

MEMORANDUM

TO: Nancy Ann
FR: Chris J.
RE: Medicare Presentation Materials

July 7, 1995

As we have discussed, the Ways and Means moderate Democrats (Cardin et al) have asked for a general briefing on Medicare as a first step towards coming up with a package of savings proposals that they think are generally consistent with ours.

Pat G. wants to make certain we lay the necessary groundwork with the Democratic Leadership before doing this. He also wants to make certain that should this occur, we understand how we need to be very careful about what we say and don't say, and play a strictly technical role.

Having said the above, Pat thinks we will have to be responsive at some point. In fact, if done right, well and carefully, he believes this development could be constructive from the President's perspective.

Cardin has asked for a briefing for this next Tuesday morning. HHS has put together a first set of briefing charts for clearance that I am forwarding to you with this cover note. (Knowing how busy you are, I am also forwarding a copy of this set of materials to Mark -- without this note.)

Please add or subtract other useful Medicare charts that you think would be helpful. I personally believe that we should have the comparisons between the President's proposal and the Republican conference agreement as well. Talk to you soon (I think we may see each other on Monday.)

MEMORANDUM

TO: Mark
FR: Chris J.
RE: Medicare Presentation Materials

July 7, 1995

Attached are some materials the Department has put together in preparation for a possible briefing for some House Members. I have also sent them to Nancy Ann with a separate cover note.

Please review, change, and most important (hopefully) clear. If there are any other materials you think should be added, please call. I would love your suggestions.

Talk to you soon. Thanks.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY



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Number of Pages (Including Cover): _____

Comments: Draft
Packet for Clearance

MEDICARE

Part A:

Hospital Insurance
\$114 billion in 1995 (CBO)

Uses of Funds:

- Inpatient Hospital Care
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care

Sources of Funds:

- Social Security payroll tax
Employers & employees each pay
1.45% of earnings

Part B:

Supplementary Medical Insurance
\$68 billion in 1995 (CBO)

Uses of Funds:

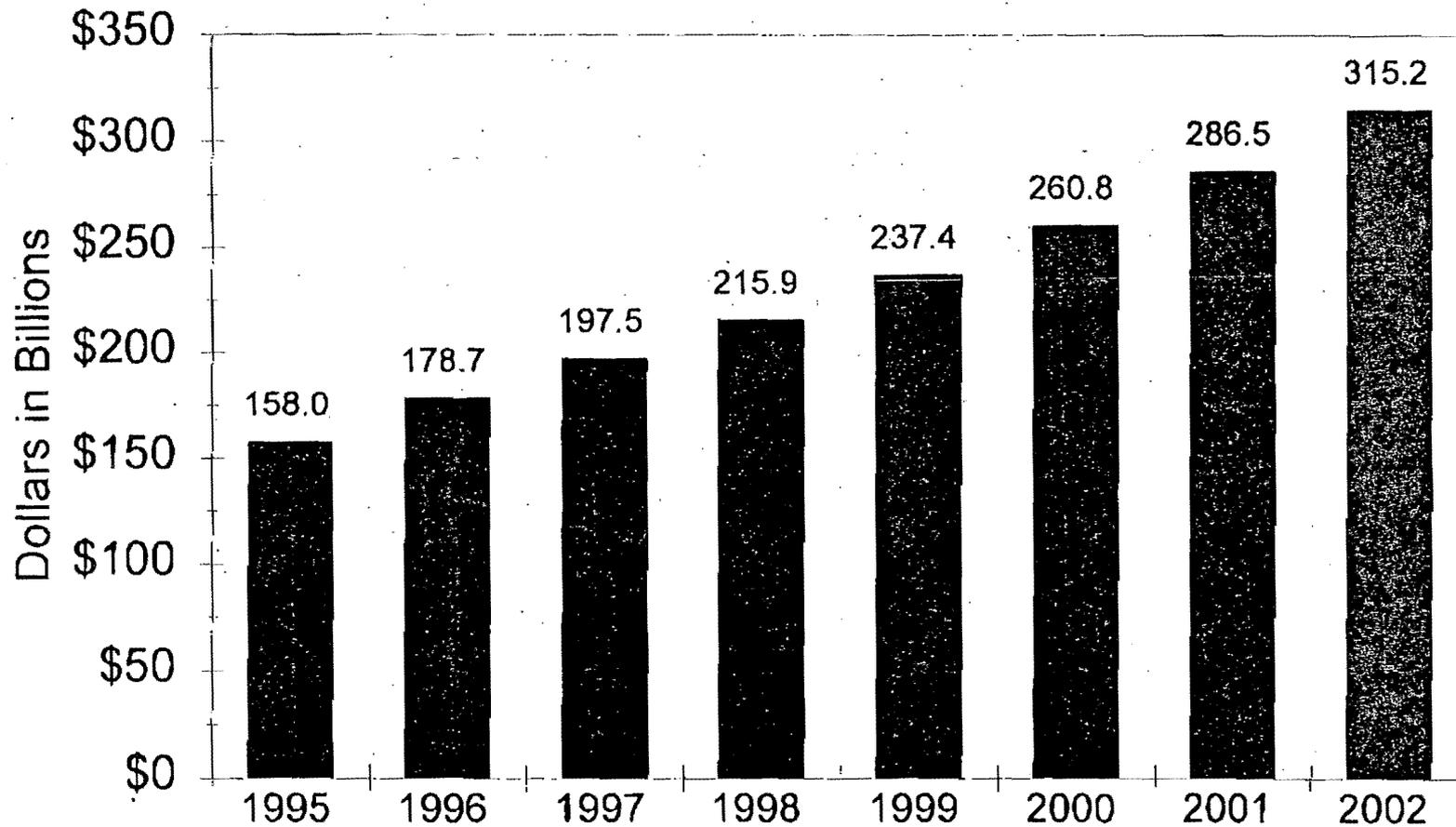
- Physicians' Services
- Home Health Services
- Other Medical & Health
Services (e.g., lab, x-ray)

Sources of Funds:

- Premiums from beneficiaries
\$46.10 per month
- General Revenues

DRAFT

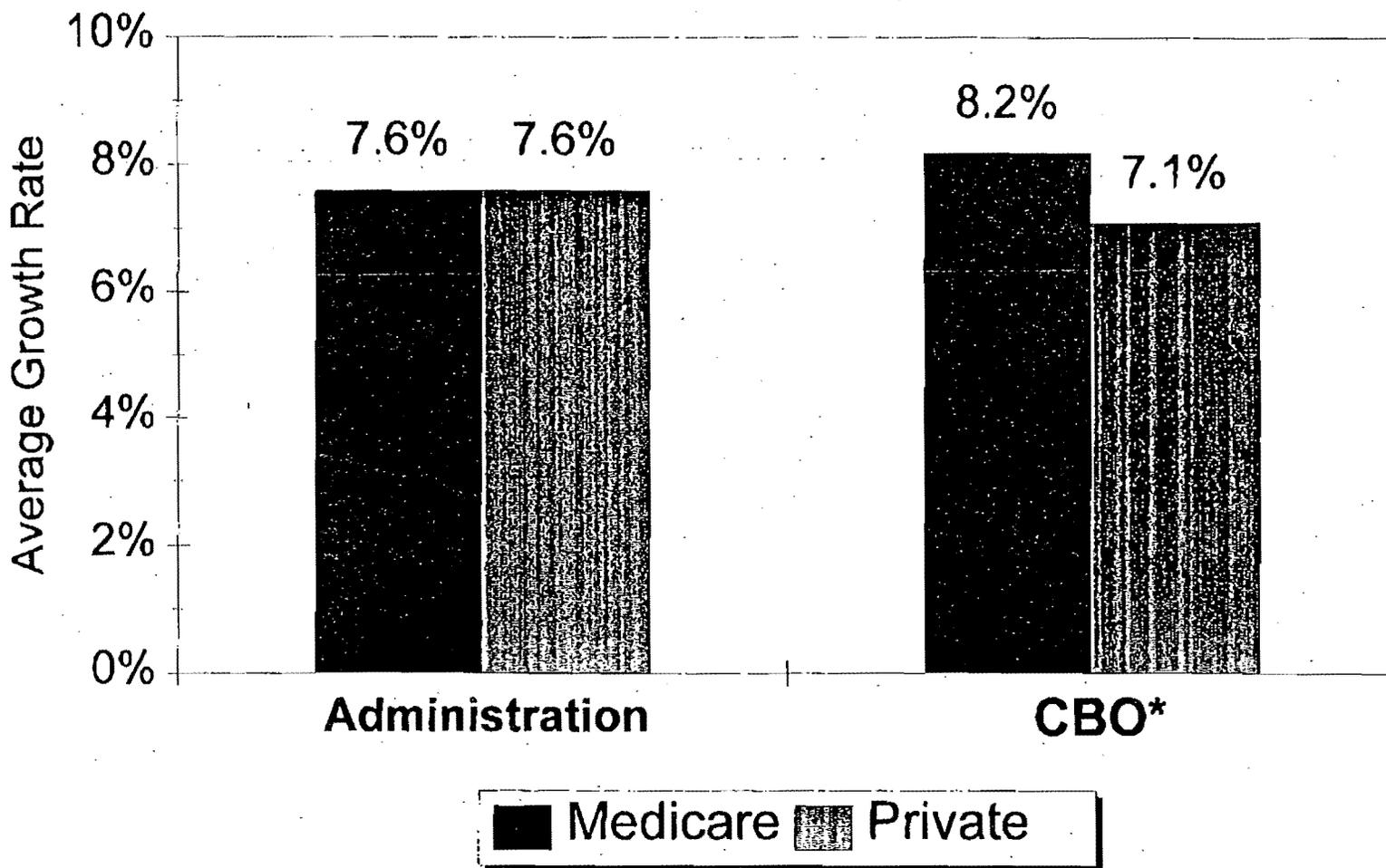
CBO Projected Federal Spending on Medicare, 1995 - 2002



Gross outlays minus premium receipts and discretionary spending

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Per Capita Growth Rates Medicare and Private, 1996-2002

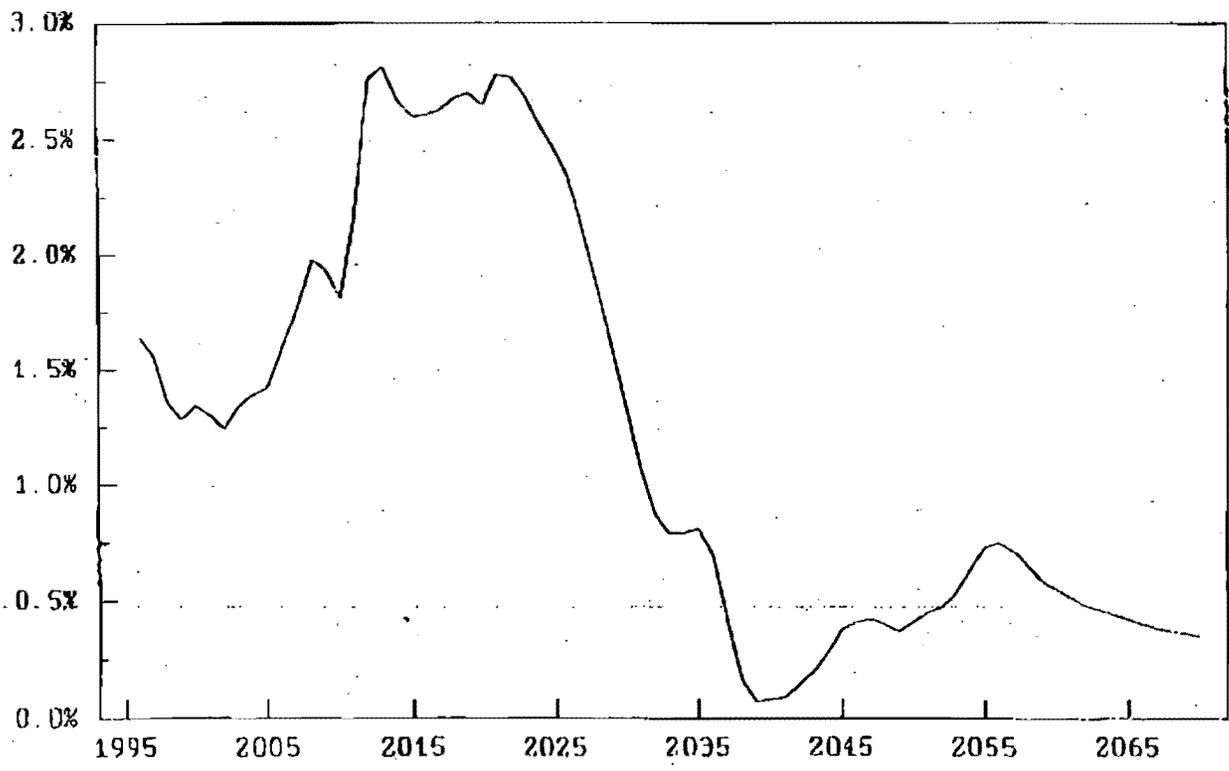


*Administration estimates, based on CBO data; fiscal years

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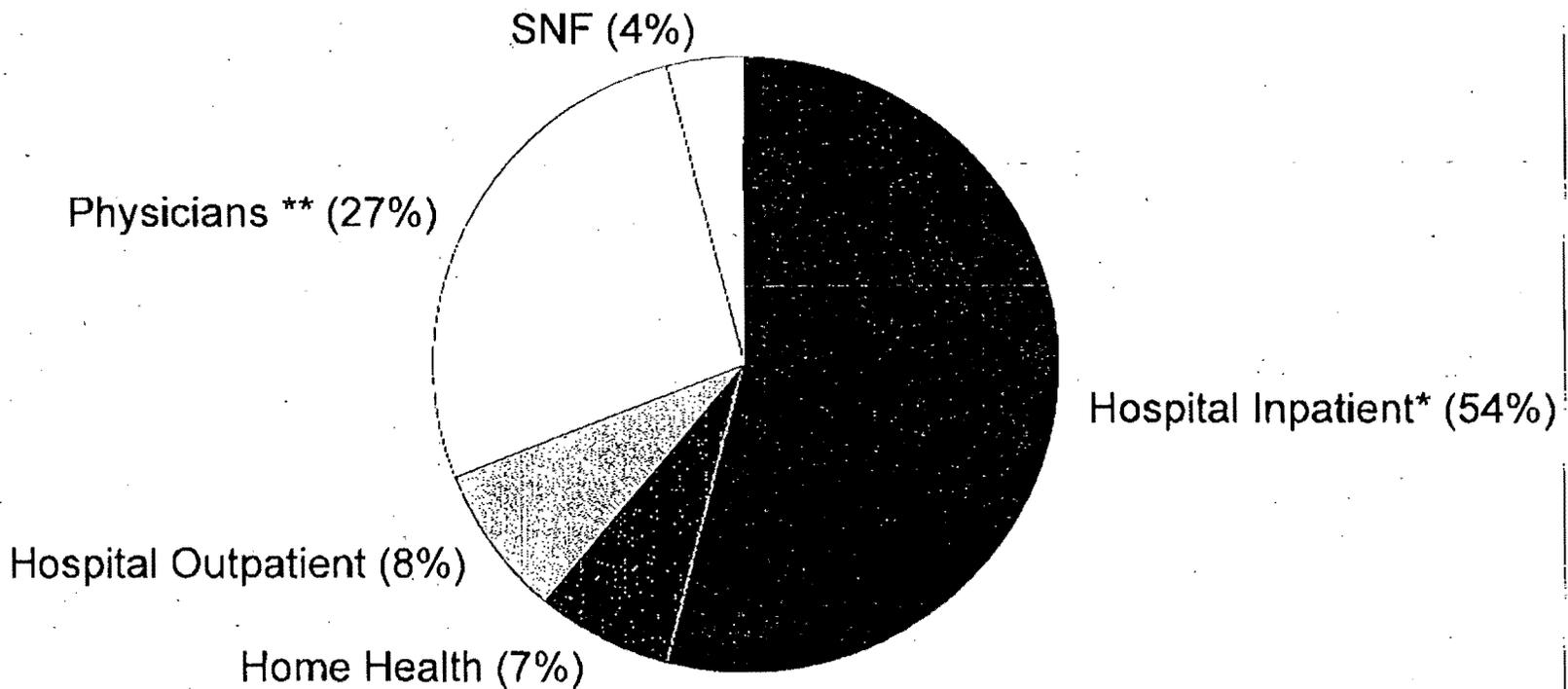
Chart 1

HI Enrollment Growth



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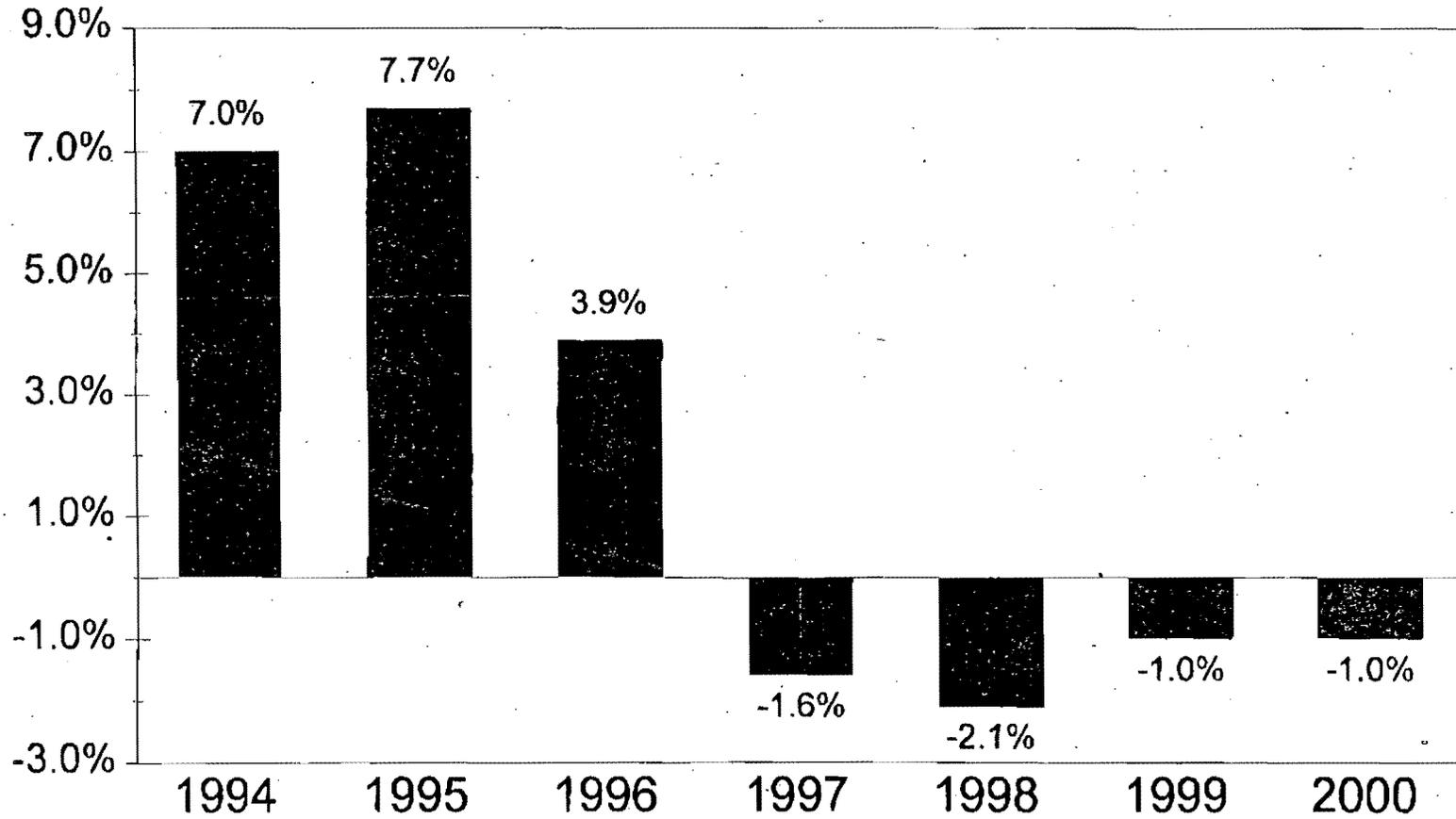
Where the Medicare Dollar Goes 1993



* Includes HMOs and other Part A expenditures; ** Includes Other Part B expenditures
Source: HCFA/Oact

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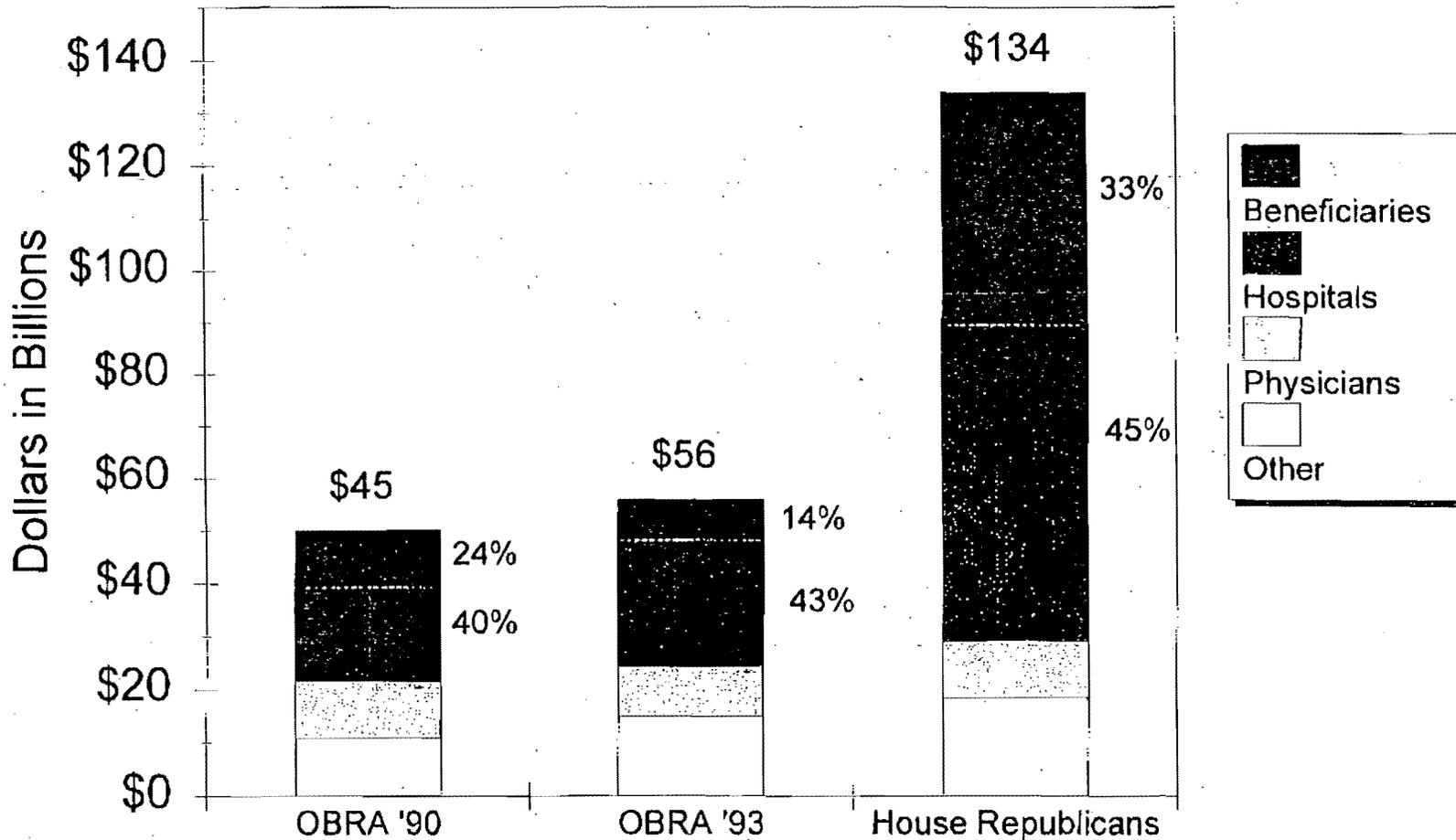
Medicare Physician Update Factors: 1996 - 2000



Source: CBO February 1995 baseline

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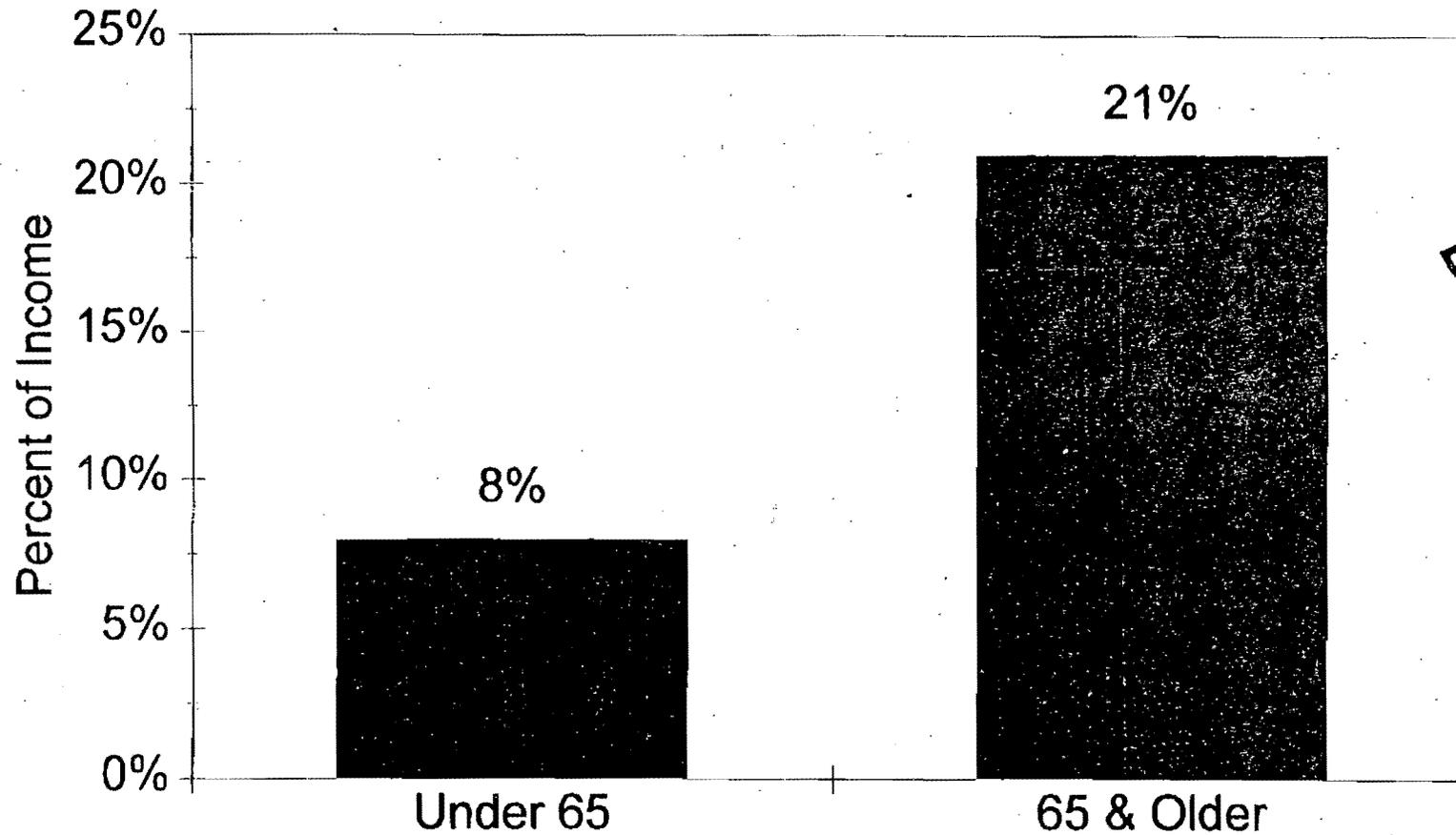
Sources of Savings in Medicare Various Proposals



OBRA '90 estimates for '91-'95; OBRA '93 estimates for '94-'98; House Republican plan estimates for '96-'00 and are based on the Republican "Plan A" released on May 11, 1995.

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Out-of-Pocket Health Costs as a Percent of Income, 1994



SOURCE: AARP Public Policy Institute and the Urban Institute, February 1995. Does not include long-term nursing home costs.

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MEDICARE: WHAT'S AT STAKE IN THE BUDGET NEGOTIATIONS

January 16, 1995

Republicans put Medicare at risk. Excessive spending cuts -- combined with premium increases and risky policy proposals -- threaten to transform Medicare into a second-class medical system. President Clinton has a more sensible approach -- one that preserves the basic structure of Medicare while expanding choice and preventive benefits, strengthening the trust fund and cracking down on fraud and abuse. The President doesn't gamble with the health of our elderly and disabled citizens.

MAGNITUDE OF CUTS. Republicans cut Medicare far below the private sector rate.

- Republicans insist on excessive cuts that reduce Medicare spending by \$168 billion over seven years -- 65% more than the President -- largely to pay for tax cuts for the well-to-do. These cuts, enforced by a rigid budget cap, constrain Medicare spending growth to an unrealistic level -- 20% below the private sector growth rate.
- The President's proposal saves \$102 billion through specific policy changes designed to strengthen the Medicare system, not undermine it. The proposal extends the life of the Medicare trust fund through 2011 -- leaving it stronger or as strong as it has been in 19 of the last 20 years. And the proposal permits spending per beneficiary to grow at close to the private sector rate.

PREMIUMS. Republicans force the elderly to pay more in out-of-pocket costs.

- Republicans insist on increasing Part B premiums beyond the current policy level of 25% of program costs -- raising premiums for an elderly couple by more than \$400 in 2002, based on the latest CBO figures. This burden -- totalling \$30 billion over seven years -- falls on a particularly vulnerable population: *Seventy-five percent of Medicare beneficiaries have incomes below \$25,000 per year.*
- The President maintains premiums at current policy levels, keeping premiums at 25% of program costs.

LOW-INCOME MEDICARE PROTECTION. Republicans abolish premium guarantees for the elderly and disabled poor, which could force many to lose physician coverage.

- Republicans effectively eliminate the long-standing provision that guarantees Medicaid coverage of the Medicare premiums, deductibles, and copayments for older and disabled beneficiaries near or below the poverty line. They fail to set aside any Medicaid funding for deductibles and copayments, and set aside less than half of the funds needed to cover the Medicare premiums of poor elderly and disabled people. Hundreds of thousands of poor elderly and disabled Americans could lose funding for their premiums -- at the same time that Republicans want to increase premiums.
- President Clinton preserves the guarantee of coverage for low-income beneficiaries, ensuring that at least 5 million poor elderly and disabled citizens have access to care.

STRUCTURAL FLAWS. Republicans insist on offering untested health care plans, such as Medical Savings Accounts, and dangerous billing practices, called "balance billing," that damage the foundation of the traditional Medicare program.

- **MEDICAL SAVINGS ACCOUNTS (MSAs).** Republicans insist on the immediate adoption of new and untested changes to the Medicare program, such as MSAs, that experts say could harm the Medicare system and increase costs.
 - Medical Savings Accounts appeal to the healthiest beneficiaries -- the only ones willing to risk joining a health care plan with a very high deductible -- leaving the sickest and most costly beneficiaries in a weakened fee-for-service program. The Congressional Budget Office projects that MSAs will *increase* Medicare costs by more than \$4 billion over seven years; Lewin-VHI puts the price tag at \$15-20 billion. *MSAs turn fairness upside-down, allowing the healthy to benefit at the expense of the sick.*
 - The President's proposal expands the range of plans available to beneficiaries to include new managed care options, such as Provider Sponsored Organizations (which are plans organized by groups of physicians or hospitals) and Preferred Provider Organizations (which are network plans that give enrollees the option of receiving services from providers outside the network). The President's new options ensure that Medicare plans compete by offering more affordable, higher quality care -- not by cherry-picking the healthiest and wealthiest beneficiaries.
- **OVER-CHARGING IN PRIVATE PLANS. Republican proposals permit physicians to charge beneficiaries extra in private Medicare plans, increasing out-of-pocket costs and slowly draining the fee-for-service system of both doctors and dollars.**
 - Republicans allow doctors to charge above the Medicare approved amount -- a practice sometimes called "balance billing" -- leaving the elderly vulnerable to higher costs. Balance billing gives doctors in the fee-for-service program an incentive to switch to private health care plans, reducing beneficiaries' access to physicians in the traditional program. Moreover, without balance billing protection, only healthy and wealthy beneficiaries will risk joining the new private plans, leaving the fee-for-service program with a larger share of the sickest beneficiaries -- those most costly to insure.
 - The President maintains the current prohibition against balance billing in the new private health care options.

- **MEDIGAP. Republicans retain Medigap rules that effectively lock beneficiaries into private plans.**

- Republicans do nothing to change Medigap rules that magnify the structural flaws in their plan. After first enticing healthy beneficiaries into Medical Savings Accounts and other private plans, Republicans make sure they never leave: Their proposal continues to let Medigap companies discriminate on the basis of age and health status against beneficiaries trying to switch back to the fee-for-service program. By reducing access to Medigap coverage in the fee-for-service program, Republicans subtly limit the health care options available to beneficiaries.
- President Clinton expands the choices available to Medicare beneficiaries, while giving them the freedom to transfer between private plans and the fee-for-service program as their needs and circumstances change. His proposal enacts long-overdue reforms, requiring Medigap companies to hold annual enrollment periods and prohibiting them from discriminating against beneficiaries based on either age or health status. The President's plan offers genuine choices -- not false ones.

ADDITIONAL REFORMS. Republicans ignore critical reforms proposed by the President that will strengthen Medicare, including new preventive care benefits and aggressive initiatives to crack down on health care fraud.

- **PREVENTIVE CARE. Republicans neglect the benefits of preventive care.**

- Even as Republicans increase premiums and out-of-pocket costs, they offer only one new benefit -- coverage of oral nonsteroidal antiestrogen for the treatment of breast cancer.
- President Clinton's balanced budget expands Medicare coverage of preventive services -- by waiving cost-sharing for mammograms, offering annual mammogram exams, providing colorectal screening for cancer, and increasing reimbursements for immunizations. The President's plan also offers a new respite care benefit for families of beneficiaries with Alzheimer's disease.

- **FRAUD & ABUSE. Republicans retreat from the fight against health care fraud.**

- Republicans put new obstacles in the way of enforcing current fraud and abuse laws. For example, they weaken the "self-referral" rules that prevent doctors from receiving "pay-offs" for referrals. They raise the standard of proof for civil sanctions, making it more difficult for prosecutors to fight fraud. They even create an exemption to the anti-kickback statute for managed care plans.
- The President's plan, by contrast, continues aggressive policies to stamp out Medicare waste, fraud, and abuse. For example, the plan expands "Operation Restore Trust" -- the Administration's successful anti-fraud program -- making it nationwide in scope. It also maintains both the current standards of proof for civil penalties -- to ensure swift punishment -- and the protections against "self-referrals" -- to ensure that profits don't cloud medical judgment.

MEDICARE: WHAT'S AT STAKE IN THE BUDGET NEGOTIATIONS

January 19, 1995

Republicans put Medicare at risk. Excessive spending cuts -- combined with premium increases and risky policy proposals -- threaten to transform Medicare into a second-class medical system. President Clinton has a more sensible approach -- one that preserves the basic structure of Medicare while expanding choice and preventive benefits, strengthening the Trust Fund and cracking down on fraud and abuse. The President doesn't gamble with the health of our elderly and disabled citizens.

MAGNITUDE OF CUTS. Republicans cut Medicare far below the private sector rate.

- Republicans insist on excessive cuts that reduce Medicare spending by \$168 billion over 7 years -- over one third more than the President -- largely to pay for tax cuts for the well-to-do. These cuts, enforced by a rigid budget cap, constrain Medicare per beneficiary spending growth 15% below the private sector growth rate.
- The President's proposal saves \$124 billion through specific policy changes designed to strengthen the Medicare system, not undermine it. The proposal extends the life of the Medicare Trust fund for at least 10 years. And it permits spending per beneficiary to grow closer to the private sector rate.

PREMIUMS. Republicans force the elderly to pay more in out-of-pocket costs.

- Republicans insist on increasing Part B premiums beyond the current policy level of 25% of program costs -- raising premiums for an elderly couple by more than \$400 in 2002, based on the latest CBO figures. This burden falls on a particularly vulnerable population: *75% of Medicare beneficiaries have incomes below \$25,000 per year.*
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STRUCTURAL FLAWS. Republicans insist on policies that will damage the foundation of the traditional Medicare program. These including offering untested health care plans, such as Medical Savings Accounts, and allowing doctors in new plan options to overcharge or "balance bill."

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• **FRAUD & ABUSE. Republicans retreat from the fight against health care fraud.**

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REPUBLICAN MEDICARE CUTS

There has been some confusion about how the Republicans' proposed Medicare cuts will affect beneficiaries out-of-pocket costs. The table below shows the increase in out-of-pocket costs that the average Medicare beneficiary would face under the Domenici and Kasich proposals, assuming that the cuts are distributed evenly between health care providers and beneficiaries.

INCREASE IN AVERAGE BENEFICIARY OUT-OF-POCKET COSTS

| | <u>2002</u> | <u>Total 1996-2002</u> |
|---------------|-------------|------------------------|
| Domenici Cuts | \$ 745 | \$3,175 |
| Kasich Cuts | \$1,030 | \$3,445 |

- These numbers differ slightly from numbers previously released by the Administration.
- The first set of Administration numbers, in which the increase in 2002 was estimated at \$815-\$980, were released BEFORE the Domenici and Kasich plans were announced. Those numbers were based on certain assumptions about what might be proposed. The updated numbers in the table above are more accurate since they are based on the actual proposals as released.
- For example, the Domenici Medicare proposal translates into an increase in average beneficiary out-of-pocket costs that is \$70 lower than originally estimated in 2002, while the Kasich 2002 cut is \$50 higher.
- The correct numbers are in the table above.

Note: In the above table, the Kasich Medicare cuts are estimated to be \$279 billion over 7 years. Some estimates have shown the actual Kasich cuts to be as high as \$283 billion over 7 years. Using the higher estimate of the cuts would yield a slightly higher increase in out-of-pocket costs.

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9/25

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MESSAGES:

of Pages including cover: 5

dpc background brief

Publication: BB-12-Social Services

September 22, 1995

Senate GOP Medicare Plan: An Initial Review

Today, Senate Republicans released information about their plan for Medicare. For the first time since the GOP took control of Congress, Senate Republicans have developed legislation more extreme than the House version.

In sum, the Senate GOP plan targets bigger hits on seniors living on fixed incomes than even the House plan. The bottom line is that the Senate plan puts in jeopardy the contract Congress made with seniors 30 years ago: Medicare.

The following is a brief analysis of the Senate GOP plan, which is scheduled to be voted on by the Finance Committee next week. Like the House plan, its number one priority is preserving the tax breaks for the wealthiest Americans—and using drastic cuts in Medicare to fund it. The Senate plan cuts Medicare three times as much—an extra \$180 billion in cuts—beyond what is needed to restore the solvency Medicare trust fund.

Senate GOP Plan Hits Seniors Hard

The Senate plan is a departure from the current Medicare system with devastating consequences to America's seniors. The Senate GOP plan:

- doubles the premiums under Medicare Part B;
- doubles the deductibles under Medicare Part B;
- increases the age of eligibility for Medicare to 67; and,
- relies on a budget gimmick—that hits seniors who want to keep their existing Medicare coverage—to achieve budget savings.



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

Tom Daschle, Chairman
Harry Reid, Co-Chairman

GOP Budget Gimmickry

The GOP plan sets annual targets for Medicare expenditures necessary to achieve the \$270 billion in savings over the next seven years. At the end of the year if savings come up short, the GOP plan requires Medicare spending to be reduced automatically. These reductions will be made to payments to providers, i.e. hospitals and physicians.

| The GOP's New Medicare Plan | |
|------------------------------------|---|
| The Untold Story | |
| \$270 | GOP Proposed Cuts |
| -89 | Needed for Trust Fund |
| <hr/> | |
| \$181 | Additional Medicare Cut— where does this money go? |

Budget Expenditure Limit Tool (BELT): How it Works

Under Senate Republican Budget gimmickry, Medicare spending would be reduced automatically by means of "an annual Medicare budget expenditure tool (BELT)" if it were anticipated that spending would exceed the limits set under the GOP budget targets. (Senate GOP plan, p. 53).

The GOP plan requires the Office of Management and Budget and the Congressional Budget Office to alert Congress annually of the possible need for a BELT adjustment. A Presidential order, specifying the reductions for payments to providers, will have to be issued on October 15th of each year.

Part B Premium Increases

The Senate Republican plan pegs the Medicare Part B premium at 31 percent of program expenditures. Although the amount of the premium is not specified, *this percentage is consistent with a doubling of current premiums from \$46.10 to \$93 per month, which will mean a \$384 increase over current law in 2002.*

Means testing begins at \$25,000? At \$75,000? The Senate GOP press materials say that their means testing increases affect only those making \$75,000 or more, but the text of their plan states that the Federal subsidy will be "phased-down ratably from the income thresholds over \$25,000 of income for singles [and \$50,000 for couples]." (Senate GOP plan, p. 44) At either level, the plan does not specify how much of an increase these seniors will pay.

Higher Part B Deductibles

The Senate GOP plan more than doubles the annual deductible seniors will have to pay from the current \$100 to \$220 in the year 2002. Like the increase in premiums, this increase in the out-of-pocket expense for seniors will not benefit the Part A trust fund. These additional costs to seniors go directly to fund the GOP tax breaks for the wealthy.

Increase In Age of Eligibility

The Senate GOP plan will change the age of eligibility from 65 to 67 gradually beginning in the year 2003.

New Choices are Bad Choices

While the Senate GOP boasts that its plan provides new options to beneficiaries beyond the current HMO and competitive medical plan, the new options proposed raise serious concerns. The new GOP options include:

- a high deductible benefit coupled with a non tax favored medical savings account;
- coordinated care health plans; and,
- union and association-sponsored plans.

The Medical Savings Accounts will undermine the basic Medicare program. If a large number of healthy beneficiaries choose this option, the solvency of Medicare will be undermined. Beneficiaries can withdraw these funds for non-medical purposes, diverting Medicare dollars from the trust fund and accelerating its bankruptcy.

In addition, the Senate GOP plan will give rebates to individuals who choose the medical savings account, encouraging healthy seniors to leave the current system adding to the potential problems.

The Anti-fraud Provisions are Phony

The Republicans claim they are going to clamp down on fraud and abuse—at the same time they are cutting fraud enforcement. The GOP majority in the House recently voted to cut funding for enforcement in the FY 1996 *Health and Human Services Appropriations* bill by 15 percent.

Achieving \$270 billion in Medicare Savings

Achieving Medicare savings of \$270 billion today over the FY 1996 - FY 2002 period requires that the proposals actually cover six years since it would not be possible to enact and implement proposals saving money in FY 1996. Achieving Medicare savings of \$270 billion today would require the same policies as contained in the Conference Agreement plus new proposals.

- (1) Conference Agreement: The Conference Agreement was originally scored by CBO as saving \$270 billion. This estimate was later revised to be \$227 billion under the December 1995 CBO baseline. Delaying proposals one year because proposals cannot be implemented before FY 1997 would result in loss of the former FY 2002 savings of \$58 billion. Thus the Conference Agreement would now save only \$169 billion over six years.

- (2) Additional Proposals: Additional savings of \$101 billion over six years would be needed to achieve \$270 billion over six years. Additional policies to achieve another \$101 billion in Medicare savings could include:

- o Indirect Medical Education: Eliminating Medicare indirect medical education payments entirely (instead of phasing it down from 7.7 percent to 5 percent) could save an additional \$30 billion.
- o Hospital Market Basket Updates: Reducing hospital market baskets to a complete freeze between FY 1997 and FY 2002 instead of the 2 percentage points per year reduction in the Conference Agreement could save an additional \$6 billion.
- o Capital for PPS Hospitals: Reducing capital payments for PPS hospitals by 50 percent instead of 15 percent could save an additional \$30 billion.
- o DSH: Eliminating Medicare DSH payments entirely (instead of gradually reducing it from 5 percent to 30 percent) could save an additional \$30 billion.
- o Hospital Bad Debt: Eliminating Medicare payments for hospital bad debts (instead of cutting it by 50 percent) could save an additional \$1 billion.
- o PPS Exempt Hospitals: Doubling the reduction in updates for PPS exempt hospitals and increasing the reduction in capital for PPS exempt hospital hospitals from 10 percent to 30 percent would save another \$4 billion.

*used on
April 1996
baseline
guesses*

*Based on April 1996
Baseline*

Part A

Page 2.

(3) Beneficiary Proposals: Since it is unlikely that a set of policies such as these would be proposed, the only other place to achieve big savings is with beneficiary proposals. A repetition of the Conference Agreement from last year would involve a 31.5 percent Part B premium and an income-related Part B premium. The following types of additional beneficiary proposals could achieve additional savings:

- o Home Health Copayment. Imposition of a copayment equal to 20 percent of home health costs would raise about \$27 billion.
- o Raise the Part B deductible. Approximately \$8 billion could be saved by increasing the Part B deductible to \$150 in 1997 and increasing it annually by per capita costs (resulting in a deductible exceeding \$200 in 2002).

+35
Billion

Previous Republican Statements on Cutting Medicare

Medicare

"The reimbursement levels of Medicare have reached potentially disastrous levels..."

From the "Minority Views" included with the Ways and Means Committee Report on the Health Security Act (H.R. 3600) signed by every Republican Member of the Committee, July 14, 1994:

"For more than a decade Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare... patients -- and the additional massive cuts in reimbursement to providers proposed in this bill [H.R. 3600] will reduce the quality of care for the nation's elderly. There will be no place else to shift."

From the "Minority Views" included with the Ways and Means Committee Report on the Health Security Act (H.R. 3600) signed by every Republican Member of the Committee, July 14, 1994:

"Medicare Part A, I hope, will not be on the table [to fund tax cuts] because I would like to see that reserved for when we reform the health care later on next year."

Congressman Bill Archer, December 18, 1994, on "Meet the Press"

"We have here in this bill the seeds of the destruction of Medicare... let's not destroy a health care program in this country that we know works and that our seniors are depending on."

- Congressman Clay Shaw, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"Make no mistake about it for the elderly in this country, [these cuts are] going to devastate their program under Medicare."

- Congressman Bill Archer, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"The Medicare cuts proposed by the President would devastate the Medicare program... The committee must not approve these destructive Medicare cuts."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

"I just don't believe that quality of care and availability of care can survive these additional cuts. And that is the price that is going to have to be paid to pay for these cuts."

- Congressman Bill Archer, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"I would love to believe that we could achieve the level of cuts you have in this bill... But history tells us that this isn't possible. And I think we are just playing games here, we are just making the numbers match. That's all Democrats have done in your bill to make it revenue neutral. You have just estimated the number needed from Medicare to make the numbers match, and I think the public understands that."

- Congressman Jim McCrery, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"The Republicans are attempting to secure the program which would be almost absolutely destroyed and trashed if the cuts that have been brought into the bill are established."

- Congressman Clay Shaw, June 25, 1994, speaking against proposed Medicare expenditure reductions during the Ways and Means Committee consideration of H.R. 3600

"Mr. Chairman, I recognize and agree with your call for bipartisan support on this issue, but there are some proposals that many of us in good conscience will never support because we know that they are bad for the American people."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

"I think those of us on this committee especially well remember the lessons of Medicare catastrophic coverage legislation, and recognize that making changes without broad public support is a potential disaster."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

NOTE: The 1994 Ways and Means Committee health reform bill would have achieved \$168 billion in Medicare savings over seven years, all of which would have been re-directed to expand health care coverage, as compared to 1995 Republican proposals to reduce Medicare spending by nearly \$300 billion over seven years.

"Forget the budget pressure, let's find out what number saves Medicare. We'll plug that into the budget. We're not going to find out what number the budget needs and try to reshape Medicare to that effect."

- Speaker Newt Gingrich, May 7, 1995, on "Meet the Press"

Every Republican on the Ways and Means Committee last year, eleven of which are on the panel this year as well, were signatories to the following statement --

"...the additional massive CUTS in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."

The current Ways and Means Chairman made the following charge last year --

"I just don't believe that quality of care and availability of care can survive these additional CUTS. And that is the price that is going to have to be paid to pay for these CUTS."

Current Subcommittee Chairman Clay made the following indictment --

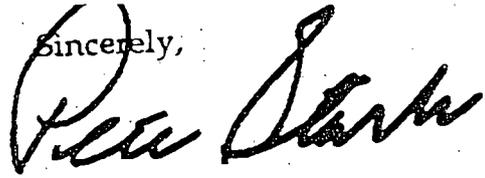
"The Medicare CUTS proposed by the President would devastate the Medicare program... The committee must not approve these destructive Medicare CUTS."

A Republican Member of the Health Subcommittee this year and last year commented --

"I would love to believe that we could achieve the level of CUTS you have in this bill... But history tells us that isn't possible."

NOTE: The 1994 Ways and Means Committee health reform bill would have achieved \$168 billion in Medicare savings over seven years, all of which would have been re-directed to expand health care coverage, as compared to 1995 Republican proposals to reduce Medicare spending by \$283 billion over seven years, none of which would be reinvested to cover uninsured Americans.

Sincerely,

A handwritten signature in black ink, appearing to read "Pete Stark". The signature is written in a cursive style with a large initial "P".

Pete Stark
Member of Congress

239 Cannon House Office Building, Washington, DC 20515 202-225-5065

May 12, 1995

IS ARMEY ACCUSING FELLOW REPUBLICANS OF LYING?

Dear Colleague:

"In a blistering attack delivered to an American Enterprise Institute forum on the politics of Medicare," the *National Journal* reported this week, "[Majority Leader Dick] Armeley insisted 'anyone claiming we are cutting Medicare is simply lying,' since the program will continue to grow, only at a slower rate."

Is Mr. Armeley saying that Republicans on the Ways and Means Committee lied last year during consideration of health care reform? It seems a reasonable conclusion to reach.

After all, Republicans in 1994 called a proposed \$168 billion reduction in Medicare spending a "cut." Why less than a year later a \$283 billion "cut" in Medicare should not be considered one would be a mystery.

[See the reverse side for Republicans' 1994 portrayal of reductions in Medicare expenditures.]

Remember, the level of cuts (or reductions in growth, or whatever one prefers to call it) proposed last year is one half the level passed by Budget Committee Republicans this year.

You decide what's a cut.

If federal policy is changed so that services now fully covered by Medicare are only partially covered, and charges currently paid by Medicare are pushed on to beneficiaries, wouldn't you call this a cut? (See page 10 of the "House Republican Budget Committee Recommendations" for three such examples.)

And if the funds not spent on Medicare beneficiaries create room in the budget to cut taxes for wealthy Americans, isn't it accurate to describe the Medicare cuts as financing tax cuts for well-to-do Americans?

I've never had difficulty accepting that reductions in projected expenditures can be considered cuts. And *this year*, because of the drastic nature of the

Item I

Persons who are covered by Medicare Part A and who elect to enroll in Part B, will be eligible to select coverage provided by MediChoice health plans, the Medisave Option, or Employer, Union, or Association-sponsored health plans.

A greatly expanded choice of plan options will be made available to Medicare beneficiaries at time of initial eligibility and during subsequent coordinated annual open enrollment seasons, as follows.

Plan Enrollment Options At Time of Initial Entitlement to Medicare

Upon becoming eligible for Medicare benefits, beneficiaries may choose to enroll in any one of the following:

- original fee-for-service Medicare, hereinafter referred to as the fee-for-service (FFS) plan;
- a privately administered MediChoice health plan in their market area;
- a privately administered Medisave health plan; or
- an Employer-sponsored, Association-sponsored, or Union-sponsored health plan for which they are eligible.

Annual Coordinated Open Enrollment

Beneficiaries will have the opportunity to change their Medicare coverage once each year during a coordinated open enrollment period in which all qualified plans must participate, except Employer-sponsored plans.

Employer-sponsored plans would operate under continuous open enrollment procedures under which retired employees, also entitled to Medicare, could elect to continue in the Medicare-qualified Employer plan without a break in coverage.

During the annual open enrollment period, beneficiaries may elect to enroll in the FFS plan, any MediChoice health plan in their area, or any Association-sponsored plan or Union-sponsored plan for which they are eligible.

Enrollment Exceptions

Beneficiaries may elect the Employer-sponsored plan option upon retirement and if eligible for Medicare.

A beneficiary enrolled in an Employer-sponsored plan who subsequently elects to disenroll from such a plan and enter a MediChoice health plan, the FFS plan, or an Association-sponsored plan, would be precluded from reentering the Employer-sponsored plan in the future.

Beneficiaries may elect the Medisave health plan option only upon initial entitlement to Medicare.

Beneficiaries initially electing the Medisave health plan would have a 120 day cooling-off period during which the beneficiary could reverse the election and choose instead to enroll in the FFS plan, until the following open enrollment period. If a beneficiary disenrolls at any time from the Medisave option, the beneficiary is precluded from re-selecting the Medisave option in the future.

Special MediChoice Health Plan Disenrollment Conditions

Beneficiaries may petition the Secretary to disenroll from a MediChoice plan before the next open enrollment period, and return to the residual FFS plan or select a MediChoice plan, if the beneficiary can demonstrate that the plan committed any one of the following:

- violated the health plan's contract;
- misrepresented the health plan's benefits or operating procedures in marketing the plan to the beneficiary; or
- provided poor quality care to the beneficiary.

The Secretary must establish procedures that permit expedited disposition of such cases.

MediChoice Plans

Through MediChoice plans, a variety of new delivery system options (such as

preferred provider organizations and point of service products) will be made available to Medicare beneficiaries.

Health plans must apply to the Secretary for certification to participate as a MediChoice plan.

The Secretary will establish and administer mandatory certification standards for MediChoice plans in the following areas:

- marketing;
- enrollment;
- disenrollment;
- benefits (covered services, and premiums and cost-sharing requirements, if applicable);
- emergency and out-of-plan services;
- reporting/disclosure;
- delivery system standards
 - service areas
 - plan capacity
 - access to providers;
- solvency;
- grievances and appeals;
- sanctions;
- quality assurance standards, both internal and external programs (see additional provisions);

The federal certification standards relate only to plans' participation in the Medicare program and do not preempt state regulation of health plans.

- The Secretary may impose user fees on MediChoice plans to finance the

costs of the certification program.

MediChoice Advisory Group

The President shall appoint a MediChoice Advisory Group to offer to the Secretary recommendations on certification standards.

The MediChoice Advisory Group shall include members with national recognition for their expertise in the business of insurance, health care delivery, health economics, and related fields.

Quality Accreditation

Health plans must be accredited as meeting quality standards in order to participate in the MediChoice program.

The Secretary will determine the frequency of quality accreditation.

The Secretary may provide that private accreditation by an approved organization is sufficient to deem a plan as meeting the quality assurance portion of the certification standards for participation in MediChoice.

To allow accreditation by a private agency, the Secretary must ensure that the agency's accreditation standards are at least equal to the quality assurance standards established by the Secretary.

The Secretary shall establish quality assurance standards covering:

- quality management and improvement processes;
- utilization management;
- credentialing;
- an internal grievance process;
- patient access to written and other information about the plan, its services,

providers of care, and patient rights and responsibilities;

- patient privacy; and
- medical records.

Quality Measurement

The Secretary shall establish quality measurement standards based on recommendations by a Working Group on Quality Measurement.

The Working Group shall be made up of experts in health care quality, data, and consumer reports.

The Working Group shall make recommendations to the Secretary on:

- establishing computer-based patient records, including issues regarding privacy;
- standardizing clinical data collection and transmission;
- standardizing consumer satisfaction data collection;
- appropriate uses of such data; and
- the format for informing beneficiaries regarding the quality performance of MediChoice health plans.

Financial Solvency and Capital Adequacy

The Secretary shall establish financial solvency and capital adequacy standards, based on recommendations made by the National Association of Insurance Commissioners by March 1, 1996.

Consumer Protections

All marketing materials must be approved under guidelines established by the Secretary. The Secretary shall establish "one-stop" approval procedures for any plan certified to offer benefits in more than one market.

The Secretary shall establish fair direct sales guidelines, including a prohibition against agents completing enrollment forms for beneficiaries.

Benefits

Requirements for basic and supplemental benefit offerings by MediChoice plans would be established as follows:

MediChoice plans shall offer services equivalent to Medicare covered services in the FFS plan, but with discretion on delivery approaches.

MediChoice plans may establish cost-sharing appropriate to the delivery system.

MediChoice plans cannot place limitations on inpatient hospital days that are more restrictive than the FFS plan.

Any supplemental benefits offered by MediChoice plans are optional for the beneficiaries (they may elect to get only Medicare benefits).

Beneficiaries may select supplemental coverage offered by any qualified health plan.

Beneficiaries will select their supplemental coverage during the same enrollment period as for basic Medicare benefits.

Premiums and Payment Rates

A series of rules on MediChoice plans' premium development, and the development of a market-based price will be established.

Health Plan Premium Submission Rules

Health plans must submit premiums for the plan's benefit package and information on the plan's MediChoice enrollment capacity, for each market area, to the Secretary by a date determined by the Secretary.

- The premiums submitted by the plans for Medicare benefits shall be the total premium required by the plan.
- Once submitted, health plans may not change their premiums until the next year and must collect from the beneficiary the difference between the total premium and the MediChoice rate, if the MediChoice rate is lower.

Health plans must agree to serve all beneficiaries in a market area on a "first-come, first-serve" basis, up to plan capacity (except that current enrollees have priority over new enrollees).

Market-Based MediChoice Rates

In each market area, beneficiaries in MediChoice health plans will get a uniform MediChoice rate paid on their behalf to the plan of their choice.

The MediChoice rate will be the lower of :

- the market rate; or
- the FFS proxy premium.

The market rate will equal the average of premiums submitted by plans in the market area less a percentage of the difference between the average and the lowest priced plan.

Payments to MediChoice Health Plans

The MediChoice rate will be adjusted for demographic and risk factors before payments are made to MediChoice health plans.

MediChoice Premiums and Rebates

If a beneficiary enrolls in a MediChoice plan that charges less than the MediChoice rate, the plan will rebate the difference to the beneficiary in cash, or, at the beneficiary's option, apply the difference to supplemental coverage premiums.

If a beneficiary enrolls in MediChoice plan that charges a premium in excess of the MediChoice rate in the market area, the beneficiary must pay the additional premium to the plan.

Market Areas

The Secretary shall be required to establish the geographic boundaries of Medicare market areas according to guidelines set in legislation.

Place of Residence

Each Medicare beneficiary will be assigned to a market area based on place of principal residence.

Guidelines

The Secretary shall set the market areas in a manner that:

- creates market areas that are larger than counties, or the equivalent of counties in areas that use other designations; and
- covers all areas in the United States without overlap

In general, a metropolitan statistical area (MSA) should be included in one market area.

- However, the Secretary may make exceptions to this rule to allow smaller market areas when an MSA is large, but the sub-MSA market areas shall be set in a manner that does not segregate the Medicare population by health status.

State Boundaries

In general, the Secretary shall accept market areas that build upon boundaries established by States for private health insurance purchasing cooperatives or similar insurance purposes if:

- the State boundaries do not generally violate the rule regarding metropolitan statistical areas; and
- adopting the State boundaries will not conflict with market areas for bordering

States.

State boundaries that are used to establish Medicare market areas need not be contiguous areas.

Administration

The Secretary will be required to establish and administer a coordinated open enrollment system for Medicare beneficiaries encompassing all MediChoice and Medigap choices.

Coordinated Enrollment

The Secretary will establish a process through which beneficiaries will elect their coverage at initial eligibility and at subsequent annual, coordinated open enrollment periods.

Beneficiaries will select their Medicare and supplemental plans (including any Medigap coverage), during the coordinated open enrollment period.

Default Enrollment

Beneficiaries not submitting an enrollment form will be automatically enrolled in the same plan they were enrolled in for the prior year.

New beneficiaries not submitting an enrollment form will be automatically enrolled in the FFS plan.

Contractor

The Secretary shall contract with a neutral entity in each market area to provide information to beneficiaries about their coverage options.

- In general, the Secretary shall use existing carriers and intermediaries, unless a carrier or intermediary is offering a MediChoice health plan or Medigap insurance in the market area.

Information for Beneficiaries

Each market area contractor shall publish an information booklet that is provided timely to all Medicare beneficiaries to permit enrollment choices at initial eligibility

for Medicare and for subsequent enrollment periods.

The booklet will include information regarding:

- plan availability;
- the premiums beneficiaries will pay for the various options;
- quality information, including consumer satisfaction information;
- beneficiary rights and responsibilities under the options.

Each market area contractor will also:

- maintain an 800 number for beneficiary inquiries; and
- sponsor enrollment period fairs, with salespersons providing approved marketing materials from all area MediChoice health plans.

Employment, Association, and Union-Sponsored MediChoice Plans.

Medicare beneficiaries will have new choices in which, under selected conditions they are permitted to enroll in employer-sponsored, association-sponsored, or union-sponsored health plans.

Employers may establish MediChoice health plans for former employees and their spouses.

Former employees shall be defined by the employer but may not exclude persons based on health status.

Unions may establish a MediChoice health plan for Medicare-eligible union members.

Qualified Associations may sponsor a MediChoice health plan for members, and such plans must meet the same standards as other MediChoice plans, except that they may limit enrollment to members of the Association.

In general, qualified Association plans will:

- have a primary purpose that is not the provision of MediChoice coverage;
- not discriminate among members based on health status; and
- offer MediChoice coverage to all members who are eligible for Medicare.

MediChoice Payments

MediChoice payments to Employer, Association, and Union-sponsored plans shall be on the same basis as payments to other MediChoice plans in the market area in which a beneficiary resides.

Alternatively, such plans may negotiate a federal payment rate certified by the Secretary as budget neutral relative to payments that would have been made on behalf of the Medicare enrollees.

Medisave, Catastrophic Plans

Beneficiaries will have an option of enrolling in a private, catastrophic medical expense plan, combined with a medical savings account.

Eligibility Criteria

To be eligible to elect the Medisave option, persons must:

- be eligible for Medicare based on age;
- maintain a qualified Medisave account;
- maintain qualified catastrophic medical expense coverage;
- self-insure for the deductible and pay all medical expenses from the account; and
- forego other Medicare coverage options permanently, after the close of the initial cooling-off period.

Cooling Off Period

Persons electing the Medisave option will have a 120-day cooling off period during which they may elect to switch to the FFS or a MediChoice plan.

The Secretary shall recoup any unspent cash payments or credits made to the beneficiary during the time the beneficiary elected the Medisave option.

Qualified High Deductible Coverage

The Secretary will establish guidelines for certification of qualified catastrophic medical expense plan coverage, including rating requirements.

- The \$ deductible shall be indexed to the CPI.

Medisave Payments

Medisave payments shall be made directly to the individual's Medisave account and will equal the MediChoice rate for the market area, adjusted for demographic factors.

Medicare Review Commission

A new Medicare Review Commission is established to replace ProPAC and PPRC.

Purpose

The commission will report to the House Committees on Ways and Means and Commerce, and the Senate Committee on Finance on all aspects of the Medicare program and make recommendations to the Committees for changes.

Membership

The Commission members will be appointed on the same basis as members are appointed to ProPAC under current law.

Authorization

The Commission is authorized at 5 million each year.

Required Annual Report

The Commission is required to provide a report by March 1 annually covering all aspects of the Medicare program, including analysis and recommendations.

The report should:

- assess fee-for-service payment systems (PPS and RBRVS);
- analyze the distribution of MediChoice payment rates across market areas;
- recommend adjustments in payments to MediChoice health plans for relative risks;
- recommend modifications to the MediChoice benefit package configurations;
- provide advice on improving the quality of care in MediChoice health plans; and
- provide advice on assuring access to care provided by MediChoice health plans.

Indexing Report

The Commission shall report by January 1, 1998 on recommendations regarding indexing the market area MediChoice rates.

The report shall include an analysis of moving to indexing instead of market-based pricing.

Transition Rules

Initiation of reform options and changes to the current HMO program will require transition periods and rules.

A transition period of three years would be established during which blended payment rates would be paid to risk and cost contractors.

Cost contractors would be required to transition to risk contracts by the close of the transition period.

Item II

Diabetic Self Responsibility

Reimburse for diabetic education and care programs.

Cardiac Disease Alternative Self Responsibility

Reimburse for coronary heart disease (CHD) education and prevention programs.

Screening Improvements

Reimburse for colorectal cancer screening. Reimburse for prostate cancer screening.
Address mammography utilization issues.

Item III

Cost Sharing Under Medicare Fee-For-Service Program

Option I

A new program would be established to encourage beneficiaries to self-insure (not purchase Medigap coverage) for Medicare coinsurance liabilities. Corresponding modifications are made to current Medigap standard policies.

Beneficiaries enrolled in Part B and agreeing to self-insure for the Part B coinsurance would get:

- a reduction in Part B coinsurance from 20% to 15%; and
- annual out-of-pocket protection of \$5000 in 1996 (indexed to overall growth in Medicare expenditures).

→ Beneficiaries who continue enrollment in any type of Medigap plan covering the Part B coinsurance will pay a coinsurance rate of 25% instead of 20%. ✓

Option II

Beneficiaries who choose to enroll in any type of Medigap plan will pay a coinsurance rate of 25% instead of 20%. ✓

Prohibit Insurance for Part B Deductible

Medigap policies would be precluded from covering the Part B deductible expense.

The Part B Deductible

Increase the Part B deductible for 1996 and index annually thereafter. ✓

Extension of Part B Premium

Maintain beneficiary responsibility for the Part B premium at the current percentage (31%) of program costs (alternatively, increase it to 33% or 35%). ✓

Income-Related Reduction in Medicare Subsidy

Medicare would be income-related by imposing an additional premium to cover part of the cost of Part B which is currently subsidized by the general fund. This additional premium would be collected annually with payment accompanying the April 15th filing of income taxes. All Part B enrollees would continue to pay the otherwise applicable premium in effect for the calendar year. / 5

Coinsurance for Home Health

Impose a 20% coinsurance on home health services.

Coinsurance for Skilled Nursing Facility Services

Impose a 20% coinsurance for skilled nursing facility services for the first 20 days of a skilled nursing facility stay.

Coinsurance for Clinical Laboratory Services

Option I

Impose a 20% coinsurance requirement on all clinical laboratory services, or

Option II

Impose a 20% coinsurance requirement on bundled clinical laboratory services.

Item IV

Fraud and Abuse

Beneficiary Incentive Program

Specific qui tam ("whistle blower") provisions for Medicare beneficiaries.

Incentive program for beneficiaries reporting of overcharges in billing (non fraud) by providers, with beneficiaries sharing in savings.

Incentive program for beneficiaries' suggestions for improving program efficiency with beneficiaries sharing in savings.

Strengthening Legal Tools

Expand mail fraud statute to explicitly include Medicare and private health plans.

Expand mail fraud statute to include private mails (eg. FedEx).

Improving Program Efficiency

Establish advisory opinions.

Privatization of Medicare fraud screens.

Clarification of Current Provider and Contractor Penalties

Voluntary disclosure program for Medicare.

Clarify program exclusion provisions to include debarment periods for specific types of violations.

Clarify the "should have known standard".

Clarify intent standard and safe harbor concept.

Amend "one purpose test" to substantial or primary reason for referrals.

Clarify discount exception (include exception for capitated programs).

Amend formula for civil monetary penalties to assure that civil monetary penalties are appropriate.

Item V

Regulatory Relief

Repeal Medicare secondary payer data match.

Physician Self-Referral

Amend the Physician Self-Referral rules as follows:

- Moratorium on effective date;
- Repeal section on compensation arrangement;
- Eliminate the prohibition against physician's practices providing durable medical equipment and parenteral and enteral services;
- Eliminate the "site of service" restriction on in-office service;
- Amend the physician supervision requirement applicable to non-physician personnel to clarify that direct supervision is not required;
- Amend the "general supervision" requirement;
- Add a community need exception;
- Add "shared services" exception;
- Expand the prepaid exception to include state regulated and Medicaid plans;
- Expand the prepaid exception to include preferred provider organizations;
- Clarify the rural exception to include state regulated and Medicaid plans.

Clarification of Medigap Non-Duplication

Revise rules to allow coordination of benefits for long-term care, nursing home, home health, and community-based care policies.

Eliminate separate disclosure notices and require plans to outline the degree to which they may duplicate/coordinate with Medicare covered benefits.

Item VI

Medicare Sustainable Growth Adjustment

Specific growth rates in Medicare outlays for Part A and Part B would be set for each of the 7 years covered by the budget resolution.

The Secretary would estimate Medicare growth rates annually. If program spending exceeds growth rates set in law, then outlay reductions will be triggered. Growth rates for the capitated programs, MediChoice and Medisave, would be set in advance to meet the targets, so outlay reductions, if necessary, would be made only in the Medicare FFS program.

Item VII

Market Basket Update

Reduce Medicare prospective payment system hospital rate update to market basket minus [Potential range 0.5 - 2.0].

Disproportionate Share

Reduce Medicare's prospective payment system disproportionate share adjustment to hospitals by (20 - 30%).

Inpatient Capital Related Costs

Rebase Medicare's prospective payment system's federal and hospital-specific rates for capital payments.

Indirect Medical Education

Reduce payments under Medicare's prospective payment system indirect medical education adjustment.

Non PPS Hospitals

Rebase the long-term care hospitals cost-based payment system.

Transitional cost reduction for rehabilitation facilities (OBRA 1993 market basket reduction formula applied for years 1996, 1997, 1998).

Establish prospective payment system for rehabilitation facilities effective 10/1/1999.

Reduction in Payment for Hospital Bad Debt

Reduce payment for hospital bad debt to 50 percent.

Extension of Skilled Nursing Facility Cost Limit

Maintain savings from skilled nursing facilities cost limits included in the President's budget.

Item VIII

Process of Updating Physician Fees.

Option 1

Adopt the Physician Payment Review Commission (PPRC) recommendations to correct the many structural problems that exist with the Medicare Volume Performance Standard (MVPS).

Option 2

Repeal the MVPS and return to the Medicare Economic Index (MEI) used prior to physician payment reform for updating physician payments as a mechanism for updating physician fees.

Replace separate conversion factors for surgical, nonsurgical and primary care services with a single conversion factor.

Establish a Hospital Outpatient Prospective Payment System.

Establish a prospective payment system (PPS) for hospital outpatient department (OPDs) based on ambulatory patient groups (APGs), that would cover all hospital-based outpatient services.

Limit beneficiary coinsurance to 20 percent of the Medicare payment amount under the Outpatient PPS.

Reduce Payments to Physicians for Overhead.

Under review.

Competitive Bidding for Durable Medical Equipment

Develop a competitive bidding process for durable medical equipment contracts.

Competitive Bidding for Clinical Laboratory Services

Develop a competitive bidding process for clinical laboratory services.

Item IX

Extensions of Secondary Payer Payment Requirements.

The Medicare secondary payer proposals are extensions of provisions that are set to expire at the end of 1998 included in the President's budget. The three MSP proposals would:

- extend the data match between HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare;
- extend the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance; and
- extend the provision requiring non-Medicare insurers to be primary payer for ESRD patients for 18 months before Medicare becomes the primary payer.

Improve MSP Program

Develop a mechanism to prospectively identify individuals with other coverage.

Home Health Service Extension of Cost Limits

Maintain savings home health services from OBRA 1993.

Establishment of Home Health Payment Limits

Establish a per visit payment system, subject to a 120 day (not visit) per episode cap, with home health agencies sharing in any savings if total per episode payments are less than the cap.

Create an "inlier policy" excluding short term use of home health care (such as 20 days) from the cap.

Create a "volume performance standard" methodology to reduce payment if savings from payment limit system are not achieved.