Kyl file

SENATOR KYL'S MEDICARE PHYSICIAN PAYMENT AMENDMENT

- **"Kyl amendment" waters down recent budget provision**: Eliminates the two-year exclusion from Medicare for physicians who privately contract with beneficiaries (i.e., Medicare doesn't pay; beneficiary agree to pay whatever rate the physician charges).

- **Senator Kyl is holding Nancy Ann Min DeParle's nomination hostage**: The Senator has put a hold on the nominee for Administrator of the Health Care Financing Administration (HCFA) until the Administration makes concessions on this provision.

Arguments in Favor of the Amendment

- **Prevents doctors from serving low-income beneficiaries**: The two-year exclusion may force some doctors who want to private contract for some of their services to abandon low-income Medicare beneficiaries who cannot afford the contract rates.

- **Beneficiary "choice":** As with the BBA, this gives beneficiaries choice -- they should have the right to pay higher rates for the doctor of their choice.

- **Even the bureaucratic National Health Service allows private contracting:** By excluding physicians who privately contract, Medicare is being more rigid than even the most overly bureaucratic, nationalized health care system in the world, the British system.

Arguments Against the Amendment

- **Opens the door to pervasive and undetectable fraud**: If physicians can selectively contract for beneficiaries and/or services, Medicare will have to track every single contract to tell which bills to pay and which are subject to private payment. Inevitably, doctors will get paid twice.

- **Encourages two-tiered system**: Encourages private contracting by creating an incentive to accept Medicare rates only for healthy beneficiaries or well-paid services.

  - **Rural beneficiaries could suffer:** Even if one rural doctor decides to privately contract for some or all services, it could result in reduced access for low-income beneficiaries who cannot pay their local doctor the full cost of the service out of pocket.

  - **The best, academic health center specialists may become inaccessible**: These physicians, who might otherwise stay in Medicare to serve all beneficiaries, could start rationing their services by wealth, eroding access to quality care for all beneficiaires.

- **British system is not enviable**: This amendment may create a British-like system -- where specialty services are available via a waiting list while the best physicians treat wealthy people privately. This two-tiered system is exactly what Medicare was designed to avoid.

- **Opposed by beneficiary groups**: While the AMA claims this provision gives beneficiaries more choice, beneficiaries do not agree. Virtually all of the aging groups, including the Leadership Coalition on Health Care and AARP, oppose this amendment as undermining Medicare and beneficiaries' protections.

- **Unfair process**: Republicans agreed to the two-year exclusion in the BBA only three months ago. To, in the last days of the session, hold up a qualified nominee on an important issue without a public or bi-partisan process is unwarranted and ill-advised.

KYL AMENDMENT QUESTIONS

Q. **ISN'T IT TRUE THAT BY OPPOSING THE KYL AMENDMENT, MEDICARE IS BEING MORE STRICT THAN EVEN THE BRITISH HEALTH CARE SYSTEM, THE MOST BUREAUCRATIC SYSTEM IN THE WORLD?**

A. Actually, if we allowed certain doctors to pick and choose which Medicare beneficiaries they want to serve based on wealth, we would end up with a system exactly like the British system -- where the government system only offers specialty services on a waiting list while the best physicians treat people in the private system at higher rates. This two-tiered system is exactly what Medicare was designed to avoid.

IS THIS OK? ANY EDITS ON THE 1-pager?

Also: Please call re 2 other time-sensitive things.

Jeanne

Union, the President's Quality Commission will have made recommendations on a range of consumer protections and the bipartisan bills on the Hill will be more fully developed. The President should ask Congress to take immediate action to pass legislation (either our own or a bill that we endorse) to improve consumers protections and quality health care.

$24

Children's Outreach Initiative. This past year we made an unprecedented investment in the health of our children, the largest ~~investment~~ commitment since the enactment of the Medicaid program in 1965. But now we have to make this investment a reality and ensure that children truly get the health care they need to grow strong and healthy. I am calling on those across the nation -- the millions of eligible foundations, states, providers, schools child care centers -- to reach out to find these kids who are eligible for the new children's health program or Medicaid and make sure they are enrolled. Our children deserve this national effort.

Fraud and Abuse. Taking steps to root fraud and abuse out of the Medicare and Medicaid programs. First step for the Medicare Commission,

File Kyl Amendment

To: Chris Jennings

From: Bill Vaughan

Re: Arguments on Kyl

The following letter might be one way of arguing this Kyl re-opening stuff!

BILL THOMAS, CALIFORNIA, CHAIRMAN
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WASHINGTON, DC 20515

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BILL VAUGHAN, SUBCOMMITTEE MINORITY

September 8, 1997

Franklin Raines, Director
Office of Management and Budget
The Old Executive Office Building
Washington, DC 20503

Dear Director Raines:

Included in the Balanced Budget Act is an amendment by Senator Kyl allowing a doctor to sign private contracts with Medicare beneficiaries requiring those beneficiaries to give up their Medicare insurance when they use that doctor. A doctor who signs such a contract must make a commitment not to bill Medicare for any of his patients for a two year period.

Advocates of private contracting support it in the name of freedom.

I had thought it was just plain greed--the desire of a doctor to bill any amount rather than have to live with the Medicare resource-based relative value fee schedule.

But perhaps it is a question of freedom, in which case the better response by the public would be to accept this proposal--but the public should have the freedom to bill the doctor, with interest, for all the public subsidies he or she has received.

The reason that American medicine is a world leader and that medicine has moved beyond the level of penicillin, amputations, and mustard plasters is the hundreds of billions of taxpayer dollars that have been poured into the National Institutes of Health, the Public Health Service, the various health professions manpower training programs, Medicare's Graduate Medical Education programs (which average about $60,000 a year in subsidy for the training of each resident doctor), and the capital assistance to the hospitals in which these doctors trained.

The doctors who advocate private contracting tend to say that they are special and can command extra fees. The only reason that is true is that the public has substantially subsidized their education and the research on which their fame and fortune rests.

For a doctor to now want to private contract and avoid Medicare patients would be like a West Point cadet saying that he or she did not want to serve in the Regular Army after graduation. That may be freedom, but it is a subsidy we do not permit.

In the case of these doctors who became competent through the massive health subsidies we have provided, we should permit them to privately contract as long as they repay, with interest, the estimated value of the subsidies they received. I hope the Office of Management and Budget could estimate the total value of physician and clinical practice health subidies, including tax subsidies, that have been provided over the past forty years. From this we could develop a formula so that when, for example, a 55 year old doctor decides he wants the freedom to private contract, he can also have the freedom to repay the public for its investment in making him such a wonderful doctor who can command such high fees.

Thank you for your assistance with this request.

Sincerely,

/s/

Pete Stark
Member of Congress

File Kyl Amendment

Memorandum

To: Sarah Bianchi
From: Kevin Brown
Date: October 3, 1997
Subject: Kyl Amendment Briefing by AARP

Longworth 1100, 10am

3 representatives from AARP led discussion

The first document attached summarizes everything discussed in the briefing. If you want a summary, I can write one, however, the attached document covers point by point what was discussed.

Can you get me some Cliff's Notes on Medicare?! I felt very overwhelmed observing the briefing, however, I find it very interesting. Please refer any documents to me that might help me understand the system better.

AARP

Bringing lifetimes of experience and leadership to serve all generations.

Medicare Physician Private Contracting
S.1194/H.R. 2497

Some physicians are urging Congress to repeal important program integrity and consumer protection provisions that are part of the Medicare private contracting section of the Balanced Budget Act of 1997. **AARP believes that such attempts would leave Medicare vulnerable to greater fraud and abuse and beneficiaries at risk of higher health care costs.**

Background

Section 4507 of the Balanced Budget Act of 1997 (BBA) allows physicians to contract privately with Medicare beneficiaries for services that would otherwise be covered by the program. Under a private contract arrangement, a beneficiary agrees to pay 100% of whatever amount the physician charges for services covered by the contract. Medicare does not pay any portion of the cost of these services. Prior to the BBA, covered services provided to a Medicare beneficiary enrolled in Part B were bound by Medicare's payment rules and private contracting was not allowed. (There are no restrictions on private contracting for services the program does not cover.) While there was some anecdotal evidence of "private arrangements" for covered services, these were not consistent with the Medicare statute.

The BBA provision, which originated in a floor amendment offered by Senator Jon Kyl (R-AZ) on June 25, was intended, according to Senator Kyl, to allow "for those 9 percent of the physicians who do not treat Medicare patients to continue to treat their patients as they always have."

To protect Medicare from fraud and to ensure that private contract arrangements are limited to the narrow subset of physicians who otherwise would not be available to Medicare beneficiaries, the BBA provision is limited to physicians who agree, in an affidavit, to forgo all reimbursement from Medicare for at least 2 years. To ensure that beneficiaries know the consequences of their decision to contract privately with one of these physicians, the new law also requires the doctor to disclose to the beneficiary that no Medicare payment will be made for privately contracted services, no balance billing limits will apply, no Medigap coverage will be available, and the services to be performed would be paid for by Medicare if provided by another physician. In other words, if a physician and a beneficiary want to have a private agreement, they can, but the beneficiary knows up front, at least in general terms, to what they are agreeing.

American Association of Retired Persons 601 E Street, NW Washington, DC 20049 (202) 434-2277

Margaret A. Dixon, Ed.D. *President* Horace B. Deets *Executive Director*

S. 1194/H.R. 2497 - Proposals to Amend the BBA Private Contracting Provision

On September 18, less than 2 months after the BBA was signed into law, Senator Kyl, with the strong backing of the American Medical Association (AMA), proposed repealing some of the program integrity and consumer protections included in the private contracting provision and expanding the scope of private contracting far beyond the original Kyl proposal.

If Section 4507 of the Balanced Budget Act of 1997 is amended by S. 1194/H.R. 2497 the resulting law would:

- Allow all physicians to charge more than the levels set by the Congress or negotiated with Medicare+Choice plans by contracting privately with beneficiaries. S. 1194 and H.R. 2497 would permit physicians in the traditional Medicare program as well as those in HMOs and the new Medicare+Choice plans to contract privately with their patients. The contract – which would have to be signed by the beneficiary and the provider prior to services being provided – would indicate that no claims would be submitted to Medicare for payment for the services identified in the contract. The beneficiary would have to agree to be responsible for 100% of the physician's charges for all privately contracted services.

- Expand the private contracting provision in the BBA to allow physicians to charge higher fees by contracting privately on a service-by-service, or "a la carte," basis. This means that a physician could bill a beneficiary for 100% of his charge for some of the services the beneficiary received and bill Medicare for other services.

- Allow physicians to negotiate higher charges privately with low-income "dually eligible" and Qualified Medicare Beneficiary (QMB) recipients.

- Repeal the requirement in the BBA for physicians who privately contract for higher fees to file an affidavit with the Health Care Financing Administration (HCFA) and forgo reimbursement from Medicare for all Medicare patients for 2 years.

- Allow Medicare to collect only "the minimum information" necessary from physicians to assure that the program doesn't pay for services that have already been paid for by the beneficiary (See page 3).

- Maintain the provision that physicians who have been excluded from the Medicare program for fraud and/or poor quality of care disclose this fact to beneficiaries in the contract.

- Maintain the BBA requirement that the contract a beneficiary signs clearly indicate that: claims will not be submitted to Medicare by either the physician or the beneficiary; the beneficiary is responsible for the full cost of the privately contracted services; balance billing limits do not apply to contracted services; Medigap coverage will not be available for contracted services; and the services to be performed could be paid for by Medicare if provided by another physician.

The Kyl Bill Would Hurt Beneficiaries and Medicare

- **The Kyl Bill Leaves Beneficiaries and the Medicare Program More Vulnerable to Fraud and Abuse**

  ⇒ HCFA – which already confronts significant fraud and abuse in Medicare – could find it more difficult to prevent or detect fraud or abuse because the bill eliminates provisions from the underlying BBA that would have made more careful tracking possible. S. 1194 and H.R. 2497 provide that only "the minimum information necessary to avoid any payment under part A or B for services covered under the contract" would be given to HCFA or Medicare+Choice plans for use in determining which claims should be paid by Medicare. This choice of language may, intentionally or not, tie the hands of program administrators seeking to protect the fiscal integrity of the program. For instance, will this information specifically include the names of the doctor and the patient, as well as the specific services affected by the contract? Consider this example: a physician who contracts privately with a beneficiary for payment of two of five services might fraudulently file a claim with Medicare for all five services – even though only three services should be paid by the program. In this case, unless HCFA has complete information on each private contract – including the doctor, patient, and specific services involved – and can align it with claim filings, both Medicare and the beneficiary could end up paying for the same services.

  ⇒ Allowing physicians to privately contract with low-income dually eligible and QMB beneficiaries also creates the possibility of Medicaid fraud if physicians bill both the beneficiary and state Medicaid programs – which are also struggling with the problem of fraud and abuse.

  ⇒ Beneficiary costs could increase significantly because physicians would be free to "unbundle" services that are normally paid for as a package of services. In these cases, beneficiaries – particularly when they are very ill -- would pay significantly more out-of-pocket because they would pay for each individual service rather than for a group of services.

- **Allowing Private Contracting Arrangements in Medicare+Choice Plans Poses Unique Problems:**

  - ⇒ Under BBA, the Medicare program will make per capita payments to the new Medicare+Choice plans. In return, these plans will provide beneficiaries with health care services, including physician services. Since the Kyl bill allows physicians to privately contract for services they provide to beneficiaries in Medicare+Choice plans, physicians could be paid twice for the same services. For instance, physicians in the new Provider Sponsored Organizations (PSO) could be paid once by Medicare through its per capita payment and again by the beneficiary for the same service through the private contract arrangement. Since the per capita payment is made in advance to the plans by Medicare, this double payment would be very difficult, if not impossible, for Medicare to recoup.

  - ⇒ The capitated payments Medicare makes to HMOs and the new Medicare+Choice plans include funds to cover physicians' services. Yet if physicians are allowed to privately contract with beneficiaries in these plans, the plans would be able to keep the funds for services not provided by the plans, but which beneficiaries paid for under private contracts.

  - ⇒ Beneficiaries are likely to join Medicare+Choice plans because they believe these plans may cost them less out-of-pocket than traditional fee-for-service coupled with supplemental insurance (Medigap). S. 1194 and H.R. 2497 would undermine efforts to encourage more beneficiaries to enroll in the new Medicare+Choice plans because beneficiaries could end up paying more, not less, for their care.

  - ⇒ Physicians who contract with employer-provided plans to provide care for younger workers typically abide by the plan's reimbursement rates and the limits on enrollee out-of-pocket costs. However, under the new Kyl proposal, doctors who contract with Medicare HMOs and the new Medicare+Choice plans would not have to adhere to the plan's reimbursement or to beneficiary out-of-pocket limits as they have to in comparable private sector arrangements. They would be able to privately contract with beneficiaries enrolled in these plans. This practice essentially would deny Medicare beneficiaries a protection enjoyed by millions of workers and their families.

- **Physicians Won't Have to Disclose the Cost of Services Being Privately Contracted:** As with the underlying BBA, the new Kyl bill does not require physicians who contract privately to disclose their fees to beneficiaries before the services are provided. There would be no fee schedule, no limits on what physicians may charge under a private contract and no protection from out-of-pocket costs under Medigap policies. Therefore, beneficiaries would not know what their out-of-pocket liability for private contract charges would be and would have difficulty budgeting for the costs of their care. While this may be manageable for some wealthy individuals, it may not be manageable for the average beneficiary.

- **The Kyl Bill Leaves Low-Income Beneficiaries Vulnerable:** The Kyl bill would allow physicians to contract privately with beneficiaries who are dually eligible for Medicare and Medicaid as well as those low-income beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) program. By definition, these are beneficiaries with very modest incomes -- below 100% of poverty. It is unclear whether or to what extent this would leave state Medicaid programs vulnerable to higher costs.

AARP believes that the new Kyl bill would weaken critical protections in BBA for beneficiaries and the fiscal integrity of the Medicare program. For many beneficiaries, the "choice" available under the Kyl bill could mean an immediate and dramatic increase in out-of-pocket costs for physicians' services. Equally as important, for the Medicare program, the Kyl bill would add to the already critical problems of fraud and abuse.

AARP Federal Affairs
10/3/97

Following are the text of the original Kyl Amendment adopted in Senate June 25;

the text of the amendment as enacted in the BBA;

and the text of HR 2497

Kyl

AMENDMENT NO. 468

(Purpose: To allow medicare beneficiaries to enter into private contracts for services)

On page 685, after line 25, add the following:

SEC. . FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b-2) the following:

"CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

"SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

"(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.—Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

"(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

"(1) analyses regarding—

"(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

"(B) the quality of the health services provided under such contracts; and

"(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

FROM BBA

SEC. 4507. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.

(a) ITEMS OR SERVICES PROVIDED THROUGH PRIVATE CONTRACTS.—

(1) IN GENERAL.—Section 1802 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

"(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

"(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

"(A) for which no claim for payment is to be submitted under this title, and

"(B) for which the physician or practitioner receives—

"(i) no reimbursement under this title directly or on a capitated basis, and

"(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

"(2) BENEFICIARY PROTECTIONS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

"(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

"(ii) the contract contains the items described in subparagraph (B); and

"(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

"(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

"(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by this title;

"(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

"(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

"(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

"(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the Medicare Program under section 1128.

"(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effe

during the period any item or service is to be provided pursuant to the contract.

"(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

"(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

"(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any Medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and

"(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

"(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

"(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

"(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

"(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a Medicare beneficiary under a contract described in paragraph (1).

"(5) DEFINITIONS.—In this subsection:

"(A) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) PHYSICIAN.—The term 'physician' has the meaning given such term by section 1861(r)(1).

"(C) PRACTITIONER.—The term 'practitioner' has the meaning given such term by section 1842(b)(18)(C)."

(2) CONFORMING AMENDMENTS.—

(A) Section 1802 (42 U.S.C. 1395a) is amended by striking "Any" and inserting "(a) BASIC FREEDOM OF CHOICE.—Any".

(B) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4319(b) and 4432, is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by adding after paragraph (18) the following new paragraph:

"(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b)."

(b) REPORT.—Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title of private contracts entered into under the amendment made by subsection (a). Such report shall include—

(1) analyses regarding—

(A) the fiscal impact of such contracts on total Federal expenditures under title XVIII of the Social Security Act and on out-of-pocket expenditures by Medicare beneficiaries for health services under such title; and

(B) the quality of the health services provided under such contracts; and

(2) recommendations as to whether Medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after January 1, 1998.

FILE h2497.ih

HR 2497 IH
105th CONGRESS
1st Session
To amend title XVIII of the Social Security Act to clarify the right of Medicare beneficiaries to enter into private contracts with physicians and other health care professionals for the provision of health services for which no payment is sought under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES
September 18, 1997

Mr. ARCHER (for himself, Mr. THOMAS, Mr. GINGRICH, Mr. ARMEY, Mr. DELAY, Mr. BOEHNER, Mr. LIVINGSTON, Mr. HYDE, Mr. STUMP, Mr. COMBEST, Mr. TALENT, Mr. CRANE, Mr. NORWOOD, Mr. GANSKE, Mr. LINDER, Mr. PAUL, Mr. COOKSEY, Mr. COBURN, Mr. SHAW, Mr. MCCRERY, Mr. RAMSTAD, Mrs. JOHNSON of Connecticut, Mr. COLLINS, Mr. CAMP, Mr. SAM JOHNSON of Texas, Mr. ENSIGN, Mr. HAYWORTH, Mr. WELLER, Mr. ISTOOK, Mr. ROHRABACHER, Mr. DAN SCHAEFER of Colorado, Mr. BARTON of Texas, Mr. BONILLA, Mr. BOB SCHAFFER of Colorado, Mr. DOOLITTLE, Mr. MILLER of Florida, Mr. SMITH of Michigan, Mr. HASTINGS of Washington, Mr. MANZULLO, Mrs. CUBIN, Mr. HOEKSTRA, Mr. UPTON, Mr. HOSTETTLER, Mr. KNOLLENBERG, Mr. STEARNS, Mr. DICKEY, Mr. THORNBERRY, Mr. SESSIONS, Mr. CANNON, Ms. GRANGER, Mr. BRADY, Mr. HILL, and Mr. SALMON) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to clarify the right of Medicare beneficiaries to enter into private contracts with physicians and other health care professionals for the provision of health services for which no payment is sought under the Medicare program.

[Italic->] Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, [<-Italic]

SECTION 1. SHORT TITLE.

This Act may be cited as the `Medicare Beneficiary Freedom To Contract Act of 1997'.

SEC. 2. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.

(a) IN GENERAL- Section 1802 of the Social Security Act (42 U.S.C. 1395a) is amended by striking subsection (b), as added by section 4507(a) of the Balanced Budget Act of 1997 (Public Law 105-33), and inserting the following:

`(b) CLARIFICATION OF USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES-

`(1) IN GENERAL- Nothing in this title shall prohibit a medicare beneficiary from entering into a private contract with a physician or health care practitioner for the provision of medicare covered professional services (as defined in paragraph (5)(C)) if--

`(A) the services are covered under a private contract that is between the beneficiary and the physician or practitioner and meets the requirements of paragraph (2);

`(B) under the private contract no claim for payment for services covered under the contract is to be submitted (and no payment made) under part A or B, under a contract under section 1876, or under a Medicare+Choice plan (other than an MSA plan); and

`(C)(i) the Secretary has been provided with the minimum information necessary to avoid any payment under part A or B for services covered under the contract, or

`(ii) in the case of an individual enrolled under a

`(ii) in the case of an individual enrolled under a contract under section 1876 or a Medicare+Choice plan (other than an MSA plan) under part C, the eligible organization under the contract or the Medicare+Choice organization offering the plan has been provided the minimum information necessary to avoid any payment under such contract or plan for services covered under the contract.

`(2) REQUIREMENTS FOR PRIVATE CONTRACTS- The requirements in this paragraph for a private contract between a medicare beneficiary and a physician or health care practitioner are as follows:

`(A) GENERAL FORM OF CONTRACT- The contract is in writing and is signed by the medicare beneficiary.

`(B) NO CLAIMS TO BE SUBMITTED FOR COVERED SERVICES- The contract provides that no party to the contract (and no entity on behalf of any party to the contract) shall submit any claim for (or request) payment for services covered under the contract under part A or B, under a contract under section 1876, or under a Medicare+Choice plan (other than an MSA plan).

`(C) SCOPE OF SERVICES- The contract identifies the medicare covered professional services and the period (if any) to be covered under the contract, but does not cover any services furnished--

`(i) before the contract is entered into; or

`(ii) for the treatment of an emergency medical condition (as defined in section 1867(e)(1)(A)), unless the contract was entered into before the onset of the emergency medical condition.

`(D) CLEAR DISCLOSURE OF TERMS- The contract clearly indicates that by signing the contract the medicare beneficiary--

`(i) agrees not to submit a claim (or to request that anyone submit a claim) under part A or B (or under section 1876 or under a Medicare+Choice plan, other than an MSA plan) for services covered under the contract;

`(ii) agrees to be responsible, whether through insurance or otherwise, for payment for such services and understands that no reimbursement will be provided under such part, contract, or plan for such services;

`(iii) acknowledges that no limits under this title (including limits under paragraph (1) and (3) of section 1848(g)) will apply to amounts that may be charged for such services;

`(iv) acknowledges that medicare supplemental policies under section 1882 do not, and other supplemental health plans and policies may elect not to, make payments for such services because payment is not made under this title; and

`(v) acknowledges that the beneficiary has the right to have such services provided by (or under the supervision of) other physicians or health care practitioners for whom payment would be made under such part, contract, or plan.

Such contract shall also clearly indicate whether the physician or practitioner involved is excluded from participation under this title.

`(3) MODIFICATIONS- The parties to a private contract may mutually agree at any time to modify or terminate the contract on a prospective basis, consistent with the provisions of paragraphs (1) and (2).

`(4) NO REQUIREMENTS FOR SERVICES FURNISHED TO MSA PLAN ENROLLEES- The requirements of paragraphs (1) and (2) do not apply to any contract or arrangement for the provision of

apply to any contract or arrangement for the provision of services to a medicare beneficiary enrolled in an MSA plan under part C.

`(5) DEFINITIONS- In this subsection:

`(A) HEALTH CARE PRACTITIONER- The term `health care practitioner' means a practitioner described in section 1842(b)(18)(C).

`(B) MEDICARE BENEFICIARY- The term `medicare beneficiary' means an individual who is enrolled under part B.

`(C) MEDICARE COVERED PROFESSIONAL SERVICES- The term `medicare covered professional services' means--

`(i) physicians' services (as defined in section 1861(q), and including services described in section 1861(s)(2)(A)), and

`(ii) professional services of health care practitioners, including services described in section 1842(b)(18)(D),

for which payment may be made under part A or B, under a contract under section 1876, or under a Medicare+Choice plan but for the provisions of a private contract that meets the requirements of paragraph (2).

`(D) MEDICARE+CHOICE PLAN; MSA PLAN- The terms `Medicare+Choice plan' and `MSA plan' have the meanings given such terms in section 1859.

`(E) PHYSICIAN- The term `physician' has the meaning given such term in section 1861(r).'.

(b) CONFORMING AMENDMENTS CLARIFYING EXEMPTION FROM LIMITING CHARGE AND FROM REQUIREMENT FOR SUBMISSION OF CLAIMS- Section 1848(g) of the Social Security Act (42 U.S.C. 1395w-4(g)) is amended--

(1) in paragraph (1)(A), by striking `In' and inserting `Subject to paragraph (8), in';

(2) in paragraph (3)(A), by striking `Payment' and inserting `Subject to paragraph (8), payment';

(3) in paragraph (4)(A), by striking `For' and inserting `Subject to paragraph (8), for'; and

(4) by adding at the end the following new paragraph:

`(8) EXEMPTION FROM REQUIREMENTS FOR SERVICES FURNISHED UNDER PRIVATE CONTRACTS-

`(A) IN GENERAL- Pursuant to section 1802(b)(1), paragraphs (1), (3), and (4) do not apply with respect to physicians' services (and services described in section 1861(s)(2)(A)) furnished to an individual by (or under the supervision of) a physician if the conditions described in section 1802(b)(1) are met with respect to the services.

`(B) NO RESTRICTIONS FOR ENROLLEES IN MSA PLANS- Such paragraphs do not apply with respect to services furnished to individuals enrolled with MSA plans under part C, without regard to whether the conditions described in subparagraphs (A) through (C) of section 1802(b)(1) are met.

`(C) APPLICATION TO ENROLLEES IN OTHER PLANS- Subject to subparagraph (B) and section 1852(k)(2), the provisions of subparagraph (A) shall apply in the case of an individual enrolled under a contract under section 1876 or under a Medicare+Choice plan (other than an MSA plan) under part C, in the same manner as they apply to individuals not enrolled under such a contract or plan.'.

(c) CONFORMING AMENDMENTS-

(1) Section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) is amended by adding at the end the following:

`(E) The provisions of section 1848(g)(8) shall apply with respect to exemption from limitations on charges and from billing requirements for services of health care practitioners described in this paragraph in the same manner as such provisions apply to

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Medicare Current Beneficiary Survey (MCBS) reveal whether beneficiaries report problems obtaining care or have become less satisfied with the care received. Gathering data on beneficiary complaints about access to physicians can complement the MCBS data. Both physician surveys and claims data can be used to assess physician willingness to serve Medicare beneficiaries. Over the years, the Commission has analyzed data from these varied sources to provide the Congress with an assessment of how Medicare beneficiaries are faring under the policies adopted in OBRA89 and modified since that time.

A key element in the Commission's monitoring strategy has been to focus on access for vulnerable groups of beneficiaries. These groups, such as African Americans and those living in poverty areas and in Health Professional Shortage Areas (HPSAs), are believed to be more likely to experience access problems related to payment policy changes. Historically, much of the research on access for vulnerable groups, including that of the Commission, has been descriptive in nature, focusing on differences in access between these groups and others. The Commission's recent work has addressed the underlying reasons for those problems, such as differences in income, supplemental insurance coverage, and health status.

Since it began its monitoring efforts, the Commission has found consistently that access has remained good for most beneficiaries. Any decreases seen in use of selected services since the fee schedule was introduced appear related not to changes in payment rates but, rather, to changes in treatment modalities and other factors unrelated to access. Beneficiaries report no increases in problems obtaining care and their satisfaction with care continues to be high.

Despite these generally positive findings on access, the Commission is concerned that some vulnerable groups, including African Americans, continue to experience access problems that existed prior to 1992. These groups use fewer primary care services than others and visit emergency rooms more often than others. In surveys, they report more problems obtaining care and lower satisfaction with care.

With respect to beneficiary financial liability, OBRA89's charge limit is constraining the additional amounts physicians bill beneficiaries. Charges above the limit have declined since 1992. Commission analyses have shown that most charges exceeding the limit do so by relatively small amounts.

The full implementation of the Medicare Fee Schedule does not diminish the need for monitoring. Further developments in both Medicare and the broader health care market will continue to affect beneficiaries. For example, flaws in the current VPS system could result in substantial reductions in payments to physicians (see Chapter 12). Proposed changes in the VPS policy to correct these flaws could have differential effects on physicians depending on the mix of services they provide. Other policy changes, such as implementation of resource-based practice expense relative values, scheduled for 1998, will reduce payments for some services while increasing payments for others (see Chapter 13). Finally, changes in the market for health services, such as the growth of managed care, could affect the cost and availability of care under Medicare fee for service as well.

The Commission's mandated reports on access and financial liability will be submitted to the Congress in May. This chapter previews analyses to be presented in those reports. The first section updates the Commission's earlier work on beneficiary access using Medicare claims data and data from the Medicare Current Beneficiary Survey. It also presents an analysis of factors contributing to the access problems of vulnerable groups of beneficiaries. The chapter then turns to issues of beneficiary financial liability for physicians' services, updating information on assignment rates and the percentage of physicians participating in Medicare. In addition, this year the Commission has broadened its examination of beneficiary financial liability to include information on beneficiary out-of-pocket spending for other services in addition to physicians' services. Plans for additional work to be included in the Commission's mandated reports are discussed in both sections of the chapter.

ACCESS TO CARE

Analyses of Medicare claims data and responses to the Medicare Current Beneficiary Survey allow the Commission to assess service use and beneficiaries' experiences in obtaining care. These Medicare program data are updated each year.

Changes in Beneficiary Use of Services

Growth in beneficiary use of services was relatively modest in 1996. The volume and intensity of all services per beneficiary rose at a rate of 1.0 percent between 1995 and 1996 (Table 14-1).[1]

The low volume growth in 1996 may be part of a trend that emerged in the early 1990s. Before 1992, volume growth was volatile. During the 10 years ending in 1991, the annual rate of volume growth ranged from 3.7 percent to 10.0 percent. Volume growth was low for two consecutive years only once during that period, in 1984 and 1985 (PPRC 1996). By contrast, volume growth has been low—5 percent or less—every year since 1992.

Claims data do not reveal changes in beneficiary access to care that are clearly related to changes in Medicare's physician payment rates (Table 14-1). Between 1995 and 1996, some services with payment rate decreases also experienced a fall-off in volume (e.g., outpatient visits and electrocardiograms), while for others the volume increased (e.g., cataract lens replacements and echocardiograms). Evidence of a possible relationship between lower Medicare payment rates and a decline in beneficiary use of services would prompt further analysis by the Commission.[2]

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[1] Two limitations of the claims data should be considered when interpreting these results. First, the claims files are incomplete since they include only those claims processed by September of each year, or three months beyond the half-years under study. Second, analysis of a 5 percent sample of claims means the payment rate and service use measures presented are subject to sampling error. Further details on the Commission's analyses of Medicare claims data are provided in *Monitoring Access of Medicare Beneficiaries* (PPRC 1995).

[2] Further analysis of the relationship between payment rates and use of services would require consideration of factors other than payment rates which may influence use of services. Those factors include health system characteristics, such as physician supply and improvements in medical technology, as well as beneficiary characteristics, such as health status and supplemental insurance coverage.

Table 14-1. Change in Payment and Use per Beneficiary for Selected Services, 1992-1996 (percentage)

Type of Service	Annual Percentage Change 1992-1995 Payment per Service	1992-1995 Volume[a]	1992-1995 Count of Services[b]	1995-1996 Payment per Service	1995-1996 Volume[a]	1995-1996 Count of Services[b]	Percentage of 1996 Physician Services Outlays
All Services	2.8	4.1	3.8	-2.2	1.0	-2.0	100.0
Primary Care Services	6.9	4.1	3.3	0.7	1.7	0.7	22.8
Office and other outpatient visits	6.2	3.0	2.7	-1.2	-0.7	-1.9	16.3
Emergency department visits	9.0	9.3	7.5	0.4	2.4	1.9	2.6
Nursing facility/rest home visits	10.8	7.6	6.0	1.4	6.5	5.4	2.1
Home visits	10.7	4.5	3.9	3.1	4.8	3.8	0.2
Other Evaluation and Management Services	5.4	5.0	2.5	1.9	0.5	-1.8	18.2
Surgical Services	2.8	2.3	5.7	-5.0	2.5	3.6	21.6
Cataract lens replacement	-1.1	-1.3	-1.3	-15.5	0.9	0.9	2.9
Joint prosthesis	2.2	5.0	4.5	-4.8	2.4	2.5	1.4
Coronary artery bypass graft	2.6	5.4	6.3	-3.1	4.5	5.7	1.4
Transurethral prostate surgery	5.6	-12.1	-11.8	0.5	-9.3	-8.4	0.3
Arthroscopy	1.6	7.5	7.3	-7.2	0.3	-0.1	0.2
Open prostate surgery	5.0	-15.5	-14.9	0.5	7.3	5.5	0.1
Other Nonsurgical Services	-0.2	4.8	4.0	-4.1	0.0	-3.4	37.4
Diagnostic radiology, other	0.2	0.4	0.8	-3.1	-0.8	-2.4	3.1
Electrocardiograms	—[c]	—[c]	—[c]	-2.7	-2.7	-5.7	2.0
Echocardiograms	-5.1	13.3	13.7	-15.2	13.2	25.3	1.8
CAT scans	-0.1	3.0	4.1	-3.8	6.2	6.0	1.6
Colorectal endoscopy	-0.8	2.3	-2.3	-5.0	2.0	-0.5	1.4
Magnetic resonance imaging	1.6	10.9	11.3	-1.2	11.3	10.7	1.1
Upper GI endoscopy	-4.2	3.8	2.5	-10.3	1.5	0.7	0.9
Angioplasty	-6.5	10.5	10.4	-10.4	8.5	5.2	0.6
Mammography	1.1	-1.7	0.8	-0.5	-3.2	-1.5	0.4

SOURCE: Physician Payment Review Commission analysis of 1992-1996 Medicare claims, 5 percent sample of beneficiaries.

[a] Measures change in outlays if prices were frozen (number and intensity of services).

[b] Measures change in the number of services only.

[c] Not applicable due to payment change.

NOTE: Data are for the first six months of each year.

The use of some services decreased between 1995 and 1996 (Table 14-1). The volume of transurethral prostate surgery dropped by 9.3 percent, and the volume of mammography fell by 3.2 percent. Other services with volume decreases are office and other outpatient visits (–0.7 percent), routine diagnostic radiology (–0.8 percent), and electrocardiograms (–2.7 percent).

Reductions in the use of transurethral prostate surgery do not appear to be related to access to care. Such reductions have occurred in previous years and appear to be part of changes in treatment modalities for prostate disease (PPRC 1996).

In the case of mammography, the Commission has found that less than 40 percent of female Medicare beneficiaries receive a mammogram every two years (PPRC 1995). Claims data show that mammography volume growth was 20 percent from 1990 to 1991, the first year that Medicare coverage was extended to include screening mammography.[3] Since then, mammography volume growth has been low, suggesting that awareness of the screening benefit may not have increased after its initial announcement.

Other declines in service use—office visits, routine diagnostic radiology, and electrocardiograms—are more difficult to explain. In an environment where practice patterns are changing, because of managed care and other influences, some decreases in volume may not be surprising. The decreases could be the result of improved efficiency in the delivery of services, or they could involve reductions in the use of needed services.

Because of the uncertainty about the cause of some volume decreases, the Commission will examine the affected services further in its upcoming access report. Some of this work will assess whether use of needed services has decreased. The Commission will use clinically based indicators of access, developed by RAND, for this analysis (PPRC 1995). These indicators will not provide a comprehensive assessment of why the volume of selected services decreased. They can show, however, whether certain services that experienced an overall decline in use also declined in relation to specific conditions for which they are considered necessary. Other work will consider decreases in use of services by geographic area to explore the relationship between health care market characteristics and changes in the volume of services.

Access As Reported by Beneficiaries

The Commission's analyses of beneficiary reports about their access to care have been updated with data from the 1995 MCBS. The MCBS provides information on specific aspects of beneficiary access to care, such as difficulty in finding a physician, delays in seeking care, availability of a usual source of care, and satisfaction with care.

Access for All Beneficiaries. Responses to MCBS questions were used to construct eight measures of access to care. Four of these measures address the process of care: whether a beneficiary (1) had trouble getting care, (2) had a problem but did not see a physician, (3) delayed care due to cost, or

[3] Previously, Medicare covered only diagnostic mammography.

(4) did not have a physician or physicians' office as a usual source of care.[4] Four other measures address nonclinical outcomes of care: (1) strong agreement with the statement "physician checks everything," (2) strong agreement with the statement "great confidence in physician," (3) very satisfied with availability of medical care at night and on weekends, and (4) very satisfied with overall quality of care. All these measures are believed to be sensitive to changes in access but can be influenced by other factors, such as the quality of care received.

Data from the 1995 MCBS show that access for most beneficiaries remains excellent and that measures of access are essentially unchanged from previous years. Among all beneficiaries, about 4 percent had trouble getting care, and 10 percent to 12 percent either had a problem but did not see a physician, delayed care due to cost, or were without a physician or physician's office as a usual source of care (Table 14-2). Measures of nonclinical outcomes (e.g., very satisfied with the availability of care) from the 1995 MCBS also show little change from previous years. Of the respondents, 26 percent strongly agreed with the statement that their physician checks everything; 27 percent reported great confidence in their physician (Table 14-3). About 21 percent said they are very satisfied with the availability of medical care, and 33 percent are very satisfied with the overall quality of care (Table 14-3).[5]

Access for Vulnerable Groups. Data from the 1995 MCBS show essentially no change in the access problems reported by some vulnerable groups in earlier rounds of the MCBS. Nonwhite and Hispanic beneficiaries, and those with no supplemental insurance, reported more trouble getting care (Table 14-2).[6] The functionally disabled, who require help with activities of daily living, were also more likely to have trouble getting care. Each of these groups was also more likely to have delayed care because of cost. Nonwhite and Hispanic beneficiaries, and those without supplemental insurance, were also less likely to have a physician or physician's office as a usual source of care.

Distinctions among groups were also found in their responses to questions on nonclinical outcomes, such as satisfaction with the availability of care (Table 14-3). Compared with their counterparts, four groups—nonwhite beneficiaries, those needing help with activities of daily living, those over the age of

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[4] Over the successive annual rounds of the MCBS, similar percentages of beneficiaries have indicated they have "had a problem but did not see a physician." This measure is influenced both by the extent to which beneficiaries have health problems and by the extent to which they do or do not see a physician. For access monitoring, the extent to which beneficiaries see a physician is more important, but the structure of the MCBS does not permit separation of the two influences. Because of the measure's stability, this limitation of the MCBS does not seem important. If the measure does change, the Commission will attempt to determine whether the change is due to the extent to which beneficiaries are seeing a physician when they have a health problem.

[5] Analyses of nonclinical outcomes distinguish those respondents who are "very satisfied" or "strongly agree" from all others. This approach conforms with concerns noted by Ware (1995) about collapsing categories in ordered scales, such as "very satisfied" and "satisfied." Collapsing categorical responses to survey questions masks important differences among perceptions of health care outcomes.

[6] Within Hispanic populations, access to care may vary depending on a person's ethnic origin (Schur et al. 1987). Since MCBS respondents designating themselves as Hispanic are not asked about ethnic origin, the analysis does not address these subgroups.

Table 14-2. Medicare Beneficiaries Reporting Problems with Access, 1995 (percentage)

Population Group	Had Trouble Getting Care	Had Problem, But Did Not See a Physician	Delayed Care Due to Cost	No Usual Source of Care[a]
All Beneficiaries	4	11	10	12
Race				
African American	5	14	12	19
White	3	10	9	11
Other	7	14	12	25
Ethnicity				
Hispanic	[b]	[b]	14	27
Other	[b]	[b]	9	11
Functional Disability				
Help needed	8	17	15	9
No help needed	3	10	9	13
Age				
85 years and over	[b]	7	5	7
Under 85	[b]	11	10	12
Supplemental Insurance[c]				
No	9	19	24	27
Yes	3	10	8	10

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

[a] Defined as not identifying a physician's office or a particular physician as a usual source of care.

[b] No statistically significant difference between population groups at the 5 percent level.

[c] Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

85, and those without supplemental insurance coverage—were less satisfied with the quality of their care. African Americans and Hispanics were also less apt to agree with statements that they had great confidence in their physician or that their physician checks everything. African Americans and those without supplemental insurance were less likely to be very satisfied with the availability of medical care.

Factors Related to the Access Problems of Vulnerable Groups

The Commission's analyses of Medicare claims and enrollment data have also shown that some groups of beneficiaries, such as African Americans and those living in urban poverty areas and urban Health Professional Shortage Areas, use fewer primary care services and make more visits to emergency rooms and hospital outpatient departments than others. Health outcomes, measured by mortality rates and other indicators, are often poorer for these groups (PPRC 1993; PPRC 1995; PPRC 1996).

Table 14-3. Medicare Beneficiaries' Attitudes Toward the Care They Receive, 1995 (percentage)

Population Group	Strongly Agree with "Physician Checks Everything"	Strongly Agree with "Great Confidence in Physician"	Very Satisfied with Availability of Medical Care	Very Satisfied with Overall Quality of Care
All Beneficiaries	26	27	21	33
Race				
African American	19	20	10	20
White	27	28	22	35
Other	28	27	21	24
Ethnicity				
Hispanic	33	[a]	[a]	[a]
Other	26	[a]	[a]	[a]
Functional Disability				
Help needed	23	[a]	18	29
No help needed	27	[a]	21	34
Age				
85 years and over	23	24	21	28
Under 85	27	27	18	34
Supplemental Insurance[b]				
No	22	22	16	25
Yes	27	28	21	34

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

[a] No statistically significant difference between population groups at the 5 percent level.

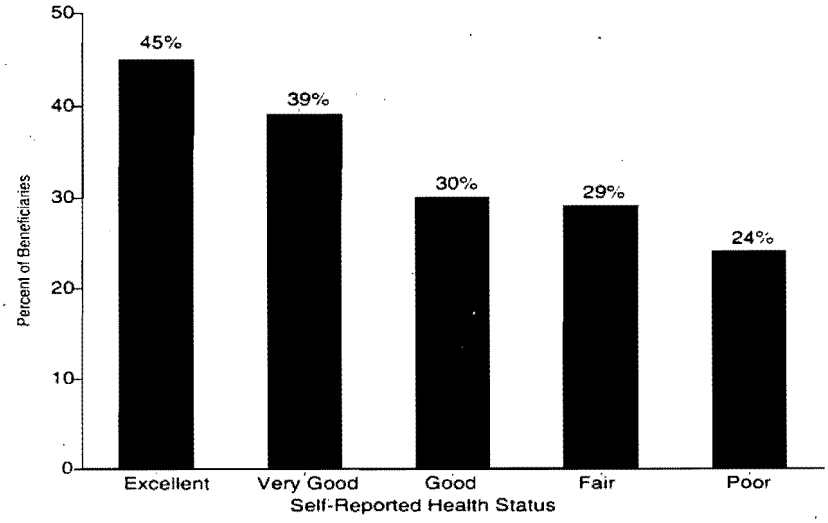
[b] Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

This year, the Commission sought to move beyond describing the access problems of vulnerable groups to identifying factors contributing to those problems. Such analyses are meant to show whether there are factors that could be influenced by Medicare payment policy. Previous research has shown that access is related, in part, to personal characteristics, such as age, income, and education, of those needing care (Aday and Andersen 1981; Weissman and Epstein 1994). Characteristics of the health care system, such as the availability and organization of services, have also been shown to be associated with access (Aday and Andersen 1981; Weissman and Epstein 1994). It is in this second area where payment policy may play a role.

Methods. To analyze factors related to the access problems of vulnerable groups of Medicare beneficiaries, regression analyses were conducted using data from the 1994 MCBS. The analyses allowed the estimation of independent statistical relationships between explanatory variables, measuring beneficiary and health system characteristics, and various measures of access to care. Some

Figure 14-1. Beneficiaries Who Are Very Satisfied with Overall Quality of Care, by Health Status (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

explanatory variables described characteristics of beneficiaries, such as age, sex, race, and self-reported health status. Residence in a HPSA described the health system available to beneficiaries.[7] Other variables captured a combination of personal and health system characteristics, such as secondary insurance coverage. Dependent variables in the analysis (measures of access to care) included the eight process and nonclinical outcomes measures used in the MCBS analysis described above.[8]

This analysis is limited by the set of variables available from the MCBS. Some important factors—such as health behaviors and attitudes, better measures of health status, and some aspects of the availability of services—are not addressed by the MCBS. Other measures, including clinically oriented outcomes of care and the use of high-tech services, could not be included in the analysis because the sample size was too small. Nonetheless, the MCBS does allow analysis of a number of important factors believed to influence access to care.

Results. Several factors help explain variation in measures of beneficiary access to care. Self-reported health status appears to have an important influence on access, controlling for other beneficiary and health system characteristics (Figure 14-1). Those reporting poorer health status also cite more access

[7] Alternative regression models were estimated using a physician-to-population ratio, based on county-level data from the Area Resource File, as a measure of the availability of services. The ZIP code-specific HPSA variable was found to have a stronger statistical relationship with the access measures than the county-level physician-to-population ratio.

[8] Since the dependent variables had a value of either zero or one, logistic regression models were estimated. The models were estimated with SUDAAN software, which corrected the standard errors of the estimates for the nonrandom design of the MCBS.

problems than others and lower satisfaction with the care received. For example, 45 percent of those reporting excellent health also report being very satisfied with the overall quality of care. Only 24 percent of those reporting poor health are very satisfied with the overall quality of care. Those saying they are in excellent health are more likely than those in poor health to be without a physician or physicians' office as a usual source of care. About 20 percent of those reporting excellent health report no physician or physicians' office as a usual source of care, whereas only 11 percent of those citing poor health report the same problem (Figure 14-2). Those reporting poor health may be more likely to have a physician or physician's office as a usual source of care owing to their greater need for care.

A marker of vulnerability, the lack of supplemental insurance coverage, is another factor associated with variation in beneficiary access to care, controlling for other beneficiary and health system characteristics. Findings with respect to two of the eight access measures—no physician or physician's office as a usual source of care and satisfaction with the overall quality of care—are illustrative. Among those without supplemental insurance, 24 percent report not having a physician or physician's office as a usual source of care compared with 11 percent of those with private supplemental coverage (Figure 14-3). Supplemental insurance coverage was not significantly related to satisfaction with the overall quality of care in this analysis.

Race also helps explain variation in beneficiary access. Compared with whites, more African-American beneficiaries are without a physician or physician's office as a usual source of care. The difference between the two groups is small, however (Figure 14-4). Fewer African-American beneficiaries are very satisfied with the overall quality of care (30 percent) compared with white beneficiaries (34 percent) (Figure 14-5). These differences are smaller than those presented earlier in this chapter (Tables 14-2 and 14-3). The results presented earlier were not adjusted for beneficiary and health system characteristics.

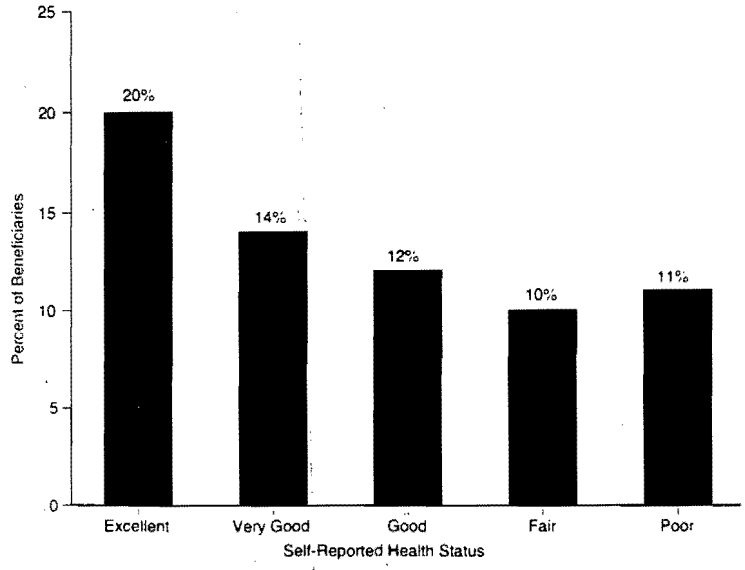
Conclusions. Some tentative conclusions are possible. Several factors help explain variation in measures of beneficiary access to care. Chief among these appears to be health status. Those reporting poorer health status also report more access problems than others and lower satisfaction with the care received.[9] Supplemental insurance coverage is another factor that appears to be related to process-oriented measures of access, such as not having a physician or physician's office as a usual source of care, but supplemental insurance does not seem to be related to satisfaction.

After adjusting for certain personal and health system characteristics, some differences in access between African-American and white beneficiaries remain unexplained.[10] There are a number of

[9] These fee-for-service enrollee findings are consistent with the findings of a Commission-sponsored survey of Medicare managed-care enrollees (Nelson et al. 1996).

[10] Other differences in access between African-American and white beneficiaries, not addressed in this analysis, could be important and deserve further research. For example, African American beneficiaries are less likely to have supplemental insurance coverage than white beneficiaries (Chulis et al. 1993). Some of the association between supplemental insurance coverage and access, found in this analysis, could be a combination of the effect of race on supplemental coverage and the effect of supplemental coverage on access.

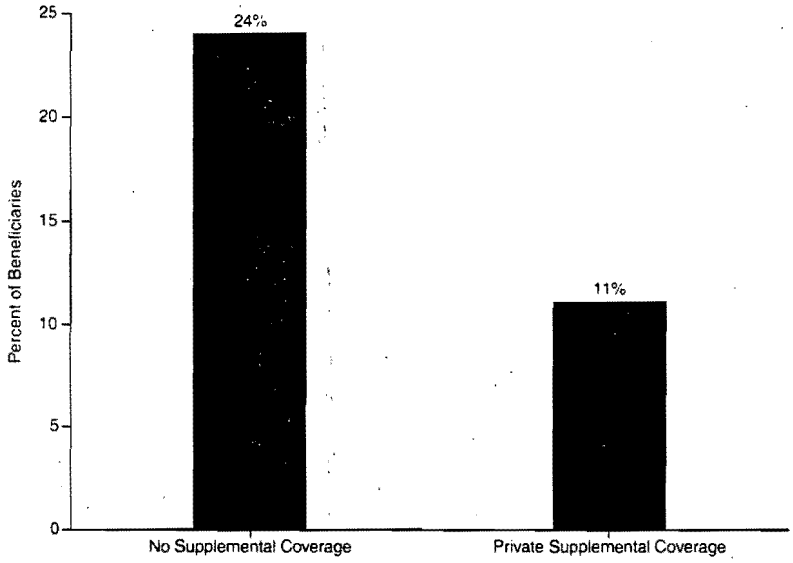
Figure 14-2. Beneficiaries with No Usual Source of Care, by Health Status (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

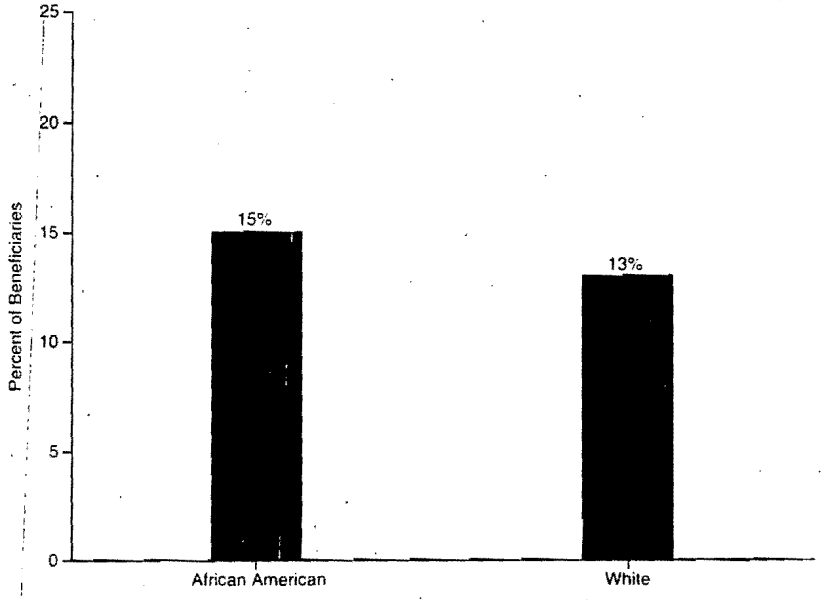
Figure 14-3. Beneficiaries with No Usual Source of Care, by Supplemental Coverage (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

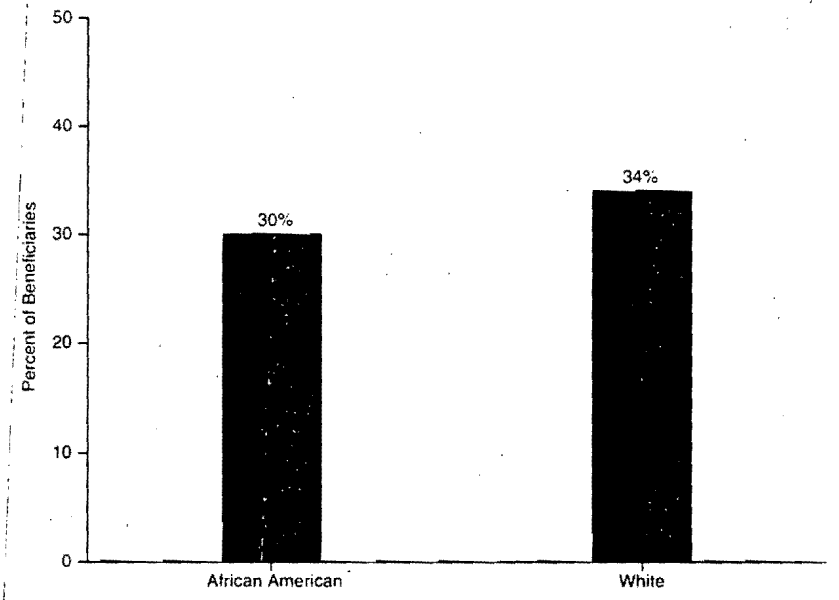
Figure 14-4. Beneficiaries with No Usual Source of Care, by Race (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

Figure 14-5. Beneficiaries Very Satisfied with Overall Quality of Care, by Race (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

possible explanations for these differences; that is, access may be affected by other factors, which could not be addressed in this analysis. These include other aspects of the availability and organization of services; personal preferences and behaviors of beneficiaries; unmeasured dimensions of health status, including genetic and environmental factors; and racial discrimination (Geiger 1996; Escarce et al. 1993).

This analysis was designed to aid development of options for solving the access problems of vulnerable groups. Not surprisingly, it has shown that solving those problems will be difficult. Multiple factors are important, and some of them, such as health status and supplemental insurance coverage, are only indirectly related to Medicare payment policy.

In the past, the Commission has recommended that multiple approaches should be considered to maintain and expand service delivery for underserved Medicare beneficiaries (PPRC 1995). Among those approaches are ensuring appropriate numbers and distribution of health professionals; changing payment policy; and making certain beneficiaries have access to new health care delivery systems. The analysis presented above reaffirms the importance of a broad-based strategy to improve access for vulnerable beneficiaries.

BENEFICIARY OUT-OF-POCKET SPENDING

A number of policies under Medicare fee for service are intended to protect beneficiaries from excessive out-of-pocket expenses for physicians' services. Providers are encouraged to bill on assignment, meaning that they accept the Medicare payment amount as full compensation and receive payment directly from Medicare. The Participating Physician and Supplier (PAR) program provides incentives for physicians to accept all of their claims in this manner. For example, payment under the Medicare Fee Schedule is 5 percent higher for participating physicians than for nonparticipating physicians. In addition, participating physicians are provided with toll-free lines if they submit claims electronically, and their names are included in the Medicare Participating Physician/Supplier Directory.

A form of beneficiary protection also exists for claims that are not assigned. OBRA89 specifies percentage limits on the amount that physicians can bill beneficiaries above Medicare's payment amount. The limits are 115 percent of nonparticipating physician payment rates, or 109.25 percent (115 percent of 95 percent) of Medicare Fee Schedule payment rates.

Together, these policies leave Medicare beneficiaries responsible for a $100 deductible, coinsurance of 20 percent of the Medicare Fee Schedule payment amount, and additional charges (balance bills) of at most 15 percent of the Medicare payment for physicians' services provided on a fee-for-service basis.[11]

[11] Most beneficiaries (about 87 percent) have some form of supplemental insurance policies that cover all or most of these cost-sharing expenses (see Chapter 15).

Each year, the Commission reports on beneficiary financial liability in the context of out-of-pocket spending for physicians' services. The Commission has consistently found that the physician payment reforms included in OBRA89 have successfully constrained balance billing and increasing numbers of physicians are accepting Medicare-allowed charges as payment in full.

To get a more complete picture of beneficiary financial liability, this year, the Commission has expanded its focus to examine beneficiaries' overall out-of-pocket costs related to health care. Those costs include Part B premiums ($43.80 per month); Part A and Part B annual deductibles ($100 and $760, respectively); Part A and Part B copayments; and balance bills. These are in addition to expenses they may incur for supplemental health insurance premiums and services not covered by Medicare. Medicare does not place any limits on overall out-of-pocket spending.

This section includes information describing beneficiaries' out-of-pocket health care expenditures, including cost sharing for Medicare-covered services, balance billing from Part B providers, cost of noncovered services, and Medicare Part B and private health insurance premiums. It also updates information on assignment of claims, the PAR program, and balance billing.

Total Out-of-Pocket Spending

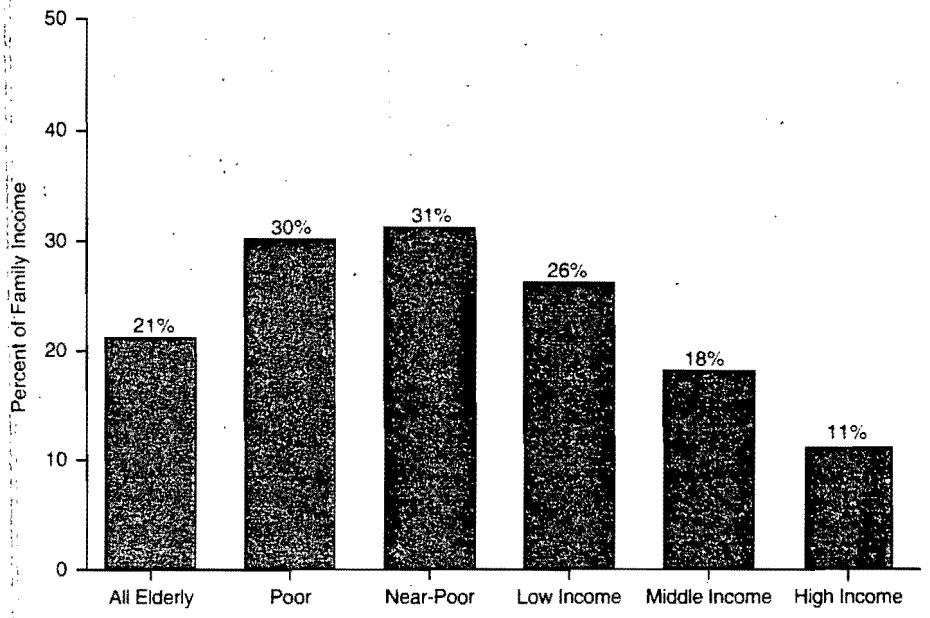
Elderly Americans spend nearly four times more out of pocket for health care than those under 65 (AARP 1995). Noninstitutionalized Medicare beneficiaries, on average, spent $2,605 for health care in 1996 (Moon et al. 1996).[12] Currently, out-of-pocket spending represents 21 percent of household income for the elderly overall. The proportion of income the elderly devote to health care spending has risen over the years. In 1987, they spent about 15 percent of their incomes on health-related services. The elderly poor and near-poor spend an even greater percentage of their income on health care services than those in wealthier groups. For example, those with incomes below 125 percent of the poverty level spend roughly 30 percent of family income on out-of-pocket health care costs (Figure 14-6) (Moon et al. 1996).

The oldest and the sickest beneficiaries are at the greatest risk for high out-of-pocket spending. Cost-sharing burdens are highly concentrated among the most severely ill. For example, in 1996, Medicare-related out-of-pocket spending for the sickest 10 percent of the Medicare population was roughly $5,600 per beneficiary, while the healthiest 20 percent had no cost-sharing expenses (Moon et al. 1996).

Out-of-pocket spending on health care also differs across age groups, with the proportion of family income devoted to health care costs increasing with age. While those aged 65 to 69 spend about

[12] This includes cost sharing for Medicare-covered and noncovered services and products, Medicare Part B premiums, private health insurance premiums, and balance billing. Noninstitutionalized beneficiaries represent 86 percent of the total Medicare population. Cost sharing is considerably higher for institutionalized beneficiaries (Moon et al. 1996).

Figure 14-6. Average Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income by Poverty Status, 1996



SOURCE: Moon et al. 1996.

NOTE: The poor are those with incomes at 100 percent or less of the poverty level; the near poor are those between 100 and 125 percent of poverty; low income are those between 125 and 200 percent of poverty; middle income are those between 200 and 400 percent of poverty; and high income as those with incomes over 400 percent of poverty.

18 percent of their household income on health care, the oldest beneficiaries (80 and older) spend about 25 percent (Moon et al. 1996).

Spending on health insurance premiums accounts for most of these out-of-pocket expenditures. Combined, Medicare Part B premiums, individual private insurance premiums, and employment-related insurance premiums account for about 45 percent of out-of-pocket costs of noninstitutionalized beneficiaries. Of the remaining costs, 17 percent is spent on physicians' services, 13 percent on home health services, 10 percent on prescription drugs, and 7 percent for hospital services. The remaining 8 percent is split between vision and dental services and durable medical equipment (AARP 1995).

Financial Liability for Physicians' Services

Policies designed to limit beneficiary financial liability have generally proven successful. In 1996, more than three-fourths (78 percent) of providers who served Medicare beneficiaries were enrolled in the participating physician program, compared with 52 percent of physicians with PAR agreements in 1992. Participation rates range from a high of 92 percent in North Dakota to a low of 60 percent in Idaho. These participating providers accounted for about 92 percent of Medicare charges for physicians' services last year. The proportion of Medicare claims, submitted by participating and

nonparticipating physicians, paid on assignment is high and continues to rise, from about 70 percent in 1986 to 96 percent in 1996.[11]

For the remaining charges that are not assigned, beneficiaries' cost sharing has largely been contained by Medicare's limiting charges. As a percentage of Medicare payments, balance bills have been declining. On average, balance bills were 23 percent of Medicare payments in 1993, 17 percent in 1994, and 15 percent in 1995. Preliminary analysis of unassigned claims with balance bills submitted during 1996 reveals that on average, balance bills were again 15 percent of the fee schedule payment. Although the 1996 average of 15 percent may indicate that some bills remain above the limiting charge, previous Commission analyses have found that most charges that exceed the limit do so by relatively small amounts. The increased compliance with the limiting charge is most likely related to Health Care Financing Administration (HCFA) initiatives aimed at better informing providers and beneficiaries of overcharges. Legislation enacted in 1994 clarified HCFA's authority to enforce the charge limits and require providers to refund any overcharges.

Future Work on Monitoring Out-of-Pocket Spending

Assessing out-of-pocket health care costs and understanding the financial burden these costs impose on different types of beneficiaries is critical to discussions about how to reform Medicare. Proposals to increase the Medicare Part B premium or to charge wealthier beneficiaries a higher premium have received attention recently as policymakers look for ways to contain rising program costs.

The Commission's upcoming report on beneficiary financial liability will include more detailed analyses on out-of-pocket health care spending. The most current data from the cost and use supplement to the 1992 MCBS will be used for these analyses.[12] The analyses will focus on how out-of-pocket spending varies among different segments of the Medicare population. Of particular interest are the out-of-pocket expenses of traditionally vulnerable groups of beneficiaries, including African Americans, Hispanics, those without supplemental insurance coverage, and the oldest and poorest beneficiaries.

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[11] The estimate for 1996 is based on claims data from the first six months of that year.

[12] Once data from the 1993 and 1994 MCBS are released, the Commission will update its analyses using the 1992 data as a baseline.

Chapter 16

The Changing Labor Market for Physicians

The Physician Payment Review Commission's interest in the changing labor market for physicians stems from two sources: its mandate to examine the supply and specialty mix of physicians, and its efforts to monitor changes in the market for health services and suggest to the Congress the implications of these changes for public policy.

Over the past 35 years, policymakers have returned periodically to issues surrounding the adequacy and competencies of the nation's health work force, focusing primarily on physicians. For many years, these debates were driven by concerns that an oversupply of physicians might undermine other efforts to bring health care costs under control, and that the nation was training relatively too many specialists and relatively too few physicians in primary care (defined as family practice, general internal medicine, and general pediatrics). (Obstetrics-gynecology is not considered a primary care field for the purposes of this chapter.) A variety of federal policies have been proposed and implemented to address these concerns.

More recently, changes in the health care marketplace have created a new context for considering these concerns. Some argue that the problems of physician oversupply and specialty imbalance are among those that will be resolved by a competitive health care market. In theory, the growth of cost-conscious integrated health systems will alter the number and mix of services used by patients and thus the number and mix of health professionals needed to provide those services. These developments will in turn result in physicians being employed at greatly reduced compensation or being unable to find jobs in medicine, thus sending a signal to students and educators to

This chapter includes:

- *Changes in the market for health services that affect the physician work force*
- *Signals of change in physician specialty mix*
- *Signs of changes in demand for physicians overall*
- *Changes in physician employment arrangements*

change. Others doubt that market forces will lead to significant change and continue to call for direct action by policymakers, educators, and payers to address concerns about supply and specialty mix. An argument can also be made that market forces cannot be expected to work, given the substantial federal subsidies for physician training.

In its 1995 and 1996 annual reports, the Commission examined whether changes in the organization and financing of health care were affecting the labor market for physicians. Two types of change in the labor market were assessed: whether there was evidence that increasing demand for primary care physicians was leading to changes in specialty mix, and whether there was any indication that the market was creating incentives to train fewer physicians overall. In last year's report, the Commission noted that the physician labor market was indeed changing, but that these changes, as captured through systematic data, were more modest than suggested by anecdotes.

In this report, the Commission once again considers the available empirical data to determine whether specialty mix and physician supply are changing. This year, the signals are ambiguous. While there are some signs that specialty mix may be changing in response to market demand for primary care physicians, there are also signs of continued strong demand for physicians in highly specialized fields. In addition, despite common beliefs to the contrary, many indicators do not reflect an oversupply of physicians. Finally, changes in the market appear to be affecting the conditions of employment for many physicians.[1]

MARKETS RELEVANT TO THE PHYSICIAN WORK FORCE

In considering whether changes in the market for health services will influence shifts in physician supply and specialty distribution, it is important to recognize that there are actually two markets of interest: the market for physicians' services and the market for physician training. This distinction matters for two reasons. First, market pressures may lead to diametrically opposed responses from the two markets. Although organized systems of care may be demanding fewer physicians and relatively more primary care physicians than in the past, teaching hospitals, under significant pressure to economize, may be more dependent than ever on using residents to meet service needs. Moreover, even if graduates of U.S. medical schools begin to respond to market pressures by increasingly seeking positions in primary care fields, hospitals may continue to meet their staffing requirements by filling positions with international medical graduates (IMGs).

Second, notwithstanding substantial changes in the market for physicians' services, the length of the training pipeline and the large stock of practicing physicians will preclude any substantial short-run impact on supply and specialty mix. For example, a large increase in starting salaries for primary care physicians will not likely affect the behavior of individuals who have just begun training in surgical

[1] This chapter does not consider the impact of market changes on the geographic distribution of practicing physicians or the demographic composition of the physician work force.

specialties. As a result, one would expect that indicators measuring the production of physicians would lag behind those measuring changes in the practice environment. Furthermore, given the size of the pool of practicing physicians, even substantial changes in the behavior of recent graduates will have only a small effect on the size and composition of the physician work force.

Data are presented in this chapter that describe both of these markets. For example, data on the number and mix of residents are indicative of changes in the market for training. Data on physician incomes and practice arrangements are relevant to changes in the market for physicians' services.

CHANGES IN THE SPECIALTY MIX OF PHYSICIANS

There are several indicators of potential changes in the mix of physicians in different specialties: relative incomes, the availability of jobs, and medical students' expressed specialty preferences. These indicators, reviewed below, suggest a moderate trend toward generalism.

In previous reports, the Commission also examined data from the annual residency match to consider whether there were changes in the types of residency positions sought by graduating medical students. Because of the difficulty in interpreting these data, the Commission has not included them in this report.[2]

Changes in Relative Incomes

The Commission noted that in 1994 physician incomes had fallen for the first time since the American Medical Association (AMA) began collecting these data. In 1995, median physician income rebounded, rising about 3.8 percent (Table 16-1). The two-year trend, however, shows a loss of about 2.5 percent. As a result, real median incomes remain below those for 1993 (Mitka 1997). Analysis of this series through 1994 found the decline in physician earnings was directly (although weakly) associated with an increase in managed-care penetration (Simon and Born 1996).

Although most specialties experienced income increases in 1995, patterns of income changes differed somewhat across specialties. Moreover, the patterns are not consistent within specialty groups (e.g., primary care, surgery). For example, while incomes of family practitioners and pediatricians are at a new high, median incomes for internists continue to drop. Median incomes across all physician specialties continue to remain far apart, however, at $250,000 for orthopedic surgeons and $124,000 for those in family practice.[3]

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[2] Data from the resident match can be difficult to interpret as indicators of labor market change for several reasons. First, the number of positions that happen to be offered through the match varies annually. Second, because it is geared to graduating medical students, the match does not encompass those fields that are entered in later years (for example, training in internal medicine subspecialties begins after completion of a residency in internal medicine).

[3] Expectations about starting salaries are another potential barometer of income shifts between generalists and specialists. Regrettably, the annual survey on physicians' expectations about starting salaries that the Commission had included in previous reports is no longer available because the firm that conducted it, Physician Services of America, has gone out of business.

Table 16-1. Real Median Physician Income, by Selected Specialties and Years
(1995 dollars in thousands)

Specialty	1981	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	$118	$107	$107	$108	$108	$115	$113	$124
Internal medicine	139	139	138	138	140	157	154	150
Pediatrics	106	106	115	116	121	126	113	129
Surgery								
General surgery	194	213	196	188	194	236	226	225
Ophthalmology	*	*	202	221	188	191	180	194
Orthopedics	*	*	311	259	269	283	279	250
Other Specialties								
Anesthesiology	194	192	230	232	237	231	205	203
Obstetrics-gynecology	181	169	212	221	204	210	187	200
Psychiatry	116	122	123	122	129	126	123	124
Radiology	191	207	230	247	258	252	226	230
All Specialties	152	155	150	154	159	164	154	160

SOURCE: American Medical Association Socioeconomic Monitoring System.

* Not available.

NOTES: Values have been adjusted for inflation using the gross domestic product deflator.

Incomes are revenues net of expenses.

Changes in Jobs Available by Specialty

Many expect the growth of managed-care organizations to result in more job opportunities for primary care physicians and fewer positions for specialists. The one longitudinal source of information on the availability of jobs in different fields is an AMA survey of residency program directors concerning the employment experience of their recent graduates, their perceptions about the difficulties graduates have in getting jobs (particularly in clinical practice), and actions they are taking at the program level to respond to those issues. This survey was conducted for the first time in 1994 and has since been repeated. In 1995, physicians in generalist fields were once again reported to have less difficulty finding positions than those in specialties (AMA 1997). For example, fewer than 1 percent of those in family practice reported difficulty finding full-time clinical positions compared with 15.8 percent of trainees in anesthesiology, 20.7 percent in gastroenterology, and 14.9 percent in ophthalmology. Overall, the percentage of residents having difficulty increased from 6.3 percent to 6.9 percent. The trend varied substantially across fields, however. Residents in a number of fields had less difficulty finding a job in 1995; these included family practice, anesthesiology, cardiology, and plastic surgery. Others had more difficulty, including residents in internal medicine, pediatrics, general surgery, obstetrics-gynecology, and ophthalmology. It is unclear whether changes in rates reflect true differences in job availability or altered perceptions about how hard it will be to find a full-time clinical position (AMA 1997).

A survey of training outcomes by the American College of Cardiology also suggests that specialists continue to be able to find jobs. Fully 98 percent of those surveyed had obtained a post-training position. While about half found the job search to be very or somewhat difficult, 42 percent found the search very or somewhat easy (American College of Cardiology 1996).[4]

Changes in Medical Students' Expressed Career Preferences

Among the indicators of changes in specialty mix, the plans of graduating allopathic medical students show a continued strong trend toward generalism (Table 16-2). Almost 32 percent of graduating allopathic medical students now indicate they are interested in primary care fields, more than double the share just five years ago. And for the first time, interest in primary care exceeds the level in 1980 when it first started to drop. Interest in primary care has traditionally been higher among osteopathic medical students; in 1995, 43 percent selected primary care as a career, the same as in 1982 (AOA/AACOM 1997).

Among allopathic students, anesthesiology and radiology continue to drop in popularity; only 1 percent of medical school seniors expressed interest in anesthesiology as a career, compared to 7 percent in 1991 (AAMC 1996a).

Table 16-2. Graduating Allopathic Medical Students' Career Preferences, by Selected Specialties and Years, 1980-1996 (percentage)

Specialty	1980	1985	1991	1992	1993	1994	1995	1996
Primary Care	31.0%	29.8%	14.9%	14.6%	19.3%	22.8%	27.6%	31.9%
Family practice	14.5	13.3	9.4	9.0	11.8	13.1	15.7	16.6
Internal medicine	10.6	10.7	2.9	3.2	4.5	6.2	7.7	9.7
Pediatrics	5.9	5.8	2.6	2.4	3.0	3.5	4.2	5.6
Surgery								
General surgery	4.8	6.2	2.1	2.1	2.1	3.0	3.4	3.8
Ophthalmology	3.5	3.6	3.4	3.4	3.2	3.4	3.0	2.7
Orthopedics	4.8	5.7	4.7	5.3	4.8	5.0	4.5	4.1
Other Specialties								
Anesthesiology	2.3	5.7	7.0	6.8	5.7	4.7	2.9	1.0
Medical subspecialties	3.7	10.6	16.0	16.4	14.2	12.2	12.0	11.0
Obstetrics-gynecology	4.2	5.4	2.5	2.7	3.1	3.8	4.0	4.5
Psychiatry	2.8	4.2	2.1	1.6	1.5	2.0	2.2	1.3
Radiology	3.8	5.7	7.7	7.2	7.3	6.6	6.7	4.2

SOURCE: 1980-1996 Association of American Medical Colleges Medical School Graduation Questionnaire.

NOTE: Percentages based only on students who had decided on a specialty. Data since 1991 based on slightly different question format.

[4] Some 8 percent had no opinion or did not conduct a job search.

Changes in the Mix of Residency Positions and Programs

Another measure of potential changes in specialty mix is the mix of first-year residents (Table 16-3). Here there is also a trend toward generalism, although the shift is less dramatic than that for the survey of medical student career preferences. In 1995, the share of first-year residents in primary care fields rose slightly from 57 percent to 59 percent, the same level as in 1993. Specialties such as obstetrics-gynecology and orthopedics experienced slight losses.[5] Although graduates of osteopathic medical schools have traditionally been more primary-care oriented, adding osteopathic residents in osteopathic programs to the count of trainees in allopathic programs does not substantially change the percentage in any field because of their relatively small numbers.

Table 16-3. Distribution of First-Year Residents, by Selected Specialties and Years, 1980-1995 (percentage)

Specialty	1980	1986	1990	1993	1994	1995
Primary Care	54%	57%	57%	59%	57%	59%
Family practice	13	13	11	12	13	13
Internal medicine	32	34	36	36	34	35
Pediatrics	10	11	11	11	10	11
Surgery						
General surgery	14	13	13	12	12	12
Orthopedics	1	1	1	2	2	1
Other Specialties						
Anesthesiology	3	2	2	1	1	1
Obstetrics-gynecology	7	6	5	5	6	5
Pathology	3	2	2	2	2	2
Psychiatry	6	5	5	5	5	5
Radiology	2	1	2	2	2	2

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

NOTES: Percentages do not add to 100 because some specialties are not displayed.

Includes osteopathic graduates in allopathic programs.

CHANGING DEMAND FOR PHYSICIANS

In its 1996 report, the Commission noted that both the market for physicians' services and the market for training appeared to be signaling that there are too many physicians overall. This year, the evidence is less clear. Physician incomes (aggregated across all specialties) and the number of first-year and

[5] The number of residents in some specialized fields such as anesthesiology is so small relative to the total number of residents that only massive changes would affect the specialty's share of first-year residents.

total residents continue to grow, although at lower rates than in the past. In addition, the number of residency programs is still climbing, although quite slowly in most fields except for family practice.

The number of first-year residents increased between 1980 and 1990, with particularly large growth in 1993. After returning to historical levels in 1994, these figures rose again in 1995 to 21,372 (nearly 11 percent) (Table 16-4). The number of first-year residents grew in every specialty tracked by the Commission with three exceptions: anesthesiology, obstetrics-gynecology, and orthopedic surgery. The overall increase cannot be attributed to international medical graduates. After reaching nearly 7,000, or 36 percent of first-year residents, in 1994, the number of first-year residents graduating from foreign medical schools fell to about 5,300 (25 percent) in 1995 (Table 16-5). The specialty distribution of international medical graduates has changed somewhat since 1990, with a mounting share of IMGs in anesthesiology, internal medicine, pathology, pediatrics, and psychiatry (Table 16-6).

Table 16-4. First-Year Residents, by Selected Specialties and Years, 1980-1995

Specialty	1980	1986[a]	1990	1993	1994	1995
Primary Care						
Family practice	2,371	2,281	1,934	2,503	2,512	2,792
Internal medicine	5,948	6,234	6,518	7,843	6,524	7,502
Pediatrics	1,864	1,938	1,937	2,454	1,999	2,273
Surgery						
General surgery	2,539	2,412	2,408	2,567	2,384	2,483
Ophthalmology	b	b	b	b	b	b
Orthopedics	218	257	269	353	311	300
Other Specialties						
Anesthesiology	523	325	358	314	258	207
Obstetrics-gynecology	1,220	1,048	1,000	1,121	1,097	1,087
Pathology	642	415	449	538	388	513
Psychiatry	1,063	980	874	1,096	899	1,010
Radiology	409	257	376	430	420	434
All Specialties	18,702	18,183	18,322	21,616	19,293	21,372

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

[a] Data from 1985 are not available.

[b] Residents may not enter training in ophthalmology in their first postgraduate year.

NOTE: Includes osteopathic graduates in allopathic programs.

Table 16-5. Trends in the Number and Percentage of Residents Who Are International Medical Graduates, by Selected Years, 1970-1995

Year	Total Number of Residents		Percentage Who Are International Medical Graduates	
	First-Year	All	First-Year	All
1970	11,552	39,463	29%	33%
1975	11,401	54,500	29	31
1980	18,702	61,465	21	20
1985	19,168	75,514	14	17
1990	18,322	82,902	19	18
1991	19,497	86,217	24	20
1992	19,794	89,368	25	20
1993	21,616	97,370	27	23
1994	19,293	97,832	36	24
1995	21,372	98,035	25	25

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

Table 16-6. Shares of Total Residents Who Are International Medical Graduates, by Selected Specialties and Years, 1990-1995 (percentage)

	1990	1991	1992	1993	1994	1995
Primary Care						
Family practice	14.8%	16.1%	18.7%	19.7%	17.9%	16.7%
Internal medicine	28.6	34.1	36.4	39.6	41.9	42.5
Pediatrics	31.4	33.1	33.3	33.6	32.1	50.6
Surgery						
General surgery	8.5	9.0	*	10.8	11.4	11.7
Ophthalmology	3.7	4.6	4.9	6.5	6.6	6.9
Orthopedics	1.3	1.3	1.2	1.2	1.4	1.7
Other Specialties						
Anesthesiology	11.5	12.8	14.3	16.1	19.9	24.4
Obstetrics-gynecology	8.0	7.4	7.1	6.1	5.8	6.1
Pathology	28.1	28.7	29.6	30.3	30.4	33.8
Psychiatry	21.0	23.0	25.2	32.8	36.1	41.4
Radiology	3.8	3.9	4.1	4.7	4.9	5.6
All Specialties	18.0	20.0	20.0	23.3	24.0	25.5

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

* Data not available.

A third indicator of the size of the graduate medical education enterprise is the total number of residents (Table 16-7) and training programs (Table 16-8). In 1995, allopathic programs grew 4 percent as the result of increases in most major specialties. The number of residents per program dropped in several specialized fields, among them anesthesiology (with 58 percent of programs becoming smaller during the 1994-1995 academic year), cardiology (30 percent) and gastroenterology

(25 percent). Fewer than 1 percent of programs in family medicine decreased the number of residents (AMA 1997).

Table 16-7. Total Residents, by Selected Specialties and Years, 1980-1995

Specialty	1980	1986*	1990	1993	1994	1995
Primary Care						
Family practice	6,344	7,238	6,680	7,976	8,587	9,261
Internal medicine	15,964	18,116	18,734	20,603	20,693	21,071
Pediatrics	5,171	5,817	6,115	7,460	7,394	7,354
Surgery						
General surgery	7,440	7,880	7,644	8,243	8,217	8,221
Ophthalmology	1,480	1,549	1,446	1,674	1,611	1,602
Orthopedics	2,418	2,822	2,630	3,029	2,903	2,872
Other Specialties						
Anesthesiology	2,490	3,864	4,889	5,696	5,490	4,861
Obstetrics-gynecology	4,221	4,525	4,315	5,074	5,046	5,007
Pathology	2,186	2,299	2,364	2,731	2,766	2,788
Psychiatry	3,911	4,892	4,673	5,044	4,979	4,919
Radiology	2,766	3,095	3,775	4,236	4,189	4,090
All Specialties	62,853	76,815	82,902	97,370	97,832	98,035

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

* Data from 1985 are not available.

NOTE: Includes osteopathic graduates in allopathic programs.

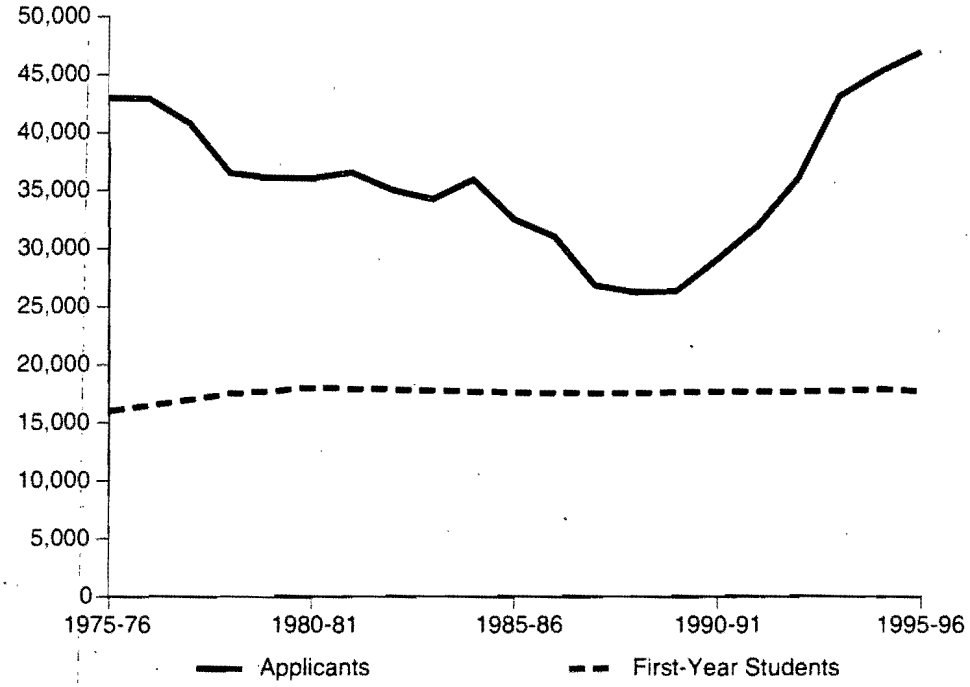
Table 16-8. Number of Allopathic Residency Programs, by Selected Specialties and Years, 1979-1995

Specialty	1979	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	385	385	383	393	395	407	430	455
Internal medicine	443	442	426	427	418	416	415	416
Pediatrics	245	236	215	217	214	215	215	215
Surgery								
General surgery	331	306	281	281	270	270	271	269
Ophthalmology	155	142	136	137	135	135	137	137
Orthopedics	180	168	163	161	161	161	160	158
Other Specialties								
Anesthesiology	161	165	155	157	155	155	149	154
Obstetrics-gynecology	304	292	275	273	273	274	273	272
Pathology	358	261	217	195	192	188	186	185
Psychiatry	223	211	196	200	197	198	196	201
Radiology	221	211	210	210	206	205	206	206
All Specialties	4,742	4,799	6,938	7,189	7,065	7,277	7,347	7,657

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

Changes in college students' willingness to pursue medical careers might be a lagging indicator of a tightened labor market for physicians. To date, however, there is no evidence that shifts in the organization and delivery of medical care are discouraging college students from becoming physicians. For the 1995-1996 school year, the number of allopathic medical school applications rose to an all-time high of 46,591, up about 3 percent from the prior year (Barzansky et al. 1996; AAMC 1996b). Medical school enrollment has remained relatively flat over the past 20 years (Figure 16-1). The 10,781 applicants to osteopathic schools in 1995 represented an increase of 5 percent over the prior year (AOA/AACOM 1997).

Figure 16-1. Applicants and First-Year Enrollment in U.S. Medical Schools, 1975-1995



SOURCE: Barzansky et al. 1996; AAMC 1996b.

As an indicator of change in the labor market for physicians, growth in the number of applications to medical school should be interpreted with caution, however. That is because employment prospects in other fields also influence students' willingness to apply to medical school. Uncertainty about future prospects in law, business, engineering, and other professional fields thus may contribute to students' growing interest in medical careers. A downturn in the labor market for lawyers has led to fewer law school applicants. Since 1990, the number of people taking the law school entrance exam has dropped by one-third, and about 50 of the nation's 180 accredited law schools have reduced class size in recent years (Chandrasekaran 1996).

Other changes, such as the number of physicians taking early retirement or relocating, might also be indicators of response to shrinking opportunities for physicians. While there is considerable anecdotal evidence that physicians are retiring, moving, and becoming more dissatisfied with their careers, there

continue to be no good data sources to track these factors.[6] Similarly, changes in the roles of nonphysician practitioners who provide primary care services (for example, nurse practitioners and physician assistants) might also signal an oversupply of physicians. Such changes are more difficult to measure, however, and may be confounded by current restrictions on payment and practice, as well as by the varying roles that these practitioners play in managed-care organizations.

CHANGING TERMS OF EMPLOYMENT

Changes in the market for health services may have another effect on the labor market for physicians—namely, the terms of employment or types of practice arrangements available to new physicians. In 1995, the share of physicians who are employees increased to 39 percent, up from 36 percent in 1994. At the same time, the share of self-employed physicians dropped to 55 percent from 58 percent (Mitka 1996). Union membership has also grown dramatically among physicians, although union members still account for a small share (less than 10 percent) of the nation's practicing physicians (Worcester 1996).

A related trend is the growth in salaried positions rather than offers of income guarantees or other forms of compensation. Merritt, Hawkins and Associates, a national physician recruitment firm, reports that 63 percent of the job searches it conducted between April 1995 and April 1996 were for salaried positions, compared with just 44 percent the year before (Kostreski 1996).

CONCLUSIONS

The evolving market for health services appears to be changing the national labor market for physicians. The lack of data at the market level precludes our ability to determine whether these changes are more pronounced in the most competitive markets. National data indicate that positions in generalist fields are becoming somewhat more attractive but that changes in relative incomes have been modest. Overall job opportunities for physicians, however, do not appear to be contracting. The changing market does appear to be affecting physicians' practice arrangements, with an increasing share of physicians becoming employees rather than being self-employed or holding equity in a group practice.

[6] Changes in the average retirement age can be obtained from the AMA's Physician Masterfile, but these calculations are not made regularly.

Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997

In 1995, Medicare Paid 393 Doctors More than $1 Million for Services; 3,152 Doctors Received between $500,000 and $1,000,000. Now a Greedy Few Want More

Mr. Speaker:

The Medicare agency tells me that in 1995, Medicare paid 393 doctors more than $1 million for services; 3,152 doctors received between $500,000 and $1,000,000. Now a Greedy Few want more.

Despite the ability of doctors to make a fortune from Medicare by providing lots of services to beneficiaries, a few doctors are pushing an amendment by Senator Kyl to let doctors privately contract with Medicare benefits.

Strip away the rhetoric, and a private contract is a contract between a doctor who holds his life in your hands in which he demands that you give up your Medicare benefits and that you promise not to file a claim with Medicare. Instead, you agree to let him charge you anything he wants--because you are desperate for your health. We like to think of contracts between equals, negotiated fairly. There is no equality, there is no fairness in these contracts.

Want an example of a private contract? Look at today's Washington Post, page B-3 , where a doctor in Manassas, Virginia is being investigated for charging a Medicare-eligible patient $12,000 for the injection of a massive dose of aloe vera into the stomach in order to combat lung cancer. The investigation is due to the fact the man died in the doctor's office after the injection. Medicare does not cover quackery. It does not pay $12,000 for an injection. But this man and this doctor had a private contract. There will be a lot more of this murderous nonsense if the Kyl amendment succeeds.

Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 22, 1997

People have trouble seeing doctors because they don't have enough money--not because Medicare pays doctors too little

Mr. Speaker:

The just-enacted Balanced Budget Act includes a provision that allows doctors not to participate in Medicare for two years at a time, but instead to private contract with patients so that they can charge these patients much more than the Medicare fee schedule.

There is now a move underway to strike the two year requirement and let doctors do wallet biopsies--decide on a patient-by-patient basis whether they are going to ask patients to give up their Medicare rights and insurance and pay the extra in an individual private contract.

I can think of nothing that will encourage patients to move into HMOs faster, so that they are protected against the fear of this type of doctor extortion. The American Medical Association supports the proposal, but it is an idea that must have been deviously planted in their Association by a mole from the HMO lobby--the American Association of Health Plans!

The proposal is pure greed wrapped in the flag of freedom.

Before the Congress is drowned in the rhetoric of this issue, we should note the facts. To the extent that Medicare beneficiaries have trouble seeing doctors, it is almost totally due to the fact that the cost is too much for the beneficiaries---not that Medicare doesn't pay the doctor enough to allow the doctor to see patients.

The latest data from the independent Congressional advisory panel--the Physician Payment Assessment Commission--shows that only 4% of all Medicare beneficiaries reported having trouble getting health care in the last year. About 11% had a medical problem, but failed to see a physician, while 12% did not have a physician's office as a usual source of care. Roughly 10% of Medicare beneficiaries delayed care due to cost. Considering all four access measures, about

26% of Medicare beneficiaries cited experiencing at least one of these problems.

PhysPRC reports that from their surveys of those who failed to see a physician for their serious medical problem, 43 cited cost as the reason. About 8 percent of those who failed to see a physician could not get an appointment or find an available physician. For another 8 percent, transportation was the problem, 13% felt there was nothing a doctor could do, and 11% were afraid of finding out what was wrong.

In another words, Congress is preparing to let doctors charge patients infinitely higher fees because less than 1% of all Medicare beneficiaries had trouble finding a doctor (perhaps they lived in a rural area, etc.). Yet over 5% of Medicare's nearly 40 million beneficiaries could not get to a doctor because they didn't have enough money--and Congress is silent.

Mr. Speaker, a humane Congress, a compassionate Congress, a logical, rational Congress would put 5 times as much effort into addressing the problem of doctors costing too much as it would in addressing what may be a 1% problem of a few doctors wanting to get paid more.

Where are our priorities, Mr. Speaker? A vote to let doctors, the richest 1% income group in our nation, charge "the sky's the limit," while ignoring the needs nearly 2 million seniors who find doctors already too expensive is a shameful vote.

WANT AN EXAMPLE OF PRIVATE CONTRACTING?

Dear Colleague:

Senator Kyl wants to make it easier for doctors to force seniors to give up their Medicare rights and be charged the sky's the limit.

No matter that doctors already make a lot of money from Medicare. In 1995, Medicare paid 393 doctors more than $1,000,000. Another 3,152 received between $500,000 and $1 million. The busiest 10% of doctors average $323,409 from Medicare.

The Kyl amendment is just pure greed. Medicare pays enough for doctors to see Medicare patients. The Physician Payment Review Commission--the Congressional advisory body on doctor payments--reports that about the same number of doctors are accepting new Medicare patients as are accepting new private-pay patients. They report that the main reason Medicare patients have trouble seeing a doctor is because the patient doesn't have enough money--not because the doctor is not being paid enough.

Medicare and the government have spent hundreds of billions to educate doctors and support medical research; we spend about $60,000 a year on each resident doctor we train; it is only fitting that doctors in turn live with the Medicare fee schedule.

You want to see an example of a private contract? Look on the back. Charging a Medicare eligible patient $12,000 for a deadly alternative is a private contract.

Oppose amendments to make it easier for doctors to private contract--**extort**--Medicare patients.

Sincerely,

Va. Doctor's Treatment of Man Who Died Is Scrutinized

9/23/97

By Leef Smith
Washington Post Staff Writer

A Texas man who had lung cancer died in the spring in the office of a Manassas physician to whom he had gone for a costly intravenous treatment that is not officially sanctioned but that he hoped would save his life, according to Virginia State Police.

The man, Clarence Holland Lander, 83, became "violently ill" shortly after the $12,000 treatment was administered, and he died May 17, according to records in Prince William County Circuit Court.

The physician, Donald L. MacNay, an orthopedic surgeon, is under investigation in connection with Lander's death and with the treatment allegedly employed—intravenous administration of "a concentrated form of aloe vera and other substances," police said. Aloe vera, a cactus-like member of the lily family, is known to have some healing properties.

Police said that their investigation is continuing and that MacNay has not been charged with any offense. MacNay, who investigators said still is licensed to practice medicine, did not return phone calls to his Manassas office yesterday.

An assistant to MacNay, Ronald Ragan Sheetz, 41, of Manassas, was arrested Thursday and charged with nursing without a license. According to an affidavit that accompanied the request for the arrest warrant, MacNay ordered Sheetz to give Lander the aloe vera injection.

"This procedure was carried out by the subject believed to be Ronald Sheetz who has no medical license on file, under Dr. MacNay's direction and presence," the warrant states. State Police spokeswoman Lucy Caldwell said MacNay also is under investigation in connection with Sheetz's action.

"We're looking into questionable medical practices, drug transactions and suspicious cancer treatments of this doctor's office," Caldwell said. "At this time we're trying to determine how wide-reaching the practice here may be. It's still too early to say."

A spokeswoman for the U.S. Food and Drug Administration said that the intravenous aloe vera treatment has not been approved by the agency and that officials with the National Cancer Institute said they are not studying aloe in connection with cancer treatment.

At the same time, the healing properties of aloe are being studied by researchers exploring alternative medicines to treat diseases, and papers and advertisements about oral aloe-based concentrates are found easily on the Internet. Experts say that as many as 50 percent of the cancer patients in the United States try some kind of therapy that is not officially sanctioned.

Such treatments include special diets, vitamins, mental imagery, wearing magnets, coffee enemas and consuming cartilage and oil from sharks.

Lander's son, James Lander, said that his father was in excellent health before the terminal cancer was diagnosed and that he jumped at the chance to beat the disease. He said his father learned about the aloe treatment from reading an article and found MacNay through word-of-mouth referrals.

"The treatment gave him hope," James Lander said. "He completely brightened up. You could just see it. I'm sure he thought it would cure him or he wouldn't have gone to Virginia" from his home in Waco, Tex.

In a search warrant affidavit filed Friday in Circuit Court, investigators said they were seeking "patient files and other records related to appointments and [the] treatment of other patients who have received this treatment and have both lived and died."

An affidavit was filed yesterday in Fairfax County Circuit Court to obtain a search warrant for an office in Annandale that police said MacNay opened in July.

Sheetz was released from jail on personal recognizance. If convicted of the felony charge, he could be sentenced to up to five years in prison.

Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997

The Greedy

Mr. Speaker:

A move is underway to let doctors force patients to give up their Medicare benefits so that a handful of doctors can charge them anything they want--without limit.

This is a gift to the greediest doctors in the nation.

Ninety-five percent of the nation's doctors accept new Medicare patients and the Medicare fee schedule. The independent Congressional advisory panel known as the Physician Payment Review Commission reports that this is comparable to the rate of doctors who are accepting new private, non-Medicare patients. In other words, there is no noticeable difference in access--ability to see a doctor--between Medicare and non-Medicare patients.

Doctors who accept Medicare and its fee schedule understand the Hippocratic Oath and the social compact in which society has paid hundreds of billions of dollars for the education and training and research that make American doctors special and in turn, these doctors accept the Medicare payment system.

But Congress is about to cater to the few who want more, more, more from people in their hour of illness.

The Employee Benefit Research Institute in its September, 1997 Issue Brief shows what a special gift this legislation will be to a few doctors who are out of step with their colleagues:

Recent findings indicate that only between 4 percent and 6 percent of physicians accepting new patients were not accepting new Medicare patients. One survey found that between 1991 and 1992, the proportion of physicians not accepting new Medicare patients increased from 4 percent to 5.9 percent (Lee and Gillis, 1994). The same survey found that between 1992 and 1993 the percentage of physicians not accepting new Medicare patients decreased to 4.7 percent. Surveys by the Physician Payment Review Commission (PPRC) also found that in 1993 less than 5 percent of physicians were not accepting new Medicare patients (Physician Payment Review Commission, 1994). The PPRC study concluded that the implementation of the Medicare fee schedule has not caused physicians to close their practices to Medicare patients.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

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BILL VAUGHAN, SUBCOMMITTEE MINORITY

September 8, 1997

Franklin Raines, Director
Office of Management and Budget
The Old Executive Office Building
Washington, DC 20503

Dear Director Raines:

Included in the Balanced Budget Act is an amendment by Senator Kyl allowing a doctor to sign private contracts with Medicare beneficiaries requiring those beneficiaries to give up their Medicare insurance when they use that doctor. A doctor who signs such a contract must make a commitment not to bill Medicare for any of his patients for a two year period.

Advocates of private contracting support it in the name of freedom.

I had thought it was just plain greed--the desire of a doctor to bill any amount rather than have to live with the Medicare resource-based relative value fee schedule.

But perhaps it is a question of freedom, in which case the better response by the public would be to accept this proposal--but the public should have the freedom to bill the doctor, with interest, for all the public subsidies he or she has received.

The reason that American medicine is a world leader and that medicine has moved beyond the level of penicillin, amputations, and mustard plasters is the hundreds of billions of taxpayer dollars that have been poured into the National Institutes of Health, the Public Health Service, the various health professions manpower training programs, Medicare's Graduate Medical Education programs (which average about $60,000 a year in subsidy for the training of each resident doctor), and the capital assistance to the hospitals in which these doctors trained.

The doctors who advocate private contracting tend to say that they are special and can command extra fees. The only reason that is true is that the public has substantially subsidized their education and the research on which their fame and fortune rests.

For a doctor to now want to private contract and avoid Medicare patients would be like a West Point cadet saying that he or she did not want to serve in the Regular Army after graduation. That may be freedom, but it is a subsidy we do not permit.

In the case of these doctors who became competent through the massive health subsidies we have provided, we should permit them to privately contract as long as they repay, with interest, the estimated value of the subsidies they received. I hope the Office of Management and Budget could estimate the total value of physician and clinical practice health subidies, including tax subsidies, that have been provided over the past forty years. From this we could develop a formula so that when, for example, a 55 year old doctor decides he wants the freedom to private contract, he can also have the freedom to repay the public for its investment in making him such a wonderful doctor who can command such high fees.

Thank you for your assistance with this request.

Sincerely,

/s/

Pete Stark
Member of Congress

Reconciliation 1997 - Medicare Issues

July 8, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

cc. John Hilley, Frank Raines, Jack Lew and Bruce Reed

SUBJECT: Major Medicare Issues for Conference

Attached is a quick summary of the three highest profile Medicare issues in the House / Senate conference: the high-income premium, changing the age eligibility for Medicare, and the home health copayment. The summary includes a brief description, an analysis of policy concerns, how the policies could be modified for possible consideration, and the degree of difficulty to make these changes.

As we have discussed, we have sent strong signals of opposition to including the age eligibility change and the home health copayment in the context of the budget agreement. John Hilley strongly believes that opening up discussion of these two issues will rupture the House Democratic Caucus and would force Senator Daschle to oppose the budget in the Senate (the Senator explicitly has pointed to these provisions as reasons why he voted against the Senate-passed bill).

While we have expressed our opposition to inclusion of the age eligibility change and the home health copayment in the budget agreement, our letter from OMB was careful not in any way to rule out possibility of improving and passing improved versions of these ideas in another context. In addition, in the OMB letter and in other communications with the Leadership, we have left the door open to the consideration of the high-income premium provision within the budget agreement. However, we believe that the current Senate provisions need to be revised to address the serious concerns outlined in the attached document.

HIGH-PROFILE MEDICARE ISSUES

HIGH-INCOME PREMIUM. Increases the Medicare Part B premium for high-income beneficiaries, administered by Health and Human Services (HHS) or Social Security (SSA):

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

In 2002, the 25 percent premium would be about $67 per month; under this policy, the highest income beneficiaries would pay an extra $200 per month, $2,400 per year.

Concerns: **Creates complex new bureaucracy.** Duplicates the IRS. HHS or SSA would have to use tax returns, ask beneficiaries their income, and bill and collect premiums. Having another agency have access to income data has potential to raise unforseen and major privacy concerns. If HHS or SSA administers the income-related premium, it could take two to three years to determine how to reconcile beneficiary income with the amount of premiums owed. This lag time would inevitably create serious administrative problems including the possibility that beneficiaries may no longer have the income attributed to them as a result of changes in their health and income status. It would also require recovery of premium payments from deceased beneficiaries' spouses. AARP cites the difficulty of HHS administering this policy as a primary reason why they oppose it.

CBO assumes that more than half the premium revenue would be lost in its first 5 years due to inefficiency. If administered by IRS, only about 5 percent would be lost.

Could encourage seniors to leave Medicare. The policy to completely eliminate any premium subsidy could cause high-income beneficiaries to drop out of Medicare Part B, leaving traditional Medicare with the sicker, more expensive beneficiaries. The HCFA actuaries assume that twice as many beneficiaries will drop out of Medicare if they must pay the full cost of the premium rather than 75 percent of the premium.

Trust Fund effect is 1 year to 1 ½ years.

Necessary Policy Modification:

Administer through the IRS; phase out the high-income premium at 75 percent, not 100 percent of the subsidy. This would reduce the annual maximum premiums to $1,600 for singles and would be paid quarterly (as estimated taxes) or annually. Some would label this as a "tax". Changing the phase-out loses

some revenue but this is more than offset by efficiency gains from IRS administration. Saves approximately $7.8 billion relative to $3.9 billion through HHS. Could raise the income threshold to address concerns that too many beneficiaries would be affected or that too much revenue is being raised.

Degree of Difficulty to Fix:

From a political perspective, this may be the easiest option since we are viewed to be relatively down the road on this issue. From a policy perspective, the administration of the policy would impose yet another burden on an already understaffed IRS which would need additional resources to carry out such a significant task. IRS administration would allay the privacy concerns.

POSTPONE MEDICARE ELIGIBILITY: Extends the eligibility age for Medicare from 65 years old to 67 years old. Phased in one month at time, with full implemented in the year 2027.

Concerns: **Increases the number of uninsured**. In 1997, an estimated 1.75 million beneficiaries aged 65 to 67 have income below $25,000. These Medicare beneficiaries may not be able to afford private insurance, possibly increasing the proportion of Americans without insurance by 5 percent, according to a preliminary Urban Institute analysis.

No partial benefit or insurance alternatives. Social Security gives people who retire early a portion of their benefits; Medicare offers nothing to such beneficiaries.

Trust Fund effect is less than six months.

Necessary Policy Modification:

Create Medicare buy-in or premium assistance for COBRA; alternatively, could specify that the Secretary must develop policy options by 2000. Note: These options may be expensive. The Medicare spending per enrollee — even after the budget agreement — is $7,300 in 2003 when the postponed eligibility begins. We would need to find a way to means-test the buy-in so that lower-income 65 year olds could afford coverage.

Degree of Difficulty to Fix:

On a policy basis, we could probably modify this in a way that addresses our primary concern -- continued, affordable access to insurance for the elderly. From a political perspective, it will be much more difficult because both the business and labor communities are focusing their opposition to this policy, fearing a direct cost shift.

HOME HEALTH COPAYMENT. Adds a new $5 payment per Part B home health visit, with an annual limit on the copayments equal to the hospital deductible ($760 in 1997).

Concerns: **Unlikely to change utilization significantly**. Over three-fourths of Medicare beneficiaries have Medigap or Medicaid and would not directly pay for the visit.

Severe impact on low-income beneficiaries. For the 15 percent of beneficiaries without Medigap or Medicaid, these costs could be high and might reduce access to needed care.

- Over 60 percent of Medicare's home health users without Medigap have incomes below $10,000. Fully 87 percent have incomes below $20,000.

- Poor home health users without Medigap protection are more likely to have more than 150 visits per year than less.

Unfunded mandate to states. Medicaid covers cost sharing for millions of low-income Medicare beneficiaries. CBO estimates that states' costs could rise by $700 million.

Necessary Policy Modification:

Extend low-income beneficiary protections; make major changes to current Medigap policies prohibiting coverage of the home health copayments below a certain threshold

Degree of Difficulty to Fix:

Although not as visible as the first two proposals, this reform may be the most difficult from both policy and political perspective. From a political perspective, both the aging advocates as well as the National Association of Home Care (Val Halamandaris) are lobbying hard to eliminate this provision

Reconciliation 1997 File

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

THE DIRECTOR

June 24, 1997

The Honorable Gerald R. Solomon
Chairman
Committee on Rules
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

As you consider this year's budget reconciliation bill, I am writing to transmit the views of the Administration on the Budget Committee reported legislation on the spending provisions. The Administration's views on the tax provisions of the legislation will be transmitted separately.

Many provisions of the reported bill are consistent with the Bipartisan Budget Agreement. We are pleased that, consistent with the Budget Agreement, the House is preparing to consider two separate reconciliation bills, the first for spending and the second for taxes. We expect that this consideration will continue throughout the process. However, there are a number of important areas where the legislation is not consistent with the Agreement. As you know, there are ongoing efforts to resolve a number of issues through an amendment at the Rules Committee. The Administration intends to continue working closely with the leadership on remedial amendments.

Key areas where the bill is inconsistent with the Budget Agreement include: failure to fully restore Supplemental Security Income (SSI) and Medicaid benefits for all disabled legal immigrants who are or become disabled and who entered the U.S. prior to August 23, 1996; assist low-income Medicare beneficiaries in paying additional premium amounts related to the home health reallocation; provide Medicaid benefits for disabled children; implement important Medicaid investments; properly implement the home health reallocation; create additional work slots for individuals subject to the Food Stamp time limits; fully provide for savings from spectrum auctions; and ensure that a substantial share of welfare-to-work funds go to cities and counties with large poverty populations.

The Bipartisan Budget Agreement is good for America, its people, and its future, and we are fully committed to working with Congress to see all of its provisions enacted into law by the August recess.

Items Contrary to the Bipartisan Budget Agreement

Assistance for Low-Income Medicare Beneficiaries -- Recognizing that premiums represent a significant burden on low-income beneficiaries, the Budget Agreement allocated $1.5 billion to ease the impact of higher premiums on this population. The reported bill falls short of this, including only $0.5 billion for this purpose. Additionally, the approach in the bill is too administratively complex for the value of the benefit provided.

Continued SSI and Medicaid Benefits for Legal Immigrants -- The President stated in his June 20 letter to Budget Committee Chairman Kasich and Ranking Member Spratt that he will be unable to sign legislation that does not include the agreement's policy protecting disabled immigrants. The Budget Agreement explicitly states: "Restore SSI and Medicaid eligibility for all disabled legal immigrants who are or become disabled and who enter the U.S. prior to August 23, 1996." The reported bill fails to reflect the Agreement. As a result, in 2002 it would protect 75,000 fewer immigrants than called for in the Budget Agreement. In addition, the President's strong preference is to cover both elderly and disabled immigrants. We will work with you to identify the necessary resources to do so.

Medicaid Benefits for Disabled Children – The Budget Agreement clearly includes the proposal to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility. The reported bill fails to include this proposal. We strongly urge the House to include this provision and retain Medicaid benefits for approximately 30,000 children who could lose their health care coverage in FY 1998.

Medicaid Investments -- After extended negotiations that preceded the Bipartisan Budget Agreement, the Administration and the Congressional leadership agreed to specified savings and investments in the Medicaid program over five years. Specifically, the Agreement calls for a higher Federal matching payment for the Medicaid program in the District of Columbia and adjustments for the Medicaid programs in Puerto Rico and the territories. The reported bill fails to include these provisions.

Home Health Reallocation -- The home health reallocation in the Budget Agreement is not properly reflected in the reported bill. During the negotiations, we discussed at great length the shift of home health expenditures to Part B, and it was always understood to be immediate. We agreed to phase in the increased Part B premium, but not to postpone the reallocation of home health spending. The Ways and Means Committee's phase-in of the reallocation means a loss of two years of solvency in the Part A trust fund, two years which we can ill afford to lose. We urge the House to incorporate the provision included in the Commerce Committee reported title.

Additional Work Slots for Individuals Subject to the Food Stamp Time Limits -- The Bipartisan Budget Agreement includes $1.5 billion in additional funding for the Food Stamp Program to increase support for work and provide States with flexibility to exempt individuals

from the Food Stamp time limits due to hardship. While we appreciate that the Committee reported bill implements the 15 percent hardship exemption consistent with the Agreement, the bill's approach for employment and training (E&T) funds for able-bodied childless adults aged 18-50 falls short of creating the maximum level of work slots. The Agreement specifically states that existing Food Stamp E&T funds will be redirected and new capped mandatory funding added "to create additional work slots for individuals subject to the time limits." The Agreement provides $1 billion for this purpose. The approach in the Committee bill would create more than 100,000 fewer work slots than the Administration's legislative proposal and approximately 60,000 fewer than the approach taken by the Senate bill. Specifically, the bill lacks performance standards and accountability to ensure that the new Federal funding creates additional work slots that meet the welfare reform statute's tough work requirements for Food Stamp recipients, particularly by allowing 100 percent of the money to be spent on job search activities.

Spectrum -- The bill needs to be modified to achieve the full $26.3 billion in savings and policies described in the Balanced Budget Agreement. At a minimum, we urge the Rules Committee to meet the target savings number in the year 2002. It is our understanding that current attempts to redraft the bill still fall over $8 billion short of target levels. The reported bill does not include two of the proposals included in the Budget Agreement, the auction of "vanity" toll free telephone numbers and the spectrum penalty fee. The bill does not include reimbursement authority for Federal users that are required to relocate to new spectrum bands. Reimbursement of Federal agencies, such as the Department of Defense, is critical in order to avoid demands for increased discretionary spending (which could total several billion dollars) under the agreed upon discretionary spending caps. Additionally, the bill does not provide a firm date for the termination of analog broadcasting, thus causing significant savings reductions.

Additional concerns include the lack of authority for the FCC: (1) to retain a portion of auction receipts to cover the expense of administering auctions that would require additional discretionary appropriations to cover these costs; (2) to use economic mechanisms other than auctions where appropriate (i.e., user fees to create incentives for efficient spectrum management); and (3) to revoke and reauction licenses when an entity declares bankruptcy, which is essential to preserving licenses awarded in previous auctions.

The reported bill also includes an expansive definition of public safety that would create loopholes permitting far too many entities to be exempted from auctions and language that would protect spectrum for use by specific Federal users, which is contrary to the Administration's policy to manage spectrum across the Federal government through a process administered by the National Telecommunications and Information Administration. The Administration also has concerns with the non-germane language that eliminates the Duopoly and Newspaper Broadcast Cross-Ownership Rules. The reported bill language could short-change our Nation's long-standing commitment to fostering a diverse marketplace of ideas and ignores potential telecommunications policy and revenue gains that may be achieved if the FCC were to repack this spectrum for alternative uses.

Targeting Welfare-to-Work Funding to Cities and Counties with Large Poverty Populations -- The Administration strongly believes that a substantial amount of all welfare-to-work funds should be managed by cities and other local areas. The welfare-to-work structure crafted by the Ways and Means Committee accomplishes this goal through its division of funds between formula (50 percent) and competitive (50 percent) grants; its formula grant sub-States allocation factors and method of administration; and its reservation of 65 percent of competitive grants for cities with large poverty populations. The Education and Workforce Committee proposal would reduce the competitive funding share from 50 percent to 5 percent, thus severely restricting the amount for which cities can apply directly. The Ways and Means proposal accurately reflects the Agreement.

Additional Concerns

Although the Budget Agreement did not specifically address the following items, the Administration has significant concerns about them. The Administration urges the Rules Committee to address these concerns.

Medicare

Medical Savings Accounts (MSAs) -- The reported bill provides for a demonstration with 500,000 participants, costing $2 billion, which is many times larger than any other Medicare demonstration. Moreover, the demonstration exposes beneficiaries to any additional charges providers choose to levy without limitation. We strongly believe that the current law limits on balanced billing should be applied to this demonstration. We commend the Senate Finance Committee for limiting this demonstration to 100,000 participants, but still prefer a demonstration limited geographically for a trial period.

Medical Malpractice -- We believe that the malpractice provisions in the reported bill are extraneous to the Bipartisan Budget Agreement. As you know, the Administration opposed the malpractice provisions in the vetoed Balanced Budget bill, as well as those adopted in the House version of the Health Insurance Portability and Accountability Act. We find these provisions highly objectionable, and we oppose them.

Preventive Benefits -- While the preventive benefits in the reported bill are largely the same as those advanced in the President's Budget, we bring to your attention the failure to waive coinsurance for mammograms. As you know, mammography saves lives, yet many Medicare beneficiaries fail to use this benefit. Research has found that copayments hinder women from fully taking advantage of this benefit. Thus, we continue to support waiving copayments for mammograms.

Medical Education/Disproportionate Share (DSH) Carve-out -- The Administration's budget would move the medical education (indirect and direct) and DSH adjustments out of

managed care payment rates and redirect these funds to eligible hospitals that provide services to Medicare managed care enrollees. This is an important proposal designed to ensure that the Nation's teaching hospitals and those that serve low-income populations receive the Medicare payments to which they are entitled. We urge the House to include the Ways and Means proposal.

MedicarePlus – The bill permits beneficiaries to be locked into a MedicarePlus plan for as long as nine months, after a lengthy transition period. We continue to support the monthly disenrollment option as an important safety valve for managed care enrollees who are dissatisfied with their managed care plan. Moreover, we would support the ability of these enrollees to opt to purchase any Medigap plan of their choice upon disenrollment.

We have expressed concerns about balanced billing limits in MedicarePlus plans and anticipate a resolution of this issue such that MedicarePlus beneficiaries maintain their current law managed care protections against excessive cost-sharing (including those prohibiting balanced billing).

Prudent Purchasing -- We are pleased that the House included our proposal to expand the "Centers of Excellence" program and included a limited demonstration of durable medical equipment competitive bidding in the reported bill. However, we urge the House to take advantage of all of our prudent purchasing proposals. The Medicare program is governed by a strict set of provider payment rules that have the effect of limiting the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the Nation's largest health insurer, to also take advantage of lower rates providers offer to other payers.

Medicare Commission – The reported bill would establish a Medicare commission. Establishing a bipartisan process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our Nation's senior citizens.

Hospital Outpatient Department (OPD) Coinsurance Waiver -- While we support the policy in the reported bill that allows hospitals to reduce coinsurance for beneficiaries without being charged with a kickback violation, we would urge the House to include language barring such hospitals from charging the Medicare program for bad debt for such waived coinsurance. We suggest that hospitals make an election with the Secretary where they choose on an across-the-board basis for all beneficiaries to waive coinsurance and consequently do not bill Medicare for the waived coinsurance. Such a policy will permit proper monitoring of bad debt.

Medicaid

Disproportionate Share Hospitals -- We have concerns about the allocation of the disproportionate share hospital (DSH) payment reductions among States included in the reported bill. Although we agree that there have been abuses of this program in the past, taking such large reductions in certain States whose Medicaid programs are particularly dependent on DSH spending will likely affect their ability to cover services. We urge the House to revisit the FY 1998 President's Budget proposal, which ensures that States with the highest DSH spending are not bearing most of the impact of the savings policy.

We are very concerned that the reported bill does not include any retargeting of DSH funds. As the Administration has stated previously, we believe that significant savings from DSH payments should be linked to an appropriate targeting mechanism. We support proposals that ensure DSH funds are better targeted to needy hospitals.

Children's Health

We believe that the $16 billion Children's Health investment should be used for health insurance coverage. The Administration does not support the direct services option in the reported bill. We are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and that children would not necessarily get meaningful coverage.

We are also concerned that the reported bill may not be the most cost-effective manner possible to expand coverage to children, as required by the Agreement. The reported bill includes both a Medicaid and a grant option; however, the incentives in the reported bill could discourage States from choosing the Medicaid option. We believe that Medicaid is a cost-effective approach to covering low-income children, and would like to work with you on strengthening this option. We also believe that the grant program should be designed to be as efficient as possible. The provision that allows States to use funds for "other methods specified under the plan" with no details on what this means implies that States may use funds for purposes other than the intent of the Agreement (e.g., to offset States' share of Medicaid). We oppose this.

We are encouraged that the Senate-reported bill includes notable improvements. Specifically, we commend the decision not to allow use of the $16 billion investment in areas other than insurance coverage and the improved definition of benefits relative to the House Commerce Committee provisions. We are also extremely concerned about the inadequacy of the bill's benefits definition and the lack of low-income protections.

As the Administration has stated many times, we do not support limiting access to medically necessary benefits, including abortion services. We would like to work with the Congress to resolve this issue.

Minimum Wage and Workfare

The Administration strongly opposes the proposals in the reported bill on the minimum wage and welfare work requirements. The proposals in the reported bill are not part of the Budget Agreement and, had they been raised during negotiations, we would have strongly opposed them. These proposals would undermine the fundamental goals of welfare reform. The Administration believes strongly that everyone who can work must work, and those who work should earn at least the minimum wage and receive the protections of existing employment laws -- whether they are coming off welfare or not. These proposals do not meet this test.

Welfare-to-Work

We are pleased that the reported bill includes provisions that would address priorities, including: the provision of formula grant funds to States based on poverty, unemployment, and adult welfare recipients; a sub-State allocation of the formula grant to ensure targeting to areas of greatest need; targeting of at least 90 percent of formula funds to individuals in greatest need; appropriate flexibility for grantees to use the funds for a broad array of activities that offer promise of permanent placement in unsubsidized jobs; funds awarded on a competitive basis; and a substantial set-aside for evaluation. We look forward to working with the Congress to refine these provisions.

Welfare-to-Work Performance Fund -- The reported bill does not include a performance fund. It is essential that welfare-to-work funds generate greater levels of placement in unsubsidized jobs than States will achieve with TANF and other funds. We hope the House will consider a mechanism to provide needed incentives and rewards for placing more of the hardest-to-serve in lasting, unsubsidized jobs that promote self-sufficiency. We look forward to working with the Congress during conference to refine these provisions.

Worker Displacement -- We strongly urge the House to adopt, at a minimum, the provisions on worker displacement included in H.R. 1385, the House-passed job training reform bill which were included in the Education and the Workforce Committee reported bill and apply both to activities under the new welfare-to-work grants and TANF.

Distribution of Funds by Year -- It does not appear that the bill's allocation of $3 billion in budget authority over fiscal years 1998-2000 would, when combined with the program structure, result in an outlay pattern consistent with an estimate of zero outlays in FY 2002, as provided in the Budget Agreement. The Department of Labor is available to help craft language that satisfies the Agreement.

Repeal of Maintenance of Effort Requirement on State Supplementation of SSI Benefits

The Administration strongly opposes the repeal of the maintenance-of-effort requirement because it would let States significantly cut, or even eliminate, benefits to nearly 2.8 million poor

Gary, Terrie, Melissa

Backup, not for dist.

This info for you to use w/ ex. of some spec. concerns we have

If you get pushed BACK on issue of what are your policy concerns

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elderly, disabled, and blind persons. Congress instituted the maintenance-of-effort requirement in the early 1970s to prevent States from effectively transferring Federal benefit increases from SSI recipients to State treasuries. The proposal also could put at risk low-income elderly and disabled individuals who could lose SSI entirely and possibly then lose Medicaid coverage as well. The Administration opposed this proposal during last year's welfare reform debate.

Student Loans

The Administration opposes the provision regarding administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan Program (FFELP). The provision would mandate ACAs to be paid at a rate of 0.85 percent of new loan volume from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA), up to a cap of $170 million in FY 1998 and 1999 and $150 million in FY 2000-2002. It would represent a new entitlement to these agencies not included in the Budget Agreement. Moreover, any allowance to these agencies should bear some relationship to the costs these agencies incur and not be based on an arbitrary formula. This is an issue for the upcoming HEA reauthorization.

MEWAs

The reported bill includes language from H.R. 1515, the "Expansion of Portability and Health Insurance Coverage Act of 1997," in the budget reconciliation legislation. We believe that the bill as currently drafted has inadequate consumer protections and has the potential to result in premium increases for small businesses and employees who may bear the burden of adverse selection. H.R. 1515 would transfer the regulation of a large health insurance market away from the States through the preemption of State laws under the Employee Retirement Income Security Act ("ERISA").

Although there currently is strong bipartisan interest in strengthening consumer protections in health plans governed solely by ERISA, the current protections in ERISA are weak and inadequate. Any legislation like the current bill that expands ERISA's scope must be accompanied by an expansion of consumer protections. The Administration opposed these MEWA provisions when they were considered last year, and we believe it would be unfortunate and unwise to introduce this level of controversy into the budget reconciliation process. This far-reaching proposal should receive much greater analysis and discussion before consideration for enactment.

Privatization

The reported bill would allow the eligibility and enrollment determination functions of Federal and State health and human services benefits programs, including Medicaid and Food Stamps, to be privatized. While certain program functions, such as computer systems, can currently be contracted out to private entities, the certification of eligibility for benefits and

A new name — related premium, a new home, the $5 co-payment, i.e. inc. in the med elig age fr. 65-66 yr

Mike McCurry

Sonny Popovich

Lori McKeogh

April Melody

Julie Mason (whoever assisting on)

Larry Harris

NSC

Gene

John H.

Janet Murguia

Susan Brophy

Christina Chaves

Josh Gotbaum

Jack Lew

HHS

Rich Gray

Elisa

Jon G.

Olena B

Meredith Miller

Janet Yellen

Mark Mazur

a new name —
related premium,
a new home
& the $5 co-payment,
& inc. in the
med elig age to
65 & 66

Mike McCurry
Jenny Rivin
Lori McKeogh
April Melody
Julie Mason (wheelchair assistance)
Larry Harris
NSC
Gen
Bruce
John H.
Janet Murguia
Susan Sleeper
Christina Chaun

Josh Gt.
Treasury
HHS
Rich
Greg
Elisa
Jon G.
Glenn B
Meredith Miller

Tony Geller
Mark Mazur

related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions. The Administration believes that changes to current law would not be in the best interest of program beneficiaries and strongly opposes this provision.

Debt Limit Extension

The Administration strongly urges the House to include the debt limit extension contained in the Bipartisan Budget Agreement in the first reconciliation bill, the spending bill.

Vocational Education in TANF and Transfers to Title XX

The Administration opposes provisions in the reported bill that alter the TANF work requirements regarding vocational education and educational services for teen parents. In particular, the Administration opposes the provision allowing States to divert TANF funds away from welfare-to-work efforts to other Title XX social service activities.

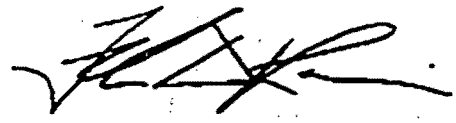
Other Provisions That May Be Added at the Rules Committee

We are also concerned by reports that the Rules Committee may consider provisions that add further restrictions to immigrants' access to public benefits. Many of the potential provisions were considered during last year's immigration reform debate and were removed from the final legislation after negotiations between Congress and the Administration because they were unacceptable to the Administration. The Administration strongly opposes these punitive provisions, which would introduce known controversies into the budget reconciliation process.

The Bipartisan Budget Agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we do so on a bipartisan basis.

I look forward to working with you to implement this historic agreement.

Sincerely,



Franklin D. Raines
Director

Identical letter sent to The Honorable Joseph Moakley, The Honorable John R. Kasich, and The Honorable John Spratt

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Memo
To Dist

Fr CJ

Re Gen. Contrac. Medicare Amend.

As you know last night the S approved 3 contrac. med provis. that we believe could threaten our abil to secure the cooperation of Medicare BB and the underlying Medicare reg that extends

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Attached is a Q&A that has been cleared by the HA with an [illegible] on [illegible] 75 [illegible]

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Memo

To Dick

Fr CJ

Re Sen. Contrav. Medicare Amend.

As you know last nite the S approved 3 contrav. Med provis. that we believe ~~the~~ could threaten ~~the~~ our abil to ~~get~~ achieve final BBZ

& secure the conclusion of Medicare ref that extends

* The spec. psov that ~~we~~ have rec. the greatest attention on

2 The life of the MBTC *

Attached is Q+A that has been cleared by the hill w/st Chm on [illegible]