

CJ-FYI - organizations opposing

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LEADERSHIP COUNCIL
-----of-----
AGING ORGANIZATIONS

June 11, 1997

U.S. House of Representatives
Washington, D.C.

Dear Commerce Committee Member:

The undersigned members of the Leadership Council of Aging Organizations (LCAO) are writing to express our shock and dismay at the decision by the Health and Environment Subcommittee to directly violate the budget agreement by not including agreed upon protections for vulnerable, low-income Medicare beneficiaries. We strongly urge you to support an amendment to provide low-income protections at a level consistent with the budget agreement.

An explicit provision of the budget agreement was a bipartisan commitment to spend \$1.5 billion over 5 years to ease the impact of increasing Medicare premiums on low-income beneficiaries. The budget includes a significant increase in Part B premiums, about \$15 more per month in 2002 relative to what beneficiaries would pay under current law (about \$66 instead of about \$51). For a low-income elderly couple, this means that they would have to pay Medicare premiums of \$1,594 per year (about \$360 more per year than under current law).

This would not be affordable for millions of low-income seniors just over the poverty line, who must also pay rising prescription drug costs and Medicare deductibles and copayments out-of-pocket. Without the full level of protection agreed upon, vulnerable beneficiaries will be forced to make sacrifices in such essential areas as food and shelter.

Under the Health and Environment Subcommittee proposal, less than half of the amount promised (\$600 million vs. \$1.5 billion) would be allocated to improve Medicare low-income protections. The proposal apparently would force many low-income seniors to pay all but \$5 of the Part B monthly premium in 2002, since only the portion directly attributable to the Medicare home health shift from Part A to Part B would be eligible for protection.

This is grossly inadequate, not only because the amount of protection is so meager, but because almost no one would actually receive it. Only 10% of those above poverty entitled to current premium protections are receiving the benefit. This is primarily due to lack of outreach and a confusing, intrusive application process that requires beneficiaries to sign up

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House Commerce Committee

at state welfare offices. Participation under the proposal will be even lower for a benefit of only \$5 per month.

The Health and Environment Subcommittee proposal is a clear violation of the terms of the bipartisan budget agreement. We strongly urge you to live up to the promises made by providing the full amount of low-income protections agreed upon.

AFSCME Retiree Program
Alzheimer's Association
American Association of Homes and Services for the Aging
American Geriatrics Society
Asociacion Nacional Pro Personas Mayores
Association for Gerontology and Human Development in Historically Black Colleges and Universities
Association for Gerontology in Higher Education
Association of Jewish Aging Services
Eldercare America, Inc.
Families USA
Gerontological Society of America
Gray Panthers
National Association of Meal Programs
National Association of Retired Federal Employees
National Caucus and Center on Black Aged, Inc.
National Committee to Preserve Social Security and Medicare
National Council on the Aging
National Council of Senior Citizens
National Hispanic Council on Aging
National Osteoporosis Foundation
National Senior Citizens Law Center
Older Women's League

Potomac Hill Budget
Meeting

TALKING POINTS FOR CONGRESSIONAL HEALTH BUDGET MEETING

June 3, 1997

- **HISTORICAL OPPORTUNITY.** This budget offers an unprecedented opportunity to pass the most significant health care reforms since Medicare and Medicaid were enacted over 30 years ago. If we succeed, we will:
 - Modernize and reform Medicare, extending the life of the Medicare Trust Fund for well over a decade, and lay the foundation for addressing the long-term financing challenges facing the program;
 - Offer states unprecedented flexibility to efficiently administer Medicaid; and
 - Extend health care coverage to millions of uninsured American children.
- **BIPARTISAN PROCESS.** We are at this point because of your cooperation and diligence in putting the interests of good policy ahead of partisan politics. This occurred both in the negotiations leading up to the budget agreement, and in the preparation for the upcoming mark-ups.
- In particular, Chairman Archer, Chairman Bliley, Subcommittee Chairman Thomas, and Subcommittee Chairman Bilirakis deserve great praise for how you have integrated our Democratic colleagues in the drafting of the respective mark-ups. I believe the final budget and the country will be all the better for the process you have established.
- **COMMON GROUND.** The result of this bipartisan work is a foundation of policies that we all agree will help reform the entitlement programs. These include:
 - Modernizing the program by offering more plan choices to Medicare beneficiaries. Mr. Thomas, you have been a leader in this area.
 - Reforming the fee-for-service program through prospective payment systems for home health, skilled nursing facilities, outpatient departments, and other fee-for-service providers. Mr. Thomas and Mr. Stark, you have been working on these issues for years.
 - Assuring that beneficiaries have adequate consumer and quality protections in both Medicare and Medicaid. Mr. Stark and Mr. Dingell, you have led the way here; and
 - Providing new Medicare preventive benefits, such as screening for cancer and diabetes self-management. Mr. Thomas, Mr. Bilirakis and Mr. Stark have worked diligently on these issues.

- **PRIORITIES.** At the beginning of the Congressional mark-up process, I would like to emphasize several of my priorities.

MEDICARE

- **Prudent purchasing reform.** I share your belief that Medicare will survive only if we take from the private sector its best lessons in competition and negotiation. That is why I hope you give serious consideration to proposals that give the Secretary the authority to negotiate lower prices through competitive bidding and other similar market-oriented mechanisms.
- **Immediate home health reallocation.** I support the immediate reallocation of long-term home health care to Part B because it is good policy. There is no reason to phase it in over time. Doing so will reduce how much we extend the life of the Trust Fund by at least two years.
- **Carving out academic health center payments from managed care.** I believe we should make it a priority for medical schools and other teaching facilities to be directly compensated for their unique additional costs -- and not dependent on whether managed care plans pass on the payment we give them for this purpose.
- **Medical Savings Accounts (MSAs).** Everyone in this room knows I have major concerns about a new Medicare Medical Savings Account. Such an approach will -- according to CBO -- cost the Trust Fund money and has great potential to adversely select healthy populations away from the traditional program. I don't believe we should move in this area.

MEDICAID

- **Disproportionate Share Hospital (DSH) reductions.** After major objections from Governors, among others, we agreed to drop the per capita cap proposal from our savings package. Now the Governors want to reduce the DSH reductions. We believe that our savings are achievable if DSH funds can be better targeted.
- **Medicaid investments.** Our investments were explicitly referenced in the budget agreement. If we can maintain our DSH savings -- as I believe we can, we should honor the agreement on the investments.

CHILDREN'S HEALTH INITIATIVE

- **Efficient investment for children's coverage.** One issue that I feel the most strongly about is the opportunity to expand children's coverage. I look forward to working with you on the most efficient way to provide meaningful coverage for up to 5 million children.

However, I have concluded that tax incentive approaches are not the best mechanisms to most efficiently target our limited \$16 billion children's health budget investment. I have become convinced that these approaches are administratively burdensome, costly and would not most efficiently pick up uninsured children. Therefore, I believe that the \$16 billion should be used through Medicaid or a capped mandatory grant option. If, however, you propose tax incentive options in the context of your tax cut proposals, I am open to reviewing them to determine their priority relative to other tax cut proposals.

- **CLOSING.** While we will not agree on everything at the beginning of this process, I am confident that we can build upon the strong bipartisan working relationship that we have developed, and finalize this historic agreement in a way that is acceptable to all.

FEDERAL HEALTH SPENDING GROWTH HAS SLOWED

Comparison of CBO's Projected and Actual FY 1998 Medicare and Medicaid Growth

Health Spending	Projected 1996 Growth	Actual 1996 Growth
MEDICARE	11.7%	7.9%
MEDICAID	11.0%	3.3%

Source: CBO's March 1995 baseline projection of FY 1998 spending (Medicare spending is gross spending), and CBO documents with actual FY 1996 growth distributed to Congressional staff, October 30, 1996

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File
⑤ Health Spending

MEDICARE BASELINE CHANGES

	Federal Spending: 1997 - 2002	Federal Spending: 2002	Per-Beneficiary Growth*: 1996-2002
March 1995 Baseline	\$1,513 billion	\$315 billion	8.2%
April 1996 Baseline	\$1,475 billion	\$301 billion	7.5%
<i>Difference Since March 1995</i>	<i>-\$38 billion</i>	<i>-\$14 billion</i>	
Possible 1997 Baseline	\$1,466 to \$1,439 billion	\$300 to \$291 billion	7.5% to 7.0%
<i>Difference Since March 1995</i>	<i>-\$47 to -\$74 billion</i>	<i>-\$15 to -\$24 billion</i>	

* Average for 1996 to 2002; Medicare is the gross spending per Part A enrollee
 Sources: The March 1995 and April 1996 estimates are based on CBO fact sheets. The "Possible 1997" baseline ranges were estimated: small change: August 1996 re-estimate of 1996 spending (CBO's August 1996 update) projected using April 1996 aggregate growth rates; larger change: reduces 1996 according to August 1996 update and assumes subsequent years' per-beneficiary growth is reduced by 0.5 percentage points in each year. THE POSSIBLE BASELINES ARE NOT FROM CBO; THEY ARE ONLY APPROXIMATIONS BASED ON THE INFORMATION AVAILABLE.

BUDGET PROPOSALS

	Cumulative Savings Targets			Federal Spending: 1997-2002	Federal Spending: 2002	Per-Beneficiary Growth: 1996-2002
	5 Years	6 Years	7 Years			
Republican BBA (12/95 score)	- \$119 b	- \$169 b	- \$226 b	\$1,258 b	\$246 b	5.6%
Breaux-Chafee Plan (5/96)			- \$154 b			
Republican Plan (5/96)	- \$114 b	- \$168 b	<i>- \$235 b</i>	\$1,307 b	\$248 b	4.6%
President's Plan (4/96)	- \$82 b	- \$116 b	<i>- \$157 b</i>	\$1,358 b	\$267 b	5.8%
Possible New Plan	- \$119 b	<i>- \$170 b</i>	<i>- \$233 b</i>	\$1,347 b	\$258 b	4.1%*

* This rate is for the 1997 to 2002 period since the budget period begins in 1998
 Source: The unitalicized and bold number are from CBO estimates; the italicized numbers were calculated by assuming that Federal spending in the subsequent year/s grows at the same rate as the last year of spending growth under the proposal scoring. The "Possible New Plan" adopts the scored savings stream from the BBA Act since it yield about \$116 b in 5 years, applied to the possible 1998 baseline (lower estimate).

MEDICAID BASELINE CHANGES

	Federal Spending: 1997- 2002	Federal Spending: 2002	Per-Beneficiary Growth*: 1996-2002
March 1995 Baseline	\$855 billion	\$178 billion	7.0%
April 1996 Baseline	\$803 billion	\$166 billion	6.8%
<i>Difference Since March 1995</i>	<i>-\$52 billion</i>	<i>-\$12 billion</i>	
Possible 1997 Baseline	\$766 to \$733 billion	\$158 to \$148 billion	6.8% to 6.0%
<i>Difference Since March 1995</i>	<i>-\$89 to -\$122 billion</i>	<i>-\$20 to -\$30 billion</i>	

* Average for 1996 to 2002; Federal benefits, administration and DSH spending per recipient

Sources: The March 1995 and April 1996 estimates are based on CBO fact sheets. The "Possible 1997" baseline ranges were estimated: small change: August 1996 re-estimate of 1996 spending (CBO's August 1996 update) projected using April 1996 aggregate growth rates; larger change: reduces 1996 according to August 1996 update and assumes subsequent years' per-beneficiary growth is reduced by 1 percentage points in each year. Also assumes lower recipient growth (average is 0.5 percentage points lower). THE POSSIBLE BASELINES ARE NOT FROM CBO; THEY ARE ONLY APPROXIMATIONS BASED ON THE INFORMATION AVAILABLE.

BUDGET PROPOSALS

	Cumulative Savings Targets			Federal Spending: 1997-2002	Federal Spending: 2002	Per-Beneficiary Growth: 1996-2002
	5 Years	6 Years	7 Years			
Republican BBA (12/95 score)	- \$53 b	- \$88 b	- \$133 b	\$694 b	\$127 b	1.7%
Breaux-Chafee Plan (5/96)	- \$28 b	- \$43 b	- \$62 b	\$759 b	\$152 b	5.1%
Republican Plan (5/96)	- \$42 b	- \$72 b	<i>- \$110 b</i>	\$731 b	\$137 b	3.4%
President's Plan (4/96)	- \$32 b	- \$54 b	<i>- \$82 b</i>	\$749 b	\$145 b	4.3%
Possible New Plan	- \$54 b	<i>- \$86 b</i>	<i>- \$130 b</i>	\$679 b	\$124 b	2.5%*

* This rate is for the 1997 to 2002 period since the budget period begins in 1998

Source: The unitalicized and bold number are from CBO estimates; the italicized numbers were calculated by assuming that Federal spending in the subsequent year/s grows at the same rate as the last year of spending growth under the proposal scoring. The "Possible New Plan" adopts the scored savings stream from the BBA Act since it yield about \$54 b in 5 years, applied to the possible 1998 baseline (lower estimate).

MEDICAID
Medicaid Policies to Achieve Targeted Savings

	Budget Period	Average Index*	Index in Last Year	Savings	Fed. Spending: 1997-2002	Fed. Spending: 2002
President's Plan: (1) CBO April 1996 baseline	1997-2002	4.8%	3.9% (GDP + 0%)	-\$54 b	\$749 b	\$145 b
President's Plan: (2) Possible 1997 Baseline	1998-2003	4.8%	3.9% (GDP + 0%)	-\$25 b	\$709 b	\$134 b
Possible New Plan (3) Possible 1997 Baseline	1998-2002	2.5%	1.4% (GDP- 2.5%)	-\$54 b	\$679 b	\$125 b

* Index average is for the year prior to implementation to the last year of the budget period

(1) President's FY 1997 budget as scored by CBO in April, 1996

(2) Same policies as in President's FY 1997 budget but implemented in 1998

(3) Assumes that per capita cap and DSH savings are about equal, and lowers the pool payments by \$5 billion

M E D I C A R E

B A C K U P

- March 95 Baseline
- Dec 95 Baseline
- April 96 Baseline
- Possible 97 Baseline
- Scenarios

MEDICARE: CBO Medicare March 1995 Baseline and Estimate of the Balanced Budget Act of 1995 (Dollars in billions; fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002		1997-2002	
									Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 5/10/95)												
Total (Gross) Spending (1)	178.2	199.1	219.4	240.4	263.4	288.1	315.2	345.3	1,870.9	9.6%	1,671.8	9.5%
Spending per capita (2)	4,815	5,292	5,743	6,207	6,712	7,245	7,833	8,479		8.2%		8.1%
Federal (Net) Spending	158.1	178.8	197.4	215.9	237.3	260.8	286.5	315.2	1,691.9	9.9%	1,513.1	9.8%
Spending per capita (2)	4,272	4,752	5,167	5,574	6,047	6,559	7,120	7,740		8.5%		8.4%
		11.2%	8.7%	7.9%	6.5%	8.5%	8.6%	8.7%				
CONFERENCE AGREEMENT (CBO Scoring, 11/16/95)												
Total Spending	178.2	195.6	209.8	218.2	227.9	248.7	267.8	290.2	1,658.2	6.8%	1,462.6	6.7%
Spending per capita (2)	4,815	5,199	5,491	5,633	5,808	6,254	6,655	7,126		5.4%		5.3%
Federal Spending	158.1	172.0	183.1	188.7	195.3	211.8	226.7	244.3	1,421.9	6.0%	1,249.9	5.9%
Spending per capita (2)	4,272	4,571	4,792	4,872	4,977	5,326	5,634	5,999		4.6%		4.6%
		7.0%	4.8%	1.7%	2.2%	7.0%	5.8%	6.5%				
Total Savings		-6.8	-14.3	-27.2	-42.0	-49.0	-59.8	-70.9	-270.0		-263.2	
Premium Savings		-3.3	-4.7	-5.0	-6.5	-9.6	-12.4	-15.8	-57.3		-54	

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

(1) Mandatory spending, including PROs. This baseline does not include the CPI adjustment made by CBO in September 1995.

(2) Spending divided by CBO's March 1995 Part A enrollment

MEDICARE: DRAFT PRELIMINARY CBO Medicare December Baseline (Dollars in billions; fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002		1997-2002	
									Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 12/22/95) (1)												
Total (Gross) Spending	177.4	186.4	215.9	236.4	258.1	280.7	305.3	331.8	1824.6	9.1%	1628.2	9.0%
Spending per capita (2)	4,714	5,132	5,556	6,002	6,473	6,953	7,475	8,034		7.8%		7.7%
Federal (Net) Spending	157.2	176.5	195.0	213.1	233.9	254.8	278.3	303.6	1654.6	9.5%	1478.1	9.3%
Spending per capita (2)	4,177	4,812	5,018	5,411	5,851	6,311	6,814	7,351		8.1%		7.9%
		10.4%	8.8%	7.8%	8.1%	7.9%	8.0%	7.9%				
REPUBLICANS' CONFERENCE AGREEMENT (CBO SCORING 12/13/95)												
Total Spending	177.4	192.9	206.6	218.6	230.3	248.0	267.0	288.6	1652.0	6.9%	1459.1	6.9%
Spending per capita (2)	4,714	5,041	5,316	5,550	5,776	6,143	6,538	6,988		5.6%		5.6%
Federal Spending	157.2	170.1	181.2	190.3	199.1	213.0	229.3	245.8	1427.8	6.3%	1257.7	6.3%
Spending per capita (2)	4,177	4,445	4,663	4,832	4,983	5,276	5,590	5,952		5.0%		5.0%
		6.4%	4.9%	3.6%	3.3%	5.7%	6.0%	6.5%				
Savings	0	-6.4	-13.8	-22.8	-34.2	-41.8	-50.0	-57.8	-172.5		-220.4	
Premium Savings		-2.9	-4.5	-5.0	-6.4	-8.1	-11.7	-14.6	-54.2			
PRESIDENT (CBO SCORING 12/13/95)												
Total Spending	177.4	185.2	212.6	229.6	245.9	263.9	284.5	306.3	1738.0	7.6%	1542.8	7.6%
Spending per capita (2)	4,714	5,101	5,471	5,829	6,167	6,537	6,966	7,417		6.4%		6.3%
Federal Spending	157	175	192	207	221	236	254	273	1557.4	7.6%	1382.1	7.3%
Spending per capita (2)	4,177	4,581	4,836	5,248	5,540	5,848	6,217	6,603		6.3%		6.0%
		9.7%	7.7%	6.3%	5.6%	5.6%	6.3%	6.2%				
Savings		-1.2	-3.2	-6.4	-12.4	-18.7	-24.4	-30.9	-87.2		-96	
Premium Savings		0	0.1	0.4	-0.2	-1.8	-3.6	-5.4	-10.6			

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.
 (1) Mandatory spending, including PROs.
 (2) Spending divided by HCFA's unduplicated beneficiary projections.
 (3) Savings from SBC/HBC Majority Staff, 12/95/95 based on CBO estimates.
 (4) HCFA estimates based on CBO estimates.
 (5) Does not include the \$8.2 billion in new revenues from HI tax.

MEDICARE: CBO Medicare March 1996 Baseline and Estimates of 1996 Proposals (Dollars in billions; fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	1996-2002		1997-2002	
										Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 4/17/96)													
Total (Gross) Spending (1)	177.1	196.1	215.5	236.4	257.4	279.5	303.2	328.5	357.0	1,816.6	9.0%	1,620.5	8.8%
Spending per capita (2)	4,799	5,229	5,656	6,124	6,583	7,076	7,580	8,091			7.5%		7.4%
Part A Spending	113.6	126.0	138.0	150.5	162.9	175.6	189.0	203.0		1,145.0	8.3%		
Part B Spending	63.5	70.1	77.5	85.9	94.5	103.9	114.2	125.6		671.7	10.2%		
Federal (Net) Spending	156.9	178.1	194.9	213.8	233.4	254.4	277.0	301.2	328.4	1,650.8	9.4%	1,474.7	9.1%
Spending per capita (2)	4,252	4,696	5,115	5,539	5,989	6,441	6,925	7,419			7.9%		7.7%
		10.4%	8.9%	8.9%	7.8%	7.9%	7.5%	7.1%					
REPUBLICANS' CONFERENCE AGREEMENT BUDGET RESOLUTION (5/13/96)													
Total Spending	177.1	196.4	208.8	223.7	235.5	248.4	263.0	278.4		1,654.2	6.0%	1,457.8	5.9%
Spending per capita (2)	4,799	5,237	5,480	5,795	6,024	6,289	6,575	6,857			4.6%		4.6%
Part A Spending (3)	113.6	126.0	133.0	140.5	146.9	152.6	159.0	163.9		1,021.9	4.5%		
Part A Savings	-	-	-5.0	-10.0	-16.0	-23.0	-30.0	-39.0		-123.0			
Part B Spending (3)	63.5	70.4	75.9	83.6	88.7	95.0	102.1	111.1		626.8	7.9%		
Part B Savings	-	0.3	-1.6	-2.3	-5.8	-8.9	-12.1	-14.5		-44.9			
Federal Spending	156.9	178.4	188.3	201.5	211.6	222.5	234.9	247.7	261.1	1,482.9	5.8%	1,306.5	5.6%
Spending per capita (2)	4,252	4,704	4,942	5,220	5,413	5,633	5,873	6,100			4.4%		4.3%
Total Savings		0.3	-6.6	-12.3	-21.8	-31.9	-42.1	-53.5	-67.3	-167.9		-168.2	
Premium Savings (3)		0	0.1	0.4	0.1	-0.8	-1.9	-3.4		-5.5			
PRESIDENT (CBO SCORING 4/17/96)													
Total Spending	177.1	196.6	209.2	227.0	241.4	257.9	276.2	297.7		1706.0	7.2%	1,509.4	7.3%
Spending per capita (2)	4,799	5,243	5,491	5,881	6,174	6,529	6,805	7,333			5.6%		6.0%
Part A Spending (4)	113.6	126.2	133.5	143.7	152.8	162.0	172.1	183.5		1073.9	8.4%		
Part A Savings	-	0.2	-4.5	-6.8	-10.1	-13.6	-16.9	-19.5		-71.1			
Part B Spending (4)	63.5	70.4	75.9	83.6	88.7	95.0	102.1	111.1		626.8	7.9%		
Part B Savings	-	0.3	-1.6	-2.3	-5.8	-8.9	-12.1	-14.5		-44.9			
Federal Spending	156.9	176.6	188.7	204.8	217.5	232.0	248.1	267.0	287.3	1534.7	7.1%	1,358.1	7.2%
Spending per capita (2)	4,252	4,709	4,953	5,306	5,563	5,873	6,203	6,578			5.7%		5.6%
Total Savings		0.5	-6.2	-9	-15.9	-22.4	-28.9	-34.2	-41.1	-116.1		-116.6	
Premium Savings		0	0.1	0.4	0.1	-0.8	-1.9	-3.4		-5.5			

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

(1) Mandatory spending, including PROs.

(2) Spending divided by CBO's March 1996 Part A enrollment

(3) The Part A savings are from the budget resolution; the resolution specifies that the Part B savings are the same as the President's; assumes President's premium savings

(4) CBO does not include the Home Health shift from Part A to Part B, which would decrease Part A spending and increase Part B spending by \$55.8 b (97-02).

NOTE: The 2003 savings were estimated assuming that the Federal spending in 2003 grows at the same rate as Federal spending in 2002

POSSIBLE Reduction in Medicare Spending
(Fiscal years, dollars in billion)

	1996	1997	1998	1999	2000	2001	2002	1996-2002 Total	Growth 96-02	1997-2002 Total	Growth 97-02
CBO MARCH 1996 BASELINE											
Total (Gross) Spending (1)	196.1	215.5	236.4	257.4	279.5	303.2	328.5	1,816.6	9.0%	1,620.5	8.8%
Spending per capita (2)	5,229	5,656	6,124	6,583	7,076	7,580	8,091		7.5%		7.4%
Federal (Net) Spending	176.1	194.9	213.8	233.4	254.4	277.0	301.2	1,650.8	9.4%	1,474.7	9.1%
Spending per capita (2)	4,696	5,115	5,539	5,969	6,441	6,925	7,419		7.9%		7.7%
1996 Reduction, Same Growth (3)											
Total (Gross) Spending (1)	195.1	214.4	235.2	256.1	278.1	301.7	326.8	1,807.3	9.0%	1,612.2	8.8%
Spending per capita (2)	5,203	5,627	6,093	6,550	7,040	7,541	8,050		7.5%		7.4%
Federal (Net) Spending	175.1	193.8	212.6	232.1	253.0	275.4	299.5	1,641.4	9.4%	1,466.3	9.1%
Spending per capita (2)	4,669	5,086	5,507	5,935	6,404	6,886	7,377		7.9%		7.7%
Federal Spending Difference:								-9.4		-8.4	
1996 Reduction, Lower Growth (4)											
Total (Gross) Spending (1)	195.1	213.4	233.0	252.5	273.0	294.7	317.8	1,779.6	8.5%	1,584.5	8.3%
Spending per capita (2)	5,203	5,601	6,037	6,459	6,910	7,368	7,828		7.0%		6.9%
Federal (Net) Spending	175	192.8	210.4	228.5	247.9	268.5	290.5	1,613.8	8.8%	1,438.7	8.5%
Spending per capita (2)	4,669	5,061	5,451	5,845	6,275	6,713	7,155		7.4%		7.2%
Federal Spending Difference:								-37.0		-36.0	

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

(1) Mandatory spending, including PROs.

(2) Spending divided by CBO's March 1996 Part A enrollment

(3) CBO's August 1996 update says that its April 1996 estimates are \$1 billion too high; this assumes lower 1996 but April 1996 gross and federal spending growth

(4) Assumes (a) 1996 spending is \$1 billion less; (b) revenues are the same as April; and

(c) gross spending per beneficiary is 0.5 percentage points lower than April 1996 baseline. Assumes Part A enrollment is unchanged.

MEDICARE: Illustration of Savings Relative to CBO Baseline (Dollars in billions; fiscal years)

NOTE: These estimates are based purely on savings targets, not scored policies; savings from policies change with different effective dates and baseline assumptions.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	1996-2002		1997-2002	
										Total	Growth	Total	Growth
1. MARCH 1996 BASELINE													
Total (Gross) Spending (1)	196.1	215.5	236.4	257.4	279.5	303.2	328.5	357.0	388.9	1,816.6	9.0%	1,620.5	8.8%
Spending per capita (2)	5,229	5,656	6,124	6,583	7,076	7,580	8,091				7.5%		7.4%
Federal (Net) Spending	176.1	194.9	213.8	233.4	254.4	277.0	301.2	328.4	359.0	1,650.8	9.4%	1,474.7	9.1%
Spending per capita (2)	4,696	5,115	5,539	5,969	6,441	6,925	7,419				7.9%		7.7%
		8.9%	8.3%	7.8%	7.9%	7.5%	7.1%						
2. PRESIDENT'S CURRENT POLICY (3)													
Total Spending	196.6	209.2	227.0	241.4	257.9	276.2	297.7			1,706.0	7.2%	1,509.4	7.3%
Spending per capita (2)	5,243	5,491	5,881	6,174	6,529	6,905	7,333				5.8%		6.0%
Federal Spending	176.6	188.7	204.8	217.5	232.0	248.1	267.0	287.3	309.2	1,534.7	7.1%	1,358.1	7.2%
Spending per capita (2)	4,709	4,853	5,306	5,563	5,873	6,203	6,576				5.7%		5.8%
Total Savings	0.5	-6.2	-9	-15.9	-22.4	-28.9	-34.2	-41.1	-49.8	-116.1		-116.6	
Premium Savings	-	0.1	0.4	0.1	-0.8	-1.9	-3.4					-6.5	
3. SAME YEARLY TARGET BUT 1998 IMPLEMENTATION (4) *													
Total Spending	196.1	215.5	230.1	248.0	263.5	281.6	301.5			1,736.3	7.4%	1,540.2	6.9%
Spending per capita (2)	5,229	5,656	5,961	6,343	6,671	7,040	7,426				6.0%		5.6%
Federal Spending	176.1	194.9	207.6	224.4	238.5	254.6	272.3	291.2	311.5	1,568.4	7.5%	1,392.3	6.9%
Spending per capita (2)	4,696	5,115	5,378	5,739	6,038	6,365	6,707				6.1%		5.8%
Total Savings	-	-	-6.2	-9	-15.9	-22.4	-28.9	-37.2	-47.5	-82.4		-82.4	
Premium Savings	-	-	0.1	0.4	0.1	-0.8	-1.9					-2.1	
4. SAME TARGET (ABOUT \$124 B) BUT 1998 IMPLEMENTATION (5) *													
Total Spending	196.1	215.5	229.9	243.2	256.8	269.8	288.6			1,699.7	6.7%	1,503.6	6.0%
Spending per capita (2)	5,229	5,656	5,956	6,220	6,496	6,745	7,108				5.2%		4.7%
Federal Spending	176.1	194.9	207.4	219.6	231.6	242.8	259.4	277.1	296.1	1,531.8	6.7%	1,355.7	5.9%
Spending per capita (2)	4,696	5,115	5,373	5,616	5,863	6,070	6,389				5.3%		4.5%
Total Savings	-	-	-6.4	-13.8	-22.8	-34.2	-41.8	-51.3	-62.9	-119.0		-119.0	
Premium Savings	-	-	0.1	0.4	0.1	-0.8	-1.9					-2.1	

MEDICARE: Illustration of Savings Relative to CBO Baseline (Dollars in billions; fiscal years)

NOTE: These estimates are based purely on savings targets, not scored policies; savings from policies change with different effective dates and baseline assumptions.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	1996-2002		1997-2002	
										Total	Growth	Total	Growth
5. POSSIBLE 1997 BASELINE (6)													
Total (Gross) Spending (1)	195.1	213.4	233.0	252.5	273.0	294.7	317.8	343.8	372.8	1,779.6	8.5%	1,584.5	8.3%
Spending per capita (2)	5,203	5,601	6,037	6,459	6,910	7,368	7,828				7.0%		6.9%
Federal (Net) Spending	175.0	193.7	212.5	231.9	252.8	275.3	299.3	326.3	356.8	1,640.5	9.4%	1,465.5	9.1%
Spending per capita (2)	4,667	5,084	5,504	5,932	6,400	6,882	7,372				7.9%		7.7%
		8.9%	8.3%	7.8%	7.9%	7.5%	7.1%						
6. SAME YEARLY TARGET BUT 1998 IMPLEMENTATION (4) *													
Total Spending	195.1	213.4	226.7	243.1	257.0	273.1	290.8			1,699.3	6.9%	1,504.2	6.4%
Spending per capita (2)	5,203	5,601	5,874	6,219	6,505	6,828	7,163				5.5%		5.0%
Federal Spending	175.0	193.7	206.3	222.9	236.9	252.9	270.4	289.2	309.3	1,558.1	7.5%		6.9%
Spending per capita (2)	4,667	5,084	5,344	5,702	5,998	6,322	6,661				6.1%		5.6%
Total Savings	-	-	-6.2	-9	-15.9	-22.4	-28.9	-37.2	-47.5	-82.4			-82.4
Premium Savings	-	-	0.1	0.4	0.1	-0.8	-1.9						-2.1
7. POSSIBLE 1997 BASELINE & SAME TARGET (ABOUT \$124 B) BUT 1998 IMPLEMENTATION (5) *													
Total Spending	195.1	213.4	226.5	238.3	250.1	261.3	277.9			1,662.7	6.1%	1,467.6	5.4%
Spending per capita (2)	5,203	5,601	5,869	6,096	6,330	6,533	6,845				4.7%		4.1%
Federal Spending	175.0	193.7	206.1	218.1	230.0	241.1	257.5	275.1	293.9	1,521.5	6.7%	1,346.5	5.9%
Spending per capita (2)	4,667	5,084	5,338	5,579	5,823	6,027	6,343				5.2%		4.5%
Total Savings	-	-	-6.4	-13.8	-22.8	-34.2	-41.8	-51.3	-62.9	-119.0			-119.0
Premium Savings	-	-	0.1	0.4	0.1	-0.8	-1.9						

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

(1) Mandatory spending, including PROs.

(2) Spending divided by CBO's March 1996 Part A enrollment

(3) As scored by CBO on 4/17/96

(4) Assumes the same program savings and premium revenue as 4/96 score; just begins this in 1998.

(5) Assumes Federal savings targets equal to the first five years of BBA as scored on the Dec 95 baseline (\$226 b); assumes same premium changes as current policy.

(6) Assumes that 1996 is lowered by \$1 billion (per CBO August 1996 report) and no change in growth rates. Note: it is likely that the baseline will go down by more than \$10 bil

* NOTE: THIS IS ILLUSTRATIVE; CBO WOULD NOT SCORE THESE SAVINGS.

NOTE: The 2003 savings were estimated assuming that the Federal spending in 2003 grows at the same rate as Federal spending in 2002

M E D I C A I N

B A C K u p

March '95 Baseline

Dec '96 Baseline

April '96 Baseline

Passible '97 Baseline

Scenarios

MEDICAID: CBO March 1995 Baseline: Medicaid Federal Expenditures (Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002		1997-2002	
									Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 4/95)												
Total Spending	89.2	99.1	109.9	122.0	134.7	148.1	162.9	177.6	954.3	10.2%	855.2	10.1%
Spending per capita	2,423	2,581	2,750	2,962	3,176	3,391	3,631	3,868		7.0%		7.1%
		6.5%	6.6%	7.7%	7.2%	6.8%	7.1%	6.5%				
REPUBLICANS' CONFERENCE AGREEMENT (CBO SCORING 11/95)												
Total Spending	89.2	96.9	104.2	108.6	113.2	118.1	122.5	127.2	790.9	4.6%	694.0	4.1%
Spending per capita	2,423	2,524	2,608	2,638	2,670	2,704	2,732	2,770		1.6%		1.2%
		4.2%	3.3%	1.1%	1.2%	1.3%	1.0%	1.4%				
Savings		-2.2	-5.7	-13.4	-21.5	-30.0	-40.3	-50.4	-163.4		-161.2	

MEDICAID: CBO December 1995 Baseline: Medicaid Federal Expenditures (Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002		1997-2002	
									Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 12/14/95)												
Total Spending	89.1	97.2	107.2	118.1	129.7	142.5	156.8	172.6	924.1	10.0%	826.9	10.0%
Spending per capita	2,519	2,855	2,815	3,019	3,223	3,439	3,697	3,966		6.9%		7.1%
		5.4%	6.0%	7.3%	6.8%	6.7%	7.5%	7.3%				
REPUBLICANS' CONFERENCE AGREEMENT (CBO SCORING 12/13/95)												
Total Spending	89.1	97.1	104.3	108.7	113.4	118.1	122.3	127.4	791.3	4.6%	694.2	4.1%
Spending per capita	2,519	2,853	2,739	2,779	2,818	2,850	2,884	2,927		1.7%		1.3%
		5.3%	3.2%	1.5%	1.4%	1.1%	1.2%	1.5%				
Savings		-0.1	-2.9	-9.4	-16.3	-24.4	-34.5	-45.2	-132.8		-132.7	
REPUBLICANS' OFFER 12/15 (1)												
Total Spending	89.1	97.1	106.3	113.7	117.4	122.1	123.3	127.4	807.3	4.6%	710.2	3.7%
Spending per capita	2,519	2,853	2,791	2,907	2,918	2,947	2,907	2,927		1.7%		1.0%
		5.3%	5.2%	4.2%	0.4%	1.0%	-1.3%	0.7%				
Savings	0.0	-0.1	-0.9	-4.4	-12.3	-20.4	-33.5	-45.2	-116.8		-116.7	
PRESIDENT'S (CBO SCORING 1/6/95)												
Total Spending	89.1	97.2	107.2	116.1	122.7	132.5	143.8	153.6	873.1	7.9%	775.9	7.5%
Spending per capita	2,519	2,855	2,814	2,968	3,049	3,198	3,391	3,529		4.9%		4.6%
		5.4%	6.0%	5.5%	2.7%	4.9%	6.0%	4.1%				
Savings		0	0	-2	-7	-10	-13	-19	-51.0		-51.0	
COALITION (Preliminary score from CBO) (2)												
Total Spending	89.1	97.1	101.3	110.3	118.0	127.4	137.4	148.6	840.1	7.3%	743.0	8.0%
Spending per capita	2,519	2,853	2,660	2,820	2,933	3,075	3,240	3,414		4.3%		5.1%
		5.3%	0.3%	6.0%	4.0%	4.8%	5.4%	5.4%				
Savings		-0.1	-5.9	-7.8	-11.7	-15.1	-19.4	-24	-84.0		-83.9	

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100. Assumes current CBO enrollment trends (no coverage loss).

(1) Savings from SBC/HBC Majority Staff, 12/15/95 based on CBO estimates.

(2) Preliminary CBO estimates, 10/28/95.

REVISED: 1/8/95

MEDICAID: CBO April 1996 Baseline: Medicaid Federal Expenditures (Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	1996-2002		1997-2002	
										Total	Growth	Total	Growth
BASELINE (CBO FACTSHEET: 5/08/96)													
Total Spending	89.1	95.7	104.8	115.4	126.4	138.2	151.5	166.4	183.0	888.4	9.7%	802.7	9.7%
Spending per capita (1)		2,603	2,751	2,955	3,157	3,366	3,600	3,862			6.8%		7.0%
HOUSE COMMERCE COMMITTEE MEDICAID (CBO, 6/17/96)													
Total Spending	89.1	95.7	105.8	113.9	119.0	124.7	130.9	137.3	144.0	827.0	6.2%	731.3	5.4%
Spending per capita (1)		2,603	2,772	2,916	2,971	3,037	3,110	3,186			3.4%		2.8%
Federal Savings			0.8	-1.5	-7.4	-13.5	-20.6	-29.1	-38.9	-71.4		-71.4	
PRESIDENT'S (CBO SCORING 4/16/96) (2)													
Total Spending	89.1	95.7	106.5	113.5	120.6	128.4	135.3	144.7	154.8	844.7	7.1%	749.0	6.3%
Spending per capita (1)		2,603	2,796	2,907	3,012	3,127	3,215	3,358			4.3%		3.7%
Federal Savings	0	0.0	1.7	-1.9	-5.9	-9.8	-16.2	-21.7	-28.2	-53.7		-53.7	
BREAUX-CHAFEE PLAN (CBO Preliminary Score, 5/10/96)													
Total Spending	89.1	95.7	104.6	112.2	120.4	130.0	140.6	151.5	164.3	855.0	8.0%	759.3	7.7%
Spending per capita (1)		2,603	2,746	2,873	3,007	3,166	3,341	3,516			5.1%		5.1%
Federal Savings	0	0.0	-0.2	-3.2	-6.0	-8.2	-10.9	-14.9	-18.7	-43.4		-43.4	

(1) Spending divided by CBO's April 1996 total enrollment.
 (2) Excludes Medicare, Welfare and Veterans' offsets.

Minimum Federal Medicaid Baseline Change: Lower 1996 base, assume post-welfare reform growth
 (Fiscal year, dollars in millions)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-02	Growth	1997-02	Growth
REVISED: May 96	89,070	95,786	105,081	115,438	126,366	138,154	151,512	166,444	898,781	9.6%	802,895	9.6%
Welfare reform			-38	-514	-567	-581	-948	-1433	-4,081		-4,081	
Post-Welfare Reform		95,786	105,043	114,924	125,799	137,573	150,564	165,011	894,700	9.5%	798,914	9.5%
August 1996 Change		-4,000										
Baseline assuming same growth*		91,786	100,656	110,125	120,546	131,828	144,276	158,120	857,338	9.5%	765,552	9.5%
Difference from April baseline									-41,443		-37,443	

Sources: CBO's April baseline and "CBO Medicaid Baseline: Incorporates Welfare Reform and August Update"

* Estimated by multiplying total expenditure growth rates from "Post-Welfare Reform" line by the August 1996 estimate.

Note: The total expenditure growth rates include DSH, whose average growth is almost half of the benefits average growth.

If the August 1996 change were only in benefits and not in DSH, then the use of the total expenditure growth would understate the baseline reduction.

POSSIBLE Medicaid Baseline
(Dollars in millions; fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-02	Growth	97-02	Growth
Benefits payments	74,457	76,785	82,925	90,751	98,479	106,578	115,842	126,208	137,671	150,318	164,243	697,567	8.6%	620,783	8.8%
DSH	10,700	10,700	11,235	11,797	12,387	13,006	13,656	14,339	15,056	15,809	16,599	87,119		78,419	
Admin	3,911	4,251	4,674	5,148	5,696	6,258	6,866	7,598	8,378	9,295	10,170	40,511		36,259	
Total	89,068	91,736	98,834	107,696	116,561	125,842	136,384	148,144	161,105	175,362	191,012	825,198	8.3%	733,462	8.4%

Federal Share of Benefit Payments - In billions

Total Benefits	74,457	76,785	82,925	90,751	98,479	106,578	115,842	126,208	137,671	150,318	164,243
Aged	23,859	24,605	26,260	28,611	31,004	33,473	36,376	39,454	42,853	46,588	50,704
Disabled	26,448	27,275	29,800	32,917	36,205	39,405	42,900	47,034	51,638	56,749	62,405
Children	14,242	14,687	15,998	17,474	18,790	20,328	22,137	24,135	26,338	28,763	31,414
Adults	9,908	10,218	10,867	11,750	12,480	13,372	14,429	15,584	16,843	18,218	19,721

Reduces benefits spending by \$4 billion in 1996; allocates the reduction across groups in proportion to their 1995 spending.

Beneficiaries - In millions

Total	36.3	37.08	37.88	38.67	39.48	40.27	41.09	41.91	42.76	43.63	44.52		2.1%		2.0%
Aged	4.1	4.20	4.31	4.42	4.53	4.64	4.75	4.87	5.00	5.12	5.25				
Disabled	5.9	6.14	6.38	6.60	6.84	7.04	7.25	7.47	7.69	7.92	8.16				
Children	17.95	18.31	18.68	19.05	19.43	19.82	20.21	20.62	21.03	21.45	21.88				
Adults	8.35	8.43	8.52	8.60	8.69	8.78	8.86	8.95	9.04	9.13	9.22				

1995 recipients from CBO table of actual recipients; 50% of 'others' in adults, 50% in kids. Growth: Aged: 2.5%, Kids: 2.0%, Adults: 1.0%; Disabled: 4% phasing down to 3%

Spending per beneficiary

Total	2,051	2,071													
Aged	5,819	5,855	6,096	6,480	6,851	7,216	7,650	8,095	8,578	9,099	9,661				
Disabled	4,483	4,445	4,670	4,984	5,296	5,597	5,915	6,297	6,711	7,161	7,645				
Children	793	802	857	917	967	1,026	1,095	1,171	1,252	1,341	1,436				
Adults	1,187	1,212	1,276	1,366	1,436	1,524	1,628	1,741	1,863	1,995	2,138				

For all groups: Assumes 1 percentage point lower than April 1996 per-beneficiary growth

NOTES: Admin. and DSH are assumed to be the same as the April 1996 baseline; Federal benefits = revised beneficiaries multiplied by revised spending per beneficiary

MEDICAID: Illustration of Savings Relative to CBO Baseline (Dollars in billions; fiscal years)

NOTE: These estimates are based purely on savings targets, not scored policies; savings from policies change with different effective dates and baseline assumptions.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	1996-2002		1997-2002	
										Total	Growth	Total	Growth
1. MAY 1996 BASELINE													
Total Federal Spending	95.8	105.1	115.4	128.4	138.2	151.5	166.4	183.0	201.2	896.8	9.6%	803.0	9.8%
Benefits & Admin	85.0	93.5	103.6	114.0	125.1	137.9	152.1	167.9	185.4	811.3	10.2%	726.3	10.2%
DSH	10.7	11.2	11.8	12.4	13.0	13.7	14.3	15.1	15.8	87.1	5.0%	76.4	5.0%
Total Spending per capita (1)	2,604	2,759	2,956	3,156	3,364	3,601	3,863				6.8%		7.0%
Benefits Spending per capita (1)	2,312	2,456	2,654	2,847	3,048	3,276	3,530				7.3%		7.5%
2. PRESIDENT'S CURRENT POLICY (2)													
Total Federal Spending	95.8	106.8	113.5	120.6	128.4	135.3	144.7	154.8	165.6	845.1	7.1%	749.3	6.3%
Federal Savings	-	1.7	-1.9	-5.8	-9.8	-16.2	-21.7	-28.1	-35.5	-53.7		-53.7	
Benefits & Admin Savings	-	-0.7	-2.3	-3.5	-5.5	-8.2	-11.9			-32.1		-32.1	
DSH Savings	-	2.4	0.4	-2.3	-4.3	-8.0	-9.8			-21.6		-21.6	
Total Spending per capita (1)	2,604	2,803	2,908	3,011	3,126	3,216	3,359				4.3%		3.7%
Benefits Spending per capita (1)	2,312	2,438	2,595	2,759	2,914	3,080	3,255				5.9%		5.9%
3. SAME YEARLY TARGET BUT 1998 IMPLEMENTATION (3) *													
Total Federal Spending	95.8	105.1	117.1	124.5	132.4	141.7	150.2	159.3	166.9	866.8	7.8%	771.0	7.4%
Federal Savings	-	-	1.7	-1.9	-5.8	-9.8	-16.2	-23.7	-32.3	-32.0		-32.0	
Benefits & Admin Savings	-	-	-0.7	-2.3	-3.5	-5.5	-8.2			-20.2		-20.2	
DSH Savings	-	-	2.4	0.4	-2.3	-4.3	-8.0			-11.8		-11.8	
Total Spending per capita (1)	2,604	2,759	3,000	3,109	3,223	3,368	3,487				5.0%		4.8%
Benefits Spending per capita (1)	2,312	2,456	2,637	2,789	2,962	3,145	3,339				6.3%		6.3%
4. SAME TARGET (ABOUT \$54 B) BUT 1998 IMPLEMENTATION (4) *													
Total Federal Spending	95.8	105.1	115.3	123.5	128.6	135.2	142.0	149.2	156.8	845.7	6.8%	749.9	6.2%
Federal Savings	-	-	-0.1	-2.9	-8.4	-16.3	-24.4	-33.7	-44.4	-53.1		-53.1	
Benefits & Admin Savings	-	-	-2.5	-3.3	-7.1	-12.0	-16.4			-41.3		-41.3	
DSH Savings	-	-	2.4	0.4	-2.3	-4.3	-8.0			-11.8		-11.8	
Total Spending per capita (1)	2,604	2,759	2,954	3,084	3,138	3,213	3,297				4.0%		3.6%
Benefits Spending per capita (1)	2,312	2,456	2,591	2,764	2,874	2,991	3,149				5.3%		5.1%

MEDICAID: Illustration of Savings Relative to CBO Baseline (Dollars in billions; fiscal years)

NOTE: These estimates are based purely on savings targets, not scored policies; savings from policies change with different effective dates and baseline assumptions.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	1998-2002		1997-2002	
										Total	Growth	Total	Growth
5. POSSIBLE 1997 BASELINE (5)													
Total Federal Spending	91.7	99.1	107.0	116.0	125.5	136.5	148.4	161.1	175.4	824.2	8.3%	732.5	8.4%
Benefits & Admin	81.0	87.9	95.2	103.6	112.5	122.8	134.0	146.0	159.6	737.1	8.7%	666.1	8.8%
DSH	10.7	11.2	11.8	12.4	13.0	13.7	14.3	15.1	15.8	87.1	5.0%	76.4	5.0%
Total Spending per capita (1)	2,474	2,617	2,767	2,938	3,117	3,321	3,539				6.2%		6.2%
Benefits Spending per capita (1)	2,185	2,320	2,462	2,624	2,794	2,989	3,197				6.5%		6.6%
6. SAME YEARLY TARGET BUT 1998 IMPLEMENTATION (3) *													
Total Federal Spending	91.7	99.1	108.7	114.1	119.7	126.7	132.2	137.9	143.9	792.2	6.3%	700.5	5.9%
Federal Savings	-	-	1.7	-1.9	-5.8	-9.8	-16.2	-23.2	-31.5	-32.0		-32.0	
Benefits & Admin Savings	-	-	-0.7	-2.3	-3.5	-5.5	-8.2			-20.2		-20.2	
DSH Savings	-	-	2.4	0.4	-2.3	-4.3	-8.0			-11.8		-11.8	
Total Spending per capita (1)	2,474	2,617	2,811	2,880	2,973	3,083	3,153				4.1%		3.8%
Benefits Spending per capita (1)	2,185	2,320	2,445	2,566	2,707	2,855	3,001				5.4%		5.3%
7. SAME TARGET (ABOUT \$54 B) BUT 1998 IMPLEMENTATION (4) *													
Total Federal Spending	91.7	99.1	106.9	113.1	116.1	120.2	124.0	127.9	131.9	771.1	5.1%	679.4	4.6%
Federal Savings	-	-	-0.1	-2.9	-8.4	-16.3	-24.4	-33.2	-43.4	-53.1		-53.1	
Benefits & Admin Savings	-	-	-2.5	-3.3	-7.1	-12.0	-16.4			-41.3		-41.3	
DSH Savings	-	-	2.4	0.4	-2.3	-4.3	-8.0			-11.8		-11.8	
Spending per capita (1)	2,474	2,617	2,764	2,865	2,884	2,925	2,957				3.0%		2.6%
Benefits Spending per capita (1)	2,185	2,320	2,398	2,541	2,618	2,697	2,805				4.2%		3.9%

* NOTE: THIS IS ALL ILLUSTRATIVE; CBO WOULD NOT SCORE THESE SAVINGS.

NOTE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

(1) Federal spending divided by enrollment

(2) As scored by CBO on 4/17/96. Counts the pool payments against the DSH savings.

(3) Assumes the savings as 4/96 score; just begins this in 1998.

(4) Assumes Federal savings targets equal to the first five years of BBA as scored on the Dec 85 baseline (\$133 b).

(5) Assumes that 1996 is lowered by \$4 billion (per CBO August 1996 report) and both recipient growth and spending per beneficiary is lower each year than May baseline

NOTE: The 2003 savings were estimated assuming that the Federal spending in 2003 grows at the same rate as Federal spending in 2002

NOTE: THIS IS PURELY ILLUSTRATIVE; THIS MAY OVERSTATE WHAT THE REAL BASELINE REDUCTION

Medicaid Savings: Estimates using CBO May 1996 Baseline

POLICY: President's FY 1997 Budget

(Fiscal years, dollars in billions)

	1995	1996	1997	1998	1999	2000	2001	2002	1997 -2002
Benefits Savings									
Current Law Spending Subject to Cap (FedShr)	72.4	78.4	86.1	95.4	105.0	115.4	127.3	140.6	748.2
Nominal GDP (CBO)		3.70%	3.90%	3.90%	3.90%	3.80%	3.80%	3.80%	
Additional Growth Allowance		2.71%	2.50%	1.00%	1.00%	0.50%	0.50%	0.00%	1998-02
Total Index Value		6.41%	6.40%	4.90%	4.90%	4.30%	4.30%	3.90%	4.8%
Benefits Savings (net of offset)			-0.6	-2.3	-3.8	-6.0	-8.8	-12.6	-34.1
DSH Savings									
Current Law DSH Spending (FedShr)	10.7	10.7	11.2	11.8	12.4	13.0	13.7	14.3	87.1
New DSH Limit			9.30	7.90	6.40	5.00	4.50	4.00	
DSH Savings			-1.9	-3.9	-6.0	-8.0	-9.2	-10.3	-39.3
Pool Payments									
Undocumented Immigrants			0.7	0.7	0.7	0.7	0.7	n/a	3.5
FQHC			0.5	0.5	0.5	0.5	0.5	0.5	3.0
Transition Pool			3.1	3.1	2.5	2.5	n/a	n/a	11.2
Total Pool Payments			4.3	4.3	3.7	3.7	1.2	0.5	17.7
TOTAL FEDERAL SAVINGS			1.7	-1.9	-6.1	-10.3	-16.7	-22.4	-55.7
Federal Spending		95.7	106.6	113.6	120.3	128.0	134.9	144.2	747.6
Growth Rates									1998-02
Aggregate spending growth		7.5%	11.3%	6.6%	5.9%	6.4%	5.4%	6.9%	7.1%
Per-beneficiary spending growth (includes DSH)		5.2%	7.4%	3.9%	3.3%	3.7%	2.8%	4.3%	4.2%
Benefits per-beneficiary spending growth		6.1%	5.4%	6.2%	5.9%	5.4%	5.5%	5.4%	5.6%

Medicaid Savings: Estimates using POSSIBLE NEW Baseline

POLICY: President's Policy Implemented in 1998

(Fiscal years, dollars in billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	1999 -2002
Benefits Savings										
Current Law Spending Subject to Cap (FedShr)	72.4	74.4	80.1	87.8	95.1	103.0	112.0	122.2	133.5	
Nominal GDP (CBO)			3.90%	3.80%	3.90%	3.80%	3.80%	3.90%	3.90%	
Additional Growth Allowance			2.71%	2.50%	1.00%	1.00%	0.50%	0.50%	0.00%	1997-2003
Total Index Value			6.61%	6.40%	4.90%	4.80%	4.30%	4.40%	3.90%	4.8%
Benefits Savings (net of offset)				0.0	-0.3	-1.2	-3.0	-5.1	-9.8	-19.4
DSH Savings										
Current Law DSH Spending (FedShr)	10.7	10.7	11.2	11.8	12.4	13.0	13.7	14.3	15.1	
New DSH Limit (1)				9.3	7.9	6.4	5.0	4.5	4.0	
DSH Savings				-2.5	-4.5	-6.6	-8.7	-9.8	-11.1	-32.1
Pool Payments										
Undocumented Immigrants				0.7	0.7	0.7	0.7	0.7		3.5
FQHC / RHC Pool (2)				0.5	0.5	0.5	0.5	0.5	0.5	2.5
Transition Pool				3.1	3.1	2.5	2.5			11.2
Total Pool Payments				4.3	4.3	3.7	3.7	1.2		17.2
TOTAL FEDERAL SAVINGS		0.0	0.0	1.8	-0.5	-4.1	-7.9	-13.8	-20.4	-24.5
Federal Spending		91.7	98.8	109.5	116.1	121.7	128.5	134.4	140.7	709.0
Growth Rates										
Aggregate spending growth		3.0%	7.7%	10.8%	6.0%	4.8%	5.5%	4.6%		1997-2002 6.3%
Per-beneficiary spending growth (includes DSH)		1.0%	5.7%	8.7%	4.0%	3.0%	3.6%	2.7%		4.4%
Benefits per-beneficiary spending growth		1.1%	5.9%	7.4%	6.2%	5.4%	5.2%	5.3%	5.3%	5.9%

POSSIBLE NEW BASELINE is the April CBO Medicaid baseline, adjusted for the August update and welfare reform, with (a) recipient growth lowered, and (b) per capita growth rates lowered by 1 percentage point. THIS IS ILLUSTRATIVE ONLY

Medicaid Savings: Estimates using POSSIBLE NEW Baseline

POLICY: \$54 billion from 1998 - 2002, Equal PCC / DSH Split

(Fiscal years, dollars in billions)

	1995	1996	1997	1998	1999	2000	2001	2002	1998 -2002
Benefits Savings									
Current Law Spending Subject to Cap (FedShr)	72.4	74.4	80.1	87.6	95.1	103.0	112.0	122.2	
Nominal GDP (CBO)			3.90%	3.90%	3.90%	3.80%	3.80%	3.90%	
Additional Growth Allowance			1.00%	0.00%	-1.00%	-1.50%	-2.00%	-2.50%	1997-2002
Total Index Value			4.90%	3.90%	2.90%	2.30%	1.80%	1.40%	2.5%
Benefits Savings (net of offset)				-1.5	-3.5	-6.0	-9.4	-13.8	-34.1
DSH Savings									
Current Law DSH Spending (FedShr)	10.7	10.7	11.2	11.8	12.4	13.0	13.7	14.3	
New DSH Limit (1)				9.9	7.5	6.5	4.5	4.0	
DSH Savings				-1.9	-4.9	-6.5	-9.2	-10.3	-32.8
Pool Payments									
Undocumented Immigrants				0.7	0.7	0.7	0.7	0.7	3.5
FQHC / RHC Pool (2)				0.5	0.5	0.5	0.5	0.5	2.5
Transition Pool				2.0	2.0	1.0	1.0		6.0
Total Pool Payments				3.2	3.2	2.2	2.2	1.2	12.0
TOTAL FEDERAL SAVINGS		0.0	0.0	-0.2	-5.1	-10.3	-16.4	-22.9	-54.9
Federal Spending		91.7	98.8	107.5	111.4	115.6	120.0	125.2	678.6
Growth Rates									
Aggregate spending growth		3.0%	7.7%	8.7%	3.7%	3.7%	3.8%	4.4%	1997-2002 4.9%
Per-beneficiary spending growth (includes DSH)		0.7%	5.4%	6.4%	1.5%	1.6%	1.7%	2.2%	2.7%
Benefits per-beneficiary spending growth		0.9%	5.6%	5.3%	4.3%	3.7%	3.6%	3.5%	4.1%

POSSIBLE NEW BASELINE is the April CBO Medicaid baseline, adjusted for the August update and welfare reform, with (a) recipient growth lowered, and (b) per capita growth rates lowered by 1 percentage point. THIS IS ILLUSTRATIVE ONLY

CBO in 1995 (about 1.5 percentage points faster than GDP), and a path in which premiums grow about 0.5 percentage points more slowly than GDP throughout the projection period. These alternatives are not meant to set boundaries for the likely growth in spending for private health insurance premiums. Rather, they show other plausible paths for that spending.

Premiums could grow faster than CBO currently projects for several reasons. The so-called managed care backlash may prove stronger than CBO expects, and states and employers may take actions that would lead to more rapid growth in costs. Many fee-for-service plans, facing new competition from managed care plans, have recently kept premiums lower than the benefits they pay would otherwise indicate. If those plans increased their rates and their enrollees stayed with them, growth in premiums would accelerate.

Historically, the path of spending for private health insurance has been volatile, and any projection of its future course is uncertain. Given the upsurge of price awareness and competition over the past five years, however, trends in the growth of premiums are unlikely to return to historical rates in the foreseeable future. Even on this higher-growth path, the growth of premiums is well below its historical average.

Alternatively, premiums could continue to grow more slowly than GDP throughout the projection period. Employers now view health insurance as an important element of costs and may be unwilling to tolerate higher growth. If their employees remained amenable to more managed care, growth in premiums would slow. As a result of decades of growth with little constraint, considerable unused capacity remains in the health sector. Health plans can use that excess capacity to leverage lower costs from providers if employers demand it. And as managed care techniques improve, plans may find additional ways to improve quality at a pace that is tolerable to employers and employees without additional costs.

Although premiums for private health insurance rose several percentage points more slowly than GDP in 1994 and 1995, CBO's projection of strong economic growth makes that situation unlikely to persist over the projection period. This slower-growth path therefore assumes that the growth of premiums is only slightly below that of GDP.

Components of the Health Insurance Projections

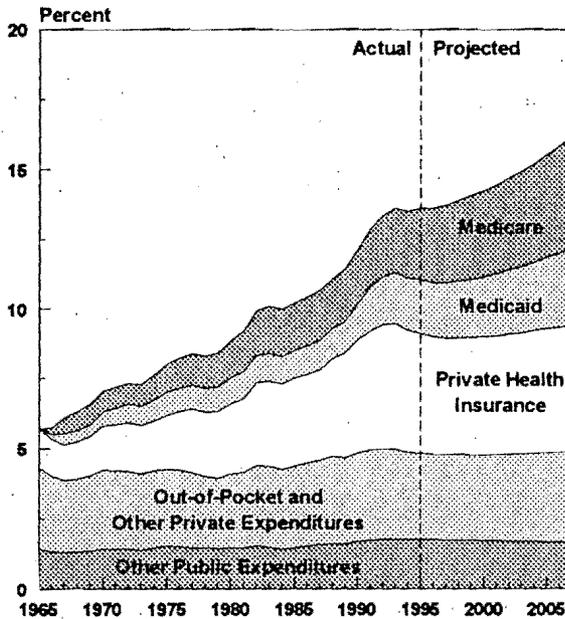
HCFA's national health accounts are constructed from total payments by source of funds (including private insurance and Medicare, for example) and by type of service (the payments received by health providers such as hospitals, physicians, and so on). As managed care has come to dominate the health sector, the distinctions between types of health services have become more difficult to identify and probably less meaningful to health analysts. Therefore, CBO is not publishing projections of health expenditures by type of service this year.

CBO is expanding the projections of health insurance, however, to include additional details on spending by type of insurance coverage. Table H-4, produced in collaboration with the Joint Committee on Taxation, shows CBO's assumptions about premiums for individual coverage (including Medigap premiums) and employer and employee contributions to employment-based coverage. Table H-5 shows the assumptions used in the projections about the number of people whose primary insurance coverage comes from employment-based insurance, individually purchased insurance, Medicare, or Medicaid. It also includes those who are uninsured.

CBO projects that as more Medicare beneficiaries choose Medicare health maintenance organizations, the number of beneficiaries remaining in fee-for-service Medicare will shrink during the projection period. Assuming that the percentage of fee-for-service beneficiaries choosing to purchase Medigap plans remains constant over the next 10 years, the number of beneficiaries with Medigap coverage will also shrink. In CBO's projections, total payments for Medigap premiums will increase by about 6 percent a year, however, because the cost of Medicare coinsurance is expected to rise relatively quickly.

Given the assumption in CBO's current projections that health insurance premiums will grow more slowly in the coming years, businesses and employees would be better able to afford coverage. Therefore, CBO has

Figure H-1.
Components of National Health Spending
as a Share of GDP (By calendar year)



SOURCE: Congressional Budget Office.

The Economic and Budget Outlook: An Update (August 1995). At that time, CBO argued that managed care plans and the competition they have spawned are helping to offset (rather than eliminate) some of the root problems that have historically weakened price competition in the health sector.

Changes in CBO's Projections

In 1992, CBO introduced its projections of national health spending using historical data published through 1990 by the Health Care Financing Administration (HCFA).⁴ In 1995, CBO undertook a major revision of the projections of health spending and its components—most notably, Medicare, Medicaid, and private health insurance spending. CBO's current projections reflect further reductions in projected Medicaid spending (discussed in Chapter 2 of this report), Medicare outlays (discussed in Chapter 2 and Appendix G), and

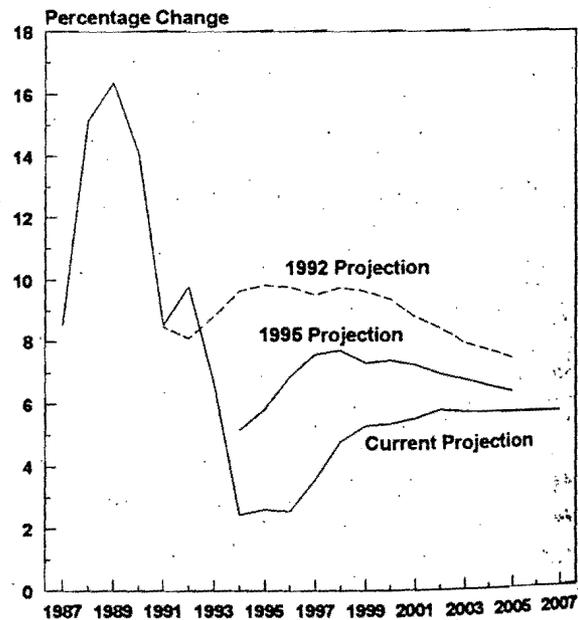
4. Congressional Budget Office, *Projections of National Health Expenditures* (October 1992).

private health insurance spending. Table H-3 shows CBO's current and past projections of the growth rate of spending for the major components of national health expenditures and of the amount by which that growth rate exceeded the growth of GDP. The latter reflects controls for any changes in the outlook for economic growth that may have occurred over the years, and is thus a more direct illustration of the assumptions about health trends.

CBO's 1992 projection of private insurance premiums averaged about 9 percent a year between 1992 and 2000 (see Figure H-2). That rate was down considerably from those seen in the late 1980s, but it was in line with historical patterns of rapid growth in spending relative to the economy as a whole. Between 1965 and 1995, private health insurance premiums grew at an average of 4.2 percentage points a year more rapidly than GDP (see Figure H-3 on page 130). Reflecting a continuation of past trends, CBO's projections from 1992 assumed that premiums would grow about 3.5 percent

SHOWS VOLATILITY

Figure H-2.
Growth in Private Health Insurance Premiums
(By calendar year)



SOURCE: Congressional Budget Office.

NOTE: The 1992 projection period begins in 1991; the 1995 projection, in 1994; and the current projection, in 1996.

Table H-2.
Projections of National Health Expenditures Through 2007, by Source of Funds (By calendar year)

Source of Funds	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
In Billions of Dollars												
Private												
Private health insurance	319	330	346	364	384	405	428	453	479	506	535	565
Out of pocket	191	199	208	218	230	243	257	272	288	305	323	342
Other	40	42	43	45	47	49	52	54	57	59	62	65
Subtotal	549	571	597	628	661	697	737	779	823	870	919	972
Federal												
Medicare	203	220	240	261	283	305	330	357	387	421	459	501
Medicaid	90	97	104	112	121	131	142	154	166	181	196	213
Other	56	58	60	63	65	68	70	73	76	79	82	85
Subtotal	349	375	404	436	469	504	542	584	630	681	737	799
State and Local												
Medicaid	57	61	65	70	76	82	89	96	104	113	123	133
Other	77	80	84	87	91	95	100	104	108	113	118	122
Subtotal	133	141	148	157	167	177	188	200	212	226	240	256
All National Health Expenditures	1,032	1,087	1,150	1,221	1,297	1,378	1,467	1,563	1,665	1,777	1,897	2,026

Annual Percentage Change

Private

Private health insurance	2.6	3.6	4.8	5.3	5.4	5.5	5.8	5.7	5.7	5.7	5.7	5.7
Out of pocket	4.4	4.6	4.6	4.9	5.4	5.5	5.8	5.7	5.9	5.9	5.9	5.9
Other	3.1	3.7	4.0	4.5	4.5	4.4	4.7	4.6	4.6	4.5	4.5	4.5
All private	3.2	3.9	4.7	5.1	5.3	5.5	5.7	5.7	5.7	5.7	5.7	5.7
4.6% ↑												
Federal												
Medicare	8.5	8.7	8.7	9.0	8.2	8.0	8.1	8.2	8.5	8.8	9.0	9.1
Medicaid	4.3	7.1	7.1	8.0	8.1	8.1	8.3	8.4	8.3	8.6	8.7	8.7
Other	2.6	3.7	3.8	4.0	3.9	3.9	3.9	3.8	3.8	3.8	3.8	3.8
All federal	6.4	7.5	7.5	8.0	7.6	7.4	7.6	7.7	7.9	8.1	8.3	8.4
State and Local												
Medicaid	4.3	7.1	7.1	8.0	8.1	8.1	8.3	8.4	8.3	8.6	8.7	8.7
Other	4.0	4.3	4.4	4.6	4.6	4.4	4.5	4.3	4.2	4.2	4.1	4.0
All state and local	4.1	5.5	5.6	6.1	6.1	6.1	6.3	6.2	6.2	6.3	6.4	6.4
All National Health Expenditures	4.4	5.3	5.8	6.2	6.2	6.3	6.5	6.5	6.6	6.7	6.8	6.8

SOURCE: Congressional Budget Office.

DRAFT

MAJOR POLICY ISSUES TO BE RESOLVED IN RECONCILIATION CONFERENCE

Prepared by the Majority Staffs, House and Senate Committees on the Budget
1 July 1997

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
MEDICARE			
<p>- MedicarePlus/Medicare Choice</p>	<p>Payments to Medicareplus Health Plans — Carve out of amounts attributable to disproportionate share hospitals [DSH], indirect medical education [IME] costs, and direct medical education [DME] costs.</p> <ul style="list-style-type: none"> - COMMERCE — Phases out amounts over 5 years. - WAYS AND MEANS — Maintains amounts in MedicarePlus payments. <p>Capitation Payment Rate — Derive from a blend of local and <u>input price-adjusted</u> national costs.</p> <ul style="list-style-type: none"> - COMMERCE — 70% local, 30% national. - WAYS AND MEANS — 50-50 blend, <u>updates links to growth in FFS Medicare.</u> <p>Minimum Monthly Payment/Minimum Update —</p> <ul style="list-style-type: none"> - COMMERCE — Floor of \$350 in 1998. Sets payment at 100 percent of 1997 rate for 1998, 101 percent for 1999-2000, 102 percent for 2001 and beyond. - WAYS AND MEANS — Floor of \$350 for 1998. Sets minimum payments increase of 102 percent of the prior year's rate. 	<p>Carves out DSH, IME, and DME from the Medicare Choice payment <u>over 4 years.</u></p> <p>Uses a 50-50 blended payment <u>of local and national costs that are not input price-adjusted.</u> Growth in payments tied to GDP growth.</p> <p>Sets floor at \$4,200 a year and maintains payment at 100 percent of the prior year. <u>Initially sets \$350 payment floor and minimum increase, but provides for adjustment to increase floor to 85% of national average (over \$400), financed by reducing minimum increase to zero.</u></p>	<p>Supports Senate and House Commerce provisions.</p> <p>Opposes any provision to allow balance billing.</p> <p>Prefers Commerce 70/30 blend, which mitigates the geographic variation in payments without major disruption; the House link to fee-for-service payments; the Commerce floor; and the House approach to risk adjustment.</p> <p>Objects to most payment provisions in the Senate bill, some of which are individually justifiable, which together could lead to abrupt changes in additional benefits now provided to Medicare enrollees.</p>

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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MEDICARE (continued)

- Home Health Spending Transfer	Transfers certain home health spending (following 100 visits or not following a hospitalization) from Part A to Part B. - COMMERCE - Makes entire transfer immediately. - WAYS AND MEANS - Phases-in transfer over 6 years.	Phases in transfer over 7 years.	Supports House Commerce Committee provision. <i>6/6</i> <i>It is explicitly consistent w/ Budget Agreement.</i>
- MSA's	Provides for medical savings account demonstration, allowing 500,000 individuals to enroll.	Allows 100,000 enrollees.	Current law balance billing limitations should apply to the demonstration, which should be as small as possible. The demo should be limited geographically for a trial period (e.g., 2 States for 3 years).
- Eligibility Age	No provision.	Conforms Medicare eligibility age to Social Security's normal retirement age, saving \$10.2 billion from 2003 through 2007 and reducing Medicare's long-term deficit by 0.2 percent of payroll.	Without alternative sources of coverage, could cause many to become uninsured while waiting for Medicare eligibility. Conferees should drop this provision.
- Income-Related Premium	No provision.	Phases up premium from current 25 percent of program costs to 100 percent, saving \$3.9 billion over 5 years, \$19.6 billion over 10 years. Phase-in would be over income ranges: for single persons with incomes of \$50,000 to \$100,000; for couples with incomes of \$75,000 to \$125,000.	The Administration has a number of concerns about this proposal, including phase-up to 100% instead of 75% of costs. Administering through HHS poses serious problems; should be administered through Treasury. Could cause adverse selection and lose significant revenue due to inefficiency.
- Home Health Copayment	No provision.	\$5 dollar copayment applying only to home health visits paid from Part B; capped at annual hospital deductible; saves \$4.7 billion over 5 years.	Ineffective at lowering use, since 85% of beneficiaries have Medigap or Medicaid. Conferees should drop this provision.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
- Medical Malpractice	- COMMERCE - Limits noneconomic damages to \$250,000 and implements other reforms. - WAYS AND MEANS - Limits noneconomic damages to \$250,000 and implements other reforms.	No provision.	Strongly opposes House provisions.
- 10-Year Savings	WAYS AND MEANS — \$386 billion. (The Commerce Committee does not have jurisdiction over the full amount.)	Saves \$447 billion over 10 years.	The Agreement calls for \$434.0 billion in net Medicare savings over ten years.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE
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MEDICAID

- Total Savings	Saves \$12.9 billion \$11.8 billion , after adjusting the CBO-reported savings for Medicaid-related changes because of the child health insurance initiatives.	Saves net of \$13.5 billion \$14.7 billion over 5 years.	The Agreement calls for \$13.6 billion over five years, net of spending on new initiatives in the Agreement.
- DSH Reductions	Reduces disproportionate share hospital [DSH] payments by \$15.3 billion <u>gross</u> over 5 years by establishing additional caps on State DSH allotments for fiscal years 1998-2002. The State DSH allotments for States in which 1995 DSH payments were less than 1 percent of total medical assistance spending would be frozen at the level of payments for DSH adjustments in those States in 1995. For States classified as "high" DSH States for fiscal year 1997, DSH allotments would be reduced from the higher of 1995 or 1996 payment levels. The reduction percentage for "high" DSH States would be equal to 2 percent in 1998, 5 percent in 1999, 20 percent in 2000, 30 percent in 2001, and 40 percent in 2002. All other States' DSH payments would be equal to the higher of 1995 or 1996 DSH payments levels reduced by one half of the reduction percentages for "high" DSH States.	Reduces disproportionate share hospital [DSH] payments by \$16.0 billion <u>gross</u> over 5 years by establishing additional caps on State DSH allotments for fiscal years 1998-2002. Freezes very low DSH States for 5 years (below 3 percent DSH); low-DSH (above 3 percent but below 12 percent) get phased-in 15-percent reduction from their allotments; high DSH (above 12 percent) get a <u>phased-in</u> 20-percent reduction and a phase-out of any spending for mental health facilities <u>from their base DSH allotments</u> . Also applies new restrictions on using DSH for mental health facilities <u>and requires States to privatize payments to hospitals based on their low-income utilization rate</u> .	As in OBRA 93, DSH policy should avoid undue hardship on any State: <ul style="list-style-type: none"> • Prefer the President's 1998 budget takes an equal percentage reduction total DSH spending, up to an "upper" limit. • DSH savings should be linked to other savings for targeting remaining DSH funds. • Prefer the House provision requiring DSH payments directly to qualify for managed care payments rather than through managed care payments.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
MEDICAID (continued)			
- DC and Puerto Rico	No provision.	Increases FMAP for DC to 60 percent for 1998 through 2000; increases payment for Puerto Rico by \$30 million in FY 1998 plus increases for other territories.	D.C. -- Prefers to drop Senate sunset in 2000 and increase match rate to 70% (as in President's 1998 budget). Puerto Rico -- Prefers to include adjustments for PR and the territories in the President's 1998 budget.
- Medicare Part B Premium Protection	Spends \$1.5 billion over 5 years in Medicaid for premium assistance for seniors with incomes of 120 percent to 175 percent of poverty. Covers the full Medicare premium for those with incomes up to 135 percent of poverty. For seniors with incomes between 135 and 175 percent of poverty, the assistance covers that portion of the Medicare Part B premium increase attributable to the home health spending transfer.	Creates a new Medicare block grant, \$1.5 billion over 5 years, to States to provide premium assistance for beneficiaries between 120 percent and 150 percent of poverty.	Prefers to finance the cost of the full Medicare premium through Medicaid. Objects to Senate provision that uses a Medicare grant for this assistance that sunsets in 2002.
- Medicaid Cost Sharing	No provision.	Requires limited cost sharing for optional benefits; prohibits cost sharing for children under 18 in families with incomes below 150% of poverty.	Prefers language in President's budget, which allows States to charge nominal copays for HMO enrollees. The Administration is concerned that the Senate bill could compromise beneficiary access to quality care.
- 1115 Waivers and Provider Tax Waivers	Extends expiring 1115 Medicaid waivers.	Extends expiring 1115 Medicaid waivers without regard to budget neutrality. Also deems provider taxes as approved for one State.	The Administration has a number of concerns about this proposal.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
-- Return-to-Work	No provision.	Allows States to allow workers with disabilities to buy into Medicaid.	Prefers President's 1998 budget proposal, which would not limit eligibility to people whose earnings are below 250% of poverty.
- Criminal Penalties for Asset Divestiture	Amend Section 215 of HIPAA to provide sanctions only against those who help people to dispose of assets in order to qualify for Medicaid.	Amend Section 215 of HIPAA to provide sanctions only against those who help people to dispose of assets in order to qualify for Medicaid.	Supports repeal of this section.
- Medicaid Management Information	Requires States to show that their State-designed Medicaid management systems meet outcome-based performance standards and would permit the collection and analysis of person-based data	No provision.	Supports House provision.
- Alaska Medicaid Match Rate	No provision.	Increases federal Medicaid matching rate for Alaska.	Opposes change to single-State FMAP in the absence of efforts to examine broader alternatives.
- Payment Rates for QMB's and Dual Eligibles	No provision.	Allows States to use Medicaid payment rates when determining whether any cost-sharing is owed for QMB's and dual eligibles, for net savings of \$2.1 billion over 5 years (\$5 billion in Medicaid savings, \$2.9 billion in Medicare costs.)	No position.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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WELFARE-TO-WORK

<p>- Fair Labor Standards Act</p>	<p>Applies language from the 1987 law creating AFDC JOBS to indicate that participants in public sector or non-profit workfare activities are not employees under the Fair Labor Standards Act.</p> <p>Specifies maximum number of hours states can require beneficiaries to work by counting TANF and Food Stamp benefits as wages for purpose of the minimum wage.</p> <p>Provides nondiscrimination and grievance procedure guidelines for workfare.</p> <p><u>No provision.</u></p>	<p>No provision.</p> <p><u>Provides non-displacement, grievance procedures, and other worker protections to WTW grant funds.</u></p> <p><u>Allows States, through the imposition of sanctions, to pay less than the minimum wage for certain recipients.</u></p>	<p>Supports Senate position and strongly opposes minimum wage and welfare work requirement proposals in House bill, which were not in the Agreement.</p> <p>Supports extending Senate provisions on non-displacement and grievance procedures and worker protections to all working welfare recipients under TANF.</p> <p>Oppose Senate provisions.</p>
<p>- Grant Distribution Formula</p>	<p>WAYS AND MEANS — Provides 50 % of funding through formula grants and 50 % through competitive grants awarded by Labor.</p> <p>EDUCATION AND THE WORKFORCE — Provides 95% of funding through formula grants and 5% through competitive grants awarded by Labor.</p>	<p><u>75% of funding by formula, 25% through competitive grants.</u></p>	<p>Prefers Ways and Means provision in House bill, which best accomplishes goal in the Agreement that funds be allocated and targeted to areas with high poverty and unemployment.</p>

HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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WELFARE-TO-WORK

<p>eliminates the maintenance of effort requirement that prevents States from lowering or eliminating State supplemental SSI payments.</p>	<p>No provision.</p>	<p>Strongly opposes repeal of the MOE provision, which was not in the Agreement.</p>
<p>DAYS AND MEANS - Limits the number of TANF beneficiaries who can be counted toward meeting the work participation requirements to 30% of the total number of people meeting the requirement rather than 50% of the total TANF caseload. Teen parents attending high school are not required to be counted within the 30%.</p> <p>EDUCATION AND WORKFORCE - Limits number of TANF beneficiaries a state can count who are in vocational education to 20% of the total number persons meeting the work requirement rather than 50% of the total TANF caseload. Teen mothers attending high school do not fall within the 20% cap.</p>	<p>Continues to permit States to calculate up to 20% of their TANF caseloads participating in vocational education as meeting the work requirement, but eliminates current requirement that teen mothers attending high school be counted as part of that 20% cap.</p>	<p>The Agreement did not address making changes in the TANF work requirements regarding vocational education and educational services for teen parents, and the Administration urges the Conferees to drop these provisions.</p>
<p>removes the requirement that States transfer \$2 to child care activities for every \$1 in TANF block grant funds that they transfer to the Title XX Social Services block Grant.</p>	<p>No provision.</p>	<p>Opposes House provisions, which were not in the Agreement.</p>

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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WELFARE-TO-WORK IMMIGRANTS

<p>- Alien Eligibility for SSI and Medicaid</p>	<p>Restores eligibility for SSI and Medicaid for <u>legal qualified</u> aliens who were in the country and on the benefit rolls receiving SSI as of August 22, 1996. Legal aliens who were in the U.S. but not receiving SSI benefits are ineligible for benefits if they become disabled in the future. Total cost is \$9 billion over 5 years.</p>	<p>Restores eligibility for SSI and Medicaid for <u>legal qualified</u> aliens who were in the country and on the benefit rolls receiving SSI <u>benefits</u> as of August 22, 1996. Provides eligibility for SSI benefits to legal aliens in the U.S. on August 22, 1996 but who were not on the benefit rolls then at any time in the future if they become disabled. <u>who entered the U.S. prior to August 23, 1996 and who are or who become disabled in the future. Gives States the option to exempt immigrant children from the 5 year ban on Medicaid. Exempts immigrants from SSI ban who are so severely disabled they are unable to naturalize.</u> Total cost is \$11.4 \$11.6 billion over 5 years.</p>	<p>Supports Senate provision, which implements the Agreement. House bill fails to fully restore SSI and Medicaid benefits for all legal immigrants who are or become disabled in the future who entered the U.S. prior to August 23, 1996. (The President stated in a June 20 letter that he will not sign legislation that does not include the policy that protects immigrants who are or become disabled.)</p>
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	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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FOOD STAMPS

<p>- Work Slots</p>	<p>Provides States with \$680 million in new funding over 5 years for Education and Training activities within Food Stamps. At least 80 percent of the total Food Stamp E & T funding of \$1.1 billion would be earmarked to able-bodied adults subject to the work requirement. Job search would not be an allowable use of the funding <u>earmarked for able-bodied adults</u>. CBO assumes the policy will generate 205,000 work slots that keep able-bodied adults subject to the work requirement eligible for benefits over 5 years. <u>However, other activities that do not meet the work requirements would be permissible.</u></p>	<p>Provides \$640 million in funding to create additional Education & Training positions within food stamps. Requires the Secretary of Agriculture to establish two different reimbursement rates for States accessing these funds. A higher rate will be paid to states drawing down funding for placing persons subject to the work requirement in work slots which keep those persons eligible for food stamps. A lower reimbursement rate will be paid to states that use funding on activities that do not keep persons subject to the work requirement eligible for benefits. CBO assumes this policy generates 250,000 work slots <u>over 5 years that keep people eligible for benefits meet the work requirements over 5 years.</u></p>	<p>Agreement provides for additional and redirected E&T funds "to create additional work slots for individuals subject to the time limits" to maximize the number of new slots. Administration endorses Senate reimbursement structure and House provisions for maintenance of effort in order to ensure that the maximum number of slots are created.</p>
<p>- "Texas" Waiver <u>Welfare Privatization</u></p>	<p>Permits any State to contract with a private sector entity to conduct <u>income verification and eligibility determinations for Food Stamps and Medicaid.</u></p>	<p>Allows up to 10 States to conduct a demonstration program of contracting out income verification and eligibility determination activities to private sector companies. No provision (dropped, per Byrd rule.)</p>	<p>Strongly opposes House provision and urges the Conferees to follow the approach taken by the Senate (i.e., no provision).</p>

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
CHILDREN'S HEALTH			
- Total Spending	Spends \$15.9 billion over 5 years for children's health insurance or services.	Spends \$24 billion (preliminary scoring) for children's health insurance, including the \$8 billion added from the tax bill (see below).	<p>Supports --</p> <ul style="list-style-type: none"> • Senate definition of benefits, limits on cost-sharing • State option in House bill to spend grant money on grants, Medicaid, or a combination of the two (Senate requires States to choose only one) • Strong maintenance of effort provision and a prohibition on using provider taxes and donations to fund States' share • Using same match rate for Medicaid, grant programs <p>Opposes --</p> <ul style="list-style-type: none"> • Provisions that allow States to pay for family coverage or pay the employee's share of employer-sponsored insurance
- Extra \$8 billion	No provision.	Provides additional \$8 billion in the tax bill.	Supports using all of the revenue from the tobacco tax for initiatives that focus on the needs of children and health. Opposes sunset in this funding after 2002.
- Medicaid Benefits for Children Losing SSI Benefits	Allows, but does not require, States to restore Medicaid benefits for children losing SSI benefits because of new, tighter SSI standards for childhood eligibility.	No provision.	Agreement calls for the restoration of these benefits. The Administration supports FY 1998 President's budget provision, which guarantees Medicaid coverage for these children.
- Direct Provision of Services	Allows States to use funds for the purchase of health insurance for the direct provision of health care.	Does not provide for the direct provision of health care.	Opposes House direct services option.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
- Funding Structure	Allows States to spend grant funds on Medicaid, a grant program, or a combination of the two.	Requires States to choose between Medicaid and a grant option.	Supports House provision.
- Eligibility	Defines targeted low-income children as those whose family income exceeds the Medicaid applicable levels but does not exceed an income level 75 percentage points higher than the Medicaid applicable income level.	Includes a ceiling of 200% of poverty for eligibility.	Opposes income ceiling.

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
- Hyde Amendment	Extends to children's health initiative funding the Medicaid prohibitions on Medicaid payment for abortion services.	Same as House. Also includes a managed care sanction to exclude abortion services except under certain circumstances.	Opposes limiting access to medically necessary benefits, including abortion services.

HEALTH INSURANCE FOR SMALL BUSINESSES

- MEWA	Includes legislation allowing small businesses and organizations to offer health insurance, extending ERISA preemptions and State regulations, requiring solvency standards for association health plans, and other regulations.	No provision.	Strongly opposes House provision.
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	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
SPECTRUM AUCTIONS			
- Analog Return	Authorizes the FCC to auction frequencies that are currently allocated for analog television broadcasting. Imposes a time limit on the television licenses that authorize analog television services. Allows the FCC to extend the time limit if more than 5 percent of the households in a market rely exclusively on analog television signals.	Comparable provision, except that the FCC is required to delay the return if the 5-percent test is not met.	Agreement includes hard cut off date with authority to extend for small and rural markets. Agreement assumed that this auction would take place in 2001 with a firm cut off date for analog broadcasting in 2006.
- Vanity Numbers	Does <i>not</i> authorize the FCC to auction the so-called vanity telephone numbers.	Does <i>not</i> authorize the FCC to auction the so-called vanity telephone numbers.	Agreement includes a proposal authorizing FCC to auction vanity telephone numbers (\$0.7B).
- Bankruptcy	No provision.	No provision.	Seeks authority to allow the FCC to revoke and reactivate a license when a licensee declares bankruptcy.
- Federal Reimbursement	No provision.	Authorizes reimbursement of Federal agencies for the costs of relocating to new spectrum bands so that spectrum they are now using may be made available by the FCC for auction for commercial use.	Agreement assumed and the Administration supports reimbursement.
- Spectrum Penalty	Does not include a penalty fee that would be levied against those entities who received "free" spectrum for advanced, advertiser-based television services, but failed to utilize it fully.	Does not include this penalty fee.	Agreement includes a fee to be levied against entities that received spectrum at no charge for digital broadcasting, but opted to utilize it for ancillary services (\$2.0B).

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
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STUDENT LOANS

- Administrative Cost Allowance	Requires payment to guaranty agencies of 0.85 percent of the principal of all new loans. Capped at \$170 million for 1998 and 1999 and \$150 million for 2000-2002.	Same provision.	Opposes this provision, which provides a new entitlement to guaranty agencies.
- Smith-Hughes Act	Eliminates the Smith-Hughes Act, the original vocational education program.	No provision.	Prefers House provision, which is consistent with the Agreement.
- Retention Allowance	Allows guaranty agencies to retain 18.5 percent on payments received when a defaulted loan is consolidated. <u>The Committee claims that this will have a retroactive effect allowing guaranty agencies to retain 27% between 1992 and 1997 if legislative intent is considered. CBO and OMB do not score the amendment as a cost item because they do not interpret the amendment to allow agencies to retain 27% retrospectively.</u>	No provision.	Opposes this provision, which would provide funding to guaranty agencies without regard to expenses incurred. <u>Interprets amendment to have only prospective, not retrospective, application.</u>

	HOUSE-PASSED BILL	SENATE-PASSED BILL	BUDGET AGREEMENT/WHITE HOUSE POSITION
VETERANS' BENEFITS			
- Medical Care Cost Recovery	Replaces the existing Medical Care Cost Recovery Fund with a new fund into which monies recovered or collected for medical care would be deposited and would be available, <i>subject to appropriations</i> , to pay for the expenses associated with veterans' medical care. If spending from the collections is not subject to appropriations, budget targets will not be met. Also includes a "failsafe" provision authorizing additional funds in the event there is a shortfall in anticipated collections in excess of \$25 million.	Replaces the existing Medical Care Cost Recovery Fund with a new fund into which monies recovered or collected for medical care would be deposited and would be available, <i>subject to appropriations</i> , to pay for the expenses associated with veterans' medical care. No "failsafe" mechanism.	Concurs with Senate position.
- VA and DoD Medicare Subvention Demonstrations	No provision.	Requires managed care and fee-for-service demonstrations of Medicare reimbursement to the Departments of Veterans Affairs and Defense.	

HOUSE-PASSED BILL

SENATE-PASSED BILL

BUDGET AGREEMENT/WHITE HOUSE POSITION

HOUSING

- Mark to Market

No Provision. (Representative Lazio has introduced, by request, the administration's bill and there is at least one other house version introduced so far.)

FHA Multifamily Mortgage Restructuring: Net savings would be \$240 million between 1997 and 2002. The reform would reduce the rents on Section 8 Housing contracts and use a new capital grant program out of the FHA in order to avert large defaults on federally insured mortgages. There are several different versions of this legislation. Without these provisions, the Banking Committee would still exceed its target reconciliation savings of \$1.5 billion over 5 years.

Prefers following changes to Senate bill:

- Allow for the conversion of subsidies to portable tenant-based assistance, allowing tenants to seek out the best available housing and permitting projects to develop a more diverse mix of income levels. (Senate maintains low-income rental assistance as project-based, tied to specific properties.)
- Give HUD more flexibility to design the most effective partnerships. (Senate establishes a preference for delegating restructuring tasks to housing finance agencies.)
- Amend tax code to allow for tax amortization in exchange for long-term affordability restrictions. (Senate attempts to address tax issues through the use of "soft" second mortgages which, as interpreted by IRS, may not have the desired effect of deferring tax consequences.)

(CBO scores \$326 million in savings over 1997-2002 from the Administration's bill.)



**Consumer Coalition
for Quality Health Care**

~~Shaw~~

Send
to Debbie Wang.

To: Chris Jennings

From: Brian Lindberg
 Andy Webber

— Alfred Chiplin Debbie

Chris wants to
know what our response
to this is. Pls
call me.

Fax #: 456 - 5557

Phone #:

Date:

— Sarah

RE:

456-5585

Number of Pages (Including this cover sheet): 6

URGENT

For Review

Please Reply/Comment

For Your Information

Comments:

Dear Chris,

We need your support for the attached compromise language on the Medicaid criminalization issue - 217. Republican staff has not accepted any offers so far - including the one we gave you last week. CRS has now said the current lang. will likely be unconstitutional. Please push for the attached compromise (which still goes after the attorneys who would advise inappropriately). Thank you!

BUDGET RECONCILIATION CONFERENCE COMMITTEE

Current Language

“(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),”

Proposed Modifications to Current Language

“(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX **and to apply for such medical assistance** if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),”

Final Language as Proposed

“(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX and to apply for such medical assistance if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),”

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American Law Div.

OFFICE OF THE CLERK OF THE SENATE



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July 11, 1997

TO : Honorable Jack Reed
Attention: Bonnie Hogue

FROM : American Law Division

SUBJECT : Proposed Amendment of Section 217 of P.L. 104-193, Criminalizing
Certain Transfers of Assets to Become Eligible for Medicaid

This memorandum provides an analysis of legal and constitutional issues that may be raised by the language of Section 5755 of S. 947, as passed by the Senate on June 25, 1997, and Section 3423 of H.R. 2015, as passed by the House on the same day. These two sections contain identical language and would amend the current law in Section 1128B(a) of the Social Security Act, 42 U.S.C. Sec. 1320a-7b(a), to read, in pertinent part, as follows:

Whoever...

"(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c)

shall ... (ii) in the case of such a ... provision of counsel or assistance under section 1917(c) by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.

Under the current provision a person who knowingly and willfully disposes of assets, including transfers to certain trusts, in order for an individual to obtain Medicaid eligibility for nursing home care may be liable for a criminal fine and/or imprisonment, if the disposition of assets results in a period of ineligibility for such Medicaid benefits. This provision, which was effective January 1, 1997, marks the first time Congress has criminalized a disposition of assets made in order to qualify for Medicaid. Prior to that time, certain transfers of assets up to 36 months prior to an application for Medicaid benefits, and certain transfers to trusts up to 60 months, could result in a period of

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ineligibility for such benefits. This period of ineligibility may still be assessed under current law, but, in addition, criminal penalties may also be imposed under certain circumstances.

The House- and Senate-passed versions of this amendment to Section 217 ("the provision"), would impose criminal liability only on a person who "for a fee knowingly and willfully counsels or assists" another person to dispose of assets in order to become eligible for Medicaid for nursing home care, and then only if the assets are disposed of and, as a result, the person applying for Medicaid has a period of Medicaid ineligibility imposed by the state Medicaid agency.

One question that has arisen is whether this provision infringes upon a person's First Amendment right to free speech in that it effectively prohibits a legal advisor or other person from counseling a client about activities that may be legal in and of themselves. To the extent that the provision would prohibit counseling about legal activities, a court would seem likely to declare it unconstitutional. The First Amendment provides that "Congress shall make no law . . . abridging the freedom of speech." Although this freedom does not include "speech and writing used as an integral part of conduct in violation of a valid criminal statute" (*Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 498 (1949)), there appears to be no reason that the First Amendment would not fully protect counseling about legal activities.

Even though the provision would be limited to counseling for a fee, it would not be considered commercial speech (which receives less than full First Amendment protection), as commercial speech is "speech that proposes a commercial transaction." *Board of Trustees of the State of New York v. Fox*, 492 U.S. 469, 482 (1989). A prohibition of counseling about legal activities would be a content-based restriction on speech, and, as such, would be subject to strict scrutiny under the First Amendment, which means that it would be upheld only if it is necessary "to promote a compelling interest," and is "the least restrictive means to further the articulated interest." *Sable Communications of California, Inc. v. Federal Communications Commission*, 492 U.S. 115, 126 (1989). It seems very unlikely that the prohibition of counseling to engage in activities which are lawful could satisfy this stringent test, as a prohibition limited to counseling about illegal activities would more directly serve Congress's interest in preventing the illegal activity.

The question then becomes, what kind of communications are implicated by this criminal provision? Some communications would not appear to be actionable under this provision. A lawyer might counsel a client about the law concerning Medicaid eligibility for nursing home care, describing actions that are permissible and not permissible under the statute. Presumably, since the lawyer has not knowingly and willfully counseled a client to dispose of assets, such a communication would not be prohibited by this provision. Or, a lawyer might set out the law, but then advise a client to dispose of assets in order to be eligible for Medicaid payments for nursing home care by actions that are lawful and that would not result in any imposition of an ineligibility period upon application for Medicaid benefits. For example, the lawyer might advise a client to transfer one half of the client's assets to a family member, enter a nursing home, use the other half of the assets to pay for nursing home care, then apply for Medicaid eligibility after the remaining personal funds run out, in which case no period of ineligibility would

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be assessed against the applicant for Medicaid. While the lawyer's advice clearly includes disposing of assets (in this case one half of the client's available assets) to become eligible for Medicaid, the means suggested and the end result are both lawful under current law. If the client follows the lawyer's advice, no period of ineligibility would be imposed upon the individual when he or she applies for Medicaid and the lawyer would not be subject to criminal liability.¹

Other communications are perhaps more problematical from an interpretive point of view. Suppose a lawyer advises a client to dispose of one half of his assets as described above, or suppose a client comes to a lawyer and says he wants to give away money to his children rather than use it for nursing home care, and the lawyer advises the client to transfer the assets to his children, but also counsels the client that if the client gives the money away the client must not apply for Medicaid benefits during the ineligibility period which begins to run from the date of the transfer until such time as the transferred moneys could have been used for nursing home care. In both instances the lawyer's communications to the client involve advice concerning actions that are lawful, and that if followed, would not result in the imposition of any Medicaid ineligibility period upon application for Medicaid benefits. However, if the client, for whatever reason, applies for Medicaid benefits before the ineligibility period has run out (the client forgets, misinterprets the legal advice, etc.), the lawyer arguably could be prosecuted under this new provision for what was, at the time of communication, legal advice. In other words, the lawyer or other adviser may be criminally liable for the giving of advice that is legal, depending upon the actions of a third party over whom the lawyer has no control.

One issue raised by this scenario is the constitutional right to free speech under the First Amendment. If the lawyer or other advisor counsels his client to dispose of assets and also counsels the client to do so in a manner that lawfully complies with the eligibility requirements for Medicaid, a court may find prosecution of the lawyer under this provision, if the client does not follow the lawyer's advice, to be an infringement upon the lawyer's First Amendment guarantee of free speech.²

¹ It is noted that the question of whether liability under Section 217 could result where assets have been disposed of but where the period of ineligibility has run out before a person applies for Medicaid has been addressed by at least one court under the current law. The U.S. District Court for Oregon (Anser L. Haggarty, U.S. District Court Judge) dismissed *Peebler & Nay v. Reno* for lack of subject matter jurisdiction on April 25, 1997. The court found that since the individual had waited out the penalty period before a Medicaid application was submitted, the criminal statute was not triggered even though a transfer of assets had occurred. Under this interpretation, one may dispose of assets, wait out the period during which one would otherwise be ineligible for Medicaid, then apply for prospective Medicaid benefits and not be subject to prosecution under Section 217.

² It is possible that a court might read this provision narrowly to avoid finding it unconstitutional. It could read the words "knowingly and willfully" to require the lawyer to know that the client intends to dispose of the assets in a manner that will result in the imposition of a period of ineligibility. This does not appear to be the most natural grammatical reading of the provision, but, in *United States v. X-Citement Video, Inc.*, 115 S. Ct. 464, 467 (1994), the Supreme Court construed the word "knowingly," in an

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This scenario also raises the question of what kind of conduct Congress intends to curtail by enactment of this provision. Would Congress be seeking to prohibit lawyers and other advisors who charge a fee for their services from discussing any and all options, even if lawful in themselves, for transferring or giving away assets to qualify for Medicaid payments for nursing home care? This issue arises because the act of giving away assets is always lawful, but a penalty, the ineligibility period, may or may not be imposed against an individual depending only upon the date of the individual's application for Medicaid.

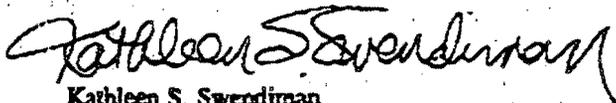
It may be reasonably argued that if a lawyer were to counsel a client to transfer assets for less than fair market value and then immediately apply for Medicaid eligibility, that the lawyer would be subject to liability under this provision if the client does so and his application is denied because of the transfer of assets. Clearly, the lawyer has advised the client to do something unlawful,³ and such communication would not be constitutionally protected as free speech. However, other than this very obvious example of a lawyer advising a client to do something unlawful, it is not clear what kinds of communications, not protected by the First Amendment, would be covered by this provision. Since this provision is currently in conference, Congress may wish to consider clarifying language in the accompanying report to assist courts in assessing interpretive issues that may arise concerning its implementation.

In a related issue, you inquired if the following alternative language would raise constitutional issues similar to those discussed above.

Whoever—...

(6) for a fee knowingly and willfully counsels or assists an individual not to disclose the disposition of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c)...

This alternative language would satisfy constitutional requirements, but Congress would need to decide whether this more narrowly drawn provision would meet policy goals for criminalizing advice or assistance for disposing of assets.



Kathleen S. Swendiman
Legislative Attorney

unrelated statute, in a comparably strained way "because of the respective presumptions that some form of scienter [knowledge] is to be implied in a criminal statute even if not expressed, and that a statute is to be construed where fairly possible so as to avoid substantial constitutional questions."

³ Interestingly, it is noted that if the client does not immediately apply for Medicaid benefits as counseled by the lawyer, but instead waits out the penalty period, that the lawyer could not then be prosecuted under this provision, since all elements of the crime would not be met.

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**THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES**

MEMORANDUM

July 9, 1997



TO: Chris Jennings
Special Assistant to the President
For Health Policy

FROM: Jack Bresch, Fish Brown

SUBJECT: CHA Position on PSO Provisions in House and Senate Bills

Hope the Conference is treating you well. We hope to meet or talk with you soon.

Attached is a summary of CHA positions on PSO issues in conference. Also attached is a Watson Wyatt study released yesterday concluding that federal Medicare consumer protections for health plans (current and in the Ways and Means bill) are more stringent than state laws.

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Attachment

Side-By-Side Comparison of House and Senate FY98 Budget Reconciliation Bills

Selected CHA Priorities – July 8, 1997, DRAFT

	House	Senate	CHA Comments
PSOs			
PSO Federal Certification	<p>Ways and Means: Back-up federal certification permitted after "completed" application has been filed and pending at state level for 90 days. Back-up certification continues indefinitely.</p> <p>Commerce: Back-up federal certification permitted after application has been filed and pending at the state level for 90 days. Deletes "completed" application requirement. Back-up certification continues indefinitely.</p>	Permits three-year federal certification period, but by January 1, 2001, all PSOs must have state licenses. No federal back-up certification.	CHA supports federal certification immediately available as in Senate bill, and at minimum, a federal "back up" certification as in House bill. "Completed" language is too restrictive and subject to state delay.
50/50 Requirement & Minimum Enrollment	<p>Ways and Means: The 50/50 rule may be waived immediately upon enactment if it is in the public interest to do so. After the interim rules are in place (6/1/98) including federal quality standards, the 50/50 requirement would be eliminated. Minimum enrollment of 1500 (500 in rural areas); HHS may waive for first 3 contract years.</p> <p>Commerce: Same provisions.</p>	The 50/50 rule is repealed as of January 1, 1999, but can be waived by the Secretary prior to that time if the plan meets all other beneficiary protections and quality standards. However, after two years, a PSO must have a minimum commercial enrollment of 1,500 commercial enrollees, or no less than 500 commercial enrollees in rural areas; HHS may waive for first 2 contract years.	CHA supports eliminating 50/50 rule at the same time for PSOs and other managed care plans.
PSO Solvency Standards	<p>Ways and Means: HHS must establish solvency standards that a PSO without a state license must meet. HHS must use negotiated rulemaking process.</p> <p>Commerce: Same Provision.</p>	Similar provision except that NAIC risk-based capital standards must be considered by HHS in the negotiated rulemaking process. PSOs must meet federal solvency standards even after PSOs become subject to state licensure requirements.	CHA supports federal solvency standards as a "safe harbor" when state standards inappropriate for PSOs as under House bill.

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Side-By-Side Comparison of House and Senate FY98 Budget Reconciliation Bills

Selected CHA Priorities – July 8, 1997, DRAFT

	House	Senate	CHA Comments
PSO Non-Solvency Standards	<p>Ways and Means: HHS must establish other (non-solvency) standards through the normal rulemaking process. These standards supersede state laws that are inconsistent with them.</p> <p>Commerce: Similar provision, but does not waive state non-solvency consumer protection laws.</p>	HHS to establish federal non-solvency requirements, however, PSOs also required to comply with state non-solvency laws.	CHA supports federal protections for beneficiaries as under Ways and Means bill.
PSO State Licensure	<p>Ways and Means: May result in the PSO's getting a state license eventually, but no requirement that a pending request be filed at the state level for licensure as the plan operates under the federal waiver process. State license opens up the commercial market if the PSO chooses to participate in that market.</p> <p>Commerce: More likely to result in the PSO's getting a state license since the licensure request is required to be pending at the state level. Opens up the commercial market if the PSO chooses to participate in it.</p>	A PSO dealing directly with the federal government will have all state standards for HMOs apply to it, be subjected to state oversight, and won't have the benefits of having a state license which opens up the commercial market to it.	If state licensure required, CHA supports a federal waiver process with a "hard" 90-day turnaround as in Commerce bill. CHA supports continuation of federal waiver process as in Ways and Means bill.
PSO Definition	<p>Ways and Means: The definition permits only PSOs that are under common ownership or control. Allows PSOs organized on the basis of "substantially shared financial risk" with "a majority financial interest."</p> <p>Commerce: Same provision.</p>	Allows PSOs organized on the basis of "substantially shared financial risk" with "a majority financial interest." Allows PSOs organized on the basis of "substantially shared financial risk" with "a majority financial interest." Requires PSOs to be "locally organized and operated."	Should clarify that "substantial portion" means "significantly more than a majority" as under Senate bill. Support House PSO definition that omits unclear "locally organized and operated" requirement.
Non-Compete Clauses	<p>Ways and Means: no provision.</p> <p>Commerce: Bars enforcement of non-compete clauses for providers forming PSOs.</p>	No provision.	CHA supports Commerce provision barring use of non-compete clauses.



THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

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NEWS RELEASE

For Immediate Release

NEW STUDY SUPPORTING PROVIDER-SPONSORED ORGANIZATIONS WELCOMED BY CATHOLIC HEALTH ASSOCIATION AND OTHER HEALTHCARE GROUPS

WASHINGTON (July 8) -- The Catholic Health Association of the United States (CHA) has joined with nine other healthcare groups in promoting the value of federally certified Provider-Sponsored Organizations (PSOs) and debunking claims made by insurance companies.

At a Washington, DC, news conference, CHA participated in the release of a new study countering insurance industry claims that state standards offer better protection for seniors. The study by Watson Wyatt Worldwide indicated that proposed federal consumer protection standards for PSOs surpass state health plan requirements in 49 of the 50 states.

"You can't dispute the facts," stated Cindy Dullea, senior consultant of Watson Wyatt Worldwide. "The findings clearly indicate that federal consumer protection and quality standards for PSOs exceed the state level by a significant margin." The study found that federal laws consistently exceed those of the states in areas that matter most to consumers, i.e., marketing, restrictions on enrollment and access, and quality assurance and utilization review.

"The study unmasks as bogus an argument the insurance companies were using with members of Congress regarding what a PSO can do in providing high quality, coordinated care to Medicare beneficiaries," stated William J. Cox, CHA's executive vice president. "There is no reason for Congress to enact anticompetitive measures to keep community-based healthcare delivery systems such as PSOs out of the marketplace and further limit the choices for Medicare beneficiaries."

Medicare PSOs will not be in the insurance business, and that may be the rub, added Cox. "There have been efforts on Capitol Hill to have PSOs look like insurance companies when they really aren't," he stated.

PSOs will give physicians and hospitals the ability to compete with managed care companies to serve Medicare beneficiaries and the community at large. The primary business of PSOs is the delivery of care, not pooling and spreading risk. As a result, PSOs reduce administrative layers common to insurance companies and many managed care organizations.

CHA and other healthcare organizations, including the American Hospital Association, the Federation of American Health Systems, InterHealth, VHA Inc., the National Association of Public Hospitals and Health Systems, the Association of American Medical Colleges, Premier, American Medical Group Association, and the National Association of Children's Hospitals, will continue to urge Congress to enact PSO legislation that establishes appropriate federal PSO oversight and makes PSOs an available option for Medicare.

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The St. Louis-based Catholic Health Association of the United States represents more than 1,200 Catholic-sponsored facilities and organizations. The members make up the nation's largest group of not-for-profit healthcare facilities under a single form of sponsorship.

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**CONSUMER PROTECTION
AND QUALITY: COMPARING
STATE AND FEDERAL HMO
LAW TO THE PROPOSED
PSO LEGISLATION**

June 1997



EXECUTIVE SUMMARY

Watson Wyatt Worldwide was retained to conduct an independent review of Medicare Risk consumer protections and quality standards and how they compare to the consumer protections and quality standards for HMO enrollees required by each state.

This report summarizes the findings of that evaluation.

Description of Methodology And Major Assumptions

The analysis was conducted via a line by line review of current state HMO laws, current Federal Medicare laws and regulations and proposed Federal Medicare legislation.

The analysis identified where there was a clear differential in the level of consumer protection, and where specific quality standards were required. In those cases where consumer protections were required by both the state and the federal governments and the protection was similar and comparable in it was identified as such. If there was a similar consumer protection at the state and federal level but the state had more specific requirements such as a time frame for resolution, the state was determined to exceed the federal requirements.

Sources used in the evaluation include:

The sources of data for the evaluation were current state HMO law and current Medicare law. The source of the proposed Federal legislation was from the Ways and Means Committee Draft as of June 9, 1997.

- ◆ State HMO legislation : Gathered using LEXIS/NEXIS and LEXSEE; June 1997
- ◆ Current Federal Law: Social Security Act, Section 1876, 104th Congress, Code of Federal Regulations (CFR), Title 42, 400.200.
- ◆ Proposed Legislation: Medicare Amendments Act of 1997, Title X, Section 1000, Subchapter A

Federal Law and Regulations were included in the analysis due to their clarity in the description of consumer protections and quality standards for Medicare beneficiaries. State law was used in the analysis to assure consistency in the review across states.

Discussion of Definitions and Methodology

Watson Wyatt Worldwide associates compared and contrasted the HMO laws in each of the fifty states to the current and proposed Medicare laws. The review concentrated on consumer protections and quality standards in the following areas:



- ◆ **Consumer Protections.** The analysis reviewed whether the current state legislation contains greater consumer protections than current and proposed federal law. Consumer protections were categorized into:
 - Enrollment and disenrollment process
 - Grievance process
 - Coverage denial and appeal process
 - Emergency and urgent care coverage and patient perception policies
 - Availability and access
 - In-network versus out of network
 - Numbers, location and types of providers
 - Information reporting requirements
 - Structural requirements

- ◆ **Quality Standards.** The analysis reviewed whether current state legislation contains greater quality standards or requirements than the current and proposed federal legislation. The quality standards were categorized into:
 - Quality assurance process
 - Utilization review process

The findings of the review were summarized into the following categories:

- ◆ **SE = State Exceeds:** Review of the State's HMO Law revealed more specific requirements than the current Federal Law or proposed Federal Legislation.
- ◆ **C = Comparable:** The consumer protection or quality standard language in the State's HMO law is equivalent to the current Federal Medicare Law and/or Proposed Federal Legislation for similar issues.
- ◆ **FE = Federal Exceeds:** The current Federal Law has more requirements for consumer protection and quality standards than the State's HMO Law.
- ◆ **FE+ = Federal Exceeds State and Current Federal:** The proposed Federal Legislation has more specific requirements compared to the State's HMO law and current Federal Medicare Law.

The summaries by consumer protection and by state are contained in the appendix that accompanies this report.



Summary of Major Findings

Overall Federal Requirements for Consumer Protection exceed those of the States

Overall, the current and proposed consumer protections and quality standards contained within federal law exceed those of the states. Specifically in the following areas:

- ***Marketing:*** Federal requirements are more specific than every state except Minnesota. The federal requirements require review and approval of materials at least 45 days prior to use and contain very specific wording regarding marketing activities which would be described as deceptive practice as well as potential enrollee discrimination.
- ***Enrollment and Coverage:*** Federal requirements are more specific than every state. Federal requirements include open enrollment periods, no limitation or discrimination of Medicare beneficiaries, and requirements for enrollment information. Both the current and proposed Federal Law stress that enrollee have freedom of choice. The Federal Law contains specific language in regards to the terms under which an organization may disenroll a Medicare enrollee.
- ***Access:*** Federal requirements are more specific than every state. Federal requirements include explicit wording on operational requirements for delivery of services to include access to providers 24 hours/day, 7 days/week, information on contracted providers and geographical locations, and assistance in getting supplemental coverage.
- ***Quality Assurance and Utilization Review:*** Federal requirements exceed those of all but six states. Proposed federal requirements stress health outcomes and provide for a review of health care services by physicians and other health care professionals. Quality Assurance activities include data collection of performance and patient results as well as the establishment of a review committee to evaluate substandard services.
- ***Information Reporting:*** Proposed federal requirements are more extensive in the amount and types of data to be reported to and regularly shared with beneficiaries than that required by all states except New York. The federal requirement requires that all operational activities which include overall financial business transactions be provided annually.
- ***Structure:*** Federal requirements regarding organizational structure detail management and solvency planning, and address potential conflict of interest issues. The specificity of the federal law was more extensive than most state requirements.

Consumer Protections and Quality Standards where the States' requirements exceed those of current or proposed Federal law.



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The review identified the following issues where the states' requirements exceeded those of the federal:

- **Agent Licensing:** Thirty-eight (38) states require some level of licensing for individuals who sell insurance including HMO coverage. There are no clear requirements in federal law for the same level of oversight for individuals who sell Medicare risk or PSO type coverages.
- **Grievance Compliance:** Three (3) states have a more specific grievance process for consumers which detail the process for registering grievances and the requirements the HMO has for responding and resolving within specified timeframes. These requirements include toll free telephone access and requirements for keeping the enrollee informed as to the grievance status.
- **Quality Standards:** Quality (QA/UR) standards are required at the state and federal levels. The federal quality standards are more specific for all but six states. The six states that exceeded federal law had more specific language regarding the requirements of the QA and/or UR program(s). Two states, in addition to having more specific language, required additional quality program components.
 - **Provider Profiling:** One (1) state requires specific levels of provider profiling where providers are compared to their peers within specific categories.
 - **Credentialing:** One (1) state requires a comprehensive credentialing process that evaluates the qualifications and credentials of a provider in association with defined criteria.
- **Organization Advisory Panel/Groups:** Twelve (12) states require consumers hold positions on the health plan's governing board or require a consumer advisory panel to analyze delivery and quality of care.
- **Mandated Benefit Language:** Eighteen (18) states have mandated benefits for their HMOs. State licensed HMOs are required to offer certain benefits in their health plans. Many Medicare HMOs have elected to offer these mandated benefits as part of their Medicare offerings. Certain Medicare HMOs do not offer these benefits. Under current federal law, Medicare benefits are generally assumed to preempt these mandates.

Conclusion

The evaluation of state versus federal consumer protections and quality standards indicates that by a significant margin, federal requirements exceed those at the state level.

Even with these areas where states exceed federal protections, the vast majority of consumer protections are greater at the federal level.

Qualifications of the Firm

Watson Wyatt Worldwide is the global alliance of two major consulting firms - The Wyatt Company, founded in the US in 1943, and R. Watson and Sons, which was founded in the United Kingdom in 1878. Together this alliance provides a full international range of health care consulting services. Our client base is diverse and includes many of the world's largest companies. We serve as consultants to more than half of the FORTUNE 1000 companies as well as numerous other mid-sized to large companies. In the healthcare arena, we serve 20% of all the US healthcare companies in some capacity.

We employ over 4,500 associates located in 90 offices worldwide. Watson Wyatt Worldwide's corporate offices are in Washington D.C. and Reigate, England.

Watson Wyatt Worldwide is uniquely qualified to assist the review of state HMO Law against the current and proposed Federal Legislation to evaluate consumer protection and quality.

- We have a broad knowledge of all components of the health care industry and keen insight into the future of health care. We advise health care purchasers, providers and insurer health care organizations nationwide and abroad.
- We have worked with other health care organizations to evaluate Medicare Risk requirements.
- Our activities are focused on assisting evolving Provider Sponsored Networks with their organizational and operational strategies.
- Our project team was comprised of both healthcare professionals as well as researchers which brought a multi-faceted approach to this engagement.

