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MEMORANDUM

TO: Laura Tyson
FR: Chris J.
RE: Medicare/Medicaid Growth Rate Comparisons
cc: Gene

July 17, 1995

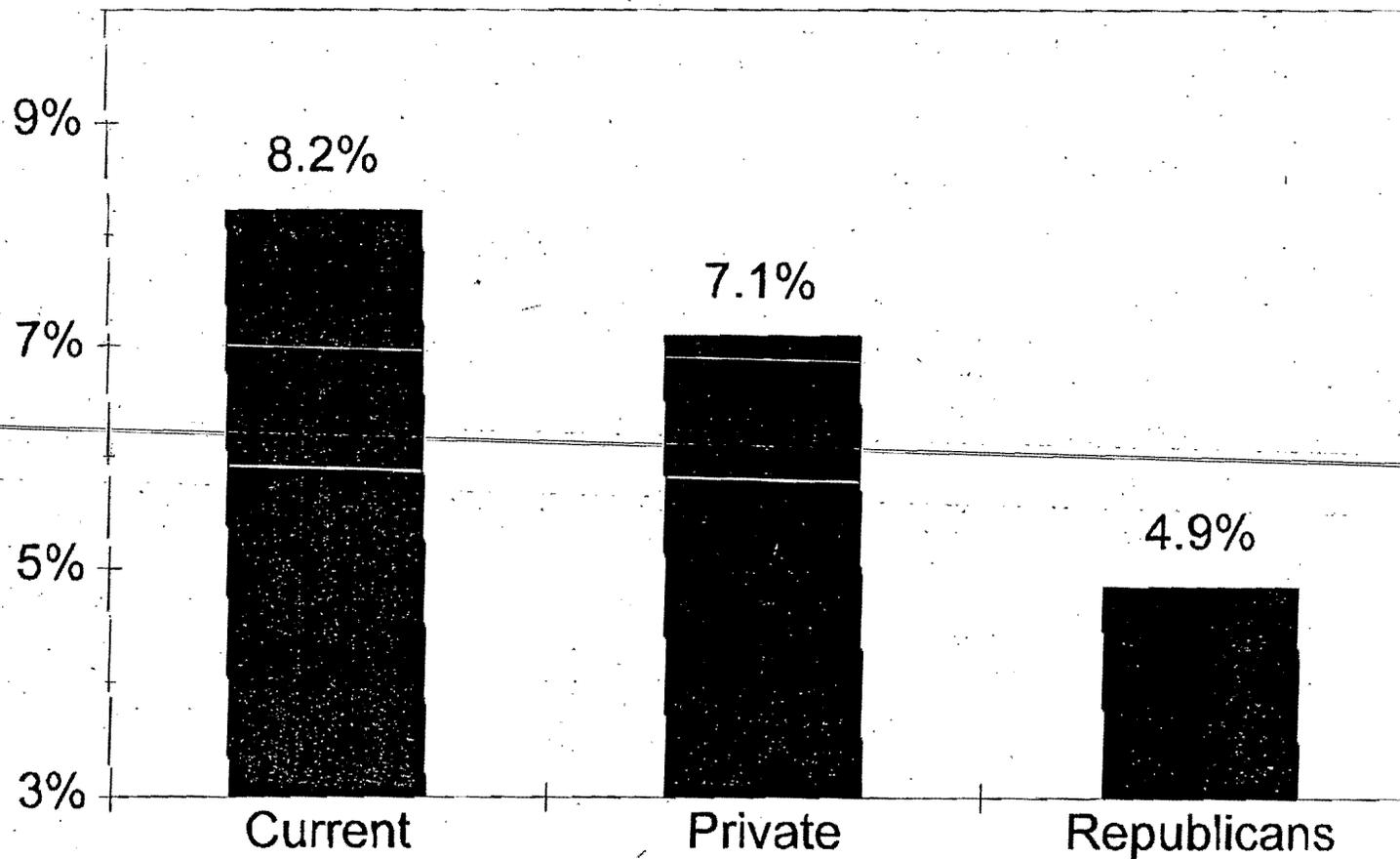
Following up our conversation today, I am attaching a set of charts and background information on Medicare/Medicare growth rate comparisons with the private sector. Since everyone is working off the CBO baseline, I had our HHS folks do our estimates working with the CBO model/numbers.

As you will note, CBO projected private sector per capita baseline over the next 7 years is running at 7.1 percent. If the Republican cuts were enacted, the Medicare/Medicaid per capita growth rates would be running at 4.9% and 1.4% respectively.

These numbers have been reviewed by OMB, but not yet finally cleared. I would say, however, that I am confident enough in them to give them to you for your use.

One last point, because the Medicaid baselines are so different, we recommend NOT attempting to try to project an Administration proposal growth rate onto the CBO baseline. However, it is important to note that our Medicare growth rate number (if you assume \$124 billion off of the CBO baseline) is 6.4% -- also less than the 7.1% CBO projection for the private sector growth rate. At this point, I would recommend against talking about our growth rates -- either Medicare or Medicaid -- on an assumed CBO baseline.

Medicare Growth Per Beneficiary: Effects of the Republican Proposal 1996-2002

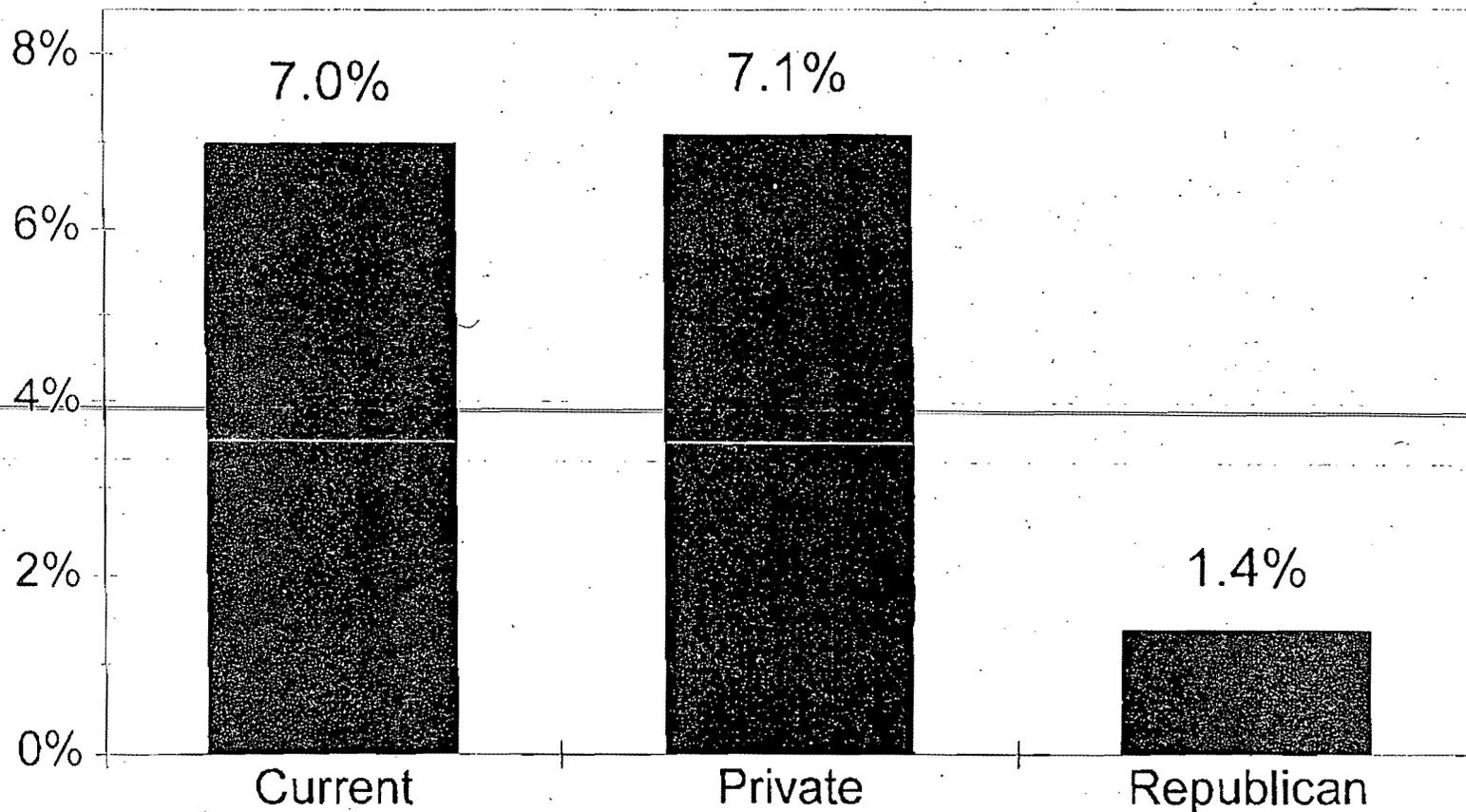


All estimates are calculated by the Administration using CBO data.

Medicaid Growth Per Recipient

Effect of the Republican Proposal

1996-2002



All estimates are calculated by the Administration using CBO data.

MEDICARE SPENDING AND GROWTH RATES UNDER THE REPUBLICANS' BALANCED BUDGET PROPOSAL

The Republicans have proposed that Medicare spending can be reduced by \$270 billion between 1996 and 2002 in their Balanced Budget Proposal.

MAGNITUDE OF THE CUTS

- **Medicare cuts are 33% of all spending reductions under the Republicans' Proposal.** Although the Medicare beneficiaries represent about 13% of the U.S. population and Medicare is 11% of the Federal outlays, Republicans have proposed that over 33% of the savings from policy change leading to deficit reduction will come from Medicare.
- **Almost all Veterans's Benefits would have to be eliminated to equal the size of the Medicare cuts.**
To get a sense of how large \$270 billion is, the Congressional Budget Office projects that Veterans' Benefits will cost about \$280 billion between 1996 and 2002. Ninety-five percent of government spending on Veterans would need to be eliminated to equal the size of the Medicare cuts.
- **Republicans would reduce Medicare spending by 14%.**
The cuts proposed by the Republicans represent a 14% reduction in Medicare spending between 1996 and 2002. This is 20% in 2002 alone. If service reductions were the only way to achieve \$270 billion dollars in savings, then Medicare could no longer cover home health and the skilled nursing facility services under the Republican proposal.

SPENDING PER BENEFICIARY

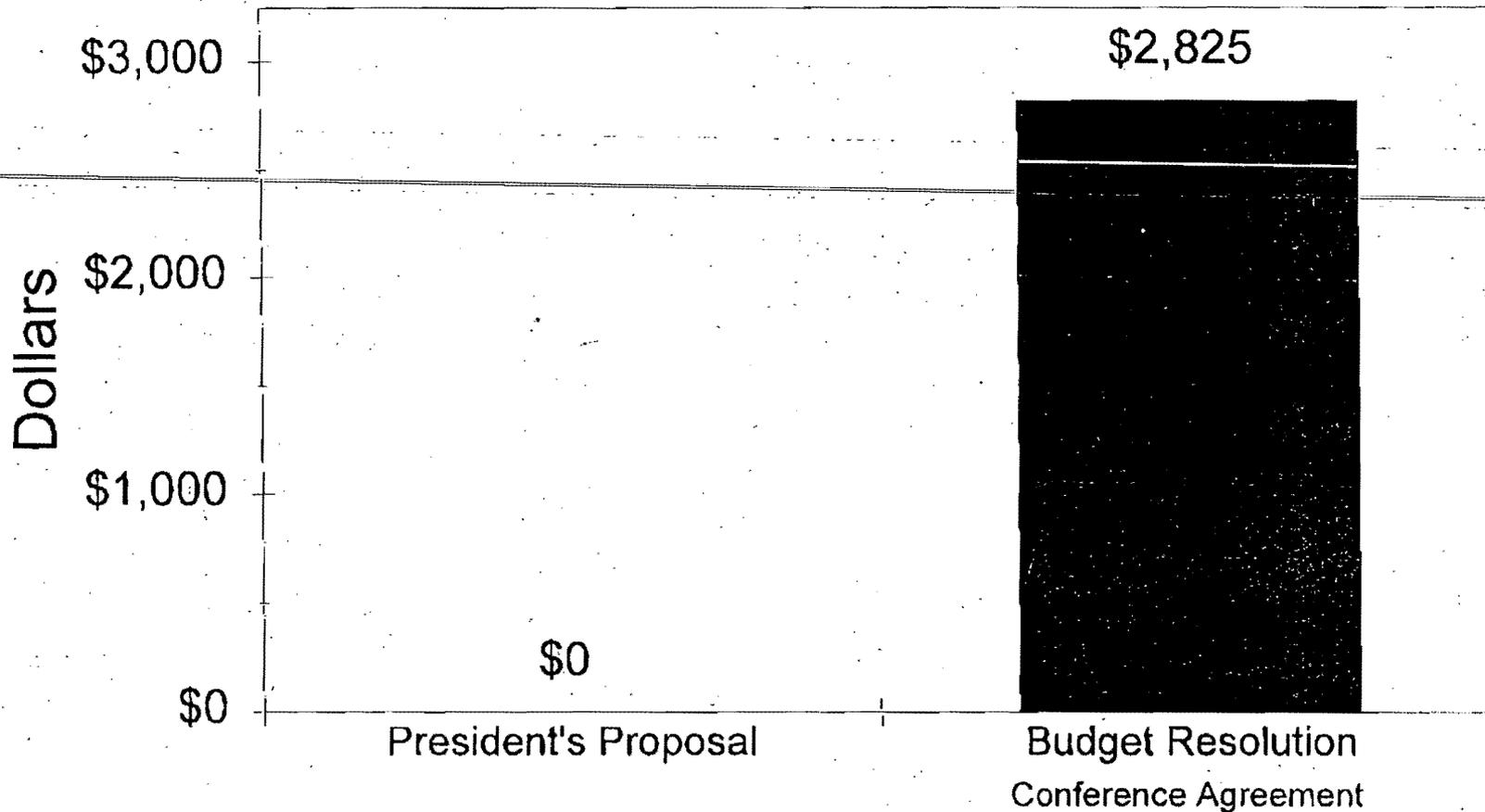
- **Medicare spending per beneficiary will fall by \$1,700 by 2002 under the Republican Proposal.**
Under current law, total Medicare spending will be \$274 billion in 2002, or \$8,350 per beneficiary. The projected Medicare spending per beneficiary after the Republican cuts would be \$6,650, or \$1,700 less.
- **Republicans cuts would add billions to older American's already high costs.**
Currently, older Americans spend 21% of their income on out-of-pocket health care costs. Assuming that the Republican cuts are divided equally between beneficiaries and providers:
 - In the year 2002 alone, each beneficiary could pay \$625 more in out-of-pocket costs than under the President's proposal; couples could pay \$1,250 more.

- Over the seven-year period, beneficiaries could pay an additional \$2,825 (\$5,650 per couple) out-of-pocket relative to the President's proposal.

GROWTH RATES

- **Republicans would reduce growth in spending per beneficiary by more than one-third.**
Growth in expenditures per recipient is expected to average 8.2% under the CBO baseline between 1996 and 2002. The Republican proposal would reduce this rate by over one-third to 4.9% over this same period.
- **Republicans' Medicare growth would be significantly slower than that of private spending per beneficiary.**
The Republican growth rate per beneficiary of 4.9% would be significantly lower than the private per recipient growth rate of 7.1%.
- **Republicans' Medicare growth would also be lower than medical inflation.**
Medical inflation (the medical component of the consumer price index (CPI)) is projected to be 5.3%, which is higher than the 4.9% projected under the Republicans' Proposal.

Increased Medicare Out-of-Pocket Costs Per Beneficiary, 1996 - 2002



The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposal adjusted to reflect the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimates

BACKUP

Comparison of President's Proposal and Republican Conference Agreement

	Baseline	President	Republicans
Medicare savings as a percent of spending changes		30%	33%
Percent Reduction from Baseline:			
1996-2002		11%	20%
2002		7%	14%
Spending per beneficiary*	\$8,350	\$7,425	\$6,650
Growth Per beneficiary, 1996-2002	8.2%	6.4%	4.9%

*Adjusts to CBO baseline by subtracting Admin. estimated savings from CBO baseline spending

DRAFT

Medicare Savings Proposals -- Balanced Budget Plan

(Dollars in billions, by fiscal year)

	Other Health/Medicare Reform Bill That Included Proposal	5-yr. Total 1996-2000	7-yr. Total 1996-2002	10-yr. Total 1996-2005
Part A Proposals				
Hospitals				
Reduce Hospital PPS Update (MB-1%, FY 1997-2002)	HSA, Dole, Mainstream, W&M'95	-7.1	-17.1	-35.9
Extend PPS Capital Reduction from OBRA 1990	HSA, W&M'94, Dole, Mainstr, W&M'95	-6.1	-9.3	-14.8
Reduce PPS-Exempt Update (MB-1%, FY 1998-2000)		-0.2	-0.5	-1.3
Reduce PPS-Exempt Capital Payments	HSA, Mainstr, Dole	-1.0	-1.6	-2.6
Moratorium on PPS Exemption for Long-Term Care Hospitals	HSA, Dole	-0.4	-0.8	-1.8
Lower IME Adjustment to 5.3% by FY 2000	HSA, W&M'94 and '95, Dole	-2.0	-7.1	-17.0
Graduate Medical Education Reform	W&M'94 (different specifics)	-2.8	-5.3	-11.0
Reduce Medicare Disproportionate Share Payments by 25%	HSA, W&M'94 and '95, Mainstr, Dole	-5.2	-8.4	-14.2
Eliminate IME/DSH Add-on Payment for "Outlier" Hospitals		-2.9	-4.4	-7.2
End Gaming of Discharge Status for SNF Transfers		-1.0	-1.6	-2.8
<i>Subtotal, Hospitals</i>		-28.6	-56.1	-108.6
Home Health and SNF				
Extend Savings from OBRA 1993 Home Health Cost Limits	HSA, W&M'94 and '95, Mainstr, Dole	-1.6	-2.5	-4.2
Extend Savings from OBRA 1993 SNF Cost Limits	HSA, W&M'95	-1.3	-2.0	-3.2
Home Health Prospective Payment (5%, 7.5%, 10% savings)		-2.4	-7.0	-15.0
SNF Prospective Payment	Mainstream	-0.7	-1.5	-2.8
Eliminate HH PIP		-1.1	-1.2	-1.5
Home Health Pay on Location of Service		-1.3	-2.0	-3.2
<i>Subtotal, Home Health & SNF</i>		-8.4	-16.3	-29.8
Medicare HMOs				
Remove IME, GME, and DSH from AAPCC		-6.2	-11.7	-23.2
Medicare as Secondary Payer (Part A portion)				
Extend Expiring MSP Provisions from OBRA 1993	HSA, W&M'94 and '95, Mainstr, Dole	-2.1	-5.2	-11.7
Insurer Reporting and Court Case Fix		-1.1	-1.8	-3.0
Part A Interactions		1.4	2.7	5.3
Total Part A Savings		-45.0	-88.3	-171.1
Part B Proposals				
Physicians				
Freeze 1996 Physician Fee Updates (not primary care)	HSA, Mainstr, Dole (similar)	-1.0	-1.6	-2.7
Eliminate MVPS Upward Bias	HSA, Mainstr, Dole (similar)	-1.5	-6.2	-21.9
Single Fee for Surgery		-0.6	-0.9	-1.5
<i>Subtotal, Physicians</i>		-3.1	-8.7	-26.2
Hospital Outpatient Departments				
OPDs: Eliminate Formula-Driven Overpayment	HSA, Mainstream	-6.6	-15.4	-49.5
Medicare as Secondary Payer (Part B portion)				
Extend Expiring MSP Provisions from OBRA 1993	HSA, W&M'94 and '95, Mainstr, Dole	-0.9	-2.5	-6.2
Insurer Reporting and Court Case Fix		-0.9	-1.4	-2.7
Other Providers				
Competitive Bidding for Labs	HSA, W&M'95	-1.1	-2.0	-3.5
Beneficiaries				
Extend Part B Premium at 25% of Program Costs	HSA, Mainstr, Dole, W&M'95	-4.1	-16.4	-57.7
Part B Interactions		3.0	7.3	22.0
Total Part B Savings		-13.6	-39.0	-123.7
TOTAL SAVINGS		-58.6	-127.3	-294.8
Medicare Benefit Expansions				
		2.3	3.4	5.4
Medicare Savings Net of Expansions		-56.3	-123.9	-289.4

NOTE: These are DRAFT estimates using FY 1996 President's Budget baseline. Totals may not add due to rounding.

MEDICAID SAVINGS PROPOSALS
(Dollars in billions, fiscal years)

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	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02	96-05
CBO Expenditures														
Total Baseline	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8	194.5	212.2	231.9	614.3	954.7	1593.3
Growth		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%	9.4%	9.1%	9.3%	10.5%	10.2%	9.9%
DSH Baseline	8.5	8.9	9.4	9.8	10.3	10.5	10.8	11	11.2	11.4	11.6			
Expenditures Minus DSH & Administration	77.2	86.4	96.3	107.4	119.3	131.8	145.6	160	175.9	192.6	211.4	11.1%	10.8%	10.5%
		11.9%	11.5%	11.5%	11.1%	10.5%	10.5%	9.9%	9.9%	9.5%	9.8%			
OPTION 1: HIGHER SAVINGS FROM PER CAPITA CAP, LOWER SAVINGS FROM DSH														
Per Capita Cap: Phased-In: GDP plus 2% in 1996, GDP plus 1% in 1997, and GDP for subsequent years														
Expenditures (excluding DSH & Administration)	77.2	86.4	95.5	104.7	114.0	124.1	134.2	144.4	155.2	166.8	179.1			
Growth		11.9%	10.6%	9.6%	8.9%	8.8%	8.2%	7.6%	7.5%	7.5%	7.4%	9.5%	8.9%	8.4%
Change (- savings, + spending)		0.0	-0.8	-2.7	-5.3	-7.7	-11.4	-15.6	-20.7	-25.8	-32.3	-16.5	-43.6	-122.3
Assuming 25% leakage		0.0	-0.6	-2.0	-4.0	-5.8	-8.6	-11.7	-15.5	-19.3	-24.2	-12.4	-32.7	-91.7
Disproportionate Share Policy: Reduce 1996 Federal Spending by 33%; Growth capped at Nominal GDP														
DSH Expenditures		6.0	6.3	6.6	6.9	7.3	7.7	8.1	8.5	8.9	9.4			
Savings		-2.9	-3.1	-3.2	-3.4	-3.2	-3.1	-2.9	-2.7	-2.5	-2.2	-15.8	-21.9	-29.2
COMBINED SAVINGS		-2.9	-3.7	-5.2	-7.3	-9.0	-11.7	-14.6	-18.2	-21.8	-26.4	-28.2	-54.5	-120.9
OPTION 2: LOWER SAVINGS FROM PER CAPITA CAP, HIGHER SAVINGS FROM DSH														
Per Capita Cap: Phased-In: GDP plus 3% in 1996, GDP plus 2% in 1997, GDP plus 1% in 1998, and GDP for subsequent years														
Expenditures (excluding DSH & Administration)	77.2	86.4	96.1	106.6	116.6	127.1	137.7	148.5	159.7	171.6	184.3			
Growth		11.9%	11.2%	10.9%	9.4%	9.0%	8.4%	7.8%	7.5%	7.5%	7.4%	10.1%	9.4%	8.6%
Change (- savings, + spending)		0.0	-0.2	-0.8	-2.7	-4.7	-7.9	-11.5	-16.2	-21.0	-27.1	-8.4	-27.8	-92.1
Assuming 25% leakage		0.0	-0.1	-0.6	-2.0	-3.5	-5.9	-8.6	-12.2	-15.8	-20.3	-6.3	-20.8	-69.1
Disproportionate Share Policy: Reduce 1996 Federal Spending by 50%; Growth capped at Nominal GDP														
DSH Expenditures		4.5	4.7	4.9	5.2	5.4	5.7	6.0	6.3	6.7	7.0			
Savings		-4.5	-4.7	-4.9	-5.1	-5.1	-5.1	-5.0	-4.9	-4.7	-4.6	-24.2	-34.3	-48.4
COMBINED SAVINGS		-4.5	-4.9	-5.5	-7.1	-8.6	-11.0	-13.6	-17.0	-20.5	-24.9	-30.5	-55.1	-117.5
OPTION 3: LOWER SAVINGS FROM PER CAPITA CAP, ALTERNATIVE DSH STREAM														
Per Capita Cap: No Phase-In: GDP plus 1%														
Expenditures (excluding DSH & Administration)	77.2	86.4	94.9	104.7	115.1	126.3	137.7	149.5	162.3	175.8	190.6			
Growth		11.9%	9.9%	10.3%	9.9%	9.7%	9.1%	8.5%	8.5%	8.4%	8.4%	10.0%	9.6%	9.2%
Change (- savings, + spending)		0.0	-1.4	-2.7	-4.2	-5.5	-7.9	-10.5	-13.6	-16.8	-20.8	-13.8	-32.1	-83.3
Assuming 25% leakage		0.0	-1.0	-2.0	-3.2	-4.1	-5.9	-7.9	-10.2	-12.6	-15.6	-10.3	-24.1	-62.5
Disproportionate Share Policy: Phase out "DSH", Implement New Program*														
DSH Expenditures		7.5	6.4	5.4	4.8	5.3	5.8	6.4	7.0	7.7	8.5			
Savings		-1.4	-3.0	-4.4	-5.5	-5.2	-5.0	-4.6	-4.2	-3.7	-3.1	-19.5	-29.1	-40.1
COMBINED SAVINGS		-1.4	-4.0	-6.4	-8.7	-9.4	-10.9	-12.5	-14.4	-16.3	-18.7	-29.8	-53.2	-102.6

Admin Needs old numbers

NOTE: Assumes that caps are applied to the aged, disabled, adults and children separately. Assumes that the cap is not enforced in 1996. Administrative costs are excluded from the caps; their inclusion would slightly increase the savings.
 * Phases out Federal DSH payment by multiplying FY 1995 Federal DSH spending by: 75% in 1996, 50% in 1997, 25% in 1998 and 0 in 1999 and subsequent years.
 The savings from phasing out DSH would be offset by implementing a Federal program whose funding is set at 1% of baseline Federal Medicaid benefits spending in 1996, 2% in 1997, 3% in 1998, and 4% for subsequent years.
 19-Sep-95

Chris G

Republican Medicare Proposals

Base Package: The base package contains a series of Part A and Part B savings proposals which total \$127 billion over 7-years, with Part A savings of \$89 billion.

Alternative 1: This alternative would change the base package by:

- o Dropping the proposal to remove IME, GME and DSH from the AAPCC and eliminating the savings from the package. The work-group will continue to consider elimination of add-ons from AAPCC and potential uses of those funds.
- o Making up the deficit-reduction savings by a legislative proposal for new guidelines for therapy services furnished to SNF patients, advancing the effective date for the IME reduction, extending the hospital update reductions for FY 03-05 and repricing two proposals.
- o Modifying the home health policy reducing limits and creating a TEFRA-like cost containment system before implementing a per-episode prospective system in FY 2000.

Alternative 2: Generally, this alternative would lessen the hit on academic health centers even further and replace the savings with an increase in the hospital update reduction. Specifically, this alternative would change the base package by:

- o Dropping the proposal to remove IME, GME and DSH from the AAPCC and eliminating the savings from the package. The work-group will continue to consider elimination of add-ons from AAPCC and potential uses of those funds.
- o Eliminating the IME hit.
- o Making up the deficit-reduction savings by a legislative proposal for new guidelines for therapy services furnished to SNF patients (same as alternative 1), extending the hospital update reductions for FY 03-05 and increasing the hospital update hit from MB-1 per year to MB - 1.5 per year from FY 97-05 and repricing two proposals.
- o Modifying the home health policy reducing limits and creating a TEFRA-like cost containment system before implementing a per-episode prospective system in FY 2000 (same as alternative 1).

Administrative
Medicare
#3

	96-00	96-02	96-05
EXTENDERS			
PART A			
Medicare Secondary Payer	2.070	5.170	11.720
SNF Freeze Extension	1.280	1.980	3.200
Home Health Freeze Extension	1.650	2.520	4.210
PART B			
Medicare Secondary Payer	0.900	2.450	6.240
Part B Premium	4.095	18.355	57.850
Part B Interactions	-0.080	-0.210	-0.670
Total Extenders	9.835	28.285	82.350
PART A PROPOSALS			
Hospitals			
Reduce Hospital PPS Update MB-1% (FY 1997-2005)	7.070	17.080	41.990
Extend PPS Capital Reduction from OBRA 1990	6.140	9.330	14.820
Reduce PPS-Exempt Update (MB-1% & MB-2%, 19	1.150	2.830	7.740
Reduce PPS-Exempt Capital Payments	1.010	1.590	2.610
Moratorium on Long-Term Care Hospitals	0.390	0.820	1.840
Expand Centers of Excellence	0.150	0.230	0.350
Lower IME Effective 7/1/98	3.800	8.800	18.780
GME Reform	2.810	5.285	10.965
Reduce Medicare DSH Payments by 25%	5.160	8.410	14.200
Eliminate Add-Ons for Outliers	2.860	4.380	7.190
PPS Redefined Discharges	1.030	1.640	2.780
Eliminate Overpayment Waivers	0.050	0.075	0.120
Home Health and SNF			
Home Health Prospective Payment	3.540	8.885	18.585
SNF Prospective Payment	1.340	2.580	4.720
Eliminate HH PIP	1.090	1.230	1.460
Home Health Pay on Location of Service	1.340	2.000	3.170
Therapy Guidelines	2.050	3.110	4.850
Medicare Secondary Payer (Part A)			
Insurer Reporting and Court Case Fix	1.100	1.775	3.005
Part A Interactions	-0.190	-0.580	-1.870
TOTAL PART A	41.690	79.470	157.485
TOTAL PART A (Including Extenders)	48.590	89.140	176.615
PART B PROPOSALS			
Physicians			
Freeze Physician Fees in 1996 (not primary care)	1.030	1.810	2.890
Eliminate MVPS Upward Bias	1.480	6.150	21.930
Single Fee For Surgery	0.570	0.910	1.540
Eliminate Urban HPSA Bonus	0.190	0.300	0.500
Reduce Overhead Payments	0.330	0.560	0.980
Hospital Outpatient Departments			
OPDs: Payment Reform	4.040	8.470	33.255
HMOs			
Impose floors & ceilings	0.635	1.205	2.205
Medicare Secondary Payer (Part B)			
Insurer Reporting and Court Case Fix	0.860	1.440	2.660
Other Providers			
Competitive Bidding for Labs	1.130	1.950	3.520
Competitive Bidding for Part B Services	0.720	1.210	2.120
Profile Lab Tests	0.810	1.290	2.220
Simplify Inherent Reasonableness	0.190	0.290	0.480
Implement Physician Rebundling Controls	0.690	1.110	1.935
Eliminate Overpayment Waiver	0.055	0.085	0.135
Expand Centers of Excellence	0.110	0.170	0.260
Part B Interactions	-3.410	-7.000	-19.575
TOTAL PART B	9.430	19.750	56.855
TOTAL PART B (Including Extenders)	14.365	38.345	120.075
TOTAL SAVINGS	51.120	99.220	214.340
TOTAL SAVINGS (Including Extenders)	60.955	127.485	296.690

Part A

- o **Reduce Hospital PPS Update:** Reduce the hospital market basket by 1 percentage point each year between FY 1997 and FY 2005 (the FY 1997 reduction is 0.5 percentage points above current law).
- o **Extend PPS Capital Reduction from OBRA-90:** Permanently capture the savings from the OBRA-90 payment reduction on an ongoing basis by giving the full update to the rates in effect at the end of OBRA-90 provision (9/30/95). Effective 10/1/95.
- o **Lower IME:** Reduce the IME adjustment from 7.7 percent to 6.8 for admissions between July 1, 1998 and September 30, 1998; to 6.0 percent from October 1, 1998 and September 30, 1999; and to 5.3 percent for October 1, 1999 and thereafter.
- o **GME Reform:** Medicare GME policy would be reformed by:
 - + Freezing the total number and the number of non-primary care residency positions that would be reimbursed under Medicare, at a hospital-specific level, effective 10/1/95 for IME and 7/1/96 for GME (base period for GME is 7/1/95-6/30/96).
 - + Extending the OBRA-93 freeze on updates for non-primary care residents for an additional 5-years through FY 2000, effective 7/1/96.
 - + Counting residents beyond their initial residency periods as 0.5 FTEs for IME (as currently done for GME), effective 10/1/95.
 - + Counting work in non-hospital settings for IME (as long as there is no increase in the hospital's resident-to-bed ratio), effective 7/1/96.
 - + Allowing GME payments to non-hospitals for primary care residents in non-hospital settings, when a hospital is not paying for the resident's salary in that setting, effective 7/1/96.
 - + Capping hospital-specific GME payments at 140 percent of the national average per resident amount, effective 7/1/96.
- o **Reduce Medicare DSH:** Reduce the current Medicare disproportionate share adjustment for PPS hospitals by 25 percent effective with FY 1997. The formula for DSH payments would be reestablished to target more precisely those hospitals which serve disproportionate shares of low income patients.
- o **Eliminate Add-Ons For Outliers:** Eliminate IME and DSH payments for outlier cases, effective with discharges beginning with FY 1996.
- o **Reduce PPS Payments for Redefined Discharges:** Redefine transfers from PPS to non-PPS facilities as discharges, effective 10/1/95.

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- o Long-Term Care Hospital Moratorium: Prohibit new long-term care hospitals from being excluded from PPS, effective upon enactment (assumed to be 10/1/95).
- o Reduce PPS-Exempt Update: Reduce the update for PPS-exempt hospitals by 1.0 percentage points each year between FY 1996 and FY 2005. Starting in FY 1996, rebase target amounts for hospitals and distinct part units excluded from PPS, limit target amounts to 150 percent of national average, eliminate bonus payments and shared-risk payments.
- o Reduce PPS-Exempt Capital Payments: Pay 85 percent of capital costs for hospitals and hospital units excluded from PPS for fiscal years 1996 through 2005.
- o Eliminate Overpayment Waiver: Do not relieve providers of services of liability for refunding an overpayment because they are found to be without fault for the overpayment, unless the overpayment was discovered subsequent to the third calendar year after the year of payment. The waiver provisions for any overpayment to the beneficiary would be maintained. Effective FY 1996.
- o Centers of Excellence: Expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so a Medicare rebate to the beneficiary equal to 10 percent of the government's savings from the center. Effective 10/1/96.
- o Home Health Payment: Reduce limits to 112 percent of the median, effective for cost reporting periods beginning 7/1/96. Effective for cost reporting periods beginning 7/1/97, reduce limits to 100 percent of the median. Full updates would apply for 7/1/96 and 7/1/97. HCFA would expand research on a PPS system for HHAs which would tie prospective payments to an episode of care.

Effective 7/1/97, implement an interim TEFRA-like system of limits. That is, an agency-specific limitation on annual cost per beneficiary would be superimposed over the existing limitations on cost per visit. Payment would be based on the lower of: (a) allowable costs per visit, (b) a per visit limitation based on 100 percent of the median, or (c) the agency-specific per beneficiary limitation. New providers would be subject to a regional or national per-beneficiary limitation. Expenditures for beneficiaries who use services furnished by more than one agency would be pro-rated among the agencies.

HCFA would report to Congress, by 4/1/99, on a full home health PPS per episode system for implementation in FY 2000. In designing the system, HCFA would consider the following features:

- + Rates under the system would be 15 percent less than those that would occur under FY 2000 Medicare expenditures for home health services.
- + All services currently covered and paid under the Medicare home health benefit and medical supplies would be subject to the per episode payment. In defining an episode of care, the Secretary would consider: an appropriate length of time for an episode; the use of services and the number of visits provided within an episode; potential changes in the mix of services provided within an episode; and, generally, a system design that will provide for continued access to quality services. The per episode payment amount will be based on the most current settled cost report data available to the Secretary.
- + The Secretary would conduct research to identify an appropriate case mix adjuster for a national PPS. When a case mix adjuster is developed that explains a significant amount of the variation in cost, the Secretary would have authority to incorporate the case mix adjustment methodology into the PPS.
- + The Secretary would be authorized to make appropriate adjustments including for geographic differences in wages and rates would be updated by an appropriate update factor. The episode payment amount would be adjusted annually by the HHA market basket index. The labor portion of the episode amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.
- + The Secretary would have the authority to designate a payment provision for outliers recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.
- + An HHA would be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to another HHA within an episode period, the episode payment would be pro-rated between the HHAs.
- o Eliminate HH PIP Payments: Eliminate PIP payments for Home Health Agencies beginning with FY 1996.
- o Home Health Pay on Location of Service: Pay for home health services based on the zip code of the location of where the service is rendered rather than where the service is billed, beginning with FY 1996.
- o SNF Prospective Payment: Implement a prospective payment system for Part A SNF services for cost reporting periods beginning on or after October 1, 1996. The system would be budget neutral with respect to FY 1996 Medicare expenditures for SNF services.

Under the interim system, routine costs would be paid at a facility-specific prospective rate, subject to regional limits. Regional cost limits would be based on 9 Census Divisions and by urban/rural location. Costs in a base year would be examined for each facility and the lesser of the facility's cost or regional limit will be trended forward to the first effective period of PPS. Facility-specific rates and regional limits would be updated by market basket each year. Savings would be generated from establishing regional limits using data only from freestanding SNFs and eliminating new cost limit exceptions and new provider exemptions. Hospital-based SNFs and low volume facilities currently paid under a special PPS system would be granted a hold harmless provision for an interim period.

Capital and ancillary costs would be paid at cost, as in the current system. New providers would be paid at the regional limits.

- o Salary Equivalency Guidelines: Effective January 1, 1996, through a legislative proposal, establish salary equivalency guidelines for Medicare payment of speech-language pathology and occupational therapy services and revise existing salary equivalency guidelines for physical therapy and respiratory therapy. These guidelines would determine the maximum Medicare payment for these services.
- o MSP Insuror Reporting: Require all third party payers, including insurers, TPAs, other plan fiduciaries and employers who have self-administered group health plans to gather information as may be prescribed by the Secretary for the purpose of identifying MSP situations, determine primary or secondary payment status to Medicare in accordance with the information gathered and rules promulgated by the Secretary, and report the results of those determinations to the Secretary in the manner and form prescribed by the Secretary. The Secretary could impose a civil money penalty up to \$1,000 per instance where the third party payer failed to report timely and accurate information with regard to any Medicare beneficiary. Effective January 1, 1996.
- o MSP Court Case Fix: Medicare MSP policy would be reformed and clarified, effective 1/1/96, by four proposals that improve the Secretary's ability to recover mistaken primary payments, and mitigate the impact of the decision of the Circuit Court.
 - + Clarify that Medicare may recover mistaken primary payments from a third party payer without regard to procedural contract limitations, such as claims filing limitations, imposed by the third party payer.
 - + Clarify that entities from which Medicare may recover include insurers, TPAs that make payments on behalf of insurance plans, and other plan fiduciaries. These entities may seek to recover the repayment to Medicare from the plan, employer or other party, as may be appropriate.

- + Specify that if a third party payer did not make a primary payment in full when required to do so, the third party payer or other entity from which Medicare may recover must repay Medicare the lesser of the amount Medicare paid or the third party payer's full primary payment obligation if the plan can prove that it did not know and could not have reasonably been expected to have known that it was the proper primary payer for services provided to the Medicare beneficiary.

Require the third party payer or other entity to advise Medicare of the following, if it made a full primary payment: the party (if any) that had submitted the claim, the party paid, the date paid, the amount paid, and an explanation of how the payment amount was determined.

Require entities that receive duplicate Medicare and third party payer primary payments to repay to Medicare the full Medicare payment received, plus interest. Unless the sum due to Medicare was repaid within 60 days of the receipt of the later duplicate payment from either Medicare or the third party payer, interest would accrue from the date of the Medicare payment.

- + If an employer or other plan sponsor took into account the Medicare entitlement of the individual and did not provide coverage to the beneficiary, the employer or other plan sponsor must repay Medicare twice the amount that Medicare paid for all services provided to the Medicare beneficiary during the period that group health plan coverage was not afforded.

Further, if an entity billed both Medicare and the third party payer, or knew that both had been billed, the entity would be required to repay double the amount that Medicare paid, plus applicable interest on this amount.

Part B

- o 1996 Physician Update: Freeze the 1996 physician update except for primary care services.
- o MVPS Upward Bias: Beginning with the FY 1996 MVPS, eliminate the inconsistency in the way performance adjustments to the update are passed through to the MVPS for the relevant fiscal year. Both upward and downward adjustments would pass-through to the current year's MVPS the full amount of the performance adjustment. Eliminate the current 5 percentage point floor on maximum reductions in updates due to physicians' performance relative to the prior MVPS.

- o Single Fee for Surgery: Effective 1/1/96, make the same payment to primary surgeons who do and do not use assistants-at-surgery in those cases when Medicare makes a separate payment (i.e., in cases where a physician, physician assistant, nurse practitioner or clinical nurse specialist is used). The Medicare payment for the primary surgeon would be reduced by the amount of the payment for the assistant-at-surgery used by the surgeon. Exceptions would be created for specific procedures or situations specified by the Secretary where separate payments would be made.
- o Reduce Overhead Payments: Implement another increment in the OBRA-93 reduction of practice expense relative value units. In 1997, practice expenses relative value units would be reduced for the same set of services reduced by OBRA-1993. The amount of the reduction in 1997 would be by the amount of the 1994, 1995 and 1996 reductions and the floor on reductions would be reduced from 128 percent to 115 percent.
- o No Urban HPSA Specialty Bonus: Eliminate current 10 percent payment bonus for non-primary care services furnished in urban Health Professional Shortage Areas (HPSAs), effective 1/1/96.
- o OPD Payment Reform: Effective with FY 1997, (a) eliminate formula driven overpayments (FDO) from calculation of blended payment amounts for radiology, diagnostic tests and ambulatory surgery services furnished in hospital outpatient departments; (b) implement a prospective payment system for certain services, and (c) set beneficiary coinsurance at specified percentages of the prospective rate.
- o Establish Part B Floors and Ceilings: Beginning in 1996, establish national floors and ceilings on the Part B portion of the AAPCC rates. The ceiling would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC. Counties whose Part B AAPCC is above 150 percent of 95 percent of the Part B USPCC would be limited to that amount. The floor would not be phased-in. Counties whose Part B AAPCC is below 80 percent of 95 percent of the Part B USPCC would be increased to that amount.
- o Competitive Bid for Selected Part B Items and Services: The Secretary would be required to contract competitively for Medicare services and supplies in a geographic area. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient amount of the item or service. The initial items for competitive procurement are: oxygen and oxygen equipment; enteral and parenteral nutrients, supplies and equipment; and MRIs and CT scans. The Secretary would be authorized to add other items in the future as appropriate.

If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price levels that would occur in CY 1997, then the Secretary would reduce Medicare fees for these selected services by the difference needed to result in a 10 percent price discount from CY 1997 levels, effective 1/1/97. Authorization to put the competitive system into place would start on enactment.

- o Competitive Bid for Laboratory Services: The Secretary would be required to establish the same kind of competitive acquisition system for Medicare clinical diagnostic laboratory services as for other selected Part B items and services.

If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services from the price levels that would occur in CY 1997, then the Secretary would reduce Medicare fees for lab services by the difference needed to result in a 10 percent price discount from CY 1997 levels, effective 1/1/97. Authorization to put the competitive system into place would start on enactment.

- o Profile Lab Tests: Effective 1/1/96, include additional chemistry tests that are commonly performed on automated laboratory equipment as part of current automated panel test. These tests are currently excluded from panel test pricing and paid as if the test were not performed on less expensive automated equipment.
- o Simplify Inherent Reasonableness Authority: Simplify the inherent reasonableness authority to allow it to be implemented in a more flexible fashion, effective 1/1/96. This would apply to both national and carrier applications of inherent reasonableness. This proposal would eliminate some of the requirements that the Secretary and carriers must prove before being able to implement inherent reasonableness.
- o Implement Physician Rebundling Controls: Effective 1/1/96, implement, through administrative procedures, physician rebundling controls developed through a contract with Administar. These controls specific which services are not separately payable when billed on the same day for the same beneficiary.

Waive Cost-Sharing for Mammography

- o Effective 1/1/97, waive Medicare Part B deductible and coinsurance for screening and diagnostic mammography services.

Medicare Respite Benefit for Beneficiaries with Alzheimer's Disease

- o Effective with FY 1996, a Medicare respite benefit would be established for beneficiaries with Alzheimer's disease or other irreversible dementia. The benefit would cover up to five days of care in a calendar year. Services could be provided in the home, or in a Medicare-certified hospital or nursing facility.

Republican Medicare Proposals — Option 2
(Dollars in billions, fiscal years)

	96-00	96-02	96-05
EXTENDERS:			
PART A			
Medicare Secondary Payer	2.070	5.170	11.720
SNF Freeze Extension	1.280	1.980	3.200
Home Health Freeze Extension	1.550	2.520	4.210
PART B			
Medicare Secondary Payer	0.900	2.450	6.240
Part B Premium	4.095	18.365	57.650
Part B Interactions	-0.090	-0.210	-0.670
Total Extenders	9.835	28.265	82.350
PART A PROPOSALS			
Hospitals			
Reduce Hospital PPS Update MB-1.5% (FY 1997-2005)	10.770	25.780	63.140
Extend PPS Capital Reduction from OBRA 1990	6.140	9.330	14.820
Reduce PPS-Exempt Update (MB-1% & MB-2%, 1998-2005)	1.150	2.830	7.740
Reduce PPS-Exempt Capital Payments	1.010	1.590	2.610
Moratorium on Long-Term Care Hospitals	0.390	0.820	1.840
Expand Centers of Excellence	0.160	0.230	0.360
GME Reform	2.810	5.285	10.985
Reduce Medicare DSH Payments by 25%	5.180	5.410	14.200
Eliminate Add-One for Outliers	2.850	4.380	7.190
PPS Redefined Discharges	1.030	1.640	2.780
Eliminate Overpayment Waivers	0.050	0.075	0.120
Home Health and SNF			
Home Health Prospective Payment	3.540	8.885	18.585
SNF Prospective Payment	1.340	2.580	4.720
Eliminate HH PIP	1.090	1.230	1.480
Home Health Pay on Location of Service	1.340	2.000	3.170
Therapy Guidelines	2.050	3.110	4.650
Medicare Secondary Payer (Part A)			
Insurer Reporting and Court Case Fix	1.100	1.775	3.005
Part A Interactions			
	0.000	0.000	0.000
TOTAL PART A	41.980	79.950	181.545
TOTAL PART A (Including Extenders)	48.880	89.820	180.875
PART B PROPOSALS			
Physicians			
Freeze Physician Fees in 1996 (not primary care)	1.030	1.810	2.690
Eliminate MVPS Upward Bias	1.480	6.150	21.930
Single Fee For Surgery	0.570	0.910	1.540
Eliminate Urban HPSA Bonus	0.190	0.300	0.500
Reduce Overhead Payments	0.330	0.560	0.980
Hospital Outpatient Departments			
OPDs: Payment Reform	4.040	8.470	33.255
HMOs			
Impose floors & ceilings	0.835	1.205	2.205
Medicare Secondary Payer (Part B)			
Insurer Reporting and Court Case Fix	0.860	1.440	2.660
Other Providers			
Competitive Bidding for Labs	1.130	1.950	3.520
Competitive Bidding for Part B Services	0.720	1.210	2.120
Profile Lab Tests	0.810	1.290	2.220
Simplify Inherent Reasonableness	0.190	0.290	0.480
Implement Physician Rebundling Controls	0.890	1.110	1.935
Eliminate Overpayment Waiver	0.055	0.085	0.135
Expand Centers of Excellence	0.110	0.170	0.280
Part B Interactions			
	-3.410	-7.000	-19.575
TOTAL PART B	9.430	19.750	58.855
TOTAL PART B (Including Extenders)	14.365	38.345	120.075
TOTAL SAVINGS			
	51.410	99.700	218.400
TOTAL SAVINGS (Including Extenders)	61.245	127.965	300.750

Part A

- o **Reduce Hospital PPS Update:** Reduce the hospital market basket by 1.5 percentage point each year between FY 1997 and FY 2005 (the FY 1997 reduction is 0.5 percentage points above current law).
- o **Extend PPS Capital Reduction from OBRA-90:** Permanently capture the savings from the OBRA-90 payment reduction on an ongoing basis by giving the full update to the rates in effect at the end of OBRA-90 provision (9/30/95). Effective 10/1/95.
- o **GME Reform:** Medicare GME policy would be reformed by:
 - + Freezing the total number and the number of non-primary care residency positions that would be reimbursed under Medicare, at a hospital-specific level, effective 10/1/95 for IME and 7/1/96 for GME (base period for GME is 7/1/95-6/30/96).
 - + Extending the OBRA-93 freeze on updates for non-primary care residents for an additional 5-years through FY 2000, effective 7/1/96.
 - + Counting residents beyond their initial residency periods as 0.5 FTEs for IME (as currently done for GME), effective 10/1/95.
 - + Counting work in non-hospital settings for IME (as long as there is no increase in the hospital's resident-to-bed ratio), effective 7/1/96.
 - + Allowing GME payments to non-hospitals for primary care residents in non-hospital settings, when a hospital is not paying for the resident's salary in that setting, effective 7/1/96.
 - + Capping hospital-specific GME payments at 140 percent of the national average per resident amount, effective 7/1/96.
- o **Reduce Medicare DSH:** Reduce the current Medicare disproportionate share adjustment for PPS hospitals by 25 percent effective with FY 1997. The formula for DSH payments would be reestablished to target more precisely those hospitals which serve disproportionate shares of low income patients.
- o **Eliminate Add-Ons For Outliers:** Eliminate IME and DSH payments for outlier cases, effective with discharges beginning with FY 1996.
- o **Reduce PPS Payments for Redefined Discharges:** Redefine transfers from PPS to non-PPS facilities as discharges, effective 10/1/95.

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- o Long-Term Care Hospital Moratorium: Prohibit new long-term care hospitals from being excluded from PPS, effective upon enactment (assumed to be 10/1/95).
- o Reduce PPS-Exempt Update: Reduce the update for PPS-exempt hospitals by 1.0 percentage points each year between FY 1996 and FY 2005. Starting in FY 1996, rebase target amounts for hospitals and distinct part units excluded from PPS, limit target amounts to 150 percent of national average, eliminate bonus payments and shared-risk payments.
- o Reduce PPS-Exempt Capital Payments: Pay 85 percent of capital costs for hospitals and hospital units excluded from PPS for fiscal years 1996 through 2005.
- o Eliminate Overpayment Waiver: Do not relieve providers of services of liability for refunding an overpayment because they are found to be without fault for the overpayment, unless the overpayment was discovered subsequent to the third calendar year after the year of payment. The waiver provisions for any overpayment to the beneficiary would be maintained. Effective FY 1996.
- o Centers of Excellence: Expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so a Medicare rebate to the beneficiary equal to 10 percent of the government's savings from the center. Effective 10/1/96.
- o Home Health Payment: Reduce limits to 112 percent of the median, effective for cost reporting periods beginning 7/1/96. Effective for cost reporting periods beginning 7/1/97, reduce limits to 100 percent of the median. Full updates would apply for 7/1/96 and 7/1/97. HCFA would expand research on a PPS system for HHAs which would tie prospective payments to an episode of care.

Effective 7/1/97, implement an interim TEFRA-like system of limits. That is, an agency-specific limitation on annual cost per beneficiary would be superimposed over the existing limitations on cost per visit. Payment would be based on the lower of: (a) allowable costs per visit, (b) a per visit limitation based on 100 percent of the median, or (c) the agency-specific per beneficiary limitation. New providers would be subject to a regional or national per-beneficiary limitation. Expenditures for beneficiaries who use services furnished by more than one agency would be pro-rated among the agencies.

HCFA would report to Congress, by 4/1/99, on a full home health PPS per episode system for implementation in FY 2000. In designing the system, HCFA would consider the following features:

- + Rates under the system would be 15 percent less than those that would occur under FY 2000 Medicare expenditures for home health services.
- + All services currently covered and paid under the Medicare home health benefit and medical supplies would be subject to the per episode payment. In defining an episode of care, the Secretary would consider: an appropriate length of time for an episode; the use of services and the number of visits provided within an episode; potential changes in the mix of services provided within an episode; and, generally, a system design that will provide for continued access to quality services. The per episode payment amount will be based on the most current settled cost report data available to the Secretary.
- + The Secretary would conduct research to identify an appropriate case mix adjuster for a national PPS. When a case mix adjuster is developed that explains a significant amount of the variation in cost, the Secretary would have authority to incorporate the case mix adjustment methodology into the PPS.
- + The Secretary would be authorized to make appropriate adjustments including for geographic differences in wages and rates would be updated by an appropriate update factor. The episode payment amount would be adjusted annually by the HHA market basket index. The labor portion of the episode amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.
- + The Secretary would have the authority to designate a payment provision for outliers recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.
- + An HHA would be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to another HHA within an episode period, the episode payment would be pro-rated between the HHAs.
- o Eliminate HH PIP Payments: Eliminate PIP payments for Home Health Agencies beginning with FY 1996.
- o Home Health Pay on Location of Service: Pay for home health services based on the zip code of the location of where the service is rendered rather than where the service is billed, beginning with FY 1996.
- o SNF Prospective Payment: Implement a prospective payment system for Part A SNF services for cost reporting periods beginning on or after October 1, 1996. The system would be budget neutral with respect to FY 1996 Medicare expenditures for SNF services.

Under the interim system, routine costs would be paid at a facility-specific prospective rate, subject to regional limits. Regional cost limits would be based on 9 Census Divisions and by urban/rural location. Costs in a base year would be examined for each facility and the lesser of the facility's cost or regional limit will be trended forward to the first effective period of PPS. Facility-specific rates and regional limits would be updated by market basket each year. Savings would be generated from establishing regional limits using data only from freestanding SNFs and eliminating new cost limit exceptions and new provider exemptions. Hospital-based SNFs and low volume facilities currently paid under a special PPS system would be granted a hold harmless provision for an interim period.

Capital and ancillary costs would be paid at cost, as in the current system. New providers would be paid at the regional limits.

- o Salary Equivalency Guidelines: Effective January 1, 1996, through a legislative proposal, establish salary equivalency guidelines for Medicare payment of speech-language pathology and occupational therapy services and revise existing salary equivalency guidelines for physical therapy and respiratory therapy. These guidelines would determine the maximum Medicare payment for these services.
- o MSP Insuror Reporting: Require all third party payers, including insurers, TPAs, other plan fiduciaries and employers who have self-administered group health plans to gather information as may be prescribed by the Secretary for the purpose of identifying MSP situations, determine primary or secondary payment status to Medicare in accordance with the information gathered and rules promulgated by the Secretary, and report the results of those determinations to the Secretary in the manner and form prescribed by the Secretary. The Secretary could impose a civil money penalty up to \$1,000 per instance where the third party payer failed to report timely and accurate information with regard to any Medicare beneficiary. Effective January 1, 1996.
- o MSP Court Case Fix: Medicare MSP policy would be reformed and clarified, effective 1/1/96, by four proposals that improve the Secretary's ability to recover mistaken primary payments, and mitigate the impact of the decision of the Circuit Court.
 - + Clarify that Medicare may recover mistaken primary payments from a third party payer without regard to procedural contract limitations, such as claims filing limitations, imposed by the third party payer.
 - + Clarify that entities from which Medicare may recover include insurers, TPAs that make payments on behalf of insurance plans, and other plan fiduciaries. These entities may seek to recover the repayment to Medicare from the plan, employer or other party, as may be appropriate.

- + Specify that if a third party payer did not make a primary payment in full when required to do so, the third party payer or other entity from which Medicare may recover must repay Medicare the lesser of the amount Medicare paid or the third party payer's full primary payment obligation if the plan can prove that it did not know and could not have reasonably been expected to have known that it was the proper primary payer for services provided to the Medicare beneficiary.

Require the third party payer or other entity to advise Medicare of the following, if it made a full primary payment: the party (if any) that had submitted the claim, the party paid, the date paid, the amount paid, and an explanation of how the payment amount was determined.

Require entities that receive duplicate Medicare and third party payer primary payments to repay to Medicare the full Medicare payment received, plus interest. Unless the sum due to Medicare was repaid within 60 days of the receipt of the later duplicate payment from either Medicare or the third party payer, interest would accrue from the date of the Medicare payment.

- + If an employer or other plan sponsor took into account the Medicare entitlement of the individual and did not provide coverage to the beneficiary, the employer or other plan sponsor must repay Medicare twice the amount that Medicare paid for all services provided to the Medicare beneficiary during the period that group health plan coverage was not afforded.

Further, if an entity billed both Medicare and the third party payer, or knew that both had been billed, the entity would be required to repay double the amount that Medicare paid, plus applicable interest on this amount.

Part B

- o **1996 Physician Update:** Freeze the 1996 physician update except for primary care services.
- o **MVPS Upward Bias:** Beginning with the FY 1996 MVPS, eliminate the inconsistency in the way performance adjustments to the update are passed through to the MVPS for the relevant fiscal year. Both upward and downward adjustments would pass-through to the current year's MVPS the full amount of the performance adjustment. Eliminate the current 5 percentage point floor on maximum reductions in updates due to physicians' performance relative to the prior MVPS.

- o Single Fee for Surgery: Effective 1/1/96, make the same payment to primary surgeons who do and do not use assistants-at-surgery in those cases when Medicare makes a separate payment (i.e., in cases where a physician, physician assistant, nurse practitioner or clinical nurse specialist is used). The Medicare payment for the primary surgeon would be reduced by the amount of the payment for the assistant-at-surgery used by the surgeon. Exceptions would be created for specific procedures or situations specified by the Secretary where separate payments would be made.
- o Reduce Overhead Payments: Implement another increment in the OBRA-93 reduction of practice expense relative value units. In 1997, practice expenses relative value units would be reduced for the same set of services reduced by OBRA-1993. The amount of the reduction in 1997 would be by the amount of the 1994, 1995 and 1996 reductions and the floor on reductions would be reduced from 128 percent to 115 percent.
- o No Urban HPSA Specialty Bonus: Eliminate current 10 percent payment bonus for non-primary care services furnished in urban Health Professional Shortage Areas (HPSAs), effective 1/1/96.
- o OPD Payment Reform: Effective with FY 1997, (a) eliminate formula driven overpayments (FDO) from calculation of blended payment amounts for radiology, diagnostic tests and ambulatory surgery services furnished in hospital outpatient departments; (b) implement a prospective payment system for certain services, and (c) set beneficiary coinsurance at specified percentages of the prospective rate.
- o Establish Part B Floors and Ceilings: Beginning in 1996, establish national floors and ceilings on the Part B portion of the AAPCC rates. The ceiling would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC. Counties whose Part B AAPCC is above 150 percent of 95 percent of the Part B USPCC would be limited to that amount. The floor would not be phased-in. Counties whose Part B AAPCC is below 80 percent of 95 percent of the Part B USPCC would be increased to that amount.
- o Competitive Bid for Selected Part B Items and Services: The Secretary would be required to contract competitively for Medicare services and supplies in a geographic area. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient amount of the item or service. The initial items for competitive procurement are: oxygen and oxygen equipment; enteral and parenteral nutrients, supplies and equipment; and MRIs and CT scans. The Secretary would be authorized to add other items in the future as appropriate.

If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price levels that would occur in CY 1997, then the Secretary would reduce Medicare fees for these selected services by the difference needed to result in a 10 percent price discount from CY 1997 levels, effective 1/1/97. Authorization to put the competitive system into place would start on enactment.

- o Competitive Bid for Laboratory Services: The Secretary would be required to establish the same kind of competitive acquisition system for Medicare clinical diagnostic laboratory services as for other selected Part B items and services.

If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services from the price levels that would occur in CY 1997, then the Secretary would reduce Medicare fees for lab services by the difference needed to result in a 10 percent price discount from CY 1997 levels, effective 1/1/97. Authorization to put the competitive system into place would start on enactment.

- o Profile Lab Tests: Effective 1/1/96, include additional chemistry tests that are commonly performed on automated laboratory equipment as part of current automated panel test. These tests are currently excluded from panel test pricing and paid as if the test were not performed on less expensive automated equipment.
- o Simplify Inherent Reasonableness Authority: Simplify the inherent reasonableness authority to allow it to be implemented in a more flexible fashion, effective 1/1/96. This would apply to both national and carrier applications of inherent reasonableness. This proposal would eliminate some of the requirements that the Secretary and carriers must prove before being able to implement inherent reasonableness.
- o Implement Physician Rebundling Controls: Effective 1/1/96, implement, through administrative procedures, physician rebundling controls developed through a contract with Administar. These controls specific which services are not separately payable when billed on the same day for the same beneficiary.

Waive Cost-Sharing for Mammography

- o Effective 1/1/97, waive Medicare Part B deductible and coinsurance for screening and diagnostic mammography services.

Medicare Respite Benefit for Beneficiaries with Alzheimer's Disease

- o Effective with FY 1996, a Medicare respite benefit would be established for beneficiaries with Alzheimer's disease or other irreversible dementia. The benefit would cover up to five days of care in a calendar year. Services could be provided in the home, or in a Medicare-certified hospital or nursing facility.

Potential Adjustments to Part A Savers -- Option 1

	<u>FY 1996-</u> <u>FY 2000</u>	<u>FY 1996-</u> <u>FY 2002</u>	<u>FY 1996-</u> <u>FY 2005</u>
Drop AAPCC Proposal	-\$6.260	-\$11.740	-\$23.220
Interaction (delta)	1.540	2.860	5.360
Drop HH PPS FY99 20% cut	-3.840	-8.420	-16.360
*Revised HH PPS	3.540	8.885	18.585
Add PPS: MB-1 (03-05)	0.000	0.000	6.110
Reprice PPS-Exempt (delta)	0.995	2.305	5.045
Add PPS-Exempt MB-1 (03-05)	0.000	0.000	1.400
Reprice SNF PPS (delta)	0.610	1.080	1.890
IME Effective 7/1/98 (delta)	1.650	1.730	1.730
Add Therapy Guidelines	2.050	3.110	4.850
Total	\$0.285	-\$0.190	\$5.390

* Preliminary.

Potential Adjustments Part B Savers

Implement MD Bundling Controls	\$0.690	\$1.110	\$1.935
More OPD Coinsurance Buydown	-0.690	-1.110	-1.935
Total	\$0.000	\$0.000	\$0.000

Potential Adjustments to Part A Savers -- Option 2 *

	<u>FY 1996-</u> <u>FY 2000</u>	<u>FY 1996-</u> <u>FY 2002</u>	<u>FY 1996-</u> <u>FY 2005</u>
Drop AAPCC Proposal	-\$6.260	-\$11.740	-\$23.220
Drop IME (i.e., no cut)	-1.950	-7.070	-17.030
Interaction (delta)	1.730	3.440	7.030
Drop HH PPS FY99 20% cut	-3.840	-8.420	-16.360
**Revised HH PPS	3.540	8.885	18.585
Add PPS: MB-1 (03-05)	0.000	0.000	6.110
PPS (-1 to -1.5, 97-05)	3.700	8.700	21.150
Reprice PPS-Exempt (delta)	0.995	2.305	5.045
Add PPS-Exempt MB-1 (03-05)	0.000	0.000	1.400
Reprice SNF PPS (delta)	0.610	1.080	1.890
Add Therapy Guidelines	2.050	3.110	4.850
Total	\$0.575	\$0.290	\$9.450

* Relative to Current package

** Preliminary.

Potential Adjustments Part B Savers

Implement MD Bundling Controls	\$0.690	\$1.110	\$1.935
More OPD Coinsurance Buydown	-0.690	-1.110	-1.935
Total	\$0.000	\$0.000	\$0.000

Administration
Medicare
Numbers

9/19/95

Republican Medicare Proposals -- Changes

- o Add remove IME, GME and DSH from the AAPCC, effective with FY 1997, and subject to a cap equal to 75 percent of the net savings (net of interaction), make payments to teaching and DSH hospitals and HMOs.
- o Reduce DSH reduction from 25 percent to 10 percent, effective with FY 1997.
- o Increase reduction in hospital market basket by 0.15 percentage points per year from FY 1997 to FY 2005.

	<u>FY 1996-</u> <u>FY 2000</u>	<u>FY 1996-</u> <u>FY 2002</u>	<u>FY 1996-</u> <u>FY 2005</u>
AAPCC Remove IME, DSH, GME and 75% give-back (net budget savings)	\$1.183	\$2.223	\$4.468
DSH @10% (vs. 25%) (Delta)	-3.096	-5.046	-8.520
Market basket (delta 0.15%/yr)	1.110	2.610	6.435
Net Change	-\$0.803	-\$0.213	\$2.383

File Medicare Growth #2

MEDICARE PROPSALS & GROWTH RATES
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02
CBO MEDICARE BASELINE													
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.9%	10.1%	9.7%	9.6%
<i>Per Capita Growth</i>												8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%
<i>Per Capita Growth</i>												8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)													
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9	331.4	358.8	387.2		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	8.7%	8.3%	7.9%	7.8%	7.7%
<i>Per Capita Growth</i>												6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8	299.8	325.6	352.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	9.1%	8.6%	8.4%	7.9%	7.8%
<i>Per Capita Growth</i>												6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-48	-58	-71	-58	-130
Budget Resolution Medicare Proposal (CBO Baseline)													
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274	291	309	328		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%
<i>Per Capita Growth</i>												4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	5.5%	6.1%
<i>Per Capita Growth</i>												4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130	-139	-270
CBO PRIVATE GROWTH RATES													
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	6.9%	6.6%	6.4%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	6.6%	6.5%	6.2%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

MEDICARE PROPSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02
CBO MEDICARE BASELINE													
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.9%	10.1%	9.7%	9.6%
<i>Per Capita Growth</i>												8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	288.5	315.2	347.3	383.2	423.9		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%
<i>Per Capita Growth</i>												8.4%	8.5%
Administration Medicare Proposal (CBO Baseline: Administration savings estimates)													
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0	334.1	362.5	392.4		
<i>Aggregate Growth</i>		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	8.8%	8.5%	8.2%	7.9%	7.8%
<i>Per Capita Growth</i>												6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9	302.5	329.3	358.0		
<i>Aggregate Growth</i>		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	9.2%	8.9%	8.7%	8.0%	7.9%
<i>Per Capita Growth</i>												6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66	-56	-124
Budget Resolution Medicare Proposal (CBO Baseline)													
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<i>Per Capita Growth</i>												4.4%	4.9%
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07-Aug-95

MEDICARE PROPSALS & GROWTH RATES

(Dollars in billions, fiscal years)

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07-Aug-95

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<i>Aggregate Growth</i>		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	8.8%	8.5%	8.2%	7.9%	7.8%
<i>Per Capita Growth</i>												6.5%	6.4%
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<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%
<i>Per Capita Growth</i>												4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	5.5%	6.1%
<i>Per Capita Growth</i>												4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130	-139	-270
CBO PRIVATE GROWTH RATES													
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	6.9%	6.6%	6.4%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	6.6%	6.5%	6.2%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

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These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

07-Aug-95

June 28, 1996



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Nancy-Ann Min

Through:

Barry Clendenin *BC*

Mark Miller *BM*

Decision needed	<input checked="" type="checkbox"/>
Please sign	<input type="checkbox"/>
Per your request	<input type="checkbox"/>
Please comment	<input type="checkbox"/>
For your information	<input type="checkbox"/>

Subject:

~~Chris~~ Jennings request re: Medicare and Medicaid spending, savings, and growth rates

With informational copies for:
HD Chron, HFB Chron

From:

Bob *BD* Donnelly and Bonnie *BO* Washington

Phone: 202/395-4930
Fax: 202/395-7840

E-mail: donnelly_r@a1.eop.gov
Room: #7002

The attached tables respond to a new request from Chris Jennings. These tables show Medicare spending, savings, and growth rates for CBO's April baseline, the President's FY 1997 Budget, and the Conference Agreement (as the Majority is likely to present the per-capita numbers). In addition, we have included spending, savings, and growth rates for the Conference Agreement as determined using the methodology in Option 2 in yesterday's growth rate memo (i.e. assuming a distribution of GME Trust Fund spending in the Conference Agreement that is the same as in the Senate version of the Budget Resolution) because we have not yet received guidance on how to estimate these numbers.

We have also attached a table showing Medicaid spending, savings, and growth rates for CBO's baseline, the President's plan, and the Medicaid Restructuring Act of 1996.

If these tables are acceptable, please forward the attached copy to Chris Jennings.

The growth rate into you requested.

Attachment

Medicare: Comparison of POTUS and Congressional Offers From CBO April Baseline

(Outlays by fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	Total 1997-2002	Average Annual Growth 1995-2002	Average Annual Growth 1996-2002
CBO April Baseline											
Medicare, Net Mandatory Outlays											
CBO April Baseline	156.9	176.1	194.9	213.8	233.4	254.4	277.0	301.2	1,474.7	9.8%	9.4%
<i>Growth</i>	—	12.2%	10.7%	9.7%	9.2%	9.0%	8.9%	8.7%			
CBO April Baseline Per-bene	\$ 4,252	\$ 4,696	\$ 5,115	\$ 5,539	\$ 5,969	\$ 6,441	\$ 6,925	\$ 7,419		8.3%	7.9%
<i>Growth</i>	—	10.4%	8.9%	8.3%	7.8%	7.9%	7.5%	7.1%			
POTUS Savings	-	0.50	(6.20)	(9.00)	(15.90)	(22.40)	(28.90)	(34.20)	(116.6)		
POTUS Proposed	156.9	176.6	188.7	204.8	217.5	232.0	248.1	267.0	1,358.1	7.9%	7.1%
<i>Growth</i>	—	12.6%	6.9%	8.5%	6.2%	6.7%	6.9%	7.6%			
POTUS Per-bene	\$ 4,252	\$ 4,709	\$ 4,953	\$ 5,306	\$ 5,563	\$ 5,873	\$ 6,203	\$ 6,576		6.4%	5.7%
<i>Growth</i>	—	10.8%	5.2%	7.1%	4.8%	5.6%	5.6%	6.0%			
GOP Claimed Conference Savings 1/	-	-	(6.8)	(11.0)	(20.5)	(28.4)	(38.4)	(52.8)	(158.0)		
GOP Claimed Conference Baseline	156.9	176.1	188.1	202.8	212.9	226.0	238.6	248.4	1,316.7	6.8%	5.9%
<i>Growth</i>	—	12.2%									
GOP Claimed Conference Per-bene 2/	\$ 4,252	\$ 4,700	\$ 4,938	\$ 5,254	\$ 5,446	\$ 5,720	\$ 5,964	\$ 6,200		5.5%	4.7%
<i>Growth</i>	—	10.5%	5.1%	6.4%	3.7%	5.0%	4.3%	4.0%			
Conference (Option 2) Savings	-	-	-	-	-	-	-	(52.8)	(168.0)		
Conference (Option 2) Proposed	156.9	176.1	-	-	-	-	-	248.4	1,306.7	6.8%	5.9%
<i>Growth</i>	—	—	—	—	—	—	—	—			
Conference (Option 2) Per-bene	\$ 4,252	\$ 4,696	-	-	-	-	-	\$ 6,117		5.3%	4.5%
<i>Growth</i>	—	—	—	—	—	—	—	—			

1/ Conference Agreement savings are derived by subtracting baseline amounts from the mandatory spending shown on page 11 of the Conference Report. Savings amounts may not match totals shown in the Conference Report, probably due to rounding.

2/ Because the Majority does not discuss net spending, we have not seen these estimates yet, but we expect that they would "round" the per-capita numbers in this way to make the growth rate look better (even though rounding \$6,117 to \$6,200 is clearly wrong).

Medicare: Comparison of POTUS and Congressional Offers From CBO April Baseline

(Outlays by fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	Total 1997-2002	Average Annual Growth 1995-2002	Average Annual Growth 1996-2002
CBO April Baseline											
Medicare, Gross Mandatory Outlays											
CBO April Baseline	177.1	196.1	215.5	236.4	257.4	279.5	303.2	328.5	1,620.5	9.2%	9.0%
<i>Growth</i>	—	10.7%	9.9%	9.7%	8.9%	8.6%	8.5%	8.3%			
CBO April Baseline Per-bene	\$ 4,799	\$ 5,229	\$ 5,656	\$ 6,124	\$ 6,583	\$ 7,076	\$ 7,580	\$ 8,091		7.7%	7.5%
<i>Growth</i>	—	9.0%	8.2%	8.3%	7.5%	7.5%	7.1%	6.7%			
POTUS Savings	-	0.50	(6.30)	(9.40)	(16.00)	(21.60)	(27.00)	(30.80)	(111.1)		
POTUS Proposed	177.1	196.6	209.2	227.0	241.4	257.9	276.2	297.7	1,509.4	7.7%	7.2%
<i>Growth</i>	—	11.0%	6.4%	8.5%	6.3%	6.8%	7.1%	7.8%			
POTUS Per-bene	4,799.5	5,242.7	5,490.8	5,880.8	6,173.9	6,529.1	6,905.0	7,332.5		6.2%	5.8%
<i>Growth</i>	—	9.2%	4.7%	7.1%	5.0%	5.8%	5.8%	6.2%			
GOP Claimed Conference Savings 1/	-	-	(6.4)	-	-	-	-	(46.4)	(141.5)		
GOP Claimed Conference Baseline	177.1	196.1	209.1	-	-	-	-	282.1	1,479.0	6.9%	6.2%
<i>Growth</i>	—	10.7%	6.6%	-	-	-	-	-			
GOP Claimed Conference Per-bene 2/	4,799.5	5,200.0	5,488.2	-	-	-	-	7,000.0		5.5%	5.1%
<i>Growth</i>	—	8.3%	5.5%	-	-	-	-	-			
Conference (Option 2) Savings	-	-	-	-	-	-	-	(46.4)	(151.5)		
Conference (Option 2) Proposed	177.1	196.1	-	-	-	-	-	282.1	1,469.0	6.9%	6.2%
<i>Growth</i>	—	10.7%	-	-	-	-	-	-			
Conference (Option 2) Per-bene	\$ 4,799	\$ 5,229	-	-	-	-	-	\$ 6,948		5.4%	4.9%
<i>Growth</i>	—	9.0%	-	-	-	-	-	-			

1/ Conference Agreement spending in FYs 1997 and 2002, and for the period FY 1997-2002 taken from pages 22-23 of the Conference Report. Conference Agreement savings derived by subtracting baseline amounts from these spending levels.

2/ From page 23 of the Conference Agreement report. This appears to be the per-capita numbers calculated in Option 2, "rounded" to show a higher growth rate (even though rounding \$6,948 to \$7,000 is clearly wrong).

Medicaid: Comparison of President's and Congressional Offers
CBO March 1996 Baseline
(Dollars in Billions)

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	Total 1996 - 2002
<u>CBO March Baseline</u>									
Total Outlays	89.1	95.7	104.9	115.5	126.5	138.3	151.6	166.6	899.1
<i>Growth</i>		7.5%	9.5%	10.2%	9.5%	9.3%	9.7%	9.9%	9.7%
Per Capita	2,472	2,603	2,750	2,955	3,155	3,363	3,599	3,862	
<i>Growth</i>		5.3%	5.7%	7.5%	6.8%	6.6%	7.0%	7.3%	6.8%
<u>President's Plan</u> 1/									
Savings	0.0	0.0	1.7	-1.9	-5.8	-9.8	-16.2	-21.7	-53.7
Resulting Baseline	89.1	95.7	106.6	113.6	120.7	128.4	135.4	144.9	845.4
<i>Growth</i>		7.5%	11.3%	6.6%	6.2%	6.4%	5.4%	7.0%	7.2%
Resulting Per Capita	2,472	2,603	2,795	2,906	3,011	3,124	3,215	3,359	
<i>Growth</i>		5.3%	7.4%	4.0%	3.6%	3.8%	2.9%	4.5%	4.3%
<u>Republican 5/22 Bill</u> 2/									
Savings	0.0	0.0	1.8	-2.0	-7.3	-13.3	-20.6	-30.1	-71.5
Resulting Baseline	89.1	95.7	106.7	113.5	119.2	125.0	131.0	136.5	827.6
<i>Growth</i>		7.5%	11.4%	6.4%	5.0%	4.9%	4.9%	4.2%	6.1%
Resulting Per Capita	2,472	2,603	2,797	2,904	2,973	3,040	3,110	3,164	
<i>Growth</i>		5.3%	7.5%	3.8%	2.4%	2.2%	2.3%	1.7%	3.3%

1/ CBO 2/26/96 Scoring of President's Medicaid Plan net of VA and Medicare interactions

Per Capita Cap Growth Index: Nominal GDP + 2.71% in FY 96, +2.50% in FY 97, +1.00% in FYs 98-99, +0.50% in FYs 00-01, +0.00% in FY 02 and thereafter.

2/ CBO 5/31/96 Scoring of HR 3507 - Medicaid Restructuring Act

June 20, 1996



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Nancy-Ann Min.
Chris Jennings

Decision needed	___
Please sign	___
Per your request	<u>X</u>
Please comment	___
For your information	___

Through:

Barry Clendenin /BC
Mark Miller

Subject:

Response to Senate Budget Committee's
Statements About Medicare Savings

With informational copies for:
HD/HFB Chrons, BC

From:

Anne Mutti *AM*

Attached is HFB's response to the Senate Budget Bulletin's criticism of Laura Tyson's and Senator Daschle's remarks, as requested by Chris Jennings. We have also attached a copy of the May 15th CBO letter to Senator Domenici on the insolvency date of the HI trust fund as well as a copy of the June 10th *Budget Bulletin*.

Sarah

Did Pauline see this?

*Please show her, if not, & get
back original to me.*

Thanks

Pauline - FY97 -


Response to the June 10th Budget Bulletin's Statements About Medicare Savings

The *Budget Bulletin* disputes that nominal cuts in hospital payments will have to be made. It cites the fact that the Balanced Budget Act of 1995 included more Part A savings than this year's resolution and that allowed hospital nominal payment increases.

Response

The *Budget Bulletin* ignores the fact that the CBO baseline was recalculated downward in December, resulting in reduced savings for their Medicare proposals. Instead of scoring at \$270 billion (including approximately \$130 billion in Part A savings), the Republican proposal scored \$226 (including approximately \$114 billion in Part A savings). The FY 1997 Conference Agreement on the Budget Resolution included \$123 billion in Part A savings¹ -- higher than the \$114 billion in the repriced vetoed reconciliation bill. Secondly, these savings estimates were for a seven year time period. Their savings target now applies to a six year time period. Therefore, the Republicans would have had to increase the severity and/or number of their proposals to achieve the same level of Part A savings.

We have suggested that one possible way to achieve these additional savings would be to increase the market basket reduction higher than their proposal of 2 percent. Because the market basket increase is estimated to be 2.7 percent for FY 1997, a higher reduction could lead to nominal cuts in hospital payments.

The *Budget Bulletin* suggests that Senator Daschle was incorrect in asserting that the new conference agreement proposal "would require Medicare per person to grow at only 4.7 percent a year." The *Bulletin* notes that its growth rate is 5.1 percent.

Response:

Senator Daschle appears to be referring to the Medicare gross average annual growth rate in the Senate budget resolution. He made his remarks in a press conference on June 3rd, prior to the release of the conference agreement.

The *Bulletin's* claim of a 5.1 percent growth rate is correct when assuming that gross per capita spending is \$5,200 in 1996 and \$7,000 in 2002. These per capita spending amounts appear to be based on the rounded conference agreement, or possibly House budget resolution, savings stream. If the more precise savings stream is assumed for the conference agreement, the gross Medicare growth rate for 1996-2002 is 4.9 percent.

¹ The Conference Agreement states that its Part A savings are sufficient to extend the solvency of the HI trust fund for 10 years. CBO has estimated that \$123 billion in Part A savings would be required to meet that goal.



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

cc: MCR exs.
MM
mg: AM
June E. O'Neill
Director

May 15, 1996

Honorable Pete V. Domenici
Chairman
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office (CBO) has examined the solvency of the Hospital Insurance (HI) trust fund. Under current law, CBO projects that the trust fund will become insolvent in 2001.

CBO estimates that the Administration's Medicare proposal, including the transfer of certain spending for home health services to the Supplementary Medical Insurance (SMI) program, would postpone this date to 2005. Without the transfer, CBO estimates that the trust fund would become insolvent in 2002.

CBO has not estimated a specific proposal to achieve the Medicare savings specified in the Budget Resolution adopted by the Committee on May 9. However, legislation that produced the savings stream assumed in the resolution would postpone the insolvency of the HI trust fund until 2007.

Sincerely,

June E. O'Neill

cc: Honorable J. James Exon
Ranking Minority Member

MEMORANDUM

June 12, 1996

TO: Nancy-Ann Min
FR: Chris Jennings
RE: Medicare Numbers

The Senate Budget Committee has been criticizing Laura Tyson's comments that were largely based on information provided to us by OMB. If you could ask Mark Miller to review the attached numbers, it would be greatly appreciated.

Vets imp. of - Medicare/icaid



Budget Bulletin

Senate Budget Committee
Majority Staff

A Weekly Bulletin produced when the Senate is in session.
Pete V. Domenici - Chairman G. William Hoagland - Staff Director
202/224-6815 <http://www.senate.gov/comm/budget/releases/bulletin.htm>

104th Congress, 2nd Session: No. 18

June 10, 1996

INFORMED BUDGETEER

SUMMARY OF FY 1997 BUDGET CONFERENCE

- The conference agreement on the FY 1997 budget was filed on June 7. Aggregate figures are as follows:

	1997	1998	1999	2000	2001	2002	6-year total
Total spending:							
On Budget-							
BA	1315	1362	1392	1433	1454	1496	8453
OT	1311	1355	1384	1416	1432	1463	8361
Off Budget-							
BA	319	335	348	358	377	389	2125
OT	311	325	334	349	365	379	2063
Total-							
BA	1633	1697	1740	1792	1830	1885	10577
OT	1622	1679	1718	1765	1797	1842	10424
Revenues:							
On-budget	1084	1130	1177	1231	1291	1359	7272
Off-Budget	385	402	423	445	465	487	2608
Total	1469	1533	1601	1676	1756	1846	9880
Deficit/Surplus:							
On-Budget	227	224	206	185	142	103	NA
Off-Budget	-74	-78	-89	-96	-100	-108	NA
TOTAL	153	147	117	89	42	-5	NA

NOTE: Totals may not add due to rounding.

- The Conference Report establishes discretionary spending limits at the following levels:

	Defense		Non-Defense		Total	
	BA	OT	BA	OT	BA	OT
1997	266	265	231	274	497	539
1998	269	264	225	263	494	527
1999	272	267	220	258	491	525
2000	274	271	225	255	499	525
2001	277	270	214	246	491	516
2002	279	270	221	245	501	514

NOTE: Totals may not add due to rounding.

SOURCES OF GROWTH IN MANDATORY SPENDING

- CBO's recently released annual economic and budgetary report again exposes that it is mandatory spending growth which is driving the federal budget and increasing federal deficits.
- CBO projects overall federal revenues will increase from \$1,428 billion in 1996 to \$2,232 billion in 2006, an \$804 billion or 56% increase.
- Over the same period, mandatory spending is projected to increase \$780 billion or 89%, and consume nearly all of the revenue increase. In fact, mandatory spending plus net interest will be \$925 billion higher in 2006 than in 1996 or \$120 billion more than the increase in federal revenues.
- CBO has also provided a detailed analysis of the sources of growth in mandatory spending. As shown in the table below, most of the growth in mandatory spending is attributable to Social Security, Medicare, and Medicaid.
- Overall, these programs increase from a combined \$640 billion in 1996 to \$1,273 billion in 2006. This is a \$633 billion increase.
- About three-fourths of the increase in Social Security spending

is due to cost-of-living increases and growing enrollment. The other quarter of growth is due to the increase in real benefits per beneficiary. Beneficiaries entering the Social Security program get, on average, higher benefits than earlier cohorts of beneficiaries. Their benefits are higher because, on average, their real wages are higher than the earlier cohorts' wages, and this gets factored into their benefits at initial eligibility.

- By contrast, only about one-fourth of the increase in combined Medicare and Medicaid spending is due to growing numbers of beneficiaries and increases in Medicare reimbursement rates.
- Some \$304 billion in the Medicare/Medicaid spending jump falls into the "other" category, which most analysts would attribute to so-called "volume and intensity", more services provided to beneficiaries and more intense services per medical encounter.
- Other, smaller sources of growth in mandatory spending include:
 - Civilian, military, and other retirement COLAs: \$31 billion;
 - Supplemental Security Income (SSI) beneficiary increases and COLAs: \$22 billion; and
 - Food Stamp automatic benefit increases: \$14 billion.

	\$ Billions	% of Total
Total mandatory spending change	+ 780	---
SOURCES:		
Social Security:		
COLA	+117	15%
Caseload	+48	6%
Real Benefits	+56	7%
Subtotal- Social Security	+219	28%
Medicare Caseload	+39	5%
Medicaid Caseload	+24	3%
Medicare Reimbursement Rates	+48	6%
Other Medicare & Medicaid Increases	+304	39%
Subtotal- Medicare and Medicaid	+414	53%
Other Retirement COLAs	+31	4%
SSI Caseload	+9	1%
SSI COLAs	+13	2%
Food Stamp Auto. Benefit Increase	+14	2%
All Other	+80	10%

MEDICARE: UNCLEAR ON THE CONCEPT

- The *Bulletin* would like to clear up a few misconceptions that were discovered during a June 3, 1996 press conference.
- DASCHLE: "Private health insurance spending per person over the next seven years is projected to grow at 7.1 percent. So, that's a reasonable standard against which to begin to say what you could expect the Medicare system to do."
- Bulletin*: Private health insurance and Medicare spending are two completely different commodities. Comparing growth rates is meaningless. In addition, increases in Medicare spending are not just price changes. They include increases in the quality and quantity of services delivered for each beneficiary.
- DASCHLE: "Their new proposal ... would require Medicare per person to grow at only 4.7 percent a year."
- Bulletin*: Per capita spending, 1996: \$5,200, Per capita spending, 2002 (proposed): \$7,000 Proposed Growth rate: 5.1 % per person per year
- TYSON: "The President's plan to balance the budget, which has

\$124 billion."

Bulletin: Savings without contingent proposal = \$102.9 billion.
Savings with contingent proposal = \$116.1 billion.
Both figures provided by CBO, April 17, 1996.

TYSON: "They are still proposing cuts that are 44 percent larger \$51 billion -- than the President's balanced budget plan."

Bulletin: The *Bulletin* is fascinated that Dr. Tyson's statement emphasizing the difference between the two plans uses the correct figure for the President's plan (\$167 billion - \$116 billion = \$51 billion) but the statement about how much savings the President's plan achieves uses a different figure (\$124 billion). The *Bulletin* hopes this is careless error, not intentional misrepresentation.

TYSON: "The CBO has indicated that our plan to balance the budget, the President's plan to balance the budget, does secure the solvency of the trust fund for a decade. There is no appreciable difference at this point between what our plan does and what their plan does on the issue of the trust fund."

Bulletin: CBO confirms that, even giving credit for the home health transfer, the President's budget fails to meet the goal of solvency through the year 2006. "CBO estimates that the Administration's Medicare proposal, including the transfer of certain spending for home health services to the Supplementary Medical Insurance (SMI) program, would postpone this date to 2005. Without the transfer, CBO estimates that the trust fund would become insolvent in 2002." [May 15 letter to Chairman Domenici from CBO Director O'Neill]

DASCHLE: "And by our calculations they even will require, we believe, nominal year-to-year cuts -- nominal cuts -- in payments to hospitals."

**Bulletin:* Last year's Balanced Budget Act of 1995 included more part A savings than this year's resolution. Nominal payments to hospitals went up in that plan in each year. The *Bulletin* urges rechecking the calculations.

TYSON: "Finally, let me just say that we, the President, led on the issue of the trust fund in 1993. The action of the 1993 budget extend the trust fund by three years."

Bulletin: ...y by primarily increasing taxes. OBRA 1993 subjected 85% of certain Social Security benefits to taxation (up from 50%).

DASCHLE: "They were slowing the rate of growth of Medicare spending so much that basically what Medicare beneficiaries would get would be insufficient to purchase the services they get today."

Bulletin: Medicare spending per beneficiary increases each year because: (1) the quality and quantity of services delivered to each beneficiary increase each year; (2) there are no market forces constraining price growth, as there are in the private sector; and (3) holding quality and quantity of services constant, prices increase each year. The Daschle quote ignores (1) and (2).

BUDGET QUIZ

Question: What was the percentage of federal receipts to GDP in 1995?

Answer: It depends. If you use the traditional budgetary measure

the NIPA (National Income Products Account) measure the ratio of receipts to GDP is 20.4%, the second highest since 1980.

- Federal budgetary revenues measure collections that are mandated by the government's sovereign power to tax. They consist of individual and corporate income taxes, excise taxes, social insurance contributions, estate and gift taxes, customs duties, and several miscellaneous receipts--or 18.9 percent of GDP in 1995.
- We arrive at the higher NIPA receipt totals, calculated by the Commerce Department, by adding to budget totals: government contributions for employee retirement, Medicare part B premiums, and deposit insurance premiums, (which are all classified as offsets to spending); and by making other small classification adjustments. This measure attempts to track the influence of the federal government in the overall economy.
- The Federal budget records the receipts included in the NIPA totals as negative outlays because they are either voluntary transactions or intra-budgetary in nature and are not considered results of the government's taxing authority. The difference is in presentation, the shift in classification does not affect the deficit.

CALENDAR

The Conference Agreement includes instructions for considering three separate reconciliation bills.

Does anyone have this?
HOUSE SCHEDULE

June 13, 1996: Welfare and Medicaid reform and Tax Relief; House committees reconciled: Agriculture, Commerce, Economic and Educational Opportunities, and Ways and Means.

July 18, 1996: Medicare Preservation; House committees reconciled: Commerce and Ways and Means.

September 6, 1996: Tax and Miscellaneous Direct Spending Reforms; House committees reconciled: Agriculture, Banking, Commerce, Economic and Educational Opportunities, Government Reform, International Relations, Judiciary, National Security, Resources, Science, Transportation, Veterans Affairs, and Ways and Means.

SENATE SCHEDULE

June 21, 1996: Assumed Welfare and Medicaid Reform and Miscellaneous Tax Relief; Senate committees reconciled: Agriculture and Finance.

July 24, 1996: Assumed Medicare Reform; Senate committees reconciled: Finance.

September 18, 1996: Assumed Tax Relief and Miscellaneous Direct Spending Reforms. Senate committees reconciled: Agriculture, Armed Services, Banking, Commerce, Science and Transportation, Energy, Environment, Finance, Governmental Affairs, Judiciary, Labor and Human Resources, and Veterans Affairs.

EDITOR'S NOTE: BEST WISHES to Senate Budget Committee Staffer Christy Condon (formerly Christy Dunn) and her new husband, Tom, who were married over the Memorial Day Recess. The *Bulletin* wishes them many happy years together and the avoidance of the marriage tax!

WASHINGTON DC 20501
223 OEOB
WHITE HOUSE
NATIONAL ECONOMIC COUNCIL

U.S.S.

Christy Condon

OFFICIAL BUSINESS
WASHINGTON, DC 20510-6100
COMMITTEE ON BUDGET

UNITED STATES SENATE

Paoline Abernethy

Rm 223