

Status of PSO Solvency Standards Negotiated Rulemaking, as of January 7, 1998

- Three sets of meetings (3 days each) in October, November, and December. First set of January meetings is underway this week.
- The committee has broken the solvency standards discussion into 3 segments: initial requirements for certification; ongoing requirements; and insolvency protections.
- At the December meeting, tentative consensus was reached on the following components of insolvency protections:
 - The rule should have criteria for declaring insolvency.
 - The rule needs to address uncovered expenditures.
 - Hold harmless provisions are one element of insolvency protections.
 - Continuation of benefits through the period for which payment was made and through discharge from an acute inpatient setting are one element of insolvency protections.
 - The rule should require some deposit to cover HCFA's administrative costs in the event of insolvency.
- This set of meetings is focusing on initial/start up requirements and ongoing requirements. The committee has developed options through 3 different caucuses -- 1) provider caucus; 2) insurer caucus; and 3) HCFA/beneficiary caucus.
- The options are difficult to summarize but have the following characteristics:
 - Insurer caucus : Would follow NAIC's HMO Model Act and statutory accounting rules but allow some flexibility in counting a portion of health care delivery assets (but only in proportion to what is used by PSO enrollees).
 - Provider caucus: Would use the NAIC's HMO Model Act as a starting point, use Generally Accepted Accounting Principles (GAAP), and would allow "credits" for PSO parental guarantees and other assets of the PSO, such as sweat equity, to reduce the initial capital requirements.
 - HCFA/Beneficiary caucus: Would use the NAIC's HMO Model Act, use GAAP, but would not allow credits or a reduction in the initial capital requirements to recognize intangible assets. Would set some limit on the total of the amount required for initial capital (\$1.5 million) that could be made up of health care delivery assets.

- Initial Requirements -- major differences:
 - Net worth calculation -- what assets can be counted in calculating net worth, e.g., PSO-specific health care delivery assets, and to what extent.
 - The absolute \$ amounts required to meet initial and ongoing capital requirements (Under the HMO Model Act, \$1.5 and 1.0 million respectively). While all 3 caucuses used the HMO Model Act, the provider caucus would likely propose a lower \$ amount if their proposal for PSO "credits" is not accepted.
 - Cash/operating losses -- what instruments (letters of credit, parental guarantees) can be used to satisfy a requirement that the PSO be able to cover its losses until it reaches break even.
- Ongoing Requirements -- major differences:
 - Issues raised above for the Initial Requirements carry over.
 - NAIC's Risk based Capital Guidelines
 - * Insurers initially suggested that the RBC guidelines be considered in setting the initial solvency standards for PSOs.
 - * Providers are concerned that the RBC guidelines do not give adequate consideration or credit to health care delivery assets and that they are geared to traditional HMO, insurance-type financial structures.
 - * At the last meeting, HCFA put on the table an option that would have RBC tested in the first group of federally waived PSOs to help us decide how/whether to use RBC as a monitoring tool but did not commit to using it from the beginning. States will begin using RBC in 1998 for HMOs, and modifications are continuing to be made.
- Status of the PSO Definitions regulation
 - Will be submitted to OS in the next week or so, with a hoped-for publication in February.
 - We initially believed that it would impossible to complete the solvency standards without the definition. It now appears that the solvency standards are being developed in a way that the exact structure of the PSO is less critical to the negotiations. However, the definition is critical to the issue of how many entities could qualify for PSO status.

- Each element of the definition is important: 1) the PSO is provider-based; 2) the affiliated providers share substantial financial risk; 3) the affiliates own a majority financial interest; and 4) the PSO provides a substantial proportion of its services directly.

- We are planning to present information to the committee tomorrow that indicates our current direction on the definition:
 - * “Substantial financial risk” will be defined in a way that will require risk beyond a risk borne by affiliated providers for their own services (capitation risk).

 - * “Majority financial interest” will permit a subset of the affiliated providers to own 51% or more of the entity, rather than requiring all to share in ownership.

 - * “Substantial proportion” will be defined as the PSO affiliates providing 70% of services directly; in rural areas, the threshold will be set at 60%.

NEGOTIATED RULE MAKING COMMITTEE ON PSO SOLVENCY STANDARDS

CAUCUS SOLVENCY STANDARD PROPOSALS

CAUCUS MEMBERSHIP

Provider Caucus: American Hospital Association, American Medical Association, American Medical Group Association, Catholic Health Association/Premier, Federation of American Health Systems, Long Term Care Coalition, National IPA Coalition/The IPA Association of America, National Rural Health Association.

Insurer Caucus: American Association of Health Plans, BlueCross BlueShield Association, Health Insurance Association of America, National Association of Insurance Commissioners.

Beneficiary Advocate Coalition: American Association of Retired Persons, Consortium for Citizens with Disabilities, Health Care Financing Administration

INITIAL/START-UP PROPOSALS*

Requirement	Provider Caucus	Insurer Caucus	Beneficiary Caucus
Net Worth	<i>Not Addressed</i>	<i>HMO Model Act</i>	<i>Not Addressed</i>
Calculation of Net Worth	<i>Adjusted GAAP</i> -less subordinated liabilities. -admit 100% of HMO Model Act list of delivery assets that are in the entity.	<i>SAP with appropriate changes.</i> -Adjustment for concentration of assets. -Include some proportion of health service delivery assets used by PSO members: -Buildings, fixtures & land under building -Medical delivery assets -Lower proportion of furniture, equipment & EDP	<i>GAAP</i> -Admit all tangible assets. Consider counting affiliate's balance sheet? How?
Financial Plan	<i>Business Plan (including financial plan).</i> Must be sound and reflect capacity to break-even.	<i>Proposed for on-going stage.</i>	<i>Financial Plan</i> How do we count additional resources? - "affiliate" guarantees - line of credit
Liquidity	<i>Not Addressed</i>	Obligation = Cash	Sufficient current assets.

***Note:** Caucuses did not specifically develop solvency standard proposals for the initial/start-up business state. Instead, they developed proposals on how to treat health service delivery assets during the initial/start-up stage. The proposed requirements listed on this grid are based on these proposals, so each caucus did not address every requirement for the initial/start-up stage.

ONGOING PROPOSALS

Requirement	Providers Caucus	Insurers Caucus	Beneficiary Caucus
Net Worth	<p><i>Adjusted HMO Model Act</i> Decrease based on:</p> <ul style="list-style-type: none"> -ability to meet cash needs; -ability to meet unexpected need through affiliated provider service capacity (sweat equity); -risk transferred to non-affiliated providers and reinsurers. 	<p><i>Risk Based Capital and HMO Model Act</i> Minimum Net Worth</p> <p>Provide continuity with state solvency standards by the end of 3 year waiver period.</p>	<p><i>HMO Model Act methodology</i> Negotiate specific dollar amounts and percentage levels.</p> <p>RBC is a potential tool for PSOs and M+C plans. Evaluate the use of RBC for PSOs and M+C plans after receiving annual data.</p>
Calculation of Net Worth	<p><i>Adjusted GAAP</i></p> <ul style="list-style-type: none"> -Admit receivables greater than 90 days (including government). -Admit all delivery assets. -Subtract subordinated debt. -Consider loans, parental and affiliate guarantees and other capital commitments. 	<p><i>Modified SAP</i> Investment Guidelines Orange Blanks (NAIC Data Base)</p>	<p>How can PSOs use assets to meet net worth requirements?</p> <p>What investment guidelines should they follow?</p>
Financial Plan	<p><i>Proposed for Initial/Start-up stage.</i></p>	<p><i>Financial Plan</i> Meet plan bench marks. File material modification File annual update.</p>	<p><i>Financial Plan</i> for all PSOs. Update if actuals vary from plan. Unnecessary if operating more than a year and earning money.</p>
Financial Indicators and Trigger Points	<p><i>Financial indicators</i> to evaluate ability to meet cash needs.</p> <p><i>Proposed for initial stage:</i> e.g. Debt equity ratio Medical loss ratio</p>	<p><i>Financial Indicators</i> Risk Ratios Identify troubled PSOs <i>Solvency Triggers</i> Risk Based Capital Licensee Action</p>	<p>Look at financial indicators.</p> <p>Establish trigger points based on current standards and consider HMO Model Act and Risk Based Capital trigger points.</p>
Liquidity	<p><i>No Requirement</i> Allow lower net worth requirement if PSO demonstrates the ability to meet cash needs.</p>	<p><i>Liquidity Requirement</i> Timely Claims Payment Requirement Actuarial Certification of Reserve Adequacy</p>	<p><i>Proposed for the ongoing stage.</i></p>
Other	<p>None</p>	<p>Deposit for Uncovered Expenditures Material Transaction Approval Supervision Standards</p>	<p>Consider modifications to orange blanks. All PSOs file quarterly financial statements for first three years. Annual statements only if PSO earned money the third year.</p>

INSOLVENCY PROPOSALS

Requirement	Provider Caucus	Insurer Caucus	Beneficiary Caucus
Uncovered Expenditures	<p>Restricted reserves for <i>uncovered expenditures</i>.</p> <p>Use <i>modified HCFA work sheet</i> (e.g. treat capitation like HMO salaries)</p>	<p><i>Uncovered expenditures calculation work sheet.</i> (Consider more than two months).</p>	<p><i>Uncovered health care expenses work sheet.</i></p>
Hold Harmless	<p><i>Hold harmless provisions for affiliated and contracted providers.</i></p>	<p><i>Include hold harmless provisions in the PSO regulation text.</i></p>	<p><i>Hold Harmless provisions required in provider contracts and included in PSO regulation text.</i></p>
Continuation of Benefits	<p><i>Service Guarantees (continuation of care) by affiliated and contracted providers.</i></p>	<p><i>Include continuation of benefits provisions in the PSO regulation text.</i></p>	<p><i>Continuation of benefits provisions required in provider contracts and included in PSO regulation text.</i> For the period for which payment has been made and until discharge from an acute care facility. Also, some period of continued coverage for individuals in the course of treatment for chronic/disabling condition to ensure continuity of care.</p>
Insolvency Deposit	<p><i>Not addressed</i></p>	<p><i>\$300,000 insolvency deposit.</i></p>	<p><i>Insolvency deposit between (\$100,00 and \$300,000).</i></p>
Replacement Coverage	<p><i>Not addressed.</i></p>	<p><i>Open Enrollment</i></p>	<p><i>Address replacement coverage issues.</i></p>
Other	<p>None</p>	<p>Receivership</p>	<p>Declaration of insolvency: Develop criteria for determining when a PSO is insolvent.</p>

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SECTION: CAPITOL HILL HEARING

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HEADLINE: REMARKS BY SENATOR PHIL GRAMM (R-TX)

TOPIC: THE BALANCED BUDGET

THE CAPITOL, THE SENATE RADIO/TV GALLERY

WASHINGTON, DC

BODY:

SEN. GRAMM: Let me first thank you for coming.

As chairman of the Health Subcommittee and as a long-standing budgeteer, I wanted to take the opportunity today to comment on comments the president made yesterday about submitting a balanced budget in 1999. I'd like to talk at the little length about the president's proposal to expand Medicare and expand the people who are covered by it. And so let me do both those things, and then I'll throw it open for questions.

First of all, I want to congratulate the president on his decision to submit a balanced budget for 1999. I think that is a wise decision. I think it will be very much appreciated by the Congress and by the American people. I intend to vigorously support that effort.

And I assume, in submitting a budget that is in balance in 1999, that the president will submit a budget that is in balance for each of the five years through the year 2003. That will be my goal. I think we can make it a bipartisan goal. And whatever may happen in other parts of the budget debate, I think if we could adopt a budget that is in balance for the next five years, at least in terms of our initial financial planning, I think it would be a very positive thing.

I think the battle line in the budget is going to come down to a battle about whether or not we stay with the spending caps that were written for the next five years in the budget that we adopted last year. Let me say that I intend to oppose any budget that violates those spending caps. I do not believe that of all the options that are available, that we should take America on a new spending spree. There are many things that we can do with a surplus if in fact a surplus occurs. If I had my wishes granted, I would like to take any budget surplus and commit it to funding a transition from our current debt-based Social Security system to an investment-based system that we could guarantee

permanently and that would be good not only for our parents but for our children.

I also believe that if we could combine that by taking any tobacco settlement money and committing that money to funding a transition to an investment-based Medicare -- which makes sense given that the cost of smoking that is borne by the federal government is primarily borne through Medicare and Medicaid -- if we could institute those two programs and begin to build an investment-based Social Security and an investment-based Social Security system, that we would have done something that would be remembered for a very, very long time.

Let me now turn to a discussion of the president's proposal about expanding coverage under Medicare. I don't delude myself into not believing that the president's proposal will be very, very popular, but I wanted to come over this afternoon and give a reality check on this proposal. And let me just run through this reality check.

Number one, under the best of circumstances, Medicare will be a \$1 trillion net drain on the federal treasury over the next 10 years. There is not an estimate that has been made by CBO or OMB or anybody else that does not project a deficit in terms of self-funding for Medicare that is at least \$1 trillion over the next 10 years.

Secondly, and, I think, alarmingly, to simply fund existing benefits and existing programs, the current Medicare payroll tax, which is 2.9 percent of wages today, will have to grow to 14.1 percent in 25 years just to fund existing Medicare as our baby boom generation moves into retirement 11 years from today, and as we move from 3.9 workers per retiree to two workers per retiree.

If you add the projected expansion in the payroll tax to fund Medicare and Social Security, we're looking at, under the most conservative estimate -- and these are not estimates that I'm giving, but estimates that the Entitlement Commission, chaired by a Democrat, presented -- we are looking at, at a minimum, the payroll tax doubling over the next 25 years from roughly 15.4 percent to roughly 31 percent.

What that would mean is that the average working American family with a joint income of \$50,000 a year would find itself paying 31 percent of its income in payroll taxes, 28 percent of its income in income taxes, and would be facing state and local taxes as well. That is an alarming, frightening reality check in my opinion.

As chairman of the Health Subcommittee in the Senate, my first obligation is to the 39 million who have paid Social Security, some since 1965, who have retired based on a contract that they believed they have with Medicare, and my first obligation is to see that the system is there to pay their benefits. If your mother is on the Titanic and the Titanic is sinking, the last thing on earth you want to be preoccupied with is getting more passengers on the Titanic. I want to be preoccupied with saying that, (a), we stop the ship from sinking; and two, if we can't do that, that we get the passengers that are on the Titanic, safely off the Titanic onto a ship that is not going to sink.

Let me go over a couple of figures that I think are important in this debate. First of all, last year Medicare spent \$5,652 per beneficiary. With any kind of adverse selection in people opting to go on Medicare at 62 if they are unhealthy or if they're sick or if -- depending on how the final program might be submitted to the Congress, if you could wait until you got sick to join the program; it is easy for me to imagine, having spent several years now looking at these numbers, that the average cost for the new beneficiaries that would be added to the program by the president's proposal, could easily equal or exceed \$5,652 a year.

I also think it is important to remember that while I don't have the data yet from the Census Bureau on 62 to 65 and the degree to which they have health insurance, I do have it from 55 to 65. From 55 to 65, in that age group, 86.7 percent of American families have health insurance. That is substantially greater than the population as a whole. And one of my fears is, if we change the system so that people can qualify for Medicare, of the population that currently is 62 to 65, if almost 87 percent of them already have private health insurance, are we going to induce people to drop their private health insurance to become eligible for Medicare?

I think a final question we need to ask ourselves in the reality check is, is the president's proposal out of sync with what we know has to happen in the next 25 years?

Now what do we know has to happen? Well, we know, under the best of circumstances, that 25 years from today, based on people who are already born and based on people who are heading toward retirement, that we're looking at roughly two workers per retiree. But that's with raising the retirement age to 67.

If the president, by giving Medicare benefits to people at 62, induces people to retire early, not only are we going to have an increase in expenditure on Medicare, but we're going to have fewer people paying payroll taxes, more people drawing retirement benefits, and we are greatly going to exacerbate the problem we have in funding retirement and funding -- through Social Security and in funding health care.

I think it is also important to remember that last year, in what I viewed as being an act of courage -- some may have viewed it as being foolish, but I viewed it as an act of courage that the United States Senate, on a bipartisan basis, voted to raise the eligibility age for Medicare to 67, to conform to the eligibility age of Social Security, recognizing the fact that we all know, the fact that we all appreciate, and that is, we're living longer, we're healthier, but the reality of the America that we live in is that with the declining growth in the number of babies that are born per family, people are going to have to use some of this improved quality of life, improved life span, and better health to work longer.

I think the president's proposal, while it is very good politics, when you do any kind of reality check, you see that it is a movement in exactly the wrong direction. It could very likely induce people -- the vast majority of whom have private health insurance that they have paid for through their employer and paid for themselves over their working lifetime -- it could induce them not to buy private health insurance, knowing they could get Medicare at 62. It could induce people to retire earlier. And when we're looking at two workers per retiree 25 years from now, to tilt that any further risks breaking the workers' back.

So I'm very concerned about this proposal. I think that it is a proposal that if people look at, they're going to realize that this is 99 percent politics and 1 percent public policy; that while we would like to live in a -- under a system where it would be possible for people to retire earlier and earlier, when we're looking at 25 years from now two workers per retiree, and when we're looking at the fact that we have already changed Social Security to try to encourage people to work longer, I think this is a movement in the wrong direction. And I don't believe that the Congress is going to go along with this proposal.

Yes, sir?

Q (I believe that ?) the opposition among Republicans is pretty strong on this. (Isn't ?) this proposal by the president simply a non-starter? It's not going to go very far at all, sir?

SEN. GRAMM: Well, I don't know. I haven't reached that conclusion.

I mean, there's no doubt about the fact that there are many people who would like to retire earlier, that are looking at what they could do if they retired at 62 versus 65 and 67.

One of the reasons that people tend to stay in the labor market until they're 65 is Medicare, because they're concerned about their health care costs during this transition.

I think that because many Americans would like to retire earlier, and if they could get this guarantee, they might be encouraged to do it, I think it's going to be quite popular. But the cold reality is, to be able to fund Social Security and Medicare for the next 25 years, we need people to decide to work longer, not to retire earlier.

So there is -- and I'm encouraged by the fact that there is strong opposition from Republicans at this point. But I don't underestimate the political appeal of telling people, in a period of time where they do feel vulnerable, that we're going to provide them with a benefit.

Now, the fact that we're talking about the most troubled program in the federal government, we're talking about a program that represents the greatest financial threat to the taxpayer that has ever existed in history, we're talking about a program that's got a \$2.3 trillion unfunded liability -- in other words, if you took the current taxes for Medicare and you said to a private insurance company, "What would we have to pay you to take this stream of revenues and pay the

projected benefits for the next 25 years?" it would be roughly \$2.3 trillion. But with all of those troubles, and when reality stares you in the face and says this is the last place on Earth you need to be expanding benefits, I don't underestimate that it's going to be popular.

Q But Senator, doesn't the president's proposal require the individual early retiree to pay the premiums themselves? In other words, they don't automatically benefit without paying in.

SEN. GRAMM: Let me respond to that in several ways. First of all, the answer is no, in that the president says he's going to have some offsetting cuts and savings through waste, fraud and abuse. Let me say that every penny we can get our hands on, we need to commit to maintaining the existing program. When we're looking at a trillion-dollar drain on the federal treasury in the next 10 years, when we're looking at raising the payroll tax in 25 years from 2.9 percent of income to 14.1 percent of income just to pay for current benefits, I think our focus -- if there are savings out there, if there's waste, fraud and abuse out there, and I believe there is, we need to ferret that out to save the existing program, not to expand it.

But it is my understanding, in listening to the president today and looking at the handout material, that there will be a net cost to the treasury involved in the program, and that that is going to be offset by waste, fraud and abuse savings.

The second thing is that that is all based on the presumption that a certain number of the people that today do not have health insurance in this age group, 62 to 65, that they will opt for this program. It doesn't take into account people that will decide not to buy health insurance while they're working for this retirement vulnerability period, and who will then opt for Medicare, or -- and it takes no account whatsoever of the fact that people as a result of this new benefit will opt to retire early and will draw Social Security rather than continuing to pay into the system.

All of those things are very hard to figure out how are people going to respond to these incentives. But I think if we're going to try to save Medicare, if we're going to try to keep the payroll tax from getting so high that it breaks the worker's back, I think those are questions we have to ask and try to answer.

Q Just for clarification, you're saying there's going to be a net cost over and above the premiums that -- (off mike).

SEN. GRAMM: That's my understanding. Now again, we've seen no real paper. The president has put out a two-page sheet on it. But in listening to what he was saying and in reading the paper in the last couple of days, what I have seen is a proposal that would have a roughly \$300 per month. That would be \$3600. Now, the average cost, as I said earlier, of Medicare benefits is \$5,652. The president is aware that you're going to get adverse selection because people who are less healthy are going to opt for the benefit. How do you figure that out? I don't know.

But even in addition to all that, the assumption, as I understand it -- and I stand to be corrected if I'm wrong -- is that that payment, both the current payment and then the higher payment when you actually do retire, discounted to the future, that that will not cover the program, that there will be several billion dollars of cost, and that they will be made up for by other changes in the existing Medicare program. Now, I don't know what those changes will be.

Q Several billion a year?

SEN. GRAMM: Several billion over the five years. But what I'm saying -- and I repeat it only because at least the arithmetic of it would be complicated -- what is missing from this whole analysis is the following thing.

Currently, in the age group 55 to 65, almost 87 percent of American families have health insurance. What is going to happen when people find out that the government is providing health insurance? Well, all I know as chairman of the subcommittee that has jurisdiction over Medicaid is that while we've had a massive expansion in Medicaid benefits for children over the last 10 years, we have seen no net change in the percentage of uninsured children. Why? Because what has happened is, when we're providing the benefit, people stop buying it. And so all we've done is taken children who had private health insurance and we have substituted Medicaid for it.

So what I'm worried about, in figuring the real cost, is two things that are totally not taken into account, and they're very significant. One is, how many people are going to drop private health insurance or, simply knowing that this benefit might be there, not buy it in the first place, and therefore it will -- the number of people who come into the program be several times the number currently projected? Number two, to what extent will you get -- more people retire early as a result of this benefit, thereby putting strain not only on Medicare but on Social Security as well? I think those are things we better know something about.

All I know is that we raised the retirement level for Social Security from 65 to 67, recognizing that in 25 years, that it was absolutely essential that -- over the next 25 years, to ask people to plan to work two years longer. The Senate voted to do the same thing for Medicare this year, and the president is moving to, in essence, allow it -- make it easier for people to retire at 62. Now either we've been wrong for the last 10 years and we're wrong now, or the president's wrong.

Q Senator, I think one of the arguments the administration makes is that whatever percentage of uninsured there are between 62 and 65, health insurance either is impossible for them to get because of their age or health problems, or in their particular age group it's so expensive they can't possibly afford it. Is that a problem? Do you view that as a problem?

SEN. GRAMM: Well, obviously it is a big enough problem that a lot of Americans work very hard during their lifetime to try to get health insurance that will -- that they can carry into retirement, especially in this vulnerable age

before Medicare kicks in.

So no one is saying that there is not a problem and that they're not people who -- find themselves wanting to retire early, but being concerned about their potential loss of health insurance if they do retire early.

The problem is we have been for the last 10 years, making policy changes to prepare America for the fact that 25 years from now, that we are expecting people to work until they're 67; not because we want them to, but because, to have any chance of funding Medicare and Social Security with only two workers per retiree, we don't really have any choice. And I am just worried that this is moving the incentives in exactly the wrong direction.

So if you could single out a few people and help them without inducing people to drop private health insurance and move into Medicare earlier and retire earlier, and all of the problems that will come with that, then this might be something you could debate. The problem here is unintended consequences.

And what we have been trying to do, and I thought we shared this with the administration, was we've been moving toward raising these retirement ages and eligibility ages. As I said, the Senate, last year on a bipartisan vote, voted to raise Medicare eligibility age from 65 to 67. Now, the president is talking about dropping it three years, from 65 to 62. I mean, somewhere somebody's confused.

Q Senator?

SEN. GRAMM: Yeah?

Q (Off mike.) And also what is going on with the commission? When do you expect it to start (work ??)?

SEN. GRAMM: I am a member of the commission. I don't know when we're going to meet.

All I would have to say is that I thought the purpose of the commission was to try to find a way to fund Medicare for the next 25 years. I never dreamed that, before we had our first meeting, the president was going to propose lowering the eligibility age from 65 to 62.

I don't know how serious people are about the commission. If I am going to spend time on it, I want to be serious about it. And again, I take this Medicare financial crisis very seriously. As I look at the future of America, the thing that I am most frightened about is our ability to fund Medicare and Social Security. I just don't know what the country's going to be like, 25 years from now, when the average working family is paying 31 percent of their income in payroll taxes. And I think something needs to be done about it.

I know the answer.

The answer is to get out of this debt-based system into an investment-based system where people's -- what they put into the system can grow at compound interest and help fund the program. But as it is now, we have no trust fund in

Medicare. The Social Security trust fund is tiny and it's phony. It's government bonds, and interest payments on the bonds don't even count as an outlay of the Treasury.

So I know how to fix it; it's funding it that's the problem. And I just see this as a movement all in the wrong direction. But again, maybe I'm more pessimistic than other people, but I think this is going to be a tough fight.

Yes, ma'am?

Q You mentioned that it would be nice if we could help the people that are caught between the ages of 62 and 65. Do you have a plan to --

SEN. GRAMM: Well, I have one proposal that I made right before the recess that would be very beneficial to them, and that is to give tax equity to people who buy their own health insurance. The biggest problem that people who are retired have in buying health care is that they've got to pay with after-tax dollars, whereas people who buy it through their employer get it tax-free. And that makes a very, very big difference in the cost.

So in my Health Care Bill of Rights which I proposed right before the recess as an answer to another presidential initiative on mandates, I -- it seems the president's got a new proposal now at least one a week. But the first proposal was to eliminate the discrimination against people who buy their own health insurance. That would cut the cost of health insurance for early retirees by about 25 percent. I think that would be a major step in the right direction. Also, going back to a question earlier, it's not clear to me that many of the people who were caught waiting to qualify for Medicare that the president's talking about are going to be able to afford the premiums he's talking about. I mean, I think that's the real question. So we may end up with a program that really doesn't reach the people who have the problem, but that induces people who can provide for themselves not to do it, knowing the government's going to be there.

Finally, are you going to let private companies cash out their health insurance and buy people into Medicare? I hope the president's not contemplating that. But as you remember, one of the things from the president's national health insurance proposal -- everybody was stunned that General Motors and all these big corporations endorsed the president's takeover of health care. Well, the reason they did is, his program was going to take these benefits that they are committed to for early retirees and basically make those government liabilities. So it was a huge multi-billion-dollar gift to corporate America. I want to look at the fine print to see if it would be possible, for example, for a company like General Motors to buy their people, their retirees, into this Medicare program and terminate their health insurance program.

Q Senator, have other Senate Republicans, you know, produced their own balanced budget this year?

SEN. GRAMM: I think there will be -- I think you're going to have a big debate this year and the debate is basically going to come down to the Democrats wanting to take revenues that might be available and spend them, and Republicans

wanting to take some of those revenues and commit them to debt reduction or Social Security and Medicare solvency and some to tax cuts. And I think that's going to be the fault line in the political structure of the country. I think you're going to have a very hot debate about it.

I am not going to support a budget that increases spending above the spending total set out in last year's budget. I hope that will be my party's position.

But I'm sort of like the basketball coach coming out at the beginning of the second half and the guy with the radio station says, "You gonna be in a full court press?" and he says, "Yeah, I'm gonna be in a full court press; I don't know about these players."

Q Senator, don't most of your arguments hold true even if the premiums were to cover the current (five six, five two) -- question one. Question two: Do you have any concern that if people opt out of what they've got and take this offer, that it would raise premiums for those still in the system who are, for example, under 62 -- in the private system.

SEN. GRAMM: Well, all of my arguments hold even if the program were totally self-funding.

Secondly, you have no way of estimating how many people are actually going to opt for this benefit because you don't know how the availability of this benefit is going to affect behavior.

I can tell you, having tried to look at this thing both for Social Security solvency and Medicare solvency, that one of the main reasons that Americans work between 62 and 65, people who have been moderately successful, is because they don't qualify for Medicare until they're 65.

If you make it possible for people to qualify at 62, you're going to have a very substantial number of people retire early, and in retiring early, they're not going to be paying income taxes to the degree they would have been paying them, they're not going to be paying Social Security taxes, they're not going to be paying Medicare taxes. And if you tilt this system from two workers per retiree to 1.8 workers or 1.7 workers per retiree, you're going to have average working blue-collar people that have effective tax rates where the federal government is taking over 50 cents out of every dollar they earn, and I just can't believe that can work.

Now, the problem is that's 20, 25 years off in the future, but it's not speculating, it's certain, given the people that are already born and already working. And getting people to understand that is very difficult, especially when you've got people who say that there can be a benefit for them right now, that they can have something right now. It's very appealing.

Thank you all very much.

Q Thank you, Senator.

(Senator Gramm leaves the broadcast studio for some time, but returns and answers more questions.)

(Audio break.)

Q (Off mike) -- clear about the Medicare. If these people do choose to retire early, they still have to pay the premiums.

SEN. GRAMM: No, I know, but they're not paying the tax.

Q Right, I understand.

SEN. GRAMM: They're not paying the Social Security tax. They're not paying the income taxes. See, it's a general equilibrium thing. And I'm just saying that, based on having looked at these things, the main reason people decide to work from 62 to 65, in many cases, is health care.

Q (Off mike.)

SEN. GRAMM: No, I'm talking about trying to take the best of both systems. I'm talking about a mandatory system where we would collect it through payroll tax but where it would go into actual investments under strict federal guidelines, but where there would be compound interest. There's only one thing powerful enough to bail us out of this \$10 trillion debt, and that's the power of compound interest.

Let me say this. I was asked about Sonny Bono.

Sonny Bono was a wonderful, loving man who didn't take himself very seriously but who took issues very seriously. He got into politics as a guy who was trying to open a restaurant. He wanted to put a sign out in front of his restaurant. The city hall said no. He took on city hall, ultimately ran for mayor, was elected. He came to Congress already famous and rich, and really dedicated himself to dealing with problems, and all the while laughed at himself and laughed at Congress. And I think he was a very important member for that reason. I think he gave us all a good perspective on things. In a town where everybody's got a big ego, he had already fulfilled his, and it made him a very, very unique person. I think he will be missed around here. There are not many people like him.

Also, when you first listen to Sonny, you remember him with Cher, you remember him as kind of a goofy guy, actor, singer; but underneath all that was a very smart, dedicated, hard-working person, very goal-oriented. And so I think Sonny Bono was a very, very special person.

Q (Off mike.)

SEN. GRAMM: When your mother is on the Titanic, and it's sinking, your first preoccupation ought not to be trying to get more passengers on the Titanic.

Thank you.

END

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REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Tim Sen.
W. Delwine
Opponent
Amendment to the Bill restate re: market exclusion re Sec 1862(b)(1)

Auth. 6/11/97



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

SEP 8 1997

Honorable Phil Gramm
United States Senate
Washington, D.C. 20510

Dear Senator Gramm:

In response to your request, I am sending 30-year estimates of the Medicare savings and investment proposals contained in the President's 1998 Budget. The estimates were prepared by HCFA's Office of the Actuary. These estimates reflect the original proposals in the President's budget, but do not reflect the additional proposals agreed to in the bipartisan budget negotiations or the actual provisions of the Balanced Budget Act. As such, I suspect that their primary usefulness is now largely historical or theoretical, but I did want to follow through on my promise to you to provide this information.

It is important to note that 30-year estimates are subject to great uncertainty and must be used very cautiously with full awareness of their limitations. In particular, the further out the projection period, the greater the uncertainty.

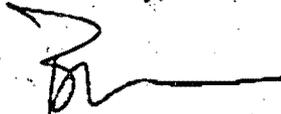
As Table 1 of the attachment indicates, dollar estimates over a 30-year projection period will naturally grow to large magnitudes, as a result of inflation and growth in the number of beneficiaries. Due to the changing value of the dollar over long periods of time, comparing dollar amounts in distant periods is very difficult and potentially misleading; accordingly, such comparisons must be interpreted very carefully. Any financial estimates over a 30-year period are likely to be strongly affected by macroeconomic and other changes that are impossible to forecast with certainty. This is particularly the case with the Medicare program where revenues and costs also depend on changes in labor force composition, advances in medical sciences, etc. over the long term. Table 2 of the attachment summarizes the 5-year totals of expenditures, premiums, and net expenditures under present law, prior to the enactment of the Balanced Budget Act, as well as the reduction in net Medicare expenditures under the Budget proposals.

The Office of the Actuary advises me that the combined impact of all the HI proposals would have improved the long-range actuarial balance by an estimated 1.89 percent of payroll. The 1997 Trustees Report shows the 75-year actuarial balance to be -4.32 percent of payroll under present law. The proposals in this package would thus have reduced the reported actuarial deficit by about 44 percent.

Page 2:

Please let me know if I can be of further assistance.

Sincerely,



Bruce Vladeck
Administrator

Attachments

Table 1—Estimated Net Savings under President's 1998 Budget Medicare Proposals
(Dollars in billions, fiscal years)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PART A PROPOSALS																							
Hospitals																							
Reduce Hospital PPS Update /a	0.0	1.4	2.1	2.9	3.9	4.2	4.5	4.8	5.1	5.5	5.9	6.4	6.8	7.4	8.0	8.7	9.4	10.2	11.0	11.9	12.9	14.0	15.2
Extend PPS Capital Reduction from OBRA 1990	1.2	1.2	1.2	1.3	1.3	1.4	1.4	1.5	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.3	2.4	2.5	2.7	2.8	3.0	3.2	3.3
Reduce PPS-Exempt Update w/ Rebasing /b	0.5	0.4	0.8	0.8	1.0	1.2	1.3	1.4	1.5	1.8	1.7	1.9	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.4	3.7	4.1	4.5
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase base payment rate to Puerto Rico	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.5	0.5	0.8	0.7	0.7	0.8	0.9	1.0	1.0	1.1
Expand Centers of Excellence	0.0	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Lower IIME /c	0.2	0.4	0.7	0.9	1.9	2.2	2.4	2.7	2.9	3.2	3.8	3.9	4.3	4.8	5.3	5.9	6.6	7.3	8.0	8.9	9.9	10.9	12.1
GME Reform	0.7	0.4	0.8	0.9	1.2	1.5	1.8	2.2	2.7	3.2	3.8	4.5	5.3	6.1	7.2	8.3	9.6	11.1	12.7	14.6	16.7	19.1	21.8
Eliminate Add-Ons for Outliers	0.5	0.5	0.5	0.5	0.8	0.6	0.7	0.7	0.8	0.9	0.9	1.0	1.1	1.2	1.3	1.5	1.6	1.8	1.9	2.1	2.3	2.6	2.8
PPS Redefined Discharges	0.7	0.6	0.6	0.9	0.9	1.0	1.1	1.2	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.3	2.4	2.6	2.8	3.0
SCH Rebasing (w/ hold-harmless)	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
RPCH expansion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare dependent hospitals	-0.5	0.0	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Remove GME, IIME, and DSH from APOC	-1.5	-2.7	-3.1	-3.3	-4.3	-5.0	-5.7	-6.4	-7.2	-8.1	-9.1	-10.1	-11.3	-12.6	-14.1	-15.0	-17.9	-20.1	-22.6	-25.3	-28.4	-31.9	-35.0
Home Health																							
HH Freeze Extension	0.1	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.9	1.0	1.0	1.1
HH Interim System	0.9	1.3	1.5	1.9	2.2	2.5	2.9	3.3	3.7	4.1	4.8	5.0	5.5	5.9	6.4	6.9	7.4	8.0	8.6	9.3	10.0	10.9	11.8
HH PPS	0.0	0.0	1.4	1.5	1.8	1.8	1.9	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.3	3.5	3.7	3.9	4.2	4.4	4.7	5.0	5.4
HH Location of Service	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Redefine "homebound"	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Normative Service Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eliminate HH PIP	0.0	0.0	0.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
Shift to Part B	12.3	12.7	12.1	13.1	14.2	15.2	16.4	17.6	18.9	20.3	21.8	23.3	24.9	26.5	28.1	29.9	31.6	33.6	35.9	38.2	40.6	43.5	46.6
SKILLED NURSING FACILITIES																							
SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
SNF PPS	0.0	1.0	1.6	2.1	2.1	2.2	2.5	2.8	3.1	3.4	3.7	4.0	4.3	4.6	4.9	5.3	5.7	6.2	6.7	7.2	7.8	8.4	9.1
HMOs																							
Medicare Choice (w/90% rate in 2000*)	3.8	7.1	12.2	14.5	17.5	20.1	22.8	25.5	28.4	31.4	34.5	37.8	41.3	45.0	49.2	53.6	58.9	64.3	70.3	76.8	84.2	92.3	101.2
PACE	d/	d/	d/	d/	d/	d/	d/	d/	d/														
Medicare Secondary Payer (Part A)																							
Insurer Reporting, Contract Limits, TPA's, etc.	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.8	0.9	0.9	1.0
MSP Extenders	0.0	0.7	0.9	1.1	1.2	1.5	1.6	1.8	2.0	2.2	2.3	2.5	2.7	3.0	3.2	3.4	3.7	3.9	4.2	4.5	4.8	5.1	5.4
Fraud and Abuse /e	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
New Benefits																							
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-0.5	-0.5	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part A Premium Offset	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-1.1	-1.2	-1.3	-1.4	-1.5	-1.6	-1.7	-1.9
Part A Interactions																							
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.7	-3.1	-3.6	-4.1	-4.7	-5.4	-6.2	-7.0
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.7	-3.1	-3.6	-4.1	-4.7	-5.4	-6.2	-7.0
Total Part A Excluding HH Transfer	4.7	9.5	18.0	21.4	26.0	29.0	32.2	35.7	39.3	43.2	47.3	51.7	56.3	61.4	66.9	73.0	79.5	86.7	94.4	103.0	112.4	122.9	134.1
TOTAL PART A	19.1	25.2	33.9	38.9	45.2	49.8	54.9	60.3	65.9	71.9	78.1	84.7	91.7	99.0	106.9	115.5	124.7	134.7	145.5	157.4	170.6	184.8	200.2
PART B PROPOSALS																							
Physicians																							
Single Conversion Factor, Overhaul Targets with GDP *	0.1	0.7	1.5	2.1	2.7	3.5	4.4	5.4	6.7	8.2	10.0	12.0	14.3	17.0	20.0	23.2	26.8	30.6	34.6	38.7	42.7	46.7	50.7
Single Fee For Surgery	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6
Incentives for In-hospital MD Services	0.0	0.0	0.3	0.5	0.7	0.9	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	2.0	2.1	2.2	2.4	2.5	2.7	2.8	3.0
Phys. Assistant, Nurse Pract., Clinical Nurse Specialists	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8
Mark-Up for Drugs	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5
Interaction among Physician Proposals	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-0.6	-0.6	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2
Hospital OPD																							
Eliminate FDO, Extend OBRA 1993, OPD PPS: N	0.0	1.6	2.0	2.2	2.4	2.5	2.7	2.7	3.4	3.8	4.7	5.5	6.4	7.4	8.5	9.7	11.0	12.4	14.0	15.7	17.5	19.4	21.4
Hospital Revenue	0.0	1.1	1.7	2.3	3.0	3.4	3.5	3.8	4.4	4.9	5.7	6.4	7.4	8.5	9.7	11.0	12.4	14.0	15.7	17.5	19.4	21.4	23.4
Beneficiary Copayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare Benefit Payments	0.0	0.5	0.3	-0.1	-0.6	-0.8	-0.8	-0.7	-0.6	-0.4	-0.2	0.2	0.2	0.3	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1
GME Reform	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.5	0.5	0.6	0.7	0.8	0.9	1.0	1.1
Medicare Secondary Payer (Part B)																							
Insurer Reporting, Contract Limits, TPA's, etc.	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.8
MSP Extenders	0.0	0.3	0.4	0.5	0.6	0.7	0.8	1.0	1.1	1.2	1.3	1.5	1.7	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.1	3.3	3.5

Table 1--Estimated Net Savings under President's 1998 Budget Medicare Proposals
(Dollars in billions, fiscal years)

	2021	2022	2023	2024	2025	2026	2027	98-02	03-07	08-12	13-17	18-22	23-27
PART A PROPOSALS													
Hospitals													
Reduce Hospital PPS Update /a	16.5	17.6	18.9	20.2	21.6	23.2	24.8	10.8	24.0	34.4	51.2	78.2	108.7
Extend PPS Capital Reduction from OBRA 1990	3.5	3.8	4.1	4.3	4.7	5.0	5.3	6.2	7.4	9.5	12.8	18.8	23.4
Reduce PPS-Exempt Update w/ Rebasng /b	4.8	5.2	5.5	5.9	6.4	6.8	7.3	3.1	6.8	0.2	14.7	22.3	31.9
Reduce PPS-Exempt Capital Payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0
Increase base payment rate to Puerto Rico	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Monetarium on Long-Term Care Hospitals	1.2	1.3	1.4	1.5	1.6	1.7	1.9	0.4	1.1	2.2	3.8	5.6	8.1
Expand Centers of Excellence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.4	0.5
Lower I/M E /c	13.4	14.4	15.4	16.5	17.7	18.9	20.3	4.1	13.5	21.9	36.7	60.7	89.7
GME Reform	24.8	26.5	28.4	30.4	32.8	34.9	37.4	3.3	11.5	28.9	58.4	108.9	183.7
Eliminate Add-Ons for Outliers	3.1	3.3	3.6	3.8	4.1	4.4	4.7	2.6	3.6	5.8	8.9	14.2	20.5
PPS Redefined Discharges	3.2	3.4	3.7	3.9	4.2	4.5	4.8	4.0	5.7	7.9	10.7	15.0	21.1
SCH Rebasng (w/ hold-harmless)	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-0.6	-0.7	-0.8	-1.1	-1.5
RPCH expansion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Medicare dependent hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0
Remove GME, I/M E, and DSH from AAPCC	-40.2	-43.0	-46.1	-49.4	-52.9	-56.6	-60.6	-14.9	-32.5	-57.1	-101.6	-179.2	-265.5
Home Health													
HH Freeze Extension	1.2	1.3	1.3	1.4	1.5	1.8	1.7	1.3	2.0	2.9	4.0	5.5	7.7
HH Interim System	12.9	13.9	15.0	16.3	17.7	19.2	20.8	7.6	18.6	27.3	40.1	59.3	89.0
HH PPS	5.9	6.2	6.6	7.0	7.5	8.0	8.6	4.6	10.3	14.4	19.6	27.0	37.7
HH Location of Service	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.4	0.5	0.8	1.1	1.5	2.1
Redefine 'homebound'	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Normative Service Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eliminate HH PIP	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.9	0.5	0.5	0.7	1.1	1.5
SNH to Part B	49.7	53.1	58.7	60.8	64.8	69.2	74.0	64.3	68.5	124.8	189.5	233.5	325.2
Skilled Nursing Facilities													
SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.4	-0.6	-0.6	-0.6	-0.6
SNF PPS	8.9	10.6	11.4	12.2	13.0	14.0	14.9	7.0	14.0	21.4	31.1	45.9	65.5
HMOs													
Medicare Choice (w/90% rate in 2000+)	111.1	119.0	127.5	136.8	146.3	156.7	167.7	55.1	128.1	207.8	324.1	507.9	734.8
PACE	d/	d/											
Medicare Secondary Payer (Part A)													
Insurer Reporting, Contract Limits, TPA's, etc.	1.1	1.2	1.2	1.3	1.4	1.5	1.6	1.0	1.7	2.5	3.8	5.1	7.0
MSP Extensions	5.7	6.0	6.3	6.7	7.0	7.4	7.4	3.9	9.0	13.7	19.7	28.9	34.9
Fraud and Abuse /e	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2
New Benefits													
Colorectal Screening	-0.8	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-1.0	-1.9	-2.5	-2.9	-3.1	-3.4
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0
Part A Premium Offset	-2.0	-2.1	-2.3	-2.5	-2.6	-2.6	-3.0	-1.8	-3.0	-4.8	-8.6	-9.3	-13.2
Part A Interactions													
Interactions Among Hospital Proposals	-8.0	-8.6	-9.2	-9.8	-10.5	-11.2	-12.0	-0.7	-3.9	-6.7	-18.2	-35.1	-52.7
Total Part A Excluding HH Transfer	149.8	157.1	168.5	180.8	193.6	207.5	221.9	79.5	179.4	283.8	438.6	673.1	972.0
TOTAL PART A	217.2	232.0	249.2	266.6	285.7	304.0	327.2	162.2	302.8	460.4	677.8	1005.3	1434.6
PART B PROPOSALS													
Physicians													
Single Conversion Factor, Overhaul Targets with GDP	54.8	59.1	63.4	67.8	71.7	75.6	78.1	7.1	28.0	73.3	153.8	254.1	367.4
Single Fee For Surgery	0.8	0.8	0.7	0.7	0.8	0.8	0.9	0.4	0.8	1.2	1.9	2.8	3.9
Incentives for In-hospital MD Services	3.1	3.3	3.5	3.7	3.8	4.0	4.2	1.5	5.3	7.9	11.1	14.9	19.3
Phys Assistant, Nurse Pract, Clinical Nurse Specialists	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2	-1.2	-0.8	-1.1	-1.6	-2.8	-3.8	-5.4
Mark-Up for Drugs	0.5	0.6	0.6	0.6	0.7	0.7	0.8	0.6	1.1	1.4	1.8	2.5	3.4
Interaction among Physician Proposals	-1.2	-1.3	-1.4	-1.4	-1.5	-1.6	-1.6	-0.2	-1.0	-2.2	-3.8	-5.8	-7.5
Hospital OPD													
Eliminate FDO, Extend OBRA 1990, OPD PPS: //													
Hospital Revenue	10.3	11.3	12.4	13.6	14.8	16.1	17.5	8.1	15.0	19.1	31.5	47.6	74.3
Beneficiary Copayments	62.5	68.5	75.1	82.3	90.1	98.6	107.7	8.0	50.7	89.8	178.1	288.0	453.7
Medicare Benefit Payments	-52.2	-57.2	-62.7	-68.7	-75.3	-82.5	-90.3	0.1	-35.8	-60.8	-148.5	-240.3	-378.5
GME Reform	1.5	1.7	1.9	2.2	2.5	2.8	3.2	0.1	0.5	1.4	3.2	6.4	12.5
Medicare Secondary Payer (Part B)													
Insurer Reporting, Contract Limits, TPA's, etc.	0.9	1.0	1.0	1.1	1.2	1.3	1.3	0.8	1.1	1.8	2.9	4.2	5.6
MSP Extensions	3.7	3.9	4.1	4.4	4.6	4.8	5.2	1.7	4.8	8.3	12.8	17.5	23.1
Other Providers													
Competitive Bid	4.2	4.4	4.8	5.1	5.5	5.8	6.2	1.3	5.3	8.6	13.5	19.5	27.4
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2	0.2	0.2
Reduce ASC update: CPE-2 (98-02)	0.9	1.0	1.0	1.1	1.2	1.3	1.3	0.3	1.1	1.9	2.9	4.2	5.8
SNF Consolidated Billing	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.3	0.4	0.5	0.8	1.2	1.7
Profile Lab Tests	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.1	0.2	0.4	0.5	0.7
HHA Shift to Part B	-48.8	-50.0	-53.5	-57.1	-61.1	-65.3	-69.6	-61.8	-83.8	-117.5	-159.9	-220.2	-308.7
HMOs													
Medicare Choice (w/90% rate in 2000+)	-4.7	-4.8	-5.6	-6.7	-8.0	-9.7	-11.9	-10.8	-10.0	-22.5	-17.7	-18.3	-41.9
PACE	//	//	//	//	//	//	//	//	//	//	//	//	//
Fraud and Abuse /e													
New Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1
Waive Mammography Costsharing	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.6	-0.7	-1.0
Annual Mammogram w/interaction of Waiving Costshare	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.6	-0.7	-1.0	-1.3
Respite Care	-1.0	-1.0	-1.1	-1.2	-1.3	-1.4	-1.4	-1.7	-1.9	-2.4	-3.3	-4.8	-6.3
Chiropractors	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.2	-0.3	-0.5	-0.8	-1.1	-1.6
Colorectal Screening	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-0.8	-1.5	-2.4	-3.0	-3.3	-3.5
Diabetic Screening	-0.8	-0.9	-0.9	-1.0	-1.1	-1.1	-1.2	-1.4	-1.7	-2.2	-2.9	-3.9	-5.3
Blood Glucose Monitor Strips	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Flu Shot Administration	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.4	-0.6	-0.8	-1.1	-1.5	-2.1
Part B Premium													
Extend 25% Premium Beyond 1998	68.9	106.6	114.9	123.7	133.3	143.5	154.4	12.7	65.3	168.8	305.7	462.5	669.9
Actuarially Determined Premium Surcharges	-1.3	-1.4	-1.5	-1.7	-1.8	-2.0	-2.2	-0.8	-1.4	-2.2	-3.6	-5.8	-8.3
Part B Premium Offset	-7.4	-7.8	-8.0	-8.1	-8.1	-7.7	-7.2	-3.8	-4.1	-8.8	-21.4	-34.8	-39.1
Total Part B Excluding HH Transfer	118.6	129.8	135.1	143.3	151.6	159.8	167.6	24.1	78.2	185.9	371.0	567.9	757.4
TOTAL PART B	52.2	55.6	59.0	62.0	64.6	66.9	68.4	-55.9	-38.6	29.2	143.5	244.6	320.9
NET SAVINGS FROM TOTAL PACKAGE	289.4	283.3	308.1	328.6	350.4	372.9	395.5	108.9	264.1	489.8	821.3	1249.9	1755.7

Table 1—Estimated Net Savings under President's 1996 Budget Medicare Proposals
(Dollars in billions, fiscal years)

Footnotes:

a/ PPS hospital update: FY98-02: MB-1.0

b/ PPS-exempt policy. Rebased: FY98-02: MB-1.5

c/ IHE schedule: 7.4% in FY 1998, 7.1% in FY 1999, 6.8% in FY 2000, 6.6% in FY 2001, 5.5% in FY 2002 and thereafter

d/ Inestimable at this time. Potentially significant cost, probably minimal through 2002, but increasing risk thereafter

e/ Fraud and abuse estimates provided by OIG

f/ "Medicare Benefit Payments" represent the net increase in SMA expenditures and are included in the totals. "Hospital Revenue" and "Beneficiary Copayments" are included for display purposes only and are not included in the totals. The increase in SMA expenditures can be thought of as the net effect of a small reduction in hospital revenue less the larger reduction in beneficiary copayments.

Notes: 1. Estimates are based on the assumptions underlying the 1997 Trustees Report. These estimates are slightly different from the 10-year estimates previously released because of different baselines. (Previous baseline based on OMB assumptions). The Trustees Report assumptions reflect more recent economic and demographic trends, and different levels of expectations for growth in the economy.

2. Zeros in the table indicate amounts less than \$50 million.

Table 2—5-Year Totals of Expenditures, Premiums, and Net Expenditures under Present Law and Reduction in Net Expenditures under the Budget Proposals

	<u>5-year totals</u> (in billions)					
	<u>1998-</u> <u>2002</u>	<u>2003-</u> <u>2007</u>	<u>2008-</u> <u>2012</u>	<u>2013-</u> <u>2017</u>	<u>2018-</u> <u>2022</u>	<u>2023-</u> <u>2027</u>
Total Medicare expenditures under present law	1362.0	2090.4	3220.1	4856.6	7041.7	9968.0
SMI premium revenues under present law	110.4	138.8	179.9	242.1	327.9	442.8
Net Medicare expenditures under present law (expenditures less premiums) 1/	1251.6	1951.6	3040.1	4614.6	6713.8	9525.2
Reduction in net Medicare expenditures under Budget proposals	106.9	264.1	489.6	821.3	1249.9	1755.7

1/ Does not include HI premiums for the uninsured



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

Phil Gramm File

June 30, 1997

MEMORANDUM TO THE DIRECTOR
DEPUTY DIRECTOR
JOHN HILLEY
GENE SPERLING

FROM: Nancy-Ann Min DeParle

NMD

SUBJECT: Senator Gramm's Request for 30-Year Medicare Projections

As you may recall, several months ago, Senator Gramm asked HHS for 10, 20, and 30-year projections of the Medicare spending and savings in the President's budget. (He first asked for them during Secretary Shalala's Senate Finance hearing on our FY 1998 budget Medicare proposals back in February; he blew up at a Vladeck hearing in March when he hadn't received a response and threatened to hold up all HHS and possibly all Administration nominees). We provided him with the 10-year numbers in late March and advised him that the actuaries were tied up in producing the 1997 Annual Medicare Trustees Report and that we would get back to him about the 20- and 30-year projections after the Trustees Report was finished.

The attached letter and tables respond to Senator Gramm's request. The letter makes clear that these projections are: (1) based on the original President's budget (\$100 billion over 5 years scored on the OMB baseline), not the CBO-scored \$115 billion in the Bipartisan Budget Agreement; and (2) highly uncertain and not very useful. The letter also makes the point that the proposals in the President's budget improved the long-range actuarial balance of the Trust Fund. The tables include not only the total 30-year savings, but also the projected current law baseline spending over the 30-year period. Thus, if Senator Gramm adds up the totals for the 30 years, he can see that we're cutting \$4,687 billion over that time period, which seems huge, but that is out of total projected baseline spending of \$27,097 billion.

Finally, you should know that the economic assumptions used by the actuaries in making these projections are slightly different than those used in the FY 1998 budget. When the actuaries make projections for the annual Trustees Reports, they use their own economic assumptions, which are less optimistic than the Administration's and closer to CBO's. That isn't highlighted here, and it isn't obvious, but it could come up.

I'd recommend that we allow HHS to go ahead and respond to Senator Gramm, but Chris Jennings and I wanted you to see this in case you have a different view. Please let me know by Thursday if you do not want this response to go forward.

cc: Josh Gotbaum
Chris Jennings
Mark Miller



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

Honorable Phil Gramm
United States Senate
Washington, D.C. 20510

DRAFT

Dear Senator Gramm:

In response to your request, I am sending 30-year estimates of the Medicare savings and investment proposals contained in the President's 1998 Budget. The estimates were prepared by HCFA's Office of the Actuary. These estimates reflect the original proposals in the President's budget, but do not reflect the additional proposals agreed to in the bipartisan budget negotiations.

It is important to note that 30-year estimates are subject to great uncertainty and must be used very cautiously with full awareness of their limitations. In particular, the further out the projection period, the greater the uncertainty.

As Table 1 of the attachment indicates, dollar estimates over a 30-year projection period will naturally grow to large magnitudes, as a result of inflation and growth in the number of beneficiaries. Due to the changing value of the dollar over long periods of time, comparisons of dollar amounts in distant periods can be virtually meaningless. Any financial estimates over a 30-year period are likely to be strongly affected by macroeconomic and other changes that are impossible to forecast with certainty. This is particularly the case with the Medicare program where revenues and costs also depend on changes in labor force composition, advances in medical sciences, etc. over the long term. Table 2 of the attachment summarizes the 5-year totals of expenditures, premiums, and net expenditures under present law as well as the reduction in net Medicare expenditures under the Budget proposals.

The Office of the Actuary advises me that the combined impact of all the HI proposals would improve the long-range actuarial balance by an estimated 1.89 percent of payroll. The 1997 Trustees Report shows the 75-year actuarial balance to be -4.32 percent of payroll under present law. The proposals in this package would thus reduce the reported actuarial deficit by about 44 percent.

Please let me know if I can be of further assistance.

Sincerely,

DRAFT

Bruce Vladeck
Administrator

Attachments

Table 1—Estimated Net Savings under Presidents 1996 Budget Medicare Proposals
(Dollars in billions, fiscal years)

	2001	2002	2003	2004	2005	2006	2007	08-07	03-07	06-12	13-17	18-22	23-27
PART A PROPOSALS													
Hospitals													
Reduce Hospital PPS Update A	18.5	17.6	18.0	20.2	21.8	23.2	24.8	10.8	24.0	34.4	51.2	76.2	108.7
Extend PPS Capital Reduction from OBRA 1990	1.5	3.8	4.1	4.3	4.7	5.0	5.3	0.2	7.4	9.5	12.5	16.8	23.4
Reduce PPS Exempt Update w/ Releasing A	4.8	6.2	6.5	5.8	6.4	6.8	7.3	3.1	6.8	10.2	14.7	22.3	31.9
Reduce PPS Exempt Capital Payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase base payment rate to Puerto Rico	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Minimums on Long-term Care Hospitals	1.2	1.3	1.4	1.5	1.6	1.7	1.8	0.4	1.1	2.2	3.6	5.2	8.1
Expand Centers of Excellence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.4	0.5
Lower DRG A	13.4	14.4	15.4	16.5	17.7	18.9	20.3	4.1	13.5	21.8	30.7	40.7	54.7
GME Reform	24.8	29.5	28.4	30.4	32.8	34.9	37.4	3.3	11.5	26.8	54.4	108.9	163.7
Eliminate Add-Ons for Outliers	3.1	3.3	3.6	3.8	4.1	4.4	4.7	2.8	1.8	5.6	8.9	14.2	20.5
PPS Redefined Discharges	3.2	3.4	3.7	3.9	4.2	4.5	4.8	4.0	3.7	7.9	10.7	15.0	21.1
SNF Releasing (w/ add-harmless)	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-0.6	-0.7	-0.8	-1.1	-1.3
RPCH expansion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Medicare dependent hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0
Remove GME, MIE, and DSH from AAPCC	-0.2	-0.0	-0.1	-0.4	-0.9	-0.8	-0.8	-1.9	-3.5	-5.7	-10.1	-17.2	-26.5
Home Health													
HH Freeze Extension	1.2	1.3	1.3	1.4	1.5	1.6	1.7	1.3	2.0	2.9	4.0	5.5	7.7
HH Inflation System	12.8	13.9	13.0	13.3	13.7	14.2	14.8	7.8	16.8	27.3	40.1	59.3	89.0
HH PPS	5.8	6.2	6.3	7.0	7.5	8.0	8.6	4.8	12.3	14.4	19.4	27.0	37.7
HH Location of Service	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.4	0.5	0.8	1.1	1.5	2.1
Redefine "homebound"	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Normative Service Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eliminate HH PPS	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.9	1.5	2.5	3.7	5.1	7.0
Shift to Part B	49.7	53.1	56.7	60.6	64.6	68.2	74.0	64.3	85.5	124.6	169.5	233.5	325.2
Skilled Nursing Facilities													
SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.4	-0.6	-0.8	-1.0	-1.3
SNF PPS	8.9	10.8	11.4	12.2	13.0	14.0	14.9	7.0	14.0	21.4	31.1	45.9	65.5
HMCs													
Medicare Choice (w/90% rate in 2000+)	111.4	119.0	127.5	136.8	146.3	156.7	167.7	55.1	129.1	207.8	324.1	507.9	736.8
PACE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare Secondary Payer (Part A)	1.1	1.2	1.2	1.3	1.4	1.5	1.6	1.0	1.7	2.5	3.8	5.1	7.0
Insurer Reporting, Contact Limits, TPA's, etc.	5.7	6.0	6.3	6.7	7.0	7.4	7.4	3.8	8.0	13.2	19.7	28.0	34.9
MSP Extenders	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.3
Fraud and Abuse A	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
New Benefits													
Colorectal Screening	-0.6	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-1.0	-1.9	-2.5	-2.9	-3.1	-3.4
HI Premiums Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0
Part A Premium Offset	-2.0	-2.1	-2.3	-2.5	-2.6	-2.8	-3.0	-1.6	-3.0	-4.6	-6.5	-9.3	-13.2
Part A Interactions													
Interactions Among Hospital Proposals	-8.0	-8.8	-9.2	-9.8	-10.5	-11.2	-12.0	-0.7	-3.8	-6.7	-16.2	-34.1	-52.7
Total Part A Excluding HH Transfer	145.6	157.1	165.5	169.8	183.6	207.6	221.9	79.5	179.4	283.6	436.6	671.1	872.0
TOTAL PART A	217.2	232.6	249.2	266.6	285.7	308.0	327.2	162.2	302.8	460.4	677.8	1005.3	1434.8
PART B PROPOSALS													
Physicians													
Single Conversion Factor, Overhaul Targets with GDP +	54.8	59.1	63.4	67.6	71.7	75.8	79.1	1.1	18.0	73.3	153.8	264.1	357.4
Single Fee For Surgery	0.0	0.0	0.7	0.7	0.8	0.8	0.9	0.4	0.6	1.2	1.9	2.8	3.9
Incentives for In-hospital MD Services	3.1	3.5	3.5	3.7	3.9	4.0	4.2	1.5	5.3	7.4	11.1	14.9	19.3
Phys Assistant, Nurse Pract, Clinical Nurse Specialists	-0.8	-0.9	-0.8	-1.0	-1.1	-1.2	-1.2	-0.8	-1.1	-1.4	-2.0	-3.0	-4.4
Mark-Up for Drugs	0.3	0.6	0.6	0.8	0.7	0.7	0.8	0.8	1.1	1.4	1.9	2.5	3.4
Interaction among Physician Proposals	-1.2	-1.3	-1.4	-1.4	-1.6	-1.8	-1.8	-0.2	-1.0	-2.2	-3.9	-5.8	-7.5
Hospital OPD													
Eliminate FDC, Extend OBRA 1993, OPD PPS II	10.3	11.3	12.4	13.4	14.8	16.1	17.5	8.1	15.0	19.1	31.5	47.8	74.3
Hospital Revenue	62.3	66.8	75.1	82.3	90.1	98.6	107.7	8.0	30.7	99.8	178.1	288.0	453.7
Beneficiary Copayments	-52.2	-57.3	-62.7	-68.7	-75.3	-82.5	-90.3	0.1	-35.8	-80.4	-148.5	-240.3	-329.5
Medicare Benefit Payments	1.5	1.7	1.8	2.2	2.5	2.8	3.2	0.1	0.5	1.4	3.2	6.4	12.5
GME Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare Secondary Payer (Part B)													
Insurer Reporting, Contact Limits, TPA's, etc.	0.9	1.0	1.0	1.1	1.2	1.2	1.3	0.6	1.1	1.5	2.0	4.2	5.8
MSP Extenders	3.7	3.9	4.1	4.4	4.6	4.8	5.2	1.7	4.8	8.3	12.9	17.5	23.1
Other Providers													
Competitive Bid	4.2	4.4	4.6	5.1	5.5	5.8	6.2	1.3	5.5	8.0	13.5	19.5	27.4
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2	0.2	0.2
Reduce ASC Update: CPI-2 (08-02)	0.9	1.0	1.0	1.1	1.2	1.3	1.3	0.3	1.1	1.8	2.8	4.2	6.0
SNF Consolidated Billing	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.3	0.4	0.5	0.6	1.2	1.7
Profile Lab Tests	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.4	0.5	0.7
HLA Shift to Part B	-46.8	-50.9	-53.5	-57.1	-61.1	-65.3	-69.8	-0.8	-5.6	-11.7	-19.9	-29.2	-39.7
HMCs													
Medicare Choice (w/90% rate in 2000+)	-4.2	-4.8	-5.4	-6.2	-6.8	-7.7	-11.8	-0.6	-10.0	-22.5	-17.7	-19.5	-41.9
PACE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fraud and Abuse A	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1
New Benefits													
Waive Mammography Costsharing	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.6	-0.7	-1.0
Annual Mammogram w/interaction of Waiving Costshare	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	0.4	-0.4	-0.6	-0.7	-1.0	-1.3
Respite Care	-1.0	-1.0	-1.1	-1.2	-1.3	-1.4	-1.4	-1.7	-1.9	-2.4	-3.3	-4.6	-6.3
Chiropractors	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	0.2	-0.3	-0.5	-0.8	-1.1	-1.6
Colorectal Screening	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-0.7	-0.8	-1.5	-2.4	-3.0	-3.3	-3.3
Diabetic Screening	-0.5	-0.8	-0.9	-1.0	-1.1	-1.1	-1.2	-1.4	-1.7	-2.2	-2.9	-3.9	-5.3
Blood Glucose Monitor/Strip	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2	0.2	0.2
HI Premiums Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Flu Shot Administration	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.6	0.4	-0.8	-0.8	-1.1	-1.5	-2.1
Part B Premium													
Extend 2% Premium Beyond 1998	98.9	108.8	114.9	123.7	133.3	143.8	154.4	12.7	65.3	106.6	301.7	482.6	699.9
Actuarially Determined Premium Surcharge	-1.3	-1.4	-1.5	-1.7	-1.8	-2.0	-2.2	-0.8	-1.4	-2.2	-3.6	-5.9	-8.1
Part B Premium Offset	-7.4	-7.8	-8.0	-8.1	-8.1	-7.7	-7.2	-3.0	-4.1	-6.6	-11.4	-14.8	-20.1
Total Part B Excluding HM Transfer	118.6	128.6	135.1	143.3	151.6	159.8	167.8	74.1	78.2	109.9	371.0	567.9	757.4
TOTAL PART B	52.2	53.6	59.0	62.0	64.5	69.9	84.4	-65.3	-38.8	28.2	143.5	214.6	320.9
NET SAVINGS FROM TOTAL PACKAGE	269.4	286.3	308.1	328.6	350.4	377.9	395.5	100.9	264.1	489.8	821.3	1219.9	1755.7

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Table 1--Estimated Net Savings under President's 1994 Budget Medicare Proposals
Dollars in billions, fiscal year

Footnotes:

1. PPS hospital update, FY99-Q1, MS-19
in PPS-extended policy. Rebased, FY98-Q2, MS-15
d IWE schedule, 7.4% in FY 1998, 7.1% in FY 1999, 7.1% in FY 2000, 6.9% in FY 2001, 5.5% in FY2002 and thereafter
d thereafter at this time. Potentially significant cost, probably minimal through 2002, but increasing thereafter
d and no other estimates provided by OIG
d Medicare benefit payments represent the net effect of a small reduction in hospital revenue and the larger reduction in beneficiary expenditures.
in Bill expenditures can be thought of as the net effect of a small reduction in hospital revenue and the larger reduction in beneficiary expenditures.

Notes: 1. Estimates are based on the assumptions underlying the 1997 Trustee Report. These estimates are slightly different from the 10-year estimates previously released because of different baselines (Previous baseline based on OMB assumptions)
The Trustee Report assumes a more recent economic and demographic trends, and different levels of expenditures for growth in the economy

2. Zeros in the table indicate amounts less than \$50 million.

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Table 2--5-Year Totals of Expenditures, Premiums, and Net Expenditures under Present Law and Reduction in Net Expenditures under the Budget Proposals

	<u>5-year totals</u> (in billions)					
	<u>1998- 2002</u>	<u>2003- 2007</u>	<u>2008- 2012</u>	<u>2013- 2017</u>	<u>2018- 2022</u>	<u>2023- 2027</u>
Total Medicare expenditures under present law	1362.0	2090.4	3220.1	4856.6	7041.7	9968.0
SMI premium revenues under present law	110.4	138.8	179.9	242.1	327.9	442.8
Net Medicare expenditures under present law (expenditures less premiums) 1/	1251.6	1951.6	3040.1	4614.6	6713.8	9525.2
Reduction in net Medicare expenditures under Budget proposals	106.9	284.1	489.6	821.3	1249.9	1755.7

1/ Does not include HI premiums for the uninsured

DRAFT

CJ - 10 year Medicare #

TO: Gene
FROM: Chris and Jeanne
RE: **MEDICARE GROWTH COMPARISONS: REVISED**
DATE: May 21, 1997

This is a modification of an earlier table that we gave to you. It now includes the 10 year as well as the 5 year numbers, and we estimated the premium revenue so it shows gross as well as net numbers.

Growth: The total (gross) Medicare spending growth per person is 4.9%, not 4.4%. The 4.4% is the net amount (the total spending minus the premium revenue). Since premium revenue is increasing, the Federal spending growth rate is lower.

When comparing to CBO's projected private premium growth of 4.7%, use 4.9%:

FY 1997 - 2002

CBO's Private Premium Growth:	4.7%
Medicare Spending / Bene:	4.9%
About:	+ 4% above private

As a reminder, in 1995, CBO's projected private premium growth was 7.1%, and Medicare spending per beneficiary grew at an average of 4.9% between 1996 and 2002. This is about 30% below private trends at the time.

GDP: We constrain the growth of Medicare as a percent of GDP considerably, although we do not stop it from increasing.

Medicare total spending will be 2.8% of GDP in 2002 under the Agreement, relative to 3.2% under current law. This is about 10% below the percentage of GDP it would be without the Budget Agreement.

Since Medicare is about 2.8% of GDP today, the Budget Agreement ends the increase in Medicare as a share of GDP.

Please call with questions.

TALKING POINTS
10-Year Medicare Savings
in
President Clinton's Balanced Budget

- The President's budget includes a major commitment to preserve and modernize the Medicare program. Through a series of reforms and restructurings, it saves \$365.9 billion over the next 10 years (FY98-07). These savings come from total baseline spending of \$3.158 trillion during that 10-year period.
- The President's plan extends the solvency of the Medicare trust fund to 2007 – ten years from now. Without this action, Medicare's Hospital Insurance trust fund would be bankrupt in 2001, just four years from now.
- The President's plan restructures the home health benefit so that hospital-related home health visits are paid out of the Hospital Insurance trust fund and non-hospital related visits are paid out of the Part B Supplemental Medical Insurance Trust Fund. This reflects the original intent of the Medicare. The President's package of home health reforms are designed to control the rapid growth of this benefit.
- The President's plan addresses the short-term deficit in the Medicare program and lays the groundwork for a bipartisan effort to deal with the long-term challenge of the retirement of the Baby Boom Generation.
- The President's plan modernizes Medicare by offering beneficiaries new preventive benefits and new choices (PPOs and PSOs).

**Questions and Answers
10-Year Medicare Savings**

Question

In your February budget release you said the 5-year Medicare savings were \$100 billion and the six-year savings were \$138 billion. Now you say it is \$106/\$146 billion. What changed?

The President's budget submitted in February was scored by OMB at \$100 billion over 5 years. A few technical changes were made to this package after the budget numbers were transmitted, including changes to respond to CBO's different baseline assumptions.

Question

The savings from the home health transfer are significantly higher in the 10-year period. Why?

They are not significantly different. This time-frame is twice as long as the previous time-frame. We said the five-year figure was \$82 billion and the six-year figure was \$102 billion. The amount increases as the change in the baseline compounds.

It is very important to note that these savings are NOT part of the \$106/\$146/\$369 billion in savings in 5/6/10 years. They restore the intent of the Medicare statute and strengthen the Part A trust fund by transferring these non-hospital-related costs to Part B.

Question

Since the President was so critical of the Republican plan to cut \$270 billion from Medicare, doesn't this \$369 billion cut seem awfully large?

No. Remember that the \$270 billion was over seven years and the \$366 billion figure is over 10 years. More importantly, there are SIGNIFICANT differences in the policies behind these numbers. The Republican plan would have capped the contribution per beneficiary and significantly increased premiums and out-of-pocket costs for seniors. The President's plan protects seniors and continues the historic defined benefit package.

The President's FY 1998 Budget: Medicare Savings and Investment Proposals a/

FY, \$'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	98-02	98-03	98-07
PART A PROPOSALS													
Managed Care	1.3	3.4	6.7	8.5	10.1	11.4	12.9	14.6	16.4	18.3	30.0	41.4	103.6
Hospitals													
Reduce Hospital PPS Update	0.7	1.4	2.2	3.1	4.0	4.4	4.6	4.9	5.1	5.4	11.4	15.7	35.0
Extend PPS Capital Reduction from OBRA 1990	1.2	1.2	1.3	1.3	1.4	1.4	1.5	1.6	1.6	1.7	6.4	7.8	14.2
Reduce PPS-Exempt Update w/ Rebasng	0.3	0.4	0.6	0.8	1.0	1.1	1.2	1.3	1.4	1.6	3.2	4.3	9.9
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.8	0.8	0.8
Reform Base Puerto Rico Payment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.5	1.5
Expand Centers of Excellence	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.5
Lower IIME	0.2	0.4	0.7	0.9	2.0	2.3	2.5	2.7	2.9	3.1	4.2	6.5	17.6
GME Reform	0.2	0.4	0.7	0.9	1.2	1.5	1.9	2.3	2.7	3.1	3.4	5.0	14.9
Eliminate Add-Ons for Outliers	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.8	0.8	2.6	3.3	6.2
PPS Redefined Discharges	0.7	0.8	0.8	0.9	1.0	1.0	1.1	1.2	1.2	1.3	4.1	5.2	10.0
SCH Rebasng	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6	-0.7	-1.2
RPCB Expansion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.2
Medicare Dependent Hospitals	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Direct Pay of GME/IIME/DSH Removed from AAPCC	-1.1	-1.9	-2.1	-2.6	-3.0	-3.5	-3.9	-4.4	-5.0	-5.7	-10.7	-14.2	-33.2
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.8	-0.9	-1.0	-0.7	-1.3	-4.6
Home Health													
Extend Savings from OBRA 1993 Freeze	0.1	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	1.3	1.6	3.3
HH Interim System	0.9	1.3	1.5	1.8	2.1	2.4	2.8	3.1	3.4	3.7	7.7	10.2	23.1
HH PPS	0.0	0.0	1.5	1.6	1.7	1.8	2.0	2.1	2.2	2.4	4.7	6.5	15.2
Part A Benes Who Choose Not to Enroll in Part B b/	0.0	0.4	0.7	0.8	0.7	0.7	0.8	1.1	1.1	1.2	2.6	3.3	7.4
Fraud and Abuse													
Clarify and Enhance MSP Authority	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	1.0	1.3	2.8
Extend Expiring MSP Provisions	0.0	0.7	0.9	1.1	1.3	1.6	1.7	1.8	2.0	2.1	4.0	5.5	13.0
Revise HIPAA Provisions	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.2	0.3	0.5
Pay Home Health at Location of Service	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.5	0.9
Eliminate Home Health PIP	0.0	0.0	0.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0	1.1	1.4
Require SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.4	-0.8
Skilled Nursing Facilities													
Extend Savings from OBRA 1993 Freeze	0.0	0.2	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.5	1.3	1.7	3.6
Establish SNF PPS	0.0	0.9	1.5	1.7	1.7	1.8	2.0	2.3	2.5	2.7	5.8	7.6	17.1
Beneficiary Investments													
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-1.1	-1.4	-3.0
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Part A Premium Offset	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-1.5	-2.0	-4.4
TOTAL PART A	4.9	10.1	18.6	21.8	25.9	28.5	31.5	34.8	38.0	41.4	81.3	109.8	255.4

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PART B PROPOSALS

Managed Care	-0.1	0.2	1.1	1.7	2.1	1.7	1.5	1.8	1.9	2.2	5.1	6.8	14.2
Hospitals													
Outpatient PPS c/	0.0	1.8	1.8	2.1	2.5	3.7	3.4	4.1	5.0	5.8	8.2	11.9	30.2
Outpatient GME Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2
Physicians and Other Practitioners													
Single Conversion Factor, Reform Update	0.1	0.8	1.5	2.1	2.8	3.6	4.5	5.5	6.8	8.2	7.3	10.9	35.8
Single Fee For Surgery	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.4	0.6	1.2
Incentives for In-Hospital MD Services	0.0	0.0	0.3	0.5	0.7	0.9	0.9	1.0	1.1	1.2	1.5	2.4	6.7
Direct Payment to PA, NP, CNS	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.8	-0.8	-1.7
Pay Acquisition Costs for Drugs	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	1.0	2.0
Increase Access to Chiropractors	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5
Interaction among Physician Proposals	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.2	-0.3	-1.1
Fraud and Abuse													
Clarity and Enhance MSP Authority	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.6	0.8	1.8
Extend Expiring MSP Provisions	0.0	0.3	0.4	0.5	0.6	0.8	0.9	1.0	1.2	1.3	1.9	2.6	7.1
Require SNF Consolidated Billing	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.6
Revise HIPAA Provisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2
Other Providers													
Competitive Bid	0.0	0.0	0.0	0.5	0.8	0.9	1.0	1.1	1.2	1.3	1.4	2.3	7.0
Reduce ASC Update	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.5	1.5
Reform Lab Payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2
Part B Premium													
Extend 25% Premium Beyond 1998	0.0	1.0	2.5	4.1	5.9	8.1	11.0	14.0	17.3	21.0	13.6	21.7	34.9
Premium Offset	0.0	-0.3	-0.7	-1.2	-1.4	-0.9	-0.6	-0.7	-0.7	-0.7	-3.5	-4.4	-7.2
Beneficiary Investments													
Waive Mammography Costsharing	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.3	-0.6
Annual Mammogram	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4	-0.5	-0.8
Respite Care	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-1.7	-2.0	-3.6
Colorectal Screening	0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.7	-0.9	-2.2
Diabetic Screening	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-1.5	-1.8	-3.3
Blood Glucose Monitor Strips	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Preventive Injections	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.4	-0.5	-1.1
Actuarially Determined Premium Surcharge	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.8	-1.0	-2.2
Appropriate Outpatient Coinsurance c/	0.0	-1.1	-1.3	-1.8	-2.8	-6.6	-8.5	-10.2	-12.4	-14.7	-8.8	-13.4	-59.2
TOTAL PART B	-0.4	2.0	4.9	7.8	10.6	11.2	13.2	16.7	20.2	24.3	24.9	36.1	110.5
NET SAVINGS FROM TOTAL PACKAGE	4.5	12.1	23.5	29.5	36.5	39.7	44.7	51.5	58.2	65.8	106.1	145.8	365.9

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	98-02	98-03	98-07
Home Health Reallocation													
Part A Home Health Spending Reallocated d/	14.4	15.6	15.8	17.3	18.9	20.5	22.2	24.0	25.8	27.8	82.0	102.4	202.1

Footnotes:
 a/ The President's FY 1998 Budget submitted in February was scored by DMB at \$100 billion over 5 years. A few technical changes were made to this package after budget numbers were transmitted, including changes to respond to CBO's different baseline assumptions. These changes took the package as scored by DMB up to \$100 billion. CBO, however, scored this revised package as saving \$82 billion over 5 years.
 b/ Includes interactions with other HFA proposals.
 c/ The net budget impact of the Outpatient PPS proposal is equal to the Federal costs of appropriate outpatient coinsurance (\$59.2 billion) net of the Federal savings of OPO PPS (\$30.2 billion) or \$29.0 billion over 10 years. In addition, there is a net budget impact of OPO PPS on the budget that equal to \$9.8 billion over 10 years.
 d/ These figures represent the total amount of the Home Health Reallocation from Part A including the impacts on both the fee-for-service and managed care factors. The line in the savings table titled Part A beneficiaries who choose not to Enroll in Part B represents the fee-for-service effect; the managed care effects are included in the Part A managed care figures.

check computer insert
Nov. 1996

Medicare: Long-term Challenge
RL

Medicare insert for Gene

The three primary drivers of Medicare expenditures are enrollment, use of services, and of course price. All three of these components are increasing at rates far beyond the current projections of incoming revenue to the program and also beyond projected per capita GDP growth rates.

Without question, the demographics associated with an aging population plays the most significant factor in the intimidating projections of future Medicare expenditures. The current elderly growth rates are nearly twice the rate of the general population. Beginning in 2010, as the baby boom starts to retire, the growth rate in the elderly population doubles. Moreover, the 85 plus population -- who are the most expensive Medicare beneficiaries -- will double between 1990 and 2010 (from 3 million to 6 million), and double again by 2040. Not surprisingly, much greater costs accrue to the program because many more Americans are reaching Medicare eligibility age and, when they do, they stay in the program and use services for longer periods of time.

The demographic changes are also contributing to the much greater use of long-term care services for the chronically ill. In recent years, we have witnessed double-digit growth rate increases in Medicare expenditures for home health, nursing home and hospice care. In fact, the 13 percent of Medicare beneficiaries with long-term care needs account for a third of all Medicare spending. [Forthcoming HCFA REVIEW]. There is little question, in fact, that the Medicare home care benefit has become an unofficial long-term care benefit for Medicare beneficiaries. Over 40 percent of home health spending is for the 10 percent of home health care users with 200 or more visits in a year. [Office of Actuary] 100 visit increase.... The increased utilization of these services, combined with a much greater reliance on high-priced technology, continue to make significant contributions to expenditure growth.

On the price side of the equation, there is little evidence to suggest that health care inflation will ever be consistently constrained to general inflation rates. In fact, despite some reductions in health care cost growth in recent years, new reports coming out suggest that health care costs are about to increase again -- much closer to the historically 1.5 to 2 times greater than CPI increases.

Managed care is having greater success than traditional fee-for-service plans in constraining costs growth. In the private sector, fee-for-service premiums are increasing at levels that are almost twice as high as managed care plans. Moreover, recent evidence seems to suggest that these lower growth rates may not be just a short-term, one-time savings phenomenon. Unfortunately for the taxpayers supporting Medicare, they are not sharing in the savings. The program's current payment methodology overcompensates plans and, as a result, the program currently is losing money on each beneficiary who opts for Medicare managed care. This is because the payment to plans is linked to the higher fee-for-service payment rates. Because current managed care enrollees appear to be much healthier than average, plans reaping great savings -- even though some are plowing back these savings into benefits.

Unfortunately, because the Medicare benefit is significantly less generous than traditional private health care plans, there is little fat to cut from the program to achieve savings. In fact, 80 percent of private health plans provide more generous benefits. (Unlike most private plans, Medicare has no limit on out-of-pocket spending, no drug coverage, and a high inpatient hospital deductible.) As a result, Medicare actually only covers 45 percent of health care spending on the elderly. Reflecting the benefit, 90 percent of older Americans either have a private Medigap wrap-around plan or Medicaid coverage that supplements Medicare.

There is little question that there is savings in Medicare program. It is currently growing at around 7 percent per capita, whereas the private sector growth rate is closer to 5.5-6 percent. The Administration's Medicare plan will get the program to at or very near this level. The outstanding question is there much more savings that can be achieved without harming the program or the beneficiaries it serves. Outside economists, like Reischauer, suggest that Medicare probably can't be expected to grow at rates significantly below the private sector.

~~The ~~best~~ ~~idea~~ ~~is~~ ~~to~~ ~~find~~ ~~ways~~ ~~to~~ ~~save~~~~

The question is this: given the nature of the current health care system, is there any way to achieve savings without harming the program or the beneficiaries it serves? The answer is probably not. The current system is a complex web of interests and incentives that make it difficult to change. The only way to achieve savings is to change the system itself, which is a task that will be extremely difficult.

If there is to be any savings, the system must be fundamentally reformed. The current system is not sustainable, and the challenges ahead will be great. The only way to achieve savings is to change the system itself, which is a task that will be extremely difficult.

June 3, 1997



Health Division



Office of Management and Budget
Executive Office of the President
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Medicare Trust Fund
Commission Briefing
Document

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Attached please find a briefing document on the Medicare Trust Fund Commission put together by the Health Financing Branch.

This document outlines a series of issues to consider in designing a Commission on the long-term financing of Medicare. It provides some history on commissions, a review of design issues (e.g., goals, staffing), and some possible Commission designs. Relevant recent legislation is also attached. It will be useful if this issue becomes a point of negotiation.

Call Mark Miller (x57810) or Bob Donnelly (x5714) with questions.

Commission to Deal With Medicare Long-Term Financing: Design Issues

ISSUE: If a commission is chosen as the vehicle to achieve Medicare reforms to address the long-term financing problems of the Medicare program, how should the commission be designed?⁷⁴

DESCRIPTION OF THE ISSUE: A recent idea in the Medicare debate has been to appoint a bipartisan commission on the long-term financing of the program and to assign that commission the task of producing an acceptable plan.⁷⁵ With reference to previous commission-based reform efforts, this paper lays out the critical dimensions of a commission on Medicare reform.

ANALYSIS:

Previous Commissions

Because of their high visibility, varied compositions, and differing results, we selected the 1983 National Commission on Social Security Reform, military base closure efforts, and the 1995 Bipartisan Commission on Entitlement and Tax Reform (the Kerrey-Danforth Commission) as starting points in evaluating design options for a Medicare commission. Each of these commissions was appointed to address serious financing problems in politically sensitive programs. The experience of these commissions can be used to guide in the establishment of a Medicare reform commission.

National Commission on Social Security Reform (NCSSR). The NCSSR was established by Executive Order 12335 on December 16th 1981 to provide recommendations to assure the long-term solvency of the Social Security Trust Funds and the provision of appropriate benefits. About one year later, the NCSSR submitted its report to the President on January 20th 1983. Of the 15 members of the NCSSR, 5 were appointed by the President (not more than 3 of the same party), 5 were selected by the Senate Majority Leader (not more than 3 of the same party), and 5 were selected by the Speaker of the House (not more than 3 of the same

⁷⁴(Note: the commission discussed in this paper is separate from the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, established by President Clinton by Executive Order 13017 on September 5, 1996. That Commission is to study quality and consumer issues in the health care industry in general, while the commission discussed in this paper would make recommendations on Medicare-specific financing reforms.)

⁷⁵In the course of the recent Presidential and Vice-Presidential debates, both parties endorsed the idea of a commission to address Medicare's financing problems. In addition, the idea of a commission to deal with the long-term financing problems if Medicare has been included in several pieces of legislation, most notably the House version of the FY 1996 reconciliation bill and the Coalition's balanced budget proposal (see Attachment A for examples of recent legislation calling for a Medicare commission).

party). In addition, the President designated a chairperson from the members of the Commission.⁷⁶ In the case of the NCSSR, staffing was not of great importance, because the Commission's negotiations involved leaders (Stockman and Ball) who had in-depth knowledge of Social Security, its problems, and the possible solutions. The NCSSR faced a hard deadline in that Social Security checks would be delayed in July of 1983 if a plan had not been enacted by late April of 1983 (SSA needed time to prepare its computers for the July checks). The NCSSR's final recommendations faced several difficult votes in Congress, but finally were passed and signed into law on April 20th, 1983.

In his book Artful Work: the Politics of Social Security Reform, Paul Light discusses the NCSSR, and finds its major contribution to be that it provided the cover for the political participants to negotiate potentially painful solutions away from public scrutiny. Since the final compromise had to get through Congress and be signed by the President, it was imperative to allow the two sides to negotiate, but negotiation required some distancing from media and interest group pressure. In Thinking in Time, Richard E. Neustadt and Ernest R. May argue that a large portion of the success of the NCSSR is attributable to the inclusion on the Commission of the most important leaders on Social Security at the time and the Administration's eventual understanding that this commission could produce real results (rather than simply shelving the problem).

Military Base Closure. In the past ten years, there have been four rounds of military base closings, overseen by two separate commissions. The Base Realignment and Closure Commission (BRAC), authorized in 1988 by P.L. 100-526, consisted of 12 members appointed by the Secretary of Defense. The BRAC had its own professional staff, with the stipulation in law that only half of the staff could have been employed by the Department of Defense in the previous year. The BRAC reached its conclusions based on private meetings, and its recommendations were subject to expedited review by Congress (no amendments) and the President -- the recommendations could not be changed. If Congress did not vote to disapprove the entire package the recommendations would have the force of law. Congress did not pass a joint resolution disapproving the BRAC recommendations in May of 1989, and so the recommendations assumed the force of law.

The Defense Base Closure and Realignment Commission (DBCRC) was established by P.L. 101-510 in 1990 to oversee three rounds of base closings in 1991, 1993, and 1995. The DBCRC's eight members were appointed by the President, the Speaker of the House, and the Senate Majority Leader. The DBCRC had its own professional staff, with limits in the authorizing law on the number and duties of Defense Department employees on the staff. The DBCRC conducted its business in open meetings, and its

⁷⁶Members of the NCSSR included: Senators Dole, Moynihan, Armstrong, and Heinz; Representatives Archer, Conable, and Pepper; and Chairman Alan Greenspan. OMB Director David Stockman, although not an official member of the Commission, played an important role in negotiating the final agreement for the Administration.

recommendations faced the same expedited rules for consideration as the BRAC's recommendations. All of the DBCRC's recommendations were approved by the President and in all three cases the Congress failed to pass a joint resolution disapproving of the recommendations.

The 1995 Bipartisan Commission on Entitlement and Tax Reform (the Kerrey-Danforth Commission). Established by President Clinton in Executive Order 12878, the Kerrey-Danforth Commission consisted of 32 members (mostly members of Congress) and had the goal of producing recommendations to curb the growth of Federal entitlement spending. All of the Kerrey-Danforth Commission's meetings were public (on C-SPAN), and the Commission had its own professional staff. While the Commission voted overwhelmingly for an interim report in 1994 which laid out the problems of out-of-control entitlement spending, it was unable to agree on a final set of recommendations. The Commission's final report, released in January of 1995, included many sets of reform proposals, each championed by an individual member or group of members of the Commission. None of the Commissioners plans have become law.

Medicare Commission Proposals

During the FY 1996 Budget Reconciliation debates, the original House bill -- as well as the Coalition's Balanced Budget -- included a provision to create a commission to address the long-term financing problems of Medicare (the lack of a similar provision in the Senate bill is probably due to the Senate's Byrd Rule against extraneous provisions in reconciliation bills). These provisions would have established a commission, which was to submit recommendations on the long-term financing of Medicare in May of 1997.

Further interest in the idea of a Medicare reform commission was expressed by both parties in the Presidential and Vice Presidential debates, and Senator Cochran (R-MS) included a provision to create a Medicare commission modeled after the military base closure commissions when he introduced the President's FY 1997 Budget Medicare policies as a stand-alone bill (S1926) in June.

Drawing from these previous commissions, we have isolated six characteristics which should be considered in designing a commission to address the long-term financing problems of Medicare. We discuss these characteristics below.

Defining the Problem

One of the most important issues in establishing a Medicare reform commission is the definition of the problem. Among the salient questions are:

- (1) Is the commission to produce a plan to meet the Trustees' definition of long-term solvency (75 years), some other solvency goal, or some other goal altogether? Is the commission to work on short-term solvency issues as well? The answer to this question will frame the types of solutions (i.e. structural or piecemeal) needed to address the problem and points to the need to define the problem in a way that does not unintentionally eliminate potential solutions.
- (2) Who certifies that the problem is fixed, and what assumptions do they use?⁷⁷ This question is pivotal, because small differences in assumptions can create vast differences over a long forecast period. In addition, it is important to select an entity to certify that the final plan solves the program's financing problems so that all participants can have confidence in the integrity of the commission's work.
- (3) Is the problem Part A solvency or overall Medicare spending growth? The answer to this question will inform the commission about the necessity to reform Part B spending as part of its work.

The Role of Pressure

The design of a commission must consider whether and how to create a political environment that will favor action over inaction. While there seems to be agreement that something needs to be done to rein in Medicare spending growth and to safeguard the program's financing, without an impending crisis it is likely that the will to reduce Medicare's growth will not materialize. Politicians are unlikely to make big reductions in a popular program when the consequences of inaction will be felt by a successor. To address a similar problem in the Social Security reform effort of the early 1980's, the Congress created an artificial crisis by allowing borrowing between the Trust Funds for only one year to support Social Security. This had the effect of ensuring that the OASI Trust Fund would run out of money during 1983, and that checks could not be mailed in July 1983 without further action. This deadline motivated political leaders to focus on Social Security's financing problems, and to agree on a compromise solution.

A similar approach could be used in establishing a Medicare commission. In the commission's authorizing legislation, for example, large, across-the-board cuts (affecting both providers and beneficiaries) could be triggered if no reforms are enacted by a date certain.

⁷⁷A possible solution to this problem would be to use the Trustees' intermediate assumptions and the Trustees' actuaries (actually HCFA's Office of the Actuary). The advantages to such a plan are that all sides seem to have defaulted to using the Trustees' intermediate assumption scenario as the best estimate of the Trust Fund's future, and that using HCFA's actuaries have traditionally played this role. Alternatively, the non-partisan American Academy of Actuaries could be engaged to do the estimation for the commission's purposes.

Alternatively, if no "short-term" Medicare savings are agreed to, the commission may have to deal with the HI Trust Fund's insolvency as a motivating crisis.

Goals of a Commission

Another point which must be clarified refers to the commission's goals. Possible goals include producing legislation for expedited review that will address the problem as posed to the commission, or simply drafting a set of recommendations to submit to Congress.

In defining the goals of the commission, it will be important to establish beforehand any solutions which will be unacceptable to the Administration. For example, if the Administration cannot support the imposition of a Part A premium, it would be preferable to include a prohibition of such a policy in the commission's authorizing legislation (although such language may require concessions on policies found to be unacceptable to the Congress). An alternative to forbidding the inclusion of a particular option in the commission's recommendations, the legislation could require two sets of recommendations, with the stipulation that one not include the objectionable provision. While such a strategy would have the effect of limiting the commission's options, it could also keep the commission from producing a recommendation which is unacceptable *a priori*.

Commission Membership

In deciding how to appoint members to a Medicare reform commission, one could follow the lead of the National Commission on Social Security Reform and the Defense Base Closure and Realignment Commission by splitting the membership between Presidential and Congressional appointees, with Congressional appointees allocated to ensure bipartisan membership. In addition one might include the OMB Director among the President's appointees in order to be sure of high-level Administration support of the resulting plan.⁷⁸ Finally, the commission should be limited to a workable number of members (as in the National Commission on Social Security Reform and the Defense Base Closure and Realignment Commission). The Kerrey-Danforth Commission is a clear example of the inability of a large commission to negotiate and agree on a plan to make painful cuts.

Hearings

In setting the commission's meetings, there is a trade-off: public hearings would allow the commission to get more information from interest groups, but also allow the interest groups a better look at the solutions being considered and a better chance to apply pressure to stop the eventual plan. Private meetings can lead to accusations of hidden dealings (as in the development of the Administration's

⁷⁸ Although the OMB Director has not been an official member of the Social Security, base closure, or Kerrey-Danforth commissions, published accounts show that the participation of David Stockman in the negotiations of the National Commission on Social Security Reform was essential, because the other participants (except Robert Ball) did not have sufficient command of the program details to negotiate effectively. Director Stockman's position in the negotiations also ensured that the Administration's position was clearly represented in the Commission's negotiations.

Health Security Act), but can provide the political cover to float compromises which would be unpopular in open hearings. A possible solution would be to hold public hearings to allow interested parties to have input into the commission's workings, but meet in private to negotiate.

Enforcement/Legislative Short-cuts

Another key component in the design of a commission to address the long-term financing problems of Medicare is the inclusion in the commission's authorizing legislation provisions to expedite the implementation of the commission's recommendations. In the case of the military base closure commissions, the President was able only to accept or reject the Commissions' recommendations in their entirety, and the Congress would have had to pass a joint resolution disapproving all of the Commission's plans in order to block implementation. In the case of the NCSSR, on the other hand, the Commission's recommendations were passed quickly by Congress and signed by the President with few changes, but quick review was enforced in this case by the looming crisis of no Social Security checks being sent.⁷⁹ Finally, the Kerrey-Danforth commission's role was merely advisory, and its recommendations received no special treatment on the Hill. Based on the outcomes of these commission efforts, if the recommendations of the commission are accorded expedited legislative procedures, then the commission's recommendations are more likely to be enacted.

Staffing

A final concern in the design of a Medicare reform commission is staffing. Because of the complexity of the issues involved in Medicare, a good professional staff will be needed to provide analysis to the commissioners as they develop options and negotiate solutions. The commission's staff can simply be hired for the life of the commission, detailed from various places (HHS, OMB, ProPAC, PPRC, Budget Committee staff, CBO), or some combination of the two. It may be possible to design the commission's staff so that OMB staff are detailed to the commission -- this will help to provide information to OMB of the commission's proceedings. Such a commission staff including detailed Federal employees would be justified, given the concentration of knowledgeable Medicare analysts in the Federal government, although it may be necessary to include analysts from outside the federal government on the commission's staff to avoid the perception that the commission is "owned" by the agencies.⁸⁰

⁷⁹The Commission left it the Congress to choose between two options -- raise the retirement age to 67, or increase taxes -- to achieve the Commission's self-imposed savings target (\$200 billion in short-term savings/revenues and 1.8% of taxable payroll in the long-term). The House considered the NCSSR's recommendations under a modified closed rule and chose to raise the eligibility age. In addition, the Senate included an amendment to extend Social Security coverage to federal employees.

⁸⁰The effort to produce the Administration's Health Security Act suffered from such a perception that the plan was drafted behind closed doors and without non-governmental input.

Possible Commission Designs

Because there are many possible designs for a Medicare reform commission, and many of the decisions involved in establishing such a commission hinge on political concerns, we are hesitant to present a firm recommendation. Instead, we present three commission configurations to lay out the range of possible outcomes.

Hard trigger/legislative short-cuts: Under this scenario, a hard trigger (a proportional reduction in payments/increase in copayments) would be included in the authorizing legislation to create pressure for a resolution. The commission would generate legislation which would be subject to an expedited process, with the President or Congress needing to act to stop implementation (i.e., a joint resolution of disapproval or a veto).

No trigger/legislative short-cuts: Under this scenario, there would be no trigger (although impending insolvency could serve that purpose). The commission's legislation would still face an expedited process and no amendments, but Congress would have to vote to pass the commission's reforms.

No trigger/no legislative short-cuts (advisory commission): Under this scenario, there would be no trigger to enforce a solution. In addition, the commission would be charged not with writing legislation, but rather with drafting a set of reform proposals for the President and Congress to consider.

Attachment A

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S.1926

Emergency Medicare Protection Act of 1996 (Introduced in the Senate)

TITLE III--NATIONAL COMMISSION ON MEDICARE REFORM

SEC. 11301. ESTABLISHMENT OF COMMISSION.

(a) ESTABLISHMENT- There is established a Commission to be known as the National Commission on Medicare Reform (in this title referred to as the 'Commission').

(b) MEMBERSHIP-

(1) COMPOSITION- The Commission shall be composed of 15 members of whom--

(A) five shall be appointed by the President from among officers or employees of the executive branch, private citizens of the United States, or both, of whom not more than 3 shall be of the same political party;

(B) five shall be appointed by the majority leader of the Senate from among Members of the Senate, private citizens of the United States, or both, of whom not more than 3 shall be of the same political party; and

(C) five shall be appointed by the Speaker of the House of Representatives from among Members of the House of Representatives, private citizens of the United States, or both, of whom not more than 3 shall be of the same political party;

(2) CHAIR- The President shall designate a Chair from among the members of the Commission.

(3) DATE- The appointments of the members of the Commission shall be made not later than 60 days after the date of the enactment of this title.

(c) PERIOD OF APPOINTMENT; VACANCIES- Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(d) INITIAL MEETING- Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(e) MEETINGS- The Commission shall meet at the call of the Chair.

(f) QUORUM- A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

SEC. 11302. DUTIES OF THE COMMISSION.

(a) IN GENERAL- The Commission shall--

(1) review relevant analyses of the current and long-term financial condition of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under title XVIII of the Social Security Act;

(2) identify problems that may threaten the long-term solvency of such trust funds;

(3) analyze potential solutions to such problems that will both assure the financial integrity of the Medicare program under such title and the provision of appropriate benefits under such program; and

(4) provide appropriate recommendations to the Secretary of Health and Human Services, the President, and the Congress.

(b) LEGISLATIVE PROPOSAL- Not later than 1 year after all of the members of the Commission have been appointed, the Commission shall develop a legislative proposal that carries out the recommendations provided under subsection (a)(4). Such legislative proposal shall be submitted to Congress in the form of an implementing bill which contains the statutory provisions necessary or appropriate to implement the proposal. An implementing bill submitted in accordance with this subsection shall be considered by Congress under the procedures described in section 11306(b).

SEC. 11303. POWERS OF THE COMMISSION.

(a) HEARINGS- The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this title.

(b) INFORMATION FROM FEDERAL AGENCIES- The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this title. Upon request of the Chair of the Commission, the head of such department or agency shall furnish such information to the Commission.

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S.1926

Emergency Medicare Protection Act of 1996 (Introduced in the Senate)

(c) **POSTAL SERVICES**- The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(d) **GIFTS**- The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 11304. COMMISSION PERSONNEL MATTERS.

(a) **COMPENSATION OF MEMBERS**- All members of the Commission shall serve without any additional compensation for their work on the Commission.

(b) **TRAVEL EXPENSES**- The members of the Commission appointed from among private citizens of the United States shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(c) **STAFF**-

(1) **IN GENERAL**- The Chair of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties.

(2) **COMPENSATION**- The Chair of the Commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(d) **DETAIL OF GOVERNMENT EMPLOYEES**- Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(e) **PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES**- The Chair of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

SEC. 11305. TERMINATION OF THE COMMISSION.

The Commission shall terminate 30 days after the date on which the Commission submits its legislative proposal to Congress under section 11302(b).

SEC. 11306. CONGRESSIONAL CONSIDERATION OF COMMISSION PROPOSALS.

(a) IN GENERAL- The implementing bill described in section 11302(b) shall be considered by Congress under the procedures for consideration described in subsection (b).

(b) INTRODUCTION AND REFERRAL-

(1) IN GENERAL- On the day on which the implementing bill described in subsection (a) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the majority leader of the House, for himself or herself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself or herself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(2) AMENDMENTS PROHIBITED- No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

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Emergency Medicare Protection Act of 1996 (Introduced in the Senate)

(c) DISCHARGE- If the committee to which an implementing bill described in subsection (a) is referred has not reported such implementing bill (or an identical implementing bill) by the close of the 30th day after its introduction, such committee shall be, at the end of such period, discharged from further consideration of such implementing bill, and such implementing bill shall be placed on the appropriate calendar of the House involved.

(d) CONSIDERATION-

(1) IN GENERAL- On or after the third day after the date on which the committee to which such an implementing bill is referred has reported, or has been discharged (under subsection (c)) from further consideration of, such an implementing bill, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementing bill. A Member may make the motion only on the day after the calendar day on which the Member announces to the House concerned the Member's intention to make the motion, except that, in the case of the House of Representatives, the motion may be made without such prior announcement if the motion is made by direction of the committee to which the implementing bill was referred. All points of order against the implementing bill (and against consideration of the implementing bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementing bill is agreed to, the respective House shall immediately proceed to consideration of the implementing bill without intervening motion, order, or other business, and the implementing bill shall remain the unfinished business of the respective House until disposed of.

(2) DEBATE- Debate on the implementing bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 30 hours, which shall be divided equally between those favoring and those opposing the implementing bill. An amendment to the implementing bill is not in order. A motion to further limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the implementing bill is not in order. A motion to reconsider the vote by which the implementing bill is agreed to or disagreed to is not in order.

(3) VOTE ON FINAL PASSAGE- Immediately following the conclusion of the debate on an implementing bill described in subsection (a), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementing bill shall occur.

(4) APPEALS- Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure

relating to an implementing bill described in subsection (a) shall be decided without debate.

(e) CONSIDERATION BY OTHER HOUSE-

(1) IN GENERAL- If, before the passage by one House of an implementing bill of that House described in subsection (a), that House receives from the other House an implementing bill described in subsection (a), then the following procedures shall apply:

(A) The implementing bill of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subparagraph (B)(ii).

(B) With respect to an implementing bill described in subsection (a) of the House receiving the implementing bill--

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Emergency Medicare Protection Act of 1996 (Introduced in the Senate)

(i) the procedure in that House shall be the same as if no implementing bill had been received from the other House; but

(ii) the vote on final passage shall be on the implementing bill of the other House.

(2) IMPLEMENTING BILL IN RECEIVING HOUSE- Upon disposition of the implementing bill received from the other House, it shall no longer be in order to consider the implementing bill that originated in the receiving House.

(f) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES- This section is enacted by Congress--

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 11307. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out the purposes of the Commission.

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H.R.2530

Common Sense Balanced Budget Act of 1995 (Introduced in the House)

SEC. 8032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT- There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the 'Commission').

(b) DUTIES-

(1) IN GENERAL- The Commission shall--

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning

approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS- In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the enforcement of medicare budget targets under section 8701 for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing coverage under Medicare Choice under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP-

(1) APPOINTMENT- The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN- The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES- Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM- A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS- The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES- Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS-

(1) STAFF- The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

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H.R.2425

To amend title XVIII of the Social Security Act to preserve and reform the medicare program. (Passed by the House)

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT- There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the 'Commission').

(b) DUTIES-

(1) IN GENERAL- The Commission shall--

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS- In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the application of the failsafe budget mechanism under section 1895 of the Social Security Act for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing coverage under MedicarePlus under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP-

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(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN- The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES- Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM- A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

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DECISIONS TO FOR OUR BOTTOM LINE ON THE BUDGET

1. MEDICARE:

- What is the highest number we can go to? \$110-117? What are the six and seven year implications? (over \$114 puts you are \$168 over six years, and over \$200 billion over seven years?)
- Which of the steps do we take to get there and in what order?
 - Drop OPD
 - Drop OPD partially?
 - Drop Alzheimer
 - Add Blue Dog Home Health shift Premium for families over \$30,000
 - High income premium (75% of subsidy) and at what income levels?
- Are there policies outside of budget window we would accept?
 - Indexing deductible or going up to \$150 and indexing?
 - Any co-payments?
- New policy on Managed care? (willing to look at different methods of different base payment rates, but not going to have differential growth rates that is not linked to the overall program growth rate or hurt Medicare Trust Fund)
- No way on MSAs, balanced billing, caps, association plans for healthy?
- Not go below private sector per capita growth rate

Context: This is not just about numbers. Republicans will care Implications It will be very hard difficult to get the home health shift without some of it included in the premiums. Domenici may be willing to accept less that he would prefer if May want to structure some of our \$100 billion downward when we come up with additional savings.

2. MEDICAID:

- Are we willing to drop per capita cap?
- If we can keep it, can we squeeze it tighter?
- Are we willing to go above \$22 billion in gross savings?
- Are we willing to give any more on flexibility?
- Are we willing to increase DSH savings if we lose per capita cap?
- Are we willing to get larger DSH savings without larger targeting?
- Are we willing to drop any of our Medicaid investments if per capita cap is dropped?
- Can we devise children's program in a way more acceptable to Republicans
- Would we drop worker's between jobs and use funds for alternative children's health coverage?
- Are we willing to drop any of our \$18 billion in children's health coverage?

Context: There may be no support for per capita cap among Governors? Do we seek to lock in per capita cap in room without Governor's support. Key issue is whether our Democrats in the room will support our per capita cap.

3. WELFARE:

- Are we willing to give in on prospective change on immigrants?
Do we have compromise provisions on prospective changes
- Bottom line on food stamps? Can we live without 18-50 change?
- Alternative proposals on 18-50 possible?
- Shelter cap deductions?
- Bottom line on \$3 billion welfare-to-work. Can we devise an add-on to TANIF that meets our need of additional work?

Context: Republicans are strongly opposed to new \$3 billion welfare to work initiative, but there is clearly a better chance if it was devised as add-on to existing program instead of a new program. Domenici is himself open on food stamp changes 18-50, but Kasich is rock-solid opposed and it may be a non-starter, though we should have alternative proposals. We seem to have agreement on retroactive application on immigrants, but prospective is very shaky. A revised proposal could help. There are other issues like shelter deduction we need to consider how hard we will fight on.

4. PRESIDENTIAL NON-DISCRETIONARY PRIORITIES?

- Which must we get?
- Above welfare choices?
- children's health initiative
- America Reads and School Construction?
- Can we fit either American Reads or School Construction in discretionary?

Context:

5. NON-DEFENSE DISCRETIONARY:

- Do we to lower?
- If so, how much in 1998 and 2002?
- How much 1998-2002
- Are there ways of making the NDD look lower?
- Which priorities are most important to lock in and how?
- Are there any major programs or even departments we could recommend eliminating?
- Do we accept a firewall for NDD if we get a number we can like?

Context: We feel we are close to our limit on NDD, and that going lower will eventually come out of priorities. Kasich contends that he can accept going significantly above a freeze, but that we have to come down significant as well for him to have any chance of selling it to House Republicans. There is some thought that if we came up with program or department eliminations that might make it easier for House Republicans to accept a much higher number than they can stomach. They have expressed a willingness to fence in some of our priorities, though they have been vague about what and how.

6. DEFENSE:

- If they offer a lower outyear number, can we accept it?
- What policies would they have to change?
- Could we get the QDR to reflect a budget deal?

Context: Republicans have lower outyear defense numbers? If they propose them to us, could we accept a number below our projections. Further problem is that they have more pork than we do, and if they insist on it would drive our policy changes further down. They will not accept lower defense number from us if QDR immediately contradicts it. Further issue is how much the two budget chairman speak for their members on this issue.

7. CPI:

- Can we take substitution bias correction sooner than BLS would bless it?
- If we go to .5, do we have to have a poor Social Security recipient equity adjustment?
- How would such a lower-income Social Security equity adjustment be designed?
- Do we seek to get something like .15 thought of as being in the baseline, because it lowers the additional number we would be adding to .35 or .15?

Context: BLS's experimental index would not be incorporated until 1999 -- lowering the potential savings. If we legislate the savings before that, we contradict the "BLS-blessing strategy. On the other hand, if we legislate additional downward adjustment for quality, one could argue that once we ask members to vote for a legislative change on .2, speeding up part of the .3 will be a minor lift.

8. BUDGET ENFORCEMENT:

Would we accept additional budget enforcement mechanism beyond the paygo rules and discretionary caps?

Context: Even though there has been virtual silence on this issue so far in negotiations, the fact is that additional budget enforcement could still be a potential trade for getting additional adjustments to our economic numbers.

9. Economic Assumptions:

Can we settle without getting the full income shares?

Would we trade additional budget enforcement for more OMB assumptions?

10. TAXES:

What do we have to have to win on our tax cuts?

What is our bottom line on education tax cuts?

Are willing to go up or down on child tax cut?

Would we drop the IRA?

Could we expand it for education without backloading?

What adjustments are we willing to make for education tax cuts?

How much could we give on capital gain?

How much could we give on estate taxes?