

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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Number of Pages + cover \_\_\_\_\_

REMARKS:

This is pretty pathetic.  
BUTLER HAS PUT OUT  
THE "SABO" METHOD OF  
BASLINE COMPARISON.

FYI

214 Massachusetts Avenue N.E.  
Washington, D.C. 20002-4999  
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# F.Y.I.

August 4, 1995

## COMPARING APPLES WITH APPLES ON MEDICARE

By Stuart M. Butler

Vice President and Director of Domestic and Economic Policy Studies

The White House and congressional Democrats have attempted in recent weeks to draw a stark distinction between the Medicare savings projected in the House-Senate Conference Budget Resolution and President Clinton's budget plan, released in June. Americans are being told that while the President's plan seeks to achieve only \$128 billion in savings over the next seven years, the Conference Budget Resolution seeks to achieve \$270 billion in savings. Hence, the impression is created that Congress intends to reduce projected Medicare spending by more than double the amount favored by the White House.

The facts are quite different. Because the "baseline" used by the White House is different from the one used by Congress, the comparison made by the White House is the numerical equivalent of comparing apples with oranges. When the same baseline is used, the savings desired by each end of Pennsylvania Avenue turn out to be much closer.

A baseline is a projection of spending under current law, using assumptions about utilization, growth of the eligible population, and other factors. There are savings in a Budget Resolution or a White House budget if the spending targets in the budget document are below the baseline. Obviously, the level of saving will depend on who develops the baseline and what assumptions they use.

The reason the White House greatly exaggerates the difference in projected savings between the Administration's plan and that of Congress is that the White House uses a Medicare baseline developed by its own Office of Management and Budget, while Congress uses the baseline developed by the nonpartisan Congressional Budget Office (which "scores" all budget-related legislation).

Even small differences in assumptions can make a significant difference in a baseline. For Medicare Part A, for instance, the CBO projects an average annual cost growth of 7.9 percent over the next ten years, while the OMB projects the rate at 7.5 percent. For Part B, the CBO expects a 12.3 percent growth rate, while the OMB projects only a 10.9 percent growth rate.

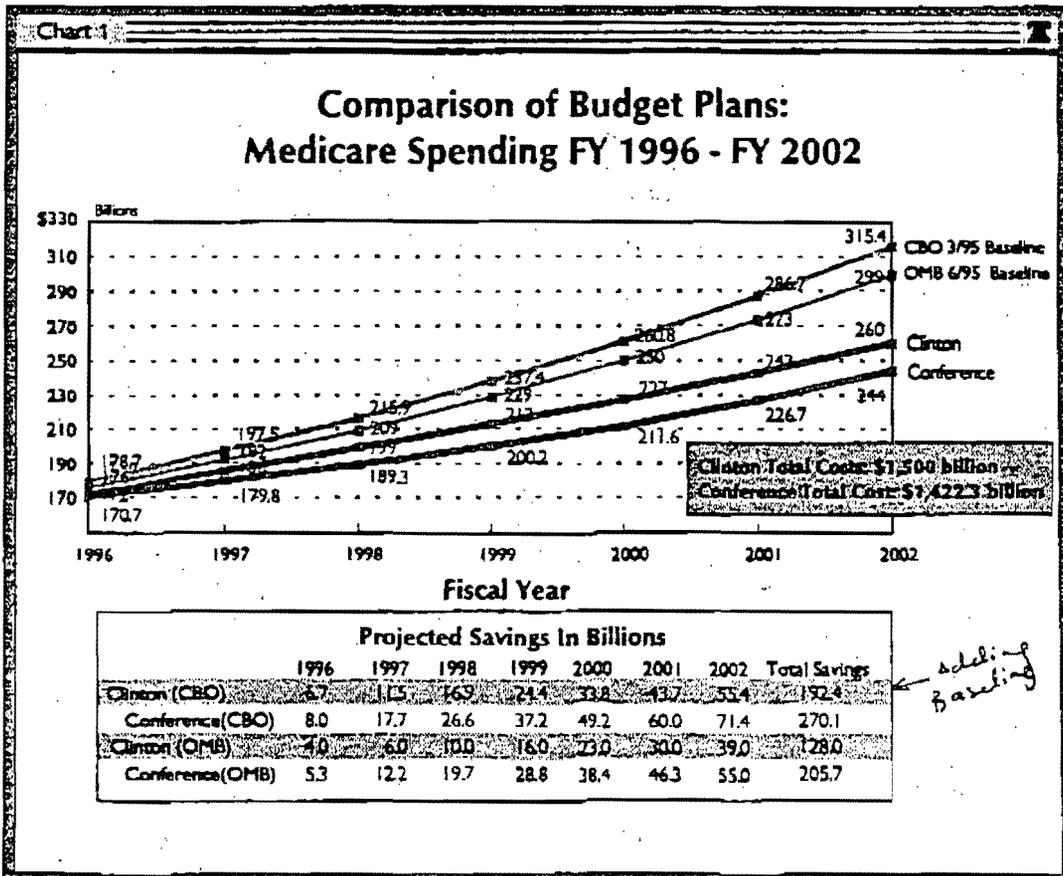
Because the OMB baseline projects a lower rate of Medicare spending under current law than the CBO projects, the savings achieved by any particular budgeted amount for Medicare would seem lower using the OMB baseline instead of the CBO baseline (or, in Washington parlance, a Medicare "cut" looks smaller using the OMB baseline).

FYI08/1995

While there can be a debate about which baseline is a more accurate forecast of Medicare spending under current law, it is clearly very misleading for the White House to use one baseline to score Congress's Medicare plan and another to score its own (especially when that suggests a lower "cut" for the White House plan).

For Members of Congress and ordinary Americans to compare the two budget proposals, it is thus necessary to provide a comparison using the same baseline. Doing so, as the following chart indicates, reveals that the projected savings are closer than the White House suggests.

- ◆ Using the OMB baseline for the White House plan and the CBO baseline for Congress's plan wrongly implies that the White House wants to reduce future Medicare spending by \$128 billion (FY 1996-2002), while Congress intends to reduce it by \$270 billion (that is, by \$142 billion more than the White House).
- ◆ Comparing the two budget plans with the CBO baseline, however, indicates that the White House wants savings of \$192 billion, not the \$128 billion it claims when comparing its plan with that of Congress. This makes the difference between the two plans just \$78 billion over seven years, not the \$142 billion claimed by the White House. This difference is about half the amount implied by the White House's apples/oranges comparison.
- ◆ If the two budgets are compared with the OMB baseline, it is Congress's savings which must be revised down to reflect the lower baseline. Using this baseline means Congress's savings amount to \$205.7 billion (compared with \$128 billion for the White House plan, using the same baseline).



August 9, 1995



# Health Division



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

Please route to:

Nancy-Ann Min  
Barry Clendenin *BC*

Decision needed	_____
Please sign	_____
Per your request	_____
Please comment	_____
For your information	_____

Through: Mark Miller *mr*

With informational copies for:

Subject: Ross Perot's Medicare/Medicaid reform book

HFB/HD Chron, HFB Examiners

From: *mc* Nani Coloretti, *cd* Caroline Davis, & *bd* Bob Donnelly

Phone: 202/395-4930  
Fax: 202/395-3910  
Room: #7001

Per your request, attached is a HFB summary and analysis of Ross Perot's book, Intensive Care: We Must Save Medicare and Medicaid Now.

*Nancy Ann*

*How is our advanced copy*

*We are still reviewing.*

*BC 8/9*

# Intensive Care: We Must Save Medicare and Medicaid Now

## by Ross Perot

DRAFT

### General Overview

- ▶ The first three chapters provide an overview of the Federal budget deficit and the Medicare and Medicaid growth rates.
- ▶ Discusses OMB's and CBO's different deficit projections. He refers to CBO's as "more pessimistic" than OMB's.
- ▶ Warns that reducing spending on Medicare and Medicaid could result in cost shifting to the private sector.
- ▶ States that slower Medicare and Medicaid growth rates do not equal cuts, and he provides the following quote by the President which also makes this point:

*Today, Medicaid and Medicare are going up at three times the rate of inflation. We propose to let it go up at two times the rate of inflation. That is not a Medicare or Medicaid cut. So when you hear all this business about cuts, let me caution you that that is not what is going on. We are going to have increases in Medicare and Medicaid, and a reduction in the rate of growth.*

(from a speech to the AARP in Culver City, CA on October 5, 1993).

- ▶ Recommends piloting any Medicare or Medicaid reforms first, to see if they work. Also, states that we should not require that the same program be adapted throughout the U.S. -- "what works in Miami may not work in Seattle."
- ▶ It should also be noted that he uses a variety of data sources (e.g., OMB, CBO, Representative Shays, 1995 Hospital Insurance Trustees Report), making it difficult to compare across charts. In one case, he even uses CBO and OMB numbers on the same chart.

### Medicare

- ▶ Chapters four, five and six give a general introduction to Medicare and the problems facing the program.
- ▶ Perot notes that the Trustees have forecasted the impending bankruptcy of the HI Trust Fund for years.

### *Short-term Medicare Reform*

- ▶ Perot outlines possible short-term reforms, but he makes no specific recommendations. Instead, he provides a menu of possible options (see attached table). In most cases, Perot provides seven-year totals. However, for several of the proposals, only five-year totals are given.

- ▶ Staff put together one possible package, based on the most aggressive proposals<sup>1</sup> from Perot's menu for which seven year totals were provided or could be estimated. This package would generate about \$260 billion in savings over seven years. It should be noted that these seven-year savings estimates are extremely preliminary since they are often based on rough projections of five-year estimates. In addition, the seven-year savings estimates do not take into account any interactions among the various proposals. These proposals are highly interactive, thus the seven-year total probably overestimates the actual savings possible.
- ▶ Most of the proposals on Perot's "savers menu" are targeted toward beneficiaries or hospitals.

## Medicaid

- ▶ Chapters eight and nine discuss Medicaid and Medicaid reform.
- ▶ Perot depicts Medicaid as a program that is growing out of control, but is essential as a safety net.
- ▶ Perot highlights that children comprise 50% of the population, but only spend 15% of total Medicaid funds. *Fact Check: In FY 1993 children composed 50% of the population, but only spent 19% of total Medicaid funds<sup>2</sup>.*
- ▶ Perot emphasizes that 67% of Medicaid expenditures are for senior citizens and the disabled, while these populations only account for 25% of Medicaid recipients. *Fact check: In FY 1993, the aged and disabled spent 67% of total Medicaid funds, and comprised 27% of Medicaid recipients<sup>3</sup>.*

## *The Problems*

- ▶ Perot highlights several problems in Medicaid without providing specific solutions.
- ▶ Federal and State spending are expected to grow at an unacceptable rate. Medicaid must continue to be affordable to Americans.
- ▶ Perot cites asset transfer as one of the most expensive abuses of Medicaid.

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<sup>1</sup>Proposals included in the "aggressive" option: increase Part B deductible to \$150 and index it to Medicare cost growth; 20% coinsurance on home health, SNF, and clinical labs; prohibit "first dollar" medigap coverage; set Part B premium at 30% of costs; eliminate payment of bad debts; eliminate DSH immediately; reduce GME and IME; reduce payments to high-cost medical staffs; income-relate Part B premium.

<sup>2</sup>Source: Urban Institute analysis of HCFA data, 1994 for The Kaiser Commission on the Future of Medicaid. The "children" category only includes non-disabled children. Data excludes Arizona and U.S. Territories, accounting adjustments, and administrative costs.

<sup>3</sup>*Ibid.*

- ▶ Perot targets DSH as an accounting scheme States have used, and largely attributes the growth in Medicaid to DSH cycling. Perot notes that DSH must be studied and further reformed.
- ▶ Perot cites a GAO report that projects a 6% increase in Medicaid spending for every 1% increase in the unemployment rate.
- ▶ Finally, Perot lists drug users, alcoholics, smokers, immigration, and AIDS as conditions that contribute to the costs of Medicaid. He does not offer any specific solutions to address these issues.

## *Reform*

- ▶ Perot lists several Medicaid reform ideas that should be studied and analyzed, and possibly tested on a limited basis. None of the ideas have savings (or cost) attached to them.
- ▶ According to Perot, DSH reform should be simple. No solution to DSH cycling is offered.
- ▶ Expanding the use of rural and urban community health centers might be one way for Medicaid to improve quality and access while controlling costs.
- ▶ Medicaid could become a voucher system. The value of each voucher would be enough to purchase private insurance or a managed care plan for basic health.
- ▶ One alternative could be block grants, with an emergency fund. Differences in State growth rates will need to be addressed. No specifics were offered.
- ▶ Another alternative would be to give the federal government full control over the program. States should still contribute to the cost. Again, no specifics.
- ▶ Federal and State financing of Medicaid could be split into acute/primary care and long term care, with the Federal and State governments taking one portion or the other. It is unclear, according to Perot, if this would save money.
- ▶ More Medicaid recipients could be moved into managed care. Perot cites TennCare as a managed care program, but states that it is premature to label this program as a success or a failure.

## Long-term Reforms for Medicare and Medicaid

Over the long-term, Perot argues that two changes in Medicare and Medicaid must occur:

- ▶ First, Medicare and Medicaid need to increase the use of managed care. Perot does not guarantee that increasing the use of managed care will control the rising costs of Medicare and Medicaid. He says we will not know this until it is tested.

For Medicare, beneficiaries should be given a choice of health care plans, including managed care option(s). He notes that, for Medicare, the choice among plans should be made by the beneficiaries, and not the government. He does not discuss, however, whether incentives could be used to make lower cost plans more attractive.

Perot inaccurately describes current Medicaid managed care enrollment, citing 15% of beneficiaries are in managed care. As of June 1994, 24% of recipients were enrolled in managed care.

Perot also does not believe that the AAPCC is flawed. He states that "some studies show the Medicare patients in managed care have the same health characteristics as the average population." However, he does not provide cites for these studies.

- ▶ Second, Perot believes that we must change how Medicare and Medicaid are financed. One possible financing mechanism Perot suggests is medical savings accounts (MSAs).

At the beginning of the MSA chapter, Perot states that much of the chapter is based on John Goodman's work. Goodman is a strong advocate of MSAs.

Perot states that, with an MSA, an individual would have \$0 in out-of-pocket costs because his/her employer or, in the case of Medicare and Medicaid, the government would contribute the entire MSA amount (i.e., the entire deductible amount). This assumes that the employer/government could use the savings from replacing the current comprehensive plan with a catastrophic plan to fully cover the MSA. However, analysis indicates that employers probably would save much less on the catastrophic plan than would be necessary to fully cover the high deductible.

Again, Perot does not guarantee that MSAs can help hold down the growth rates for Medicare, Medicaid, or, for that matter, the entire health care system. He recommends testing them to see what benefits, if any, they can yield.

## Conclusions

- ▶ Discusses again the challenges of today's society, pointing out changes in urban America, modern medicine, and technology.
- ▶ Emphasizes personal responsibility.
- ▶ Finally, Perot states that just reforming Medicare and Medicaid will not be enough. The entire health system must also be strengthened.

**DRAFT**

**Possible Medicare Savings Proposals – Perot Menu**

(\$ in billions)

		5-yr Total	7-yr Total
<b>Increase and index Part B deductible</b>			15.2
<b>20% home health, SNF, and lab coinsurance</b>	1/	28.3	45.5
<b>Prohibit Medigap from paying first \$1,500</b>	1/	34.9	55.9
<b>Part B premium:</b>			
\$20 increase in 1999			3.8
30%	1/	26.3	46.6
50%	2/	121.5	
<b>Eliminate payments for bad debt</b>			2.7
<b>DSH:</b>			
Reduce to 5%, pay only to large urban hospitals	2/	21.9	
Eliminate immediately	1/	22.4	33.2
Phase out	1/	13.4	26.7
<b>Reduce GME</b>			6.1
<b>Reduce IME</b>			21.1
<b>High-cost medical staffs</b>			6.0
<b>Income-related Part B premium</b>	1/	13.9	28.2
<b>Merge Part A&amp;B</b>		NO ESTIMATE	
<b>Pay 10% of recoveries to beneficiaries reporting fraud and abuse</b>		NO ESTIMATE	
<b>Increase eligibility age</b>		NO ESTIMATE	
<b>Total, Aggressive Plan</b>	3/		260.5

Notes:

Savings shown are from the Perot book. Staff estimates would differ marginally.

1/ Seven-year estimate done by staff based on Perot five-year estimate and the CBO Savers Book.

2/ Unable to estimate seven-year savings with the information given.

3/ The "aggressive plan" includes the highest-saving provisions for which seven-year savings were provided or could be projected.

The proposals included are highlighted in bold. Adding up one combination of the savings estimates in Perot's book produces \$154 billion in savings. However, this total is incorrect because it includes both five- and seven-year estimates.

**CAVEATS:**  
All estimates are preliminary and directional ONLY.  
Many of the seven-year estimates are based on rough projections of Perot five-year estimates and the CBO Savers Book.  
Pricing does not include any interactions.  
Many of the proposals are highly interactive. Thus, the total savings estimate likely overestimates the actual savings.

# dpc talking points

Publication: TP-xx-Social Services

July 20, 1995

Medicare Talk Points File

## Medicare's 30th Anniversary

### GOP Tells Seniors to Pay More/Get Less

- 1** On the 30th Anniversary of Medicare, remember that Medicare is a Democratic priority. Democrats always have taken the lead in protecting seniors and strengthening Medicare. The historical record is clear: If it had been up to Republicans, Medicare never would have been enacted.
- 2** Republicans want to break the 30-year contract with seniors in order to pay for tax breaks for the rich.
- 3** Republicans are keeping their secret plan to cut Medicare under wraps, but from the details we have it is clear that the consequences of the GOP plan are: Seniors pay more/get less.

**dpc**

Democratic Policy Committee  
United States Senate  
Washington, D.C. 20510-7050

Tom Daschle, Chairman  
Harry Reid, Co-Chairman

**1** On the 30th Anniversary of Medicare, remember Medicare is a Democratic priority. Democrats always have taken the lead in protecting seniors and strengthening Medicare. The historical record is clear: If it had been up to Republicans, Medicare never would have been enacted.

July 30 marks the thirtieth anniversary of the signing of Medicare into law by President Lyndon B. Johnson. The bill was signed in Independence, Missouri, home of former President Harry Truman, whose campaign for national health care reform was the impetus for Medicare.

For 30 years Medicare has enabled Americans to receive quality health care through their retirement years without risking their financial security— a successful program of which Democrats can be proud.

The historical record is clear: Medicare is a Democratic priority.

*President Truman offered several proposals to Congress.*

*President John Kennedy made health care for seniors an issue in his 1960 campaign and saw his plan defeated in Congress. Over and over again, Democrats attempted to pass Medicare legislation. Over and over again, Republicans voted overwhelmingly against it.*

*Only after Democrats called the 1964 election a "mandate" for Medicare, and triumphed at the polls, did the Democratic vision of Medicare become a reality.*

Even then, the majority of Republicans voted against it. They called it socialism and said we did not need it.

**Today, Medicare is once again under Republican attack. They are making the same arguments they made in the 1960s, when they sought to defeat it.**

- *Back then Republican Senator Gorton Allott called it a "foot in the door" for socialized medicine.*
- *House Majority Leader Richard Armey says he "deeply resents the fact that when I am 65, I must enroll in Medicare." He calls it part of government that teaches dependence, and says it is a program "I would have no part of in a free world."*

**2** **Republicans want to break the 30-year contract with seniors  
In order to pay for tax breaks for the rich.**

**Republicans threaten Medicare by proposing unprecedented cuts in order to provide tax breaks for the rich.**

**Republicans want to cut \$270 billion from Medicare so that the wealthiest Americans can get thousands on tax breaks. Seniors will pay more—and nothing will be done to protect Medicare for the future.**

**Republicans are using concerns about the solvency of the Medicare Trust Fund as a smokescreen to get the money they need for tax breaks for the wealthy. From the beginning, Republicans fought this program tooth and nail. Democrats fought for seniors and for Medicare.**

**Democrats have always taken the lead in protecting seniors and Medicare.**

- *During this year's budget debate, Democrats tried to put money back in Medicare by eliminating the GOP tax breaks for the rich. Republicans voted in lockstep to defeat this effort.*
- *In 1993, Democrats took steps to strengthen the Medicare trust fund—without a single Republican vote.*

**In 1995, Democrats will continue to protect Medicare and fight for its solvency.**

**3** **Republicans are keeping their secret plan to cut Medicare under wraps, but from the details we have it is clear that the consequences of the GOP plan are: Seniors pay more/get less.**

The Republicans have tried to keep their secret plan to cut \$270 billion from Medicare under wraps. But leaked documents show that their proposal relies on a "voucher system." Without a doubt, the secret GOP plan will mean seniors pay more/get less.

Seniors will have to pay more in premiums, co-payments and deductibles—an extra \$1000 per year or more.

Under the "secret" Republican plan:

- *seniors who wish to keep their family doctor instead of joining an HMO will have to pay more;*
- *seniors who are forced for financial reasons to choose an HMO will have their current benefits threatened—they will get less; and,*
- *Republicans want to cap Medicare at a rate far below private sector health care costs.*

That's not choice; that's financial coercion!

While the wealthiest Americans are receiving tax breaks under the GOP plan, seniors on fixed incomes will be paying an extra \$1,000 or more a year by 2002 for their health care.

The GOP plan is unfair to seniors and Democrats will continue to fight to ensure that seniors have access to quality and affordable health care.

**Republicans say people should ask Democrats the following questions. We're glad they asked!**

**Republican Question #1: If Republicans increase Medicare spending from \$4,800 today to \$6,700 in 2002, where's the cut?**

If seniors are going to pay more but get less, that's a cut. According to the GOP secret plan:

- *the annual deductible would increase each year;*
- *the average senior receiving home health care services would pay \$1,020 more;*
- *the average senior recipient of skilled nursing home services would pay about \$1,000 more; and,*
- *the average senior choosing to stay with their current plan (and doctor) would pay at least \$400 more in part B premiums.*

If Republicans are not cutting Medicare, then why will their plan require senior citizens on fixed incomes to pay more—by increasing premiums, co-payments and deductibles?

How can they argue that they are not making drastic cuts?

**Our Question to Republicans:**  
*How are you going to reach \$270 billion in cuts?*

**Republican Question #2: Do Democrats accept the warning of the Medicare Trustees and three Clinton cabinet members that Medicare is going to be bankrupt in seven years?**

Yes, and that is why Democrats are asking Republicans to sit down and solve this problem outside of the budget debate. In the past, when action was needed to strengthen the trust fund, Democrats always took the lead. Most recently, in 1993, Democrats extended the solvency of the trust fund—without a single Republican vote.

Democrats are committed to finding a long-term solution to ensure that Medicare will be there for future generations. Republicans are cutting Medicare in order to pay for their tax cuts for the wealthy—that's not reforming Medicare!

**Our Question to Republicans:**

*If you accept the warning, are you willing to abandon your plan to give the top one percent of America's wealthiest a huge tax break and put the money back into Medicare's future?*

### **Republican Question #3: What is the Democratic Plan to save Medicare?**

Democrats always have taken the lead in protecting seniors and strengthening the Medicare Trust Fund. The real question is what is the Republican agenda for Medicare?

The GOP plan does not address the long-term solvency of the program.

- *Their unprecedented cuts in Medicare are used to fund the tax cuts for the rich—not a single dollar is reinvested in Medicare to help it remain solvent in the long-term.*
- *Their plan does not address the problem Medicare will face in 2010 when the baby boomers begin to retire.*

It's hard to believe that Republicans—who fought against enacting Medicare and continue to try to privatize it—are concerned about Medicare when they are cutting it to pay for tax breaks for the rich. We should be saving the trust fund, not creating a slush fund.

### **Can Americans Trust Republicans to Protect Medicare?**

Before the election last year, Republicans promised they would not make massive cuts in Medicare:

*Majority Leader Bob Dole said, "President Clinton and Vice President Gore are resorting to scare tactics... falsely accusing Republicans of secret plans to cut...Medicare benefits..." Washington Post, 11/6/94*

*Haley Barbour, RNC Chair, said, "[T]he outrage, as far as I'm concerned is the Democrats' big lie campaign that the Contract with America... would require huge...Medicare cuts. It would not." CNN's Late Edition, 11/6/94.*

In 1995, they passed a budget which cuts Medicare by an unprecedented \$270 billion in order to pay for tax breaks for the rich.

In 1995, Republican House Majority Leader Arney says that Medicare is "a program I would have no part of in a free world." *Chicago Tribune*, 7/11/95

**Our Question to Republicans:**  
*What are the details of the secret  
GOP plan and why won't they share them  
with the American people?*

Med/Med Tally Pont

### NOTES ON MEDICARE MEANS TESTING

The President's comments on means testing last night were completely consistent with his past position and the comments of his Chief of Staff Leon Panetta and his OMB Director Alice Rivlin on last Sunday's morning news shows. The President and his top economic advisors have stated that they are not opposed to means testing in principle, but that they do not believe that there should be any new increases in premiums in a budget plan that uses those savings to pay for a large and unnecessary tax cut.

"Look, we don't object to the principle of means testing, but if you don't have to do it, why do it? The purpose is, let's look at the Trust Fund. What do you need to repair the Trust Fund?"

Chief of Staff Leon Panetta on "Face the Nation,"  
September 17, 1995

"The President does not think that at this time it is necessary to put more burden on beneficiaries. Well, the Republicans want to do this in order to... have people pay more for Medicare at high incomes so that they can give more money in a tax break to people at high incomes. We just don't think that is necessary.... We do not think that means testing Medicare is necessary if it has to be done for producing a tax cut for the wealthy."

OMB Director, Alice Rivlin, "Meet the Press," September  
17, 1995



State & Local  
Issue

## OFFICE OF THE MAYOR

CITY OF CHICAGO

RICHARD M. DALEY  
MAYOR

September 28, 1995

The Honorable William V. Roth, Jr.  
Chairman  
Committee on Finance  
United States Senate  
104 Hart Senate Office Building  
Washington, D.C. 20510-0801

Dear Mr. Chairman:

I am writing in strong opposition to the Finance Committee's proposal to impose a mandatory Medicare tax on pre-1986 employees of state and local governments.

While I realize that reform of the Medicare system is a vital national issue, this proposal is a direct assault on the taxpayers of the City of Chicago. It would require the spending of \$17 million in 1996 alone directly out of the City's corporate budget for the cost of the City's share of these employee's Medicare taxes. The Chicago Board of Education will also be taxed \$14.7 million for these costs just at a time when it has made great progress in balancing the Schools budget for the first time in many years. Other local government bodies in Chicago, including Cook County, the Chicago Transit Authority, City Colleges and the Chicago Park District face increased costs of \$12.6 million. The total impact on Chicago taxpayers is over \$44 million, and when the requirement of matching individual contributions is taken into account, the total Medicare tax increase is over \$88 million for the Chicago area alone. This also represents a tax increase on those individual employees who are currently exempt from the Medicare tax. While I know that these amounts do not sound like a lot to the federal government, this additional tax on local government will have to be paid by Chicago taxpayers or we will have to make cuts in essential services.

Senator, not only is this a new tax on local government, but it is just the kind of mandate on local officials which Congress has said it is no longer going to pass on to local government. In fact, I believe that it would be subject to a point of order under the mandates legislation passed just this year but not formally in effect until January 1st of next year. I am disappointed that Congress would see fit to so quickly abandon its commitment to stop imposing new mandates. This proposal also represents a renegeing by the Congress on an agreement made in 1986 to only impose mandatory Medicare taxes on a prospective basis.

As Mayor of Chicago, it is my responsibility to defend the interests of the taxpayers of my city. I ask that the Finance Committee rethink its proposal, keeping in mind all the discussion in Congress earlier this year about how the time has passed when Washington can simply impose new costs and mandates on local government in order to raise its own revenues.

Sincerely,

A handwritten signature in cursive script that reads "Richard M. Daley".  
Mayor

OFFICE OF LEGISLATIVE &  
INTER-GOVERNMENTAL AFFAIRS  
FAX COVER SHEET

# of Pages: Cover + 2

DATE: 5/18/95

TO:

*Christ Jennings*

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

FROM:

*Debbie Cherry*

Fax: (202) 690 - 8168

Phone: \_\_\_\_\_

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION  
Washington, D.C.

Part B Premium

<u>Year</u>	<u>25 Percent</u>	<u>31.5 Percent</u>	<u>25% to 31.5% Difference</u>
1993	\$36.60		
1994	41.10		
1995	46.10		
1996	43.50	\$54.70	+\$11.20
1997	47.80	60.20	+12.40
1998	52.50	66.20	+13.70
1999	57.70	72.60	+14.90
2000	63.20	79.60	+16.40
2001	69.40	87.40	+18.00
2002	76.40	96.30	+19.90

President's Budget

- o The 25 percent premium figures reflects the President's budget proposal to extend the 25 percent Part B premium for 1999 and thereafter (using the Administration baseline), but excludes the effect of the other President's budget extenders which would slightly lower the Part B premium.

Domenici Proposal

- o The 31.5 percent premium figures shows the projected maximum monthly Part B premium under the Domenici proposal. The actual Part B premium will be less if other Part B savings proposals are enacted.

Comparison

- o The dollar difference shows how much more beneficiaries will have to pay each month for their Part B coverage under the Domenici proposal compared to what they would pay under the President's budget.
  - + In 2002, beneficiaries would pay \$19.90 each month more under the Domenici proposal than under the President's budget proposal.

o In 2002, Medicare beneficiaries would pay up to \$238.80 more for the Part B premium under the Domenici (31.5 percent) proposal than under the President's budget proposal (extension of the 25 percent premium).

+ The \$238.80 figure is based on a monthly increase of \$19.90 times 12 months.

o The Domenici proposal will increase beneficiary payments for the Part B premium in each year from 1996 and 2002.

+ The annual increase rises from \$134.40 in 1996 (\$11.20 times 12 months) to \$238.80 in 2002 (\$19.90 times 12 months).

+ For the seven years 1996 to 2002, a Medicare beneficiary will be responsible for an additional \$1,278.

Chris J

DRAFT

**TALKING POINTS FOR  
SIGNING HR 483 (MEDICARE SELECT)**

- ▶ By extending and expanding the Medicare SELECT demonstration to all 50 states, this bill allows Medicare beneficiaries to continue to voluntarily purchase Medicare SELECT policies, which are special types of Medicare supplemental health insurance. SELECT enrollees agree to use a restricted provider network in exchange for premiums that are typically lower than those of regular Medicare supplemental health insurance policies.
  
- ▶ While I am signing this bill, I remain concerned about issues raised in the preliminary results of our evaluation of the demonstration, particularly the potential for Medicare cost increases and concerns about the requirements for quality of and access to care in the SELECT networks.
  
- ▶ The Medicare SELECT debate during this Congress has also raised awareness of problems associated with the use of attained-age rating for establishing premiums. Under this type of rating methodology, the insurer adjusts the premiums based on the beneficiary's age. This means that a policy may be sold at what appears to be a bargain rate when the beneficiary is younger, but that it becomes rapidly unaffordable in later years when the policy may be needed the most. Although SELECT policies have been touted by some as a "great value," I am concerned that the use of attained-age rating may exaggerate the reported value of these products.
  
- ▶ While we are committed to expanding and improving choices for Medicare beneficiaries, we want to do it the right way. We will be closely watching this program as it is expanded to the additional states and will not hesitate to return to the Congress if the final evaluation results do not demonstrate that this new option is a true value for Medicare beneficiaries.

# OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

# of Pages: Cover + 1

DATE: 7/5/95

**TO:**  
*Chris Jennings*

**Fax:** 202-456-7431

**Phone:** \_\_\_\_\_

**FROM:**  
*Debbie Chang /  
 Jennifer Messersmith*

**Fax:** (202) 690-8168

**Phone:** 690-5960, 7916

REMARKS:

**HEALTH CARE FINANCING ADMINISTRATION**  
 Washington, D.C.

**POINTS FOR  
SIGNING HR 483 (MEDICARE SELECT)**

- ▶ By extending and expanding the Medicare SELECT demonstration to all 50 states, this bill allows Medicare beneficiaries to continue to voluntarily purchase Medicare SELECT policies, which are special types of Medicare supplemental health insurance. SELECT enrollees agree to use a restricted provider network in exchange for premiums that are typically lower than those of regular Medicare supplemental health insurance policies.
  - ▶ While I am signing this bill, I remain concerned about issues raised by the preliminary results of our evaluation of the demonstration, particularly the potential for Medicare cost increases and concerns about the requirements for quality of and access to care in the SELECT networks.
  - ▶ The Medicare SELECT debate during this Congress has also raised awareness of problems associated with the use of attained-age rating for establishing premiums. Under this type of rating methodology, the insurer adjusts the premiums based on the beneficiary's age. This means that a policy may be sold at what appears to be a bargain rate when the beneficiary is younger, but that it becomes rapidly unaffordable in later years when the policy may be needed the most. Although SELECT policies have been touted by some as a "great value," I am concerned that the use of attained-age rating may exaggerate the reported value of these products.
  - ▶ While we are committed to expanding and improving choices for Medicare beneficiaries, we want to do it the right way. We will be closely watching this program as it is expanded to the additional states and will not hesitate to return to the Congress to work with them if the final evaluation results do not demonstrate that this new option is a real value for Medicare beneficiaries.
-

THE WHITE HOUSE  
WASHINGTON

July 5, 1995

MEMORANDUM FOR ALL EOP STAFF

FROM: JODIE TORKELSON  
DEPUTY ASSISTANT TO THE PRESIDENT FOR  
MANAGEMENT AND ADMINISTRATION

SUBJECT: New EOP Pass System

On Monday, June 26, the United States Secret Service introduced a revised pass system at entry points at the White House and Old Executive Office Building, similar to the system used at the New Executive Office Building. This new pass system includes "hard" appointment, volunteer, intern, worker and temporary badges which will replace the "paper" passes presently in use.

There are only four "forgotten badge stations" located on the complex: 17th & G Street entrance, Southwest Gate, East Appointments Gate and the NEOB. Staff without their pass must enter the complex through one of these gates to receive a temporary pass for the day. The passholder's pin number will be transferred to this temporary pass for the period of 12 hours. This temporary pass is to be used by that staff member during this period of time and returned only at the end of the day.

Appointments entering the building as part of a large group, 20 or more attendees, will receive a "Large Event" badge. Visitors cleared as appointments for specific events on the complex should only attend that event. The visitor will need to be cleared through WAVES as a regular appointment and switch badges at any entry point if there is a need for them to remain on the complex for other matters. Visitors with "Large Event" badges roaming the halls will be challenged by the Secret Service.

Passholders parking in the NEOB parking garage must have their pass to enter the garage. If passholders do not have their pass, they must proceed to the NEOB lobby to get a temporary pass before being allowed to enter the NEOB garage.

Please call the United States Secret Service White House Division at x54259 with any questions regarding this revised pass system.

# FAX



## Health Division



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

TO: *Chris Jennings*

FROM: *Mark*

**Fax Destination**

Organization:

Phone Number:

Number of Attached Pages: *2*

Notes:

**HD Fax Number:** 202/395-3910

**Voice Confirmation:** 202/395-4922

202/395-4925

202/395-4926

202/395-4930

*Health Division Front Office  
Health & Human Services Unit  
Health Programs & Services Branch  
Health Financing Branch*

NEM  
Chris

Attached is draft language for the Medicare SELECT enrolled bill memo. It is written from the perspective of the Director concurring with views expressed by HHS. That is the current structure of the enrolled bill memo.

LRD would like our comments on the enrolled bill memo today. Please provide guidance.

- Mark

**DRAFT**

## Language for the Medicare SELECT Enrolled Bill Memo

HHS recommends approval of H.R. 483. However, in its views letter, HHS points out that it has consistently recommended a six month extension of the existing program in order to allow HHS to complete research that is currently underway. HHS has pointed out two concerns. The first concern is the adequacy of the beneficiary protections in SELECT plans. There is no requirement for states to review the actual operations of SELECT plans for access and quality once they are approved [checking this].

The second concern is whether SELECT will make any contribution to the efficiency of the Medicare program. HHS points out that its experience under the demonstrations is that plans ~~plan~~ achieve savings for the beneficiary through discounting arrangements. However, since the plans do not manage care, no program savings accrue. In point of fact, preliminary evidence that has only recently become available from the two research organizations evaluating the program point to increases in Medicare expenditures. That research indicates that in 8 of the 12 states the demonstration is currently operating in, Medicare SELECT ~~significantly increased~~ Medicare expenditures an average of 17.5 percent. (Only 1 state showed ~~significantly~~ declines in Medicare expenditures, the remainder showed no impact). *actuarial* Although these results are preliminary, they are compelling enough for the HCFA ~~to~~ estimate a PAYGO impact associated with the extension of Medicare SELECT to all 50 states.

## PAYGO Impacts

FY95	<\$50 million
FY96	\$0.9 billion
FY97	\$1.4 billion
FY98	\$1.8 billion
FY99	no impact in
FY00	FY99-00 because the Secretary of HHS is assumed <del>to</del> discontinue the program due to costs.



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

**FAX COVER SHEET**

Number of pages 3  
(excluding cover sheet)

Date 5/16/95

Urgent

Time 8:15 am / pm

Confidential

From: Chuck Konigsberg  
OMB Legislative Affairs  
Phone: 395-4790  
Fax: 395-3729

To: Chris Lennige

Fax: 67431

Additional information:

Draft

The Administration supports a temporary extension of the 15-State Medicare SELECT demonstration program. However, the Administration does not support H.R. 483, in its present form, for the reasons stated in the attached letter from Secretary Shalala. The Administration looks forward to working with the Congress on this matter.



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

March 7, 1995

file # 59

The Honorable Bill Archer  
Chairman, Committee on Ways and Means  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

This letter expresses the Administration's views on H.R. 483, as reported by the Subcommittee on Health. H.R. 483 would make the Medicare SELECT demonstration program permanent and extend it to all States.

Our experience with the Medicare SELECT demonstration should be part of the effort to improve current and future managed care choices under Medicare. We have previously made available the case study portion of the Medicare SELECT evaluation. Other pieces of the evaluation are still in process; these include a survey of SELECT plan enrollee satisfaction and an analysis of SELECT enrollee utilization experience. Preliminary results will not be available until the later part of this summer. We believe that Congress would benefit from a review of the full evaluation results before beginning the deliberations on Medicare SELECT as a permanent program.

The case study portion of the Medicare SELECT evaluation has already raised a number of questions about the Medicare SELECT demonstration. As managed care options under Medicare are expanded, we want to ensure that our beneficiaries are guaranteed choice and appropriate consumer protections. In addition, many of the SELECT plans consist solely of discounting arrangements to hospitals. We would be concerned if the discounting arrangements under Medicare SELECT were to be expanded to Medicare Supplementary Insurance (part B) services. Discounting arrangements, particularly for part B services, may spur providers to compensate for lost revenues through increased service volume. Consequently, we are concerned that such an expansion would lead to increased utilization of part B services, rather than contribute to the efficiency of the Medicare program through managed care. We would therefore oppose such a change.

Page 2 - The Honorable Bill Archer

Given that the Medicare SELECT demonstration is under an expiring authority with an impending deadline, the Administration supports a temporary extension of the 15-State demonstration. Such an extension would provide sufficient time to examine what we have learned from the demonstration and to make needed changes to SELECT based on our findings.

We are committed to working with the Congress to improve and extend the available choices to Medicare beneficiaries so that they have the full range of managed care options enjoyed by the general insured population.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



Donna E. Shalala



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

**FAX COVER SHEET**

Number of pages 3  
(excluding cover sheet)

Date 5/17/95

Urgent

Time 7:27 am / pm

Confidential

From: Chuck Konigsberg  
OMB Legislative Affairs  
Phone: 395-4790  
Fax: 395-3729

To: ERIN O'CONNOR (WH/LA) 66220  
CC: CHRIS JENNINGS 67078-68878  
NANCY-ANN MIN 57289  
BOB PELLICCI 56148

\* ERIN--AS A FOLLOW-UP TO YOUR CONVERSATION WITH CHRIS JENNINGS,  
PLEASE PAGE JANET MURGUIA REGARDING THE ATTACHED SAP. THANKS.

URGENT

Draft--NOT CLEARED FOR TRANSMITTAL

May \_\_, 1995  
(Senate)

H.R. 483, A Bill to Permit Medicare Select Policies  
to be Offered in All States

The Administration supports a temporary extension of the 15-State Medicare SELECT demonstration program. However, the Administration has concerns about H.R. 483, in its present form, for the reasons stated in the attached letter from Secretary Shalala. The Administration looks forward to working with the Congress on this matter.

\* \* \* \* \*

file # 59

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WASHINGTON, D.C. 20201

March 7, 1995

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Page 2 - The Honorable Bill Archer

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We are committed to working with the Congress to improve and extend the available choices to Medicare beneficiaries so that they have the full range of managed care options enjoyed by the general insured population.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



Donna E. Shalala

## **President Signs Medicare Select Extension Into Law -- Talking Points**

Today President Clinton signed into law H.R. 483, a bill to permit "Medicare Select" policies to be offered to all 50 states. The law will expand choices for Medicare beneficiaries who wish to purchase this new type of Medicare supplemental "Medigap" insurance.

### **Background**

Medicare Select policies are the same as Medigap policies (private insurance that fills in Medicare gaps in coverage -- copayments, deductibles, etc.) except that they only pay full supplemental benefits if covered services are provided through "preferred providers."

These policies, currently available through a 15 state Medicare demonstration, are popular among beneficiaries and insurers because they are frequently cheaper than traditional Medigap policies. This is due to the fact that insurers offering these plans can obtain discounts from "select" providers who agree to offer services more cheaply if they are in a more limited pool of "attractive" providers whose services are 100 percent covered by the plan.

Before H.R. 483 passed the Congress, the Administration took the position that it would prefer to have the results back from the demonstration study PRIOR to supporting a 50-state expansion. (The final study won't be complete until the end of this year.) We wanted to make certain that sufficient quality provisions were in place and that there were no unexpected costs to the Medicare program itself.

### **Legislative Action and the President's Response**

Because of the Select program's popularity, the Congress decided to move ahead and expand the program without waiting for the report on the 15 state demo program. Despite some reservations, the President decided to sign the bill into law because of his overriding commitment to expand choices for Medicare beneficiaries.

We will be monitoring this program closely in the upcoming years. We want to make certain the Select option is delivering on its promise of providing a cost-effective, high quality, and broadly accessible benefit to those Medicare beneficiaries who choose it and the taxpayers who support the Medicare program. If it does not meet this criteria, the HHS Secretary has the authority to terminate the program in three years. If it meets this criteria, the President and the Congress can and should look back at a bipartisan legislative achievement that was consistent with one of the President's Medicare reform priorities: providing more coverage choices to beneficiaries.

Carroll

Dole / Packwood Bill  
FL

**GHAA**

GROUP HEALTH ASSOCIATION OF AMERICA

## Memorandum

Date: June 21, 1995  
To: Julie James  
From: Diana Jost  
Re: **Comments on Draft Insurance Reform Bill**

Thank you for the opportunity to review the draft bill. We really appreciate this. It's nice to be on someone's "A" list! I'm sorry we didn't have the time to review the data reporting provisions in the bill; most of us are at our annual meeting in San Diego this week.



GROUP HEALTH ASSOCIATION OF AMERICA

## Comments on Draft Insurance Reform Bill

### Scope

Applies comprehensive insurance reform to the entire group market, both insured and self-funded. Appears to include a full range of health plans, including entities that are "similar" to insurers, which presumably would include physician-hospital organizations and other emerging entities. Applies more limited reforms to the individual market.

*Comments:* GHAA strongly supports the provisions applying insurance reforms to all types of health plans. Such provisions are necessary to ensure uniform consumer protections and a fair competitive environment.

We reiterate our serious concerns about including the individual market in insurance market reforms in the absence of either universal coverage or adequate subsidies. Because of the selection issues in this market, individual reform of the sort proposed-- without subsidies -- would lead to increased premiums for currently insured individuals and small employers, and therefore may increase the ranks of the uninsured. Because of these concerns, we cannot support reforms applicable to the individual insurance market as they are included in this bill.

### Guaranteed Issue

Required for groups of all sizes. An exception to the guaranteed issue requirement is allowed for health plans that reach capacity limits. The bill also would allow health plans to impose participation requirements in the group market.

With respect to individuals not covered under an employer-sponsored health plan, guaranteed issue would be required for those who: 1) had similar group coverage for nine months during the previous 12 month period; 2) lost group coverage because of non-payment of premiums, fraud or misrepresentation by the plan sponsor; 3) are eligible for COBRA continuation coverage; or 4) had similar individual coverage for nine months during the previous 12 month period and lose that individual coverage because they have a change in residence or dependency status. (§2111(b)(1), pp.12-14)

*Comments:* With respect to the group market, GHAA believes any guaranteed issue provision should recognize that HMOs may face capacity limitations and that they provide coverage only to persons working or living within their service areas. The bill recognizes the first of these issues, but not the second (although the bill summary indicates that the

bill does address the service area issue). Language should be included in the bill to require guaranteed issue by HMOs (and other health plans with limited geographic service areas) only within their service areas. GHAA also supports the bill's inclusion of participation requirements, which are used to minimize adverse selection, by helping to ensure that health plans will receive a mix of both healthy and unhealthy enrollees.

With respect to the individual market, we believe substantial complications could arise if portability rules are extended beyond "group-to-group" coverage to include individuals moving to or from individual products. GHAA believes that group-to-group coverage provisions are a good starting point for insurance reform. However, based on our experience in states that have adopted similar portability provisions, we believe that the market is not yet ready to extend such provisions to people moving between individual coverage or from individual to group (or group to individual) coverage, as the bill would allow, under certain circumstances.

The portability provisions raise another significant issue for HMOs. For health plans that offer comprehensive coverage, such as HMOs, serious adverse selection problems can arise if individuals can convert from high-deductible or bare bones coverage to comprehensive HMO plans. The bill appropriately addresses this issue by limiting the portability requirement to movement between similar coverage options.

### **Guaranteed Renewal**

Required. Exceptions are provided for non-payment of premiums, fraud, misrepresentation, noncompliance with plan requirements, and failure to maintain participation rates. (§2111(c), p.19)

*Comments:* GHAA supports this provision, but the exceptions need to be expanded to include cases in which individuals move outside of a health plan's service area.

### **Benefit Design**

The bill is silent on the issue of what coverage a health plan is required to provide on a guaranteed issue basis.

*Comments:* To avoid gaming of the guaranteed issue requirement, e.g., by a health plan offering only a bare bones benefit package to high-risk enrollees, GHAA supports requiring that all products offered in the small group market must be made available on a guaranteed issue basis.

## **Preex/Continuity of Coverage**

Allows a 6/3 preex limit for group markets, 12/6 for individual market, except for pregnancy. Continuity (portability) required for individuals with similar prior coverage in a benefit plan that had lapsed for a period of not more than 90 days. (§2111(b)(2), pp.15-17)

*Comments:* GHAA supports eliminating the use of preexisting condition waiting periods in the small group market. The provisions allowing continued, but limited, preexisting condition restrictions provide no recognition of the fact that HMOs are not designed to administer such restrictions. Even if the *legal* barrier to federally qualified HMOs' use of preexisting condition restrictions is addressed (i.e., the federal HMO Act provisions), the *structural* barrier HMOs face -- namely, that traditional HMOs are not designed to pay or track claims -- would remain. To address this concern, if preex waiting periods are permitted, HMOs should be allowed to use alternative, actuarially equivalent, methods to address adverse selection, such as imposing a 90-day affiliation (delayed coverage) period, during which no premiums are paid and no benefits are received.

In addition, provisions should be made for extended preexisting condition waiting periods/affiliation periods for late entrants.

## **90-Day Initial Open Enrollment Period**

Individuals would have "immunity" from preex requirements during an initial 90-day open enrollment period. States could limit the number of enrollees health plans must accept during this period, according to market share. (§2111, p.17)

*Comments:* As noted earlier, GHAA supports eliminating preex restrictions in the small group market. However, we are very concerned that this provision could be interpreted to require that health plans provide guaranteed issue coverage in the individual market. As noted at the beginning of our comments, GHAA cannot support guaranteed issue of individual coverage in the absence of adequate subsidies or universal coverage. We also believe that the state programs to cap guaranteed issue enrollment according to a health plan's market share would be exceedingly complex and difficult to administer.

## **Rating**

The bill includes no limitation on rating.

*Comments:* Guaranteed issue, in the absence of any rating requirements, would do little to ensure access to coverage to high risk individuals. Health plans would be free to price coverage for high-risk individuals beyond their reach, thereby ensuring that they would continue to provide coverage only to healthy people. The bill thus fails to address a major

problem in this market -- the significant variation in rates small employers can be charged as a result of the health status or claims experience of their employees.

GHAA supports modified community rating in the small group market. While we have concerns about ensuring that appropriate adjustments are allowed for age and geographic area, we believe that allowing experience rating would be a mistake. Many states have enacted modified community rating in one form or another. (GHAA can supply this information, upon request.)

### **FEHBP Provisions**

The bill would require health plans participating in the Federal Employees Health Benefits Program (FEHBP) to offer small employers (50 or fewer employees) and self-employed individuals the option of enrolling in the same benefit plans -- at the same price -- that are offered to federal employees. The bill provides a strict timetable, along with required enrollment targets (tied to health plans' market share) for enrollment of small groups into the FEHBP. In addition, the bill appears to allow state governments to participate in the FEHBP (§121, pp.25-33)

*Comments:* GHAA has serious concerns about this provision. The Office of Personnel Management (OPM) currently manages the FEHBP for approximately nine million federal employees and annuitants. Proposals to open up this program to the small group market -- which could more than quadruple that number -- represent a significantly increased government role in the private insurance market and would exacerbate the administrative problems OPM already faces. Moreover, it would subject private health plans to ill-conceived government policies that would affect adversely their ability to serve the small group market.

For example, OPM recently imposed a mid-contract year requirement for FEHBP plans to cover autologous bone marrow transplants (ABMT) for breast cancer. This action did not permit plans to adjust their premiums immediately in light of the new benefit. OPM also failed to recognize the potential impact of this precedent on private sector coverages, which do not routinely cover this treatment because it is still considered experimental. In addition, not long ago, OPM essentially closed the FEHBP to new HMOs, denying them the opportunity to serve an important segment of their markets.

In addition, because the bill's insurance reform provision include no rating restrictions in the small group market, this provision -- requiring health plans to offer small employers coverage at the same rate as federal employees -- almost certainly would result in adverse selection against the FEHBP. Higher-risk small groups would flock to the FEHBP, assured of lower rates than in the less rate-regulated group market, causing premiums to rise for federal workers and the federal government.

Further, we believe that the required timetable and enrollment targets are excessively prescriptive.

Finally, our concerns about significantly increasing the size of the FEHBP would be exacerbated by allowing state governments to participate in the FEHBP.

### **Regulatory Structure**

The bill provides federal insurance reform standards, implemented through the states, but includes a federal fallback provision for non-compliant states. It also provides a role for the NAIC in developing specific standards to implement the federal requirements. It provides for a federal tax penalty for noncompliance equal to 25 percent of gross premiums. (§2101, p.4)

*Comments:* GHAA supports the overall structure of federal standards with state implementation, but believes the federal fallback provisions are unnecessary, given the significant federal tax penalty for noncompliance.

### **Medical Savings Accounts**

The bill would modify the current tax code to permit employees with employer-sponsored coverage to make tax-free contributions to a medical savings account (MSA), but only if they receive coverage under a catastrophic-type plan. Catastrophic coverage is defined as coverage with a deductible no less than \$1,000 (\$2,000 for families). The favorable tax treatment of MSA contributions would be limited; eligible individuals could deduct no more than the lesser of \$2,000 (\$4,000 for families) or the difference between the premium of the "catastrophic" health plans and the premium of the highest cost health plan offered by their employer (or such premium to be defined under the statute).

The level of the deduction would be phased in over a five-year period. Employer contributions to employees' MSAs would be excluded from employees' income and limited in the same manner as individual deductions. Interest on amounts in the MSA would be treated as taxable income. Eligible individuals could make tax-free withdrawals from their MSA for approved health-related expenses. They also could make withdrawals for non-health related expenses; however such withdrawals would be treated as taxable income and assessed a 10 percent penalty.

*Comments:* GHAA has strong concerns with this provision because it: explicitly links the favorable tax treatment of MSAs with catastrophic coverage; allows individuals to build up an unlimited amount of "savings" in their MSA over the course of their lifetimes; and permits MSA withdrawals for non-health related expenses. Such provisions create significant incentives for individuals to choose the MSA/catastrophic option over other forms of coverage. Moreover, giving preferential tax advantages to MSA designs that

require the purchase or selection of catastrophic coverage would undermine advances in the delivery of health care through HMOs and other managed care arrangements. These health plans focus on coordination of care, prevention, and early diagnosis to control the full range of health care costs and ensure that patients are receiving the most appropriate care in the most appropriate setting.

June 21, 1995

Boz

Pl file under  
Medicare Select.

Thanks  
JD

Laurie:

As we discussed, the President is scheduled to sign this bill into law sometime today, Friday, July 7. However, please make certain he has actually signed the bill prior to using these talking points.

If there on any questions, please don't hesitate to call either me (6-5560) or Nancy Ann Min (5-5178). Since we are signing the bill, however, I don't anticipate many (or maybe any) questions.

## **President Signs Medicare Select Extension Into Law -- Talking Points**

Today President Clinton signed into law H.R. 483, a bill to permit "Medicare Select" policies to be offered to all 50 states. The law will expand choices for Medicare beneficiaries who wish to purchase this new type of Medicare supplemental "Medigap" insurance.

### **Background**

Medicare Select policies are the same as Medigap policies (private insurance that fills in Medicare gaps in coverage -- copayments, deductibles, etc.) except that they only pay full supplemental benefits if covered services are provided through "preferred providers."

These policies, currently available through a 15 state Medicare demonstration, are popular among beneficiaries and insurers because they are frequently cheaper than traditional Medigap policies. This is due to the fact that insurers offering these plans can obtain discounts from "select" providers who agree to offer services more cheaply if they are in a more limited pool of "attractive" providers whose services are 100 percent covered by the plan.

Before H.R. 483 passed the Congress, the Administration took the position that it would prefer to have the results back from the demonstration study PRIOR to supporting a 50-state expansion. (The final study won't be complete until the end of this year.) We wanted to make certain that sufficient quality provisions were in place and that there were no unexpected costs to the Medicare program itself.

### **Legislative Action and the President's Response**

Because of the Select program's popularity, the Congress decided to move ahead and expand the program without waiting for the report on the 15 state demo program. Despite some reservations, the President decided to sign the bill into law because of his overriding commitment to expand choices for Medicare beneficiaries.

We will be monitoring this program closely in the upcoming years. We want to make certain the Select option is delivering on its promise of providing a cost-effective, high quality, and broadly accessible benefit to those Medicare beneficiaries who choose it and the taxpayers who support the Medicare program. If it does not meet this criteria, the HHS Secretary has the authority to terminate the program in three years. If it meets this criteria, the President and the Congress can and should look back at a bipartisan legislative achievement that was consistent with one of the President's Medicare reform priorities: providing more coverage choices to beneficiaries.

DRAFT

While we recommend signing this bill, we remain concerned about issues raised in the preliminary results of the evaluation of the demonstration, particularly the potential for Medicare cost increases and concerns about the requirements for quality and access to care in the SELECT networks.

HHS recommends approval of H.R. 483. However, HHS points out that it has consistently recommended a six month extension of the existing program in order to allow HHS to complete research that it was directed by Congress to conduct to assess the cost efficiency and quality of the Medicare SELECT demonstration program. Further, HHS has noted its concern with the adequacy of the beneficiary protections in SELECT plans. There is no requirement for states to review the actual operations of SELECT plans for access and quality once they are approved.

After Congress took action to extend and expand the Medicare SELECT demonstration, HCFA obtained preliminary results from the organizations that have conducted the Congressionally-mandated research on the program's costs. That research indicates that in 8 of the 12 states in which the demonstration is currently operating, Medicare SELECT increases Medicare expenditures by an average of 17.5 percent. (Only 1 state showed declines in Medicare expenditures; the remainder showed no impact). Although these results are preliminary, they are compelling enough for the HCFA actuaries to estimate a PAYGO impact associated with the extension of Medicare SELECT to all 50 states.

While we are committed to expanding and improving choices for Medicare beneficiaries, we want to do it the right way. We are particularly concerned that Medicare SELECT will attract beneficiaries who would have otherwise enrolled in other Medicare managed care options that offer coordinated care and the potential to reduce Medicare costs. Therefore, we will be closely watching this program as it is expanded to the additional states and will return to the Congress if the final evaluation results demonstrate that this new option fails to reduce costs for beneficiaries and the Medicare program, while maintaining a high standard of care.

In addition we are concerned about the ability of all Medigap plans, including SELECT plans, to use attained-age rating for establishing premiums. Attained-age rating allows plans to adjust premiums based on the beneficiaries age, and may exaggerate the reported value of the product of a plan when marketing to younger beneficiaries. **[Please advise whether this paragraph should be included.]**

#### PAYGO Impacts

FY 95	<\$50 million
FY 96	\$0.9 billion
FY 97	\$1.4 billion
FY 98	\$1.8 billion
FY 99-	
FY 2000	

No impact in FY 1999-2000 because the Secretary of HHS is assumed to discontinue the program due to costs.

Pl. L. to

Jerry Uhlmer

ASAP and notes

Pl. review ASAC.

You don't have Smully,

Pl. call Chris

DRAFT

**TALKING POINTS FOR  
SIGNING HR 483 (MEDICARE SELECT)**

- ▶ By extending and expanding the Medicare SELECT demonstration to all 50 states, this bill allows Medicare beneficiaries to continue to voluntarily purchase Medicare SELECT policies, which are special types of Medicare supplemental health insurance. SELECT enrollees agree to use a restricted provider network in exchange for premiums that are typically lower than those of regular Medicare supplemental health insurance policies.
- ▶ While I am signing this bill, I remain concerned about issues raised in the preliminary results of our evaluation of the demonstration, particularly the potential for Medicare cost increases and concerns about the requirements for quality of and access to care in the SELECT networks.
- ▶ The Medicare SELECT debate during this Congress has also raised awareness of problems associated with the use of attained-age rating for establishing premiums. Under this type of rating methodology, the insurer adjusts the premiums based on the beneficiary's age. This means that a policy may be sold at what appears to be a bargain rate when the beneficiary is younger, but that it becomes rapidly unaffordable in later years when the policy may be needed the most. Although SELECT policies have been touted by some as a "great value," I am concerned that the use of attained-age rating may exaggerate the reported value of these products.
- ▶ While we are committed to expanding and improving choices for Medicare beneficiaries, we want to do it the right way. We will be closely watching this program as it is expanded to the additional states and will not hesitate to return to the Congress if the final evaluation results do not demonstrate that this new option is a true value for Medicare beneficiaries.



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

The Honorable Alice M. Rivlin  
Director, Office of Management  
and Budget  
Washington, DC 20503

JUL 6 1995

Dear Mrs. Rivlin:

This is in response to your request for a report on H.R. 483, an enrolled bill "To amend the Omnibus Budget Reconciliation Act of 1990 to permit medicare select policies to be offered in all States."

We recommend that the President approve the enrolled bill.

Medicare SELECT is a demonstration program that permits insurers to market Medicare supplemental policies under which benefits may be reduced if services are provided outside of a SELECT insurer's network. H.R. 483 would extend the Medicare SELECT program through June 30, 1998 (and permit all States, rather than only 15, to participate). The Secretary would be required to conduct a study, and determine by December 31, 1997, whether (1) savings in premium costs have not been realized under Medicare SELECT, (2) there have been significant additional Medicare expenditures due to Medicare SELECT, and (3) access to and quality of care has been significantly diminished. If any of the above three determinations were positive, Medicare SELECT would be terminated after June 30, 1998; otherwise it would become permanent.

In March of this year the Administration recommended a short extension of the existing 15-State Medicare SELECT program pending completion of a currently ongoing evaluation of the program, to permit the development of recommendations for needed changes to the program. The preliminary results raise concerns about quality and access standards under the program and about how it fits into the managed care options that we want to offer to Medicare beneficiaries.

The enrolled bill would expand the program to all States without the benefit of the final evaluation results. While our continued preference is for a temporary extension of the existing 15-State demonstration, strong congressional support for Medicare SELECT leads us to believe that a veto would be difficult to sustain. We therefore recommend that the President sign the enrolled bill.

Sincerely,

Donna E. Shalala

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Enrolled Bill H.R. 483 - Medicare Select Policies Sponsors - Rep. Johnson (R) CT and 132 others

Last Day for Action

July 12, 1995 - Wednesday

Purpose

(1) Extends the Medicare Select demonstration program nationwide through June 30, 1998; and (2) makes the program permanent thereafter, unless the Secretary of Health and Human Services determines that the program is not meeting specified criteria.

Agency Recommendations

Office of Management and Budget	Approval
Department of Health and Human Services (HHS)	Approval

Discussion

Under current law, Medicare beneficiaries can purchase Medigap health insurance policies (i.e., private insurance to supplement their Medicare coverage). Medigap insurance is regulated by Federal and State law. The Omnibus Budget Reconciliation Act of 1990 (OBRA) established a demonstration program under which insurers could market a Medigap policy known as Medicare Select.

Medicare Select policies are the same as other Medigap policies except that they only pay full supplemental benefits if covered services are provided through preferred providers. OBRA limited the Medicare Select demonstration program to three years (CYs 1992-1994) and to 15 non-specified States. The Social Security Amendments of 1994 (P.L. 103-432) extended the demonstration for six months, through June 30, 1995.

By

According to HHS, health care coverage for current Medicare Select beneficiaries will not be affected if the enrolled bill is signed into law after June 30th. New enrollees, however, will not be permitted to purchase Medicare Select policies until H.R. 483 is approved.

#### Description of H.R. 483

The enrolled bill would extend the 15-State Medicare Select demonstration program to all States for three years, through June 30, 1998. The Medicare Select program would become permanent on July 1, 1998, unless the Secretary of HHS determines by December 31, 1997, that the demonstration program has had adverse effects on Medigap premiums, Medicare program costs, or the quality of and access to care. If any of these determinations are made, the Medicare Select program would be terminated.

H.R. 483 would also require the General Accounting Office (GAO) to conduct a study of all types of Medigap insurance. Specifically, the GAO report would provide (1) an analysis of problems in the current Medigap system for beneficiaries who wish to change Medigap policies; (2) options to address problems identified; and (3) an analysis of the impact of each option on the cost and availability of Medigap insurance. The GAO study would have to be submitted to Congress by June 30, 1996.

#### Experience to Date with the Medicare Select Program

During congressional consideration of H.R. 483, the Administration supported only a temporary (six-month) extension of the 15-State demonstration project. This temporary extension was supported because HHS is currently evaluating the Medicare Select demonstration program. The purpose of the evaluation is to determine whether the original intent of the Medicare Select demonstration program -- i.e., to reduce unnecessary health care utilization among participating Medicare beneficiaries, thereby reducing costs for both beneficiaries and the Medicare program -- is being achieved. The evaluation is scheduled for completion by the end of the year.

Preliminary results of the HHS evaluation indicate that Medicare Select is not achieving its original goal. Data show that Medicare expenditures have increased by an average of 17.5 percent in eight of the 12 States participating in the demonstration program. Medicare expenditures decreased in only one State, and there was no Medicare impact in the remaining three States participating in the demonstration. In addition, HHS is concerned that Medicare Select plans may not have adequate beneficiary protections. In particular, States are not required to review the actual operations of Medicare Select plans to ensure the quality of and access to care.

Scoring for the Purpose of Pay-As-You-Go

H.R. 483 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of OBRA 1990. This Office estimates that pay-as-you-go effect of the enrolled bill would be less than \$50 million in FY 1995, \$.9 billion in FY 1996, \$1.4 billion in FY 1997, and \$1.8 billion in FY 1998. Although enactment of this bill would not trigger a sequester 15 days after the adjournment of this session of Congress, the cost of the bill for FYs 1997 and 1998 would exceed the current pay-as-you-go balances in each of those years.

Conclusion and Recommendations

HHS recommends approval of H.R. 483. In its views letter, HHS states that while its "continued preference is for a temporary extension of the existing 15-State demonstration, strong congressional support for Medicare Select leads [the Department] to believe that a veto would be difficult to sustain."

I join HHS in recommending approval of H.R. 483, which passed the House by a vote of 350-68 and the Senate by voice vote. Medicare Select offers beneficiaries an additional choice in purchasing Medigap insurance, and H.R. 483 would expand that choice to all States. There is concern, however, that Medicare Select will attract beneficiaries who would otherwise enroll in other Medicare managed care options that offer coordinated care and the potential for reduced Medicare expenditures. Working with HHS, we will closely monitor the expansion of Medicare Select provided by this enrolled bill. If the final results of the ongoing HHS evaluation indicate that Medicare Select fails to achieve its intended purpose, we will revisit with Congress the appropriateness of continuing this program.

Alice M. Rivlin  
Director

Enclosures

LRD:B. Pellicci 07/06/95

Approved by HD (Miller/Mutti) and BASD (Balis).

National  
Association  
of Insurance  
Commissioners

June 29, 1995

The President  
The White House  
Washington, D.C.

RE: H.R. 483 (Medicare Select)

Dear Mr. President:

As you know, the Senate has adopted the conference report on H.R. 483 extending the Medicare Select program for three years and expanding it to all fifty states. The House is expected to vote on the conference report some time this evening, and we anticipate the report's adoption by the House.

The Medicare Select program is scheduled to expire on June 30, 1995. The members of the National Association of Insurance Commissioners, the nation's oldest association of public officials composed of the chief insurance regulators of the fifty states, the District of Columbia and four U.S. territories, understands that you intend to sign the bill. However, it is unlikely that the bill could be signed before June 30, 1995, the expiration date of the program. You should know that this creates a problem for the states presently participating in the demonstration project, Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. The problem is that as of July 1, 1995, there will be no statutory authority for the program, which puts the states in an awkward position regarding further sale of policies under the program. Until H.R. 483 is signed by you and enacted into law, the states will not know with any authority that the program is to be extended.

As President of the National Association of Insurance Commissioners this year, I respectfully ask that if our understanding is correct that you intend to sign H.R. 483, then please publicly announce your intention as soon as possible and before June 30, 1995. This announcement by you would be a tremendous help to state insurance regulators in the above-named states.

Thank you for your consideration of this request.

Sincerely,



Lee Douglass  
President, NAIC  
Commissioner of Insurance, State of Arkansas

Medicare Select FY

Note to Chris Jennings

Subject: Medicare Select

OBRA 1990 (P.L. 101-508) authorized the Medicare Select demonstrations to be run in 15 states during the 3 year period beginning in 1992. The law requires the Secretary to conduct an evaluation of the demonstration and to report to Congress by January 1, 1995.

Timeline for Medicare Select Demonstration

Because it is not possible to evaluate a demonstration program the day after it ends, HCFA contracted with Research Triangle Institute (RTI) to evaluate Medicare Select by December 1, 1995.

The RTI evaluation of Medicare Select has 4 parts. The first is an evaluation of claims data to determine if beneficiary utilization and Medicare program costs differ between Medicare Select enrollees and enrollees of other medigap policies. RTI has completed analysis of 1992 and 1993 claims data which show that Medicare Select enrollees are significantly more expensive to the Medicare program than are other beneficiaries. (See attached.) RTI will complete its analysis of the 1994 claims data over the next 4 to 6 weeks.

The remaining three parts of the evaluation involve case studies to describe implementation of Medicare Select in each participating state, a beneficiary survey, and an insurer survey. RTI expects to complete all analyses by the end of August and will inform the Department of their findings in a preliminary report immediately thereafter. A draft report will be submitted to the Department in October. The final evaluation report is due December 1, 1995.

History of the June 16 document

The attached description of RTI's claims evaluation findings so far (dated June 16) came about as part of the contractor's monthly progress review of all their HCFA contracts. In this progress review report, RTI noted "unexpected findings" from the analysis of Medicare Select claims costs. The project officer inquired further about this report and was told that RTI had found "unusually robust" statistics demonstrating the significantly higher cost of Medicare Select enrollees to the Medicare program. The June 16 document explains this finding in more detail.

## EVALUATION OF THE MEDICARE SELECT AMENDMENTS

### A Summary of Empirical Findings To Date

June 16, 1995

*Prepared by the Research Triangle Institute and Health Economics Research, Inc.*

**Evaluation Plans:** HCFA contracted with Research Triangle Institute (RTI) and Health Economics Research, Inc. (HER), in February 1993 for a 36-month evaluation of the Medicare SELECT program. The evaluation has four parts: (1) case studies of each participating state to describe the implementation process, (2) analysis of Medicare claims data to determine if beneficiary utilization and Medicare program costs differ between SELECT enrollees and beneficiaries enrolled in other Medigap products, (3) a survey of Medigap insurers and HMOs that do not offer SELECT, in all participating states, to determine why they do not participate in the program, and (4) a survey of Medicare beneficiaries enrolled in SELECT and a comparison group of beneficiaries enrolled in other Medigap products, in six states, to determine factors that contribute to choice of SELECT, satisfaction with SELECT, and access to care under SELECT.

**Project Status:** The case study report was completed in February 1994. Analyses of the cost and utilization experience through 1993 are now substantially complete. A second impact analysis investigating the cost and utilization experience through 1994 is just beginning. The beneficiary and insurer surveys have both been completed and analyses of this more comprehensive data set is beginning.

**Cost and Utilization Findings To Date:** We were surprised to find that Medicare SELECT is significantly associated with Medicare cost increases in eight of the twelve SELECT states--Alabama, Arizona, Florida, Indiana, Kentucky, Minnesota, Texas and Wisconsin. For the eight states indicating positive impacts on Medicare program costs, the average impact is 17.5 percent. The estimates vary from 7.5 percent in Minnesota to 57 percent in Indiana. However, only the Indiana estimate is much more than 20 percent. The results indicate that the cost increases substantially reflect increases in inpatient hospital utilization. The estimates are unusually robust.

The expected cost decreasing impact is indicated, with statistical significance, in only one state, Missouri.<sup>1</sup> No impact is indicated for the three remaining SELECT states--California, North Dakota and Ohio. In California, SELECT was not implemented until the last quarter of 1993. Since this data set only reflects experience through 1993, there is not enough SELECT experience to observe an impact in that state. In North Dakota and Ohio, the sample sizes are too small for reliable estimates.

**Analytic Design for Evaluation of the Cost and Utilization Impacts:** Within each SELECT state, the evaluation data reflects experience for (1) all Medicare beneficiaries enrolled in SELECT plans, for whom a HIC number was available, plus (2) a matched sample of Medicare beneficiaries enrolled in traditional Medigap, supplemental insurance products. The beneficiaries were matched, to the extent possible, by age, gender and geographic area. We also have an analogous matched

<sup>1</sup> In Missouri, the estimate indicates a 7.6 percent cost reduction.

sample of pre-OBRA network and non-network enrollees; however, analysis to date has focused on the SELECT experience where we also have stronger quasi-experimental comparisons. Nevertheless, the results obtained with the pre-OBRA comparisons have been consistent with those for the post-OBRA (or SELECT) analyses.

The initial data set includes three years of Medicare claims data for the SELECT and non-SELECT beneficiaries--calendar years 1991, 1992 and 1993. Utilization and cost experience has been summarized by beneficiary for each of the twelve quarters in this time interval. Thus, the analyses are conducted using a pooled cross section/time series design with a maximum of twelve data points for each individual beneficiary. The data included only those quarters for which the beneficiaries were (1) alive, (2) continuously eligible for Medicare (both Parts A and B) and (3) not enrolled in an HMO.

For the post-OBRA SELECT comparison, we have a four-way, quasi-experimental design with both before-and-after and treatment-control comparisons. Some 25 different dependent variables, or impact assessment measures, have been defined. However, analyses to date have focused on the total allowable Medicare expense (including deductibles and copayments) for both Parts A and B. The basic results do not change if one looks only at the amounts actually paid by Medicare. Furthermore, the results are corroborated from looking at individual utilization and cost components (e.g., hospitalization, physician services and ancillary services). We have estimated OLS, log-linear and two-part Probit models. The results obtained with different model specifications are essentially equivalent. In particular, the SELECT impact estimates are unusually robust.

The SELECT "treatment" or impact assessment variable is a dummy-type indicator that ranges between zero and one. For SELECT enrollees, it is set equal to zero for quarters prior to SELECT enrollment; and it is set to one for quarters after SELECT enrollment. For non-SELECT enrollees, this variable is always zero.

The following are included as independent variables:

- a dummy variable for gender (i.e., male or female);
- six continuous variables specifying age in a piecewise linear fashion (including a segment for under age 65);
- two dummy variables for race--distinguishing black and other nonwhite;
- two time trend variables--quarter number (i.e., 1 thru 12) and quarter number squared;
- dummy variables for the disabled and renal beneficiaries;
- two dummy variables indicating those with dual entitlement--distinguishing the aged-disabled and the aged with renal disease;
- dummy variables for each county--to control for geographic differences in provider availability and payment rates;

- dummy variables for each insurer—to control for insurer differences in risk SELECTION;
- dummy variables for each OBRA "plan letter"—to control for differences in benefits;<sup>2</sup>
- dummy variables for each season—to control for seasonal variation in health care utilization; and
- a dummy variable set equal to one throughout for beneficiaries who subsequently join SELECT—to control for prior use and cost differences between the treatment and comparison groups.

To date, all models have been estimated separately for each state, since the programs were implemented so differently in different states. A pooled model with additional explanatory variables representing the characteristics of states and insurers will soon be tested to assess the impact of implementation choices on cost and use.

Alternative Interpretations of the Results: A number of alternative explanations are possible:

(1) *SELECTION Bias* Absent a truly randomized experimental design, it is not possible to preclude the possibility of biased SELECTION (i.e., having noncomparable treatment and comparison populations). At least two kinds of SELECTION bias could yield the apparent cost-increasing empirical results. One of these is SELECTive enrollment of "bad" risks. Most of the SELECT plans involve hospital-only provider networks. That is, the plans do not restrict physician choice. To the extent that SELECT insurers emphasize their "high quality" hospital providers in marketing, they may unintentionally be attracting beneficiaries that anticipate hospitalization (i.e., bad risks). Indeed, our results indicate that most of the apparent cost increases are related to hospitalization

SELECTION bias is also possible due to SELECTive enrollment of formerly uninsured beneficiaries. It is possible, albeit somewhat less likely, that SELECT, due to its pricing advantage and market positioning, is relatively more attractive to Medicare beneficiaries without a prior supplemental plan. Research has shown that, due to the "moral hazard" involved, those with Medigap, supplemental plans have higher Medicare program costs than those without. Thus, a cost increasing result could be obtained if those enrolling in SELECT were less likely to have had a supplemental plan prior to enrollment. Unfortunately, no information was available on the prior insured status of either the SELECT or traditional enrollees included in this analysis.

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<sup>2</sup>Minnesota and Wisconsin are both nonstandard states. Thus, no plan letter variables could be indicated for beneficiaries in those states.

(2) *Volume Response.* Early analyses of commercial PPOs found that providers responded to price discounts by increasing volume and thereupon total health benefit costs. A similar explanation is possible here. However, a volume response of this type has never before been attributed to hospital providers, and, again, much of the apparent cost increases reflect increased hospital volume.

(3) *More Aggressive Patient Screening.* Some Medicare HMOs have reported dramatically high initial costs due to their preventive care orientation. New patient screening has detected a large backlog of formerly undiagnosed and untreated problems. This has meant that new patients have unexpectedly large, albeit short-term requirements for medical treatment. If so, the apparent cost-increasing impacts of SELECT would diminish rapidly over time.

Continuing work will seek to discriminate between these and other alternative explanations of the results.

**Schedule for Reporting Additional Results:** Substantially all analyses will be completed by mid-August. A draft final report is due to HCFA on October 1, 1995. The revised final report is due December 1, 1995.

Medicare Select FY

Draft--NOT CLEARED FOR TRANSMITTAL

May \_\_, 1995  
(Senate)H.R. 483, A Bill to Permit Medicare Select Policies  
to be Offered in All States

The Administration supports a temporary extension of the 15-State Medicare SELECT demonstration program. However, the Administration has concerns about H.R. 483, in its present form, for the reasons stated in the attached letter from Secretary Shalala. The Administration looks forward to working with the Congress on this matter.

\* \* \* \* \*

file # 59

THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

March 7, 1995

The Honorable Bill Archer  
Chairman, Committee on Ways and Means  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

This letter expresses the Administration's views on H.R. 483, as reported by the Subcommittee on Health. H.R. 483 would make the Medicare SELECT demonstration program permanent and extend it to all States.

Our experience with the Medicare SELECT demonstration should be part of the effort to improve current and future managed care choices under Medicare. We have previously made available the case study portion of the Medicare SELECT evaluation. Other pieces of the evaluation are still in process; these include a survey of SELECT plan enrollee satisfaction and an analysis of SELECT enrollee utilization experience. Preliminary results will not be available until the later part of this summer. We believe that Congress would benefit from a review of the full evaluation results before beginning the deliberations on Medicare SELECT as a permanent program.

The case study portion of the Medicare SELECT evaluation has already raised a number of questions about the Medicare SELECT demonstration. As managed care options under Medicare are expanded, we want to ensure that our beneficiaries are guaranteed choice and appropriate consumer protections. In addition, many of the SELECT plans consist solely of discounting arrangements to hospitals. We would be concerned if the discounting arrangements under Medicare SELECT were to be expanded to Medicare Supplementary Insurance (part B) services. Discounting arrangements, particularly for part B services, may spur providers to compensate for lost revenues through increased service volume. Consequently, we are concerned that such an expansion would lead to increased utilization of part B services, rather than contribute to the efficiency of the Medicare program through managed care. We would therefore oppose such a change.

Page 2 - The Honorable Bill Archer

Given that the Medicare SELECT demonstration is under an expiring authority with an impending deadline, the Administration supports a temporary extension of the 15-State demonstration. Such an extension would provide sufficient time to examine what we have learned from the demonstration and to make needed changes to SELECT based on our findings.

We are committed to working with the Congress to improve and extend the available choices to Medicare beneficiaries so that they have the full range of managed care options enjoyed by the general insured population.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



Donna E. Shalala

The Honorable  
Chairman, Subcommittee .....  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

This letter expresses the Administration's views on the Chairman's mark for Medicare Select legislation, H.R. 483, under consideration by the House..... Subcommittee.

Our experience with Medicare SELECT demonstration should be part of the effort to improve current and future managed care choices under Medicare. We have previously made available the case study portion of the Medicare SELECT evaluation. The four remaining pieces of the evaluation are still in process; these include: a survey of SELECT plan enrollee satisfaction; a survey of SELECT insurers; an analysis of the relative efficiency of SELECT physician networks and an analysis of SELECT enrollee utilization experience. Preliminary results will not be available until this summer. We believe that Congress would benefit from a review of the full evaluation results before beginning the deliberations on Medicare SELECT as a permanent program.

The case study portion of the Medicare SELECT evaluation has already raised a number of questions about the Medicare SELECT demonstration. As managed care options under Medicare are expanded, we want to make sure that seniors are guaranteed choice and the appropriate consumer protections. In addition, many of the SELECT plans consist of discounting arrangements to hospitals. We would be concerned if the discounting arrangements under Medicare SELECT were to be expanded to Part B services. We believe that such an expansion would lead to increased utilization of services, rather than contributing to the efficiency of the Medicare program. We would therefore oppose such a change.

Given that the Medicare SELECT demonstration is under an expiring authority with an impending deadline, the Administration supports a temporary extension of the 15-State demonstration for existing plans. Such an extension would provide sufficient time to examine what we have learned from the demonstration and to make the requisite changes to SELECT based on our findings.

We are committed to working with the Congress to improve and extend the available choices to Medicare beneficiaries so that they have the full range of managed care options enjoyed by the general insured population.