

## **GOP ASSAULT ON RETIREMENT SECURITY**

**The Republican Message to Retirees: Tax Breaks First, Health Care and Financial Security Last.** Today, Secretary Reich joins with Congressional leaders to release a report documenting how companies are dropping their private health care coverage for older Americans. This drop in coverage is most alarming since it occurs at the same time as Republicans are ramming through legislation that would raid pensions and cut \$450 billion from Medicare and Medicaid, to pay for huge tax cuts to people who need them least.

According to the Labor Department report, "Retirement Benefits of American Workers," being released today, these drastic cuts in health care expenditures will only increase pressure on private plans to drop coverage for retirees. The Republican message to retirees is simple and clear: tax breaks first, health care and financial security for retirees last.

**At Least Half Of All Retirees Vulnerable To Cost Increases In Medicare.** 50 percent of private sector retirees, 65 or older, report that the only employment related benefits they receive is Social Security. Only 24 percent of retirees receive employer health benefits while 42 percent report that they have received some type of pension benefits. For all retirees, including 4 million between the age of 55 and 65, the majority of whom are not yet eligible for Social Security, the numbers are very similar, with 54% reporting no employer benefits. *This tells us that at least half of all retirees remain vulnerable to cost increases in programs such as Medicare.*

- **These retirees are surviving on limited and generally fixed incomes and simply do not have the ability to pay hundreds of dollars more each year for their health care.**

## **TAKING THE "CARE" OUT OF MEDICARE**

**The Republican Medicare proposals make unprecedented cuts in Medicare spending -- three times larger than any cut previously enacted by the Congress.**

The \$270 billion seven-year reduction in Medicare means that Medicare will spend \$1,700 less per beneficiary in 2002 compared to the CBO baseline. As a result, Medicare spending for our parents and grandparents will grow 33 percent more slowly than private health insurance spending for working-age Americans.

**Both House and Senate Republican Medicare plans would increase out-of-pocket costs for every Medicare beneficiary, regardless of their income or health status.**

Both plans would increase current Part B premiums paid by all beneficiaries, and would impose even greater premiums on higher income beneficiaries. And, the Senate plan would more than double the Part B deductible from \$100 a year today to \$210 a year in 2002.

**The Senate Republican plan would phase-in a delay in eligibility for Medicare from age 65 to age 67 beginning in 2003.**

The Senate Republican proposal means that a person who is age 35 today, who is working and paying Medicare payroll taxes, will have to work and pay taxes for an additional two years to get two fewer years of Medicare benefits. A person who is 45 today would have to work and pay taxes for another year and get one fewer year of benefits.

**The Republicans use untested approaches for Medicare beneficiaries**

The Republican plans would encourage elderly individuals to gamble on Medical Savings Accounts. The likely result -- the wealthy and healthy would benefit. The math is simple: if more is spent on the healthy, there is less available to care for the sick.

**The Republican Medicare cuts threaten to undermine traditional Medicare benefits and endanger the future of vitally needed hospitals in rural and urban parts of this country.**

By making the deepest cuts in history to Medicare payments to health care providers, the Republican plan would lead to hospital closures and create huge incentives for physicians to refuse to take Medicare patients. As payments to providers are squeezed more and more, the Republican plan ultimately could lead to rationing of care for Medicare beneficiaries.

**The Senate Republican Medicare plan raises taxes on working Americans.**

The Senate plan imposes new payroll taxes on state and local government workers at a time when the Republicans are cutting taxes for the wealthy. This tax increase also violates the recently enacted law prohibiting "unfunded mandates" on state governments.

From Hill ?  
2

## Questions Americans Should Ask Newt Gringich and the Republicans About Their Medicare Plan

September 15, 1995

1. According to Republicans, the reason for cutting Medicare spending by \$270 billion is to "save" Medicare from going bankrupt.
  - How much of the \$270 billion in cuts goes to "save" the Medicare Trust Fund?
  
2. The New York Times reports that there is an \$80 billion shortfall in the Republican plan.
  - Is this true?
  - How are these savings going to be achieved?
  - Who will bear the brunt of these secret cuts -- the beneficiaries? inner-city hospitals? rural clinics? **Who?**
  
2. The Congressional Budget Office has reported that Medicare cuts of this magnitude end-up being shifted to families covered under private health insurance.
  - How much will private health insurance premiums rise because of these Medicare cuts?
  
3. Earlier this year, Republicans cut taxes to upper-income seniors that will result in a loss of \$87 billion to the Medicare Part A Trust Fund over the next decade.
  - Has this money been put back into the Part A Trust Fund in order to protect its solvency?
  
4. If Medicare's solvency was of such critical import to Republicans, why did they make no mention of it during the entire health care debate in 1993 and 1994?"

- Furthermore, why did they oppose reasonable Democratic efforts to slow the growth in Medicare? in that debate?
5. If Medicare's solvency was of such critical import to Republicans, why was there no mention of it in their "contract with America?"

## **PART B CUTS:**

1. News reports indicate that the Part B premium will double under the Republican plan between now and 2002.
  - Is this accurate?
  - How much will the Part B premium actually be?
2. How much of this increased premium seniors will pay out of their pockets will go back into the Medicare Trust Fund?
3. If seniors on a fixed income such as Social Security face a higher premium, where will the money come from?
4. Currently, the Medicare and Medicaid programs build on each other in providing coverage to seniors of modest incomes.
  - As such, Medicaid covers the Part B premium of seniors at or below 120% of the poverty level.
  - Will this protection be maintained under the Republican plan?
  - In addition, current federal law provides protection for seniors with incomes at or below 100% of poverty by covering their deductibles and copayments.
  - Will this protection be preserved?
  - If these protections are not maintained, won't low and moderate-income seniors be forced into HMOs?

5. Couldn't seniors actually lose coverage for doctor visits and outpatient services if they can't afford the Part B premium?
6. Why are Republicans going to raise premium taxes on upper-income Medicare recipients if they are going to just turn around and give the money away in tax breaks to some other group of upper-income Americans?
7. If we are going to means-test the Part B premium, why don't we put the money toward strengthening the Medicare Trust Fund?

## **MEDICAL TRAINING**

1. Under the Republican plan, will funding for training our nation's doctors be cut?
  - Who is going to pick-up this cost?
2. What will be the impact of the Republican policy of ending payment for international medical graduates on inner-city hospitals which are heavily dependent on these individuals for providing basic medical services?
  - Do the Republicans intend to provide any transitional assistance to these hospitals?

## **CHOICE**

1. Republicans claim to expand choice for Medicare beneficiaries, but it seems that their plan will in fact damage the choices already available to beneficiaries. How is choice really expanded?
  - What doctors will they be able to see under the Republican plan that they cannot see today?

- If payments to doctors are dramatically cut, as it appears the Republican plan will do, won't the number of doctors willing to participate in Medicare decline, and drastically?
2. Over three-quarters of all beneficiaries already have the choice of one or more managed care plans, many that offer added benefits like some prescription drug coverage and eye glasses.
    - If the payment to these HMOs is reduced by 24%, won't the "extras" offered by these plans disappear?
    - Won't this have the effect of reducing the choices available to seniors?
  3. Reportedly, Medicare payments to contracting HMOs will not be set as they are today -- based upon the costs of treating Medicare beneficiaries in the area served by the plan. Instead, HMO payments are going to be capped in order to match the Republicans' budget goals.
    - What happens if the capped payment to the HMOs is insufficient and the HMOs run out of money?
    - Who picks-up the tab?
    - Will beneficiaries have to pay more?
    - After all the "extras" are gone, will managed care plans ration care?
  4. In prior years, the Congress has considered a medical savings account (MSA) option under Medicare but concluded that such a proposal would actually damage the Medicare program.
    - Won't beneficiaries who are healthy and wealthy enough to take the risk opt for the MSA, leaving the sick behind?

- If this is done, won't the Medicare Trust Fund lose millions of dollars that would otherwise be available for beneficiaries when they are sick?

## **CONSUMER PROTECTIONS**

1. Are there any changes to the beneficiary protections provided in current law?
2. It is rumored that the quality standards in effect today for nursing home care will be eliminated.

- Is this true?

3. Horror stories appear constantly in the press about managed care plans.

- Are there protections in this bill against these abuses?

- Are the beneficiaries protections introduced by Members on both sides of the aisle included in the bill?

- If not, why not?

4. The Republican plan states that managed care plans must meet "solvency" standards.

- What about the other standards that are in current law?

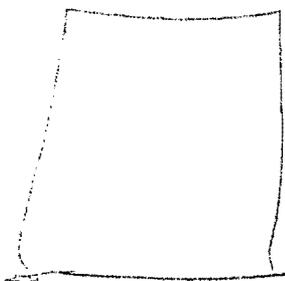
5. The Republican plan apparently proposes to let unlicensed networks act as insurance companies.

- Is this true?

- Who will oversee these plans providing services to Medicare beneficiaries if they are not licensed and supervised like other insurance companies?

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U. S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

September 29, 1995

Honorable Fortney Pete Stark  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Congressman Stark:

This responds to your letter, dated September 25, 1995, which requested the Department's views on certain proposals relating to Medicare reform legislation. For purposes of this request, we have reviewed H.R. 2389, the "Safeguarding Medicare Integrity Act of 1995." The Department of Justice has a very active health care fraud enforcement program which we believe would be undermined by certain of the bill's provisions. We understand that some or all of these proposals may be considered by the Congress in connection with its deliberations on the "Medicare Preservation Act."

Section 106: Consolidated Funding for Anti-Fraud and Abuse Activities Under Medicare Integrity Program. Although Section 106 is rather complex, it seems that this Section would create a Fund consisting of monies from the following sources: monies currently used by the Health Care Financing Administration to fund the anti-fraud activities of the Medicare carrier and intermediary Fraud and Abuse Units; proceeds of administrative penalty actions; criminal fines; and penalties and damages (after restitution and relators' awards) recovered under the False Claims Act. Pursuant to the bill, these funds would not be used to supplement the health care fraud enforcement activities of law enforcement agencies. Rather, the funds would be used to "enter into contracts with private citizens" for the review of activities of providers, audits of cost reports, education of providers, beneficiaries, and others.

The Department of Justice has several concerns about this Fund for private anti-fraud activities. First, by establishing an Anti-Fraud and Abuse Trust Fund to finance private contractors but not law enforcement and federal health care program agencies, the bill arguably could be read to transfer to private contractors traditional law enforcement responsibilities, although we doubt this was the sponsor's intent.

Second, although the need for funding for federal health care fraud enforcement efforts has grown, the bill provides funding for private entities but no funding for law enforcement agencies. The number of health care fraud prosecutors and investigators simply have not kept pace with the dramatic increase in the number of criminal and civil health care fraud investigations and prosecutions presently handled by the Department of Justice. This problem will only grow more acute in the future. For example, the Federal Bureau of Investigation has 1760 health care fraud matters under investigation, up from 1051 in 1993. In addition, the Department of Justice receives health care fraud cases from numerous agencies other than the Federal Bureau of Investigation, such as the Department of Health and Human Services ("HHS") and the Department of Defense as well as private insurers. Further exacerbating the demand on resources, the bill itself imposes expanded duties upon the Department of Justice and HHS, such as the requirement that all requests for special fraud alerts be investigated and acted upon. The efficacy of any health care fraud enforcement program depends on adequate resources for law enforcement.

Our third concern involves the source of the funds for the new Anti-Fraud Fund. Specifically, the Department of Justice does not endorse depositing criminal fines into the Fund. Criminal fines are not presently deposited into the Treasury but rather into the Crime Victims Fund to be used to assist and compensate victims of crimes all over the country. We do not support diverting fines from this critical law enforcement activity.

**Section 108: Establishment of Health Care Anti-Fraud Task Force.** This Section requires the establishment of a Health Care Anti-Fraud Task Force, which would have a separate "accounting of its finances," and have a separate staff, distinct from the rest of the Department of Justice components. The Attorney General would be required to consult with an Advisory Group in connection with the establishment of the Task Force. We believe that it is unnecessary to separate the Department's health care fraud enforcement effort from the rest of the Department's enforcement activities in this manner. Such a structure represents an unnecessary administrative burden that could serve to detract from our overall enforcement efforts. By mandating fully staffed operational segments of the Task Force, the proposal limits the discretion of individual United States Attorneys to respond to changing investigative and prosecutorial needs, which may vary greatly over time and between judicial districts.

Moreover, the proposed structure risks disrupting the present health care fraud enforcement effort which has had so many demonstrated successes. The Attorney General in 1993 named health care fraud enforcement her number two new initiative, behind violent crime. Since then the Department has had a

coordinated health care fraud enforcement program, headed by a Special Counsel for Health Care Fraud reporting directly to the Deputy Attorney General. The Special Counsel has been chairing an Executive Level Health Care Fraud Policy Group which has been meeting monthly since November, 1993 to coordinate the health care fraud efforts of the Department of Justice and HHS. As part of this effort, the Department of Justice has increased its investigations and prosecutions, facilitated greater cooperation among investigative and regulatory agencies and coordinated the use of all available sanctions -- criminal, civil and administrative.

At the local level, every United States Attorney's Office has a criminal and civil health care fraud coordinator. They lead health care fraud working groups in all judicial districts experiencing significant health care fraud. These groups allow all federal and state agencies working on health care fraud enforcement collectively to share information on emerging fraudulent schemes, develop joint enforcement strategies, and decide priorities. Changing this successful law enforcement structure to create a separate nationally based health care fraud task force would be counterproductive and risks omitting particular agencies with strong records of health care fraud enforcement.

**Section 201 (c): Limiting Imposition of Anti-kickback Penalties to Actions with Significant Purpose to Induce Referrals.** This Section would overturn case law interpreting the Medicare anti-kickback statute and serve to heighten the government's burden of proof in criminal anti-kickback prosecutions.

Kickbacks are pernicious because they corrupt the medical providers' decisionmaking, often replacing profit for patient welfare. Kickbacks have lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment, at great additional expense to the American consumer and taxpayer.

The courts have interpreted the Medicare anti-kickback statute (42 U.S.C. 1320a-7b) to prohibit the payment of remuneration if "one purpose" of the payment is to induce referrals of services which are paid for by Medicare. United States v. Greber, 760 F. 2d 68 (3rd Cir. 1085). See also United States v. Kats, 871 F.2d 105 (9th Cir., 1989); United States v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989). In light of this interpretation of the criminal intent element of the offense, the government is charged with the burden of proving beyond a reasonable doubt that one purpose of a payment is to induce referrals. As with many intent based prosecutions, the prosecution must often rely on circumstantial evidence to prove the intent required by the statute.

To further heighten the prosecution's burden of proof, as would occur upon enactment of Section 201(c), would seriously undercut the government's health care enforcement efforts in the anti-kickback arena. To require the government to prove that the remuneration was paid for the "significant purpose of inducing" referrals, is tantamount to immunizing a range of conduct which was, in truth, intended to induce referrals. Moreover, the phrase "significant purpose" is vague and will result in unnecessary and burdensome litigation. In sum, the proposed amendment will seriously undercut our anti-kickback enforcement efforts.

Instead, we believe Congress should be expanding our anti-kickback authority to cover the inducement of the referral of business that is paid for by any government health care program and to provide a civil anti-kickback remedy. Our anti-kickback enforcement efforts have confronted significant obstacles because of the limited coverage of the current Medicare/Medicaid anti-kickback statute. Defense counsel routinely argue that the statute does not apply unless the majority or totality of a provider's business is paid for by Medicare/Medicaid. They also contend that the absence of an explicit civil anti-kickback remedy limits the government's opportunities to recover damages and civil penalties. To rebut these arguments, kickback prosecutions now require extensive prosecutorial resources. Nevertheless, we were able to prosecute and settle two major anti-kickback cases in the last year obtaining convictions and settlements of \$379 million in one case and \$161 million in the second case, which returned significant savings to the Medicare Trust Fund and the Treasury. To limit our ability to bring such cases, rather than to strengthen our statutory authority, would seriously impair our health care fraud law enforcement efforts.

**Section 202: Clarification of and Additions to Exceptions to Anti-kickback Penalties.** This Section would immunize from prosecution the payment of remuneration with the intent to induce referrals, provided that the health care item or service involved is provided, inter alia, through an organization that assumes financial risk, or is a disease management program.

These statutory safe harbor provisions are very broad and may result in immunizing kickback activity which should be prohibited. Indeed, a large number of health care providers could arguably be construed as engaged in "disease management." We believe that additional safe harbors should be narrowly drawn and should be crafted only after a careful study of the practices which could be encompassed by the provision.

**Section 204: Issuance of Advisory Opinions.** This Section requires the Secretary of HHS to issue advisory opinions concerning, inter alia, what constitutes a violation of the criminal Medicare anti-kickback statute. The Department of

Justice opposes this provision on both legal and practical grounds.

First, the Department of Justice has the exclusive authority to enforce all federal criminal laws. This authority extends to all prosecutorial decisions, including those based on the Medicare anti-kickback statute. In that regard, the rendering by an agency other than the Department of Justice of opinions concerning the prosecutive merit or lack of prosecutive merit of a particular case would be beyond that agency's authority. Furthermore, we feel that it would be inappropriate for the Department of Justice to defer to another department's judgment, such as HHS, regarding what constitutes a prosecutable case under any criminal provision of the United States Code.

Second, we believe that the rendering of advisory opinions is generally ill-advised. This is especially true where, as in the instant case, a violation of the statute depends on proof of a knowing and willful intent to do the act proscribed. For obvious reasons, a putative defendant's presentation of the "relevant" facts is apt to be slanted and incomplete and, therefore would be a poor basis on which to render a prosecutive judgment. Assuming that HHS is not going to conduct an investigation of each advisory opinion request which is filed, the prosecutor will, in all likelihood, have inadequate information on which to base his or her decision.

Third, we are concerned that advisory opinions would produce unnecessary problems in the context of a subsequent criminal and/or civil prosecution by introducing additional factual issues into these cases relating to the interpretation and applicability of the advisory opinion at issue.

In sum, we believe that the rendering of advisory opinions would immunize the individuals who committed the conduct to which the opinion relates, and would engender complex litigation in other cases in which the defense would rely on advisory opinions.

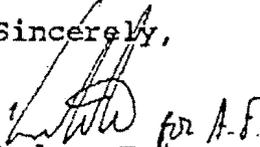
Section 104: Voluntary Disclosure Program. This Section would mandate the establishment of a voluntary disclosure program. Since the Inspector General of HHS recently announced a pilot voluntary disclosure program, in conjunction with the Department of Justice, we question the need for this provision.

This section provides that the Secretary of HHS may waive, reduce, or mitigate any sanctions against individuals who make voluntary disclosures, including statutory sanctions which include criminal remedies. As noted above, the Attorney General has the exclusive authority to enforce federal criminal laws. Accordingly, the Department of Justice opposes this provision.

We also do not endorse the provision in Section 104 that would bar qui tam actions under the False Claims Act against entities or individuals who make disclosures with respect to acts or omissions which constitute grounds for imposition of enumerated sanctions. First, the False Claims Act already provides a reduction of liability of any person or entity where that person or entity has voluntarily disclosed wrongdoing to the government and satisfied other statutory criteria. Second, even if such a restriction were appropriate, the statute as drafted would presumably prohibit qui tam actions where the allegations of wrongdoing were not disclosed but somehow were related to the matters disclosed. That result is not warranted and unwise. Finally, modifications of the qui tam provisions, if any, should be done in the context of amendments to the False Claims Act generally and should not be limited to voluntary disclosures involving health care fraud.

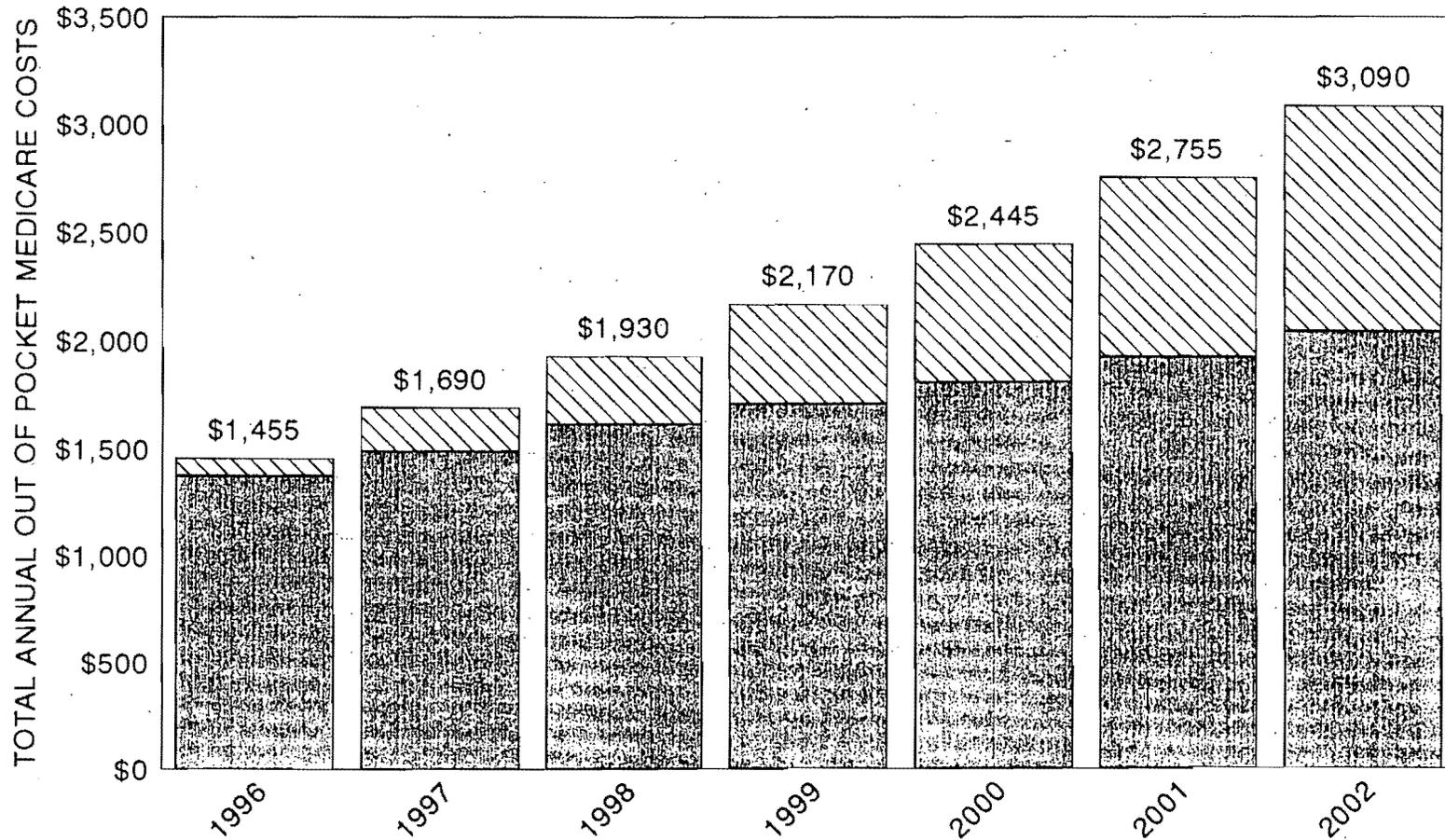
Thank you for the opportunity to provide our views on these important proposals. Please do not hesitate to contact us if we may be of additional assistance in connection with this or any other matter. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report.

Sincerely,

 for A.F.  
Andrew Fois  
Assistant Attorney General

# HOUSE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS

## SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3500



Proposed Increase	\$80	\$200	\$315	\$460	\$635	\$830	\$1,045
Current Law Costs	\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

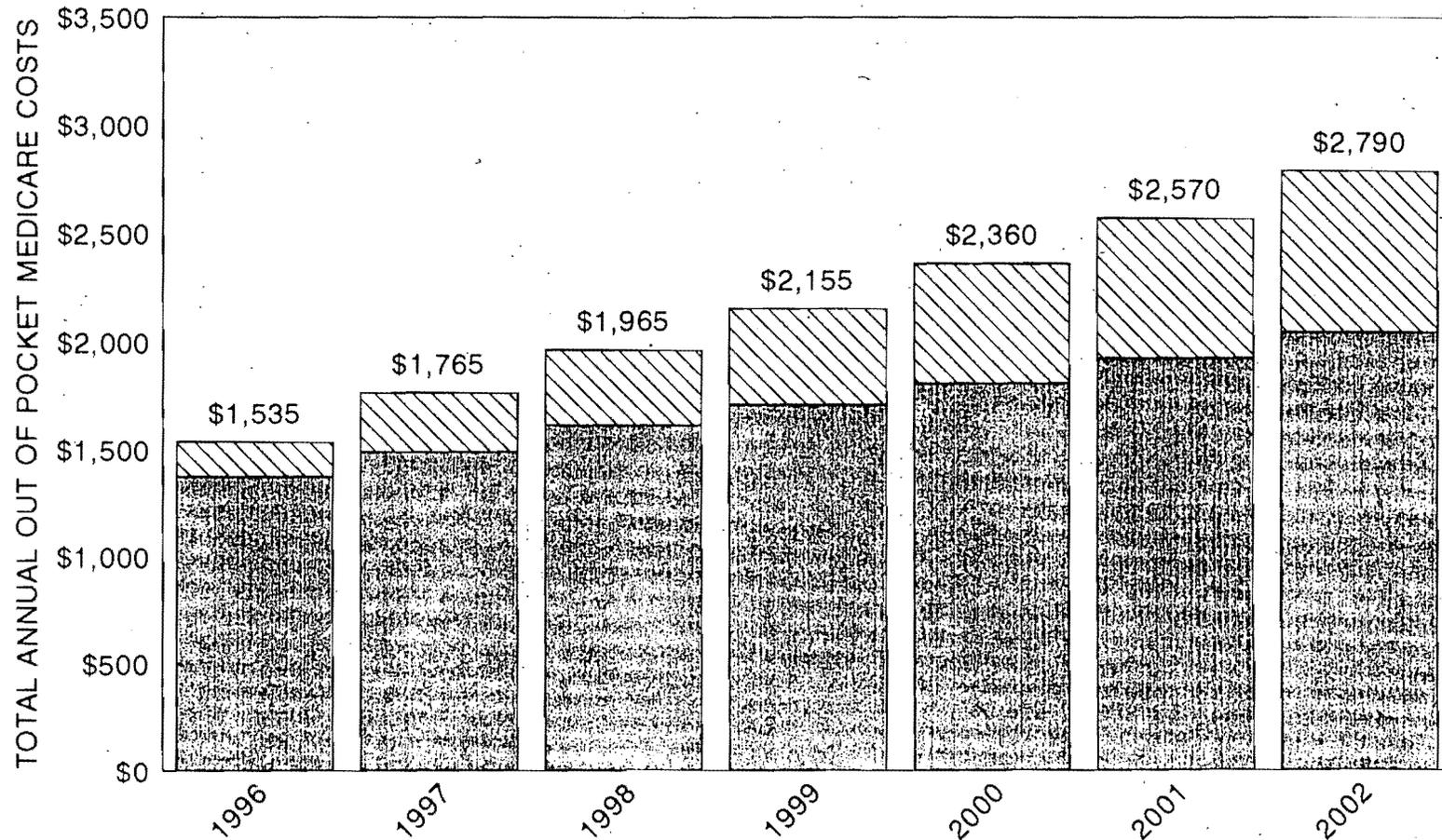
FISCAL YEAR

Assumes \$288 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.

# SENATE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS

## SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3,100



Proposed Increase		\$160	\$275	\$350	\$445	\$550	\$645	\$745
Current Law Costs		\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

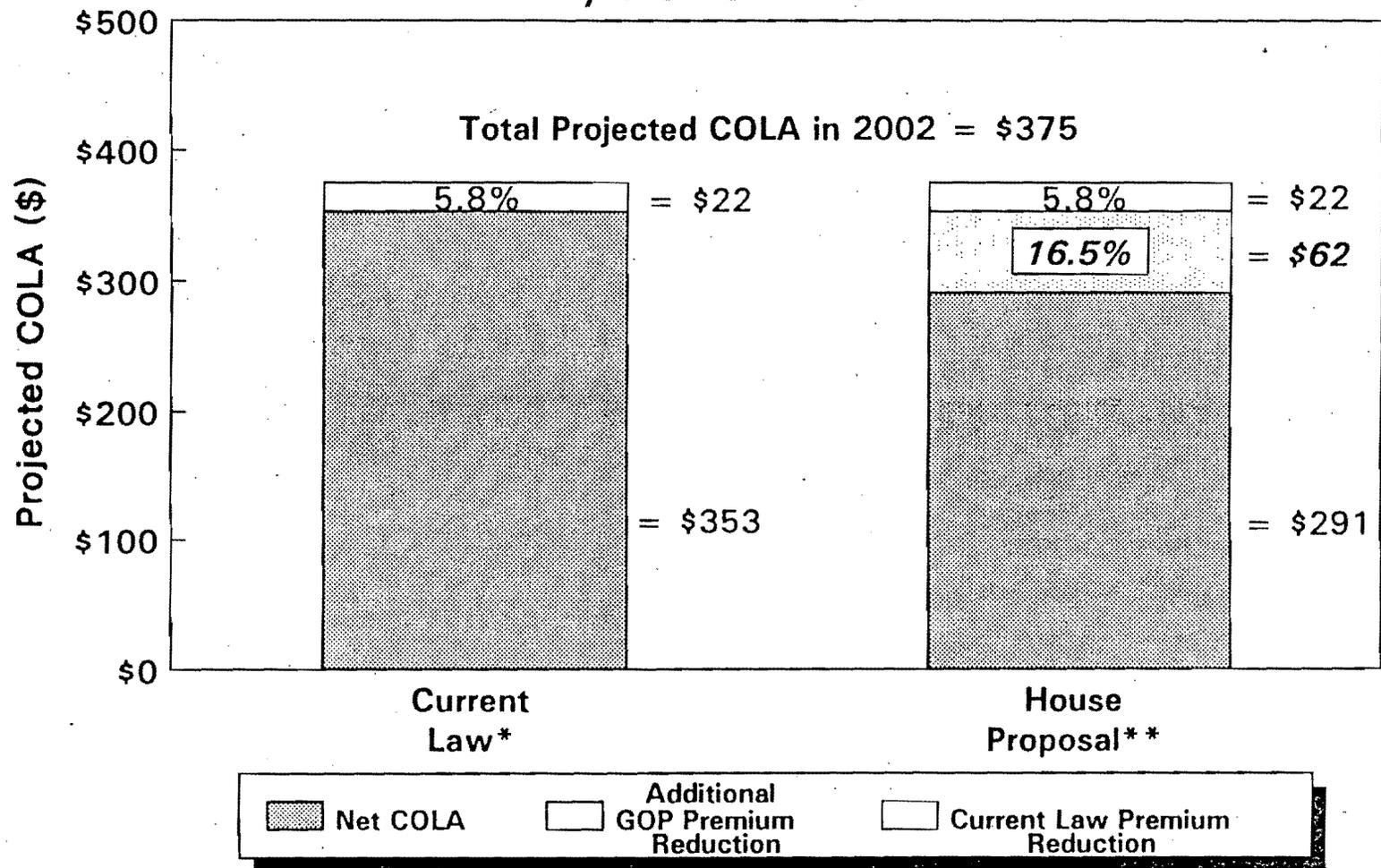
FISCAL YEAR

Assumes \$256 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premlums.

Source: Health Care Financing Administration

## House Medicare Premium Proposals Would Consume Over 15% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



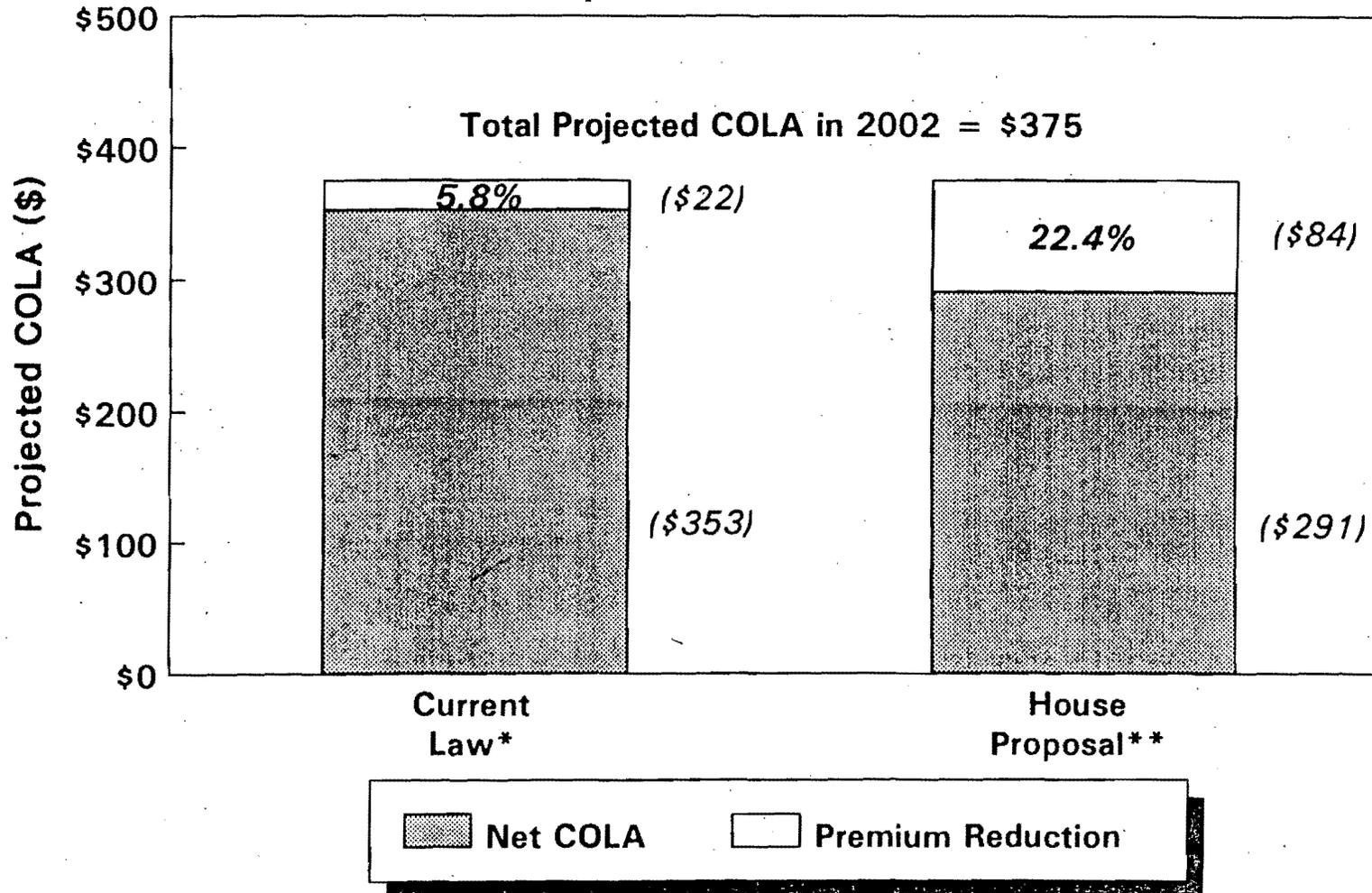
\* Does NOT Include PB 25% Premium Extension Proposal

\*\* Does NOT Include Effect of Proposal to Means Test Premium

Source: DHHS Estimates

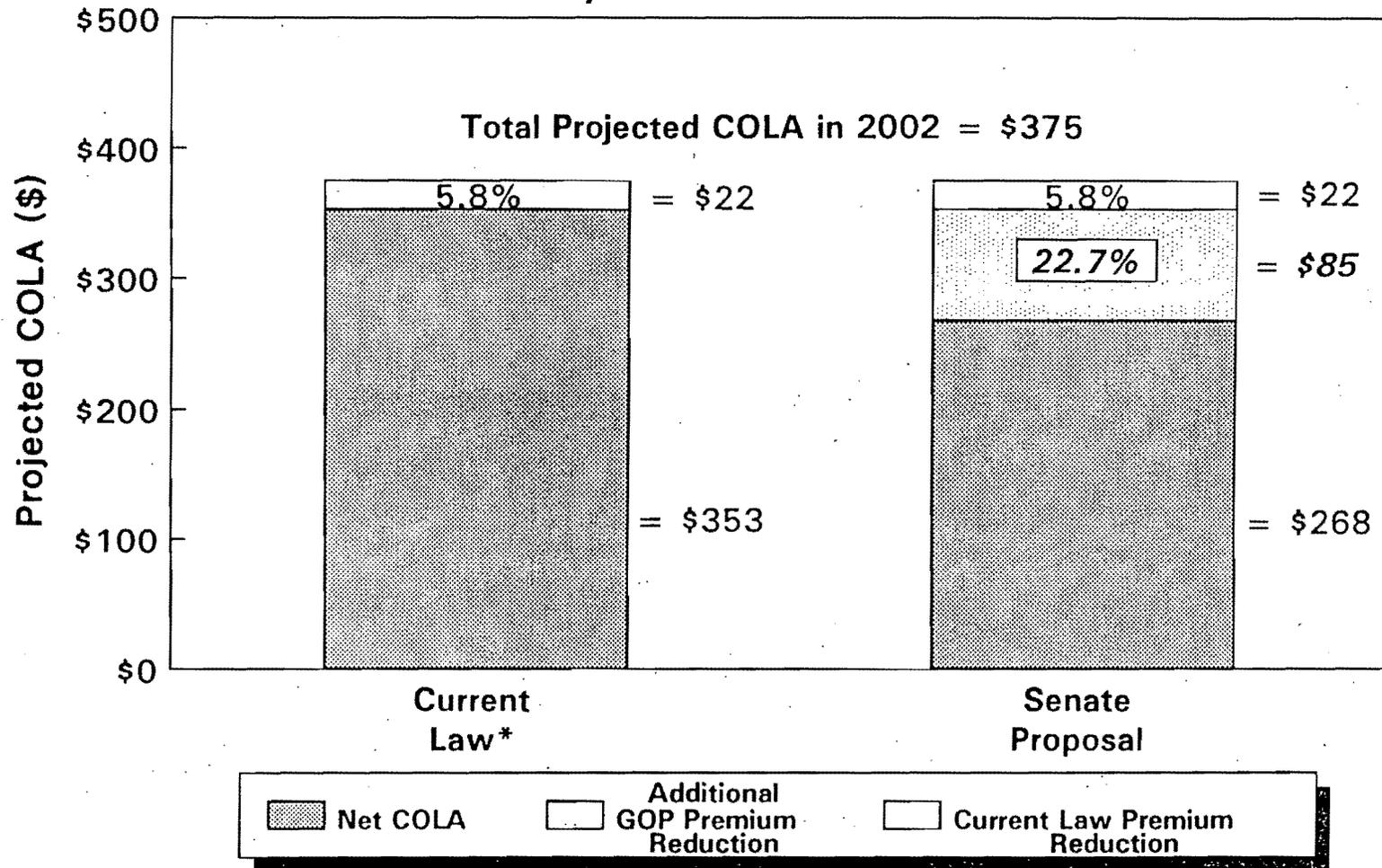
Note: Assumes \$288 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total that is Slightly Different.

## House Medicare Premium Proposals Would Consume Nearly 25% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



- Does NOT Include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs
- Does NOT Include Effect of House Income-Related Premium Proposal

## Senate Medicare Premium Proposals Would Consume Over 20% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002

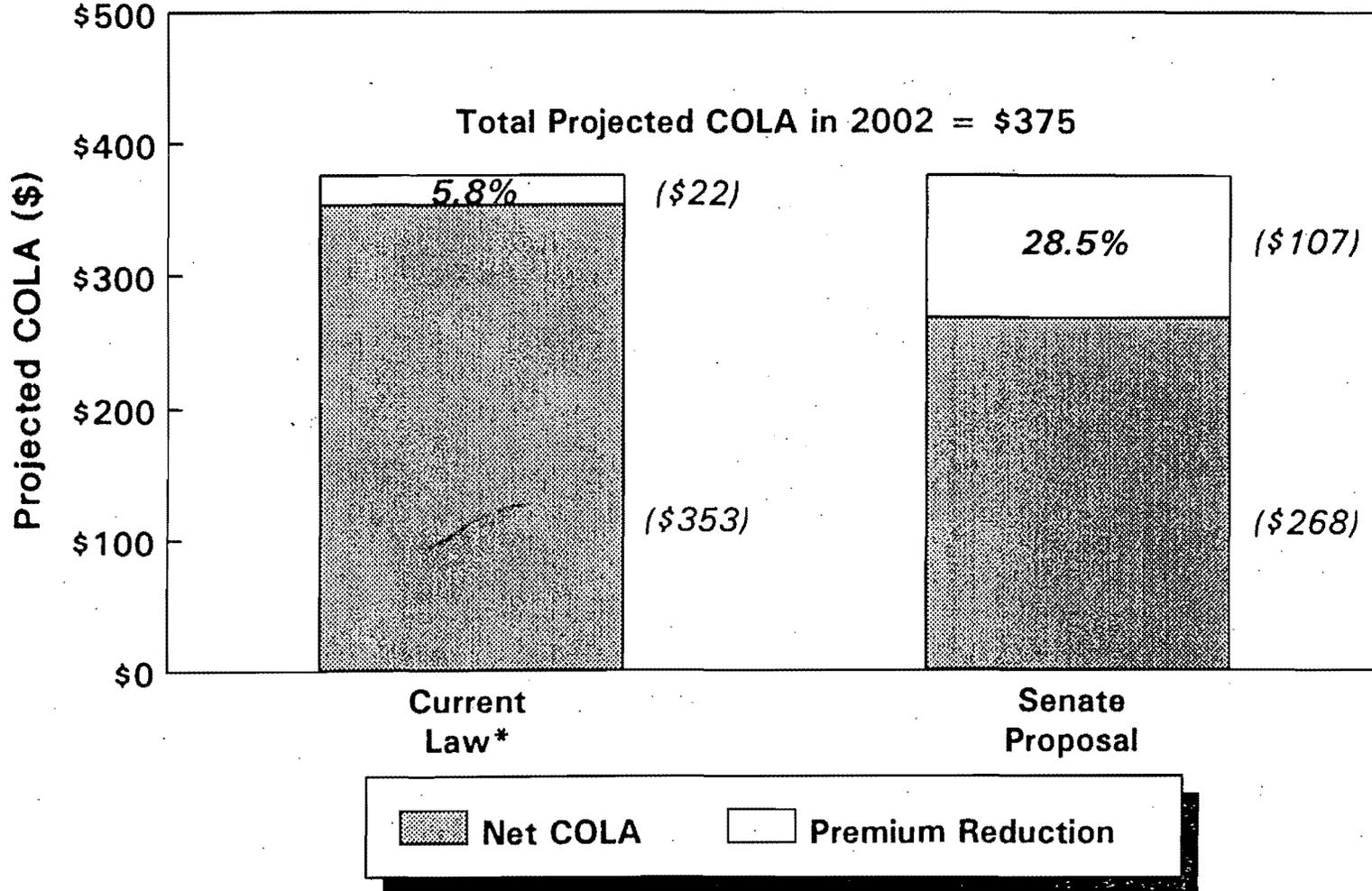


\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Source: DHHS Estimates

Note: Assumes \$256 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries.

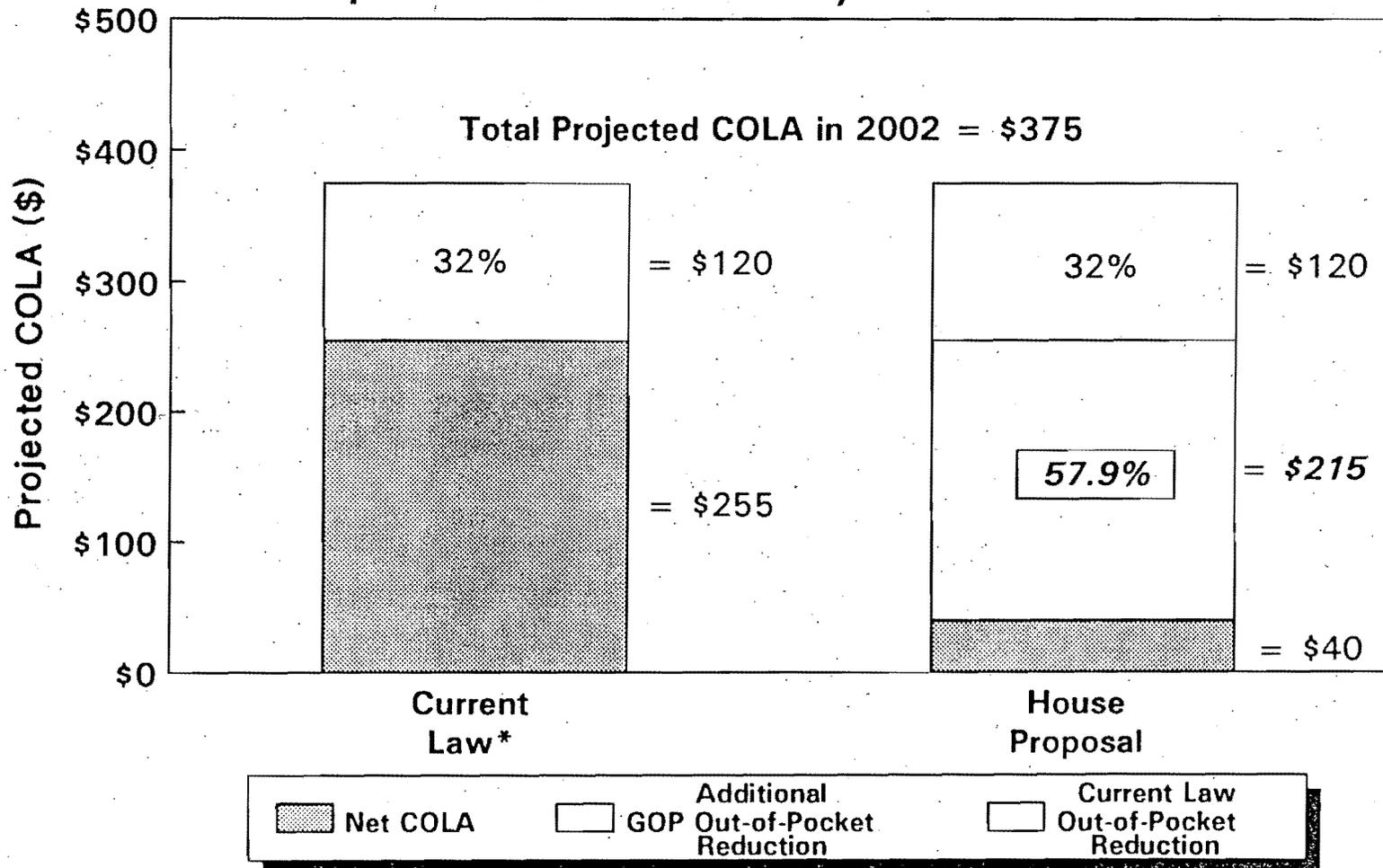
## Senate Medicare Premium Proposals Would Consume Nearly 30% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Assumes \$256 Billion Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total That is Slightly Different.

## House Medicare Out-of-Pocket Proposals Would Effectively Consume Nearly 60% of a Social Security Beneficiary's Expected COLA Increase by the Year 2002

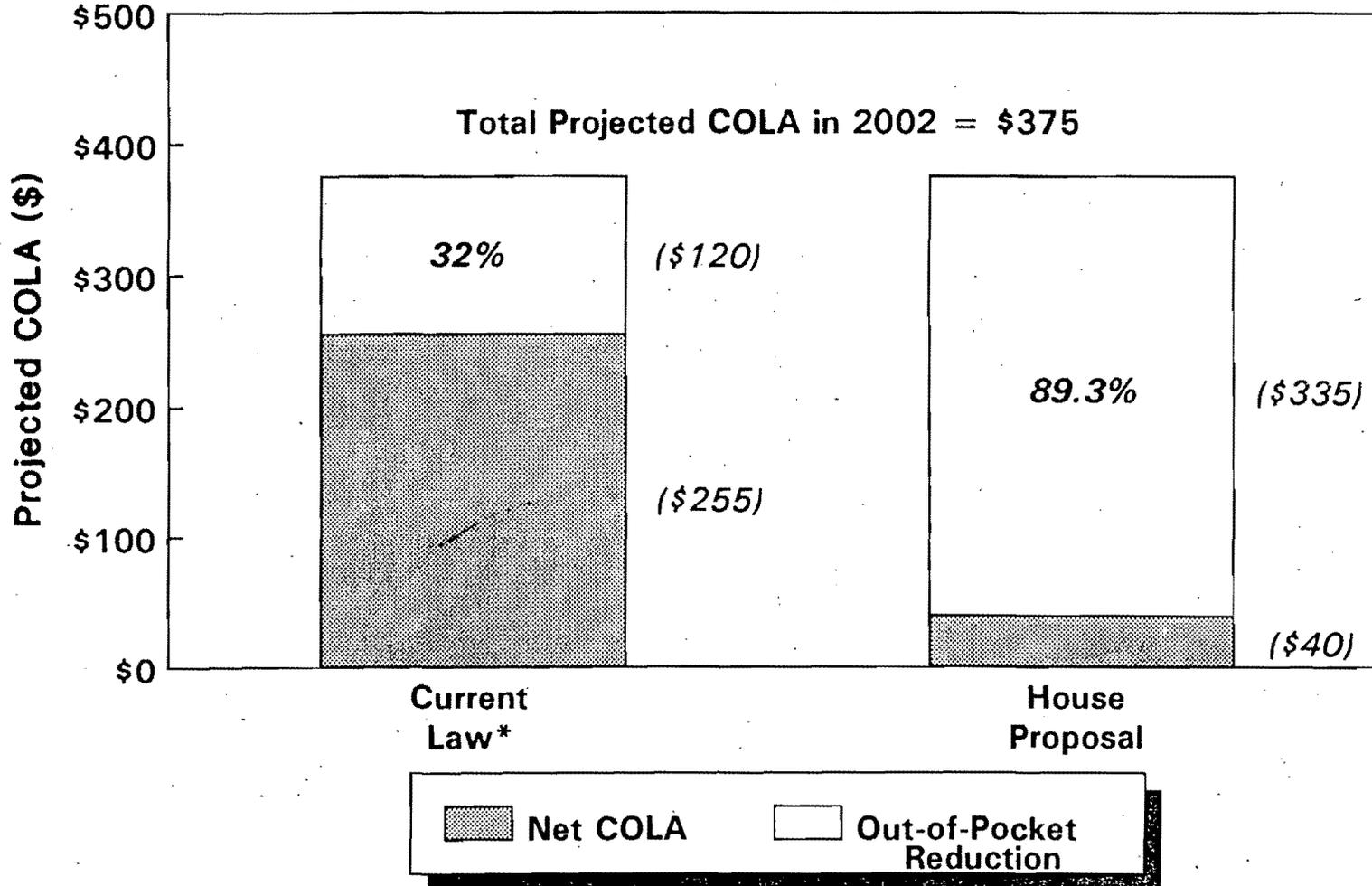


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Source: DHHS Estimates

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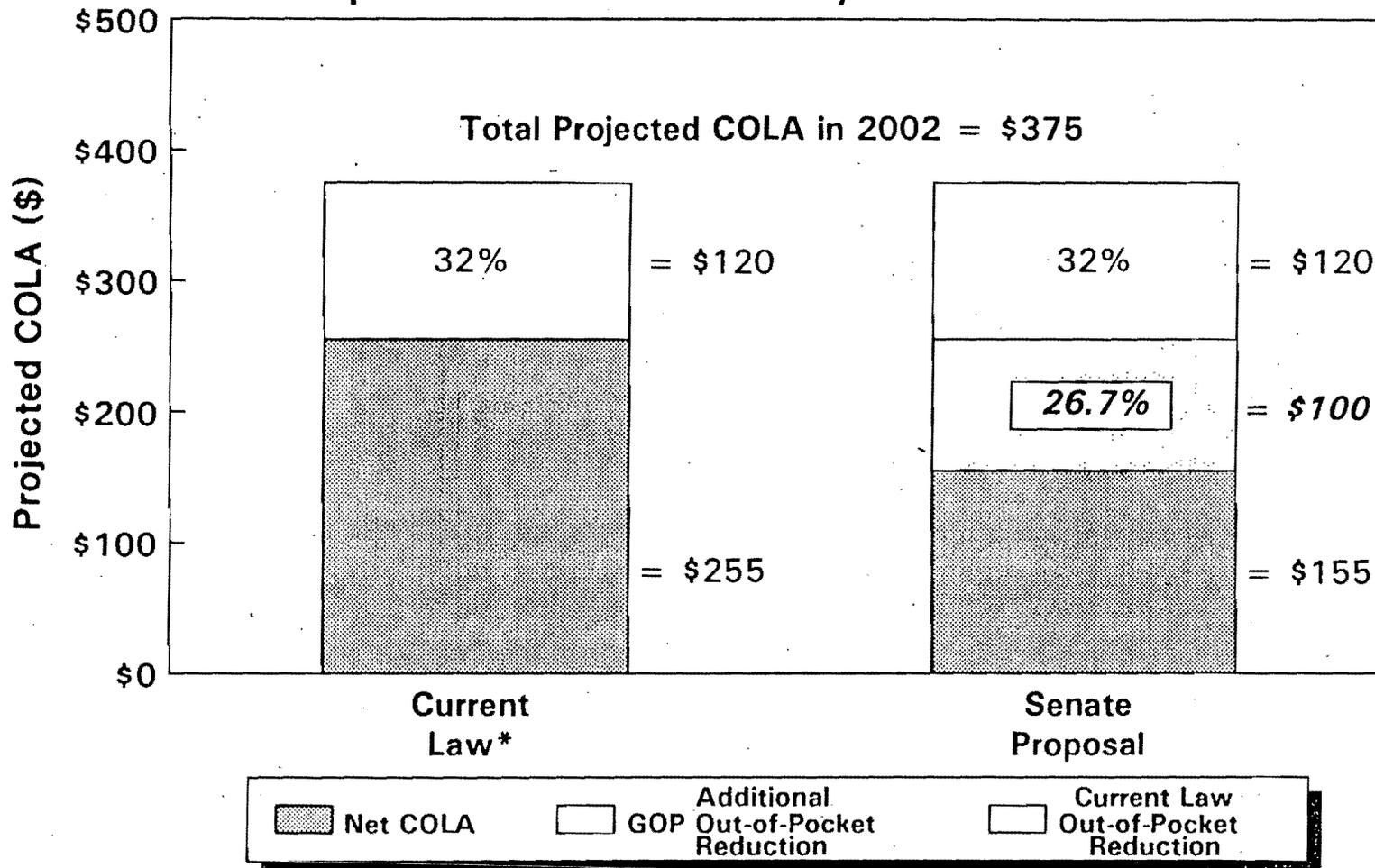
## House Medicare Out-of-Pocket Proposals Would Effectively Consume Nearly All of a Social Security Beneficiary's Expected COLA Increase by the Year 2002



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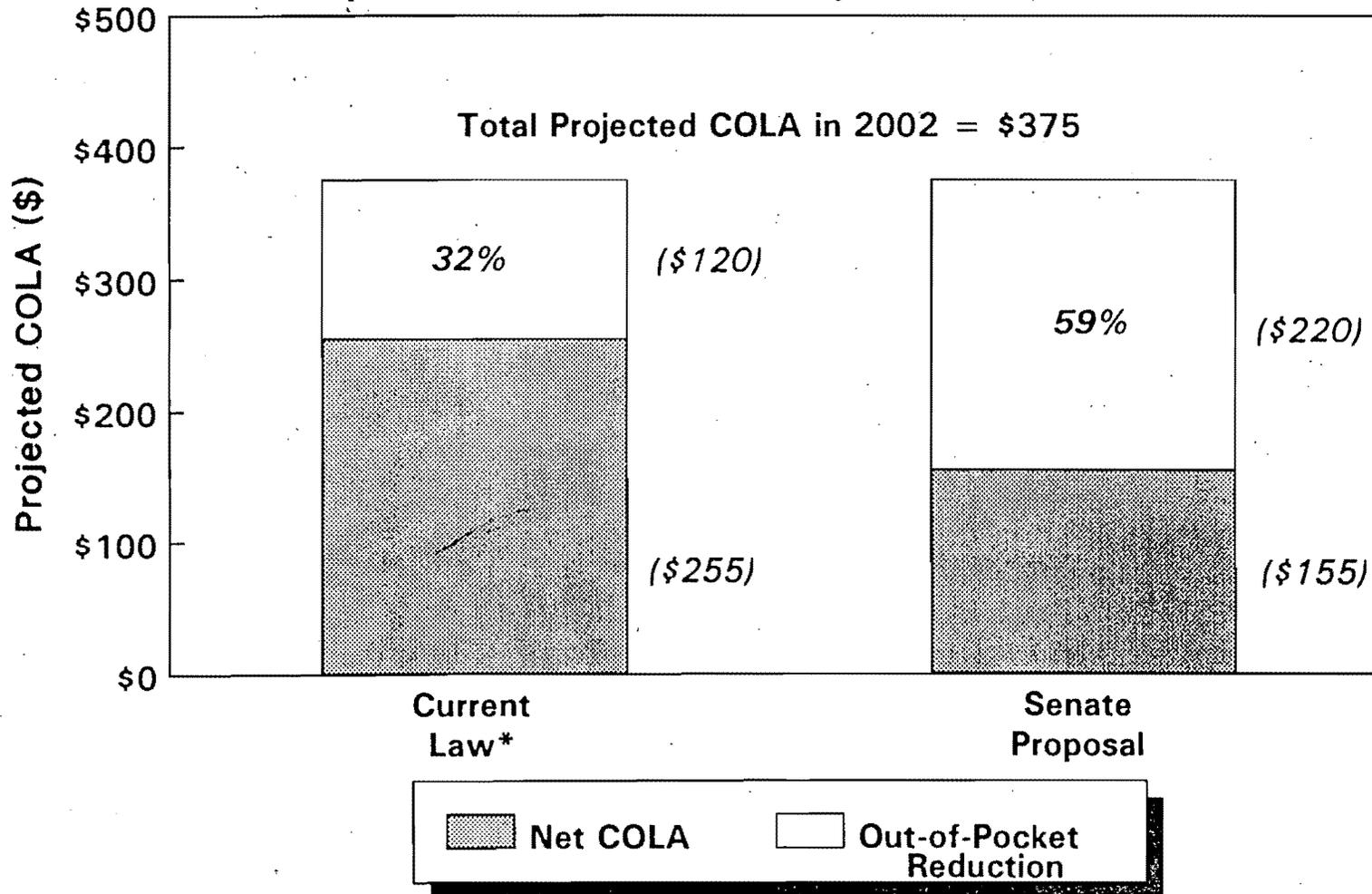


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Source: DHHS Estimates

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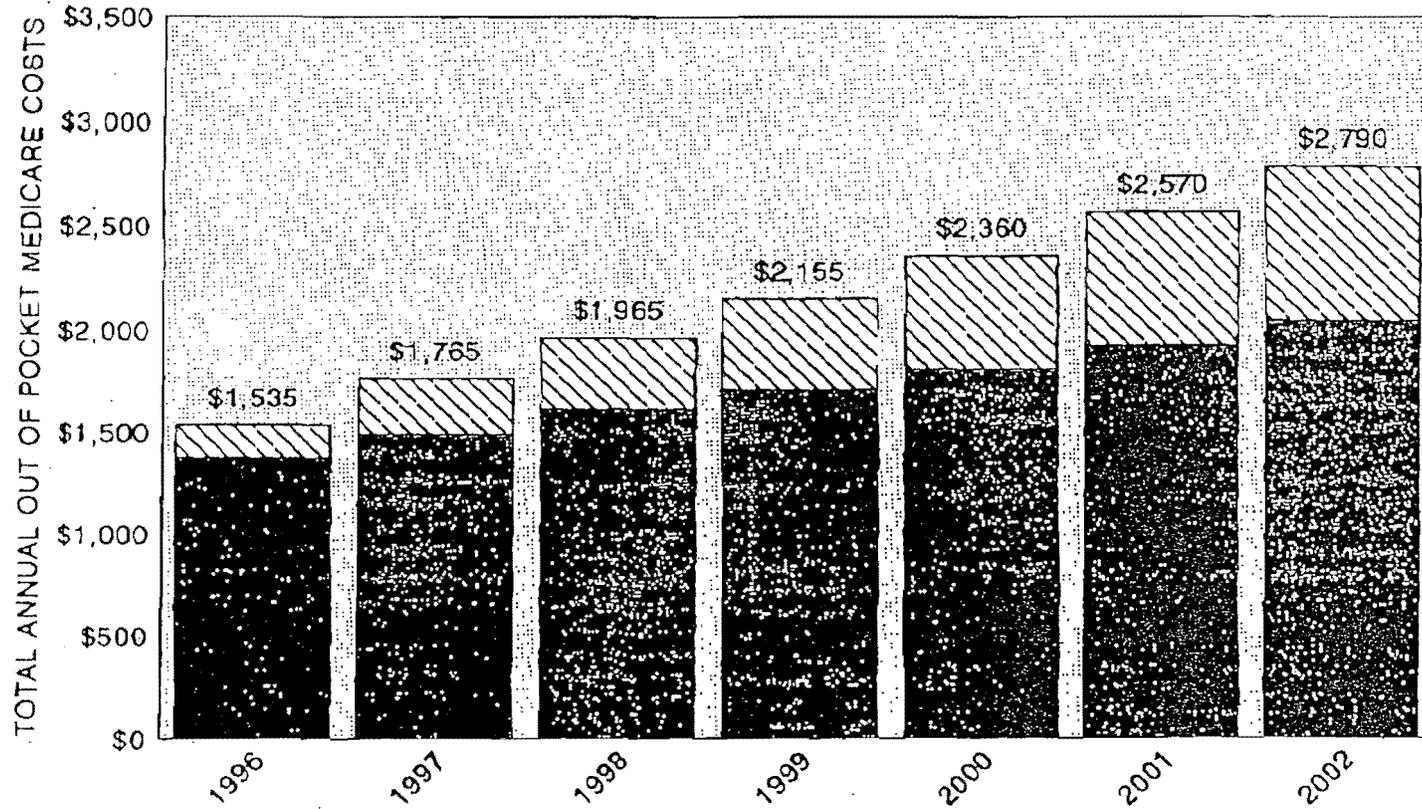
## Senate Medicare Out-of-Pocket Proposals Would Effectively Consume Almost 60% of a Social Security Beneficiary's Expected COLA Increase by the Year 2002



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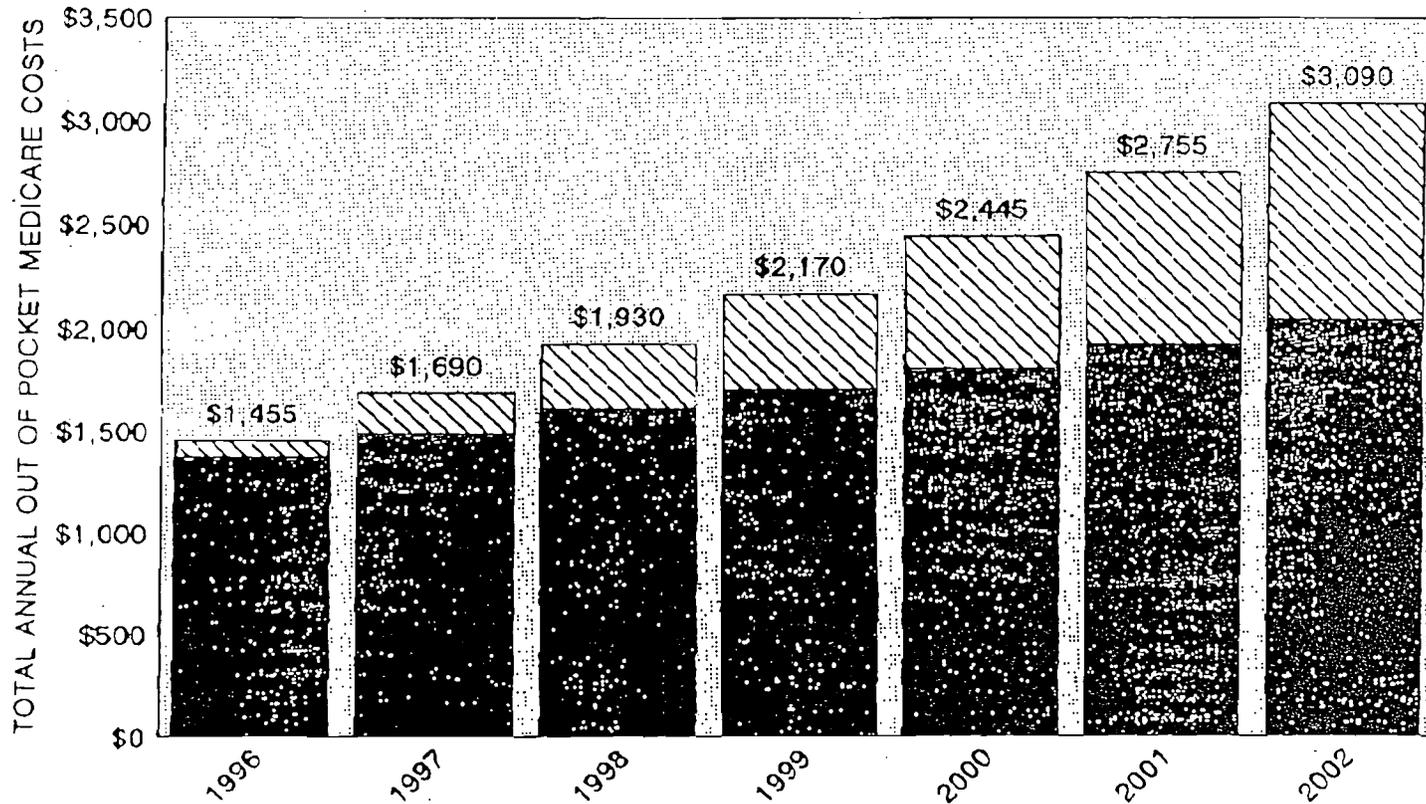
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Assumes \$256 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.

Source: Health Care Financing Administration

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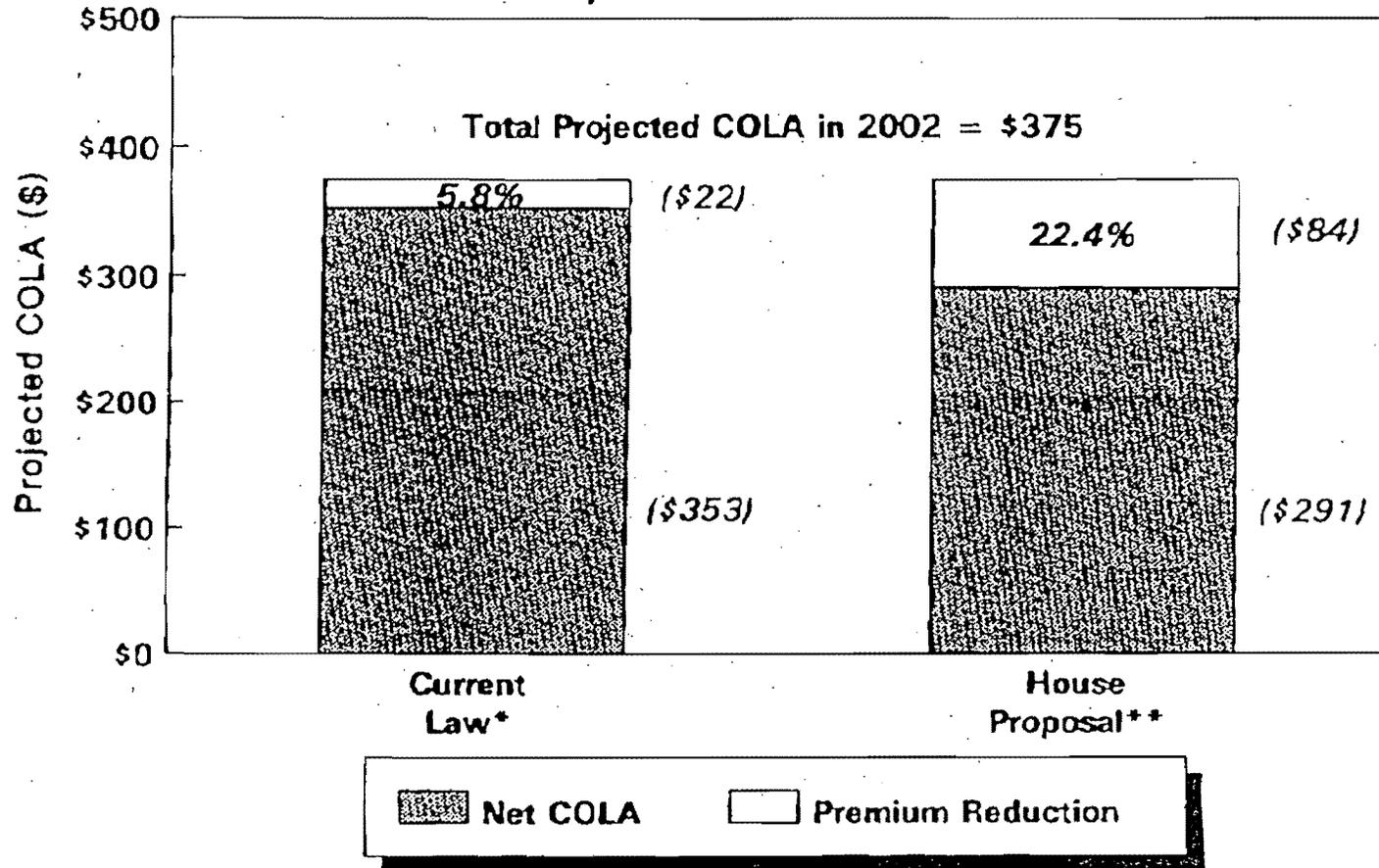
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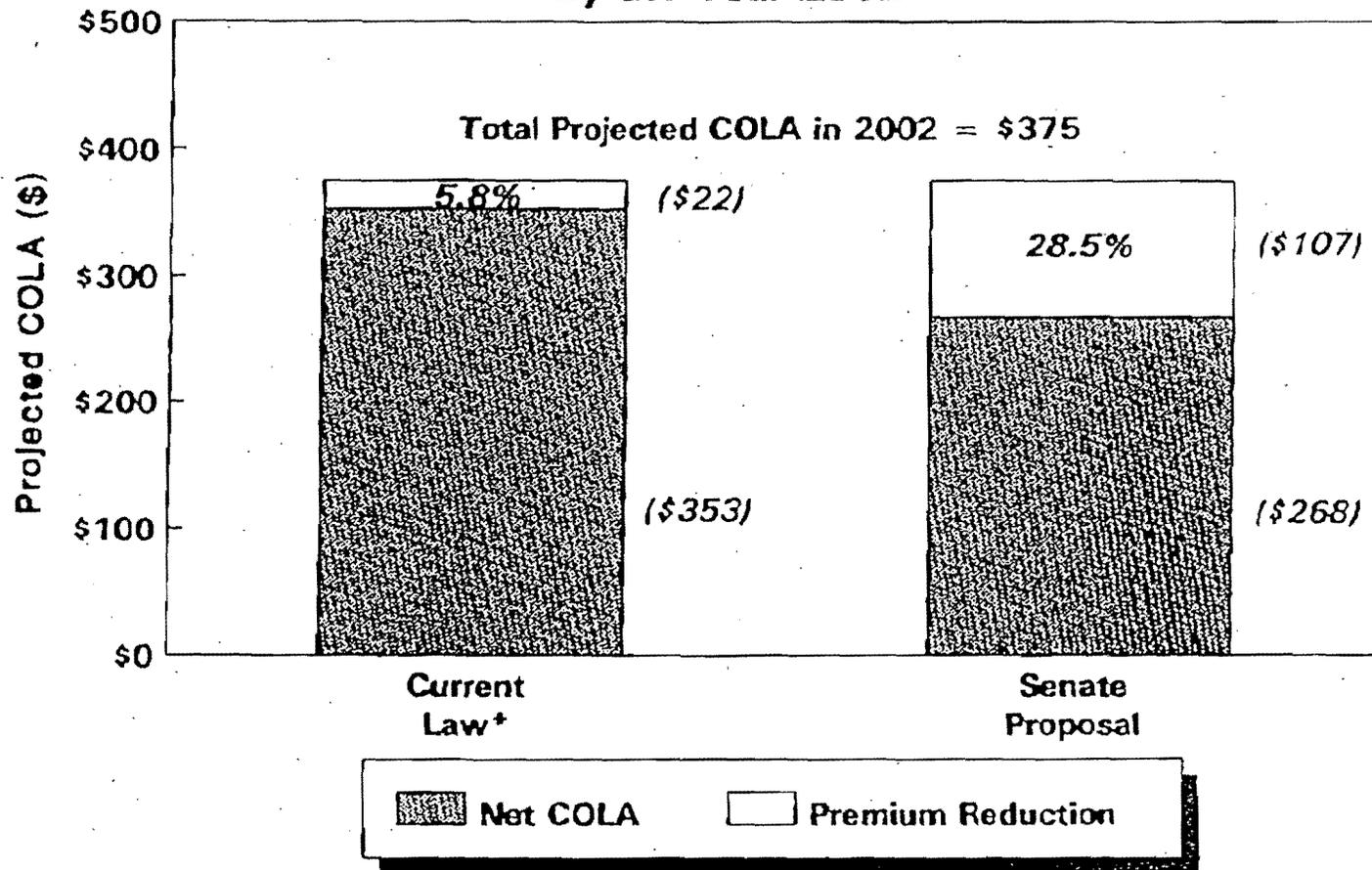
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## House Medicare Premium Proposals Would Consume Nearly 25% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



- \* Does NOT Include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs
- \*\* Does NOT Include Effect of House Income-Related Premium Proposal

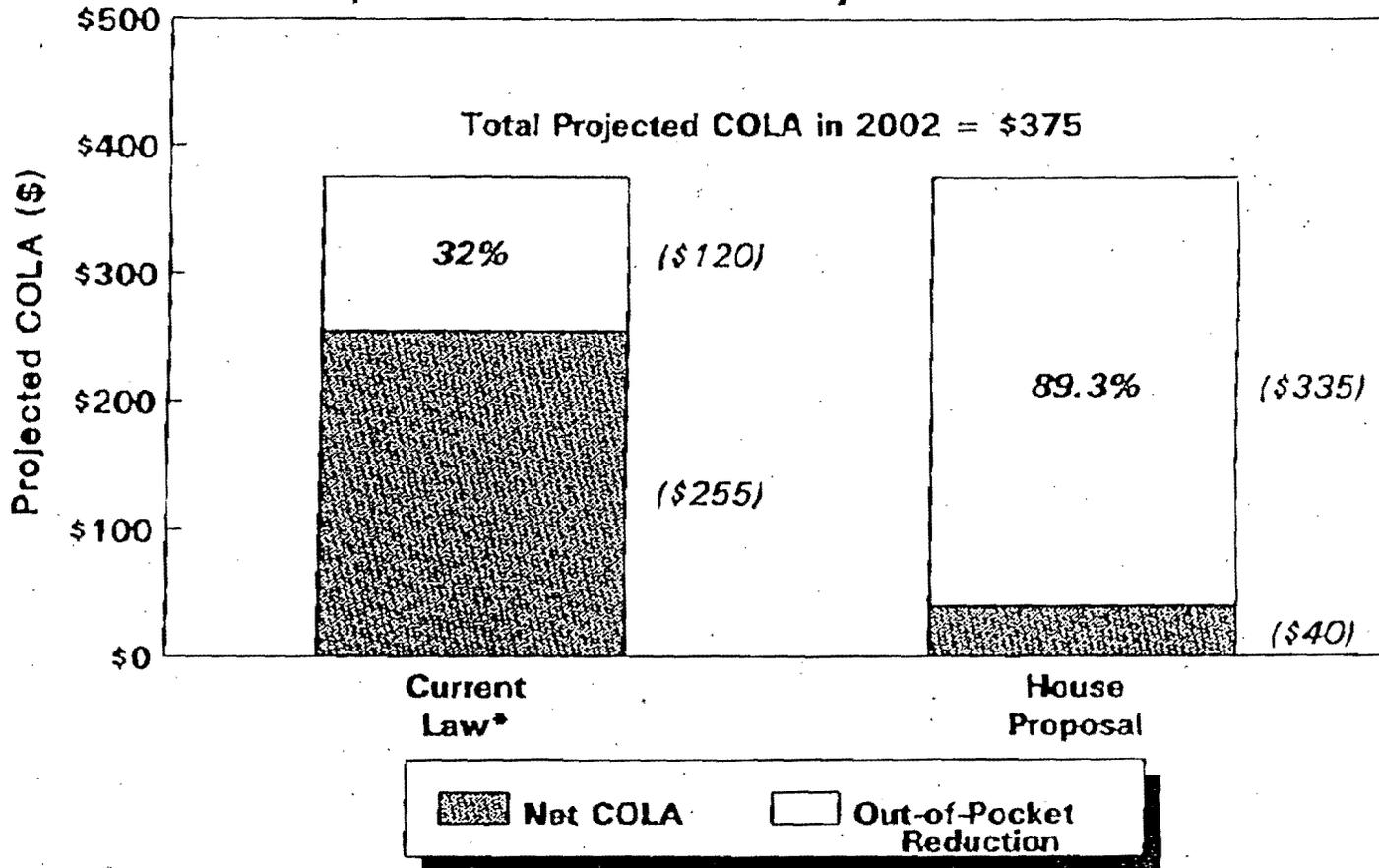
## Senate Medicare Premium Proposals Would Consume Nearly 30% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Assumes \$256 Billion Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total That is Slightly Different.

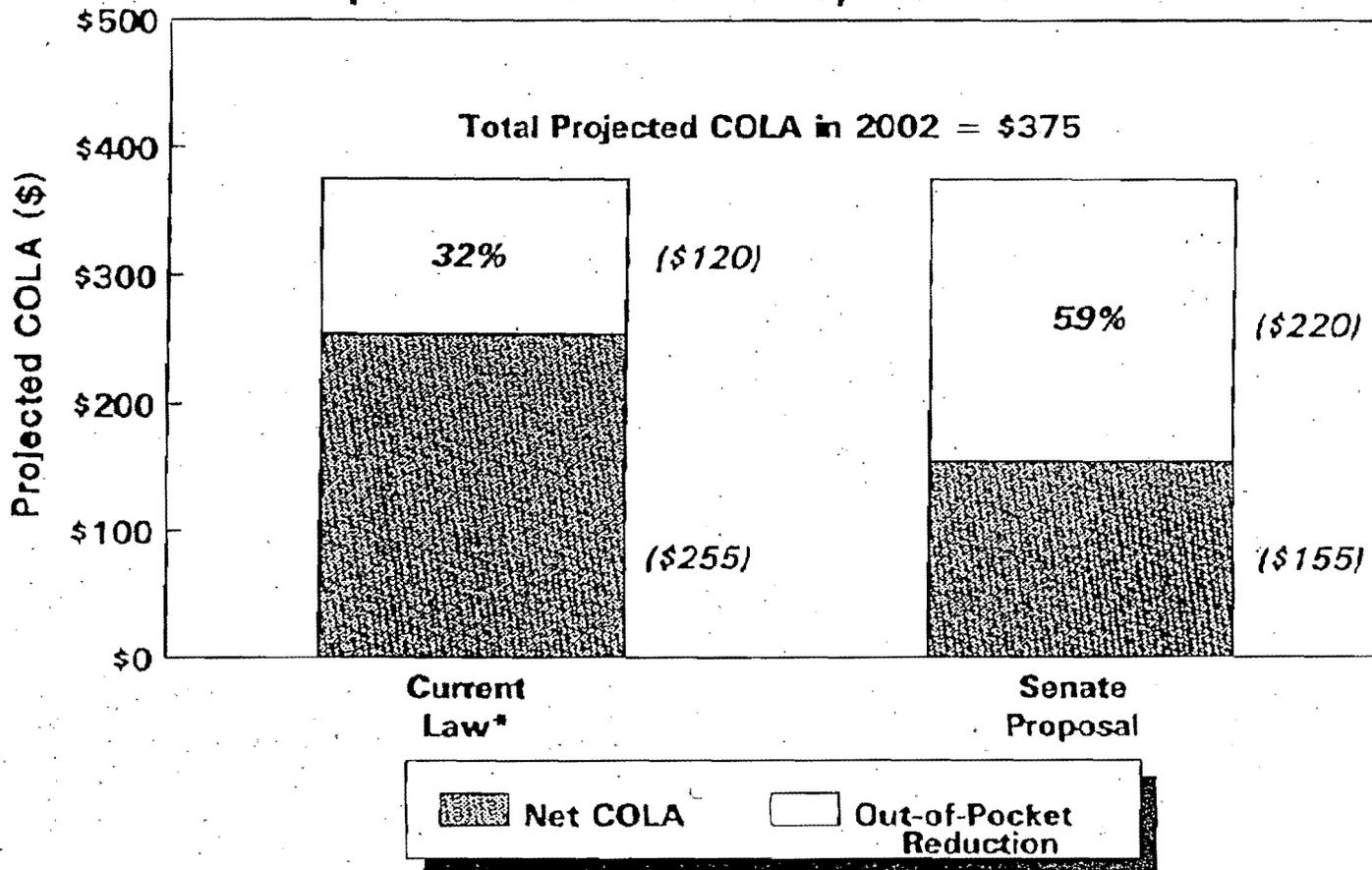
## House Medicare Out-of-Pocket Proposals Would Effectively Consume Nearly All of a Social Security Beneficiary's Expected COLA Increase by the Year 2002



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Assumes \$288 Billion Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total That is Slightly Different.

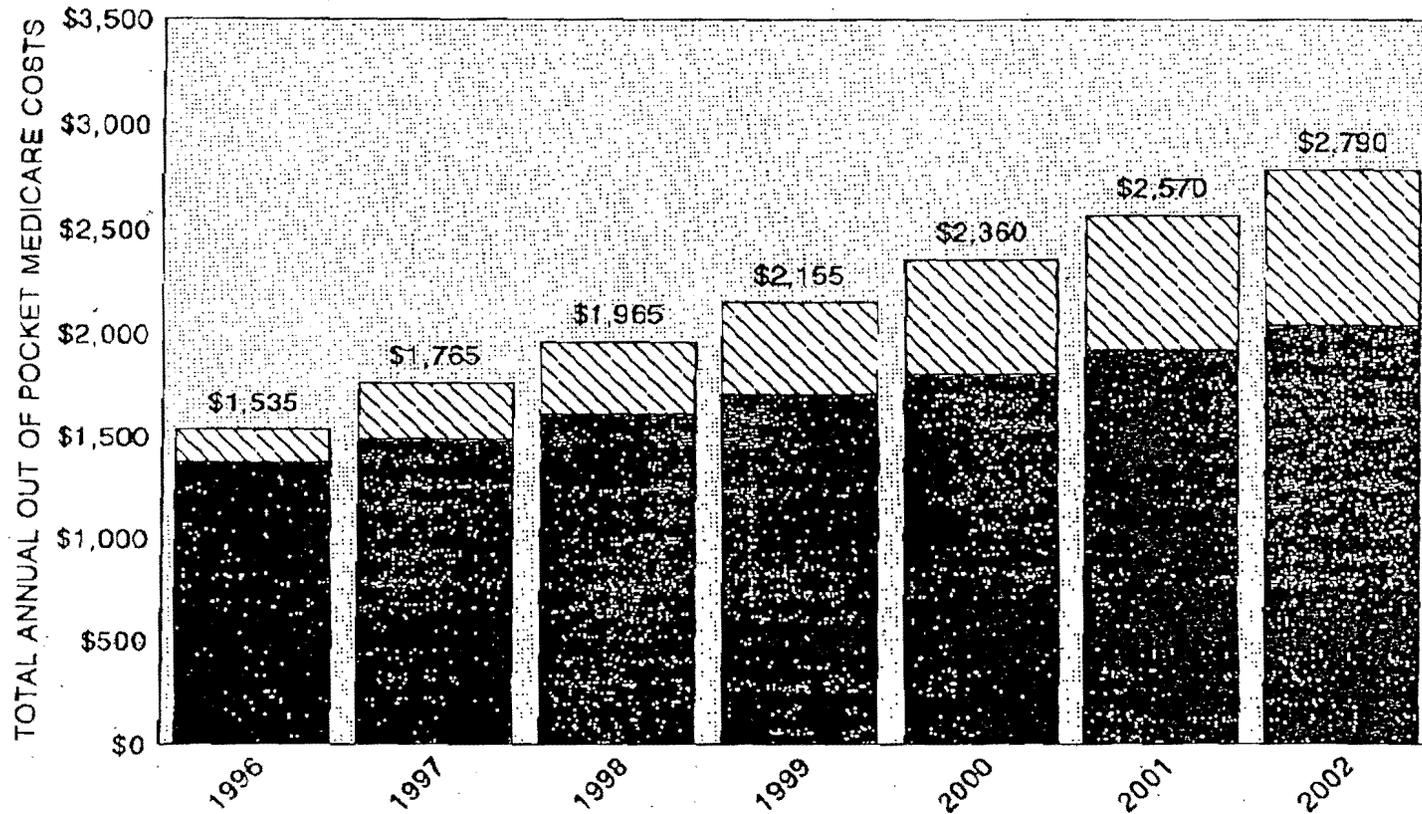
**Senate Medicare Out-of-Pocket Proposals Would Effectively Consume Almost 60% of a Social Security Beneficiary's Expected COLA Increase by the Year 2002**



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Assumes \$256 Billion Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total That is Slightly Different.

**SENATE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS**  
**SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3,100**



Proposed Increase		\$160	\$275	\$350	\$445	\$550	\$645	\$745
Current Law Costs		\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

**FISCAL YEAR**

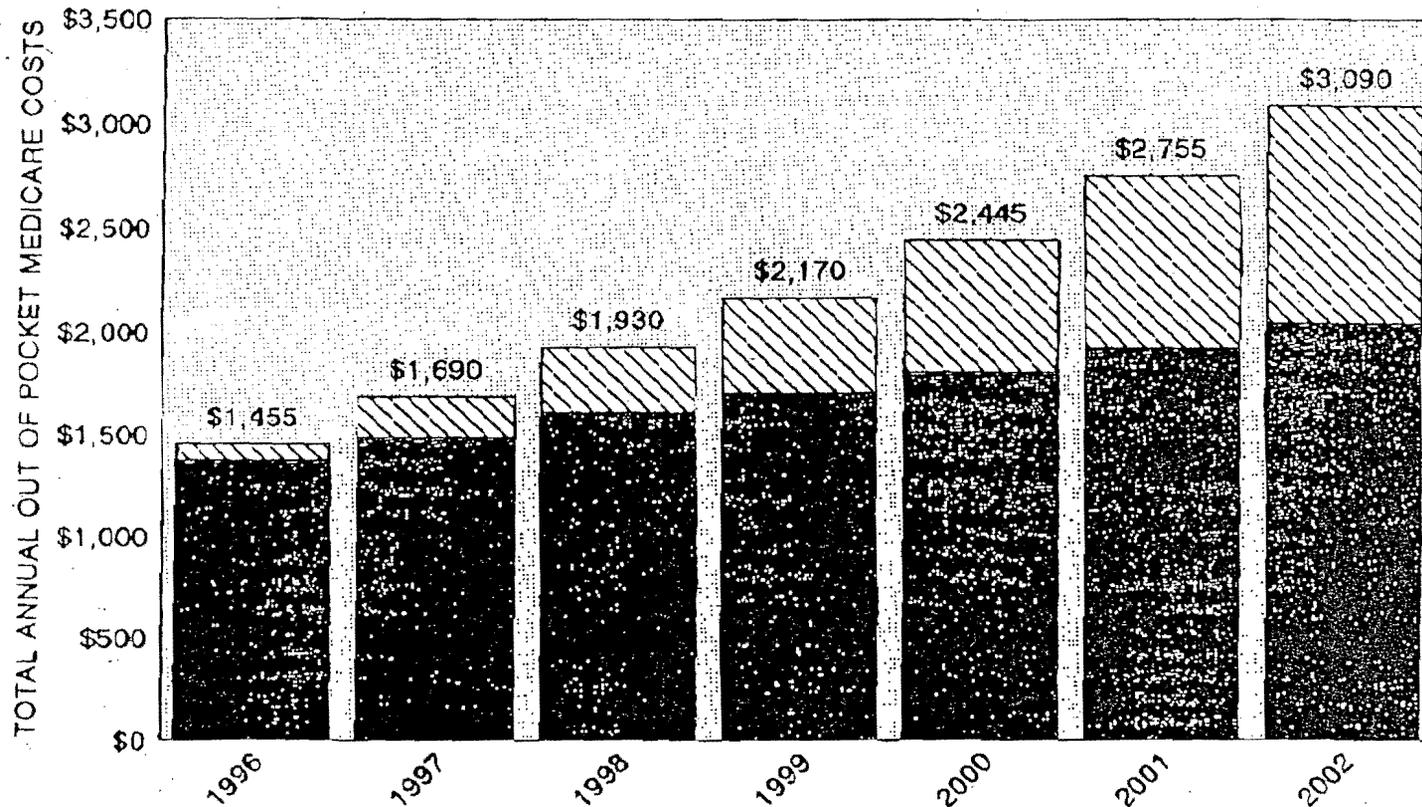
Note: Technical re-estimates of the aggregate savings may result in a slightly different 7-year total.

Assumes \$258 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.

Source: Health Care Financing Administration

**HOUSE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS**  
**SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3500**



Proposed Increase	■	\$80	\$200	\$315	\$460	\$635	\$830	\$1,045
Current Law Costs	■	\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

**FISCAL YEAR**

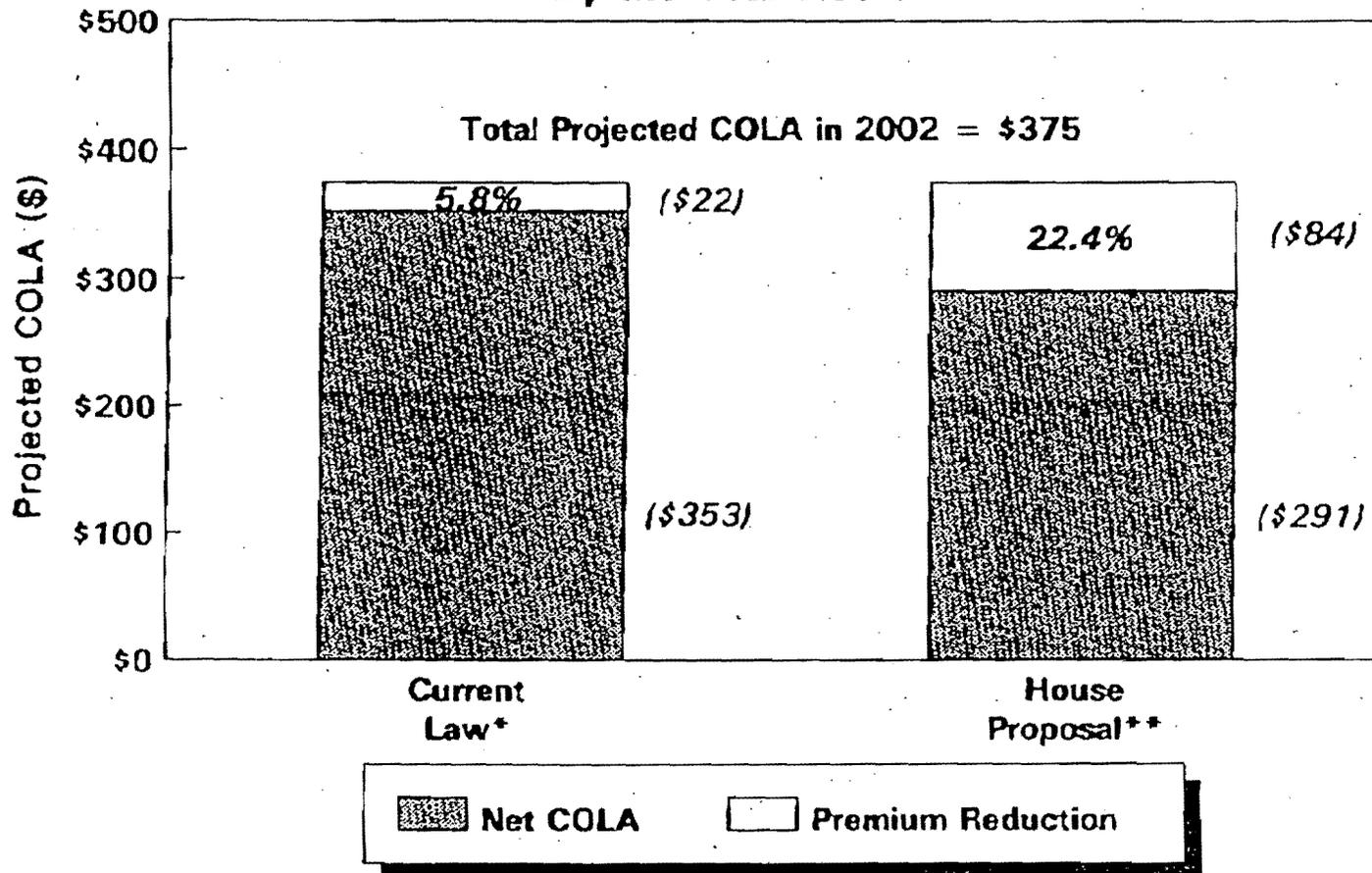
Note: Technical re-estimates of the aggregate savings may result in a slightly different 7-year total.

**Assumes \$288 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.**

**Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.**

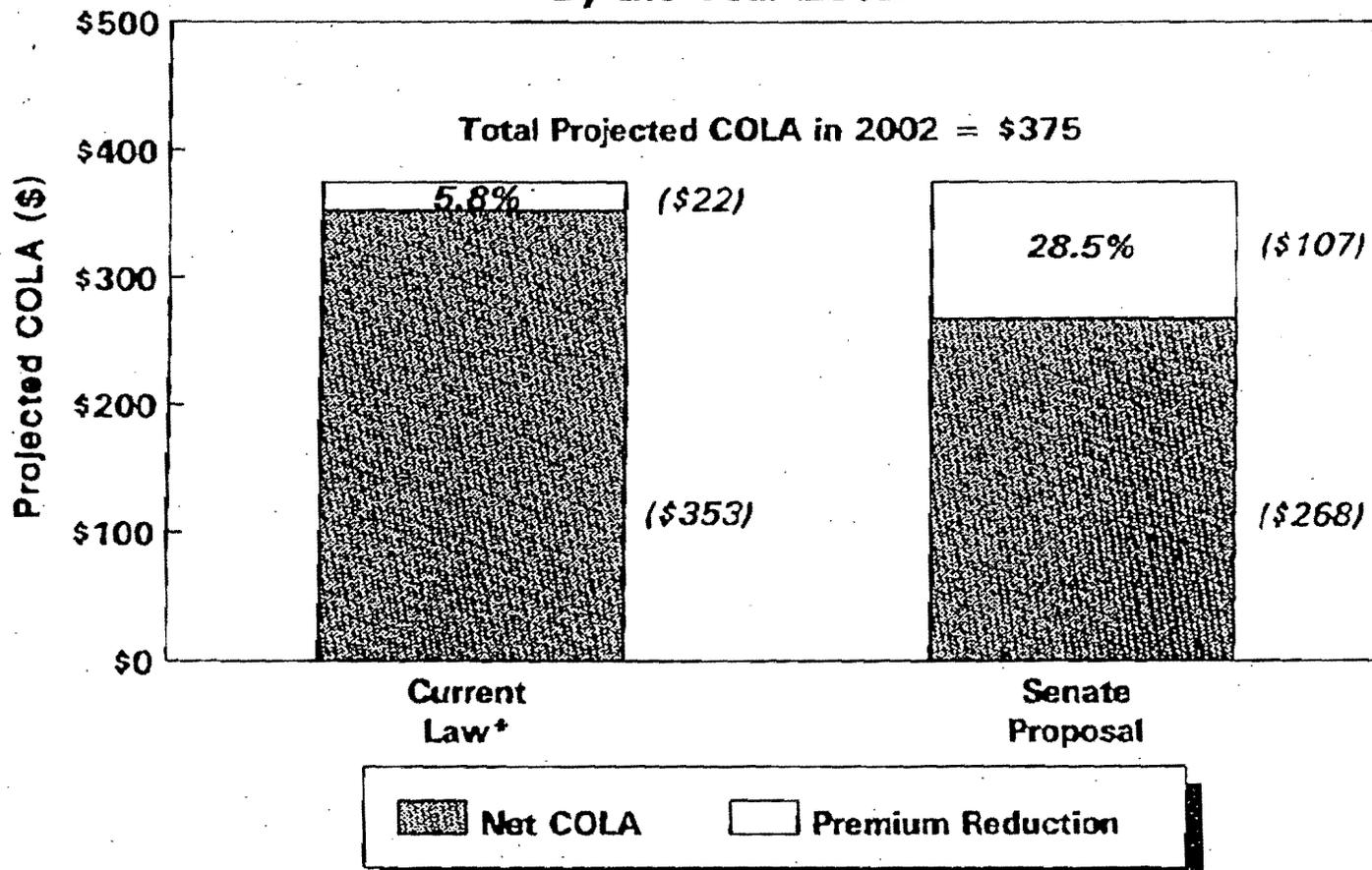
Source: Health Care Financing Administration

## House Medicare Premium Proposals Would Consume Nearly 25% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



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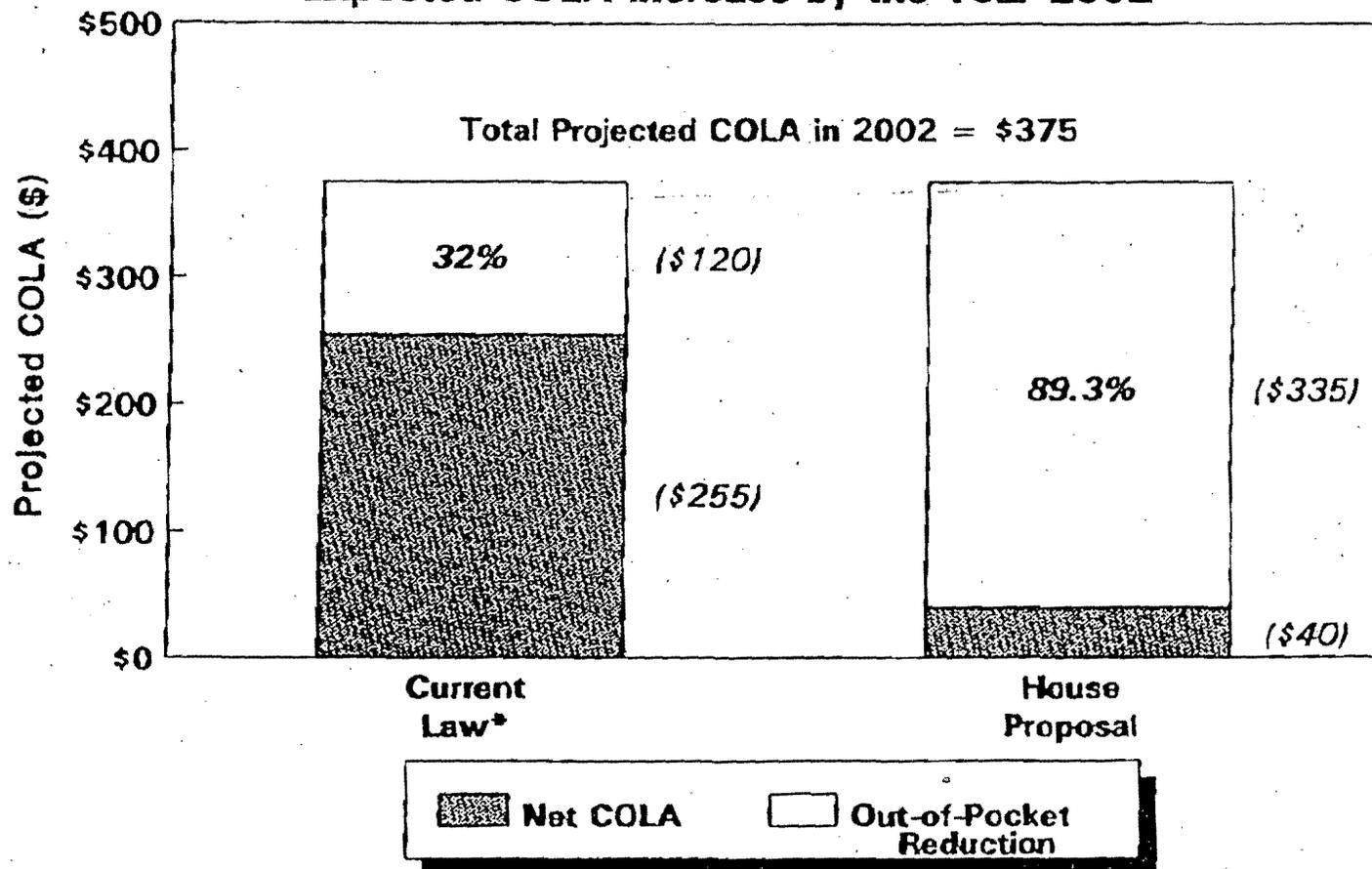
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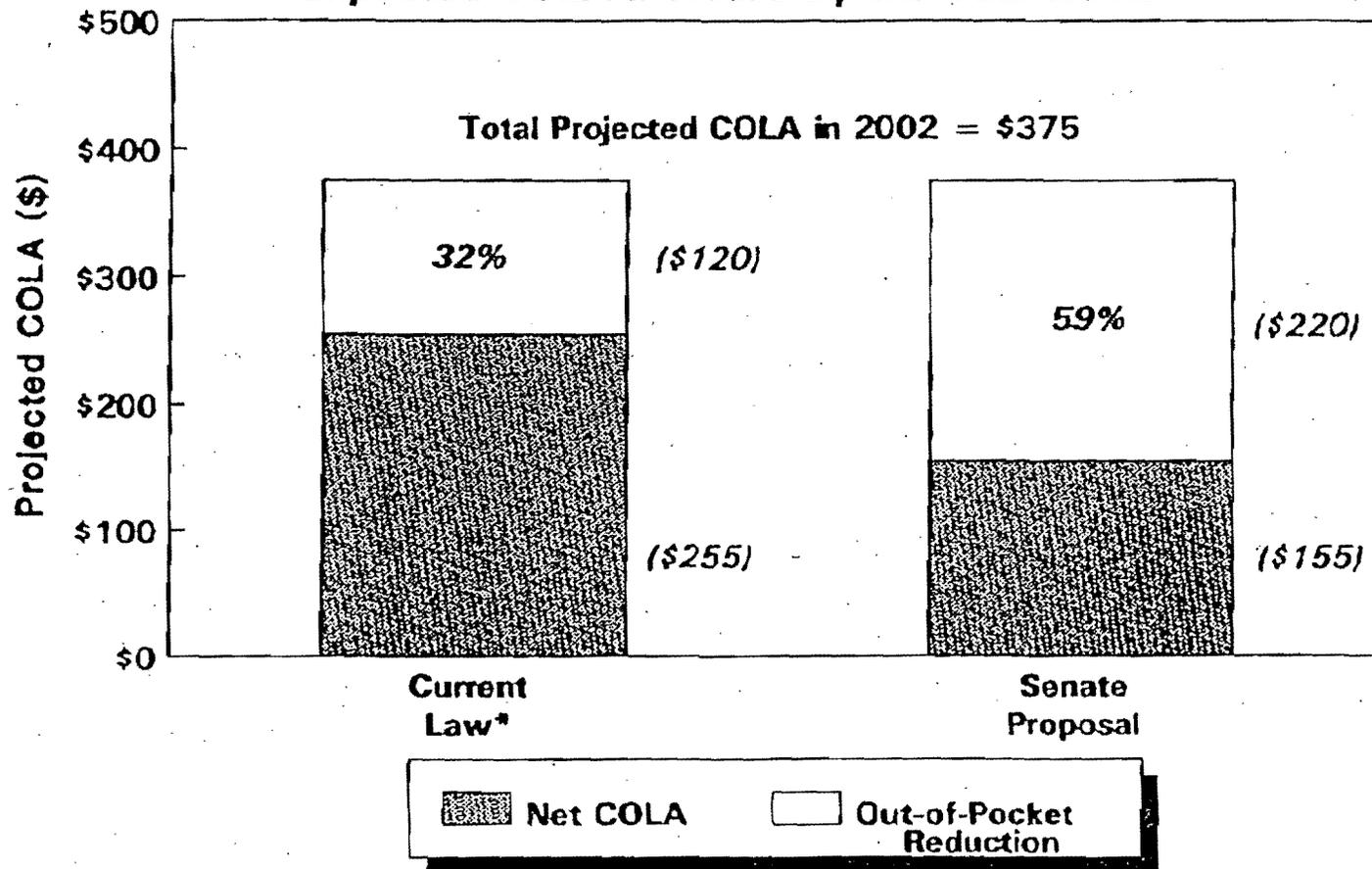
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## REPUBLICAN MEDICARE CUTS

**REPUBLICANS PROPOSE THREE TIMES THE LARGEST CUTS IN MEDICARE IN HISTORY TO PAY FOR THEIR TAX CUTS.** The Republican Medicare cuts--\$256 billion in the Senate, \$288 billion in the House--are three times larger than the largest previous Medicare cut in history. Yet this **entire** cut would be unnecessary if Republicans did not need to pay for their tax cuts. The Medicare cut makes room for most--but not all--of the \$345 billion Contract tax cut, which provides a \$20,000 break to the wealthiest 1%.

### **REPUBLICANS WOULD RAISE HEALTH CARE COSTS TO ELDERLY COUPLES BY OVER \$2,000 IN 2002--ACCORDING TO THEIR OWN DOCUMENTS.**

On May 8, the *New York Times* reported on Newt Gingrich promising a "huge but painless" cut in Medicare. On May 16, the *Times* reported a very different story--noting that Republican cuts "almost certainly would mean charging beneficiaries more while squeezing payments to hospitals and other health care providers." Official documents circulated by a leading architect of Republican Medicare cuts show that Republicans would increase premiums, copayments, and deductibles. These changes would raise Medicare costs by over \$2,000 per couple in 2002 alone. The cuts would include:

- **Doubling deductibles** from their current level.
- **Increasing premiums for 7 straight years.**
- **Dramatically increasing co-payments** (i.e., beneficiary payments for services) for home health care and other services.

**REPUBLICANS WOULD MAKE MEDICARE A SECOND-CLASS SYSTEM FOR 37 MILLION SENIOR CITIZENS, CUTTING GROWTH PER PERSON FAR BELOW GROWTH IN PRIVATE HEALTH CARE.** Republicans claim that they are just slowing the "exploding" rate of growth in Medicare. In fact, over the next 7 years, the cost *per person* in Medicare is projected to be about the same as that of private insurance. Ignoring the problem of health care costs generally, the Republicans would simply cut the average growth rate for a Medicare recipient far below the level for other Americans. This means reducing quality and **turning Medicare into a second-class health care system.**

### **REPUBLICAN PROPOSALS ARE ABOUT COERCION, NOT CHOICE.**

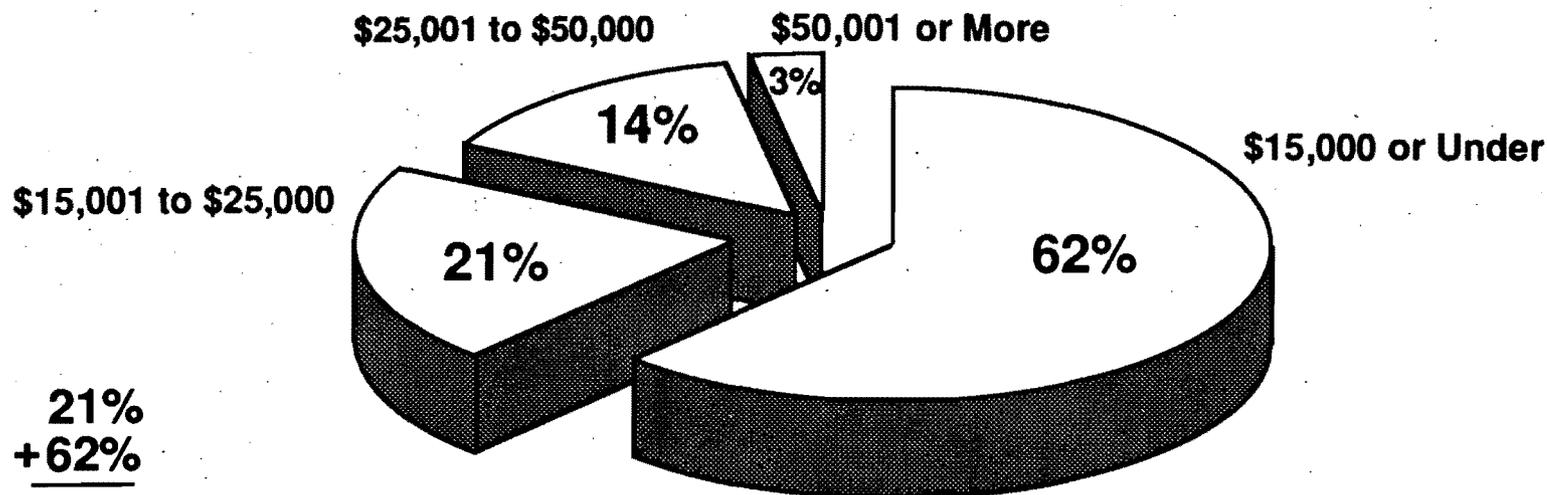
Republicans have produced no evidence that their plans can achieve significant savings through managed care among the populations that Medicare and Medicaid overwhelmingly serve--the elderly and disabled. Some of their proposals would provide a capped voucher to Medicare recipients that likely would not be enough for older and less healthy seniors to afford the coverage they need. Other proposals would raise the costs for seniors to continue seeing the doctors of their choice--forcing them to pay money they may not have or give up the doctors they trust. Rather than expanding choice, such proposals place a coercive "sick tax" on the Americans who need Medicare most.

**REPUBLICAN MEDICARE CUTS WOULD ELIMINATE UP TO 55% OF THE SOCIAL SECURITY COST-OF-LIVING ALLOWANCE.** Their increases in Medicare costs will be taken directly from the Social Security checks of typical Medicare beneficiaries. By 2002, these increases would eliminate up to 55% of the Social Security COLA.

### **HOSPITALS WOULD BE ESPECIALLY HARD HIT BY GOP MEDICARE CUTS.**

According to the American Hospital Association, costly but crucial services like trauma care, burn units, and intensive care units would have to be closed in many hospitals. Teaching hospitals would receive less money per case in 2002 than in 1996 under the House proposal.

## Share of Program Expenditures by Income Of Medicare Individuals or Couples, 1992



21%  
+62%

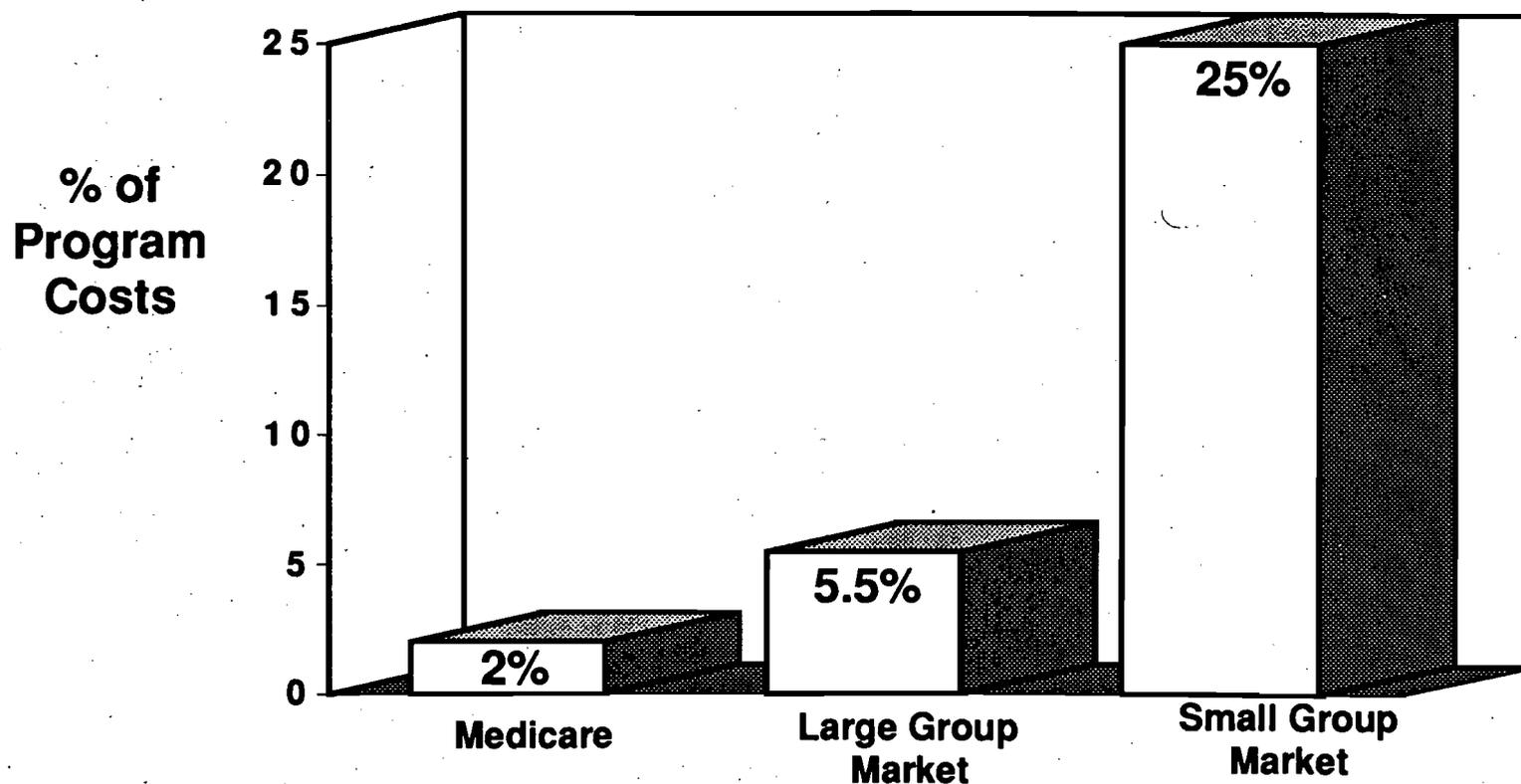
**83% of Expenditures on Behalf of Those With an Annual Income of \$25,000 or Less**

Excludes 2.2% Not Reporting Income. Also Excludes HMO Enrollees (6%)

Source: HCFA/OACT

# Administrative Costs

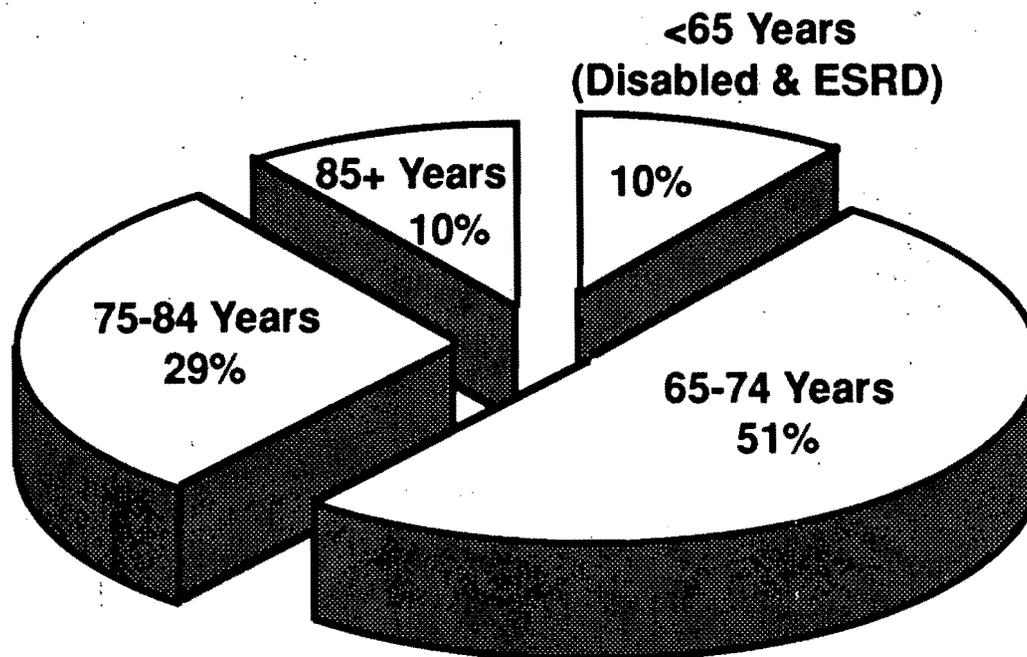
## Medicare vs. Private Plans



(Small Group Market - Firms With Less Than 50 Employees;  
Large Group Market - Firms With More Than 10,000 Employees)

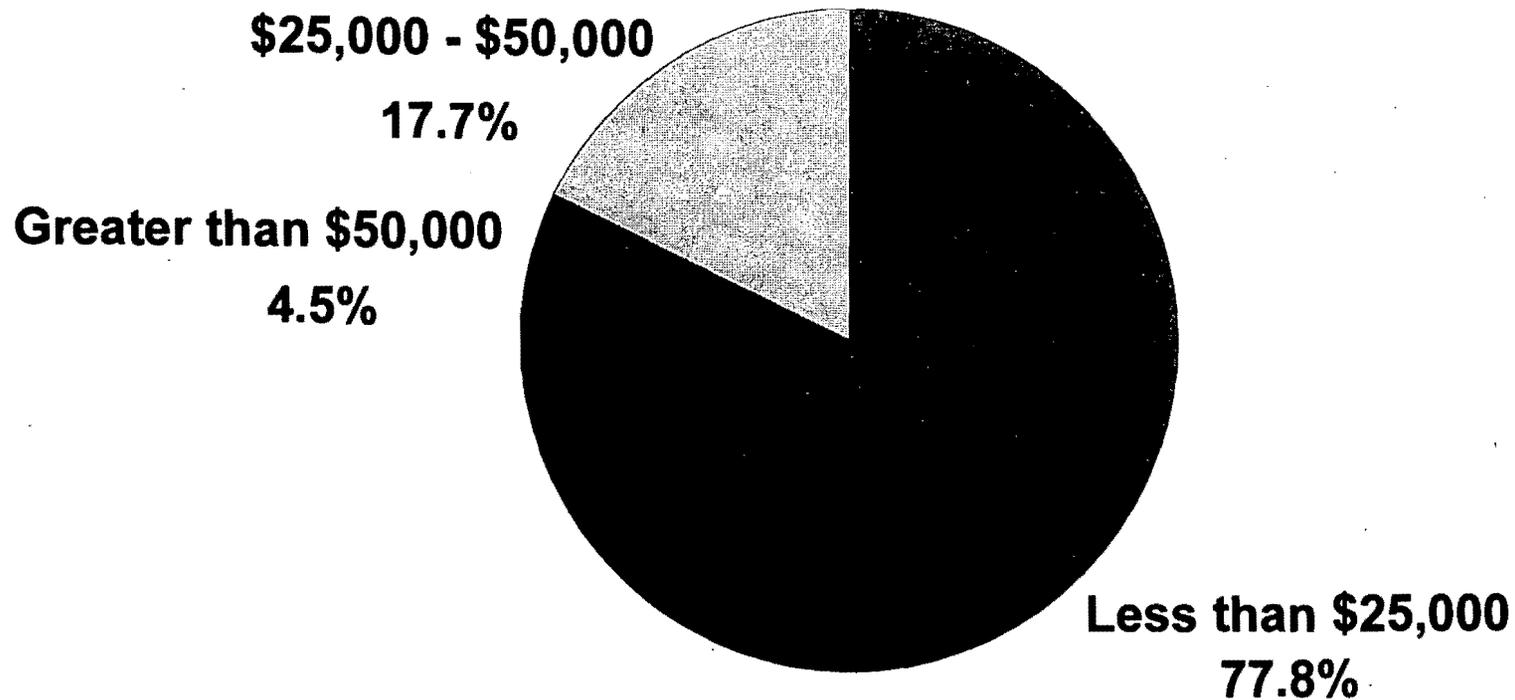
Source: HCFA/OACT and CRS, "Costs and Effects of Extending Health Insurance, 1988"

## The Composition of the Medicare Population Elderly, Disabled and ESRD, 1992



**Total Beneficiaries = 35.6 Million**

# Medicare Beneficiaries' Income Distribution in 1992

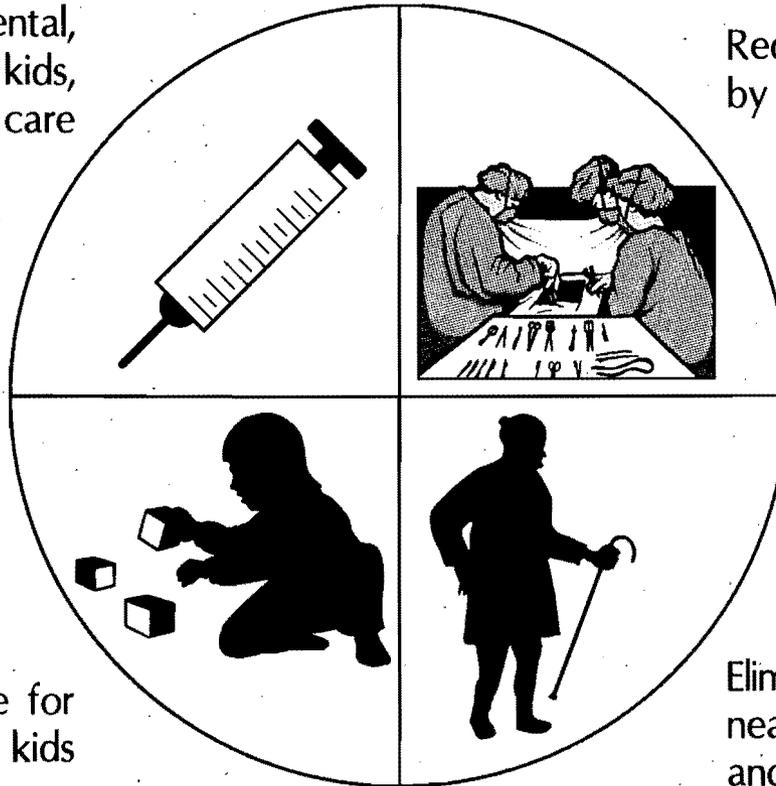


HCFA/OAct: Medicare Current Beneficiary Survey

# Medicaid Cuts That States Would Be Forced to Make

2002

Eliminate coverage for dental,  
screening services for kids,  
and hospice and home care



Reduce provider payments  
by almost \$13 billion

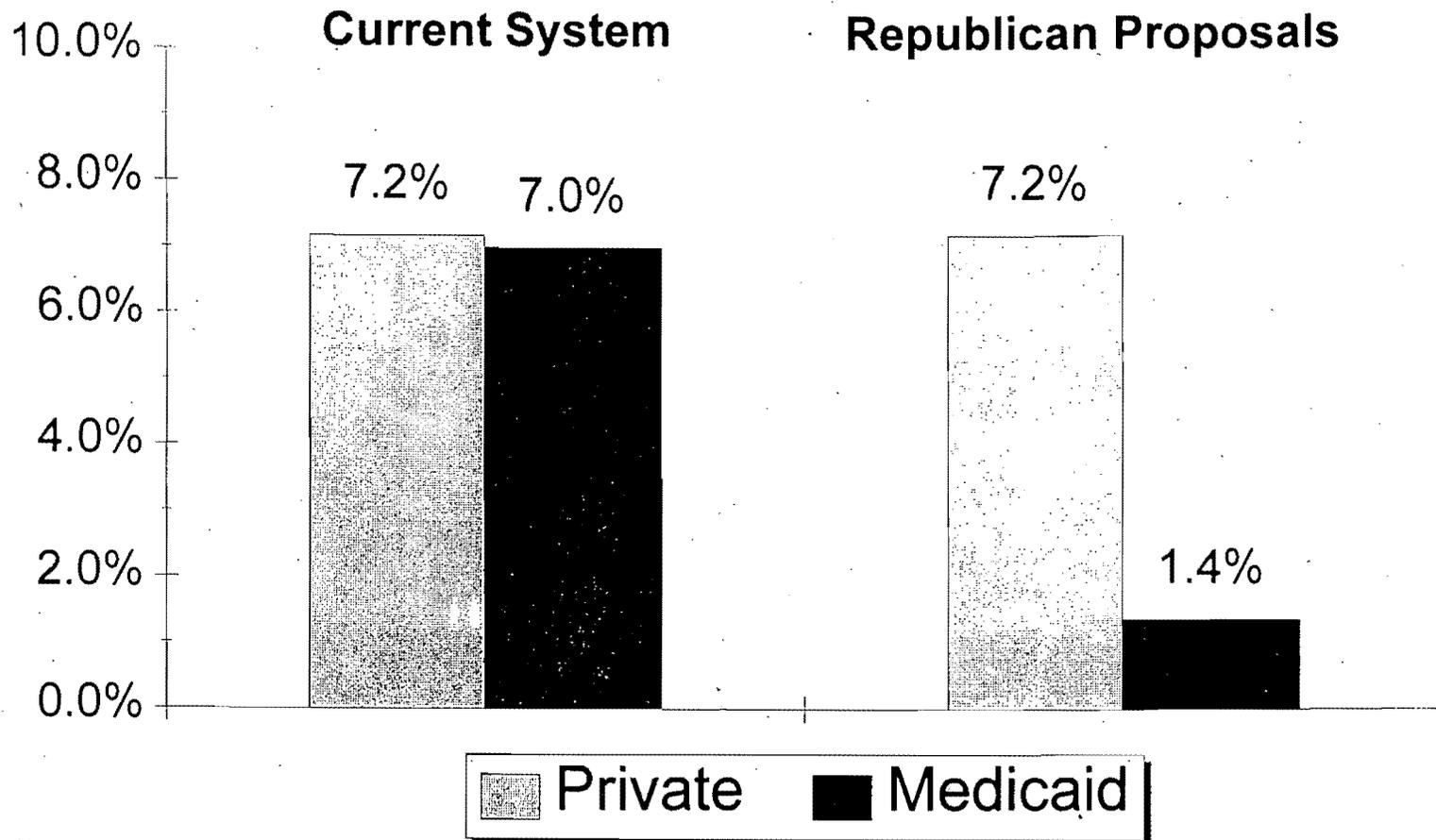
Eliminate coverage for  
7 million kids

Eliminate coverage for  
nearly one million elderly  
and persons with disabilities

*NOTE: Assuming 25% cut in each of these categories.*

# Per Capita Growth Rates

## Private & Medicaid, 1996 - 2002

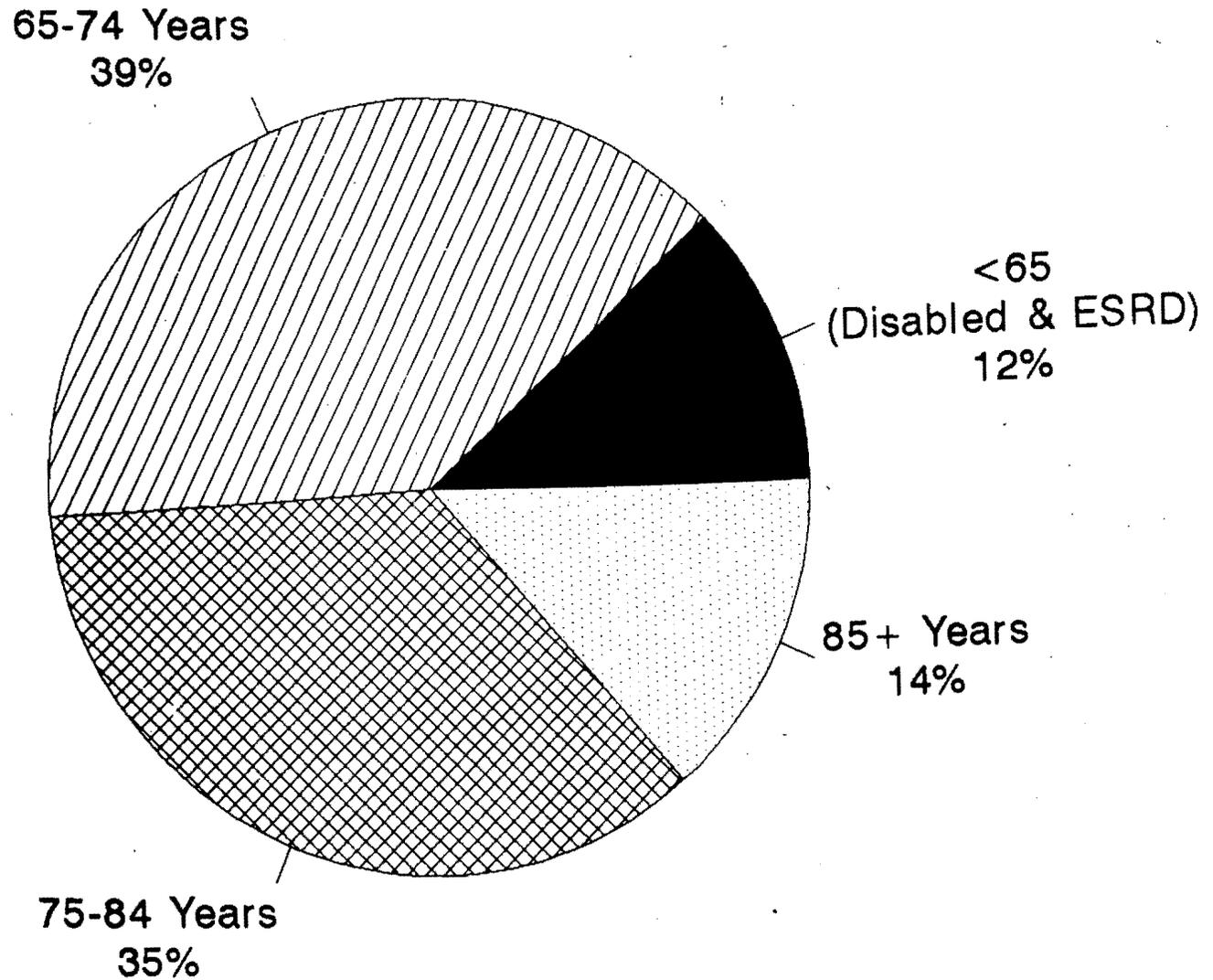


Source:

CBO Baseline, Calendar Years

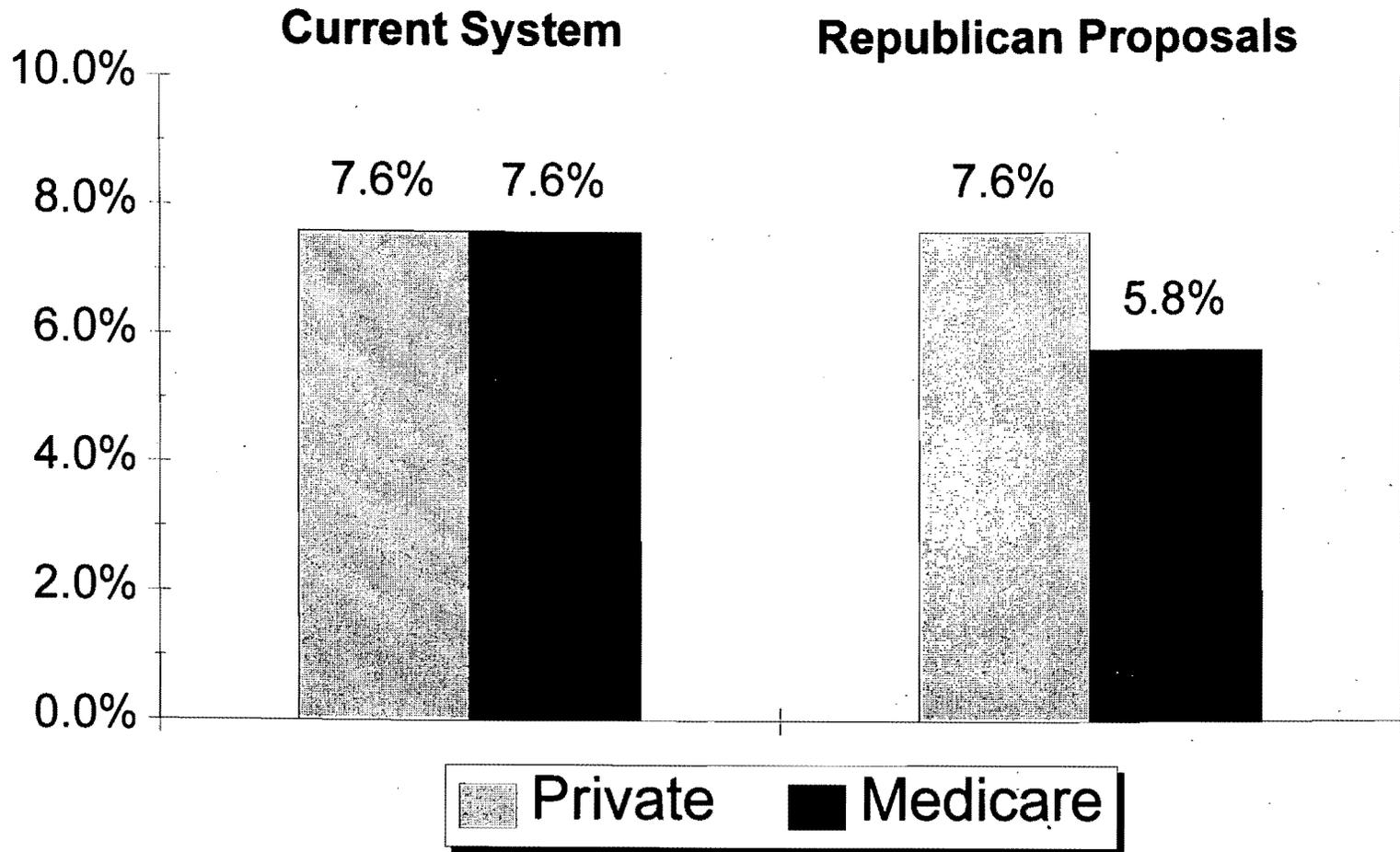
# Distribution of Medicare Program Payments, 1992

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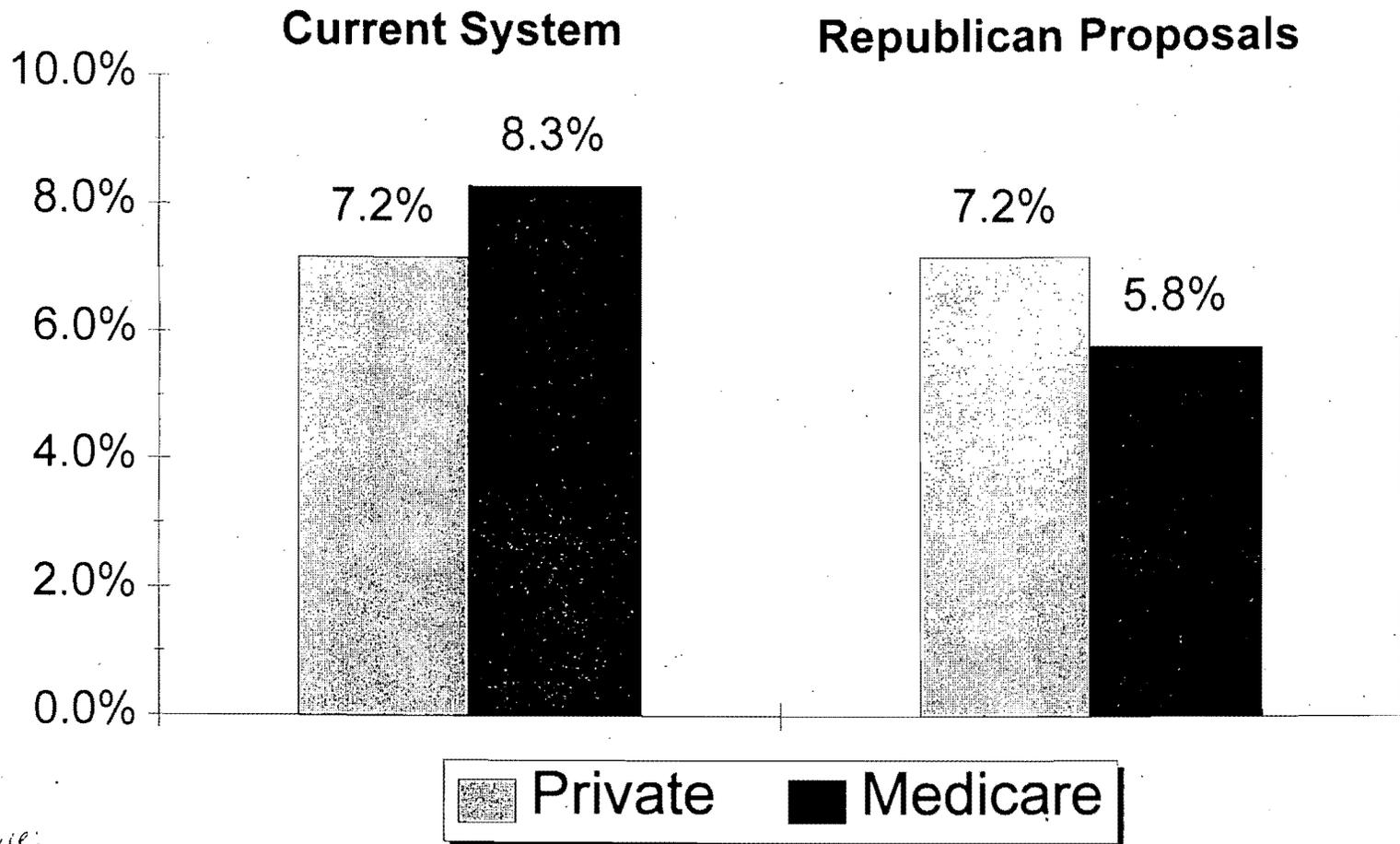
Total Payments = \$120.7 Billion

# Per Capita Growth Rates Private & Medicare, 1996 - 2002



Administration Baseline, Calendar Years

# Per Capita Growth Rates Private & Medicare, 1996 - 2002



Source:

CBO Baseline, Calendar Years



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

Congressional Budget Office  
House Republican Medicare File

June E. O'Neill  
Director

October 18, 1995

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

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2485, the Medicare Preservation Act of 1995, as introduced on October 17, 1995.

The table shows the budgetary effects of the bill over the 1996-2002 period. CBO understands that the Committee on the Budget will be responsible for interpreting how savings contained in this proposal measure against the budget resolution reconciliation instructions. The estimate assumes that the bill will be enacted by November 15 and could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

A handwritten signature in cursive script that reads "June E. O'Neill".  
June E. O'Neill

Enclosure

cc: Honorable Sam Gibbons  
Ranking Minority Member

# CONGRESSIONAL BUDGET OFFICE

## COST ESTIMATE

1. BILL NUMBER: H.R. 2485
2. BILL TITLE: Medicare Preservation Act of 1995
3. BILL STATUS: As introduced on October 17, 1995
4. BILL PURPOSE:

The bill would provide for the establishment of MedicarePlus plans, reduce payment rates to certain health care providers, increase certain payments required of beneficiaries, take steps to reduce fraud and abuse, and make other changes to reduce the growth of Medicare spending and extend the solvency of the Hospital Insurance trust fund.

Medicare beneficiaries would be given the option of enrolling in the existing fee-for-service (FFS) Medicare program or enrolling in a MedicarePlus plan. MedicarePlus plans would include health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), high-deductible insurance plans operated in conjunction with a medical savings account (MSA), and union or association-sponsored health plans, as well as traditional indemnity insurance plans. Medicare would make a specified payment to a MedicarePlus plan for each beneficiary enrolling in the plan. The proposal would modify the way Medicare sets payment amounts for risk-based plans and sever the link to costs in the fee-for-service sector. Beneficiaries would be liable for any premium charged by the plan in excess of Medicare's payment, but they would receive a credit or refund if their plan charged less than Medicare paid. The Secretary of Health and Human Services (HHS) would establish an annual open enrollment period for MedicarePlus plans and would provide enrollees with comparative information about the options available to them.

Payments to doctors, hospitals, and other providers of health care services would be scaled back from the levels anticipated under current law. The proposal would reduce projected payment rates for physicians' services, inpatient and outpatient hospital services, hospitals' cost of capital, disproportionate share hospitals, clinical laboratory services, hospice services, and durable medical equipment. The proposal would also establish new methods for paying for nursing homes and home health services.

Medicare beneficiaries would be required to pay higher premiums. The premium for Supplementary Medical Insurance (SMI, or Medicare Part B) would be set to cover 31.5 percent of program costs in future years, as it is now, instead being allowed to decline as a share of spending, as would be the case under current law. Single people with income over \$75,000 and couples with income over \$125,000 would also be charged an additional supplemental premium. The growth of premiums would be slowed somewhat, however, by provisions that reduced the rate of growth of program costs.

Steps would be taken to reduce health care fraud and abuse. Mandatory appropriations would be established for Medicare's payment safeguard activities and for the enforcement activities of the HHS Inspector General, and the levels of spending would be increased. Civil monetary penalties for health care offenses would be doubled. At the same time, the bill would loosen antikickback and antitrust provisions and rules against physician self-referrals.

In addition to the specific policies outlined above, the bill would establish a failsafe budget mechanism to assure that total spending for benefits in fee-for-service Medicare would not exceed specified amounts. Using the procedure specified in the bill, the Secretary would reduce payment rates to health care providers in an amount sufficient to assure that the targets would be met.

The bill would also establish a new trust fund to pay for graduate medical education. The trust fund would receive payments from Medicare, as well as a mandatory appropriation from general revenues.

#### 5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

CBO projects that under current law spending for Medicare benefits would grow at annual rate of 9.9 percent from 1995 to 2002. The bill would slow the rate of growth to 7.1 percent a year. Table 1 summarizes the effects of the bill on the federal budget.

Table 1. BUDGETARY IMPACT OF H.R. 2485  
(By fiscal year, in billions of dollars)

	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
CURRENT LAW								
Benefit Payments a/	178.1	199.0	219.4	240.4	263.4	288.0	315.1	345.1
Flat-Rate Premiums	<u>-20.1</u>	<u>-20.3</u>	<u>-21.9</u>	<u>-24.4</u>	<u>-26.0</u>	<u>-27.2</u>	<u>-28.5</u>	<u>-29.9</u>
Total, Medicare	158.1	178.8	197.5	216.0	237.4	260.8	286.6	315.3
H.R. 2485								
Benefit Payments a/ b/	178.1	194.3	208.7	217.3	228.1	246.5	265.6	288.0
Flat-Rate Premiums b/	-20.1	-23.4	-26.0	-27.4	-29.4	-33.5	-37.2	-42.0
Income-Related Premiums	<u>0</u>	<u>0</u>	<u>-0.3</u>	<u>-0.7</u>	<u>-1.1</u>	<u>-1.4</u>	<u>-1.7</u>	<u>-2.0</u>
Subtotal, Medicare	158.1	170.9	182.4	189.1	197.5	211.6	226.7	244.0
Graduate Medical Education	<u>0</u>	<u>0</u>	<u>1.3</u>	<u>1.5</u>	<u>2.3</u>	<u>3.1</u>	<u>3.6</u>	<u>4.0</u>
Total	158.1	170.9	183.7	190.6	199.8	214.7	230.3	248.0
DIFFERENCE								
Benefit Payments a/ b/	0	-4.7	-10.7	-23.1	-35.3	-41.5	-49.5	-57.1
Flat-Rate Premiums b/	0	-3.2	-4.2	-3.0	-3.5	-6.2	-8.7	-12.1
Income-Related Premiums	<u>0</u>	<u>0</u>	<u>-0.3</u>	<u>-0.7</u>	<u>-1.1</u>	<u>-1.4</u>	<u>-1.7</u>	<u>-2.0</u>
Subtotal, Medicare	0	-7.9	-15.1	-26.9	-39.9	-49.2	-59.9	-71.3
Graduate Medical Education	<u>0</u>	<u>0</u>	<u>1.3</u>	<u>1.5</u>	<u>2.3</u>	<u>3.1</u>	<u>3.6</u>	<u>4.0</u>
Total	0	-7.9	-13.8	-25.4	-37.6	-46.1	-56.3	-67.3

a. Includes mandatory administrative costs.

b. Includes estimated effects of failsafe mechanism.

Compared to spending projected under current law, the bill would reduce outlays by \$7.9 billion in fiscal year 1996, \$13.8 billion in 1997, and \$67.3 billion in 2002. Over the 1996-2002 period, the bill would reduce Medicare spending by \$270.2 billion, provide for mandatory appropriations of \$15.8 billion to the graduate medical education trust fund, and achieve net savings of \$254.5 billion.

The seven-year savings in Medicare would be distributed as follows:

- o \$146.8 billion from specified reductions in scheduled payments to doctors, hospitals, and other providers of health care.
- o \$47.1 billion from increasing Medicare's monthly premium for all beneficiaries.
- o \$7.3 billion from imposing a supplemental premium on high-income beneficiaries.
- o \$1.4 billion from proposals to reduce fraud and abuse, provide regulatory relief, and limit awards for medical malpractice.
- o \$34.2 billion from allowing beneficiaries to enroll in MedicarePlus plans and changing the formula for reimbursing capitated plans.
- o \$33.4 billion in additional reductions in payments to providers required by the failsafe mechanism.

#### 6. BASIS OF ESTIMATE:

CBO's estimate of the effects of the bill reflects the economic and technical assumptions underlying the baseline used for the 1996 budget resolution. The estimate was prepared in three steps:

- (1) Estimate the savings from reducing reimbursements to health care providers, increasing payments by beneficiaries, and curtailing fraud and abuse, as specified in the bill. For this step only, we assume that the enrollment of Medicare beneficiaries in HMOs and other capitated plans would increase at the rates projected under current law.
- (2) Estimate the savings associated with establishing the MedicarePlus program. Substantial savings would stem from reducing the rate of growth of payments

to capitated plans, even assuming the enrollment levels projected under current law. Providing additional options for beneficiaries would cause enrollment in capitated plans to rise more rapidly, however, and would generate further savings. Medicare's costs would rise for beneficiaries who choose an MSA plan.

- (3) To the extent that the first two steps do not reduce projected spending on benefits to the target levels specified in the bill, estimate the additional savings that would be required by the failsafe mechanism.

The following paragraphs provide further details on the estimating process and the most important assumptions. Table 2 (attached) shows the budgetary effects of the major provisions of the bill.

#### Lower Growth of Reimbursements to Providers

Projections of Medicare payments to fee-for-service providers reflect changes in the number of beneficiaries, changes in their use of medical care services, and changes in the prices the federal government pays for those services. Many of the provisions of the bill would reduce reimbursements to providers by modifying the third factor cited. To estimate the savings from these policies, CBO compared the rate of increase in payments proposed in the bill with the rate of increase projected under current law. For example, hospital payments per admission would increase 2.5 percentage points less in 1996 than under current law and 2 percentage points less each year thereafter. The estimated savings from this provision equals the change in the payment per admission times the projected number of admissions, assuming no change in the number of FFS beneficiaries and adjusting for the effects of behavioral responses by providers.

Inpatient Hospital Capital. The bill would reduce reimbursements to hospitals paid under the prospective payment system (PPS) for their inpatient capital-related costs and would change the distribution of capital payments.

The bill would reduce the basic rates of payment. During the transition to a fully prospective payment system for capital spending, payments are determined by a complicated method based on a number of factors, including federal and hospital-specific payment rates. These rates are increased annually. Recent data suggest that the initial federal and hospital-specific rates were overestimated. The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) reduced the federal rate by 7.4 percent. H.R.2485 would further reduce the unadjusted standard federal capital

payment rate by 7.47 percent and would reduce the unadjusted hospital-specific rate by 8.27 percent.

In addition, the bill would require the Secretary to set payments to achieve an aggregate reduction of 15 percent in spending for inpatient hospital capital, compared to what would have been spent under the old reasonable cost system. CBO has assumed that this provision and the reduction in basic payment rates would be additive; that is, after reducing the federal and hospital-specific payment rates, aggregate payments would be reduced by an additional 15 percent. Officials of the Health Care Financing Administration (HCFA) have expressed concern that this assumption may overstate savings, because it becomes increasingly difficult each year to determine what would have been paid under the reasonable cost system.

Treatment of property taxes would be modified in a budget neutral manner. Although only one-quarter of PPS hospitals pay property taxes, those costs are currently reflected in the federal capital rate paid to all hospitals. The proposed change would remove property tax costs from the federal capital rate and establish a property tax add-on for hospitals that pay property taxes, primarily proprietary hospitals. According to one estimate, this provision would redistribute about \$57 million in spending each year.

Graduate Medical Education. The proposal would reduce Medicare's payments for both the direct and indirect costs of medical education. Under current law, direct medical education (DME) payments to a teaching hospital are based on Medicare's share of the hospital's inpatient days, the direct costs per medical resident that the hospital incurred during a year in the mid-1980s (generally updated for inflation), and the number of residents training at the hospital. The proposal would allow consortia of providers to receive payments, freeze the number of residents that could be counted for payments, reduce payments for noncitizens (except Canadians) other than permanent residents or refugees, and eliminate payments for board-eligible residents and those past their fifth year of residency training. These changes would reduce Medicare outlays by \$2.0 billion over the 1996-2002 period.

Indirect medical education (IME) payments to a teaching hospital are calculated as an adjustment to the payments that Medicare makes to a hospital for inpatient services. Under current law, a hospital receives approximately 7.7 percent more in payments for each 0.1 increase in the resident-to-bed ratio. The proposal would reduce this factor in two steps to 5.6 percent for each 0.1 increase in the resident-to-bed ratio by 2000. This change would save \$6.6 billion over seven years.

The proposal would establish a graduate medical education trust fund to make annual

distributions to teaching hospitals. The trust fund would receive money from two sources: Medicare's DME and IME payments (as outlined above) and a separate mandatory appropriation from general revenues. The bill specifies mandatory appropriations of \$15.8 billion over the 1997-2002 period.

Skilled Nursing Facilities. Under current law, skilled nursing facilities (SNFs) are reimbursed for routine services (nursing, room and board, administrative costs, and other overhead) on the basis of reasonable costs. Routine costs are subject to per diem cost limits, which are calculated separately for free-standing and hospital-based SNFs by urban and rural area and are updated annually. OBRA-93, however, froze the routine cost limits for 1994 and 1995. Nonroutine, or ancillary, services and capital payments are excluded from the costs limits and are paid on the basis of reasonable cost. The proposal would reduce all three types of SNF costs--routine, non-routine, and capital--and would save \$10.0 billion over the 1996-2002 period.

The proposal would maintain the savings from the temporary freeze on cost limits for routine care included in OBRA-93 and change the definition of routine costs to include a number of items (including supplies) that would now be subject to the cost limits.

The primary source of growth in SNF expenditures has been increases in nonroutine costs, especially therapy services. Beginning in fiscal year 1997, the bill would subject nonroutine costs to new limits based on 1994 costs inflated to 1997 and updated annually thereafter by the growth in the price of the SNF market basket (a representative sample of items purchased by nursing homes) less 2 percent. This procedure would generate savings by ignoring all increases in utilization from 1994 through 1997. Facilities would receive payments for ancillary services based on a blended limit that averages facility specific costs and national average costs of ancillary services per stay. Nursing homes that have aggregate nonroutine costs per stay below the blended payment would keep 50 percent of the savings up to 5 percent of aggregate Medicare payments per facility.

Capital costs would be reduced by 15 percent. CBO estimates that capital represents approximately 10 percent of all SNF expenditures. Under current law, the Secretary is authorized to provide for exceptions to the cost limits based on the case mix of certain facilities. The proposal would limit these exceptions to 5 percent of total nonroutine payments each year.

Physicians' Fees. The fees that Medicare pays for physician services are set by a complicated set of formulas based on trends in practice costs, utilization, and other factors. The formulas generally attempt to reward physicians as a group for low

growth of physician spending by raising their fees in subsequent years and to penalize rapid growth of spending by cutting future fees. For example, as a result of slower than expected spending growth in 1992 and 1993, physician fees were raised by 7 percent in 1994 and 1995.

This bill would simplify the setting of physician fees. In general, fees would be set such that overall physician spending would grow by about 2 percentage points faster than GDP. By comparing actual spending with a cumulative target, and by increasing the range over which the Secretary could adjust fees to meet that target, the new formulas would better ensure that spending remains on track. Because the new spending targets would be lower than CBO's projections of physician spending under current law, this provision would save \$26.1 billion in the 1996-2002 period.

Medicare's payments to physicians are based on a conversion factor, which averages about \$36.15 in 1995. Because CBO assumes that physician spending will grow rapidly under current law, the conversion factor is projected to decline to about \$33.50 in 2002. Under this bill, with more stringent controls on expenditures, the Medicare conversion factor for physician fees would decline somewhat more rapidly, to about \$26.00 in 2002.

Clinical Laboratories. H.R. 2485 would freeze payment rates for services of clinical laboratories through 2002 and reduce the national ceiling on payment amounts by about 10 percent in 1997. The bill would also remove certain quality standards for laboratory tests performed in physicians' offices and regulate how private insurance plans could pay for laboratory services and how providers could bill for them.

The fee controls account for virtually all of the estimated \$6 billion in cumulative savings from these proposals. CBO assumes that, in reaction to reductions in fees, the number of laboratory services billed to Medicare would increase. CBO and HCFA both assume a volume offset of 50 percent for laboratory services when fees are reduced.

Although loosening quality standards may encourage doctors to provide more in-office laboratory tests and cause a net increase in the number of tests performed, CBO assumes that the cost of this provision would be negligible. Similarly, the provision on private contracting for laboratory services would have little direct impact on Medicare, and its impact on private plans would not be large enough to discourage enrollment of Medicare beneficiaries in those plans.

Home Health Services. Under current law, home health agencies (HHAs) are paid for each visit on a retrospective cost basis up to a limit. The overall cost limit is set at

112 percent of the mean costs of all free-standing HHAs and is updated annually by the increase in the cost of the home health market basket (a representative sample of goods and services purchased by home health agencies). Agencies are paid the lower of their actual costs or the aggregate cost limit. The current system provides no incentive for agencies below the cost limits to control costs, and there are no limits on utilization. Home health expenditures, visits, and users have all been increasing rapidly in recent years, and expenditures are expected to grow at an average annual rate of about 11 percent between now and 2002.

The proposal would set up a prospective payment system for home health services based on per episode limits for 18 different categories of home health care. The episode limits would be calculated for home health agencies by region. The limits would be updated annually by the increase in the cost of the home health market basket less 2 percent. Each agency would be given a target based on the agency's number of episodes multiplied by the regional limit per episode. Agencies that held aggregate costs below their target would be able to share 50 percent of the savings up to 5 percent of the agency's Medicare payments in that year. The regional episode payment limits would be calculated based on the average costs incurred by agencies for care during the 120 days following admission of a beneficiary to home health. If a beneficiary continued to need home health visits after 120 days, the agency would be responsible for providing care through the 165th day. Upon certification by a physician that additional services are required, visits provided after 165 days would be paid on a per visit basis. The proposal would also maintain the savings from the temporary freeze on payment increases on home health services from OBRA-93.

The proposal would save an estimated \$17.3 billion over seven years. It would have two main effects. First, the proposal would limit the growth in the number of home health visits per user (termed intensity of use). Since a home health agency's target would be based on visits per episode in 1994, an agency would have no incentive to continue to increase the number of visits per user. Second, Medicare would not be responsible for paying for home health visits for the 121st through 165th days of an episode. These visits represent approximately 7 percent of all home health visits under current law.

Under current law, the number of users and the intensity of use are both increasing rapidly. Although the proposal would limit the growth of intensity, CBO assumes that some of these savings would be offset by efforts of home health agencies to increase the number of users. The amount of this and other behavioral offsets would be limited by provisions such as rebasing per visit rates every 5 years, rebasing per episode rates every 2 years, requiring physician certification for an individual to receive more than 165 home health visits, periodic medical review by an

intermediary, extending the start of a new episode from 45 to 60 days, tracking patients who receive services from more than one agency, and profiling short stay patients.

Increasing Payments by Beneficiaries

The proposal would not increase copayments or deductibles for participants in fee-for-service Medicare. It would, however, increase the portion of the cost of Supplementary Medical Insurance borne by beneficiaries through premiums relative to current law. In addition, high-income people would be required to pay a supplementary premium.

Flat-Rate Premium. At present, according to HCFA estimates, premiums cover 31.5 percent of costs for Medicare Part B. Under current law, the premium is to cover 25 percent of costs in 1996 through 1998. Thereafter, the premium is to increase by the rate of the cost-of-living adjustment for Social Security and will fall as a share of program costs. The proposal would permanently set the premium to cover 31.5 percent of program costs.

The following table shows CBO's projections of monthly flat-rate premiums under current law, the proposal excluding the failsafe, and the proposal including the failsafe (by calendar year, in dollars):

<u>Calendar Year</u>	<u>Current Law</u>	<u>Proposal without Failsafe</u>	<u>Proposal including Failsafe</u>
1996	43.70	53.50	53.50
1997	48.20	57.60	56.90
1998	53.20	61.90	59.40
1999	55.00	67.00	63.80
2000	56.80	74.90	72.10
2001	58.60	81.40	78.90
2002	60.50	90.30	87.60

Income-Related Premium. Section 15612 would establish an additional SMI premium for higher income Medicare enrollees. The maximum premium would be set so that the sum of the flat-rate premium and the supplemental premium would equal the average monthly costs of an aged SMI enrollee. Single enrollees and married enrollees would be subject to the maximum premium if their modified adjusted gross

income exceeded \$100,000 and \$175,000, respectively. Enrollees with income between \$75,000 and \$100,000 for singles and between \$125,000 and \$175,000 for married persons would pay prorated increases. The additional premiums are estimated to total \$0.3 billion in 1997 and \$2.0 billion in 2002.

Because previous proposals to impose income-related premiums would have been administered through the income tax system, they were treated by CBO and the Joint Committee on Taxation as increases in governmental receipts. The income-related premiums in this bill would be administered by the Health Care Financing Administration, however, and are shown as offsetting receipts, or reductions to outlays. Although HCFA would have limited access to Internal Revenue Service (IRS) tax information for verification purposes, the IRS would have no direct role in enforcing the provision.

Without recourse to the income tax system, the federal government would not be able to collect all of the potential increase in premiums. Some loss in premium collections would result from lags in applying tax return information. Also, some enrollees would shift income from one year to another in order to minimize their additional premium liability. Ultimately, CBO assumes that 90 percent of the potential additional premiums under this provision will be collected. In 1997, while the new system is being implemented, the collection rate is assumed to be only 50 percent.

#### Limiting Fraud and Abuse

The proposal includes several proposals to limit fraud and abuse in Medicare.

Payment Safeguards and Enforcement. The proposal would establish mandatory appropriations for HCFA payment safeguards and for the antifraud activities of the HHS Inspector General (IG) and would increase the amount of real resources devoted to those two activities. After a few years, reduced Medicare spending and additional fines and penalties would more than offset the added administrative costs. Over the 1996-2002 period, the net savings would total \$2.4 billion.

The scorekeeping rules included in the conference report on OBRA-93 preclude attributing changes in mandatory spending to changes in discretionary funding for program administration. That prohibition does not apply to these proposals, however, because they would establish long-term mandatory appropriations to cover all of the payment safeguard and enforcement activities of HCFA and the IG. Both the base amounts and the additional resources would be earmarked for the designated purposes and could not be reallocated for other activities.

CBO's estimate attributes savings only to the projected increase in resources, not to the base level itself. The estimate assumes that HCFA and the IG could productively use only a limited amount of additional resources each year, and that additional resources will be subject to diminishing marginal returns. Based on studies by the General Accounting Office and HCFA, the estimate assumes that an additional dollar devoted to HCFA payment safeguard activities will at first return eight dollars in lower benefit payments. Data from the IG indicate that an additional dollar devoted to its enforcement efforts will initially return seven dollars in recoveries. The estimate assumes that the marginal benefit-to-cost ratio in each case will decline to less than four-to-one by 2002. If this proposal is adopted, CBO expects that the savings would be documented and subject to independent audit. These documented savings would then be used to make any estimates of new proposals and provide a basis for updating projections of spending under current law.

Civil Monetary Penalties. The bill would double civil monetary penalties for health care fraud. Based on an analysis of the recoveries generated by the HHS Inspector General's current caseload, CBO estimates that this provision would generate \$0.3 billion in added penalties over the 1996-2002 period.

Other Provisions. The bill would make certain offenses involving health care fraud subject to provisions of criminal law. Based on conversations with officials of the Department of Justice, CBO assumes that those provisions would modestly increase successful prosecutions and result in the recovery of \$46 million in fraudulent Medicare payments over the next seven years

In addition, the bill would establish a hotline and provide incentives for beneficiaries to report suspected fraud in Medicare. Based on an examination of a similar program operated by the Department of Defense, CBO estimates that this program would produce \$43 million in additional recoveries from 1996 through 2002.

### Regulatory Relief

The bill would relax prohibitions on physician self-referral, add exceptions to antikickback rules, provide for advisory opinions by HHS on the interpretation of certain regulations, exempt medical self-regulatory bodies from antitrust laws, and limit awards for medical malpractice.

Physician Self-Referral. This provision would substantially revise the list of health services subject to the ban on physician self-referral. It would also institute several exceptions to the ban, including removing the ban in instances in which the referring

physician or an immediate family member has a compensation arrangement with an entity providing designated health services.

For some services, lifting the ban on physician self-referral would have no budgetary impact, either because Medicare spends no money on the service or because studies indicate that physician ownership has no effect on referrals. For services such as in-office laboratory services, ultrasound, X-rays, nuclear medicine, comprehensive outpatient rehabilitation, radiation therapy, and home health spending, however, allowing physician self-referrals is likely to increase the volume of services provided. CBO estimates that this provision would cost \$0.4 billion over the 1996-2002 period.

Adding exceptions to the ban would also result in additional costs to the federal government, but CBO is unable to estimate those costs at this time.

Other Regulatory Relief. Other provisions would require the HHS Inspector General to prove that a provider knowingly submitted false Medicare claims before civil monetary penalties could be imposed, provide additional exceptions to the antikickback statute for risk-sharing arrangements, and require the IG to issue binding advisory opinions to providers on whether proposed remuneration devices would violate the antikickback statute. The Inspector General has stated that enactment of these provisions would have a chilling effect on prosecutions. CBO's estimate reflects a gradual loss of recoveries generated from the prosecution of fraudulent claims and kickback schemes.

Physician Self-Policing. The bill would exempt from antitrust laws activities of medical self-regulatory bodies pertaining to standard setting and enforcement, if those activities are intended to promote the quality of patient care. Two types of activities would remain prohibited: those conducted for financial gain and those interfering with the provision of care by providers who are not members of the profession subject to the authority of the self-regulatory body.

This provision would give the federal government the burden of proving that medical self-regulatory bodies were engaging in antitrust activities. Meeting this additional burden of proof would increase the cost of prosecuting antitrust cases and reduce the likelihood of conviction. As a result, some self-regulatory entities would be able to engage in additional activities that would increase the cost of health care. CBO estimates that these activities would increase the annual growth of Medicare costs in the fee-for-service sector by 0.001 percent. This accelerated rate of growth would cost \$2 million in 1996, \$14 million in 2002, and \$43 million over the 1996-2002 period. The impact on MedicarePlus plans would probably not be substantial enough to discourage enrollment of Medicare beneficiaries in those plans.

Medical Liability Reform. The bill would limit to \$250,000 the amount of noneconomic damages that could be awarded in cases of medical malpractice. As a result, because this limit is more stringent than those currently established by states, CBO assumes that premiums for malpractice insurance would grow by about 1 percentage point less a year. The Medicare economic index, which is used to update physicians' fees, would in turn increase about 0.05 percentage points less rapidly each year, and Medicare's spending on physicians services would be about \$200 million less over seven years than under current law.

### Expanding Medicare's Capitated Sector

Under current law, CBO's projections assume a doubling of the share of Medicare beneficiaries in risk-based capitated plans--from 7 percent in 1995 to 14 percent in 2002. This growth is expected for two main reasons. First, each year a larger share of newly eligible beneficiaries will have had experience with managed care plans during their working years. Second, capitated plans often provide enrollees with benefits beyond the basic Medicare package with little or no supplemental premium charge. In 1995, for example, plans expected to return nearly 16 percent, on average, of the capitation amounts they received from Medicare to enrollees through additional premium-free benefits.

The bill would alter Medicare in ways intended to encourage more plans and more beneficiaries to participate in its capitated sector, called MedicarePlus. Options in the Plus sector would be expanded to include the whole range now available to privately insured people--including both closed- and open-panel HMOs, preferred provider organizations, fee-for-service indemnity plans, and high-deductible plans.

Enrollees in high-deductible plans would be required to maintain a medical savings account into which Medicare's contributions in excess of the premium would be deposited. MSA contributions would not be made for enrollees in other Medicare plans. Other Plus enrollees could use any excess from their capitation rate to purchase additional benefits or receive a nontaxable cash rebate up to the amount of the Part B premium.

CBO's estimate assumes that over seven years the bill would significantly increase the share of beneficiaries choosing a plan in Medicare's capitated sector. That share is expected to reach about 25 percent by 2002. About 23 percent of all Medicare beneficiaries would be in low-deductible Plus plans, and 2 percent would be in high-deductible plans.

Savings for the MedicarePlus provisions would occur for two reasons. First, even if the share of beneficiaries choosing risk-based plans did not change, the bill would reduce Medicare's spending because it would set lower capitation rates than are projected under current law. Second, the expected increase in the share of Medicare beneficiaries who would choose low-deductible risk-based plans would further reduce Medicare's costs because the bill's new capitation rates would be lower than the average amount Medicare would have spent in the fee-for-service sector for those Plus enrollees. Those savings would be partially offset, however, by the increase in Medicare's costs that would occur for enrollees who chose a high-deductible plan.

Recent studies suggest that higher risk-based enrollment might also generate savings through spillover effects for Medicare's fee-for-service sector. CBO's estimate assumed that such effects would enable the fee-for-service sector to absorb the bill's fee-for-service payment reductions with fewer adverse effects on access to and quality of care.

To estimate the effects of expanding Medicare's capitated sector, CBO had to predict responses by beneficiaries to options not previously available to them. It is also uncertain how well the methods Medicare would use to adjust its capitation payments to Plus plans would compensate for the risk segmentation among plans that might occur. If risk adjusters were inadequate, inefficient plans that experienced favorable selection could prosper, while efficient plans with adverse selection could fail. The estimate assumes that Medicare's risk adjusters would not fully compensate for selection, but they would be adequate to assure the orderly development of the MedicarePlus sector and the continued viability of Medicare's fee-for-service sector.

Savings from Lower Capitation Rates for Risk-Based Enrollees. Currently, Medicare's capitation payments to risk-based plans are linked to fee-for-service costs because Medicare pays these plans 95 percent of its estimated average cost for comparable beneficiaries in the fee-for-service sector. Because of this linkage, amounts paid by Medicare for each risk-based enrollee increase at about the same rate as amounts paid by Medicare for each enrollee in the fee-for-service sector.

The bill would introduce a new mechanism for updating capitation rates that would sever the link to growth in per capita costs in the fee-for-service sector. Current-law area-specific capitation rates for 1995 would serve as the base for future updates. For 1996 and later years, the average increase in these rates would be set in law, with annual growth rates averaging about 4.7 percent through 2002 and set at 5 percent thereafter. Differential rates of growth would apply to specific counties, which would be classified into one of 5 groups based on their utilization compared to the national average. High utilization counties would receive lower-than-average updates and vice

versa. As under current law, variation in fee-for-service costs among different enrollee groups (defined by age, sex, reason for entitlement, and other factors) would be used to adjust capitation payments to reflect the demographic mix of each plan's enrollees.

For risk-based enrollment projected under current law, estimated savings due to lower capitation rates are equal to the amount by which capitation rates would be lower under the bill, multiplied by the number of risk-based enrollees expected under current law each year. By 2002, for example, the average capitation rate would be about \$2,100 lower under the bill than projected under current law. Using this amount, multiplied by current-law projections of risk-based enrollment, yields savings of about \$10.9 billion for 2002. Over the 7 years from 1996 through 2002, savings would total an estimated \$33.6 billion.

Savings from Higher Enrollment in Low-Deductible Capitated Plans. A number of nonprice elements in the bill would accelerate enrollment growth in capitated plans, at least initially. More risk-based plans would be willing to participate because additional sponsors and organizational forms would be permitted, and because plans' marketing and enrollment costs for the Medicare population would be reduced by the government-sponsored open enrollment process. More beneficiaries would select a risk-based option instead of fee-for-service care partly because there would be more such plans and partly because a wider variety of options--perhaps better tailored to beneficiaries' preferences--could be offered. For example, open-panel or point-of-service plans that would permit risk-based enrollees occasionally to use out-of-plan providers might become more common. Some plans might offer enrollees only the basic Medicare package together with a rebate on the Part B premium, an option not currently available. As under current law, plans offering only the basic Medicare package would be prohibited from charging a supplemental premium for it.

Further, for the first time all beneficiaries would have comprehensive and timely comparative information about the Medicare options available to them (although relevant comparisons between the fee-for-service and Plus sectors might not exist because Medigap plans would apparently not be required to participate in the open enrollment process). The offerings of capitated plans would carry an implicit stamp of approval in this government-sponsored process, reducing the reluctance that some beneficiaries might feel to try an unfamiliar system. Medicare's constraints on payment rates for providers in the fee-for-service sector might induce some providers to serve Medicare beneficiaries only through Plus plans where Medicare's limitation on balance billing need not apply; beneficiaries wanting to stay with these physicians would then have to move to the Plus sector. Finally, if states used the new options they would have under the accompanying Medicaid bill to reduce coverage for

Medicare beneficiaries, more lower-income beneficiaries might opt for capitated plans in an effort to reduce or eliminate their out-of-pocket costs.

Competitive pressures would provide incentives for plans to manage care more efficiently, potentially limiting enrollees' exposure to rising out-of-pocket costs. At least in the near-term, most Plus enrollees in urban areas would probably be able to purchase a medigap-like package of additional benefits for a lower supplemental premium than they would have to pay for a medigap plan in the fee-for-service sector.

The savings associated with additional beneficiaries who would choose low-deductible risk-based plans were estimated by comparing how much they would have cost Medicare had they stayed in the fee-for-service sector with the capitation payments that would be made on their behalf in the Plus sector. Despite the significant increase in enrollment in capitated plans assumed by CBO, the estimated additional savings computed in this step of the calculation are relatively small. Indeed, once the lower payments to fee-for-service providers under the bill have been taken into account, there are relatively little additional savings associated with movement to capitated plans. In addition, the estimate assumed some favorable selection into the capitated sector, for which Medicare's risk adjusters would not fully compensate.

The additional 9 percent of beneficiaries expected to choose a low-deductible capitated plan by 2002 would generate savings of about \$5 billion over 7 years.

Costs from Enrollment in High-Deductible/MSA Plans. The bill would introduce a new MedicarePlus option--high-deductible insurance. Beneficiaries choosing a high-deductible plan would be required to maintain a qualifying medical savings account (MSA). Contributions to MSAs would be made by Medicare and would equal the excess, if any, of Medicare's capitation payment for the enrollee over the premium charged by the enrollee's high-deductible plan. Interest earned on MSA balances would not be taxable.

Enrollees could withdraw funds from their MSAs for any purpose, but withdrawals not used to pay for qualified medical expenses would be subject to income taxes. Further, enrollees in high-deductible plans who made nonqualified withdrawals during the year that would reduce their MSA balance carried over from the previous year below 60 percent of their current plan's high-deductible amount would be subject to a 50 percent penalty on the excess withdrawals. The bill does not specify whether persons no longer in a high-deductible plan would owe any penalty on nonqualified withdrawals. If not, people could disenroll from a high-deductible plan, withdraw all funds from their MSA account without penalty (although the funds would be taxable

as income), and then rejoin a high-deductible plan the following year. In addition, the bill would not require those who disenrolled from a high-deductible plan to repay remaining balances or refund amounts spent from their MSAs in earlier years for nonqualified expenses.

Like all Plus offerings, high-deductible plans would cover at least those services covered in Medicare's fee-for-service sector. High-deductible plans would pay no benefits until an enrollee's covered expenses had reached the plan's deductible amount, which could be as high as \$10,000. (Because no minimum deductible amount is specified in the bill, high-deductible plans could actually have very low--even zero--deductibles.)

High-deductible plans would be required, at a minimum, to reimburse for either the full costs of covered services above the deductible, or the full amount that would have been allowed by Medicare in the fee-for-service sector, whichever was less. Once they exceeded their plan's deductible amount, enrollees would still incur out-of-pocket expenses to the extent that their providers charged more than Medicare's allowed amounts.

Enrollees in high-deductible plans would not be permitted to count medigap premiums as a qualified medical expense from their MSA, although they could purchase those plans with other funds. Beneficiaries also in the Federal Employee Health Benefits plan would be ineligible for the high-deductible option.

High-deductible plans would tend to experience more favorable selection than would other Plus plans or the fee-for-service sector. In fact, the favorable selection into high-deductible plans could be very large under this bill because beneficiaries would be permitted to join or leave these plans during each open enrollment period, just as they could with other plans. Beneficiaries could take financial advantage of the system by choosing a high-deductible plan when they were healthy and moving to another Plus plan or the fee-for-service sector once they developed medical problems or wanted to schedule expensive non-emergency procedures, such as a hip replacement. The CBO estimate assumes that Medicare's risk adjusters would not fully compensate for this favorable selection into high-deductible plans and, as a result, enrollment in high-deductible plans would increase program costs.

CBO assumed that 1 percent of the eligible population would select the high-deductible option initially, and that the number would grow to 2 percent by 2002. With this level of participation, the high-deductible option would increase total program costs by about \$4 billion over 7 years.

Because there is no prior experience with this type of option for the Medicare population, it is difficult to estimate how many would choose high-deductible plans. If a large percentage of low-risk beneficiaries chose the high-deductible option, participation would be substantially higher than CBO has assumed, and the cost of this option would also be higher. This could trigger additional reductions in fee-for-service payment rates through the bill's failsafe provisions. The reductions might make the fee-for-service sector less attractive and encourage even greater participation in high-deductible or other Plus plans.

### Failsafe Mechanism

The bill incorporates a complex failsafe mechanism designed to ensure that expenditures on Medicare benefits in any year would not exceed the Medicare benefit budget specified for that year. The failsafe would operate both prospectively and retrospectively to control fee-for-service expenditures on a sector-by-sector basis. Expenditures in the MedicarePlus market would not be directly affected because they would be determined by the updates to capitation rates specified in the bill.

Overview of the Failsafe. Beginning in 1998, the overall limit for fee-for-service benefit expenditures for the year would equal the overall Medicare benefit budget less projected MedicarePlus expenditures. Specific limits would be established for each of nine fee-for-service sectors, or classes of service, according to an allocation formula specified in the bill. In any year, a sector's proportion of the fee-for-service budget would equal the proportion of total Medicare spending on that sector that CBO projected under current law in March 1995 for that year.

If the Secretary estimated that a sector's expenditures in the upcoming fiscal year would exceed its allocated amount, he would reduce payment rates in that sector for the fiscal year. The bill specifies that expenditures in the affected sector would be reduced by 133.3 percent of the excess amount, which reflects CBO's assessment that such a mechanism would be no more than 75 percent effective in constraining expenditures.

Beginning in 1999, the Secretary would estimate what the actual fee-for-service budget and spending limits for each sector should have been for the second preceding fiscal year, by taking into account actual MedicarePlus spending for that year. If actual spending for a sector had exceeded its limit, then the sector's allotment for the current fiscal year would be reduced accordingly. Conversely, if actual spending had been less than the limit, the current year's allotment would be increased by the corresponding amount. The bill would explicitly allow retrospective adjustments only

to sector allotments rather than payment rates. No provision would raise payment rates for sectors that experienced lower expenditure growth than was permitted under their allotment.

Effects of the Failsafe. CBO estimates that the failsafe mechanism would have to be used to meet the Medicare budget targets in the bill. The failsafe would reduce payments to providers by \$33.4 billion, net of premiums, over the 1996-2002 period. That amount represents the difference between the savings arising from all other policies in the bill and the aggregate savings target.

If a sector was projected to exceed its allotment, reductions in payment rates would occur regardless of whether fee-for-service expenditures overall were projected to exceed the fee-for-service expenditure target. Thus, under some circumstances, aggregate spending reductions could exceed the reductions necessary to achieve the target Medicare expenditures in the bill. CBO's estimate assumes that the failsafe would not reduce spending below the targets.

Although the failsafe is intended to control total spending, it would not give individual providers an incentive to help meet that target. Individual providers would perceive that actions to increase their own volume of Medicare billings could reduce the impact of sector-wide reductions in payment updates on their incomes. In this regard, the failsafe is no different from any other policy that works through price reductions.

The allocation formula in the failsafe provision reflects the sector growth rates that CBO projected for Medicare in March 1995 under current law, rather than growth rates likely to occur once the bill is implemented. Projected growth rates for different fee-for-service sectors would differ considerably from current law under the bill, as a result of the specific fee-for-service spending reductions and the establishment of the MedicarePlus market. Fixed spending allocations based on past projections may not be compatible with the new policy environment.

The retrospective failsafe, or lookback, mechanism could provide a safeguard against excess expenditures resulting from projection errors. Projection errors would be unavoidable with the prospective failsafe because of the difficulties of projecting MedicarePlus expenditures and sector-specific fee-for-service expenditures, and the difficulties of making the correct adjustments to payment rates. However, while the lookback provision would identify the amount of any shortfall in savings that may have occurred in a prior year, it would not provide any additional tools to recover those savings. Instead, it would simply raise the target to be met by prospective reductions in payment rates.

The fee-for-service market would bear the full brunt of the additional spending reductions that would be necessary under the failsafe. Fee-for-service providers would face the certain reductions in payment rates that resulted from explicit provisions in the bill as well as the uncertain reductions that resulted from the failsafe. The combination of potentially large reductions in payment rates and the uncertainty of those rates would probably increase the incentive for providers to move from fee-for-service to the MedicarePlus market.

### Other Effects

This section discusses the effects of H.R. 2485 on the status of the Hospital Insurance trust fund, beneficiaries' out-of-pocket costs, the resources devoted to Medicare benefits, the regulation of health plans, and the situation of low-income beneficiaries.

Status of the Hospital Insurance Trust Fund. In addition to the elements of H.R. 2485 that would reduce total Medicare spending, the bill would shift the funding for about one-third of home health costs from Part A to Part B. These additional costs would be excluded from the determination of the Part B premium. This provision would reduce spending in Part A by \$54.3 billion over seven years and increase spending in Part B by the same amount.

Under current law and the assumptions of the budget resolution, CBO projects that the Hospital Insurance trust fund will be exhausted in fiscal year 2002. Under the bill, the trust fund would have a balance of \$193 billion, or 114 percent of the following year's outlays, at the end of 2002. Extrapolating from that point, the fund balance would total \$209 billion, or about 105 percent of annual outlays, at the end of 2005.

Effects on Beneficiaries' Out-of-Pocket Costs. The bill would directly increase beneficiaries' out-of-pocket liabilities under Medicare in two ways. First, it would increase the flat-rate Part B premium beyond increases scheduled under current law. Second, it would impose a new income-related Part B premium for beneficiaries with modified adjusted income greater than \$75,000 for singles and \$125,000 for couples.

The new income-related premium would first apply for 1997, and it would affect about 2.5 percent of Part B beneficiaries in that year. The 1.4 percent of Part B beneficiaries with modified adjusted income greater than \$100,000 for singles or \$175,000 for couples would be liable for the maximum amount of \$1,480 per beneficiary. For beneficiaries reporting income this high, the Part B subsidy would be entirely eliminated. The 1.1 percent of Part B beneficiaries with modified adjusted

income between the upper and lower thresholds for the income-related premium would see their Part B subsidy reduced by varying amounts, but not eliminated; people in this group would pay an average additional amount of \$633 in 1997. In later years, the proportion of beneficiaries affected would increase because the income thresholds would not be indexed. Further, the maximum amount paid by each beneficiary affected would also increase because Part B benefit costs would rise.

The effect on beneficiaries' actual out-of-pocket costs cannot be reliably estimated, because it would depend on the insurance options facing beneficiaries under current law compared to those that would become available under the bill. Many risk-based plans could initially offer benefits equivalent to those in the fee-for-service sector at lower cost. In 1995, for example, risk-based plans estimated that the basic Medicare package would cost them only 84 percent, on average, of the capitation payments they would receive from Medicare. They expected to use the other 16 percent of the capitation payment to provide enrollees with additional benefits free of any supplemental premium. It is difficult, however, to predict the extent to which this price advantage for risk-based plans would be maintained over time.

Beneficiaries who now purchase Medigap policies in the fee-for-service sector might continue this coverage or select a MedicarePlus plan that offered equivalent additional benefits for a smaller supplementary premium. These beneficiaries typically pay annual Medigap premiums of about \$1,000, for which they get coverage for most of Medicare's cost-sharing requirements and, in some cases, additional services. On average, in 1995, Medicare's risk-based plans expected to give enrollees premium-free additional benefits (above the basic Medicare package) that were valued at about \$755 for the year. Thus, out-of-pocket costs for beneficiaries who now purchase a Medigap plan could fall significantly if they switched to a Plus plan offering equivalent additional benefits.

Some beneficiaries who currently receive Medicaid payments for Medicare's premiums and cost-sharing requirements in the fee-for-service sector might no longer be eligible for full payment by Medicaid of these costs under the Medicaid Transformation Act of 1995, depending on decisions made by states. If so, more of this group might be attracted to plans in the Plus sector, especially to those plans whose costs were low enough to provide full coverage of Medicare's cost-sharing and Part B premium requirements without charging a supplementary premium. If no such plans were available, these enrollees might be attracted instead to a plan that gave a Part B premium rebate but no additional benefits. The out-of-pocket costs for this latter group would rise.

Resources Devoted to Medicare Benefits. One important question is the extent to which the growth in the capitation rate specified in the bill would allow for increases in the quantity and quality of medical care for beneficiaries. Such a calculation would require knowledge of how fast the prices of medical care services are rising after allowing for the huge improvements in medical technology that have occurred. But it is extremely difficult to collect prices of medical care and to make the necessary quality adjustment. Existing medical care price indices are not helpful on this score as they do not take into account, for instance, how the success rates of various courses of treatment may have changed; how a drug treatment (which could be both cheaper and more effective) may substitute for surgery; how diagnostic techniques may be more accurate and less invasive; or how much individuals value such innovations as the polio vaccine or laser surgery. Existing medical care price indices are simply aggregates of prices of hospital stays, surgery, drugs, and other inputs. Moreover, little or no account is taken of changes in the productivity of these inputs.

In the absence of an historical price index that reflects how individuals value changes in the quality of medical care, it is difficult to estimate even a range of growth rates for medical prices. An upper bound that appears reasonable is the growth rate of labor compensation. If medical care is considered to be labor-intensive, and if productivity growth is assumed to be zero, then, roughly speaking, the quality-adjusted price of medical services should rise at the same rate as labor compensation--3.8 percent per year in CBO's current economic projections. Of course, given the innovations in medical care, productivity growth is probably much greater than zero. Some studies indicate that an estimate of the lower bound would be a negative growth rate. That is, the quality-adjusted price of medical care has been falling and would probably continue to fall throughout the projection period.

The implication of this analysis is that the specified growth in the capitation rate--4.7 percent a year--would cover medical inflation and allow for increases in the quantity and quality of services. If the upper bound estimate of inflation is correct, the margin for improved services would be about one percent a year. But it is more likely that inflation would be lower, perhaps much lower, than 3.8 percent, allowing room for greater improvements in care.

One straightforward way to assess the impact of the bill is to see what it would do to the proportion of the nation's resources devoted to Medicare. Under current policy, Medicare spending accounts for 2.5 percent of the gross domestic product (GDP) and is projected by CBO to grow to 3.5 percent in 2002. Under the bill, Medicare spending would rise to 2.9 percent of GDP in 2002. Thus, while the bill moderates the growth in Medicare spending, it still permits Medicare to command an increasing share of the nation's resources during a period of slow growth in the aged population.

Regulation of Health Plans. Under the bill, some rules now applicable to Medicare's risk-based plans would be eliminated or relaxed, and these provisions could give some new types of risk-based plans competitive advantages over other plans.

The current requirement that risk enrollment be open to all beneficiaries would be eliminated for certain sponsors--enrollment could be limited to members in plans sponsored by unions, Taft-Hartley multiemployer associations, and other membership associations organized for reasons other than providing health insurance. In addition, plans would no longer be required to limit their Medicare and Medicaid enrollees to no more than half of the plan's total enrollment. Allowing various associations to sponsor limited enrollment plans might cause more selection bias than now exists, both within Medicare's risk-based sector and between that sector and the fee-for-service sector. Some associations might be formed to sponsor plans that would indirectly but effectively screen out poor risks.

The bill would also encourage groups of providers, such as physicians or hospitals, to form their own organizations that would directly market Plus plans to Medicare beneficiaries. Federal standards for such provider-sponsored organizations (PSOs) would be established, preempting state laws concerning initial capitalization and financial reserves required for insurers and HMOs. The bill would also require application of a rule of reason in any action under anti-trust laws.

CBO assumed that, on balance, the bill's special treatment for PSOs would not affect the number of beneficiaries enrolled in Plus plans and would therefore not affect Medicare outlays. On the one hand, the PSO provisions might encourage the formation of Plus plans in areas where they might otherwise not exist, adding to the choices available to beneficiaries. On the other hand, setting inadequate requirements on initial capitalization or financial solvency for PSOs could lead to service problems or interruptions that would deter enrollment.

The fact that an insurance organization is owned by health providers does not argue for different solvency requirements. For example, if an unprofitable HMO were no longer able to pay its physicians, some doctors might accept a pay cut while others might leave to work elsewhere, with a resulting disruption of services to enrollees. If, because of poor financial management, a PSO were no longer able to pay its physician-owners what they had expected in income (including returns on ownership shares), some of them might leave the PSO to work elsewhere, with the same sort of potential disruption in services that would be faced by patients in a failing HMO.

Effects on Low-Income Beneficiaries. Under current law, many low-income elderly and disabled Medicare beneficiaries also receive Medicaid benefits. The effects of

H.R. 2485 must, therefore, be considered in conjunction with proposed changes to the Medicaid program. Three groups of beneficiaries are of concern: those who receive full Medicare and Medicaid benefits (dual eligibles), those who have both Medicare premiums and cost sharing paid by Medicaid (qualified Medicare beneficiaries or QMBs), and those who have only Medicare premiums paid by Medicaid (specified low-income Medicare beneficiaries, or SLMBs).

The Medicaid Transformation Act of 1995, as reported by the Commerce Committee, would end the individual entitlement to benefits, cap the amount of federal funds that a state could receive, and significantly reduce the rate of growth of those federal funds. The MediGrant proposal would also allow states the flexibility to define benefit packages and to set their own eligibility criteria, while meeting certain set-aside requirements. To qualify for MediGrant funds, states would have to devote certain percentages of their federal funds to poor elderly and disabled, including a minimum percentage to pay for Medicare premiums for the poor elderly (but not the disabled).

Although states' responses to the new program would be varied, it is quite likely that many states would discontinue paying Medicare cost-sharing for low-income Medicare beneficiaries, because many states have claimed that the cost-sharing requirements under current law are particularly burdensome. As discussed earlier, reduced cost-sharing for low-income Medicare beneficiaries may drive some to enroll in a low-cost-sharing plan in the MedicarePlus sector.

Also, the incentives and the opportunities for states to shift costs to Medicare would expand under the new programs. Facing limited federal allocations under the MediGrant program, states might increase efforts to shift costs to Medicare. They could use their new flexibility to define benefit packages specifically for dually-eligible enrollees that would maximize the use of Medicare benefits. Similarly, MedicarePlus plans could be designed specifically for low-income beneficiaries. The bill would require the Secretary to conduct demonstration projects in at least 10 states designed to integrate Medicare and MediGrant financing streams and program requirements. Until effective integration occurred, however, managed care plans that provided the comprehensive acute and long-term care services that many dually-eligible beneficiaries need would be unlikely to develop.

7. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

We have not completed our analysis of the costs to state or local governments.

8. ESTIMATE COMPARISON: None

9. PREVIOUS CBO ESTIMATE:

On October 16, 1995, CBO issued estimates for H.R. 2425 as reported by the Committee on Commerce and the Committee on Ways and Means. This bill and those two bills are substantially the same, and the methodologies underlying the estimates are identical.

10. ESTIMATE PREPARED BY:

Jean Hearne, Lisa Layman, Jeffrey Lemieux, Anne Hunt, Murray Ross, and Robin Rudowitz (226-0910); Daniel Kowalski (226-2880); Paul Cullinan (226-2820); James Baumgardner (226-2663); Sandra Christensen (226-2665).

11. ESTIMATE APPROVED BY:



Paul N. Van de Water  
Assistant Director for Budget Analysis

Table 2, H.R.2485

18-Oct-95

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
<b>CHANGE IN DIRECT SPENDING</b>								
Subtitle A—MedicarePlus Program /1	-0.5	-1.0	-2.1	-3.8	-6.2	-8.8	-11.8	-34.2
<b>Subtitle B—Preventing Fraud and Abuse</b>								
Payment Safeguards and Enforcement	0.3	-0.1	-0.3	-0.5	-0.6	-0.6	-0.6	-2.4
Doubling Civil Monetary Penalties	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.3
Other Provisions	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
<b>Subtotal, Subtitle B</b>	<b>0.3</b>	<b>-0.1</b>	<b>-0.4</b>	<b>-0.6</b>	<b>-0.7</b>	<b>-0.7</b>	<b>-0.7</b>	<b>-2.8</b>
<b>Subtitle C—Regulatory Relief</b>								
Physician Ownership Referral	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Other Regulatory Relief	0.0	0.1	0.2	0.2	0.2	0.2	0.2	1.1
Physician Self Policing /2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subtotal, Subtitle C</b>	<b>0.1</b>	<b>0.2</b>	<b>0.2</b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>0.3</b>	<b>1.6</b>
Subtitle D—Medical Liability Reform	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.2

Table 2, H.R.2485

18-Oct-95

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
<b>Subtitle F--Medicare Part A</b>								
<i>Part 1--Hospitals</i>								
Reduce PPS update /3	-0.2	-1.1	-2.4	-3.8	-5.4	-7.1	-9.0	-29.0
Reduce disproportionate share payments	-0.6	-0.8	-1.0	-1.1	-1.1	-1.2	-1.2	-7.1
Reduce PPS capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0
Rebase Capital rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7
Reduce nonPPS capital by 15%	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5
Adjustment for capital-related tax costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital exceptions revisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reduce indirect medical education /4A	-0.7	-0.8	-0.8	-0.9	-1.1	-1.1	-1.2	-6.6
Reduce direct medical education /4B	-0.0	-0.1	-0.2	-0.4	-0.4	-0.4	-0.4	-2.0
Reduce nonPPS update	0.0	0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.4
Rebase LTC hospitals /5	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7
LTC hospitals within other hospitals /6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Reduce payments for hospital bad debt	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-1.1
Extend hemophilia pass through /7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Christian Science practitioners	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EAC/RPC Hospitals /8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Rural referral centers	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Floor on area wage index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<i>Part 2--Skilled Nursing Facilities</i>								
Skilled Nursing Facilities	-0.2	-0.6	-1.0	-1.4	-1.8	-2.2	-2.8	-10.0
<b>Subtotal, Subtitle F</b>	<b>-3.1</b>	<b>-5.1</b>	<b>-7.3</b>	<b>-9.4</b>	<b>-11.8</b>	<b>-14.2</b>	<b>-16.7</b>	<b>-67.6</b>

Table 2, H.R.2485

By fiscal year, in billions of dollars

18-Oct-95

	1996	1997	1998	1999	2000	2001	2002	Total
<b>Subtitle G--Medicare Part B</b>								
<i>Part 1--Payment Reforms</i>								
Reduce payments for physicians' services	-0.4	-1.3	-2.4	-3.6	-4.8	-6.1	-7.5	-26.1
Eliminate formula driven overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9
Reduce updates for durable medical equipment /9	-0.1	-0.3	-0.4	-0.5	-0.7	-0.8	-1.0	-3.8
Reduce updates for clinical labs	-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0
Extend outpatient capital reduction	0.0	0.0	0.0	-0.1	-0.1	-0.2	-0.2	-0.6
Extend outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4
Freeze payments for ASC services	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Establish REACH program /10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Anesthesia Payment Allocation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Separate physician fee schedule for Wisconsin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fee schedule for ambulance services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Standards for physical therapy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Regulate private billing for labs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interactions	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.1	-0.9
<i>Part 2--Part B Premium</i>								
Extension of Part B premium at 31.5%	-3.2	-4.2	-3.9	-5.0	-7.6	-10.0	-13.2	-47.1
Income-related reduction in medicare subsidy	0.0	-0.3	-0.7	-1.1	-1.4	-1.7	-2.0	-7.3
<b>Subtotal, Subtitle G</b>	<b>-4.8</b>	<b>-7.7</b>	<b>-9.9</b>	<b>-13.8</b>	<b>-18.9</b>	<b>-24.3</b>	<b>-30.9</b>	<b>-110.3</b>
<b>Subtitle H--Medicare Parts A and B:</b>								
Payment for home health services	0.0	-1.4	-2.3	-2.8	-3.2	-3.6	-4.1	-17.3
Home Health Changes to Part A	-5.9	-7.8	-9.3	-10.4	-11.5	-12.7	-13.9	-71.6
Home Health Changes to Part B	5.9	6.4	7.0	7.7	8.4	9.1	9.9	54.3
Clarifying coverage for investigational devices	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Exempt physician labs from standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare second payer improvements	0.0	0.0	0.0	-1.3	-1.5	-1.6	-1.8	-6.2
<b>Subtotal, Subtitle H</b>	<b>0.0</b>	<b>-1.4</b>	<b>-2.3</b>	<b>-4.0</b>	<b>-4.6</b>	<b>-5.2</b>	<b>-5.9</b>	<b>-23.3</b>
<b>Change in Net Mandatory Medicare</b>								
<b>Outlays before Failsafe</b>	<b>-7.9</b>	<b>-15.1</b>	<b>-21.7</b>	<b>-31.3</b>	<b>-42.0</b>	<b>-52.9</b>	<b>-65.8</b>	<b>-236.8</b>
<b>Additional Outlay Reductions Required</b>								
<b>by Failsafe, Net of Premiums /11</b>	<b>0.0</b>	<b>0.0</b>	<b>-5.1</b>	<b>-8.6</b>	<b>-7.2</b>	<b>-7.0</b>	<b>-5.5</b>	<b>-33.4</b>
<b>Total, Medicare</b>	<b>-7.9</b>	<b>-15.1</b>	<b>-26.9</b>	<b>-39.9</b>	<b>-49.2</b>	<b>-59.9</b>	<b>-71.3</b>	<b>-270.2</b>

Table 2, H.R.2485

By fiscal year, in billions of dollars	18-Oct-95							
	1996	1997	1998	1999	2000	2001	2002	Total
Subtitle E—Teaching Hospitals and Graduate Medical Education Trust Fund	0.0	1.3	1.5	2.3	3.1	3.6	4.0	15.8
<b>Total, H.R.2485</b>	<b>-7.9</b>	<b>-13.8</b>	<b>-25.4</b>	<b>-37.6</b>	<b>-46.1</b>	<b>-56.3</b>	<b>-67.3</b>	<b>-254.4</b>

MEMORANDUM: Monthly Part B Premium (By calendar year)

Estimated premium before failsafe	\$53.50	\$57.60	\$61.90	\$67.00	\$74.90	\$81.40	\$90.30
Estimated premium after failsafe	\$53.50	\$56.90	\$59.40	\$63.80	\$72.10	\$78.90	\$87.60

FOOTNOTES:

- /1 Estimate includes medical savings accounts provision.
- /2 This provision would increase spending by about \$40 million over the period 1996 through 2002.
- /3 Includes provision for sole community hospitals.
- /4A These provisions are described in Subtitle E and included by reference in Subtitle F. The estimate assumes a 6% adjustment in FY96-99, as indicated in the text of the provision. The title of the provision is not consistent with the text.
- /4B These provisions are described in Subtitle E and included by reference in Subtitle F.
- /5 This estimate assumes that the provision will only be applied to existing LTC facilities.
- /6 This estimate assumes that grandfathering would apply only to existing long term care hospitals that are located in the same building as, or on the same campus as, another hospital.
- /7 This provision would cost approximately \$5 million per year.
- /8 This provision is budget neutral if EACH/RPCH designation is limited to those hospitals currently so designated. hospitals/facilities can be designated as such.
- /9 This line includes a 1% annual update for prosthetics and orthotics
- /10 This estimate assumes that policy is to provide cost-based reimbursement for specified Part B services only, as specified in substitute. The provision would cost approximately \$20-\$30 million per year.
- /11 For this estimate, CBO assumes that the target levels of benefits would be consistent with the mandatory spending levels specified in the budget resolution. Reductions in outlays for benefits would be larger than the amounts shown here because of interactions with the Part B premium.

NOTES:

Details may not sum to totals because of rounding.

These estimates assume an enactment date of November 15, 1995. The estimates would change if the proposal was enacted at a later date. To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall. These estimates do not incorporate changes in discretionary spending for administration.