

THE WHITE HOUSE
WASHINGTON

Fraud & Abuse File

August 25, 1995

MEMORANDUM TO LAURA TYSON

FROM: Jennifer Klein *J.K.*
SUBJECT: Fraud, Waste and Abuse in Medicare

You had asked how much might be saved in Medicare with a more aggressive program in place for controlling fraud, waste and abuse. Attached please find a memo from the Chief Counsel to the Inspector General, D. McCarty Thornton. As you can see, their analysis shows that vigorous enforcement can bring significant returns. However, their proposals are controversial because they are costly and some are funded through the Medicare Trust Fund.

Please feel free to let me know if you have additional questions.

cc: Chris Jennings

AUG 21 1995

NOTE TO JENNIFER KLEIN**Re: Medicare Savings Achievable Through Fraud and Abuse Control**

You posed the question -- how much Medicare savings could be realized with an aggressive program for controlling fraud and abuse? As you know, in 1992 the GAO estimated the Medicare losses due to fraud and abuse at about 10 percent of program expenditures, or almost \$20 billion per year with current Medicare outlays of about \$200 billion.

The following principal governs the answer. Increased fraud and abuse control requires an investment of resources in investigators, auditors, program evaluators and prosecutors. The rate of return of investment is known to be about 80:1; the size of the investment determines the result. The first three of the above functions with respect to Medicare are provided by the HHS/Office of Inspector General (OIG); the last function (prosecution) is handled mainly by the Justice Department, and the FBI also contributes investigative work.

The good news is that each dollar invested in OIG activities generates at least \$80 in program savings and monies recovered for the U.S. Government. This figure was carefully arrived at; it is fully explained on pages 3-5 of the attached testimony the Inspector General delivered on July 31. (See also the charts attached to the testimony). Basically, the figure includes (1) funds put to better use through adoption of changes suggested by OIG to legislation (using CBO figures), regulations, policies or procedures, (2) audit disallowances recommended by OIG, and (3) investigative receivables. This 80:1 ratio focuses on OIG activities in general. If one were to focus on the return on investment from OIG's Medicare anti-fraud activities, the return is about 50 percent higher than that. However, we prefer to use the 80:1 figure to be on the conservative side.

With respect to the last category above, investigative receivables, over the last five years every dollar devoted to OIG investigations of specific Medicare wrongdoers has yielded an average return of nearly \$7 to the Medicare Trust Funds and the Treasury, a return ratio of 7:1. See the attached July 26, 1995, memo to CBO. [Note: most of OIG's overall 80:1 return on investment is due to the program savings due to OIG recommendations and audit results.]

OIG is developing a proposal for the Secretary for funding OIG's Medicare activities through the Medicare Trust Funds, and for increasing the amount significantly for FY 97. In FY 95, OIG will devote approximately \$43 million to control of fraud and abuse in

Medicare. The return on this investment will be at least \$3.4 billion (80:1). Increases in the amount provided to OIG could be expected to have an 80:1 return ratio, as we have no indication of reaching a point of diminishing returns on the return from OIG's efforts.

Please give me a call at 619-0335.


for D. McCarty Thornton
Chief Counsel to the Inspector General

Attachments:

- A - OIG: Proposal for Funding of OIG Medicare Activities from Medicare Trust Fund**
- B - Testimony of June Gibbs Brown, July 31, 1995 (excerpt)**
- C - Memorandum to CBO: Receivables Attributable to the OIG Activities in Health Care**

Office of Inspector General

Proposal For Funding of OIG Medicare Activities from Medicare Trust Fund

Concept

- OIG audits, investigations, and evaluations of Medicare activities would be funded directly using Medicare Trust Fund(s). The funds recovered from OIG efforts (e.g., investigations, sanctions, and audit recoveries) would be returned to the Trust Fund.

Current OIG Activities Related to Medicare

- Operation Restore Trust--a multidisciplinary, intensive strike at fraud, waste and abuse in the home health, nursing home and hospice, and durable medical equipment providers
- Hospitals--reviews of inappropriate payments (including duplicate payments), coding, credit balance and Medicare secondary payer reporting, components of costs, and emerging models of care impacting the program
- Physicians, Laboratories and Ambulances--reviews of inappropriate payments, coding accuracy, appropriateness of fee schedules
- Managed Care--reviews of accuracy of payments, appeals and grievances
- Contractor Operations--reviews of administrative costs, fraud unit operations, effectiveness of information resources management
- Program Integrity and Patient Protection--sanctions of health care providers that abuse the program and its beneficiaries

Cost of Current OIG Medicare Activities

- For the current OIG activities related to Medicare, the OIG commits about 487 FTEs, which is comprised of investigators, auditors, evaluators, attorneys, and other support staff. The corresponding fully-loaded cost is \$42 million.

If We Had More Resources

- More ORT type interventions--directed at other States, other payment categories
- More coverage on fraud--adding investigators and auditors to parts of the country where fraud schemes are unfolding
- More investment in fraud, waste and abuse prevention--including direct beneficiary outreach, development of fraud detection systems for use by contractors
- More oversight on quality of care issues
- More activity in resource-intensive areas where Medicare payments are significant, such as hospitals
- More resources devoted to helping the Department and Congress devise solutions to problems identified
- Participation in assessment of Medicare demonstrations intended to create program efficiencies
- More direct input from program beneficiaries on issues of fraud, waste and abuse, through local hotlines, public relations campaigns, beneficiary surveys
- Development of enhanced data systems to assess trends and identify possible fraud and abuse
- More penetration of complex multi-level fraud schemes
- Expand the use of program exclusion and monetary penalty authorities to better protect the Medicare program and its beneficiaries

Cost of Additional OIG Resources to Intensify Medicare Efforts

- It will cost an additional \$6.9 million to add 62 investigators, auditors, evaluators, and other support staff to fully fund the OIG at its planned FY 1996 FTE ceiling of 977. This would amount to \$48.9 million of OIG funding being devoted to Medicare activities.
- The OIG would be able to add as many as 60 investigators and 60 auditors, evaluators, attorneys, and other support staff without negatively impacting its effectiveness. Adding 120 FTEs would exceed the OIG ceiling in its streamlining plan by 58 FTEs. It would amount to an additional cost of \$12 million over the present funding level, and result in a total of \$54 million of OIG resources being committed to Medicare activities.

Accounting for OIG Medicare Activities

- **The OIG has in place suitable time reporting systems in each of its components (e.g., audits, investigations, evaluations) to account for the time charged to individual assignments and, accordingly, to Medicare activities. Other resources expended on Medicare activities can be accounted for using existing management information and accounting systems. The OIG is certain that all appropriate charges, including a fair allocation of overhead costs, can be accounted for with precision.**



Testimony
Before the Committee on Finance,
United States Senate

Fraud and Abuse in the Medicare Program

**Statement of
June Gibbs Brown,
Inspector General**

July 31, 1995



Office of Inspector General
Department of Health and Human Services

For Release on Delivery
Expected at 9:30am
Monday, July 31, 1995

reverse the downward trend of funding for efforts to combat health care fraud and abuse.

OVERVIEW - THE OFFICE OF INSPECTOR GENERAL

By way of background, the OIG was established in 1976, and is statutorily charged with protecting the integrity of Departmental programs, as well as promoting their economy, efficiency, and effectiveness. Through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department, and to protect its programs and beneficiaries from fraud, waste, and abuse, we strive to detect and prevent fraud and abuse, and to ensure that our programs provide high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress. We perform our mission through an organizational structure of regional and field offices staffed by auditors, investigators, evaluators, and analysts. We work closely with other law enforcement agencies, including the Department of Justice; the Inspectors Generals in other Federal agencies; State and local authorities; as well as private third-party payers.

↙ One important indicator of the OIG's success over the years has been the savings accruing to the Federal Government as a result of our activities. Since 1981, the estimated return on Federal investment in OIG has totalled over \$59 billion in fines, restitution, settlements, receivables, and savings to the Federal Government. Last year alone, the OIG generated fines, restitution, penalties, receivables, and savings of over \$8 billion. These savings represent a substantial

increase over the years in the return to the public as a result of OIG activities: from \$160,000 per OIG employee in FY 1981 to \$6.4 million per OIG employee in FY 1994. Another perspective on this rate of increased savings over the years is to compare dollars appropriated to OIG to dollars saved as a result of OIG activity. In FY 1981, OIG generated savings of \$4 for every dollar appropriated to it. This figure has grown to \$80 for every dollar appropriated to OIG in FY 1994.

These savings come in three broad categories (See Chart 1, attached):

1. "Implemented Recommendations to Put Funds to Better Use" – These amounts represent funds or resources that will be used more efficiently as a result of changes to legislation, regulations, policies and procedures implemented by the Congress or by HHS program managers in response to OIG recommendations. Implementation is considered to occur in the year legislation is passed, when final regulations are issued, or, in the case of administrative savings, when final action is taken by management.¹ The FY 1994 total was about \$6.9 billion.
2. "Disallowances from OIG Questioned Costs" - These are amounts that have been identified for recovery as a result of management decisions in response to OIG audit and inspection findings and recommendations. For FY 1994, the total was \$876 million.

¹ Legislative/regulatory savings are annualized figures drawn from 5-year budgetary savings projections as issued by Congressional Budget Office. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected, or if appropriate, for a projected multi-year period.

3. "Investigative Receivables" - This is the total of fines, savings, restitutions, settlements and recoveries accruing during the fiscal year from judicial or administrative processes that result from OIG investigations. They include both actual and court-ordered recoveries to the Treasury, the Social Security and Medicare trust funds, and Departmental programs victimized by fraud and abuse. For FY 1994, the total was \$300 million.

With respect to the third category, investigative receivables, over the last five years every dollar devoted to OIG investigations of health care fraud and abuse has yielded an average return of nearly \$7 to the Federal Treasury, Medicare trust funds, and State Medicaid programs, a return ratio of 7 to 1. In FY 1994 alone, the return ratio was \$14 to one. (See Chart 2, attached) In addition, it is well established that law enforcement activity has a deterrent effect. Even though this deterrent effect cannot be readily quantified, it is an important additional "multiplier" of the dollars invested in health care fraud enforcement.

CURRENT HEALTH CARE DELIVERY SYSTEM - THE PROBLEMS

The Department's Health Care Financing Administration (HCFA) actuaries have estimated that national health care expenditures for 1994 were at least \$938 billion. The Federal Government is the fastest growing payer of health care costs. Federal outlays are expected to exceed \$177 billion for Medicare and \$88 billion for Medicaid in FY 1995.

These national statistics must be considered in conjunction with a General Accounting Office (GAO) report issued several years ago which estimated that fraud and abuse in the health care

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
FY 1994 SAVINGS**

(in millions)

Funds Put to Better Use		Audit Disallowances		Investigative Receivables	
Health Care	\$4,373.3	Health Care	\$754	Health Care	\$264
SSA	2,509.9	OS	99	Savings	22
PHS	11.3	Other	23	Other	14
TOTAL	\$6,894.5	TOTAL	\$876	TOTAL	\$300

Department of Health and Human Services

Office of Inspector General

Office of Investigations

Fiscal Year	Medicare and Medicaid Investigative Recoveries ¹ (in millions)	OIG Health Care Investigative Costs ² (in millions)	Return Ratio
1990	\$23.8	\$16.2	1.5 to 1
1991	52.3	15.0	3.5 to 1
1992	44.2	14.8	3 to 1
1993	171.2	16.0	11 to 1
1994	264.0	18.9	14 to 1
TOTALS	\$550.5	\$80.9	7 to 1

¹Federal, Civil and Administrative health care fraud cases

²DOJ costs not included



JUL 25 1995

MEMORANDUM

TO: Paul Van de Water
Assistant Director, Budget Analysis Division
Congressional Budget Office

FROM: Dennis J. Duquette *D. Duquette*
Deputy Inspector General for
Management and Policy

SUBJECT: Receivables Attributable to the Office of Inspector General (OIG)
Activities in Health Care Cases

This memorandum is in response to your request to provide specific information regarding the productivity of the anti-fraud and abuse efforts of the OIG of the U.S. Department of Health and Human Services (HHS). Based upon our analysis of the figures for the previous 5 years (Fiscal Year 1990 - Fiscal Year 1994), we have determined that, on average, every dollar devoted to investigation of health care fraud and abuse has yielded seven dollars to the Federal Treasury, Medicare Trust Funds and State Medicaid programs.¹ The OIG's effectiveness has been increasing each year for the last 5 years and in Fiscal Year (FY) 1994, for every dollar devoted to health care fraud investigation, \$14 was earned for the Government.

A. BACKGROUND

Various legislative proposals have been introduced in Congress that would create an Anti-Fraud Control Account to fund anti-fraud and abuse activities by the Federal

¹ When one includes the future savings or "cost avoidances" generated by all oversight activities -- audits, investigations and program evaluations -- the OIG recovers or conserves over \$80 for every Federal dollar invested. This includes savings generated as a result of legislative and administrative changes made in response to OIG recommendations. It also includes disallowances of inappropriately spent money from audits and inspections of HHS grants and contracts.

Government, including the OIG. The sources of contributions to such Anti-Fraud Accounts vary with the different legislative proposals. Deposits into the account could include criminal fines in health care cases, civil penalties and damages in health care cases under the False Claims Act, administrative penalties and assessments under the Social Security Act and amounts resulting from forfeiture in health care cases.² For example, Section 101(b) of S. 245, the Health Care Fraud Prevention Act of 1995, would establish such an account. The Administration's proposed legislation, the Medicare and Medicaid Payment Integrity Act of 1995, would establish a smaller version of such an account.

An Anti-Fraud Account would increase funding available for combatting health care fraud by allowing the Government to reinvest certain recoveries generated by health care anti-fraud activities to fund additional enforcement activities. Thus, the individuals and corporations who defraud our nation's health care system will foot the bill for increased policing of those programs. The account would be available to fund expanded and innovative methods to investigate fraud and abuse, to sanction offenders and to deter future misconduct. We believe the Anti-Fraud Account would result in significant additional resources for anti-fraud enforcement, as well as a greater return to the Trust Funds and State Medicaid Programs.

B. OIG PRODUCTIVITY

In order to determine the amount of monetary receivables attributable to OIG health care investigative activities, we used actual budget figures and monetary receivables from the last five FYs (FY 1990 - FY 1994). As set forth in detail below, we divided the monetary receivables from Medicare and Medicaid cases from the past 5 years by the amount OIG spent on health care fraud investigations during the same period. This calculation provides a ratio of dollars earned for every dollar invested.

1) OIG Receivables

The monetary receivables from health care cases include court-awarded fines and restitution and global settlement amounts involving the Medicare and Medicaid

² The False Claims Act authorizes treble damages and the Social Security Act authorizes assessments of not more than twice the amount claimed. Under all existing legislative proposals, actual damages and assessments would be returned to the applicable Trust Fund or State Medicaid program. Any damages and assessments recovered over the actual amount billed would be deposited in the account.

programs. As set forth in the attached chart from the Office of Investigations Statistical Digest through FY 1994, the receivables are as follows:

<u>Fiscal Year</u>	<u>Medicare</u>	<u>Medicaid</u> (In millions of dollars)	<u>Total</u>
1990	20.4	3.4	23.8
1991	42.2	10.1	52.3
1992	34.9	9.3	44.2
1993	167.8	3.4	171.2
1994	247	17.0	264

The total amount of monetary receivables for this period was \$550,500,000. (See Attachment A for a copy of the chart.)

2) OIG Expenditures on Health Care Fraud Cases

The amount OIG spent on health care investigations for each year was obtained by multiplying the budget of the Office of Investigations (OI) by the percent of that staff time devoted to health care for each year.

<u>Fiscal Year</u>	<u>OI Budget in Millions of Dollars</u>	<u>Percent Expended on Health Care</u>	<u>Health Care Investigative Budget In Millions of Dollars³</u>
1990	30.986	52.29	16.203
1991	30.483	49.10	14.967
1992	28.918	51.13	14.786
1993	29.198	54.83	16.009
1994	33.344	56.59	18.869

Using these figures, the total amount spent by OIG on health care cases from FY 1990 - FY 1994 was \$80,834,000.

3) Ratio

We divided the total monetary receivables (\$555,500,000) by the amount that OIG spent on health care cases (\$80,834,000) to obtain a ratio of 6.87 to one. In other words, on average, for every dollar invested on investigation of health care fraud and

³ The numbers in this column have been rounded to the nearest thousand.

Page 4 - Paul Van de Water

abuse by the OIG, we earned seven dollars for the Federal Treasury, Medicare Trust Funds and the State Medicaid programs. The OIG's effectiveness has been increasing each year for the last 5 years and in FY 1994, for every dollar devoted to health care fraud investigation, \$14 was earned for the Government. (See Attachment B for a copy of this calculation.)

C. CONCLUSION

We hope this information is helpful. We would be happy to provide you with any additional information regarding these figures. Please call me at 205-9117 or D. McCarty Thornton, Chief Counsel to the Inspector General, at 619-0335 if you have any questions.

Attachments

ATTACHMENT A

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

OFFICE OF INVESTIGATIONS

STATISTICAL DIGEST

THROUGH FISCAL YEAR 1994



JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1994

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS

MONETARY RETURNS FROM
MEDICARE/MEDICAID CASES

1985 - 1994
(Dollars in Millions)

FY	MEDICARE		MEDICAID		TOTAL A + B
	Investigative Receivables(a)	Savings*	(A) Subtotal	(B)	
1985	\$ 12.6	\$ 8.3	\$ 20.9	\$ 7.8	\$ 28.2
1986	\$ 12.5	\$ 7.4	\$ 19.9	\$ 8.9	\$ 28.8
1987	\$ 19.0	\$ 8.5	\$ 27.5	\$ 8.3	\$ 35.8
1988	\$ 21.8	\$ 28.1(b)	\$ 49.9	\$ 11.4	\$ 61.3
1989	\$ 33.5	\$ 7.6	\$ 41.1	\$ 19.2	\$ 60.3
1990	\$ 20.4	\$ 47.3(b)	\$ 67.7	\$ 3.4	\$ 71.1
1991	\$ 42.2	\$ 5.0	\$ 47.2	\$ 10.1	\$ 57.3
1992	\$ 34.9	\$ 5.0	\$ 39.9	\$ 9.3	\$ 49.2
1993	\$167.8	\$ 6.0	\$173.8	\$ 3.4	\$177.2
1994	\$247	\$ 22	\$269	\$ 17	\$286

(a) Includes fines, restitutions, recoveries, settlements, and judgments.

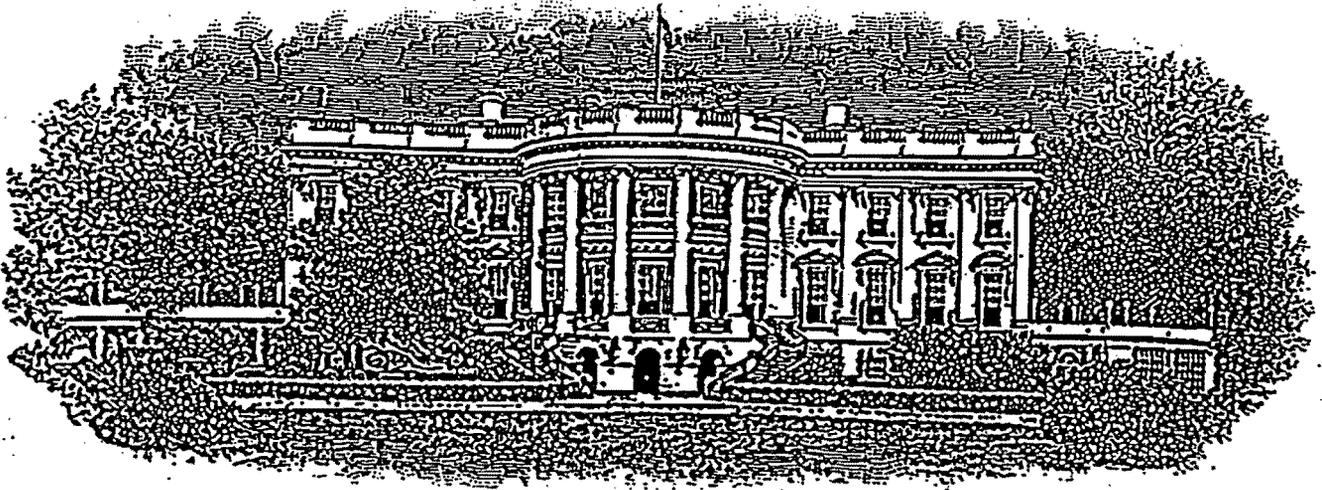
(b) Includes high single-year savings resulting from a special project.

* This column represents a one year estimate of the amount that would have been lost to Medicare if the fraud had continued.

ATTACHMENT B

Year	OI Budget	% on Health Care	Revised Budget	OI Receivables Medicare	OI Medicaid	Total	Ratio
90	30,986	0.52	16,203	20,400	3,400	23,800	1.47
91	30,483	0.49	14,967	42,200	10,100	52,300	3.49
92	28,918	0.51	14,786	34,900	9,300	44,200	2.99
93	29,198	0.55	16,009	157,800	3,400	171,200	10.69
94	33,344	0.57	18,869	247,000	17,000	264,000	13.99
			80,834	512,300	43,200	555,500	6.87

THE WHITE HOUSE



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

Facsimile Transmission Cover Sheet

To: ANITA SHALIT

Fax Number: 8 690-81686-994

Telephone Number: _____

Pages (Including Cover): _____

Comments: One-pager is ~~forthcoming~~
included should be section
when ORT currently
discussed

The President's Record on Fraud and Abuse

Since the President took office, he has implemented or proposed the following initiatives which have saved billions of dollars:

- **Closed Loopholes in the FY 1993 Budget.** The President's first budget closed a number of loopholes in Medicare and Medicaid, tightening up on fraud and abuse. Under the President's leadership, the Justice Department has also made this a major priority, dramatically increasing health care fraud investigations, criminal prosecutions, convictions, and civil recoveries.
- **Implemented Operation Restore Trust to Combat Fraud and Abuse.** Two years ago the President introduced Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has produced returns of \$10 for every \$1 spent.
- **Fraud and Abuse Initiatives in Kassebaum-Kennedy.** Last year, the President signed the Kassebaum-Kennedy legislation into law, which expanded Operation Restore Trust nationwide, for the first time, creating a stable source of funding for fraud control. The fraud and abuse provisions of the Kassebaum-Kennedy legislation contain an estimated savings of \$5.2 billion for FY 1997 alone, with a \$12 return for every \$1 spent.
- **New Initiatives to Combat Fraud and Abuse in the President's FY 1998 Budget.** The FY 1998 budget contains a number of new initiatives, including cracking down on abuses in home health services and skilled nursing facilities. CBO has estimated that the fraud and abuse savings in your budget will be worth \$9.7 billion over ten years. In March the President announced yet another series of anti-fraud initiatives. Some of the initiatives in the President's budget and subsequent legislation have been included in the House and Senate mark-up. We are working to ensure that all of these provisions are included in reconciliation. And we encourage the House and the Senate to work with us in this regard.

FOR NEXT
FRAUD DISCUSSION

MEDICARE FRAUD FILE

DRAFT: MEDICARE FRAUD, WASTE & ABUSE LEGISLATIVE PROPOSALS

POLICY	COMMENTS	5-YEAR SAVINGS (\$ B)	STATUS
JANUARY 23 LIST			
1 Reducing payments for 22 drugs	This proposal has raised some opposition in Congress [HHS: do you know which members?]	-\$0.7 (OMB) -\$0.6 (CBO)	In H.R. 3471
2 Ending overpayment for epogen	Savings estimates differ between CBO / OMB	-\$0.3 (OMB) -\$0.1 (CBO)	In H.R. 3471
3 User fee for all audit and cost settlement activities for cost-based providers		None (OMB) None (CBO)	In H.R. 3471
4 Expand nationwide competitive pricing for equipment and non-physician services	This version did not include the fall-back reduction in payments that was included in last year's budget	None (OMB) None (CBO)	
5 Require outpatient mental health services to be provided only in appropriate settings	CBO assumes that there are problems in outpatient mental health, but that this proposal will not address those concerns.	-\$0.1 (OMB) None (CBO)	In H.R. 3471
6 CMPs for false certification of need for care		None (OMB) None (CBO)	
7 Giving Medicare fines / recoveries priority when providers file for bankruptcy	On OIG list of 1998 proposals	None (OMB) None (CBO)	In H.R. 3471
8 Allowing court orders against and civil remedies for anti-kickback schemes		None (OMB) None (CBO)	In H.R. 3471
9 Medicare secondary payment proposals		-\$0.7 (OMB) -\$0.4 (CBO)	
10 Centers of Excellence		-\$0.6 (OMB) -\$0.3 (CBO)	
OTHER PROVISIONS IN H.R. 3471			
11 Parental nutrition overpayments	Not really fraud; overpayment		In H.R. 3471
12 Fix knowledge required for imposition of CMPs	On OIG list of 1998 proposals; OK with staff		In H.R. 3471
13 Repeal expanded exception for risk-sharing contracts in anti-kickback provisions	[NOTE: What do staff think of this provision?]		In H.R. 3471

POLICY	COMMENTS	5-YEAR SAVINGS (\$ B)	STATUS
ADDITIONAL PROPOSALS: CROSS-AGENCY AGREEMENT			
14 CMPs for parties who order or prescribe services during periods of exclusion from Medicare	On OIG list of 1998 proposals; OK with staff		
15 Anti-dumping provisions for physicians at specialty hospitals	On OIG list of 1998 proposals; OK with staff		
ADDITIONAL PROPOSALS: NO CROSS-AGENCY AGREEMENT			
16 Add SS numbers to Health Integrity Protection Data Bank (HIPDP) when reporting final adverse action	On OIG list of 1998 proposals; HHS concerns about privacy protections		
17 Allow information from criminal cases to be shared with civil government attorneys	On Justice list; HHS is basically OK on the policy but would like to discuss the need for this policy		
18 Allows U.S. Attorneys to approve use of civil tools to investigate fraud	On Justice list; HHS is basically OK on the policy but would like to discuss the need for this policy		

Nancy Ann DePaul
NANCY-ANN MIN DeParle

202

690 6262

Q: What is your response to the fact that Medicare is losing about \$20 billion last year to the fraud, waste and simple errors?

A: Any report that suggests any problem in this area causes concern. We are proud of our anti-fraud and abuse record and are committed to doing more.

The Administration has a strong record of fighting fraud and abuse. In fact, since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. In this time, convictions have gone up a full 240 percent and we have saved some \$20 billion in health care claims. The Kassebaum-Kennedy legislation the President signed into law created -- for the first time ever -- a stable funding source to fight fraud and abuse. This law authorized our extremely successful Operation Restore Trust initiative, a nationwide program to fight abuse and fraud that has identified \$23 for every one dollar invested in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

We welcome the Inspector General's report, but point out that it does not reflect numerous initiatives to fight waste and fraud that are underway or that the President has asked the Congress to pass. There are more than sixteen legislative or administrative actions that HCFA has taken that this report does not include, including implementing the first ever home health moratorium, doubling the number of medical review audits, expanding on-site visits, tightening enrollment standards, and requiring home health agencies to post surety bonds. We have also proposed a number of new legislative initiatives to fight waste and abuse, such as doubling audits to ensure that Medicare only reimburses for appropriate provider costs and eliminating wasteful excessive Medicare reimbursement for drugs.

Moreover, it is important to note that last year's report did not include a review of Durable Medical Equipment, an area that is fraught with waste and fraud. Despite the fact that this year's audit did include a review of this, the audit shows less fraud and waste than in last year's report.

Our anti-waste and fraud efforts are already paying new dividends. Earlier this year, the Medicare actuary reported that the home health baseline spending has been reduced from 25 percent to 5.4 percent. These successes are at least partially attributable to our efforts.

Health Tax Policies

1. Long-term care tax credit

- **How much is the credit:** \$1,000 and phases out for higher income tax payers (\$110,000 for couples, \$75,000 for unmarried taxpayers). It is partially refundable for taxpayers with three or more dependents. The credit would be given on the basis of long-term care needs rather than long-term care expenses because, otherwise, it would not help people receiving unpaid long-term care.
- **Who is eligible:** Both taxpayers or taxpayers' spouses with long-term care needs and taxpayers who have dependents with long-term care needs are eligible. About 2.3 million people with long-term care needs would benefit from this credit. About half are taxpayers with long-term care needs or their spouses, and the remainder are people with long-term care needs claimed as dependents by a taxpayer. Over half are elderly.
- **Cost:** \$6.5 billion over 5 years
- **Comments:** Because of the process last summer, this policy has strong, interagency support and has been reviewed by the President. To be well received, however, it needs to be accompanied by (a) option to provide Federal employees with private long-term care insurance; (b) new Administration on Aging program for informal caregivers; and (c) education campaign for Medicare beneficiaries about what long-term care options exist.

2. Tax credit for workers with disabilities

- **How much is the credit:** This proposal would give a tax credit of \$1,000 to people with disabilities who work in recognition of their formal and informal costs associated with employment. It would be structured in the same way as the long-term care credit.
- **Who is eligible:** The credit would be available for people who are limited in one or more activities of daily living (ADLs) who need personal assistance. About 300,000 taxpayers will benefit in 2000.
- **Cost:** About \$700-800 million over 5 years
- **Comments:** This will help with the non-health care as well as out-of-pocket health care costs of getting to and from work and functioning within the workplace. Treasury is generally supportive and it has been recommended by the Task Force on Employment of Adults with Disabilities.

3. Tax incentives for small business purchasing coalitions.

- **What is proposal:** Provides employers with a credit of up to 10 percent of their payments for employees' health premiums if in purchasing coalition AND provides some type of non-profit status to the coalitions or contributions to the coalition to encourage capital investment by foundations and other sources.
- **Who is eligible:** Small businesses (< 50) who have not previously offered health coverage and join these coalitions are eligible for the credit. Organizations that meet the definition of a coalition could receive the non-profit treatment provision.
- **Cost:** \$50 to 100 million over 5 years (structured as a 3 year demonstration)
- **Comment:** Treasury strongly objects to giving coalitions non-profit status but just submitted a counter-proposal to allow contributions to such coalitions to be treated as charitable contributions. We believe this probably would be an acceptable compromise, but are now checking with business coalition types. (Please request cost estimates.) In contrast, Treasury does not find the credit to employers as objectionable. Unfortunately, the non-profit status issue is probably more important to obtaining validation from purchasing coalitions. Unlike first two initiatives outlined above, this two-part proposal needs a strong push from us to get in the package. DPC/NEC believe we need this (albeit modest) small business health access initiative. (If had to drop anything, CJ would recommend employer tax credit.)

Q: Senator Breaux and Senator Frist accurately point out that the Medicare Trust Fund is projected to become insolvent far sooner than Social Security's Trust Fund. Both have stated that Medicare's more acute problem deserves serious attention and, in fact, have said that addressing Medicare should be the Administration's and Congress' first priority. (Senator Breaux is no longer saying Medicare first, but is definitely wants the program to get equal billing). How do you respond? Don't they have a point?

A: Assuring a strong, modern Medicare program has always been and always will be a top priority for this President. Last year, the President enacted into law arguably the most significant changes to Medicare since the program's enactment in 1965. A provision in that legislation, one that he strongly supported, was the establishment of the Medicare Commission. The Commission, which has 17 Members -- including four Administration appointees -- and is chaired by Senator Breaux, is charged with developing recommendations to begin dealing with the long-term health care delivery, financing, and demographic challenges facing the Medicare program. Because of the President's strong commitment to the program, we are closely following the work of the Commission and are hopeful that we will be able to embrace its final report, now scheduled to be released in March of next year.

Unlike Medicare, however, we have all benefited from the completion of the work of the Social Security Advisory Commission. This Commission produced a comprehensive analysis of the challenges facing Social Security and produced a series of options that are now being seriously reviewed by all parties interested in this critically important program. As a result, we now have a historic opportunity to ensure the solvency of Social Security well into the next century. We need to respond to this opportunity. Doing so now will make it easier for us to focus on the future of Medicare.

Q: Are you saying that the President and the Administration will do nothing about Medicare until the Commission files its report?

A: Of course not. The President has and will continue to take administrative actions and propose legislative initiatives that strengthen the Medicare program. For example, his record on advocating for anti-fraud and program integrity initiatives is clear. As such, we are currently reviewing options for this upcoming budget. However, we are doing so in a way that complements rather than undermines the Commission's work.

Premium Support Paper: Questions and Comments

General Questions on Premium Support

- **What are the key questions about the design of a premium support option?** The paper presented today mentions an earlier paper, which was not distributed to the public, that discussed key questions about premium support. Could you summarize these questions?
- **Why is this specific model presented? Aren't there others?** In the course of the past 8 months, we have heard about a number of options to restructure Medicare. In fact, at the August meeting, when there was a full commission discussion of premium support models, none of the experts discussed this FEHBP model. Why wasn't a competitive model like that proposed by Dr. Reischauer chosen for presentation? And aren't there restructuring options beside premium support that have been discussed?
- **What is the impact of any proposal on beneficiaries?** To be able to fully assess options, information on the impacts on beneficiaries by age, income, location, marital status and by health status is needed.

Specifics of the FEHBP Model: Benefits

- **Why replace the guarantee of a minimum benefits package with an actuarially equivalent plan?** The Commission staff have written that all plans in the FEHBP model would have to offer a plan that is "actuarially equivalent" to Medicare's fee-for-service coverage. Does this mean that a plan could not pay for home health care if it provides more hospital care? Could a beneficiary in need of physical therapy find herself with no plan options that offer that offer this basic coverage? Won't this result in all beneficiaries with certain types of illnesses migrating to the plans that offer the services that they need -- putting strain on those plans and jeopardizing access to care?
- **What are the "core" benefits that all plans would offer and who would make that decision?** As it is, Medicare's actuarial value ranks below four of out five private plan options. What are its "extra benefits" that beneficiaries can afford to allow vary from plan to plan? Who would decide this -- the new private administrative board?
- **Would there be any standardization of supplemental benefits offered by private plans?** If not, how can beneficiaries "comparison shop" when all of the products are different? Isn't this the reason why we standardized Medigap options in 1990?

Amount of the Government of Contribution

- **Don't beneficiaries have to pay more to stay in traditional Medicare -- or any other average priced plan?** The Commission staff paper says that the minimum contribution for a beneficiary is 10 percent of the premium. This amount equals the Part B premiums that beneficiaries currently pay. But, since only beneficiaries choosing low-cost plans -- below

90 percent of the national average -- pay 10 percent, by definition, all other beneficiaries pay more. In fact, according to this schedule, beneficiaries choosing an average plan, which is where traditional Medicare would be, would pay 12 percent -- translating into over \$60 per month for beneficiaries, nearly 25 percent higher than current law. Isn't this simply a cost shift to beneficiaries?

- **Will competition in this model really reduce costs?** Under this model, the government pays some percent of the plan's premium up to a cap. This cap is set at about 15 percent above the national average contribution. Since the cap on the government contribution is above the national average contribution, don't plans have an incentive to offer extra benefits up to this cap since the government subsidizes extra benefit costs? Won't this raise the national average premium and thus Medicare costs?
- **Will negotiation with this independent board really reduce costs?** FEHBP prevents plans from charging premiums equal to the maximum government contribution by limiting allowable private plan growth to that of private businesses in the region. Is it feasible that a board could impose such requirements given Medicare's size, enrollment composition, etc?
- **Since most of the savings come from restraining Medicare to private sector growth, what happens under alternative projections of private sector growth?** As the modeling task force emphasized, projections of health spending are highly variable. Although two Medicare baselines are presented -- one of the Trustees, the other from the Commission -- only one set of private sector growth rates is used. Shouldn't there be a similar range of estimates for the savings proposals? Can't you use the HCFA Actuaries projections?
- **With a national versus regional government contribution, won't there be very different options depending on where beneficiaries live?** The Commission paper explicitly says that even if there were a geographic adjustment to the government contribution, it would only adjust for wage rate differences -- not utilization rate or practice pattern differences. Doesn't this mean that beneficiaries in high cost areas have to pay more for Medicare just because of their location? Aren't extra benefits less likely to be offered in high-cost areas since the government would pay less of them than it would in low-cost areas?
- **How would the government contribution grow in future years?** The paper mentions that a key question is who is at risk if costs increase faster than expected. This is not simply a key question but a key design issue. Would the proposal rely on competition to constrain the growth of the government contribution? Would it place caps on premium growth? Would it change the percent that the beneficiaries pay?
- **Would premium support for low-income beneficiaries be maintained?** Would low-income beneficiaries be able to choose any plan with full premium support? Would their choices be restricted? Would this mean that they could not access extra benefits? The paper implies that Medicare will pick up the full premium costs for beneficiaries eligible for the QMB/SLMB programs. Isn't this a large cost shift from Medicaid to Medicare?

Administration

- **What does a separate administrative board accomplish?** What would prevent HCFA from acting as a purchaser in the same way as it does for managed care plans today? Many large purchasers, including CalPERS, operate a self-funded plan as well as managing private plan options. Would this board be accountable for elements such as quality standards, appeals and grievances, risk adjustment, etc.? If the Board is to “oversee both public and private plans,” as HCFA currently does, what is to prevent the Board itself from developing a “conflict of interest” with respect to one or another of the options available?

Substance Abuse Treatment Funding

We could increase substance abuse treatment in two ways:

1) Substance Abuse Block Grant

These funds are allocated to states on a formula basis with states deciding how to target the funds. SAMHSA requested an increase of \$270 million for FY 2000. OMB passback holds them to FY 99 level of \$1.585 billion (plus an additional \$100 million in advance funding -- need to find out how this works).

2) Targeted Capacity Expansion Grants

These funds are designed to address treatment needs for emerging substance abuse problems specific to a city, county, state or region. These grants focus on meeting local needs since the block grant goes to states. For FY 1988, SAMHSA identified several target groups including: substance abusing women and their children, clients participating in welfare reform programs, juvenile and adult criminal justice-referred offenders, dually diagnose youth offenders, substance abusing physically and cognitively challenged individuals, and hard-to-reach IV drug users. FY 98 funds supported 41 grants totalling \$24 million to a combination of state, local, and tribal agencies and community-based organizations. This funding will serve an additional ___ people on an annual basis. Grants are available for three years, with first year funding generally between \$500,000 and \$700,000. Approximately one-third of the FY 1998 grants are targeted to TANF or substance abusing women with children. For example, Women in Need in Brooklyn received \$250,000 to expand capacity to serve an additional 85 homeless women and women with children receiving TANF. The Wisconsin Department of Health and Family services received \$750,000 to provide intensive family treatment to 121 women with children and TANF recipients.

FY 2000 proposal: SAMHSA requested an increase of \$100 million to bring total funding to \$121 million. OMB passback held them to \$26 million.

US Conference of Mayors staff indicated strong support for these grants -- in fact, they would like to see an increase of around \$250 million.

Medicare ReBms Legislation File

DRAFT: March 14, 2000

Less than 50
pages

MEMORANDUM TO JOHN PODESTA

FROM: Chris Jennings

RE: Medicare legislation

cc: Steve Ricchetti, Karen Tramontano, Gene Sperling, Bruce Reed,
Jack Lew, Chuck Brain, Joel Johnson

Consistent with our commitment to Senator Moynihan, we are planning to convey statutory language for the President's Medicare reform proposal to the Hill at the end of this week. Spurred on by Members and staff of the Finance Committee, Robert Pear and other reporters continue to write articles suggesting that the fact we have not submitted bill language reflects our lack of commitment to acting on Medicare reform this year.

As you requested, what follows is a brief summary of the provisions in the legislation that have the most potential to reignite criticism of the President's proposal. It is important to underscore that the only significant changes that we are making to the proposals from last year are the moderation of the provider payment reductions (they are about 33 percent less) and the addition of the \$35 billion catastrophic drug cost reserve fund. Consistent with our desire to stay "low-key," we would highlight these two changes and cast the bill language submission as "old news", since the legislation merely reflects the detailed specifications that we released last July.

POTENTIALLY CONTROVERSIAL PROVISIONS:

- **Provider Payment Reforms.** Although 33 percent less than the \$100 billion in savings from last year's Medicare proposal, the Administration's bill includes \$70 billion (over 10 years) in savings from provider payment reforms. They include our competitive defined benefit (our alternative to premium support), anti-fraud provisions, fee-for-service modernization reforms (like Centers of Excellence and new authority for selective contracting with physicians), and traditional payment reductions (like reductions in hospital market basket payments). All of these are defensible and the so-called elites would largely validate them. However, submitting language on all or some of these has the risk of incurring the provider's wrath, particularly at a time when the hospitals and others are trying for another provider give-back bill. It could also give the Republicans some ammunition for their upcoming budget mark-ups. Already, the press release for the House Republican Budget Resolution states that their resolution "rejects the President's \$18.2 billion hit on Medicare beneficiaries and providers."
- **Beneficiary Cost-Sharing Reforms.** In addition to our prescription drug benefit, we eliminate all copayments for preventive benefits. However, we also included beneficiary cost-sharing reforms that restore a 20 percent coinsurance and deductible to lab services and

MEDFAC

Hoyle
m3m
g3m
d3m

index the \$100 Part B deductible to inflation. These are justifiable policies that have given us credibility for being serious about reform. We have not had negative feedback from any of the beneficiary groups in part because, with the prescription drug benefit, lower Part B premium and reduced preventive cost sharing, beneficiaries gain from this bill on the whole. However, any time such issues are raised there is a potential for problems.

- **Greater Detail on Prescription Drugs.** The prescription drug benefit language will be intensely scrutinized by drug manufacturers, pharmacy groups, insurers, and PBMs – as well as Congressional Republicans looking for signs of a HCFA-run benefit. Although we have done our best to make the bill as clean and short as possible, it inevitably will result in some controversy.
- **Reserve Fund / Dedication of surplus to Medicare.** Given that we have not yet submitted the transfer language, it may be criticized as a “gimmick” and could reignite the “double counting” allegations.

We believe that we can adequately respond to any issue raised about the legislative language for the President’s Medicare reform initiative. As we stated earlier, there really is little news here. Having said this, submitting the bill may make the media more likely to perceive that there is a real possibility of getting a bipartisan agreement on Medicare through the Finance Committee. This will particularly be the case if Senator Moynihan validates it as substantive and desirable reform. We will need to have you talk to the Senator as this is being conveyed.

ISSUES:

We are planning on conveying the legislation to Capitol Hill on Friday. At this time, we are assuming that we will forward the language to the authorizing committee chairs and ranking members (Finance, Ways and Means, and Commerce). However, we will not forward it directly to the Republican leadership. Here are several outstanding issues that need to be resolved.

1. First, we are currently carrying all the Medicare savings but are unclear about whether we came to final resolution on the inclusion of some of the more controversial savings provisions like the hospital reductions and beneficiary savings (the down-side of excluding some savings is that the out-year cost growth will remain high and some validators may criticize us for dropping them).
2. Should we give Congressional Democrats a heads up and give them an opportunity to argue against forwarding this language to the Hill?
3. Regardless of the savings issue, should the transmittal letter be signed by the President, Jack Lew, or Donna Shalala?
4. Do we (1) request that HHS quietly release a press announcement to the trade reporters; (2) issue a White House statement to trades and selected print media health reporters; or (3) a release a statement from the President with a broader press roll-out to larger papers and /or other media outlets?



THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

TO: Nancy ANN

FROM: Jeanne + Chris

ATTACHED ARE:

- (1) Summary of Medicare + Medicaid SAVINGS, with "#" INDICATING THAT THE Policy WAS RECOMMENDED BY OIG
- (2) THE OIG REFERENCE (COULDN'T FIND THE EPO. REPORT)

ALTOGETHER, \$675m in 2000
\$5.4 billion / 5 years -
Came from OIG - Recommended
Program INTEGRITY

PRESIDENT'S CLINTON'S FY 2000 BUDGET:
IMPROVING THE EFFICIENCY AND INTEGRITY OF MEDICARE AND MEDICAID
February 1, 1999

The President's FY 2000 budget proposes a series of Medicare and Medicaid policies to continue the ongoing effort to put these critical programs on sound financial footing to better prepare for the challenges of the next century. Since taking office, the President has proposed and implemented many policies to reduce overpayment and combat fraud and abuse in Medicare and Medicaid. This no-tolerance approach has yielded billions of dollars in savings, and has contributed to very low growth rates in the past several years. This budget proposes additional efforts to strengthen our commitment to eliminate fraud, waste and abuse in the Medicare program and ensure that payments to hospitals and other providers are reasonable. Together, they will save an estimated \$1.3 billion in the year 2000 and \$10.9 billion over 5 years.

MEDICARE

The President's budget contains a series of policies to reduce overpayments and waste, fraud, and abuse in Medicare. These policies are grounded in studies and research that indicates that they are not only reasonable but necessary to assure Medicare's fiscal integrity. Together, they save an estimated \$1.265 billion in FY 2000, \$9.55 billion over 5 years (including Part B premium offset and Medicaid effects).

- ① • **Eliminating overpayments for epogen.** This proposal reduces Medicare reimbursement for Epogen (a drug used to treat anemia) to reflect current market prices. The HHS Office of the Inspector General (OIG) found in a 1997 study that the current Federal reimbursement rate for Epogen exceeded the market price of the drug by \$1 per 1,000 units. (Savings: \$70 million in FY 2000; \$450 million over 5 years).
- ② • **Ensuring that Medicare does not pay for claims owed by private insurers.** This proposal would take steps to ensure that Medicare does not pay for claims owed by private insurers, including requiring private insurers to report any Medicare beneficiaries they cover, allowing Medicare to recoup double the amount owed by insurers who purposely let Medicare pay claims the group plan should have made, and imposing fines for failing to report no-fault or liability settlements for which Medicare should have been reimbursed. Too often, Medicare pays claims that are owed by private insurers because it has no way to verify that the beneficiary has other insurance that should pay those claims. (Savings: \$10 million in FY 2000; \$640 million over 5 years).
- ③ • **Eliminating excessive Medicare reimbursement for drugs.** This proposal would eliminate the mark-up for drugs by basing the Medicare reimbursement on the provider's actual acquisition cost of the drug. A recent report by the OIG found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. (Savings: \$140 million in FY 2000; \$950 million over 5 years).

- ④ • **Eliminating abuse of Medicare's partial hospitalization benefit.** This proposal would preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or nursing home. It would also authorize the Secretary of Health and Human Services to set additional criteria for partial hospitalization services furnished by community mental health centers. Currently, many providers bill Medicare for partial hospitalization services that do not meet the reimbursement criteria. (Savings \$20 million in FY 2000 and \$205 million over 5 years).
- **Using a competitive pricing process for certain routine surgical procedures.** This proposal would expand HCFA's current "Centers of Excellence" demonstration to allow Medicare to receive volume discounts on certain routine surgical procedures. In a smaller scale demonstration that HCFA conducted in the early 1990's, evaluators found that HCFA was able to reduce its costs by approximately 12 percent per procedure while improving clinical outcomes. (Savings: \$0 in FY 2000 (effective in FY 2001); \$690 million over 5 years).
- **Establish a national limit for all prosthetics and orthotics.** This proposal would establish national payment limits, based upon the median state fee schedule, for prosthetics and orthotics. Currently, some prosthetics and orthotics are paid on the basis of regional fee schedules that are subject to floors and ceilings, which is inconsistent with how other prosthetics and orthotics and durable medical equipment is paid. (Savings: \$70 million in FY 2000; \$580 million over 5 years).
- ⑤ • **Reducing the Medicare lab test fee reimbursement ceiling.** This proposal would lower the cap on lab payment amounts from 74 percent of the median of all fee schedules to 72 percent of the median. HCFA has found that it overpays for numerous lab compared to the private sector. This policy corrects for this overpayment nationwide (Savings: \$70 million in FY 2000; \$550 million over 5 years).
- **Reducing the hospital market basket.** This proposal would reduce the FY 2000 inpatient PPS update by 0.9 percent below the current level provided by the BBA. Recent data from the Medicare Payment Advisory Commission and other independent sources confirm that hospitals will have record-high margins in FY 1999 and maintain these high levels through at least 2002. Hospitals are projected to earn 16 percent Medicare margins over this time period. This policy would bring Medicare payments more in line with the current cost structure of the hospital industry. (Savings: \$650 million in FY 2000; \$3.880 billion over 5 years).
- ⑥ • **Reducing Medicare bad debt payments.** This proposal would reduce Medicare bad debt payments to hospitals from 45 percent to 55 percent and extend the reductions to other providers. The Congressional Budget Office and the OIG argue that Medicare's policy to pay for bad debts creates incentives for providers not to collect their unpaid deductibles and copayments. The Balanced Budget Act took a step towards removing these incentives, but did not apply the reductions to all providers or reduce payments as much as recommended. (Savings: \$360 million in FY 2000; \$2.47 billion over 5 years).

MEDICAID

The President's budget would address two issues in Medicaid that have led to overpayments to states and providers: administrative cost allocation and rebates for generic drugs. Together, they save an estimated \$74 million in FY 2000, \$1.405 billion over 5 years (including interactions with Medicare policy changes).

- **Medicaid cost allocation.** As an unintended consequence of welfare reform, states' Medicaid administrative expenditures have increased because of changes in how administrative costs are shared by TANF and Medicaid. Last year, Congress addressed this issue for Food Stamps. This proposal would extend the same approach to Medicaid. Rather than a flat reduction in the Medicaid matching rate, it would determine liabilities on a state-by-state basis. It would also allow states to use TANF block grant funds to cover shared TANF-Medicaid costs. (Savings: \$59 million in FY 2000; \$1.2 billion over 5 years).
- ⑦ • **Medicaid rebates from generic drug manufacturers.** This proposal would revise the Medicaid drug rebate law to require additional rebates from generic manufacturers when they increase the price of drugs in excess of the CPI-U. Under current law, generic manufacturers are exempt from the additional Medicaid rebates imposed on brand name manufacturers. This proposal would treat generic drug manufacturers more like brand name drug manufacturers. (Savings: \$5 million in FY 2000; \$125 million over 5 years).

2

IMPROVE MEDICARE SECONDARY PAYER SAFEGUARDS

Current Law:

Medicare is the secondary payer (MSP) to certain group health plans in instances where medical services were rendered to Medicare-entitled employees or to the Medicare-entitled spouses and other family members of employees. Medicare is also the secondary payer in situations involving coverage under Worker's Compensation; black lung benefits; automobile and nonautomobile, no fault, or liability insurance; and Department of Veterans Affairs programs. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary benefits paid on behalf of Medicare beneficiaries.

Proposal:

The HCFA should (1) ensure that contractor resources are sufficient and instruct contractors to recover improper primary payments from insurance companies other than the Blue Cross and Blue Shield insurance companies, (2) implement financial management systems to ensure all overpayments (receivables) are accurately recorded, (3) develop detailed procedures to properly handle employers that refuse to provide other health insurance coverage information, and (4) resubmit the justification of a legislative proposal that would require insurance companies, underwriters, and third-party administrators to periodically submit private insurance coverage data directly to HCFA.

Legislative

Regulatory

Other Administrative

Reason for Action:

Although agreement was reached to relieve all Blue Cross and Blue Shield plans of past due MSP overpayments and although there is a 3-year future plan to identify MSP situations, it applies only to the Blue Cross and Blue Shield plans and not to other insurance companies. Additional measures are still needed to collect accurate and timely information on other primary payers. This will help to reduce future Medicare overpayments that result from unidentified MSP cases and improve the recovery process for overpayments.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA is pursuing the recommended administrative actions through improved processes to identify and recover overpayments related to MSP, as well as improved information systems to guard against making improper Medicare payments where the Blue Cross and Blue Shield plans are primary payers. However, safeguards are still needed to guard against improper payments where insurance companies other than the Blues are primary payers.

Report:

- A-09-89-00100 (Final management advisory report, Mar. 1990)
- OEI-07-90-00760 (Final report, Aug. 1991)
- OEI-03-90-00763 (Management advisory report, Nov. 1991)
- A-09-91-00103 (Final report, Aug. 1992)
- A-14-94-00391 (Final report, Dec. 1993)
- A-14-94-00392 (Final report, Mar. 1994)

3

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare Part B covers prescription drugs for certain medical disorders, such as end stage renal disease and cancer, and when necessary for the effective use of durable medical equipment. Reimbursement is based on the lower of an estimated acquisition cost or a national average wholesale price (AWP). Payment for drugs under the Medicaid program varies among the States but generally includes use of a discounted acquisition cost, as well as a federally mandated manufacturers' rebate program.

Proposal:

The HCFA should reexamine its Medicare drug reimbursement methodologies with a goal of further reducing payments as appropriate.

Legislative



Regulatory



Other Administrative



Reason for Action:

Several OIG studies have indicated that Medicare pays more than other payers for prescription drugs. For example, for three nebulizer drugs in 1994, Medicare and its recipients could have saved substantial amounts by using a discounted AWP reimbursement formula similar to that used by many Medicaid States. Another review of 17 high-volume prescription drugs in the Medicare program in 1994 showed the possibility of substantial savings based on a manufacturer rebate similar to that obtained by the Medicaid program. A more recent review found that manufacturers' published AWP considerably overstates the actual wholesale cost. For 22 drugs with high Medicare allowance amounts, Medicare could have saved \$447 million in 1996 by using actual wholesale prices rather than the manufacturers' published AWP. Savings for all Medicare drugs could have been as much as \$667 million in 1996.

Savings (in millions):

The savings will depend on the percentage by which the AWP is discounted for Medicare payments. The Balanced Budget Act of 1997 reduced Medicare payments to 95 percent of the AWP. The following estimates, based on a Congressional Budget Office estimate of those savings, show the effects of additional 5 and 10 percent reductions.

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
90% of AWP	\$ 80	\$110	\$110	\$40	\$30
85% of AWP	160	220	220	80	60

Status:

The HCFA concurred with our recommendation. As noted above, the Balanced Budget Act of 1997 limited Medicare payments for drugs to 95 percent of the AWP.

Report:

- OEI-03-94-00390 (Final report, Mar. 1996)
- OEI-03-95-00420 (Final report, May 1996)
- OEI-03-97-00290 (Final report, July 1997)

4

LIMIT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR HOSPITAL ADMISSIONS NOT REQUIRING AN OVERNIGHT STAY

Current Law:

Under the prospective payment system (PPS), hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis related groups (DRG). Current Medicare instructions provide that an admission occurs when it is expected that the patient will occupy a bed and remain overnight. This applies even if the person is later discharged or transferred to another hospital without actually using a hospital bed overnight.

Proposal:

The HCFA should seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality.

Legislative

Regulatory

Other Administrative

Reason for Action:

Based on Medicare records for 1989, our follow-up review (A-05-92-00006) revealed that the volume of 1-day admissions on a national basis had increased approximately 150 percent over 1985 levels and that Medicare had paid for 179,500 admissions that did not require overnight stays. Many of these cases related to observations after emergency or outpatient services, to surgeries later canceled, or to acute care stays of doubtful necessity. In many cases, documentation revealed that few, if any, services were provided while the patient was an inpatient.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$210	\$210	\$210	\$210	\$210

Status:

The HCFA proposed to implement our recommendation through administrative remedies which would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.

Report:

- A-05-89-00055 (Final report, July 1989)
- A-05-92-00006 (Final report, Jan. 1992)

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount the Medicare program pays for most clinical lab tests is based on fee schedules. These fee schedules, effective July 1, 1984, were established by each carrier at 60 percent of the Medicare prevailing rate (the rate most frequently used by all suppliers). The Congress took action in the Omnibus Budget Reconciliation Act of 1990 to pay comparable prices by limiting the annual fee schedule increase to 2 percent for 1991, 1992, and 1993 and by reducing the national cap to 88 percent of the median of all fee schedules. The Omnibus Budget Reconciliation Act of 1993 further reduced the national Medicare fee cap to 80 percent of the median of carrier prices in 1995 and to 76 percent in 1996. The law also called for no cost-of-living increases for 1994 and 1995.

Proposal:

The HCFA should (1) develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests and (2) study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Legislative

Regulatory

Other Administrative

Reason for Action:

The Omnibus Budget Reconciliation Act of 1993, if fully implemented, should reduce the higher profit rates from Medicare billings. However, although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests to Medicare. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The HCFA's guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry or the problem of industry billing for the contents of the panels individually. In our opinion, these conditions have contributed to the significant increase in the use of laboratory services.

Savings (in millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Panels	TBD	TBD	TBD	TBD	TBD
Co-payment	\$1,130	\$1,240	\$1,370	\$1,520	\$1,690

Status:

The HCFA concurred with our first recommendation but not our second. The agency recently added that it is encouraging the individual ordering of tests to help control utilization and is therefore discouraging the creation of laboratory or physician specific customized panels.

The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.

Report:

- A-09-89-00031 (Final report, Jan. 1990)
- A-09-93-00056 (Follow-up report, Jan. 1996)

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

6

Current Law:

Under Medicare's prospective payment system (PPS), hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a diagnosis related group (DRG). However, bad debts related to unpaid deductible and coinsurance amounts are reimbursed separately as pass-through (i.e., reimbursed outside of DRG) items under reasonable cost principles.

Proposal:

We presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals which are profitable, and the inclusion of a bad debt factor in the DRG rates. The HCFA should seek legislative authority to further modify bad debt policies.

Legislative

Regulatory

Other Administrative

Reason for Action:

Our review of HCFA's Hospital Cost Report Information System showed that total Medicare bad debts increased from \$159 million during the second year of PPS (FY 1985) to \$398 million during the fifth year of PPS (FY 1988). During this same period, hospitals continued to earn significant profits. Also, hospital bad debt collection efforts have often been less than adequate since there is little incentive for a hospital to collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status:

Agreeing with our recommendation to include a bad debt factor in the DRG rates, HCFA said that our report should assist the Congress in understanding the rapid growth in hospital bad debts. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers, but additional legislative changes are needed to implement the modifications we recommended.

Report:

A-14-90-00339 (Final report, June 1990)

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE IMPACT OF HIGH-PRICED
GENERIC DRUGS
ON MEDICARE AND MEDICAID**



**JUNE GIBBS BROWN
Inspector General**

**JULY 1998
OEI-03-97-00510**

EXECUTIVE SUMMARY

PURPOSE

To determine the impact of high-priced generic drugs on the Medicare and Medicaid programs.

BACKGROUND

Both Medicaid and Medicare pay billions of dollars each year for prescription drugs. The Medicaid program paid nearly \$10 billion for prescription drugs in 1995. Although Medicare provides reimbursement for only certain types of drugs, the Part B program still paid more than \$2.3 billion dollars for prescription drugs in 1996.

On January 1, 1998, Medicare Part B began to reimburse covered drugs at 95 percent of the average wholesale price (AWP). This change in reimbursement was the result of legislation enacted by Congress. Previously, Medicare carriers determined the amounts that Medicare paid for prescription drugs based on the lower of the Estimated Acquisition Cost (EAC) or the national (AWP). Historically, carriers had used 100 percent of AWP and not estimated acquisition cost to determine Medicare reimbursement allowances for prescription drugs.

For drugs with generic versions, Medicare carriers determine reimbursement based on 95 percent of the median AWP for all generic versions of the drug. Prior to January 1998, Medicare reimbursed drugs with generic versions at 100 percent of the median AWP. Medicare reimbursement amounts include both the amount that Medicare and its beneficiaries pay a drug supplier.

In general, State Medicaid agencies use either a discounted AWP or estimated/wholesale acquisition cost method to reimburse prescription drugs. State Medicaid agencies also receive manufacturer drug rebates.

This inspection report resulted from a Congressional request concerning high-priced generic drugs. Using the drugs identified in the request, we collected data from three main sources. To verify NDC codes and average wholesale prices, we reviewed data from the July 1997 *Red Book* CD-ROM update. We compiled Medicare statistics from the National Claims History (NCH) File. We collected drug rebate data from the Medicaid Drug Rebate Initiative (MDRI) System.

FINDINGS

Medicare and its beneficiaries could have saved \$5 million to \$12 million for four drugs if 1997 reimbursement had not been based on higher-priced generic versions.

We found several cases where average wholesale prices for generic products were three to four times greater than the brand price. For the four drugs reviewed, we determined that the Medicare program and its beneficiaries could have saved \$5 million dollars if 1997 reimbursement had been based on the average wholesale price of the brand-name products. If reimbursement had been

based on the median of generic drugs with prices less than the brands, Medicare and its beneficiaries could have saved \$12 million for the four drugs.

Florida's Medicaid program could have saved half a million dollars for just eight drugs in 1996 if higher-priced generic drugs had been reimbursed at brand prices.

Using the current reimbursement formula, Florida Medicaid in some cases paid three times more for a generic than it did for the brand version of the eight drugs reviewed. After factoring in manufacturer rebates, the program paid more than five to eight times more for generics than brand products. If Florida Medicaid had capped reimbursement for higher-priced generic drugs at the reimbursement level for the highest-priced brand drug, nearly half a million dollars would have been saved for just eight drugs in 1996.

RECOMMENDATIONS

There is evidence that high-priced generic drugs have a significant financial impact on Medicare and Medicaid reimbursement. We found that the inclusion of higher-priced generic drugs in Medicare payment calculations can raise allowances above the price of brand-name drugs. In the Medicaid program, utilization of higher-priced generic drugs was widespread among the drugs reviewed.

We believe further reductions need to be made in Medicare and Medicaid reimbursement for prescription drugs. We continue to support the Health Care Financing Administration's legislative proposal to link Medicare reimbursement to the acquisition cost of prescription drugs. However, until broader legislation is enacted, we believe refinements to the current system are needed. Since the changes recently enacted by Congress continue to link reimbursement to average wholesale prices, we believe that mechanisms should be in place to limit the impact that high-priced generic drugs have on reimbursement. Medicare's new reimbursement methodology for prescription drugs will not prevent higher-priced generics from increasing Medicare allowances. Higher-priced generic drugs will still be included in the median calculation. When the median generic policy was implemented, generic prices were normally less than those of the brand-name product. However, what may have originally been a cost-saving mechanism has, for certain categories of drugs, become a losing proposition.

We believe that the Medicare program should take action to prevent these situations. We recommend that the Health Care Financing Administration 1) not include higher-priced generic drugs in the median calculation to determine Medicare allowances, or 2) propose limiting Medicare allowances to brand prices when higher-priced generic drugs are involved.

In contrast to the Medicare program which pays for brand and generic drugs at the same rate, Medicaid reimburses based on the specific drug supplied. Therefore, we recommend that the Health Care Financing Administration limit Medicaid reimbursement of higher-priced generic drugs to the amount reimbursed (prior to rebate) for lower-priced brand or appropriately-priced generic drugs.

PRESIDENT CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES

BACKGROUND: January 13, 1999

Today, President Clinton will unveil an historic new initiative that will remove significant barriers to work for people with disabilities. This three-part budget initiative, which invests over \$2 billion over five years, includes: (1) full funding of the Work Incentives Improvement Act which will be introduced by Senators Jeffords, Kennedy, Roth, and Moynihan next week; (2) a new \$1,000 tax credit to cover work-related costs for people with disabilities; and (3) expanded access to information and communications technologies. With these new proposals, the Administration will have taken action on every recommendation made in the report of the President's Task Force on the Employment of Adults with Disabilities, which the Vice President accepted last month. Justin Dart, one of the foremost leaders of the disability communities, stated in response to today's proposals: "The Clinton-Gore Administration has a long history of supporting the disability community. This policy initiative is one of the boldest since the landmark passage of the ADA."

BARRIERS TO WORK FOR PEOPLE WITH DISABILITIES

- **Millions of working-age adults have disabilities.** About 1.6 million working-age adults have a disability that leads to functional limitations (i.e., needs help with at least one activity of daily living). About 14 million working-age adults are disabled using a broader definition (e.g., uses a wheelchair, or walker; has a developmental disability).
- **The unemployment rate among people with disabilities is staggering.** Nearly 75 percent of people with disabilities are unemployed. Not only is it more difficult for people with disabilities to work; when they do work, their earnings are lower. According to one study, the average earnings for men with disabilities are 15 to 30 percent below those of men without disabilities. These disparities are greater for those needing help with daily activities.
- **Multiple barriers to work.** People with disabilities face a number of challenges, including:
 - **Lack of adequate health insurance.** In most places in the U.S., people with health problems can be charged high premiums by private insurance companies or denied coverage altogether. Those who are insured may not be covered for some of their needs, such as personal assistance. Medicaid covers these services, but eligibility is generally restricted to people who cannot work. Thus, there is little incentive to return to work.
 - **Higher costs of work.** People with disabilities not only face lower than average wages, but typically pay more to get to and from work and to function at work. Thus, for some, returning to work may decrease rather than increase their savings.
 - **Disconnected employment service system:** A variety of vocational rehabilitation, educational, training and health programs exist to facilitate work for people with disabilities, but they rarely work together in a coordinated way.
 - **Inaccessible or unavailable technology:** Technological advances facilitate work, improve productivity and reduce the costs of such technology. Yet, people with disabilities often lack information on what exists, how to use it, and how to afford it.

ADMINISTRATION COMMITMENT TO IMPROVING OPPORTUNITIES

The President has made expanding economic opportunities to all Americans -- particularly people with disabilities -- a priority. His accomplishments include:

- **Most diverse Administration in history** by appointing a large number of people with disabilities to senior positions. The Federal government now employs about 127,000 employees with some type of disability.
- **Strong efforts to end job discrimination.** In July 1998, the President directed key federal civil rights agencies (Department of Justice, Equal Employment Opportunity Commission and the Small Business Administration) to increase outreach and implementation efforts.
- **New Medicaid buy-in option for workers with disabilities.** The Balanced Budget Act of 1997 created an optional program whereby states could allow people with disabilities who were earning up to 250 percent of poverty to purchase Medicaid coverage.
- **Improving employment services.** On August 7, the President signed the Workforce Investment Act (WIA), including the Rehabilitation Act Amendments of 1998. It establishes better links between the vocational rehabilitation and the workforce development systems.
- **Expanding accessible transportation.** In September 1998, the Department of Transportation issued the final regulation implementing the Americans with Disabilities Act (ADA) provisions for over-the-road bus (OTRB) accessibility.
- **Reauthorizing and expanding the Assistive Technology Act.** In October, 1998, the President signed the "Tech Act" which provides assistive technology to low-income people with disabilities and encourages small businesses to design and market innovative ideas.
- **TASK FORCE ON EMPLOYMENT OF ADULTS WITH DISABILITIES.** One of the most important actions taken by President Clinton was the signing of the executive order establishing the Presidential Task Force on Employment of Adults with Disabilities on March 13, 1998. Led by Alexis Herman, Secretary of Labor, and Tony Coelho, this Task Force is charged with coordinating an aggressive national policy to bring adults with disabilities into gainful employment. It produced a set of interim recommendations in December, 1998, summarized below:

RECOMMENDATION

1. Work to pass the Work Incentive Improvement Act
2. Work to pass the Patients' Bill of Rights
3. Examine tax options to assist with expenses of work
4. Foster interdisciplinary consortia for employment services
5. Accelerate development/adoption of assistive technology
6. Direct Small Business Administration to start outreach
7. Remove Federal hiring barriers for people w/ mental illness
8. Develop a model plan for Federal hiring of people w/ disabilities

ACTION

- President includes in budget
High Presidential priority
President includes in budget
President includes in budget
President includes in budget
Vice President announced 12/98
Mrs. Gore announced tomorrow
Vice President announced 12/98

WORK INCENTIVES IMPROVEMENT ACT

The Work Incentives Improvement Act is an historic bill produced through the bipartisan efforts of Senators Jeffords, Kennedy, Roth and Moynihan in collaboration with leaders in the disability community and staff throughout the Administration. It is the centerpiece of the President's initiative to provide economic opportunities to people with disabilities. Altogether, it would cost an estimated \$1.2 billion over 5 years. Its major components are described below.

HEALTH INSURANCE PROTECTIONS

Health care -- particularly prescription drugs and personal assistance -- is essential to enabling people with disabilities to work. This proposal would: (1) expand option and funding for the Medicaid buy-in for workers with disabilities; (2) extend Medicare coverage for people with disabilities who return to work; and (3) create a demonstration of a Medicaid buy-in for people with disabilities that have not yet gotten severe enough to end work and qualify them for disability, Medicaid or Medicare.

- **Expanding the State Medicaid Buy-In Option for Workers with Disabilities.** Two new optional eligibility categories would allow states to expand Medicaid coverage to workers with disabilities beyond the current option created in the Balanced Budget Act of 1997 (BBA). Additionally, a new grant program would be provide \$150 million in funds to states taking these option to help them start their programs and outreach to eligible workers.

The BBA option allows people with disabilities who would be eligible for Supplemental Security Income (SSI) but for earned income up to 250 percent of poverty to buy into Medicaid at a premium set by the state. This would be expanded through two new options:

Workers with higher earned income, unearned income, and assets. The first new option allows states to expand this Medicaid buy-in to people with disabilities with earned income above 250 percent of poverty with assets, resources and unearned income to limits set by the state. This is important since many workers with disabilities have either assets and resources that exceed the current limit of \$2,000 or are transitioning from Social Security Disability Insurance (SSDI) and have unearned income exceeding the limit of about \$500.

Workers whose conditions improve but still are disabled. The second new option would allow states that elect the first option (covering working people with disabilities with assets, resources and unearned income below limits set by the state) to also extend the Medicaid buy-in to people who continue to have a severe medically determinable impairment but lose eligibility for SSI or Social Security Disability Insurance (SSDI) because of medical improvement. Often, such improvements are possible only with health care.

To give an example of who might be helped by this option, a person with rheumatoid arthritis whose condition prevents work could receive disability and health coverage. If, at the medical review, laboratory tests were still positive but the therapy and a new drug allowed the person to work, benefits would essentially end. Although this temporary remission is mostly attributable to health care coverage, the improvement would disqualify the person from disability and thus health benefits under current law.

Grant assistance. States that take one or both of the new eligibility options for working individuals with disabilities would be eligible for a new grant program. This program would give states funds for infrastructures to support working individuals with disabilities as well as to build the capacity of states and communities to provide home and community-based services. Funds could also be used for outreach campaigns to connect people with disabilities with resources. A total of \$150 million would be available for the first 5 years, and annual amounts will be increased at the rate of inflation for 2004 through 2009. States meeting these criteria would receive a grant no less than \$500,000 and no more than equal to 15 percent of expenditures on medical assistance for individuals eligible under the new state options. Funds would be available until expended.

Both options would be treated like any other Medicaid eligibility option (e.g., same Federal matching rate, benefits rules). States could not supplant existing state spending with Medicaid funding under these options and would have to maintain effort for current spending for people made eligible under these options.

- **Continuation of Medicare Coverage for Working Individuals with Disabilities.** A ten-year trial program would allow people who are receiving Medicare because of their receipt of SSDI payments to continue to receive Medicare coverage when they return to work. Under current law, these individuals may receive Medicare coverage during the 39-month period following their trial work period, but have to pay the full Medicare Part A premium after that time. In many cases, people returning to work following SSDI either work part time and thus are not eligible for employer-based health insurance or work in jobs that do not offer insurance. This leaves them no alternative to the individual insurance market which can charge people with pre-existing conditions exorbitant premiums or deny them coverage altogether in many states. This option, which allows these workers to maintain their Medicare coverage so long as they remain disabled (as determined through continuing disability reviews), would remove a critical barrier to returning to work.
- **Demonstration of Coverage of Workers with Potentially Severe Disabilities.** A demonstration program would allow states to offer the Medicaid buy-in to workers that, as defined by the State, have a disability that without health care could become severe enough to qualify them for SSI or SSDI. Funding of \$300 million would be available for this demonstration, which sunsets at the end of FY 2004. States could participate in this demonstration if they have opted to expand coverage through at least one of the new Medicaid eligibility options for workers with disabilities. People covered in this demonstration would receive the same coverage as other workers with disabilities.

This demonstration is intended to help people whose condition has not yet deteriorated enough to prevent work but who need health care to prevent that deterioration. For example, a person with muscular dystrophy, Parkinson's Disease, or diabetes may be able to function and continue to work with appropriate health care, but such health care may only be available once their conditions have become severe enough to qualify them for SSI or SSDI and thus Medicaid or Medicare. This demonstration would provide new information on the cost effectiveness of early health care intervention in keeping people with disabilities from becoming too disabled to work.

TICKET TO WORK AND OTHER PROVISIONS

- **Ticket to Work.** Currently, SSDI and SSI disabled beneficiaries believed to benefit from employment-related services are mostly referred to state vocational rehabilitation (VR) programs administered by the Department of Education, which are then reimbursed based on cost. This provision would give more consumer choice in receiving employment services and increases provider incentives to serve SSI and SSDI beneficiaries. Components of the ticket proposal include:

Consumer Options for Employment Services. The ticket would enable an SSI and SSDI beneficiary to go to either a public or a participating private provider.

Provider Options for Reimbursement. Providers who accept the ticket would select their preferred reimbursement: (1) outcome payments system (e.g., 40 percent of benefits saved for five years once the recipient leaves the rolls), or (2) an outcome-milestone payment system (e.g., a flat payment when a specific employment related goal is achieved plus a portion of benefits saved once the recipient leaves the rolls).

Temporary Suspension of Continuing Disability Reviews. During the period when a beneficiary is "using a ticket" the individual would not be subject to continuing disability reviews -- medically scheduled or triggered by work activity.

- **Demonstrations.** This provision requires SSA to undertake a demonstration project that reduces SSDI benefits by \$1 for each \$2 earned above a certain level. Under current law, a DI beneficiary in the extended period of eligibility who earns more than the substantial gainful activity level, currently \$500 a month, does not receive a cash benefit. Another provision would extend SSA's SSDI demonstration authority which expired in June 1996.
- **Changes in Continuing Disability Reviews (CDRs).** SSA uses CDRs to determine if a beneficiary continues to meet the definition of disability over time. This provision would prohibit using work activity as the sole basis for scheduling a CDR for individuals during the first 24 months of DDSI eligibility. Additionally, this proposal would provide an expedited eligibility determination process for SSDI applicants who received benefits for at least 24 months & engaged in substantial gainful activity during their extended periods of eligibility.

WORK INCENTIVE GRANTS

The Work Incentive Grant proposal would combine the strong ideas in Title IV of the Work Incentive Improvement Act with those of the Task Force on the Employment of Adults with Disabilities to improve the existing infrastructure for providing information and services to individuals with disabilities. The new grant program would build upon the *Workforce Investment Act (WIA)*, signed into law by the President last year, by ensuring that people with disabilities have access to the full range of employment and re-employment services in the One-Stop delivery system established by the WIA.

- **New partnerships.** Competitive grants (totaling \$50 million a year) would be awarded to partnerships of organizations (public and private), including organizations of people with disabilities in every state. These partnerships will be responsible for working with the One-Stop system to augment that system's capacity to provide a wide range of high quality services to people with disabilities working or returning to work, including:
 - Providing benefits planning and assistance;
 - Facilitating access to information about services and work incentives available in the public, private, nonprofit sectors (e.g., availability of transportation services in the local area, eligibility for health benefits, and access to personal assistance services);
 - Better integrating and coordinating employment and support services on the Federal, state, and local levels of government.
- **Building on current efforts.** The new grant program would build upon the solid base formed by the state and local workforce investment boards mandated by the Workforce Investment Act. The WIA sets forth a new priority on ensuring that individuals with disabilities are provided access to employment and training information and services. The Federally-funded Vocational Rehabilitation agencies are required to participate in the One-Stop delivery system of employment and training services. Further, the local workforce investment boards are required to include representatives of community-based organizations, including those that represent persons with disabilities. DOL will encourage local boards to include business leaders with experience in employing such individuals.
- **Administration.** As the lead Federal agency for employment and training services for all Americans, DOL would administer these grants. DOL would consult with National Council on Disability, the President's Committee on the Employment of People with Disabilities, and the Task Force on the Employment of Adults with Disabilities, the Education Department, the Department of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Small Business Administration, the Department of Commerce, and others on the development of its solicitation for grant applications, on review of applications for quality and comprehensiveness, and on monitoring and evaluating the grants and the operations of the One-Stop system.

TAX CREDIT FOR WORKERS WITH DISABILITIES

Eligible workers with disabilities would receive a \$1,000 tax credit beginning in 2000. This would help about 200,000 to 300,000 people, at a cost of \$700 million for 2000-04.

- **Goal.** This new tax credit would help offset some of the formal and informal costs associated with employment for people with disabilities. As such, it would provide a greater incentive to begin working, and help those people with jobs maintain them. It would complement the Work Incentives Improvement Act and would be available to all people with disabilities, irrespective of their state Medicaid eligibility options. For participants in a Medicaid buy-in, it could pay for services not covered (e.g., special clothing, transportation). It also gives the person with disabilities flexibility in directing the credit toward the services that they need the most.
- **Amount of the credit.** The credit would be \$1,000. It would phase out for higher income tax payers (taxpayer with modified adjusted gross income exceeding \$110,000 for couples, \$75,000 for unmarried taxpayers, and \$55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). This credit cannot exceed the total amount of tax liability except, however, that it may be refundable for taxpayers with 3 or more dependents.
- **Eligibility.** A taxpayer (or his or her spouse) would qualify for the proposed tax credit if he or she had earnings and was disabled. "Disabled" for this credit would be defined as being certified within the previous 12 months as being unable, for at least 12 months, to perform at least one activity of daily living (bathing, dressing, eating, toileting, transferring and continence management) without personal assistance from another individual, due to loss of functional capacity.
- **Interaction with other tax provisions:** Worker with severe disabilities who also qualify for the President's proposed long-term care credit may receive both credits since they are intended to help with different types of costs.

Individuals receiving this credit may also be eligible for the present-law deduction for impairment-related work expenses of persons with disabilities (this deduction is not subject to the 2 percent limit). However, many individuals with disabilities may not be able to itemize their deductions or incur significant work-related expenses outside the workplace (which do not qualify for the deduction).

- **Who benefits.** About 200,000 to 300,000 workers would receive this credit.
- **Cost:** \$700 million over 5 years.

EMPOWERING AMERICANS WITH DISABILITIES WITH ASSISTIVE TECHNOLOGY

This multifaceted initiative would improve the development, adoption and prevalence of technologies that help people with disabilities work. It would cost \$35 million in FY 2000, more than doubling the government's current investment in deploying assistive technology.

- **Goal:** This initiative would accelerate the development and adoption of information and communications technologies that can be easily used by Americans with disabilities. Information technology has the potential to significantly improve the quality of life for people with disabilities, enhance their ability to participate in the workplace, and make them full participants in the Information Society.
- **Elements of the initiative.** This initiative has five parts:
 - **Making the Federal government a model employer.** The government would expand its purchases of assistive technology and services to increase employment opportunities for people with disabilities in the federal government.
 - **Supporting state loan programs to make assistive technology more affordable.** The Department of Education's National Institute on Disabilities and Rehabilitation Research (NIDRR) would provide matching funds to states that create or expand loan programs to make assistive technology more affordable for people with disabilities.
 - **Investing in research and development and technology transfer to make technology more accessible.** NIDRR and the National Science Foundation would invest in research on technologies such as "text to speech" for people who are blind, automatic captioning for people who are deaf, or speech recognition and eye tracking for people who cannot use a keyboard.
 - **Developing an "Underwriters Laboratory" for accessible technologies.** The government would provide start-up funding to a private sector organization, analogous to the Underwriters' Laboratory, that would test information and communications technologies to see if they are accessible. This would help expand the market for accessible technologies.
 - **Encourage industry to make products more accessible.** Building on a successful partnership with the Internet industry (the Web Accessibility Initiative), the government would provide matching funds to industry consortia that work with disabilities community to make key technologies accessible, such as interactive television, small, hand-held computers, and cellular phones.
- **Cost:** \$35 million per year.

Disability Initiative Q & A's
January 12, 1999

Q. How is this initiative funded?

A. This initiative is fully funded through offsets in the President's proposed FY 2000 budget. All of these provisions will be described in the budget documents released in early February.

Follow-up: Isn't it irresponsible to announce specific spending proposals without announcing how these proposals will be financed?

Not at all. The President will ensure that this -- and all other new initiatives -- will be fully paid for as part of his overall balanced budget proposal. Like most budgets, the President's FY2000 budget will not contain a specific dollar-for-dollar link between new proposals and offsets. The bottom line, however, will reflect the President's long-standing commitment to a balanced budget. Moreover, not one dime will be taken away from the surplus for this initiative.

Q. Shouldn't this tax credit be refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. The vast majority of low-income people with disabilities are already covered by Medicare and Medicaid. This initiative enables states to cover people who would be rendered ineligible by virtue of returning to work and gaining a higher income. Thus, most of the funding in this initiative is targeted toward those low-income people in the process of returning to work.

The tax credit helps offset the higher costs of work (e.g., personal assistants, special transportation) for people with disabilities who pay taxes, irrespective of their income or state of residence. It also, unlike Medicaid and Medicare, allows the worker to use the funds for whatever expenses they incur.

Q. Why are we only doing tax initiatives? Are you rejecting traditional Medicare and Medicaid program expansions? Aren't you catering to Republicans?

A: Each policy in the President's budget was designed to be the most cost-effective approach to solving a particular problem. This tax credit for workers with disabilities is no exception. Workers with disabilities have very different costs -- for rural residents, it may be transportation; for people with limited use of their hands, it may be assistive devices. A tax credit offers the flexibility to assist with a wide-ranging and changing set of needs in a way that Medicaid expansions cannot.

Similarly, the informal, unmeasurable costs of family caregiving are best addressed through a tax credit, as proposed in our long-term care initiative. If Medicaid or Medicare expanded to cover respite care, for example, it would undermine rather than strengthen informal family caregiving and cost billions more.

In no way does the President's support for these tax credits undermine his commitment to Medicare and Medicaid. This President has an unparalleled record of protecting, strengthening and expanding these programs. For example, the President's aggressive actions to reduce Medicare fraud contributed to record-low spending growth in 1998 -- the same year that he added new preventive benefits, health plan choices, and low-income protections to Medicare.

Q. How many people will benefit from this proposal?

A. Between 200,000 and 300,000 people would likely benefit from the tax credit. Millions more could benefit from the new options, services and programs in the Work Incentive Improvement Act and the assistive technology initiative.

Q. What are this initiative's prospects of passing?

A. Removing barriers to work for people with disabilities goes beyond partisan politics. We can all agree that something must be done so that people with disabilities can fully participate in today's strong economy. Senators Jeffords, Kennedy, Roth and Moynihan have already committed to working hard for the Work Incentive Improvement Act. We hope that early passage of this bill can show the American public that this Congress and President can work together to address real problems that are affecting people's lives today.