's 1993 budget which extended the Trust Fund for three years.
- **Contained important new preventive benefits.** The Balanced Budget Act included new preventive benefits including annual mammograms for all Medicare beneficiaries over forty; regular pap smears and pelvic exams; diabetes management benefits, and regular colorectal cancer screening.

- **Enacted important new structural reforms.** The BBA also included new market-oriented reforms, such as adding new plan choices including Provider Sponsored Organizations, Preferred Provider Organizations, prospective payment system reforms, and a number of prudent purchasing provisions that allow Medicare to buy services in the same way private health plans do.
- **Growth in line with private spending.** Because of the important BBA reforms, Medicare growth per beneficiary will actually be slightly less than projected private insurance spending growth: 4 percent versus 5 percent between 1997 and 2002.

#### **STRENGTHENING MEDICARE FOR THE RETIREMENT OF THE BABY BOOMERS.**

While the Balanced Budget Act strengthened Medicare in the short term, the program will face new challenges as the baby boomers retire. The President highlighted some of these challenges and made a strong commitment to work with the Commission to develop consensus for long-term Medicare reforms. The challenges include:

- **An unprecedented number of Americans will enter Medicare as the baby boom generation retires.** The number of elderly will increase by 45 percent in the next 20 years. By 2030, one in five Americans will be elderly.
- **The ratio of workers to Medicare beneficiaries will drop significantly by 2030.** The number of workers per Medicare beneficiaries will decline from 3.9 to 2.3 during this period, straining the financing of the Medicare program, which is partly financed through a payroll tax.

**The President reiterated his confidence that the Commission, working with Congress and the Administration, will successfully meet the new challenges facing the Medicare program.** He pointed out that the American people have always been able to reach consensus to address this extremely important program, which provides needed services to tens of millions of Americans.



Medicare

OCT 20 1997

## MEMORANDUM FOR THE PRESIDENT

As the time approaches for the Medicare Commission to begin its deliberations, we must consider how to help frame the questions that the Commission will address. Although we will not set the Commission's agenda, we can help shape it through our public statements and through our work with the people and organizations who speak out about Medicare's future. I have outlined below the principles I believe should guide our thinking on Medicare reform and some of the questions I believe the Commission needs to consider actively.

Although the Balanced Budget Act sets forth areas for the Commission to study, the Act's directives do not provide a clear or rigorous focus for deliberations. I am concerned that unless we work actively to broaden the agenda for the debate, the public will focus only on financial estimates and years of potential solvency. We must help focus the debate on the fact that Medicare's future is as much about health care and retirement security as about financing. If we solve the system's financial problems, yet the program ceases to deliver meaningful, high-quality benefits or to protect beneficiaries against excessive health costs, we will have failed.

### Key Principles

I believe that the following principles should guide our thinking about Medicare reform:

1. **Medicare is inextricably linked with other retirement programs, the rest of the health care system, and the overall economy; planning about changes to the program should not occur in a vacuum.**

Medicare cannot be considered separately from other public policies. In the lives of workers and beneficiaries, income and health care are the key considerations as people plan for retirement. Thus, Social Security, private pensions, savings, and supplemental sources of insurance -- employers, individual plans, and Medicaid -- are all linked to the future of Medicare.

In addition, trends in the health care market will affect Medicare. For example, increases in health care costs -- driven by inflation, changing technology, and changing practice patterns -- have contributed to rising Medicare costs. Conversely, because Medicare pays for a quarter of all hospital expenditures and a fifth of all physician expenditures, changes in Medicare also affect the health care market. These interactions create both opportunities and hazards for Medicare reform.

The same dynamic exists in the larger economy. For example, savings, labor supply, and immigration policies affect the resources available to pay for Medicare. Part of the solution to

"the Medicare problem" may lie in policy changes in these and other areas. Future changes that we make within Medicare may create problems in other programs.

- 2. Any long-term solution should be flexible enough to respond to substantial uncertainty about the program's future actuarial status. Long-term reform should be thought of as a series of measured changes with regular reassessment of the program's quality and financial status.**

When the Medicare trustees provide forecasts of the financial status of the Medicare program, they present a range of alternative estimates to accommodate this uncertainty. They show that the future status of the program is highly sensitive to small changes in financial assumptions. The uncertainty of our predictions grows as they reach farther into the future.

Because of this uncertainty, the "long-term" problems that we try to solve in 1999 may not exist by 2030, and other problems will have arisen. In 1965, we would not have imagined that more than 80 percent of workers with insurance would get it through some form of managed care. Thirty years from now, new diseases will emerge, and new treatments and technologies will evolve. A cure for a major disease such as Alzheimer's could transform the needs of the elderly. In addition, unforeseen changes to the economy -- in global markets, new forms of communication and transportation, changes in the work force, and immigration -- further limit our ability to forecast with precision future health care needs and our ability to pay for them.

We must commit to making lasting changes in the Medicare program. In this dynamic system, this can best be achieved through a series of measured changes made according to a consistent plan. This phased strategy will build over time into larger structural reform, while allowing for corrections along the way to respond to unforeseen changes in the system. This Commission is a critical first step in reform -- but we should not see it as the final step. We should institutionalize a process for ongoing assessment and reform.

- 3. The discussion must be as much about retirement security and the future health care needs of the elderly and disabled as it is about the budget.**

The upcoming process should not be a typical budget reconciliation debate, driven solely by financial issues. The Commission should move away from simply taking the actuaries' assumptions as given and focusing only on how to limit expenditures. Such a narrow approach would give the edge to those who are using Medicare's fiscal problems as a justification for radically changing the program's design and the government's role.

Despite the progress that we made this summer toward slowing growth in per capita costs with the provisions included in the Balanced Budget Act, per capita costs will continue to be an issue. However, the demographic trends that will drive program enrollment are independent of per capita costs -- and are much more significant. To shift the discussion, it could be helpful to

highlight this distinction between the level of cost increases that is due to rising per capita costs and the level of cost increases that is due to rising enrollment. The public is likely to be more willing to support higher revenues to cover more people than to cover higher costs per person.

The needs of this growing elderly and disabled population should be the real focus of the debate. As retirement systems change, Medicare must retain its ability to provide beneficiaries with financial security against health care costs. And Medicare will remain the primary way that our society will meet the changing health care needs of future elderly and disabled individuals, particularly those without substantial resources. Determining how Medicare can best meet those needs should be the primary task of the Commission.

### **Key Policy Questions**

The next section of this memorandum develops some issues that the Commission and the Administration must consider.

#### **Who should participate in Medicare?**

Historically, Medicare has been enormously successful in providing insurance protection to all persons over 65, without splintering the healthy from the sick or the low-income from the better off. Proposals to change eligibility rules could fundamentally change the universal nature of the program.

One proposal has been to raise the eligibility age to correspond with the increase in the eligibility age for Social Security. This could have two effects: leaving a pool of older, sicker beneficiaries enrolled in Medicare, and leaving more retirees, especially those with lower incomes, without coverage. The Commission should examine trends in the availability of health care for workers who retire before they are eligible for Medicare, the needs of the youngest Medicare eligibles, and the potential effects of raising the eligibility age. The Commission should also examine the possibility of allowing individuals to buy into the Medicare program before they reach the eligibility age.

Means-testing benefits -- excluding wealthy beneficiaries from the program or giving them fewer benefits -- would be a more significant change to Medicare's historical role. Medicare's universality and status as "the" health care program for the elderly have been the cornerstones of its success. While we can and should build additional progressivity into Medicare's financing, we must ensure that Medicare is available and attractive to elders of all incomes.

#### **What is the guarantee that Medicare represents to beneficiaries?**

Medicare guarantees access to a particular set of benefits, regardless of changes in health care costs. Critics have argued that Medicare's guarantee should shift toward a defined financial

contribution, which could limit Medicare's liabilities and increase beneficiaries' liabilities if health care costs increased.

An examination of the options along the continuum between a defined benefit package and a defined contribution is unavoidable. However, this exercise should acknowledge that changing Medicare's basic guarantee and reducing Medicare's contribution has the potential to shift billions of dollars of costs to employers, states, and beneficiaries. Perhaps more importantly, a defined contribution approach has a substantial potential to undercut the integrity of Medicare as one program and lead to a tiered structure in which the quality of care depends on a beneficiary's financial status.

#### **What benefits will Medicare offer?**

The Commission should examine both the level and the mix of benefits that Medicare offers. Compared with many private plans, the fee-for-service Medicare benefit package is not generous. Cost sharing is relatively high, and certain benefits widely available to the under-65 insured population (such as prescription drugs) are not provided. In some parts of the country, beneficiaries enrolled in HMOs receive benefits more comparable to what the working insured receive. Other beneficiaries obtain these benefits through supplemental coverage. The relationship between Medicare and these other sources of coverage -- managed care, employers, individual plans, and Medicaid -- should be addressed.

Medicare's benefit package should also be reexamined in the context of changes in health care delivery. When Medicare started, our entire health care system was organized primarily around providing care in hospitals. Over the last decade, delivery has shifted out of the hospitals and into other settings, like doctors' offices and patients' homes. As the population ages and retirees change, the mix of services that Medicare beneficiaries need may change even more. Medicare's role in financing long-term care may also become a more pressing issue.

Beyond the benefits enjoyed by individual beneficiaries, Medicare also finances public goods like medical education, research, and care for the uninsured through disproportionate share facilities. Other financing structures may be necessary to sustain these programs and to more properly account for them as health care system costs rather than Medicare benefit expenses.

#### **How will Medicare's costs be financed?**

Current sources of financing for Medicare include payroll taxes, beneficiary premiums and out of pocket payments, federal budget support for Part B, and Medicaid for low income beneficiaries. The Commission should address what share of Medicare costs each of these sources should bear.

One factor to consider in examining the appropriate financing mix is the possibility of merging Part A and Part B. The extent to which Medicare relies on each funding source is in part driven

by separate funding sources for Hospital Insurance and Supplementary Medical Insurance. As patterns of care change, this split is becoming less and less relevant to the way that care is delivered.

A second issue in the distribution of responsibility for Medicare's costs will be the resources available from each source over time. For example, trends in beneficiary income and tax revenues may show shifting abilities to pay. The current period of sustained economic growth, and stock market growth will affect financing options, public perceptions, and future approaches -- but the Commission should also consider what will happen if this growth slows or reverses.

We also need to remember that not all seniors are the same. The Commission should pay particular attention to vulnerable subgroups enrolled in Medicare. It should look at how changes affect different age groups, ethnicities, genders, and income levels. For example, in considering how Medicare's costs will be financed, we must also determine how to continue to protect beneficiaries with the lowest incomes. Conversely, if we build additional progressivity into the program's financing by income-relating the premium, we must be careful to ensure that Medicare remains the right choice for elders of all incomes.

#### **What are the trends in employer-based insurance and financial planning?**

Employment shifts to a service economy and to home-based work have changed the working population's access to insurance. Furthermore, employers have been reducing coverage of retiree health benefits. As the health benefits and retiree health benefits that workers receive change, the needs of Medicare beneficiaries and of workers who retire before they are eligible for Medicare, may also change.

Changes are also taking place in Americans' retirement planning. The balance is changing among company pensions, the evolving 401(k) self-directed pensions/savings, traditional savings, housing, and Social Security. Medicare will have to be evaluated as part of this changing system of financial protection. The Commission should be doubly cautious about providing less protection to beneficiaries if their retirement income is also becoming less secure.

#### **How will different policy options interact and shift responsibilities from some to others?**

It is essential that the Commission not consider options individually but also in the context of other options, because of the possible interactions that may arise. For example, if the Commission changed the copayment and deductible structure of the program, this could interact with proposals to change the supplemental insurance system or with proposals to income-relate premiums. Consideration should be given not only to the merit of individual options but what a combined package would be.

Any set of solutions must acknowledge the full burden of health care spending for the elderly and disabled and what resources there are to meet these needs across society as a whole. Limiting Medicare's role will shift costs to other parts of the budget or to beneficiaries and employers. For example, if the Commission raised the age of eligibility, the health care needs of the ineligible population would not disappear. They would be paid for by employers, beneficiaries, and public safety net programs.

Other changes may redistribute the impacts among future vs. current beneficiaries, within the beneficiary population, or among public programs. Postponing reforms may favor current beneficiaries while forcing future beneficiaries to experience more significant changes, for example. Increasing premiums or cost-sharing will shift some of Medicare's burden to Medicaid and the states, in addition to beneficiaries.

#### **How will Medicare's management responsibilities change?**

We should continue to seek out ways to strengthen the integrity of the Medicare program so that each benefit dollar is being spent for needed care and services. Stopping fraud and abuse creates budget savings, but again, it is not only a budget issue. Vigorous oversight is also necessary to sustain public confidence in the program. We should continue to strengthen HCFA's authority and resources to detect fraud, and to prevent it before it occurs.

As we work to address payment issues for the program, we should learn from the successes of the private sector. We also have the opportunity, however, to use our resources to design systems that will also help the private sector. For example, when Medicare was successful in controlling hospital costs with its system of prospective payments for diagnostic related groups, private insurers were able to use the system to control their costs as well.

However, Medicare is no longer just a payer. It now has oversight over a complex and changing health care delivery system. This new emphasis on delivery expands the government's responsibility to ensuring high quality care and consumer protections, in addition to traditional financial oversight.

As we think about how the program will be organized to purchase benefits in the future, we should continue to ask what new responsibilities come with that organization. We should clarify the respective roles and responsibilities of government and the private sector in managing a system of plan choice. And we should ensure that Medicare's administrative resources are sufficient to fulfill these responsibilities.

#### **How shall the Commission educate the public?**

The debates over Medicare and Social Security will require a broad segment of the population -- pre-retirees, baby-boomers, and generation X-ers -- to engage in a broad public debate on the

options outlined by the Commission. Public education and dissemination of information should be one explicit task of the Commission. They should view regular interaction with Congress and other key policy-influencing groups, including the media, as a high priority. These interactions can be the means to shape the way the press, Congress and the public consider these issues.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala'. The signature is fluid and cursive, with a large initial 'D' and 'S'.

Donna E. Shalala

**WHITE HOUSE STAFFING MEMORANDUM**

DATE: 10/21 ACTION/CONCURRENCE/COMMENT DUE BY: 10/23

SUBJECT: Sealata memo on Medicare Commission

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McCURRY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BOWLES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McGINTY	<input type="checkbox"/>	<input type="checkbox"/>
McLARTY	<input type="checkbox"/>	<input type="checkbox"/>	NASH	<input type="checkbox"/>	<input type="checkbox"/>
PODESTA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RADD	<input type="checkbox"/>	<input type="checkbox"/>
MATHEWS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	REED →	<input checked="" type="checkbox"/>	<input type="checkbox"/>
RAINES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RUFF	<input type="checkbox"/>	<input type="checkbox"/>
BLUMENTHAL	<input type="checkbox"/>	<input type="checkbox"/>	SMITH	<input type="checkbox"/>	<input type="checkbox"/>
BERGER	<input type="checkbox"/>	<input type="checkbox"/>	SOSNIK	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ECHAVESTE	<input type="checkbox"/>	<input type="checkbox"/>	SPERLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>
EMANUEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	STREETT	<input type="checkbox"/>	<input type="checkbox"/>
GIBBONS	<input type="checkbox"/>	<input type="checkbox"/>	TARULLO	<input type="checkbox"/>	<input type="checkbox"/>
HILLEY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	VERVEER	<input type="checkbox"/>	<input type="checkbox"/>
IBARRA	<input type="checkbox"/>	<input type="checkbox"/>	WALDMAN	<input type="checkbox"/>	<input type="checkbox"/>
KLAIN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	YELLEN	<input type="checkbox"/>	<input type="checkbox"/>
LEWIS	<input type="checkbox"/>	<input type="checkbox"/>	BEGALA	<input checked="" type="checkbox"/>	<input type="checkbox"/>
LINDSEY	<input type="checkbox"/>	<input type="checkbox"/>	<u>Jennings</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
MARSHALL	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
			_____	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: Please advise.

RESPONSE:



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OCT 20 1997

## MEMORANDUM FOR THE PRESIDENT

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- 1. Medicare is inextricably linked with other retirement programs, the rest of the health care system, and the overall economy; planning about changes to the program should not occur in a vacuum.**

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In addition, trends in the health care market will affect Medicare. For example, increases in health care costs -- driven by inflation, changing technology, and changing practice patterns -- have contributed to rising Medicare costs. Conversely, because Medicare pays for a quarter of all hospital expenditures and a fifth of all physician expenditures, changes in Medicare also affect the health care market. These interactions create both opportunities and hazards for Medicare reform.

The same dynamic exists in the larger economy. For example, savings, labor supply, and immigration policies affect the resources available to pay for Medicare. Part of the solution to

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When the Medicare trustees provide forecasts of the financial status of the Medicare program, they present a range of alternative estimates to accommodate this uncertainty. They show that the future status of the program is highly sensitive to small changes in financial assumptions. The uncertainty of our predictions grows as they reach farther into the future.

Because of this uncertainty, the "long-term" problems that we try to solve in 1999 may not exist by 2030, and other problems will have arisen. In 1965, we would not have imagined that more than 80 percent of workers with insurance would get it through some form of managed care. Thirty years from now, new diseases will emerge, and new treatments and technologies will evolve. A cure for a major disease such as Alzheimer's could transform the needs of the elderly. In addition, unforeseen changes to the economy -- in global markets, new forms of communication and transportation, changes in the work force, and immigration -- further limit our ability to forecast with precision future health care needs and our ability to pay for them.

We must commit to making lasting changes in the Medicare program. In this dynamic system, this can best be achieved through a series of measured changes made according to a consistent plan. This phased strategy will build over time into larger structural reform, while allowing for corrections along the way to respond to unforeseen changes in the system. This Commission is a critical first step in reform -- but we should not see it as the final step. We should institutionalize a process for ongoing assessment and reform.

- 3. The discussion must be as much about retirement security and the future health care needs of the elderly and disabled as it is about the budget.**

The upcoming process should not be a typical budget reconciliation debate, driven solely by financial issues. The Commission should move away from simply taking the actuaries' assumptions as given and focusing only on how to limit expenditures. Such a narrow approach would give the edge to those who are using Medicare's fiscal problems as a justification for radically changing the program's design and the government's role.

Despite the progress that we made this summer toward slowing growth in per capita costs with the provisions included in the Balanced Budget Act, per capita costs will continue to be an issue. However, the demographic trends that will drive program enrollment are independent of per capita costs -- and are much more significant. To shift the discussion, it could be helpful to

highlight this distinction between the level of cost increases that is due to rising per capita costs and the level of cost increases that is due to rising enrollment. The public is likely to be more willing to support higher revenues to cover more people than to cover higher costs per person.

The needs of this growing elderly and disabled population should be the real focus of the debate. As retirement systems change, Medicare must retain its ability to provide beneficiaries with financial security against health care costs. And Medicare will remain the primary way that our society will meet the changing health care needs of future elderly and disabled individuals, particularly those without substantial resources. Determining how Medicare can best meet those needs should be the primary task of the Commission.

### **Key Policy Questions**

The next section of this memorandum develops some issues that the Commission and the Administration must consider.

#### **Who should participate in Medicare?**

Historically, Medicare has been enormously successful in providing insurance protection to all persons over 65, without splintering the healthy from the sick or the low-income from the better off. Proposals to change eligibility rules could fundamentally change the universal nature of the program.

One proposal has been to raise the eligibility age to correspond with the increase in the eligibility age for Social Security. This could have two effects: leaving a pool of older, sicker beneficiaries enrolled in Medicare, and leaving more retirees, especially those with lower incomes, without coverage. The Commission should examine trends in the availability of health care for workers who retire before they are eligible for Medicare, the needs of the youngest Medicare eligibles, and the potential effects of raising the eligibility age. The Commission should also examine the possibility of allowing individuals to buy into the Medicare program before they reach the eligibility age.

Means-testing benefits -- excluding wealthy beneficiaries from the program or giving them fewer benefits -- would be a more significant change to Medicare's historical role. Medicare's universality and status as "the" health care program for the elderly have been the cornerstones of its success. While we can and should build additional progressivity into Medicare's financing, we must ensure that Medicare is available and attractive to elders of all incomes.

#### **What is the guarantee that Medicare represents to beneficiaries?**

Medicare guarantees access to a particular set of benefits, regardless of changes in health care costs. Critics have argued that Medicare's guarantee should shift toward a defined financial

contribution, which could limit Medicare's liabilities and increase beneficiaries' liabilities if health care costs increased.

An examination of the options along the continuum between a defined benefit package and a defined contribution is unavoidable. However, this exercise should acknowledge that changing Medicare's basic guarantee and reducing Medicare's contribution has the potential to shift billions of dollars of costs to employers, states, and beneficiaries. Perhaps more importantly, a defined contribution approach has a substantial potential to undercut the integrity of Medicare as one program and lead to a tiered structure in which the quality of care depends on a beneficiary's financial status.

#### **What benefits will Medicare offer?**

The Commission should examine both the level and the mix of benefits that Medicare offers. Compared with many private plans, the fee-for-service Medicare benefit package is not generous. Cost sharing is relatively high, and certain benefits widely available to the under-65 insured population (such as prescription drugs) are not provided. In some parts of the country, beneficiaries enrolled in HMOs receive benefits more comparable to what the working insured receive. Other beneficiaries obtain these benefits through supplemental coverage. The relationship between Medicare and these other sources of coverage -- managed care, employers, individual plans, and Medicaid -- should be addressed.

Medicare's benefit package should also be reexamined in the context of changes in health care delivery. When Medicare started, our entire health care system was organized primarily around providing care in hospitals. Over the last decade, delivery has shifted out of the hospitals and into other settings, like doctors' offices and patients' homes. As the population ages and retirees change, the mix of services that Medicare beneficiaries need may change even more. Medicare's role in financing long-term care may also become a more pressing issue.

Beyond the benefits enjoyed by individual beneficiaries, Medicare also finances public goods like medical education, research, and care for the uninsured through disproportionate share facilities. Other financing structures may be necessary to sustain these programs and to more properly account for them as health care system costs rather than Medicare benefit expenses.

#### **How will Medicare's costs be financed?**

Current sources of financing for Medicare include payroll taxes, beneficiary premiums and out of pocket payments, federal budget support for Part B, and Medicaid for low income beneficiaries. The Commission should address what share of Medicare costs each of these sources should bear.

One factor to consider in examining the appropriate financing mix is the possibility of merging Part A and Part B. The extent to which Medicare relies on each funding source is in part driven

by separate funding sources for Hospital Insurance and Supplementary Medical Insurance. As patterns of care change, this split is becoming less and less relevant to the way that care is delivered.

A second issue in the distribution of responsibility for Medicare's costs will be the resources available from each source over time. For example, trends in beneficiary income and tax revenues may show shifting abilities to pay. The current period of sustained economic growth and stock market growth will affect financing options, public perceptions, and future approaches -- but the Commission should also consider what will happen if this growth slows or reverses.

We also need to remember that not all seniors are the same. The Commission should pay particular attention to vulnerable subgroups enrolled in Medicare. It should look at how changes affect different age groups, ethnicities, genders, and income levels. For example, in considering how Medicare's costs will be financed, we must also determine how to continue to protect beneficiaries with the lowest incomes. Conversely, if we build additional progressivity into the program's financing by income-relating the premium, we must be careful to ensure that Medicare remains the right choice for elders of all incomes.

#### **What are the trends in employer-based insurance and financial planning?**

Employment shifts to a service economy and to home-based work have changed the working population's access to insurance. Furthermore, employers have been reducing coverage of retiree health benefits. As the health benefits and retiree health benefits that workers receive change, the needs of Medicare beneficiaries and of workers who retire before they are eligible for Medicare may also change.

Changes are also taking place in Americans' retirement planning. The balance is changing among company pensions, the evolving 401(k) self-directed pensions/savings, traditional savings, housing, and Social Security. Medicare will have to be evaluated as part of this changing system of financial protection. The Commission should be doubly cautious about providing less protection to beneficiaries if their retirement income is also becoming less secure.

#### **How will different policy options interact and shift responsibilities from some to others?**

It is essential that the Commission not consider options individually but also in the context of other options, because of the possible interactions that may arise. For example, if the Commission changed the copayment and deductible structure of the program, this could interact with proposals to change the supplemental insurance system or with proposals to income-relate premiums. Consideration should be given not only to the merit of individual options but what a combined package would be.

Any set of solutions must acknowledge the full burden of health care spending for the elderly and disabled and what resources there are to meet these needs across society as a whole. Limiting Medicare's role will shift costs to other parts of the budget or to beneficiaries and employers. For example, if the Commission raised the age of eligibility, the health care needs of the ineligible population would not disappear. They would be paid for by employers, beneficiaries, and public safety net programs.

Other changes may redistribute the impacts among future vs. current beneficiaries, within the beneficiary population, or among public programs. Postponing reforms may favor current beneficiaries while forcing future beneficiaries to experience more significant changes, for example. Increasing premiums or cost-sharing will shift some of Medicare's burden to Medicaid and the states, in addition to beneficiaries.

#### **How will Medicare's management responsibilities change?**

We should continue to seek out ways to strengthen the integrity of the Medicare program so that each benefit dollar is being spent for needed care and services. Stopping fraud and abuse creates budget savings, but again, it is not only a budget issue. Vigorous oversight is also necessary to sustain public confidence in the program. We should continue to strengthen HCFA's authority and resources to detect fraud, and to prevent it before it occurs.

As we work to address payment issues for the program, we should learn from the successes of the private sector. We also have the opportunity, however, to use our resources to design systems that will also help the private sector. For example, when Medicare was successful in controlling hospital costs with its system of prospective payments for diagnostic related groups, private insurers were able to use the system to control their costs as well.

However, Medicare is no longer just a payer. It now has oversight over a complex and changing health care delivery system. This new emphasis on delivery expands the government's responsibility to ensuring high quality care and consumer protections, in addition to traditional financial oversight.

As we think about how the program will be organized to purchase benefits in the future, we should continue to ask what new responsibilities come with that organization. We should clarify the respective roles and responsibilities of government and the private sector in managing a system of plan choice. And we should ensure that Medicare's administrative resources are sufficient to fulfill these responsibilities.

#### **How shall the Commission educate the public?**

The debates over Medicare and Social Security will require a broad segment of the population -- pre-retirees, baby-boomers, and generation X-ers -- to engage in a broad public debate on the

options outlined by the Commission. Public education and dissemination of information should be one explicit task of the Commission. They should view regular interaction with Congress and other key policy-influencing groups, including the media, as a high priority. These interactions can be the means to shape the way the press, Congress and the public consider these issues.

A handwritten signature in black ink, appearing to read "Donna E. Shalala". The signature is stylized with a large, sweeping initial "D" and a long, horizontal tail stroke.

Donna E. Shalala

Medicare

THE WHITE HOUSE

WASHINGTON

October 8, 1997

MEMORANDUM TO THE PRESIDENT

cc: Vice President, Erskine Bowles, Bruce Reed, Gene Sperling

FROM: Chris Jennings

RE: NEW YORK AND THE PROVIDER TAX ISSUE

Tomorrow, DHHS will announce the results of its policy review of Medicaid provider taxes and its policy changes regarding New York. In brief, they will announce (1) policy clarifications that include clarify that certain provider taxes previously in question, including New York's regional tax, are permissible; and (2) support for legislation that expedites identifying impermissible taxes and ending their use. This is the culmination of an intensive process that involved HHS, OMB, DPC/NEC, Legislative and Intergovernmental Affairs, the Office of the Vice President and other senior staff. This memo provides you with detailed information on the policy review, subsequent actions, and the roll out plans.

BACKGROUND

**Financing scheme and the law limiting it.** During the late 1980s, many States established financing schemes that had the effect of increasing their Federal Medicaid funds without using additional State resources. Typically, States would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the State was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

Because provider taxes and donations were effectively siphoning off potentially billions of dollars from the Federal Treasury, the Congress limited states' use of these schemes in a bill enacted by President Bush in 1991. The subsequent regulatory interpretation of these limits was, as you know, negotiated with the states and the National Governors' Association in 1993.

**States' continued reliance on impermissible provider taxes and our enforcement record.** Despite the new law and the regulations, many states continued to use provider taxes that at least appeared to be out of compliance. To date, these possibly impermissible taxes total an estimated \$2 to 4 billion and, in the future, could cost billions more. In response, HCFA issued letters and discussed its concerns about certain taxes with states, but -- for a variety of reasons -- never took any final action. Unfortunately, this has meant that a number of states continue using these taxes, believing that HCFA might never enforce the law, or that if they did, they could seek recourse through the White House or the Congress.

**The New York provision in the balanced budget.** To ensure that New York would never be vulnerable to Medicaid provider tax enforcement actions, Senator Moynihan and Senator D'Amato successfully added a provision to the Balanced Budget Act to exempt all of its provider taxes (it has dozens), both retrospectively and prospectively, from disallowances. Both in writing and orally we repeatedly objected to this provision. Moreover, we provided alternative statutory language that would have forgiven about \$1 billion. As you know, however, the Senators (through their staff) rejected our offer and insisted on their original provisions.

**Line-item veto and New York's reaction.** In announcing the line-item veto on August 11, we raised concerns about the cost and ramifications of singling out as permissible one state's provider taxes. Although our actions were generally viewed as responsible and defensible by those who know the program and/or who are budget experts, the same clearly cannot be said of New York's political establishment. The Governor's office, the New York Congressional delegation, the Mayor, providers and unions reacted strongly and negatively to the veto. Among a host of complaints, they charged that they were singled out and were never made aware that this provision could be subject to the line-item veto. Most recently they have criticized us for our delay in getting back to them and our willingness to support fixes for the other two vetoed provisions without addressing their problem.

**Tomorrow's actions.** The line-item veto of New York's special provider tax waiver provision accelerated a review process of these tax policies that was already underway at DHHS. This process has yielded two results. First, tomorrow HCFA is issuing a set of policy clarifications in a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid; this letter will be viewed as good news for at least nine states. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent; this will make New York's regional tax permissible.

The State Medicaid Director's letter also includes an announcement of our support for legislation that (a) lays out in statute how to identify impermissible taxes; and (b) would provide enhanced authority to the Secretary to forgive up to the entire amount of individual states' current liabilities if they come into full compliance with the law resolve current liabilities if the states comes into full compliance prospectively. If, however, by a date certain -- August 1998 -- no legislation is passed, HCFA will aggressively enforce its current policies.

**Need for legislation.** The Administration's goal in these actions is to work with the states to end the impermissible use of provider taxes. Given the staggering size of the liabilities for some states, we agree that this is best accomplished through negotiation. Specifically, we are interested in trading reductions in some or all of states' retrospective liabilities for discontinued use of such taxes in the future. However, the administrative process that HCFA has at its disposal offers many opportunities for states to continue to stall (as they have done in the past). More importantly, final settlements must be approved by the Department of Justice which may take a hard line in terms of recouping retrospective liabilities. This could force states to look for a legislative "rifle shots" to fix their particular problem, or to go to court.

Consequently, we think that the best way to bring states to the negotiations is through reliance on a legislative strategy. By strengthening the Secretary's ability to negotiate, we avoid the uncertainty inherent in an ordinary administrative process. By stating what type of legislation we would support; we get ahead of the rifle shots and possibly prevent them, as well as to get the Congress invested in developing a mutual solution to the provider tax mess. And by offering to clarify our ways of identifying impermissible taxes, we may engage states that have concerns about our interpretation, thus possibly preventing suits. These incentives are reinforced by threat of a deadline for passage of such legislation (August 1998) that triggers an aggressive enforcement action by HCFA.

**Reaction from New York.** DHHS's review produces good news for New York. One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration has published a clarifying amendment to the regulation in today's *Federal Register*. This action relieves New York of over \$1 billion of provider tax liability.

However, there will be no final resolution on New York's other provider taxes. The New York delegation has already put us on notice that nothing less than a "hold harmless" solution is acceptable. They define this as meaning that they want us to waive all current taxes both retrospectively and prospectively; in other words, they want the provisions we line-item vetoed. Thus, even though there is good news for the state, it will almost certainly be viewed as insufficient.

**Reaction from other states.** Although nine other states benefit from the new policy clarifications, it is news of our support for legislation that will catch states' attention. The dozen or so states that have widely used provider taxes may view this positively. It is these states that we want to engage in discussion and eventually negotiations. However, the remaining states that either ended their provider tax use or who never used them to begin with may view our action as too conciliatory. We will make sure that we communicate to states that we have not -- and will not -- change our opposition to the use of provider taxes. We are simply looking for the most effective way to end states' reliance on impermissible taxes.

**Roll-out strategy.** The timing of briefings on this tax issue is crucial given the political sensitivity in New York. Since the Vice President is in New York until 4pm that day, we are scheduling this briefing for 3:30 (tentatively). Donna called the Governor last night to tell him that we would meet with his staff on Thursday afternoon. Gene sent a similar message to Charlie Rangel last night with a consistent message and we have also notified other key members of the New York delegation. HHS has also planned briefings for committees of jurisdiction, the NGA, and other interested parties later in the afternoon.

Because of New York's media market, there is no question that tomorrow's announcement will attract significant coverage. We do believe, however, that the approach we are taking represents the best way to start a long-overdue process of eliminating impermissible provider taxes from the Medicaid program. We will keep you apprised of developments.

THE WHITE HOUSE  
WASHINGTON

*Medicare*

Date 7/12

*Gene Spermy*  
To: *Bure Reed*  
*Chris Jennings*  
From: The Staff Secretary

I think this needs a  
cover note / summary from you  
before going to POTUS.

Please advise

*Paul*

cc: *Eastline*



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

JUL 11 1997

MEMORANDUM FOR THE PRESIDENT

As you know, the Senate has proposed a number of changes that would affect Medicare beneficiaries, including the introduction of an income-related Part B premium starting at \$50,000 for single beneficiaries and \$75,000 for couples. In our letter to the Conferees, the Administration made clear that while we do not oppose income-relating the Medicare premium in principle, we have a number of concerns about the proposal as currently structured. I wanted to raise to your attention the two aspects of the proposal that I think raise the most significant problems. (I have discussed my concerns with Secretary Rubin).

First, if the Administration agrees to an income-related premium, I believe we should strongly oppose the Senate provision for HHS to administer the collections process. The Administration has consistently taken the position that any such premium should be collected by the Treasury Department, where it could be managed simply and efficiently as part of the filing of a beneficiary's tax return. (As you may recall, this is how we proposed to collect the income-related premium in the Health Security Act; we adhered to this position in the balanced budget negotiations). Part I of this memorandum sets forth in more detail the reasons why administration of an income-related premium by HHS would be impractical, expensive, and more burdensome to beneficiaries. Administration by HHS runs serious risks of alienating several million senior citizens.

Second, I am concerned that the Senate proposal has the potential to cause a substantial percentage of the highest income beneficiaries to opt out of Medicare Part B altogether, because it phases out the premium subsidy entirely at the top end of the income scale. Part II of the memorandum explains why it is very important that we not agree to an income-related premium that includes this feature.

I. Concerns about Administrability of Income-Related Premium by HHS

Administration of an income-related premium by HHS would be a formidable undertaking. HHS does not now have access to information on beneficiary income. In addition to serious concerns about the privacy of income information, requiring HHS to collect an income-related premium would mean establishment of a large and expensive bureaucracy at HHS, a task for which the Department has no expertise or comparative advantage. We estimate that such a bureaucracy, which would duplicate functions performed by Treasury, would require more than 300 new

Federal employees and cost more than \$30 million per year (not counting start-up costs), and run counter to Administration and Congressional goals of downsizing the Federal government.

Furthermore, the inefficiencies inherent in the Senate proposal for HHS to collect the income-related premium have led both CBO and HCFA actuaries to estimate that less than half of the revenue theoretically obtainable would be achieved. We believe that CBO would estimate that the income-related premium in the Senate bill would raise about \$8-\$9 billion over five years if the collections were handled by Treasury, compared to only the \$4 billion that CBO has estimated if the premium were administered by HHS.

#### A. What HHS Would Have to Do to Administer Income-Related Premium

The Senate bill would require HHS to undertake a complicated series of steps.

- (1) The Senate bill requires Treasury to provide HHS with income information on Medicare beneficiaries since HHS does not have such information. Collecting and reconciling information about beneficiary incomes would be an entirely new function for HHS, one that some beneficiaries may not find appropriate, given the sensitivity of such information.
- (2) The income information provided by Treasury would be three years old. Treasury would send HHS 1995 tax return information, the latest available information, in order to give HHS sufficient time to develop and send to beneficiaries an initial determination (i.e., a preliminary estimate which would need to be reconciled after the actual tax filing for the year) of their 1998 income and an initial determination of their 1998 income-related premium liability, and give the beneficiary an opportunity refute the HHS estimate.

Use of income data three years old is problematic. It would be inherently confusing. Past income is not a good indicator of a Medicare beneficiary's future income. For example, income for beneficiaries who were working in 1995 but later retired would result in an overstatement of estimated 1998 income for the beneficiary. Similarly, if a beneficiary had a capital gain in 1995, that gain would be included in the beneficiary's 1995 income used to project 1998 income.

In contrast, if Treasury were administering the income-related premium, they would not have to use three year-old data. Rather, because the income-related premium would be collected as part of the filing of the beneficiary's tax return, it would be based on actual income information for the relevant year.

HHS would have to respond to the many letters from beneficiaries or Congressional Offices who might be concerned with the general notion of a governmental agency estimating their income for a year and why they had to supply income data to two different governmental agencies.

- (3) The Senate bill requires that HHS send the beneficiary an estimate of their income by September 1 of the year before the year for which the income-related premium applied and that the beneficiary be given thirty days to refute the estimate. If the beneficiary refutes the HHS estimate, the Senate bill provides that the beneficiary's estimate would hold. If the beneficiary does not challenge the HHS estimate, the Senate bill specifies that the HHS estimate would hold.
- (4) While the Senate bill does not specify how the income-related premiums would actually be collected, they could be collected either by HHS direct billing, or SSA deductions from the Social Security check (for the bulk of beneficiaries).

In the case of exclusive HHS direct billing, HHS would have to send quarterly bills to about 3 million beneficiaries in 1998. For those beneficiaries who did not make timely payment, additional efforts at collection would need to be undertaken.

Alternatively, the beneficiary-specific income-related premium liability could be sent to SSA before the beginning of a year and SSA could deduct the amount from the beneficiary's Social Security check. This method could be used for 85 percent of beneficiaries; the remainder would need to be direct-billed by HHS.

- (5) If high-income beneficiaries did not make premium payments, they would be terminated from Medicare Part B coverage. Challenges to terminations could consume additional HHS resources. Termination may also involve correspondence with beneficiaries and Congressional offices.
- (6) Since the initial premium payments for a year would be based on the "initial determination" of income and since "actual" income and the actual income-related premium liability for the year may be different from the estimated amounts, the Senate bill requires that there be a reconciliation after the year. The Senate bill requires Treasury to send HHS income information after the beneficiary filed their tax returns for the year. Using actual income, HHS would determine the actual premium liability for the year.

For income-related premium liabilities for 1998, the reconciliation would occur in 2001. This could be confusing to beneficiaries since the reconciliation would involve resurrecting their actual information from a tax return three years earlier and generate additional correspondence.

- (7) After HHS reconciled estimated and actual income and income-related premium liabilities, underpayments would have to be collected from beneficiaries and overpayments would have to be refunded. If a beneficiary had died, collections would have to be made from, and refunds made to, the surviving spouse or estate. Special efforts may be needed to recoup underpayments from heirs where estates had already disbursed assets.

- (8) The paperwork burden for HHS administration of an income-related premium is staggering. New forms would have to be developed to send income estimates to beneficiaries, receive their responses and reconcile estimated and actual income. Twelve million bills would need to be sent if HHS did exclusive billing for income-related premiums. Additional correspondence would be involved for delinquent collections. Up to 3 million letters might be sent to handle overpayments and underpayments for a year. Special paperwork might be needed to recoup underpayments from surviving spouses or estates.

#### B. Comparison with Administration by Treasury

In contrast, an income-related premium could be calculated through the income tax return, in a manner similar to the way that the tax on Social Security benefits is currently determined. One line would be added to the 1040 tax form representing the amount owed for income-related premium. Determination of the income-related premium owed would be calculated on a worksheet in the 1040 instructions in the same manner that individuals calculate the amount of their Social Security benefit subject to income taxation. If the individual pays estimated taxes, the income-related premium liability could be included as part of the individual's periodic filing. There would be some increase in Treasury's administrative costs to run this program, but we believe those costs are relatively small.

#### C. Potential Costs of Administration by HHS

In an era of ever more constrained funding for program administration, requiring HHS (and SSA) to take on these administrative functions would be impossible without a more than \$30 million annual increase in administrative funding (and \$20 million in start-up costs) and more than 300 new Federal employees. These estimates of administrative costs do not take into account the need to deal with inquiries or complaints from Congressional offices, or the IRS itself (which will continue to be identified as the source of final income data). In the absence of additional resources, processing those inquiries would detract from the capacity of those organizations to provide other services. Nor do those estimates reflect the additional costs to beneficiaries who believe -- rightly or wrongly -- that there are errors in the information on which their filings are based. Just as other taxpayers incur considerable expenses for accountants, lawyers, and so forth, so for the first time would thousands of Medicare beneficiaries.

## II. Concerns about the Maximum Beneficiary Contribution in Senate Proposal

The Administration's Health Security Act proposed that beneficiaries pay a maximum contribution of 75 percent at or above the top income level. In other words, there would be a 25 percent subsidy for the highest income beneficiaries.

There is an important rationale for this policy. If the entire subsidy is removed, the younger and

healthier persons among highest income beneficiaries would have strong incentives to drop out of Part B coverage. On average, Medicare spending for high-income beneficiaries is about 15 percent lower than for all beneficiaries. Since their average expenses would be considerably less than their Part B premium contributions, they could probably purchase a Part B benefit package privately, at less cost than a Medicare premium equal to 100 percent of the average cost for all aged beneficiaries. If a significant number of high-income beneficiaries dropped out, it would raise costs for those who remain. HCFA actuaries assume that about 30 percent of high-income beneficiaries would drop out if the income-related premium were set equal to 100 percent of average program costs. This would increase the Part B premium for every other beneficiary. The Administration believes that the maximum beneficiary contribution at the highest incomes should be 75 percent.

#### Conclusion

For all of these reasons, I strongly believe we should support an income-related premium only if it is administered through Treasury. I also believe that if this provision remains in the bill, the maximum beneficiary contribution should be 75 percent.



Donna E. Shalala

cc: Robert Rubin  
Secretary, Department of Treasury

John Callahan  
Acting Commissioner, Social Security Administration

THE WHITE HOUSE  
WASHINGTON

*Medicare*

MEMORANDUM

*BRUCE REED*

**TO:** DISTRIBUTION  
**FROM:** Chris Jennings  
**RE:** MEDICARE HIGH-INCOME PREMIUM  
**DATE:** July 11, 1997

Attached are several pages describing:

- A side-by-side comparison of the approaches;
- A list of major concerns with the Senate proposal;
- How the Senate-passed income-related premium works; and
- How such a policy would work if administered by Treasury.

Please call with questions.

## COMPARISON OF THE ADMINISTRATION OF THE HIGH-INCOME PREMIUM

PROVISION	SENATE BILL ADMINISTERED BY HHS*	SENATE BILL ADMINISTERED BY TREASURY*
<b>Who Administers</b>	Health & Human Services (HHS), Social Security Administration (SSA), & Treasury	Treasury
<b>Savings</b>	\$3.9 billion (assumes loss of over 50% of savings in the first 5 years)	\$8 to 9 billion (assumes traditional compliance rates)
<b>Administrative Costs</b>	\$30 to 50 million per year	\$5 to 10 million per year
<b>How Eligible Beneficiaries Are Identified</b>	HHS identifies beneficiaries by: (1) Getting income from the latest reviewed Treasury tax data, which is 2-3 years old (e.g., 1995 for 1998) (2) Sending notices to at least 3 million beneficiaries to ask if this past income is what they will receive in the next year and require them to respond in writing in 30 days <b>Note: Sharing income data across agencies raises significant privacy concerns</b>	Beneficiaries report their income, reference a schedule, and add the extra premium to the bottom line of their tax return
<b>How Premiums Are Collected</b>	Assumes that extra premium is subtracted from monthly Social Security check after HHS sends to SSA their estimate of who gets how much taken out of their checks	See above
<b>Reconciling Income</b>	To ensure that the right amount of premium was assessed, Treasury would send the actual income from reviewed tax data to HHS. However, because this would be done retrospectively this would take 2-3 years (e.g., 2001 correction for 1998 mistake)	Since income is not projected but is the actual reported income, no reconciliation is required.

\* This policy assumes the Senate policy which phases in 100% of the premium for beneficiaries with incomes between \$50,000 and \$100,000 for singles, \$75,000 and \$125,000 for couples. The Administration opposed the Senate's 100% phase out, administration through HHS/SSA, and lack of indexing of the income thresholds.

## The Senate's Medicare High Income Premium Policy Concerns

- **Duplicates bureaucracy.** Today, the Treasury Department is the only Federal agency that has the income information needed to collect a high-income premium. HHS or SSA would either have to collect their own income information, like a second tax return, or borrow the Treasury income information. In either case, a large, new bureaucracy, with hundreds of new workers, would be needed to duplicate the Treasury structure. This could cost \$30 to \$50 million per year — many times more than it would cost if administered through Treasury.
- **Errors likely.** HHS cannot easily identify who should be paying the extra premium. It would base its identification of these people on 3-year old income information received from the Treasury. One in four seniors who are above the income thresholds fall below them three years later, mostly because they have been working but have since retired. Others may have died or have spouses that have died, changing the amount that they owe. Beneficiaries have a 30-day window to mail in any corrections, but this may be too short of a time period and could be difficult to understand or process for some seniors.
- **Collections difficult.** Collecting this extra premium is not as simple as reducing beneficiaries' Social Security checks. Three agencies — HHS, SSA, and Treasury — would have to coordinate information to ensure that the right premium is collected. This not only raises major privacy concerns, but is inefficient. The right amount of the premium won't be known for years, since it takes time for Treasury to review tax returns, HHS to match the actual income with that used to determine the premium, and SSA to collect any over- or under-estimate. Recouping the extra premium years later creates bureaucratic challenges — HHS would need practices like a collections agency — as well as hardship for beneficiaries. Since most beneficiaries' incomes will decline as they age, beneficiaries will be paying no extra premium when they can afford it and more when they can afford it less.
- **Major loss of revenue.** A consequence of this administrative complexity is the loss of the premium revenue from the policy. Cost estimators at CBO and OMB assume that more than half of the potential revenue will be lost due to problems in administration. In contrast, only a small percent will be lost if administered by the Treasury, which already has most of the administrative structures in place.
- **Loss of healthier, wealthier beneficiaries.** Totally phasing out the premium could cause long-run problems for Medicare. Faced with a large, extra premium, the healthiest beneficiaries have a strong incentive to leave Medicare. It is likely that an insurance market will develop that can offer Part B services at a lower price — especially since Medicare spends, on average, 15 percent less for high-income beneficiaries than for all beneficiaries. HHS Actuaries assume that about half a million healthy, wealthier beneficiaries would leave Medicare if the premium rose to 100 percent. The loss of these beneficiaries not only means less premium revenue but could raise the cost of Medicare for those who remain.

## The Senate's Medicare High Income Premium Policy How It Would Work

**Senate Policy.** The Senate bill increases the Medicare Part B premium for high-income beneficiaries from 25 to 100 percent of Part B costs.

*Single beneficiaries:* Begins at \$50,000 with full payment at \$100,000  
*Couple:* Begins at \$75,000 with full payment at \$125,000

### Maximum Extra Premium in 2002

*Single beneficiaries:* About \$200 per month, \$2,400 per year  
*Couple:* About \$400 per month, \$4,800 per year

This premium increase would be administered by Health and Human Services (HHS) or Social Security (SSA).

### How It Would Work.

- Before the beginning of each year, the Treasury Department will send the latest available, reviewed tax information to HHS. For 1998, this would be 1995 income, for example.
- HHS will then send notices to beneficiaries who appear to be eligible to ask if this income from the older tax returns is accurate for the coming year. Beneficiaries will have 30 days to respond.
- After incorporating any mailed-in changes, HHS will send this income information to SSA, which will deduct any extra premium from Social Security checks (or HHS sets up its own collections and billing process)
- At the end of the year, HHS will use the Treasury tax information to check actual income against income used to assess the premium. For 1998, this actual income information will be available in the summer of 2000.
- HHS will increase or decrease the next year's premiums based on the previous year's error -- plus interest. If the beneficiary had died, the surviving spouse or estate will have to pay the premium owed. For a beneficiaries whose income was understated in 1998, an extra amount will be taken out of their 2001 Social Security check.

## Treasury Department-Administered Medicare High Income Premium How It Would Work

**Policy.** Like the Senate bill, this policy would increase the Medicare Part B premium for high-income beneficiaries. It differs from the Senate approach since beneficiaries pay at most 75 percent of the premium and the income thresholds are indexed to inflation.

*Single beneficiaries:* Begins at \$50,000 with full payment at \$100,000  
*Couple:* Begins at \$75,000 with full payment at \$125,000  
*Indexed to inflation for years after 1998*

### Maximum Extra Premium in 2002

*Single beneficiaries:* About \$130 per month, \$1,600 per year  
*Couple:* About \$260 per month, \$3,200 per year

This premium increase would be administered by the Treasury Department.

### How It Would Work.

- The extra premium will be collected through the tax system. Most eligible beneficiaries will fill out an extra line on their annual tax returns. This will be done by comparing income (modified adjusted gross income) with a premium schedule that will be included in the tax instructions.
- Beneficiaries who pay quarterly taxes will take the premium into account when calculating their withholding and / or quarterly estimated tax payments.
- The income information will be checked through the usual Treasury review process.
- The revenue from the extra premium will be transferred periodically to the Medicare trust fund.

Reconciliation Action as of 6/13/97: **MEDICARE**

cc: Elmer - [unclear]

Major Issues	Budget Agreement	Committee Action
Home Health Reallocation	Extend solvency of the Part A Trust Fund for at least 10 years through a combination of savings and structural reforms (including home health reallocation). Maintain Part B premium at 25% of program costs and phase in over seven years the inclusion in the calculation of the part B premium the portion of home health expenditures reallocated to Part B.	<p><i>Ways &amp; Means</i> -- Shifts home health spending from Part A to Part B over seven years.</p> <p><i>Commerce</i> -- Adopted Administration's proposal (i.e., shift the spending from Part A to Part B immediately and phase in the impact of the shift on the Part B premium over 7 years).</p> <p><i>Finance</i> -- Includes proposal similar to <i>Ways &amp; Means</i>.</p>
MSAs	Agreement is silent on this issue.	<p><i>Ways &amp; Means</i> -- Provides for a 4-year demonstration with 500,000 participants and does not protect beneficiaries from balance billing.</p> <p><i>Commerce</i> -- Provides for a 5-year demonstration with 500,000 participants and does not protect beneficiaries from balance billing.</p> <p><i>Finance</i> -- Same design as <i>Ways &amp; Means</i>. We believe that the demonstration would not protect beneficiaries from balance billing.</p>
Medical Malpractice	Agreement is silent on this issue.	<p><i>Ways &amp; Means</i> -- Contains objectional provisions from the House balanced budget act (1995) and Kennedy Kassebaum (e.g., cap on non-economic damages, statute of limitations).</p> <p><i>Commerce</i> -- Same as <i>Ways and Means</i>.</p> <p><i>Finance</i> -- No provision.</p>
Preventive Benefits-- Co-payments for Mammograms	Funding for new health benefits including expanded mammography coverage.	<p><i>Ways &amp; Means</i> -- Includes most preventive benefits contained in the Administration's proposal, but fails to waive coinsurance for mammograms.</p> <p><i>Commerce</i> -- Includes most preventive benefits contained in the Administration's proposal, but fails to waive coinsurance for mammograms.</p>

# Reconciliation Action as of 6/13/97: MEDICARE

Major Issues	Budget Agreement	Committee Action
<p>Medical Education/ Disproportionate Share (DSH) Carve-out</p>	<p>Agreement is silent on this issue.</p>	<p><i>Ways &amp; Means</i> -- Does not include the policy to move medical education and DSH adjustments out of managed care payment rates and redirect the funds to hospitals that provide services to Medicare managed care enrollees.</p> <p><i>Commerce</i> -- Includes the carve-out proposal, with a 5-year transition period (i.e., removes 20% of IME/GME/DSH in 1998, 40% in 1999, 60% in 2000, 80% in 2001, and 100% in 2002).</p> <p><i>Finance</i> -- Similar to Commerce proposal, but includes a 4-year transition period.</p>
<p>Prudent Purchasing</p>	<p>Agreement is silent on this issue.</p>	<p><i>Ways &amp; Means</i> -- Adopted the Administration's "Centers of Excellence" proposal, but fails to adopt the other proposals (e.g., global purchasing, competitive bidding for DME) which would allow Medicare to take advantage of lower rates providers offer to other payers.</p> <p><i>Commerce</i> -- Same as <i>Ways and Means</i>, but also added a durable medical equipment competitive billing demonstration.</p> <p><i>Finance</i> -- Fails to adopt all the prudent purchasing proposals.</p>
<p>Commission</p>	<p>Agreement is silent on this issue.</p>	<p><i>Ways &amp; Means</i> -- Would establish a Medicare commission.</p> <p><i>Commerce</i> -- Would establish a Medicare commission.</p>
<p>Private Fee-For-Service Plans in Medicare Choice</p>	<p>Structural reforms will include provisions to give beneficiaries more choices among competing health plans, such as provider sponsored organizations and preferred provider organizations.</p>	<p><i>Finance</i> -- Available language indicates that the Finance Committee will allow private fee-for-service plans in Medicare Choice with no restrictions on balance billing.</p>

## Reconciliation Action as of 6/13/97: MEDICARE

Major Issues	Budget Agreement	Committee Action
Home Health Co-pay	Agreement is silent on this issue.	<p><i>Ways &amp; Means</i> -- No provision.</p> <p><i>Commerce</i> -- No provision.</p> <p><i>Finance</i> -- Impose a Part B home health co-payment of \$5 per visit, capped at an amount equal to the annual hospital deductible.</p>
Raise in Eligibility Age	Agreement is silent on this issue.	<p><i>Ways &amp; Means</i> -- No provision.</p> <p><i>Commerce</i> -- No provision.</p> <p><i>Finance</i> -- Conform the Medicare eligibility age to the eligibility age for Social Security (i.e., 67).</p>
HI Tax for All State and Local Workers	Agreement is silent on this issue.	<p><i>Ways &amp; Means</i> -- No provision.</p> <p><i>Commerce</i> -- No provision.</p> <p><i>Finance</i> -- Extend the HI tax to States and local government employees.</p>

## Reconciliation Action as of 6/13/97: MEDICAID<sup>1</sup>

Major Issues	Budget Agreement	Committee Action
Investments	Net Medicaid savings include a higher match for D.C., and an adjustment for programs in Puerto Rico and other territories	<p>Commerce----- Committee bill did not include the following investments that were specified in the Agreement: a higher FMAP for the District of Columbia and adjustments for the Medicaid programs in Puerto Rico and the territories. At full committee, Chairman Bliley stated that he would work to include these provisions at a later point in the process.</p> <p>Finance----- Committee bill includes a 60 percent FMAP for D.C. that sunsets in 2000. Funding for Puerto Rico and the territories appears lower than in the President's Budget.</p>
Low-Income Beneficiary Protections	Net Medicaid savings include \$1.5 billion in spending over five years to ease the impact of increasing Medicare premiums on low-income beneficiaries.	<p>Commerce----- Committee bill included only \$600 million for protections for low-income Medicare beneficiaries from the increasing Medicare premiums, while the Agreement specified that \$1.5 billion should be invested for these protections.</p> <p>Rather than cover the entire Part B premium for people between 120 and 150 percent of poverty, as was intended by the agreement, the Committee bill would cover only the increment in the premium increase due to the home health reallocation.</p> <p>Finance----- The Finance Committee mark includes no provision to expand protections for low-income Medicare beneficiaries.</p>

<sup>1</sup>As of June 13th, Commerce favorably reported their Medicare reconciliation legislation. Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

<b>Major Issues</b>	<b>Budget Agreement</b>	<b>Committee Action</b>
Disproportionate Share Hospital Savings	Savings derived from reduced disproportionate share payments and flexibility provisions	<p>Commerce----- The Committee bill allocates the greatest proportion of DSH cuts to 'high-DSH' states. The Committee does not include re-targeting of DSH funds.</p> <p>Finance----- DSH allotments are reduced by imposing freezes, making graduated proportional reductions and reducing payments by amounts claimed for mental health services.</p>
SSI Disabled Children	Restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility.	<p>Commerce----- Full committee amendment eliminates the continuation of Medicaid eligibility for current disabled children who lose SSI benefits due to the new, more strict definition of childhood disability.</p> <p>Finance ----Chairman's mark does not include a provision to restore Medicaid benefits to current disabled children.</p>

**Reconciliation Action as of 6/13/97:  
CHILDREN'S HEALTH<sup>1</sup>**

Major Issues	Budget Agreement	Committee Action
Direct Services/ Use of \$16 billion Investment	Spend \$16 billion over 5 years (to provide up to 5 million additional children with health insurance coverage by 2002)	<p>Commerce----- Subcommittee bill provides a direct services option to states (i.e., payment for services rather than insurance for children).</p> <p>Finance --</p> <p>Still working out the details of a capped grant and Medicaid option for States</p>
Cost-effective Use of Resources	Resources will be used in the most cost-effective manner possible to expand coverage and services for low-income and uninsured children with a goal of up to 5 million currently uninsured children being served.	<p>Commerce----- Subcommittee bill includes both a Medicaid and a grant option.</p>
Limit on Access to Abortion	Agreement is silent on this issue.	<p>Commerce----- Subcommittee bill includes Hyde language limiting access to medically necessary benefits, including abortion services.</p>

<sup>1</sup>As of June 13th, Commerce favorably reported their Children's Health reconciliation legislation. Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

**Reconciliation Action as of 6/13/97:  
HEALTH CARE REFORM<sup>1</sup>**

<b>Major Issues</b>	<b>Budget Agreement</b>	<b>Committee Action</b>
Multiple Employer Welfare Associations (MEWAs)	Agreement is silent on this issue.	Education and Workforce -- Includes Rep. Fawell's Expansion of Portability and Health Insurance Coverage Act. This bill would enable small firms and individuals to buy health insurance through Association Health Plans. These AHPs would not be subject to state insurance laws.

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<sup>1</sup>As of June 13th, both Ways & Means and Commerce favorably reported their Medicare reconciliation legislation. Ways & Means reported out June 9th and Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

**MAJOR RECONCILIATION ISSUES (non-tax)**

Administration Position	House	Senate
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**\* Immigrant benefit restorations**  
 Consistent with the agreement, restore \$9.7 billion in benefits for all legal immigrants who are or become disabled after 8/22/96

**Food Stamps**  
 \* Invest \$1.5 billion to restore benefits and create 350,000 work slots for 18-50s; include performance standards and target all funds to 18-50s

**Ways and Means:**  
 Restores benefits for current beneficiaries, including the elderly, but not for new applicants (those who were in the country prior to 8/22/96 and became disabled after that date)

**Agriculture:**  
 Spends \$1.5 billion to create about 190,000 work slots; does not include performance standards and has lower requirement than in Administration policy to target funds to 18-50s

**Finance:**  
 Similar to Ways and Means, but restores benefits for new applicants who become disabled prior to August 1997 (date is in flux).

**Agriculture:**  
 Spends \$1.5 billion to create 250,000 slots; includes acceptable performance standards but only 75% of funds are targeted to 18-50s (vs. 100% in Administration policy)

**Welfare to Work**  
 \* Invest \$3 billion, with a significant share provided directly to cities with large poverty populations

**Ways and Means:**  
 Invests \$3 billion split 50/50 between formula and competitive grants, with an acceptable share of funds to urban areas through JTPA system (PICs)

**Education and Workforce:**  
 Invests \$3 billion split 95/5 between formula and competitive grants, with somewhat smaller share to cities; funds flow through JTPA system

**Finance:**  
 Invests \$3 billion split 75/25 between formula and competitive grants; funds flow through TANF instead of mayors, which the Administration opposes

**MAJOR RECONCILIATION ISSUES (non-tax)**

Administration Position	House	Senate
<b>Minimum Wage</b> Supports minimum wage for welfare recipients in welfare	<b>Ways and Means\Education and Workforce:</b> Denies minimum wage by allowing States to either reduce hours of work requirements or by counting Medicaid/child care/housing/etc. as income for calculating minimum wage	<b>Finance:</b> Not in the draft mark; may be introduced during markup
<b>Student loans</b> Opposes House and Senate proposal	<b>Education and Workforce:</b> Establishes separate entitlement to pay the administrative costs of guaranty agencies; currently, annual funding is determined by the Secy of Education	<b>Labor/Human Resources:</b> Same as House
<b>Privatization</b> Opposes any privatization of determination of eligibility functions	<b>Commerce:</b> Allows all States to privatize Medicaid eligibility determinations  <b>Agriculture:</b> Allows all States to privatize Food Stamps eligibility determinations	<b>Finance:</b> Allows ten States to privatize eligibility functions for all health and human services programs (including Medicaid, Food Stamps, WIC); approves TX waiver
<b>SSI Maintenance of Effort (MOE)</b> Opposes repeal of MOE requirement	<b>Ways and Means:</b> Repeals MOE requirement	<b>Finance:</b> Does not repeal MOE requirement

**Differences between the Republicans' \$270 Billion Medicare Plan  
and the Balanced Budget Agreement's Medicare Plan**

• **The total Medicare savings are still billions less than the \$270 billion package that the President vetoed. There are many other important differences as well:**

- 1) **Vetoed Budget had premiums that were about \$18 more per month than in the 1997 Balanced Budget Agreement.** The monthly premium under the Budget Agreement will be about \$69 in 2002. If the policy were a 31.5% premium instead of 25%, this premium would be about \$87. On an annual basis, this difference is about \$215 for a single beneficiary, \$430 for a couple.
- 2) **Vetoed Budget would have raised the percent of the program funded by beneficiaries by over one fourth.** The 1997 Balanced Budget Agreement keeps the Medicare Part B premium at its current level of 25% of program costs — far below 31.5% the 1995 Republican Budget that the President vetoed.
- 3) **Vetoed Budget's investments are only 1% of the 1997 Balanced Budget Agreement's investments.** The Budget Agreement includes critical investments:

- **Preventive services: \$3 to 4 billion**, including services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.
- **Protection against excessive hospital outpatient coinsurance: \$4 billion**
- **Premium assistance for low-income beneficiaries: \$1.5 billion**

In contrast, the vetoed Budget included extremely modest investments, **\$100 million** for coverage of oral breast cancer drugs.

- 4) **Vetoed Budget had larger provider reductions.** The vetoed Budget had policies that put much tighter constraints on provider payment growth. For example, under the vetoed plan, hospital payment update reductions would be twice as big as is needed in the 1997 Budget Agreement. This translates into savings of \$22 billion over five years under the vetoed plan versus \$11 billion under the Agreement.
- 5) **Vetoed Budget included flawed structural reforms.** The 1997 Balanced Budget Agreement does not sanction the use of balance billing, association plans, and other ideas that put beneficiaries at risk.

Bruce:

Two documents to help you respond to the likely lack of structural reforms question:

- ① - Our talking points emphasizing our structural reforms.
- ② - My insert on the Denver competitive bidding debate. You can use it for validation that we are trying to implement ~~the~~ market-oriented reforms that (ironically) the private managed care industry opposes.

Call with any questions.

Bruce

## THE PRESIDENT'S MEDICARE STRUCTURAL REFORMS

The President's budget contains important structural changes necessary to modernize Medicare for the 21st century. It adopts the best innovations in the private sector, which has developed new techniques to control health care costs and improve quality. It also restructures Medicare, offering more choices for managed care, shifting to competitive pricing, enhancing preventive coverage, and offering consumers more information. The following are just some of the more significant reforms in the President's plan.

### **Restructures the Payment System for Medicare's Fastest-Growing Services**

- **Problem:** Medicare costs are skyrocketing for home health care, skilled nursing facilities, and hospital out-patient services. These services account for most of the excessive growth in Medicare spending. They are rising so quickly because Medicare pays after the fact, creating incentives for overutilization.
- **The President's budget** builds on the success Medicare has had in controlling hospital costs, restructuring the entire payment system so that rates are set in advance. This prospective payment system will prevent health care providers from charging too much in these areas.

### **Offers Consumers More Choices for Managed Care**

- **Problem:** Current law only enables Medicare to contract with a narrow range of managed care plans. Also, under today's rules, many older Americans are reluctant to try managed care for fear that, if they don't like it, they will be unable to return fee-for-service with their previous Medigap plan.
- **The President's budget:** By allowing Medicare to work with Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs), the President's budget opens up new options that have proved popular and cost-effective in the private sector. By providing annual Medigap enrollment without fear of higher premiums or penalties for pre-existing conditions, it also provides older Americans with a meaningful choice.

### **Broadens Availability of Managed Care and Ensures that Medicare Trust Fund Shares in the Savings**

- **Problem:** Today, the Medicare Trust Fund actually loses money on the average beneficiary that enrolls in a managed care plan because Medicare pays too much money to insure the relatively healthier Medicare beneficiaries in managed care plans.
- **The President's budget** takes steps to remedy this well-documented overpayment through a one-time reduction of about 5 percent in HMO payments in the year 2000. It also addresses the flawed payment methodology that has led to great geographical disparity, which has limited most of rural America's access to managed care.

## **Introduces Successful Competitive-Bidding Strategies to Lower Costs**

- **Problem:** Although the Health Care Financing Administration is the largest purchaser of health care services in the United States, Medicare often pays more for services and equipment because it lacks the legal authority to negotiate lower prices. Too often, Medicare pays far more for medical supplies and durable medical equipment than other purchasers.
- **The President's budget** institutes competitive pricing to introduce market pressures and keeps Medicare costs down by leveraging the government's enormous buying power in the health care sector. It also builds on innovative cost-cutting pilot programs like "Centers of Excellence," which use new payment incentives for hospitals or health centers that provide outstanding service while keeping costs down. In a Medicare demonstration, these incentives have achieved real savings of 12 percent on coronary bypass graft procedures with a higher quality of service.

## **Encourages More Prevention and Prepares for the Retirement of the "Baby Boomers"**

- **Problem:** Medicare does not cover many of the preventive services that can cut costs and help people lead healthier lives.
- **The President's budget** expands coverage for mammograms and colorectal screening, improves self-management of diseases like diabetes, and extends respite benefits that are increasingly important to our older Americans. These benefits will be good for beneficiaries and, over time, will save Medicare dollars.

## **Gives Consumers the Information They Need**

- **Problem:** Many seniors today lack the basic information they need to make informed choices about which Medicare plan to choose.
- **The President's budget** empowers America's seniors to make educated choices about their health care by providing beneficiaries with comparative information on all managed care and Medigap plans in the area where they live. To help make those comparisons meaningful, the budget would create standardized packages for additional benefits.

## HCFA's Competitive Pricing Demonstration in Denver

May 17, 1997

On Friday, a Federal judge issued a temporary restraining order allowing managed care plans to defer submitting bids for a new competitive pricing demonstration in Denver. As a result, these plans will be permitted to wait until the judge makes a final ruling on whether to make this a permanent restraining order. The final ruling is expected to be on June 12. This restraining order represents at least a temporary setback for the Administration's attempts to establish a market-oriented bidding process within the Medicare program.

Under current law, we are, on average, actually losing money for each enrollee who signs up for Medicare managed care. Despite the fact that we pay 95% of our average fee-for-service costs on payments to managed care plans, these payments are excessive because plans (whether purposefully or not) are attracting disproportionately healthy beneficiaries.

For the last two years we have been trying to set up a competitive bidding demonstration within Medicare to test the theory that the program would save money if it purchased health care more like the private sector. Not surprisingly, despite its rhetoric that Medicare should be more like the private sector, the managed care industry is quite satisfied with the current reimbursement structure and fights us every time we either try to inject competition into the program or in any other way try to address the current overpayment problem.

The industry usually wins the battle of public relations in these demonstration debates because they argue that competitive pricing will force them to reduce the extra benefits that they currently provide to beneficiaries. (Interestingly, before the ruling, a few plans secretly submitted bids for a benefit plan that mirror the benefits that most HMOs are currently offering in Denver; each of the bids came in below the rates we are now paying plans.)

At a time when we are being inaccurately criticized for our reluctance to advocate long overdue structural reforms to Medicare, this somewhat public feud with the industry may help us win points with the elite validators who heretofore have been criticizing us. Retired Senator Dave Durenberger has already offered to do whatever he can to help us highlight the inconsistencies of the industry's position. As a Republican who has consistently advocated a market-oriented approach to managed care purchasing, he could help us make our case. We are thinking about raising this issue with other validators as well and will keep you informed as further developments arise.

## Medicare Beneficiary Provisions in the Balanced Budget Agreement

- **The Balance Budget Agreement includes \$18 billion in savings from premiums**
  - About \$9 billion comes from extending the current law policy that beneficiaries contribute to 25% of Part B costs. Without this extension, premiums would decline to 20% of program costs by 2002.
  - Another \$9 billion comes from gradually including home health in the 25% premium.
- **Of the \$18 billion in savings, fully half will be reinvested in new benefits**
  - **Preventive services: \$3 to 4 billion**

All 38 million beneficiaries will benefit from this investment that includes services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.
  - **Protection against excessive hospital outpatient coinsurance: \$4 billion**

Under current law, the coinsurance for the 18 million Medicare beneficiaries who use hospital outpatient departments is 46%. Without a change in this policy, the coinsurance will continue to increase.

The Balanced Budget Agreement stops this upward coinsurance liability and makes a down payment on eventually bringing it back to the traditional 20%.
  - **Premium assistance for low-income beneficiaries: \$1.5 billion**

About 2.5 million Medicare beneficiaries have incomes between 125 and 150 percent of poverty. Over one-third of them are widows age 75 and older. Elderly between 100 and 150 percent of poverty already spend about 30 percent of their family income on out-of-pocket health costs including Medicare Part B premiums.

The Balanced Budget Agreement extends premium assistance to beneficiaries above today's Medicaid protections (120% of poverty, about \$9,500 for a single).
- **The other \$9 billion is dedicated directly to extending the life of the Medicare Trust Fund**
  - The reallocation of a portion home health expenditures to Part B of Medicare helps extend the life of the Trust Fund for at least a decade.
  - Because this reallocation is gradually added to the Part B premiums, beneficiaries' premiums contribute directly to those extra years of Medicare solvency.

Note: Total Premium Contributions: About \$106 billion over 10 years  
New Benefits: About \$31 billion over 10 years (30% of premium contribution)  
Amount directly dedicated to extending the life of the Trust Fund: About \$40 billion over 10 years

**Q: THE REPUBLICANS ARE PROVIDING NUMBERS THAT SHOW THAT THE MEDICARE CUTS YOU SAID WOULD DEVASTATE THE PROGRAM IN THE LAST DEBATE ARE ESSENTIALLY THE SAME YOU NOW ENDORSE. DOESN'T THIS PROVE YOU WERE DEMAGOGING THE ISSUE?**

**A: It is true that the Medicare savings in the Balance Budget Agreement meet the Republicans half-way. The seven-year savings in the Budget Agreement are about \$70 billion below the Republican's 1995 budget.**

**However, there are fundamental differences between the 1997 Balanced Budget Agreement and the Medicare proposal the President vetoed.**

- 1) Vetoed Budget had premiums that were about \$18 more per month than in the 1997 Balanced Budget Agreement. The monthly premium under the Budget Agreement will be about \$69 in 2002. If the policy were a 31.5% premium instead of 25%, this premium would be about \$87. On an annual basis, this difference is about \$215 for a single beneficiary, \$430 for a couple.**
- 2) Vetoed Budget would have raised the percent of the program funded by beneficiaries by over one fourth. The 1997 Balanced Budget Agreement keeps the Medicare Part B premium at its current level of 25% of program costs — far below 31.5% the 1995 Republican Budget that the President vetoed.**
- 3) Vetoed Budget's investments are only 1% of the 1997 Balanced Budget Agreement's investments. The Budget Agreement includes critical investments:**
  - Preventive services: \$3 to 4 billion, including services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.**
  - Protection against excessive hospital outpatient coinsurance: \$4 billion**
  - Premium assistance for low-income beneficiaries: \$1.5 billion**

In contrast, the vetoed Budget included extremely modest investments, \$100 million for coverage of oral breast cancer drugs.

- 4) Vetoed Budget had larger provider reductions. The vetoed Budget had policies that put much tighter constraints on provider payment growth. For example, the reduction in the rate of increase in Medicare's hospital payments was twice as big as that needed to hit the budget agreement's target.**
- 5) Vetoed Budget included flawed structural reforms. The 1997 Balanced Budget Agreement does not sanction the use of balance billing, association plans, and other ideas that put beneficiaries at risk.**

**DRAFT PRELIMINARY: FOR INTERNAL USE ONLY**  
**Medicare Monthly Premiums**  
*(CBO January 1997 Baseline, Calendar Years)*

	1998	1999	2000	2001	2002	1998-2002
<b>Current Law Which</b>						
Declines to about 20% by 2002*	\$45.80	\$47.10	\$48.50	\$50.00	\$51.50	
<b>Budget Agreement</b>						
25% Premium *	\$45.80	\$49.50	\$52.50	\$55.90	\$61.20	
25% Premium w/ Home Health by 2004						
Based on CBO Scoring as of 5/1/97 **	\$46.80	\$51.70	\$55.90	\$60.70	\$67.60	
HH Component Relative to 25%	\$1.00	\$2.20	\$3.40	\$4.80	\$6.40	
Revised Based on New CBO Scoring **	\$47.00	\$52.10	\$56.60	\$61.80	\$69.30	
HH Component Relative to 25%	\$1.20	\$2.60	\$4.10	\$5.90	\$8.10	
31.5% Premium w/ Home Health by 2004**	\$59.20	\$65.60	\$71.30	\$77.90	\$87.30	
<b>Monthly Difference in 2002 between</b>						
<b>25% Premium w/ Home Health and:</b>						
Current Law (about 20% by 2002)	\$1.20	\$5.00	\$8.10	\$11.80	\$17.80	
25% Premium	\$1.20	\$2.60	\$4.10	\$5.90	\$8.10	
31.5% Premium	-\$12.20	-\$13.50	-\$14.70	-\$16.10	-\$18.00	
31.5% Premium Annual Difference	-\$146	-\$162	-\$176	-\$193	-\$216	-\$894
31.5% Premium Annual Difference/Couple	-\$293	-\$324	-\$353	-\$386	-\$432	-\$1,788

\* CBO scoring

\*\* Administration staff estimates based on CBO scoring

NOTE: There are several ways to calculate how home health is included: CBO has already produced 3 sets of numbers

The Medicare Actuaries would suggest that none of the 3 CBO methods would be what they would use.

The method recommended by the Actuaries is used in the bolded bank of numbers

The 25% premium is based on CBO's March scoring of the President's budget.

It is likely that it will decrease with additional Part B savings in the \$115 b package



to the fee-for-service plan. (This provision is consistent with bipartisan legislation pending before Congress.)

**Provides new private plan choices (through new PPO and Provider Service Network choices) for beneficiaries.**

## **Provider impact**

### **Hospitals**

**Through a series of traditional savings (reductions in hospital updates, capital payments, etc.), achieves about \$33 billion in savings over 5 years (about \$45 billion over 6 years).**

**Establishes new provider service networks (PSNs), which will allow hospitals (and other providers) to establish their own health care plans to compete with current Medicare HMOs.**

**Establishes a new pool of funding, about \$11 billion over 5 years (about \$14 billion over 6 years) for direct payment to academic health centers by carrying out medical education and disproportionate share (DSH) payments from the current Medicare HMO reimbursement formula to ensure that academic health centers are compensated for teaching costs.**

### **Managed care**

**Through a series of policy changes, the plan will address the flaws in Medicare's current payment methodology for managed care. Medicare will reduce reimbursement to managed care plans by approximately \$34 billion over 5 years (\$46 billion over 6 years). Savings will come from three sources:**

**(1) The elimination of the medical education and DSH payments from the HMO reimbursement formula (these funds will be paid directly to academic health centers).**

**(2) A phased-in reduction in HMO payment rates from the current 95% of fee-for-service payments to 90%. A number of recent studies have validated earlier evidence that Medicare significantly overcompensated HMOs. The reduction does not start until 2000 and it accounts for a relatively modest \$6 billion in savings over 5 years (about \$8 billion over 6 years); and**

**(3) Indirect savings attributable to cuts in the traditional fee-for-service side of the program (to the extent that HMO payments are based on a percentage of fee-for-service payments, HMO payments are reduced as the traditional side of the program is cut).**

<b>Home care</b>	<p>Saves about \$15 billion over 5 years (\$20 billion over 6 years) through the transition to and establishment of a new prospective payment system and a number of program integrity (anti-fraud and abuse) initiatives.</p> <p>Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. Originally designed as an acute care service for beneficiaries who had been hospitalized, home health care has increasingly become a chronic care benefit not linked to hospitalization. The President's proposal restores the original split of home health care payments between Parts A and B of Medicare. The first 100 home health visits following a 3-day hospitalization would be reimbursed by Part A. All other visits -- including those not following hospitalization -- would be reimbursed by Part B.</p> <p>Beneficiaries will not be affected by this restoration of the original policy; nor will it count toward the \$100 billion in savings in the President's plan. The policy avoids the need for excess in reductions in payments to hospitals, physicians, and other health care providers while helping to extend the solvency of the Part A Trust Fund.</p>
<b>Physicians</b>	<p>Saves about \$7 billion over 5 years (about \$10 billion over 6 years) through a modification of physician updates. This reduction is relatively small because Medicare has been relatively effective in constraining growth in reimbursement to physicians.</p>
<b>Skilled Nursing Facilities</b>	<p>Saves about \$7 billion over 5 years (\$9 billion over 6 years) through the establishment of a prospective payment system.</p>
<b>Fraud and Abuse</b>	<p>Saves about \$9 billion over 5 years through a series of provisions to combat fraud and abuse in areas such as home health care, and by repealing the provisions Congress enacted last year that weaken fraud and abuse enforcement.</p>
<b>Structural Reform</b>	<p><i>Brings the Medicare program into the 21st century by:</i></p> <ul style="list-style-type: none"> <li>(1) Establishing new private health plan options (such as PPOs and Provider Service Networks) for the program;</li> <li>(2) Establishing annual open enrollment for all Medicare plans</li> </ul>

within independent third party consumer consulting.

**(3) Establishing market-oriented purchasing for Medicare including the new prospective payment systems for home health care, nursing home care, and outpatient hospital services, as well as competitive bidding authority and the use of centers of excellence to improve quality and cut back on costs;**

**(4) Adding new Medigap protections to make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to opt for managed care because it addresses the fear that such a choice would lock them in forever.**

**Rural Health Care** The plan will have a very strong package of rural health care initiatives, including continuation and improvement of sole community and Medicare dependent hospital protections, the expansion of the so-called RPCH facilities that allow for designation of and reimbursement to facilities that are not full-service hospitals, and the modification of managed care payments to ensure they are adequate for rural settings. The rural hospital investment alone is \$1 billion over 5 years (\$1 billion over 6 years).

# Withdrawal/Redaction Marker

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	John Hilley & Chris Jennings to POTUS re: Suggested telephone call to Congressman Bill Thomas (2 pages)	5/5/97	P5, P6/b(6)

**This marker identifies the original location of the withdrawn item listed above.  
For a complete list of items withdrawn from this folder, see the  
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**COLLECTION:**

Clinton Presidential Records  
Domestic Policy Council  
Bruce Reed (Subject File)  
OA/Box Number: 21204

**FOLDER TITLE:**

Health Care-Medicare [1]

rs42

### RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(n)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

# Withdrawal/Redaction Marker

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. talking points	POTUS conversation with Congressman Thomas (2 pages)	5/97	P5

**This marker identifies the original location of the withdrawn item listed above.  
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Health Care-Medicare [ 1 ]

rs42

### RESTRICTION CODES

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MEMORANDUM

April 24, 1997

TO: Distribution List  
FR: Chris Jennings  
RE: Updated Medicare Trust Fund Talking Points

Attached are the updated Medicare Trust Fund talking points that were revised after the report was released. I have also attached a letter from HCFA's Chief Actuary confirming that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

We hope you find this information useful. Please call me at x6-5560 if you have any questions.

## **MEDICARE TRUST FUND TALKING POINTS**

April 24, 1997

**THE MEDICARE TRUSTEES REPORT CONFIRMS WHAT THE PRESIDENT HAS CONSISTENTLY STATED -- THAT REPUBLICANS AND DEMOCRATS SHOULD COME TOGETHER AND ENACT MEDICARE REFORM THIS YEAR.**

- The 1997 Trustees Report estimates that the Medicare Trust Fund will remain solvent until 2001.

**WE WELCOME CONCERNS ABOUT THE TRUST FUND. PRESIDENT CLINTON HAS BEEN ACTING TO ADDRESS THE PROBLEM SINCE HE TOOK OFFICE.**

- The President's 1993 Economic Plan extended the life of the Trust Fund by three years.
- In 1994, the reforms included in the Health Security Act would have strengthened the Trust Fund by five years.
- In 1995 and 1996, the President proposed Medicare reforms in the context of his balanced budget that would have extended the life of the Trust Fund for at least a decade.

**THIS YEAR THE PRESIDENT'S BALANCED BUDGET GUARANTEES THE LIFE OF THE TRUST FUND AT LEAST A DECADE.**

- An April 24, 1997 letter from HCFA's Chief Actuary confirms that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

**ACTION IS NEEDED -- REPUBLICANS AND DEMOCRATS SHOULD USE THIS OPPORTUNITY TO COME TOGETHER IN A BIPARTISAN MANNER TO ADDRESS THE NEED FOR REAL MEDICARE REFORM.**

- **The need for responsible intervention to improve the Trust Fund is real.** The President has a proposal that addresses this need in a responsible way, without imposing devastating provider cuts, increasing beneficiary costs, or enacting structural changes that devastate the program and the people it serves.
- **This report should not be used irresponsibly.** The upcoming Trust Fund report should not be used to recklessly frighten the 38 million Medicare beneficiaries and their families into thinking that their benefits are in imminent danger. They simply are not.
- **We have time to act this year.** Over \$120 billion remains in the Trust Fund (as of March 1997). While incoming revenues are somewhat less than outgoing payments, the current balance in the Trust Fund means that there is no danger that claims will not be paid.

**IT IS TIME TO PUT PARTISAN DIFFERENCES ASIDE AND AGREE ON MEDICARE REFORMS THAT WILL EXTEND THE LIFE OF THE TRUST FUND AND STRENGTHEN THE MEDICARE PROGRAM.**



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care  
Financing Administration

## Memorandum

Date April 24, 1997

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for the HI Trust Fund under the Medicare Legislative Proposals in the President's 1998 Budget, Based on 1997 Trustees Report Assumptions

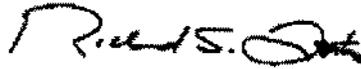
To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare legislative proposals developed for the President's 1998 Budget. Based on the intermediate set of assumptions in the 1997 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in calendar year 2008 under the Budget proposals.

In the absence of corrective legislation, trust fund depletion would occur in calendar year 2001 based on the intermediate assumptions. Thus, the Budget proposals would postpone the year of exhaustion by about 7 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Budget proposals is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Medicare proposals in the President's 1998 Budget, we would be happy to provide it.

  
Richard S. Foster, F.S.A.

Medicare

MEMORANDUM

April 3, 1997

TO: Bruce  
FR: Chris  
RE: Medicare Options

As I mentioned, Erskine asked for a list of additional Medicare savings so that our policy would score at \$100 billion and \$115 billion over five years according to the Congressional Budget Office numbers. Attached is the paper that we worked off of yesterday to get to those numbers.

In short, we believe that we can get \$100 billion in Medicare savings without any further beneficiary cuts. These savings would fall particularly hard on hospitals, but they are defensible policy-wise (if not politically).

If we want the additional \$15 billion in savings, however, new beneficiary cuts would be required. These cuts could include the high-income premium, calculating the home health reallocation in the premium, and/or dropping beneficiary investments that are now included in the President's budget. You should also keep in mind that if the CPI is put back on the table, these beneficiary cuts would be much more difficult to swallow for the aging advocacy community.

If you would like a briefing on this issue, please call me at 6-5560.

## MEDICARE OPTIONS

### 1. MOVE TO \$100 BILLION IN CBO-SCORED SAVINGS

- CBO scored the Administration's \$100 billion package as achieving only \$82 billion in savings over 5 years. Because of differences in baselines and assumptions, CBO said that our savings policies would save less than the HCFA actuaries project, and our new benefits and program improvements would cost more.
- To close the gap with CBO, we would need to consider adding additional savings policies, and modifying some new benefits. We could achieve most of the additional savings through policy changes that would not be particularly controversial.

For example, we could raise our CBO-scored savings by:

- **Convincing CBO to modify its scoring--\$1 billion.** We believe we should be able to recapture as much as \$1 billion in savings that CBO failed to credit because of misunderstandings about the Administration's proposals.
- **Dropping premium surcharge policy--\$3 billion.** Our budget included a policy to replace the premium surcharge assessed against Part B beneficiaries who enroll in the program after the deadline with a surcharge that reflects the actual cost to the Medicare program of late enrollment at a cost of \$1 billion. CBO scored this new policy as costing \$3 billion; HHS agrees that if we need more savings, this policy should be dropped.
- **Adopting PROPAC's recommendation for no hospital increase in 1998--\$4 billion.** PROPAC's recommendation, which was based on data showing high hospital profits from Medicare payments, would give PPS hospitals no increase in 1998. Our policy, which was determined before PROPAC made its recommendation, gives hospitals a 1.8% increase in 1998. If we were to adopt the PROPAC recommendation for 1998 and then return to our policy for 1999-2002, we could save about \$3 billion more, including an additional \$1 billion from its indirect effect on managed care.
- **Additional hospital reductions --\$4 to 5 billion.** This could include policies such as freezing the non-PPS hospital update (\$0.8 billion); reducing the PPS capital payments by 5% (\$2.0 billion); value of capital when ownership changes (\$0.3 billion); and reducing IME to 5.5% in FY 1999 (\$2.0 billion).
- **Other provisions -- \$5.5 billion.** Savings could be increased by speeding up the implementation of the incentives for high volume physicians (\$400 million); further reductions in skilled nursing facility payments (\$2 billion); and putting regulations reducing oxygen payments (\$1.3 billion) and therapy guidelines (\$1.8 billion) into legislation.

- Achieving more than \$100 billion in CBO-scored policies would require us to make more significant, and more controversial, changes in our original package, such as dropping some of the new benefits; increasing savings from hospitals by further reductions in hospital reimbursements; and adopting other beneficiary savings proposals.

## 2. MOVE TO PLAN X-- \$113 BILLION IN CBO-SCORED SAVINGS

- Plan X achieves \$113 billion in savings over 5 years. Savings from managed care are lower than our plan (\$20 billion rather than \$30 billion); hospital savings are higher (\$33 billion rather than \$25 billion); savings from other providers are comparable, and Plan X includes the home health transfer from Part A to Part B to extend the solvency of the Trust Fund.
- Relative to the Administration's plan, the major issues with Plan X are that it:
  - **does not include any new preventive benefits**, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;
  - **has a higher Part B premium** because it includes the home health spending transferred from Part A in the calculation of the premium;
  - **proposes to income-relate the Part B premium**;
  - **includes a Medicare MSA**; and
  - **cuts medical education funding more deeply** than the Administration and does not include the IME/GME/DSH carve-out policy.
- If the Administration attempts to achieve around \$113 billion in savings, possible options to achieve this number are:
  - **home health reallocation in the Part B premium--\$6 billion** (with low-income beneficiary protections). Approximately \$11 per month increase in 2002 but only for individuals over \$30,000 (less than one-third of beneficiaries) -- same proposal as Blue Dogs -- or other approaches to assure that low-income beneficiaries are not disproportionately affected.
  - **income-relate the Part B premium --\$3 to 6 billion**. This phases in payment of 75 percent of the Part B costs (triple the current premium) for high-income beneficiaries. This means that high-income beneficiaries will pay about \$184 a month, over \$2,000 more a year. The low-range estimate reflects the policy included in the Health Security Act (\$90,000 for singles, \$110,000 for couples) while the high-range estimate reflects a policy that begins the phase out at \$50,000 for singles, \$75,000 for couples.
  - **other provisions--\$3.2 billion**. Includes policies like lower SNF updates (MB-1) (\$0.7 billion); and redefine PPS discharges for home health (\$2.5 billion).

Note: One could substitute elimination of the coinsurance protections -- which ensure that beneficiaries are paying the 20 percent coinsurance that current law intended-- (\$7 billion over five years) for one of the two beneficiary provisions outlined above.

Relative to Plan X, we achieve the \$113 billion in savings in this option without dropping the preventive benefits and the Alzheimer's respite provision, and without including MSAs.

### 3. MOVE TO PLAN Y--\$143 BILLION IN CBO-SCORED POLICIES OVER 5 YEARS

- Plan Y achieves \$143 billion in savings over 5 years. Savings from managed care are lower than in the Administration's plan (\$18 billion as opposed to \$30 billion); savings from hospitals are substantially higher (\$54 billion as opposed to \$25 billion); savings from other providers are comparable; and Plan Y does include the transfer of home health spending from Part A to Part B to extend the solvency of the Trust Fund.
- Relative to the Administration's plan, the major issues with Plan Y are that it:
  - **does not include any new preventive benefits, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;**
  - **has a higher Part B premium** because it includes the home health spending transferred to Part B in the calculation of the premium;
  - **increases the Part B deductible from \$100 to \$150 and indexes it to inflation;**
  - **includes a Medicare MSA and private fee-for-service options** that appear to be similar to those in the vetoed balanced budget bill;
  - **includes much higher hospital cuts; and**
  - **cuts medical education funding more deeply than the Administration and does not include the IME/GME/DSH carve-out policy.**
- If the Administration attempts to achieve \$143 billion in savings, we would be forced to adopt some of the policies in Plan Y. For example, we would probably have to drop all new benefits, include significantly higher hospital reductions, and possibly adopt additional beneficiary reductions. **Achieving \$143 billion in savings is substantially more difficult than achieving \$100 billion or \$113 billion in savings. This would be the equivalent of having more than \$270 billion in savings over 7 years -- the same number that we criticized so strongly in the last Congress.**

**MEDICARE SAVINGS OPTIONS****\$100 BILLION****CBO Baseline****(Fiscal years, Dollars in billions)**

	1998-2002
<b>BASE PACKAGE SAVINGS</b>	<b>-81.6</b>
<b>ADDITIONAL SAVINGS</b>	<b>-18.7</b>
<b>CBO SCORING FIXES</b>	<b>-1.0</b>
<b>HOSPITALS</b>	
Freeze PPS Update in FY 1998 (MB - 1)	-4.1
Freeze non-PPS Update in FY 1998 (MB - 1.5)	-0.8
Reduce PPS capital payments by 5%	-2.0
Value of capital when ownership changes	-0.3
Reduce IME: 6.6% in FY 1998, 5.5% in FY 1999	-2.0
<b>SUBTOTAL</b>	<b>-9.2</b>
<b>PHYSICIANS</b>	
Begin incentives for high-volume in CY 1999	-0.4
<b>SKILLED NURSING FACILITIES</b>	
Require Secretary to eliminate case mix creep	-0.5
Eliminate new provider exemptions	-0.4
Remove new providers from FY 1995 base rates	-1.1
<b>SUBTOTAL</b>	<b>-2.0</b>
<b>OTHER</b>	
Legislation for 40% cut in oxygen (net of premium)	-1.3
Therapy guidelines	-1.8
<b>SUBTOTAL</b>	<b>-3.1</b>
<b>BENEFICIARIES</b>	
Eliminate premium surcharge	-3.0
<b>TOTAL MEDICARE SAVINGS</b>	<b>-100.3</b>

**MEDICARE SAVINGS OPTIONS****\$115 BILLION****CBO Baseline****(Fiscal years, Dollars in billions)**

	<b>1998-2002</b>
<b>BASE PACKAGE SAVINGS</b>	<b>-81.6</b>
<b>ADDITIONAL SAVINGS</b>	<b>-33.9</b>
<b>CBO SCORING FIXES</b>	<b>-1.0</b>
<b>HOSPITALS</b>	
Freeze PPS Update in FY 1998 (MB - 1)	-4.1
Freeze non-PPS Update in FY 1998 (MB - 1.5)	-0.8
Reduce PPS capital payments by 5%	-2.0
Value of capital when ownership changes	-0.3
Reduce IME: 6.6% in FY 1998, 5.5% in FY 1999	-2.0
<b>PPS redefined discharges: extend to HH</b>	<b>-2.5</b>
<b>SUBTOTAL</b>	<b>-11.7</b>
<b>PHYSICIANS</b>	
Begin incentives for high-volume in CY 1999	-0.4
<b>SKILLED NURSING FACILITIES</b>	
Require Secretary to eliminate case mix creep	-0.5
Eliminate new provider exemptions	-0.4
Remove new providers from FY 1995 base rates	-1.1
Update SNF PPS by MB - 1 for FY 1998-2002	-0.7
<b>SUBTOTAL</b>	<b>-2.7</b>
<b>OTHER</b>	
Legislation for 40% cut in oxygen (net of premium)	-1.3
Therapy guidelines	-1.8
<b>SUBTOTAL</b>	<b>-3.1</b>
<b>BENEFICIARIES</b>	
Eliminate premium surcharge	-3.0
Income-related premium, HSA level **	-3.0
Income-related premium, \$50/75	-6.0
Home health premium (Blue Dog approach)	-6.0
Eliminate OPD **	-7.0
<b>SUBTOTAL</b>	<b>-15.0</b>
** Note included in subtotal	
<b>TOTAL MEDICARE SAVINGS</b>	<b>-115.5</b>