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

November 19, 1991
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 3595 - Medicaid Moratorium Amendments of 1991
(Waxman (D) CA and 135 others)

The Administration strongly opposes H.R. 3595. If it were presented to the President, his senior advisers would recommend a veto.

H.R. 3595 would extend through September 30, 1992, the moratorium on Medicaid regulations pertaining to the use of provider-specific taxes and donations to increase Federal funding for State Medicaid programs. The current moratorium would otherwise expire on December 31, 1991. H.R. 3595 would also allow voluntary contributions to be used as the State share for Medicaid through December 31, 1992. In addition, a new and permanent moratorium would be applied to any regulation changing the treatment of intergovernmental transfers of funds as a source of the State share of Medicaid costs.

H.R. 3595 is unacceptable legislation because:

-- Inappropriate State spending through these schemes, if unchecked, could increase the Federal deficit -- adding an estimated $5.5 billion this year and $40 to $50 billion for FYs 1992 through 1996.

-- The bill violates the Budget Enforcement Act of 1990 (BEA). It designates the provisions of the bill as emergency requirements under the BEA and prohibits the added costs from being counted under the pay-as-you-go provisions of the BEA. In addition, H.R. 3595 includes a "directed scorekeeping" provision that specifies the dollar amounts that are to be used in estimating costs under the bill. The President has stated previously that he would veto any legislation that contained such a provision.

-- The moratorium on provider-specific taxes and donations was established in 1988 and has been extended twice in Administration-opposed provisions in OBRA 1989 and OBRA 1990 that received little congressional attention. Congress and the States have been on notice since 1988 that the Federal Government was planning to act in this area. Yet Congress has twice extended the moratorium, declaring that more time is needed to examine the issue. During this time, the number of States with provider-specific taxes, donations programs, or both has skyrocketed from seven States and $200

million in 1990 to over 40 States and an estimated $5.5 billion in 1992. Last year's moratorium alone resulted in at least a tenfold increase in Federal funding associated with States' use of provider tax and contribution programs. Many more billions of dollars will be provided to the States inappropriately through a distorted match system under another moratorium.

-- A permanent moratorium on changing the treatment of intergovernmental transfers is unnecessary and unwise. The Health Care Financing Administration (HCFA) is <u>not</u> eliminating the use of traditional intergovernmental transfers in Medicaid. Under the HCFA regulation, public funds transferred between different levels of local government will continue to be matched by the Federal Government.

State donation and provider-specific tax programs, if unchecked, will undermine a basic premise of the Medicaid program -- that States have a stake in the costs of the program. The Administration cannot condone the alteration of the Medicaid program through financing mechanisms that go beyond the conventional matching rate structure. States are accountable for the appropriate management and financing of their programs and the Federal Government is responsible for holding them accountable to operating fairly and appropriately in the Medicaid partnership.

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

November 25, 1991
(Senate)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 3595 - Medicaid Moratorium Amendments of 1991
(Bentsen (D) TX)

The Administration strongly supports the agreement that was reached with the National Governors Association. This agreement allows the Medicaid program in every State to continue their pre-September 30, 1991 policies until at least October 1, 1992, and in some cases through June 30, 1993. Further, the agreement equitably addresses the individual fiscal concerns of the States while assuring the long-term structural integrity of the Medicaid program.

The compromise agreement should be passed this year before Congress adjourns. This is a major health and fiscal policy problem for Federal and State governments. The States and many legislatures need clear legislative or regulatory policy guidance before State legislatures meet next spring.

The Administration opposes any temporary moratorium that would leave these issues unresolved until March 1992 or later. Should legislation be presented to the President that includes a "two-sided" moratorium that precludes Federal regulatory activity, and State program expansions, the President's senior advisers would recommend that he veto it if it is not consistent with the Budget Enforcement Act.

* * * * * * * *

CATASTROPHIC

CURRENT LAW: The new catastrophic benefit is financed by two premiums. The first is a flat amount paid by all Medicare beneficiaries. This year it is $4.00 per beneficiary per month; in 1990 it will be $4.90 per month.

The second premium, called the supplemental premium, is a surcharge on income tax liability above $150. The surcharge is 15% of the tax liability above $150, up to maximum of $800 for an individual and $1600 for a couple. The amounts would rise to 28% and $1,050 for an individual by 1993.

GEORGE BUSH ON THE RECORD: Last mention was April 21 letter to Rep. Rostenkowski: "I have supported the implementation of the Medicare Catastrophic Coverage Act on schedule, as enacted. I continue to do so. It would be imprudent to tinker with Medicare catastrophic insurance literally in its first few months of life. We should not now reopen the legislation."

WAYS AND MEANS PROPOSAL: Make the program voluntary, but not taking catastrophic means you can´t have part B (insurance for doctors´ bills.) Cut the supplemental premium in half but leave the maximum premium the same. (Ups the point where the maximum is reached.) Make up the revenue loss in variety of ways: the flat premium would be increased for 1990 - 1993 by $3.50 in 90 rising to $4.10 in 1992. Deductible for the drug benefit goes up from $600 to $800 in 1991; $650 to $950 in calendar 1992.

TALKING POINTS:

- o We respect the Ways and Means Committee´s desire to adjust the distribution of the revenue raising to finance the benefit package, and our technical experts are working with the committee staff.
  - As Secretary Sullivan said, "we will only support changes which improve the original legislation."
  - We´re still going over what the committee has done, and haven't concluded whether its an improvement.

But note:

- o Our first priority is to have a financially sound program.
- o Even if the package is financially neutral with respect to the current law, our actuaries indicate the program does not have a stable financial future.

Physician payment reform will help maintain access to care and help provide the security that Medicare will continue to be there for people like that San Diego teacher, his 86 year old mother, the 30 million more Americans who today count on the financial viability and security of Medicare, and the millions of Americans in the future who will need Medicare.

CATASTROPHIC CARE

Perhaps this would be a good time to address recent changes which are being considered in Congress concerning the scope of Medicare benefits available for our elderly citizens.

Last year Congress passed the Medicare Catastrophic Care Coverage Act, which provided an expansion of acute catastrophic care benefits for older Americans, including a cap on personal expenditures and a drug benefit.

There has been much discussion about the legislation in recent weeks. Tuesday's vote by the House Ways and Means Committee is one example of efforts to change the legislation. In that vote, the Committee approved changes in the financial mix of the surtax on the elderly and the premium paid by all enrolleees in catastrophic coverage. The changes would also allow beneficiaries to opt out of the catastrophic coverage program.

P.17
JUL-26-89 WED 11:00

I would like to reassure each one of you that the Bush Administration remains committed to the objectives of the legislation preventing an acute illness from having a devastating financial effect on the family. We will only support changes which improve the original legislation, allowing it to more fully meet its objectives.

SULLIVAN SPEECH TO AARP THIS WEEK

I am certain that the debate on the Act is far from finished. I know that the membership of AARP is concerned about the course of this debate. Again, I would reiterate that the President and I will carefully look at each proposed change on a case-by-case basis to provide the best benefits package and financial arrangements possible.

CONCLUSION

In conclusion, your work today will help to shape and mold the future of many of America's older minorities. Please remember that my department supports and encourages your work. This is a vital program to assist efforts to reach our older citizens. As for the Department of Health and Human Services, we will do everything possible to help you make this Initiative a big success.

JUL-26-89 WED 11:01 P.18

Proposed

July 26, 1989

Administration Position on Catastrophic Health Insurance(CHI)

The Administration support the objectives of the Catastrophic Health Insurance - - so that the elderly are not impoverished when they become acutely ill.

too detailed for Pres.

We recognize that Congress, the Congressional Budget Office and others now recognize that the CHI was not adequately funded, particularly the drug benefits.

The Ways and Means Committee has taken action to realign the financing and the benefits to meet the concerns of solvency, and permit beneficiaries to elect Part B coverage and CHI. Part B has always been elective.

The Administration recognizing the committees desire to retain rather than repeal CHI supported the modification. In light of the BiPartisan Budget Agreement, the Administration will work to eliminate the artificial change in the timing of Medicare payments to meet certain Congressional rules.

We will look at other proposals as the legislative process considers the Ways and Means amendments.

Document No. 096373SS

WHITE HOUSE STAFFING MEMORANDUM

DATE: 12/11/89 ACTION/CONCURRENCE/COMMENT DUE BY: COB, WED., DEC. 13

SUBJECT: ENROLLED BILL H.R. 3607 -- MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☐	☑	MCCLURE	☑	☐
SUNUNU	☐	☑	NEWMAN	☐	☐
SCOWCROFT	☐	☐	PORTER	☑	☐
DARMAN	☐	☑	ROGICH	☐	☐
BATES	☑	☐	UNTERMEYER	☐	☐
CARD	☐	☑	BOSKIN	☑	☐
CICCONI	☐	☑	CLERK	☐	☑
DEMAREST	☑	☐		☐	☐
FITZWATER	☐	☑		☐	☐
GRAY	☑	☐		☐	☐
HAGIN	☐	☐		☐	☐

REMARKS:

Please provide comments/recommendations on the attached enrolled bill memo directly to my office no later than COB, WEDNESDAY, DECEMBER 13. Thank you.

RESPONSE:

James W. Cicconi
Assistant to the President
and Deputy to the Chief of Staff
Ext. 2702

EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF MANAGEMENT AND BUDGET

WASHINGTON, D.C. 20503

THE DIRECTOR

December 11, 1989

1989 DEC 11 PM 7:44

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Enrolled Bill H.R. 3607 - Medicare Catastrophic Coverage Repeal Act of 1989
Sponsors - Rep. Donnelly (D) MA and four others

Last Day for Action

December 19, 1989 - Tuesday

Purpose

Repeals the Medicare provisions in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), effective January 1, 1990; retains the Medicaid improvements for pregnant women and infants, and elderly and disabled individuals; and makes various conforming and technical amendments.

Agency Recommendations

Office of Management and Budget	Approval
Department of Health and Human Services	Approval
Department of the Treasury	Approval
Council of Economic Advisers	Approval

Discussion

H.R. 3607 is the congressional response to the strong and vocal objections by Medicare beneficiaries to having to pay the entire cost of the benefits enacted in the Medicare Catastrophic Coverage Act of 1988 (MCCA).

The bill culminates a year-long debate on the MCCA and represents an unprecedented rollback of a major social welfare program so soon after its creation. Initially, the Administration had preferred that no changes be made to the MCCA. However, as bipartisan legislation to reform or repeal the MCCA gained momentum in Congress, the Administration did not take an official position in favor of any one of the competing substantive amendments.

H.R. 3607 in its final form is the product of extensive congressional deliberation. It passed by voice vote in the Senate and by a vote of 352-63 in the House.

Background

The MCCA of 1988 was approved on July 1, 1988, and represented the largest expansion of Medicare since the program's inception in 1965. The new law was intended to protect elderly and disabled Medicare beneficiaries from "catastrophic" hospital and doctor bills for acute (i.e., not long-term) care. It provided full coverage of all hospital inpatient care costs, no matter how many hospital stays, after payment of one deductible a year ($592 in 1990, rising annually). All hospital copayment amounts were to be eliminated.

The MCCA also limited the amount beneficiaries pay out-of-pocket each year for physician services. The maximum deductible and coinsurance charges were to be $1,370 in 1990, indexed in future years to ensure that a constant 7 percent of beneficiaries would receive benefits.

Under the MCCA, the Medicare program was to be expanded to cover, for the first time, outpatient prescription drugs, mammogram screening, and respite (in-home) care. Medicare benefits were increased for home health care, extended care skilled nursing services, and hospice care.

The new and expanded benefits in the MCCA were to be financed by a combination of a flat premium and an income-related surtax (supplemental premium) paid by Medicare beneficiaries. The surtax provoked the strongest protest from senior citizens, and is the main reason for the repeal of the MCCA contained in H.R. 3607.

Description of the Enrolled Bill

H.R. 3607 would repeal all of the Medicare benefits contained in the MCCA as well as the provisions financing those benefits. The enrolled bill does not, however, repeal certain Medicaid improvements enacted in the MCCA. These require State Medicaid programs to:

-- pay Medicare premiums, copayments, and deductibles for all beneficiaries with incomes below 100 percent of poverty level, on a phased-in basis.

-- cover the prenatal care expenses of pregnant women and infants (up to one year old) whose family incomes are at or below the poverty level.

-- allow the spouse of an individual who enters a nursing home for long-term care to keep a certain amount of income per month ($1,000 by 1993), and at least $12,000 but no more than $60,000 in liquid assets (excluding home ownership).

H.R. 3607 includes transition provisions for individuals who started receiving inpatient hospital and extended care services under the MCCA before January 1, 1990. The bill also contains authority to make adjustments in Medicare payments to hospitals because of the repeal of the MCCA. Finally, H.R. 3607 requires insurers of Medigap plans (insurance designed to supplement Medicare's coverage) to offer to restore coverage to people who were covered at the end of 1988 but who cancelled their plans in 1989 because of the MCCA.

The benefit repeals included in H.R. 3607 are effective January 1, 1990; the repeal of the surtax is retroactive to the beginning of calendar year 1989.

Budget Impact

The following table, which was prepared by the HHS Medicare program actuary, shows the projected five-year budget impact of H.R. 3607. (The figures represent changes from the FY 1990 Mid-Session budget estimates to reflect various re-estimates, mainly for the MCCA's skilled nursing care benefit):

	(Fiscal Years - $ in billions)				
	1990	1991	1992	1993	1994
Outlay savings	4.2	11.3	15.3	16.9	18.5
Revenue losses	9.0	10.2	10.7	11.7	13.6
Increase (Decrease) in deficit*	4.8	(1.2)	(4.5)	(5.2)	(4.9)

* Due to rounding, does not always equal difference.

Agency Views

The Department of Health and Human Services (HHS) recommends approval of H.R. 3607. In its views letter on the bill, HHS states that the benefits contained in the MCCA provide needed financial protection to millions of elderly Americans. The Department further states that the benefits focus acute care coverage on extraordinary expenses while maintaining appropriate levels of beneficiary expenses for more routine costs. HHS believes that repeal of these benefits is a regrettable step.

HHS points out, however, that the repeal of these benefits has enjoyed overwhelming support in Congress, and among major segments of the elderly population. The Department also believes that disapproval of H.R. 3607 would almost certainly lead to the rapid repassage of a similar measure.

The Department of the Treasury states that repeal of the catastrophic program and the unpopular supplemental premium would enable Congress in the future to consider alternatives which might win broader public acceptance. Accordingly, Treasury recommends approval of H.R. 3607.

The Council of Economic Advisers (CEA) recommends approval of the enrolled bill, but advises that it does not believe the issue of catastrophic insurance will disappear. The CEA suggests that it may be useful for the Administration to develop its own position regarding specific elements of catastrophic insurance for the elderly it would like to see enacted.

Conclusion and Recommendation

As indicated above, H.R. 3607 is the response by Congress to the very strong opposition expressed by Medicare beneficiaries to the financing arrangement for the catastrophic coverage enacted last year. We join HHS, Treasury, and the CEA in recommending approval of this bill.

Richard G. Darman
Director

Enclosures

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release December 13, 1989

The President today signed the following legislation:

H.R. 3607, which repeals the Medicare provisions in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), effective January 1, 1990; retains the Medicaid improvements for pregnant women and infants, and elderly and disabled individuals; and makes various conforming and technical amendments.

# # #

Sept 12

MR. FITZWATER: In the meeting this morning with Republican members of Congress, they discussed with the President administration position on a number of pieces of legislation. But certainly, one of the foremost of concern to them is the catastrophic bill. And the President assured them that we share their concern for its impact on senior citizens, that we have been looking for a way to mitigate this situation for the last couple of months.

We have not found an answer yet. Our primary concern is that this bill, as you know, would add some $6 billion to the Treasury, and without that income we would automatically trigger the sequester under Gramm-Rudman-Hollings and violate the congressional budget agreement. So we have financial concerns, but we are looking for ways to deal with this problem.

Q Marlin, as you know, the President supported this thing that he said was not a tax when it happened. He said it was a good way -- remember in the debates last year --

MR. FITZWATER: Right.

Q -- a good way to provide services. It was a premium.

MR. FITZWATER: Yes.

Q What does it portend for this whole process if when we pass a small premium for an added service, catastrophic -- which the Reagan administration wanted to put on -- that suddenly there's a rebellion and that elderly people who are middle and upper income don't want to pay for it? Is the President going to essentially say now we'll mitigate it for these people, we'll take it back? Is his mind set to repeal this piece of legislation?

MR. FITZWATER: His mind set is that we have learned, as the Congress has learned -- when this passed the Senate only 11 people voted against it -- that you need to be very careful and considerate of the cost of these kinds of entitlement programs before they are passed. And that the President did agree with this. President Reagan signed it; indeed, he had proposed it. And as you suggest, the message is clear that when you pass this kind of legislation you'd better know what it costs before you do it.

And so, we're looking at --

Q So does the President want to repeal it? Does he --

MR. FITZWATER: Well, that's what we haven't decided yet. But, obviously, many members of Congress are pushing for repeal. But our problem is that repeal has rather devastating effects on the deficit side with regard to triggering a sequester.

Q Is that the only real concern, Marlin?

Q But he's obviously changed from support to "I don't know," right?

MR. FITZWATER: No. We have always said that we support the bill and we are concerned about the program -- about the taxes and the impact on the deficit. But we recognize this impact on the elderly, we recognize their concern, and we are working with members of Congress now to try to develop some kind of solution.

Q But you just said -- someone asked you, does the President want to repeal it, and you said he hasn't decided. He has changed from outright support, obviously.

MR. FITZWATER: Yes, but repeal implies a solution that we don't have yet. A lot of congressmen just want a straight out repeal, but we're not sure that that's the best way to approach it.

Q But President Bush is not going to stand up and fight for keeping it the way it is, either?

MR. FITZWATER: Well, he says at the moment our position is that we support it and we don't see any change. But we are looking for alternatives.

Q Does the President think this is a necessary program, Marlin; the problem is just he doesn't know how to pay for it? Or is he not so sure it's a good idea now?

MR. FITZWATER: Well, the administration thought it was a good program in the past, as did most of the Congress. People still think it's got good objectives, but they have felt the heat. And the people at home in the August recess obviously made their views very clear about paying for this benefit. So they're taking another look at the financing and see what can be done.

Q But, Marlin, you're talking about -- you say the present Congress has learned that you'd better know what these things cost before you pass it. It seems in fact -- are you saying that in fact there are cost overruns here that the President, when he was Vice President, didn't foresee, or are you really saying that the President is feeling the heat, too, from the elderly lobby?

MR. FITZWATER: Everybody is, sure. I hope there is not any misapprehension about the political aspects of this program. I mean, the elderly complaints are rolling in in tidal waves of immense proportions.

Q Well, is that what the President has really learned --

MR. FITZWATER: And that has not been lost on anyone -- certainly not members of Congress and not the administration. And our point being that we need to be very -- our point is -- what the lesson for the future is, when you've got these entitlement programs that provide a service that everyone agrees is needed, you'd better be sure you understand the financing. And in this case we didn't. Not the administration, not the Congress.

Q And did you also underestimate the reaction you'd get from the elderly?

MR. FITZWATER: Absolutely.

Q I want to see if I can pin you down on whether the President's primary concern on repeal -- in fact, only major concern on repeal -- is triggering the sequester? Were it not for that, would the President repeal this program? Would he support repeal?

MR. FITZWATER: Well, I can't say that because obviously we'd like to provide the benefits. We thought it was a good program, and so forth. But we have to look at all the aspects of it.

Q Are you searching now for a way to repeal the program and avoid the sequester? Is that the focus of your search?

MR. FITZWATER: We're searching for a way to mitigate the financial problems.

Q Of repealing the program?

MR. FITZWATER: And saving the program. And that's where we've been for the last couple of months.

Q Well, I'm sorry. I really don't understand whether you're aiming to save the program or whether you're aiming to repeal and save the budget.

MR. FITZWATER: Well, we're saving the program. We have testified that we support the program and we don't see any need for

MORE

9/12

change, but we have also been searching for a couple of months for possible changes. We continue to do that.

Q On another subject -- back on --

Q No. Marlin.

Q Wait a minute.

Q No, let's kick this around a little longer.

Q Marlin, Marlin, do you have a quantitative count of this rolling in of complaints? I mean, how many -- has the switchboard been flooded and the mail way up?

Q What is the income distribution of this tidal wave?

MR. FITZWATER: Probably 535 to zero.

Q No, the complaints you've heard are directly from Congress and not from elderly citizens? They have not been calling?

MR. FITZWATER: Oh, there may have been elderly -- there probably have been elderly concerns directly to the government through HHS and other places, but certainly in the Congressional meetings it has been relatively unanimous.

Q Marlin, are you saying that this tidal wave of objections is from all elderly across the board or primarily those that are paying taxes and would have to pay the surtax?

MR. FITZWATER: I don't know specifically, although this morning several members of Congress emphasized that in terms of their constituents and the people they talked to in August, it was from all categories of the elderly.

Q One of the suggestions is to have the surtax -- to just cut that in half and raise the premiums which affect all people, primarily all the elderly recipients. And this would not increase the deficit in any way. Primarily it would be budget-neutral but would change the mix. Is the administration willing to consider that since there's no difference in --

MR. FITZWATER: Well, I can't comment on various options, Paula, but obviously we're looking at whatever can be done. And I know that's one of them, but we don't want to commit at this point until we've reached some kind of an agreement.

Q Well, last week your OMB Deputy Director testified that they -- the administration would prefer that we just keep the program as is and, as you said, the concern for sequester and triggering the deficit. If you were to consider repeal, would it be only on condition that that $6 billion in revenue loss be offset?

MR. FITZWATER: Well, as you correctly point out, our position is to keep the program, but it's also true that we have agreed to look at various alternatives, but I'm just not free to discuss what we might do or what we might not do.

Q But would any of them have to be budget-neutral? I mean, if you were to go with repeal, you'd lose $6 billion, so would you have to offset that?

MR. FITZWATER: But I don't want to signal that in advance, Paula. We'll have to -- something we'd work out in the negotiating process.

Q But when you say "keep the program," are you talking about no program reductions at all? No reductions in services?

MR. FITZWATER: Well, there again I can't specify that kind of detail because when you get into discussions of how the

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9/12

program might be altered or financing changes, those things are all up to negotiation. And we just don't want to make any commitments other than the public one, so at the moment our policy is to continue to support the program.

Q Well, do you want to keep it for its own sake or because you need it for budgetary reasons?

MR. FITZWATER: Both. We want to keep it for its own sake, first of all, and secondly, to make changes, there are significant budgetary problems.

Q It sounds like you're just hung up on the budget side of the equation.

MR. FITZWATER: No, we're hung up on all sides. It's a very difficult issue.

Q Back to another difficult issue, drugs, was the White House surprised by the Democratic response to the President's proposal? Was it more critical than you expected, and were you surprised that some Democrats talked about raising taxes?

MR. FITZWATER: I'd say we were a little surprised that the Democrats thought raising taxes was a viable response, yes.

Q Were you pleased that that was their response because you think that's --

MR. FITZWATER: Well, it did make it clear that we're for fighting drugs and they're for raising taxes.

Q Is this what you call stopping the partisan --

Q Is there any possibility that --

MR. FITZWATER: (Laughter.) Hey, she asked the question. Nick, go ahead.

Q Is there any possibility that Yeltsin would be available to the press while he's here on the White House grounds?

MR. FITZWATER: I don't know. You'd have to ask him.

Q Can we find out --

Q I mean, which way is he coming out?

Q Will you allow him to go out and talk in the driveway, or where is his limo?

MR. FITZWATER: He's free to do whatever he wants.

Q Marlin, before you leave, what's the purpose --

MR. FITZWATER: What time is the speech? We've got 15 minutes?

Q What's the purpose of the Hassan visit?

MR. FITZWATER: He's here to talk about a wide range of issues, primarily, however, economic assistance.

Q To who? To who? Economic assistance --

MR. FITZWATER: To Jordan.

Q To Jordan? For what purpose? Just because the oil prices are down? Is that why?

MR. FITZWATER: Yes, they're having significant economic

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9/14

that be done without busting the budget? And is it your view now that the White House is going to have to take a far more active role in this if this program is to be saved?

MR. FITZWATER: On catastrophic? Well, we are working with the Senator and others on the Hill on a solution. We don't want to commit to any one course of action at this point.

Q How do you feel about making it voluntary? He's commiting to a solution.

MR. FITZWATER: Well, he is, but we've got a lot of people to discuss it with and we don't want to take a public position until we can reach a greater consensus.

Q Can it be made voluntary and not bust the budget?

MR. FITZWATER: I don't know.

Q I mean there are a lot of senators and congressmen, as you well know, up on the Hill who insist that short of a very active White House position -- presidential position on this, that he'll be steamrolled and the thing will be repealed outright. That came up the other day when Gingrich and company were in here.

MR. FITZWATER: Well, we are --

Q Yet there still seems to be no well -- clearly defined White House position on this thing, and I'm curious as to why.

MR. FITZWATER: The reason for that is that we are discussing it with any number of members and there are a number of different ways to approach it. And we are not wedded to any single one, but to working out the best solution. And as we have said here before, there are a lot of people who feel strongly on both sides, and there are different alternative financing mechanisms. So it doesn't pay us to take a position on voluntary implementation or whatever until we work out a consensus.

Q Marlin, when you talk about the best solution, are you talking about the best solution for all the elderly or for keeping any alternative within the budget?

MR. FITZWATER: The best solution for the elderly, in terms of preserving the benefits, making the premiums realistic, and preserving the fiscal aspects of it in terms of the budget.

Q Are you willing to preserve the progressivity of the payments?

MR. FITZWATER: We'd like to preserve the benefits, but the payments and progressivity, all those are aspects that are under discussion.

Q You're not trying to keep that principle in there?

MR. FITZWATER: Well, we're not going to say. We're

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saying we're willing to discuss it, but we're not committing to any specifics.

Q Do you want to preserve all the benefits under current --

MR. FITZWATER: That's our initial position, sure -- that we think it's a good program, we proposed this program, and we'd like to keep it.

10/3

Q Is the President making any calls on the catastrophic -- before the catastrophic vote today?

MR. FITZWATER: I don't believe so, no.

Q Do you have a preference among the three alternatives they will be considering?

MR. FITZWATER: Our position is the same as it's always been, that we prefer to maintain the benefits while finding some way to mitigate the cost of the premiums.

Q Well, they have three actual alternatives they're going to choose from. Can we presume from that that you like the Ways and Means approach the best?

MR. FITZWATER: We wouldn't want to specify publicly which we favor until we see the final product.

Oct 3

Q But you are against the repeal amendment, aren't you?

MR. FITZWATER: Yes. We've opposed repeal.

10/2

Q Do you have a position on the various options taken about catastrophic health in the House tomorrow?

MR. FITZWATER: That's another case where there are still a number of options in the works. Our position is clear, but we'll work with various peoples.

Q Why are there options in the works? I mean, we know what amendments will be offered on the floor. You don't have a position on the bill or one of those amendments?

MR. FITZWATER: Well, our position, basically, is that we want to retain the benefits and mitigate the premium cost. But there are some ways that some of the bills want to reduce all the benefits, some want to eliminate the premium entirely, some want to eliminate the surtax. I mean, there's any number of different approaches.

Q But there's three approaches the House is going to vote on. Do you have a position on those?

MORE #106-10/02

MR. FITZWATER: No. We'll wait and work with them still. We haven't reached a final point yet.

Q Don't want to get out in front on this one, huh?

MR. FITZWATER: Nope. We're right where we want to be. (Laughter.)

Q Obscure.

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

THE DIRECTOR

October 5, 1989

TEXT OF A LETTER ADDRESSED INDIVIDUALLY TO SENATORS DANFORTH, DURENBERGER, McCAIN, AND ROTH

We understand that you intend to offer an amendment to legislation pending in the Senate that would modify the Catastrophic Health Insurance (CHI) program.

You have provided us a copy of your amendment (description attached) and asked whether or not adoption of your amendment would yield a revised G-R-H deficit estimate that would require sequester. As we approach the crucial October 15 deadline, there are several new elements in the calculus that I would call to your attention. The DOD paydate shift, which had been a subject of dispute, has now been overtaken by events. It has already taken place. In addition, the House includes Medicare scoring language, which we did not support but which is now moving forward in the reconciliation bill. If enacted, this language would direct us to score certain shifts in Medicare payments between fiscal years that we would otherwise be prohibited from scoring. And if the emerging reconciliation bill, including the language dealing with the scoring of Medicare payment shifts, is enacted, our current estimate of the G-R-H baseline deficit would be reduced by approximately $12 billion. This would then yield a revised G-R-H deficit estimate that could accommodate your amendment without triggering sequester.

Let me be clear: This CHI amendment would unquestionably have a serious adverse effect on the actual fiscal year 1990 deficit. But in view of the scoring issues I've noted, it is now the case that your CHI amendment would <u>not</u> trigger a sequester if reconciliation, including the Medicare payment shift language, continues on its present course, and is passed by the Congress and signed by the President before October 16th.

I write this letter in response to your inquiry on this matter. Nothing in this letter should be construed as an expression of support for or opposition to one CHI substantive amendment as opposed to another. Indeed, the Admnistration is not taking an official position in favor of any one of the competing CHI substantive amendments as opposed to the others. The purpose of this letter is to report on the relationship of scoring issues to a possible sequester -- as currently estimated -- and to clarify that we are not officially choosing among the competing CHI substantive amendments.

With best regards,

Richard G. Darman

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

The Honorable Lloyd Bentsen, Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

OCT 5 1989

Dear Mr. Chairman:

The purpose of this letter is to clarify this Administration's position on Medicare catastrophic legislation pending before the Senate.

As I have emphasized on other occasions, our preference has been that no changes be made to the program, and that it be implemented as crafted. However, the Congress, under pressure from what we believe is a relatively small and in many cases misinformed group, is moving toward repealing or drastically changing this new benefit.

I believe the House action yesterday will be regretted. I wish a proposal could have been offered in the House that would have, at a minimum, preserved the core benefits of the program as originally outlined in President Reagan and former Secretary Bowen's plan. It is my understanding the Senate may still have such an opportunity. It is critical that we preserve a catastrophic program that offers financial protection to the millions of Americans who do not have this protection.
I am aware that Senator Durenberger has a compromise that incorporates our mutual priorities. This plan has also addressed the concerns of many others by significantly lowering the supplemental premium.

Our nation's health policy cannot afford the set-back repeal would cause. It is an undisputed fact that our Medicare system needs a catastrophic program if it is to remain sound. Catastrophic continues to be confused with the issue of long term health care. Our nation must address both of these urgent health care priorities but we cannot and should not attempt to address them as if they were one. If the Senate chooses to ignore this proposal which preserves the core and essential components of a catastrophic benefit program, our dilemma in providing appropriate health care for our nation's elderly will reach a magnitude that is almost unmanageable.

I appreciate all that you have done to move this issue forward. Thank you for your continued assistance towards a sound health policy for our nation.

Sincerely,

Louis W. Sullivan

Louis W. Sullivan, M.D.

IMPORTANTLY, ESSENTIAL SERVICES PERFORMED CURRENTLY BY THE SOCIAL SECURITY ADMINISTRATION WILL MOST LIKELY BE DISRUPTED IN THE NEAR TERM AND IMPORTANT IMPROVEMENTS IN SERVICES THAT HAVE BEEN MADE RECENTLY WILL BE REVERSED. AS WELL, OVER THE LONG TERM, INDEPENDENT AGENCY STATUS WILL ACTUALLY INCREASE THE COST OF PROVIDING SOCIAL SECURITY SERVICES AT A TIME WHEN COST SAVINGS ARE AN INCREASINGLY IMPORTANT PRIORITY.

- EXAMPLES OF RECENT IMPROVEMENTS IN SERVICE DELIVERY, WITH SUPPORT FROM HHS STAFF, INCLUDE A SHORTENING OF THE TIME IT TAKES TO RECEIVE SOCIAL SECURITY CARDS, THE TIME IT TAKES FOR SENIOR CITIZENS TO RECEIVE SOCIAL SECURITY CHECKS, AND THE TIME REQUIRED TO COMPLETE THE EARNINGS TEST ELIGIBILITY. THESE ARE CRUCIAL IMPROVEMENTS IN SERVICES THAT RESULT, IN MANY INSTANCES, IN THE ELDERLY BEING SAVED FROM DIRE PERSONAL CIRCUMSTANCES. THE PROCESS OF EXTRACTING SSA FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS SURE TO REVERSE THESE GAINS IN THE NEAR TERM, IF NOT, OVER THE LONG TERM AS WELL.

- FURTHERMORE, MAKING SSA AN INDEPENDENT AGENCY WILL ELIMINATE THE CONSIDERABLE BENEFIT TO THE ELDERLY OF BEING ABLE TO OBTAIN INFORMATION AND DIRECTION ON SOCIAL SECURITY AND MEDICAL PROGRAMS IN ONE LOCATION, THE SO-CALLED "ONE-STOP SHOPPING" BENEFIT. IT WILL CERTAINLY LENGTHEN THE AMOUNT OF TIME IT TAKES TO PROCESS BOTH SOCIAL SECURITY AND MEDICARE-MEDICAID PAYMENTS. IT WILL DELAY DISABILITY DETERMINATION.

- FOR THESE REASONS, IT SEEMS WITHOUT QUESTION THAT DISMANTLING THE SOCIAL SECURITY ADMINISTRATION'S RELATIONSHIP WITH HHS IS PROFOUNDLY BAD HEALTH AND SOCIAL SERVICES POLICY. IT IS ASTOUNDING TO ME THAT SUCH SIGNIFICANT REVERSAL OF HEALTH AND SOCIAL POLICIES IS OCCURRING AT THE ELEVENTH HOUR, AND WHOLLY IN THE DARK.

- THERE HAS BEEN NO SIGNIFICANT DEBATE ON THIS IMPORTANT MATTER EITHER IN THE MEDIA OR IN THE CONGRESS. IN THE SENATE, FOR EXAMPLE, THE COMMITTEE HAVING THE MOST SIGNIFICANT JURISDICTION HAS NOT HELD ANY HEARINGS OR EVEN WEIGHED IN ON THIS MATTER. THIS ISSUE DESERVES MORE SERIOUS TREATMENT.

- THIS ADMINISTRATION, IN THE STRONGEST POSSIBLE TERMS, OPPOSES ANY EFFORT TO DISLODGE THE IMPORTANT RELATIONSHIP BETWEEN SSA AND HHS. AT THE VERY LEAST, THE CONGRESS HAS THE RESPONSIBILITY TO CONSIDER DISMANTLING THIS RELATIONSHIP THOROUGHLY AND DELIBERATELY. THE PRECIPITOUS AND POORLY CONSIDERED ACTION CURRENTLY BEING CONSIDERED IS SURE TO BE DISASTROUS TO AMERICA'S GROWING ELDERLY POPULATION.

ADDITIONAL REMARKS
IN PRESS CLUB SPEECH
October 5, 1989

- AS IMPORTANT AS THE AIDS PROBLEM IS, I AM SURE MOST OF YOU HERE ARE ALSO QUITE INTERESTED IN THE DEBATE IN THE SENATE ON CATASTROPHIC HEALTH INSURANCE. IN ANTICIPATION OF QUESTIONS YOU MAY HAVE ON THAT ISSUE, I HAVE A FEW THINGS I WOULD LIKE TO SAY

- TO TAKE BACK FROM TENS OF MILLIONS OF ELDERLY AMERICANS THE COMFORT OF KNOWING THAT SERIOUS ILLNESS WILL NOT CAUSE THEM FINANCIAL RUIN WOULD NOT ONLY BE UNWISE HEALTH POLICY, BUT WOULD SIMPLY BE AN UNFORGIVABLE ACT OF POLITICAL EXPEDIENCE

- THE NEED OF THE ELDERLY FOR SECURITY AGAINST FINANCIAL DEVASTATION FROM ILLNESS IS DENIED BY NO ONE. YET, THE RUSH FOR REPEAL OF THE CATASTROPHIC BILL IS SHOCKING. THERE ARE CLEARLY PROBLEMS WITH THE LAW THAT NEED TO BE ADDRESSED, BUT THE SAFETY NET OF BASIC PROTECTION AGAINST FINANCIAL RUIN CANNOT BE IGNORED

- FOR THESE REASONS, I AM NOW REDOUBLING MY EFFORTS AND WILL BE WORKING VIGOROUSLY WITH SENATORS DURENBURGER, DOLE, BENTSEN, AND OTHERS TO URGE THE SENATE TO PASS A MEASURE THAT CONTAINS THE CARE PROVISIONS OF THE CURRENT LAW WHILE REDUCING THE COST TO THOSE WHO HAVE TO PAY FOR IT. I HAVE NO DOUBT THAT ADEQUATE COVERAGE CAN BE PROVIDED WITHOUT STRAIN TO THE BUDGETS OF THE ELDERLY OR TO THE NATIONAL BUDGET.

- AS CONCERNED AS I AM ABOUT THE CATASTROPHIC BILL, I AM TERRIBLY TROUBLED ABOUT PENDING ACTION IN THE CONGRESS THAT CAN CAUSE EVEN GREATER HARM TO MILLIONS OF AMERICANS. IN THE HOUSE RECONCILIATION BILL AND, MOST LIKELY, IN THE SENATE RECONCILIATION BILL IS A PROVISION TO MAKE THE SOCIAL SECURITY ADMINISTRATION A SEPARATE AGENCY. IF THESE PROVISIONS BECOME LAW, IT WILL BE DEVASTATING TO ELDERLY AMERICANS.

- FOR THE SOCIAL SECURITY ADMINISTRATION TO BE DOWNGRADED TO JUST ANOTHER INDEPENDENT AGENCY MEANS THAT THE SERIOUS AND LEGITIMATE CONCERNS REGARDING THE CARE AND SUPPORT OF OUR SENIOR CITIZENS WILL LOSE CABINET LEVEL ADVOCACY. MORE

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

THE DIRECTOR

October 4, 1989

Honorable Leon Panetta
Chairman, House Budget Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

We understand that the House has just voted to support an amendment to the Omnibus Budget Reconciliation Act that would exempt the Catastrophic Health Insurance (CHI) program from scoring under the Gramm-Rudman-Hollings (G-R-H) legislation. The Administration strongly opposes this exemption from G-R-H scoring. We have opposed exemptions to G-R-H consistently in the past. The most recent case was the exemption proposed, but not enacted, as part of the financial institutions reform and recovery legislation. We believe that the fiscal discipline imposed by the G-R-H legislation -- admittedly imperfect, but nonetheless important -- would be substantially weakened if exemptions to it were allowed.

Further, in this particular case there does not now appear to be a need to grant a G-R-H exemption for the purpose of avoiding sequester. As we approach the crucial October 15 deadline, there are several new elements in the calculus that I would call to your attention. The DOD paydate shift, which had been a subject of dispute, has now been overtaken by events. It has already taken place. In addition, the House includes Medicare scoring language, which we did not support but which is now moving forward in the reconciliation bill. If enacted, this language would direct us to score certain shifts in Medicare payments between fiscal years that we would otherwise be prohibited from scoring. And if the emerging House reconciliation bill, including the language dealing with the scoring of Medicare payment shifts, is enacted, our current estimate of the G-R-H baseline deficit would be reduced by approximately $12 billion. This would then yield a revised G-R-H deficit estimate that could accommodate the CHI roll-back without triggering sequester.

IDENTICAL LETTER SENT TO HONORABLE BILL FRENZEL

Let me be clear: The CHI amendment would unquestionably have a serious adverse effect on the actual fiscal year 1990 deficit. But in view of the scoring issues I've noted, it is now the case that without the undesirable G-R-H exemption the CHI amendment would not trigger a sequester if the House version of the reconciliation bill, including the Medicare payment shift language, were passed by the Congress and signed by the President before October 16th.

I write this letter in response to your inquiry on this matter. Nothing in this letter should be construed as an expression of support for or opposition to one CHI substantive amendment as opposed to another. The sole purpose of this letter is to report on the relationship of scoring issues to a possible sequester -- as currently estimated.

With best regards,

Richard G. Darman

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^House Votes to Repeal Catastrophic Health Insurance Program<
^Eds: Combines pvs<
^By JERRY ESTILL=
^Associated Press Writer=

WASHINGTON (AP) - The House, responding to a firestorm of protest from elderly Americans against having to pay for expanded Medicare benefits, voted 360-66 today to repeal the catastrophic health insurance program.

It then turned to consideration of a proposal to salvage a small piece of the year-old Medicare expansion.

However, Rep. Fortney Stark, D-Calif., chairman of the House Ways and Means Committee's health subcommittee, said the outright repeal was likely to stand.

Stark was one of the main authors of the catastrophic program, signed into law last summer with great fanfare by then-President Reagan and hailed as the most significant expansion of Medicare in its two-decade existence.

Today's vote to repeal it was a startling reversal of last year's 328-72 vote to pass the original measure.

Despite the repeal vote, however, the final judgment on catastrophic health insurance is far from over.

The action now shifts to the Senate, where repeal sentiment is also strong but where Finance Committee Chairman LLoyd Bentsen, D-Texas, is looking for ways to save the framework of the program.

Complicating the final decision was the fact that both the House and Senate wove the catastrophic health issue in with a massive deficit-reduction bill containing a number of other controversial topics - including a capital gains tax reduction, child care and taxes on ozone-depleting chemicals.

In the end, the massive compromise measure will return as one big package to both chambers for a single up or down vote.

The feature in last year's legislation that prompted the cries for repeal stemmed from a bipartisan agreement that the cost of the expanded benefits must be born fully by the 33 million elderly and disabled people covered by Medicare.

Congress structured the increased fees so those in higher income brackets would pay a larger share in proportion to their tax liability - up to a maximum of $800 this year.

But that financing feature generated a firestorm of protest and overshadowed the big expansion in benefits for hospitalization, doctor bills and other costs.

The cry for repeal came mainly from three quarters:

-Retirees who complained their former employers were already giving them additional benefits they were being forced to purchase from Medicare.

-Upper-income retirees who objected to having to pay a disproportionate share of the costs to make up for the modest $4-a-month assessment on the estimated 56 percent of Medicare beneficiaries who don't have enough money to owe any income taxes.

-Those who complained that the program did not address the main need of elderly Americans: insurance for nursing homes and other long-term care.

With repeal or a massive rollback a virtual certainty, congressional health policy leaders said they anticipate even greater difficulty in the future in winning support for expan[illegible]d health programs for the elderly.

''Future programs are going to have to be more carefully considered,'' House Speaker Thomas S. Foley told reporters Tues[illegible]y.

Formally called the Medicare Catastrophic Coverage Act, the program was designed to protect the elderly and disabled from financial ruin in the event of a prolonged hospital stay or other high medical costs.

It would pay for unlimited hospitalization after a once-a-year deductible of $560 in 1989. Previously, Medicare charged a deductible for each hospital stay during a year and provided full payment of hospital bills only up to 59 days a year.

The plan also would cap, starting Jan. 1, the amount that beneficiaries must pay for physician services and, beginning Jan. 1, 1991, would phase in a new prescription drug benefit.

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^

^Catastrophic Care

^By RITA BEAMISH=

^Associated Press Writer=

^

SAVE - ost health file

WASHINGTON (AP) - The Bush administration, facing ``tidal waves'' of complaints from the elderly, says it is willing to consider replacing an unpopular surtax to finance catastrophic health insurance.

As the Senate Finance Committee searched Tuesday for last-ditch ways to prevent repeal of the program, administration officials said a repeal is unacceptable because of the revenue loss it would cause.

The administration is ``listening and learning'' to what Congress proposes in the way of alternatives to finance the insurance program, said William Diefenderfer III, deputy director of the Office of Management and Budget.

The surtax, paid by the wealthiest 40 percent of all retirees, is the chief financing mechanism for the catastrophic insurance program enacted a year ago as an expansion of Medicare.

Bush supported the plan during his presidential campaign last year.

``The administration thought it was a good program when it passed'' during the Reagan administration, said White House Press Secretary Marlin Fitzwater.

But now, he said, the ``political aspects'' of the program have become clear.

``The elderly complaints are rolling in tidal waves of immense proportion,'' Fitzwater said. ``We recognize the impact on the elderly ... We recognize their concern. We're working with Congress ..., searching for a way to mitigate the financial problems and save the program.''

Most of the complaints come from middle and upper income retirees who contend they are bearing most of the cost of the program, and those who are covered by private insurance plans.

But Diefenderfer said repeal of the entire program - and the loss of its $4 billion to $7 billion in surtax revenue - probably would force automatic spending cuts in other federal programs, including those that benefit the elderly and needy Americans.

Sen. Lloyd Bentsen, D-Texas, chairman of the Senate Finance Committee, said after a closed-door session of the panel Tuesday that, ``There is no question in my mind that we are going to face an amendment on the (Senate) floor to repeal catastrophic.''

He said the committee is working to strip away all but basic elements of the program to reduce costs to the minimum. This could lead to elimination of payments for prescription drugs and for skilled nursing care.

The House Ways and Means Committee already has voted to reduce benefits and the two taxes that finance the program.

Strong sentiment from House members for repeal was conveyed to Bush on Tuesday in a meeting with GOP congressional leaders.

House Republican Whip Newt Gingrich of Georgia said after the meeting that he had noted ``a dramatic shift'' in the administration's willingness to amend the program.

The Senate Finance Committee agreed informally last week that the surtax would be cut significantly, that the flat monthly premium would not be changed and that beneficiaries would have to pay a bigger share of expenses for drugs and doctors' bills before reimbursement under the catastrophic care program begins.

Everyone eligible for Medicare is required to pay into the catastrophic care program. About two-thirds of the costs are paid by retirees who make enough to pay more than $150 a year in federal income taxes. Their surtax - of up to $800 - is 15 percent of their income taxes.

The remaining costs come from a flat $4 monthly premium paid by all but the poorest of the 33 million people eligible for Medicare.

When catastrophic illness protection was enacted last year, it was predicted to cost about $31 billion over five years. The latest forecasts put that figure at $45 billion or more.

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Alixe:

1. You might want to contact the person who was the contact at the campaign ...

2. Materials:

   - Pamphlet on the benefit structure.

   - A discussion piece on why the Congress thought the supplemental premium (read tax) was a good idea.

   - A piece from the WSJ from the former chief actuary of the Social Security Administration giving the simplest explanation of the financing scheme for catastrophic.

   - The material from the Jt Tax committee on catastrophic reform. See the highlighted ite-s for info on premium amounts and how many people are paying the supplemental premium/surtax.

If you have questions, I'm at 6563 or 6515.

Hanns Kuttner

disciplined/
balanced solution

not a give-away prog.
Reconciliation make it
fit the bottom line –

keep benefit structure in tact
but w/in budget realities –

repeal means finding $6B.

fray cst. w/ in Reconcilliation

George Bush for President

FOR IMMEDIATE RELEASE
THURSDAY, JUNE 9, 1988

CONTACT: Alixe Glen
(202) 842-1988

STATEMENT BY THE VICE PRESIDENT

I am glad that the House and Senate have passed the Catastrophic Health Bill. I salute Health and Human Services Secretary Otis Bowen who has long championed catastrophic care. The legislation which passed yesterday will, for the first time since the founding of Medicare, extend benefits for our seniors. Now they do not have to live in fear that their life's savings would be wiped out by a prolonged hospitalization.

I was particularly pleased that the final bill contains a provision to eliminate the threat of spousal impoverishment from long term health costs. I have advocated this as a major part of the solution to the problem of long term care. No spouse should become broke paying the cost of his or her partner's nursing home costs. I am pleased to see that this will no longer be the case.

# # # #

Rationale for the premium

Income Related Supplemental Premium;

In addition to providing for beneficiary financing of the catastrophic benefit, the catastrophic legislation includes an income related concept where beneficiaries at higher income levels will pay a higher share of the premium costs through the introduction of an annual supplemental premium in addition to the basic monthly premium assessed all Medicare beneficiaries. As the benefit package was developed and cost estimates for the new benefits increased, the need for income related premiums became apparent. Factors influencing the decision to include this additional method of financing included;

- Initial Administration catastrophic proposal was intended to provide basic Part A and B catastrophic protection and keep anticipated program cost at low level. With relatively modest changes in program structure financing through a modest monthly premium paid by all enrollees was considered feasible.

- In considering catastrophic proposals, the Congress was persuaded that a more extensive benefit package was desired by beneficiaries and would be appropriate. Beneficiary groups also emphasized need for an increased benefit package.

- Additional benefits were included under Part A and B of the program and a new outpatient prescription drug benefit was added to both the House of Representatives and Senate drafts. These additional benefits were retained in the final legislation approved and signed by the President.

- The expanded benefits in the legislation resulted in substantial increases in the revenues needed to finance the bill. Financing through only a basic monthly premium paid by all beneficiaries was not feasible. The monthly rate required would have become excessive for many beneficiaries, especially those in lower income categories not eligible for Medicaid entitlement and premium buy-in.

- Congress identified the income related supplemental premium as an appropriate way to finance the catastrophic benefit. This form of financing was included in the early House and Senate versions of the legislation even prior to the addition of a drug benefit.

- The income related supplemental premium addressed the need for additional revenues while keeping the cost affordable to lower income beneficiaries, especially those above income levels required for Medicaid eligibility.

- Through the assessment of a supplemental premium, beneficiaries who are in higher income levels will pay a higher amount of the benefit cost, thus assisting those lower income beneficiaries with paying for the cost of their improved protection.

Medicare Entitlements: A Question of Fairness

A Catastrophic Act? It Depends

By Robert J. Myers

Many elderly are dissatisfied with the Medicare Catastrophic Coverage Act of 1988, which phases into effect by 1993. But the question of whether the new law is inequitable is like the fable of the blind men describing the elephant—it depends on what you examine.

The plan's aged and disabled participants are, in the aggregate, intended to pay the entire cost of the new benefit protection—a rare feature. Accordingly, what causes discord is the nature of averages—some (higher-income people) pay more than their added protection is worth, while others (lower-income people) pay less.

Furthermore, a special problem of equity arises for those who have had supplementary protection from post-retirement health plans established by employers—especially when such plans are comprehensive and the employers pay all (or most) of the cost. Under such circumstances, individuals may end up paying much more for the same protection they had before. A special temporary provision requires the employer to make up the cost difference in some cases, but this is not effective over the long run.

Up to this point, the situation seems very inequitable to many Medicare participants. However, let us look at the "elephant" from another angle. More than 95% of Medicare participants elect coverage under Supplementary Medical Insurance—the optional Part B program that mainly covers physicians' fees. Last year, they received a tax-free subsidy of $893 from the General Treasury (i.e., from taxpayers of all ages) amounting to about three times the Supplementary Medical Insurance premium they paid themselves. It is estimated that in 1993 this tax-free payment will amount to $1,515 per participant.

The new plan requires a so-called Supplemental Premium to be paid by all people eligible for the Hospital Insurance portion of Medicare for more than six months in a calendar year if they have income-tax liability of at least $150. The Supplemental Premium is a surcharge on the income-tax liability, which starts at 15% this year and reaches 28% in 1993. A per-capita limit on the Supplemental Premium is also established—beginning at $800 this year and reaching $1,050 in 1993. These limits apply to single people with incomes of $30,000 or more and to married couples filing joint returns with incomes of $50,000 or more.

Thus, high-income people will have to pay a substantial added charge not being asked of lower-income people. The additional benefit protection is worth far less than the additional premium.

SIMPLE EXPLANATION OF CURRENT LAW

Let's examine the situation for high-income participants in 1993, when the new plan is first fully effective. The annual maximum Supplemental Premium will be $1,050. In addition, the monthly Flat Premium rate for catastrophic benefits will increase to $10.20 for all participants (including a portion that pays part of the cost for the new Catastrophic Drug Insurance benefits).

Accordingly, the Medicare Catastrophic Coverage Act will increase premiums a maximum of $1,172.40 from their pre-act rates. Thus, this additional expenditure for high-income people slashes (but does not eliminate) the tax-free subsidy of $1,515 mentioned previously. It can be argued, when viewed from this angle, that high-income people are not, overall, being inequitably treated. Rather, most of the tax-free windfall they have received under Medicare has been "taken back." Other recipients continue to receive a bigger chunk of the windfall, however, so in that sense the high-income people are being inequitably treated.

This situation is somewhat similar to that of the "notch babies"—those born in 1917-21 who worked well beyond age 62. Such people receive equitable Social Security benefits as compared with those born in later years but often far less than those born before 1917. And so it depends on which way one looks as to whether fair treatment is being given.

Thus, on the average, high-income people participating in all parts of Medicare will not have any "net" loss from their increased out-of-pocket costs. Such costs merely partially offset bonanzas from the General Treasury that are provided under the provisions of previous law. Such people cannot avoid most of the new, increased premium costs; if they drop out of Supplementary Medical Insurance and Catastrophic Drug Insurance (to avoid paying the monthly Flat Premium), they must still pay the annual Supplemental Premium (and not receive any of the SMI and CDI benefits that are partially financed by a portion of it).

Although high-income people without employer-paid supplementary health insurance "lose" most of the government subsidy they had received for many years, they do have increased benefit protection (of a catastrophic nature). Still, these people will not be convinced that they are not being inequitably treated when a bonanza they have had for a long time is partially taken away.

Mr. Myers was chief actuary of the Social Security Administration, 1947-70, and deputy commissioner, 1981-82. He was executive director of the National Commission on Social Security Reform, 1982-83.

original liquidation) will not be taken into account. However, reliquidation under 19 U.S.C. section 1501 (voluntary reliquidation by the Customs Service within 90 days of the original liquidation to correct errors in appraisement, classification, or any element entering into a liquidation or reliquidation) or reliquidation under 19 U.S.C. section 1520(c)(1) (to correct a clerical error, mistake of fact, or other inadvertance within one year of a liquidation or reliquidation) will be taken into account in the same manner as, and take the place of, the original liquidation in determining customs value.

(e) *Drawbacks.* For purposes of this section, a drawback, that is, a refund or remission (in whole or in part) of a customs duty because of a particular use made (or to be made) of the property on which the duty was assessed or collected, shall not affect the determination of the customs value of the property.

(f) *Effective date.* Property imported by a taxpayer is subject to section 1059A and this section if the entry documentation required to be filed to obtain the release of the property from the custody of the United States Customs Service was filed after March 18, 1986. Section 1059A and this section will not apply to imported property where (1) the entry documentation is filed prior to September 3, 1987; and (2) the importation was liquidated under the circumstances described in paragraph (c)(9) of this section.

/s/Lawrence B. Gibbs
Commissioner of Internal Revenue

Approved: June 26, 1989

/s/Kenneth W. Gideon
Assistant Secretary of Treasury

JOINT COMMITTEE ON TAXATION STAFF DESCRIPTION (JCX-45-89) OF PRESENT LAW AND POSSIBLE REVENUE OPTIONS RELATING TO MEDICARE CATASTROPHIC INSURANCE PROGRAM, AND SENATE FINANCE COMMITTEE STAFF OPTIONS TO REFORM MEDICARE CATASTROPHIC BENEFITS, CONSIDERED BY FINANCE COMMITTEE SEPT. 7, 1989 (TEXT)

JCX-45-89

CONTENTS

INTRODUCTION

I. PRESENT LAW
   A. Medicare Benefits
   B. Financing of Medicare Benefits

II. DESCRIPTION OF POSSIBLE REVENUE OPTIONS
   A. Reduce Supplemental Premium Rates and Caps
   B. Increase the Wage Base for the Medicare Hospital Insurance Tax to $60,000

APPENDIX A: DISTRIBUTIONAL EFFECT OF THE SUPPLEMENTAL PREMIUM

INTRODUCTION

The Senate Committee on Finance has scheduled a markup on September 7, 1989, on the Medicare catastrophic insurance program of the Medicare Catastrophic Coverage Act of 1988.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a discussion of present law, possible revenue options proposed, and distributional effects of the supplemental premium and options.

Part I of the document provides a summary description of present law relating to Medicare benefits and financing of the benefits. Part II describes possible revenue options. The Appendix provides data on the distribution of the current Medicare supplemental premium by income group.

[1] This document may be cited as follows: Joint Committee on Taxation, *Present Law and Possible Revenue Options Relating to the Medicare Catastrophic Insurance Program* (JCX-45-89), September 7, 1989.

I. PRESENT LAW

A. Medicare Benefits

In general

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Medicare consists of three parts: the hospital insurance program (Part A), the supplementary medical insurance program of Part B (SMI), and the catastrophic drug insurance program of Part B (CDI).

Individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement benefits are covered under Part A of Medicare at no cost. Part A coverage is also available at no cost to certain disabled individuals who have not attained age 65 and to persons who have end-stage renal disease. Persons who have attained age 65 and who are not eligible for social security or railroad retirement benefits may obtain Part A coverage providing they pay for the coverage. The monthly premium for such coverage, as of January 1, 1989, is $156.

Within limits, Part A of Medicare provides coverage for inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Coverage under Part B, which includes the SMI and the CDI programs, is voluntary. All persons age 65 or older and individuals eligible for Part A benefits by virtue of disability or end-stage renal disease may elect to enroll in both these programs by paying the monthly premium. Enrollees may not elect to enroll in only one of these programs.

SMI covers doctor's services, other medical and health services (e.g., laboratory and other diagnostic tests, ambulance services, outpatient services at a hospital), and certain home health services not covered under Part A. SMI covers 80 percent of the reasonable charges for such services, subject to a deductible. Beginning in 1990, enrollees in Part B will also be eligible for prescription drug benefits.

Published by THE BUREAU OF NATIONAL AFFAIRS, INC., Washington, D.C. 20037

SEP 12 '89 17:05 WASH RGNL OFFICE P.2/8

Benefits under the Medicare Catastrophic Act of 1988

The Medicare Catastrophic Act of 1988 (the "Act") significantly expanded the benefits covered by Medicare. Major changes to the benefits are described below.

Part A benefits

Inpatient hospital care. — Under the Act, Medicare pays all hospital inpatient costs above an annual deductible amount ($560 for 1989). Under prior law, the number of days covered by Medicare was limited for a single spell of illness, covered individuals paid a deductible for each spell of illness, and coinsurance amounts were payable after the 60th day of each spell of illness. The Act eliminated the concept of a spell of illness, which began with a hospital admission and ended on the 61st day following discharge from the hospital or from a skilled nursing facility (SNF) entered after the hospital stay.

Skilled nursing facility care. — Under the Act, the limit on SNF care is 150 days per year, and no prior inpatient stay is required for coverage. Coinsurance payments are required for the first 8 days of care each year, at a rate of 20 percent of average SNF costs per day ($25.50 for 1989). Under prior law, the limit on SNF care was 100 days per spell of illness, after a hospital stay of at least 3 days. Coinsurance payments were required for days 21 through 100 at a rate of 1/8th of the deductible amount ($67.50 for 1988).

Home health care. — Under prior law and the Act, there is no limit on the overall number of covered home health care visits and no coinsurance requirement. To be covered, home health care visits must be required on an intermittent basis. Under prior law, the intermittent requirement was interpreted to mean that there could be 5 to 7 visits a week, for 2 to 3 consecutive weeks. Under the Act, beginning in 1990, covered individuals may receive up to 38 consecutive days of home health care, 7 days a week.

Hospice care. — The Act eliminated the 210-day lifetime limit on hospice care.

Part B benefits

SMI benefits. — Beginning in 1990, the Act expands Part B benefits. Each enrollee's annual liability for Part B copayments is capped. The cap is $1,370 for 1990, and will be adjusted each year to keep the proportion of enrollees subject to the cap constant at 7 percent. Part B coverage is expanded to include mammography screening for women, subject to a maximum of $50 (indexed) per screening and the usual copayment requirements. In addition, once sufficient costs have been incurred to receive benefits under either the copayment cap or the new drug provisions (see below), enrollees are eligible for respite benefits. Under this benefit, Medicare will pay 80 percent of reasonable costs for up to 80 hours a year of in-home personal services, to give the usual caretakers of homebound enrollees a respite.

Catastrophic drug insurance. — Effective January 1990, the Act provides coverage for drugs administered intravenously at home and for immunosuppressive drugs after the first year following a transplant, subject to an annual deductible amount of $550. Coinsurance of 20 percent will be required on drugs administered intravenously, while coinsurance will initially be 50 percent for newly-covered immunosuppressive drugs. (Medicare already covers 80 percent of the costs of immunosuppressive drugs in the first year following an organ transplant.)

Effective January 1991, the CDI program will be expanded. Coverage will include all outpatient prescription drugs and insulin, subject to an annual deductible amount ($600 in 1991) that will be adjusted each year to keep the proportion of enrollees paying the maximum deductible constant at 16.8 percent. Coinsurance requirements will be 50 percent of reasonable charges above the deductible in 1991, 40 percent in 1992, and 20 percent in 1993 and subsequent years.

B. Financing of Medicare Benefits

Part A benefits

Part A benefits are financed through the Hospital Insurance Trust Fund. This trust fund is financed primarily through payroll tax contributions paid by employers, employees, and the self-employed. The payroll tax rate for 1989 is 1.45 percent of compensation up to $48,000 per employee. An equal amount is paid by the employer. Self-employed individuals pay both the employers' and employees' portion of the tax.

SMI benefits

SMI benefits are funded through the Supplementary Medical Insurance Trust Fund (SMI Trust Fund) by premiums paid by enrollees in the Part B program and general revenues. In 1989 a temporary provision requires that enrollee premiums provide 25 percent of the financing of Part B. Thereafter, premium rates will be derived annually based upon the projected costs of the program for the coming year, but premium increases will be limited to increases in the social security cost-of-living adjustment. Therefore, the share of benefits financed by premiums is expected to drop below 25 percent, while the general revenue share will grow. The basic Part B monthly premium for 1989 is $27.90, without regard to the additional premium added by the Act (see below).

Financing of benefits under the Medicare Catastrophic Coverage Act of 1988

In general

The new benefits provided by the Act are financed through the combination of (1) an increase in the Part B flat monthly premium and (2) a new supplemental premium based on income tax liability. It was anticipated that the supplemental premium would finance approximately 63 percent of the costs under the Act, and that the flat premium would finance the remaining 37 percent of costs.

Flat premium

The Act provides for increases in the monthly Part B premium otherwise determined to finance the catastrophic coverage benefit and the prescription drug benefit. Through 1993, the amount of the increase is set by law. After 1993, the flat premium is adjusted through use of a formula designed to maintain a reserve for the catastrophic program.

For 1989-1993, the additional flat monthly premium for Part B enrollees is as follows: [1]

Year	Catastrophic Coverage Premium	Prescription Drug Premium	Total Catastrophic Flat Premium
1989	$4.00	$ .00	$ 4.00
1990	4.90	.00	4.90
1991	5.46	1.94	7.40
1992	6.75	2.45	9.20
1993	7.18	3.02	10.20

[1] Residents of Puerto Rico, other U.S. commonwealth or territories, and individuals not entitled to or eligible for Medicare Part A have different premium schedules.

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SEP 12 '89 17:06 WASH RGNL OFFICE P.3/8

Supplemental premium

The supplemental premium is payable in a year by any individual who is eligible for Part A of Medicare for at least 6 months during the year (except for those who pay the Part A primium), who has income tax liability for the year of at least $150, and who resides in one of the 50 states or the District of Columbia. Subject to a limit on the maximum premium payable by an individual, the annual premium is determined by multiplying (1) the supplemental premium rate by (2) the amount determined by dividing the individual's adjusted income tax liability by $150.

For years 1989 through 1993, the supplemental premium rate is set by law. For years after 1993, the supplemental premium rate will be adjusted by a formula that is designed to maintain a reserve for the catastrophic program.

The supplemental premium rate for 1989-1993 is equal to the sum of the catastrophic coverage premium rate and the prescription drug premium rate as follows:

Year	Catastrophic Coverage Premium	Prescription Drug Premium	Total Supplemental Premium	Total Percent Rate[1]
1989	$22.50	$ .00	$22.50	15%
1990	27.14	10.36	37.50	25
1991	30.17	8.83	39.10	26
1992	30.55	9.95	40.50	27
1993	29.55	12.45	42.00	28

The maximum annual supplemental premium is not to exceed the following amounts for 1989-1993:

In the case of taxable years beginning in:	The limitation is:
1989	$800
1990	850
1991	900
1992	950
1993	1,050

For years after 1993, the cap on the maximum supplemental premium is increased through the use of a formula.

[1] This column shows the total supplemental premium as a percent of tax liability.

III. DESCRIPTION OF POSSIBLE REVENUE OPTIONS

A. Reduce Supplemental Premium Rates and Caps

Present Law

The supplemental premium rates are 15 percent of tax liability in 1989, 25 percent in 1990, 26 percent in 1991, 27 percent in 1992, and 28 percent in 1993. The maximum supplemental premium per enrollee is $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

Explanation of Proposals

1. The supplemental premium rate would be 15 percent of tax liability and the maximum supplemental premium per enrollee would be $585 through calendar year 1994.

2. Alternatively, the supplemental premium rate would be 10 percent of tax liability and the maximum supplemental premium per enrollee would be $585 through calendar year 1994.

3. Alternatively, the supplemental premium rate would be 10 percent of tax liability for calendar year 1989 and 15 percent thereafter. The maximum supplemental premium per enrollee would be $585 through calendar year 1994.

Revenue Effect
(Fiscal years: billions of dollars)

Proposal	1990	1991	1992	1993	1994	1990-1994
1. 15 percent rate/maximum premium of $585	-1.5	-2.7	-2.9	-3.5	-4.3	-14.9
2. 10 percent rate/maximum premium of $585	-2.7	-3.7	-3.8	-4.4	-5.2	-19.8
3. 10 percent rate for 1989, 15 percent thereafter/maximum premium of $585	-2.3	-2.7	-2.9	-3.5	-4.3	-15.7

B. Increase the Wage Base for the Medicare Hospital Insurance Tax to $60,000

Present Law

FICA taxes are generally imposed on the employee and the employer at equal rates. The current tax rate for both the employer and the employee is 7.51 percent of wages (7.65 percent in 1990 and thereafter), consisting of 6.06 percent (6.2 percent in 1990 and thereafter) for Old-Age, Survivors and Disability Insurance (OASDI) and 1.45 percent for Medicare Hospital Insurance (HI). Corresponding taxes are imposed on earnings from self-employment.

The amount of earnings from employment subject to both the OASDI and HI taxes are capped at $48,000 in 1989. The earnings base increases each year based on the increase in average wages in the economy. The earnings base is currently projected to be $50,700 in 1990.

Explanation of Proposal

Beginning in 1990, the earnings base for the HI tax would be increased to $60,000, or the earnings base for the OASDI tax, whichever is greater.

Revenue Effect
(Fiscal years: billions of dollars)

Proposal	1990	1991	1992	1993	1994	1990-94
Increase wage base to $60,000	0.6	1.6	1.1	0.5	0.1	3.9

APPENDIX A: DISTRIBUTIONAL EFFECT OF THE SUPPLEMENTAL PREMIUM

WHO PAYS HOW MUCH in 1989

Table 1

Medicare Catastrophic Coverage Act of 1988
Distribution of Medicare Enrollees
By Level of Supplemental Premium

(Calendar Year 1989)

Supplemental Premium Per Enrollee	Medicare Enrollees (Thousands)	Percent Distribution
Not Subject To Premium.......	19,248	58.8 ← % paying nothing
Less than $100..............	4,031	12.3
100 to 199..................	2,824	8.6
200 to 299..................	2,024	6.2
300 to 399..................	1,093	3.3
400 to 499..................	626	1.9
500 to 599..................	335	1.0
600 to 699..................	460	1.4
700 to 799..................	261	0.8
Maximum Premium ($800).......	1,848	5.6
TOTALS..................	32,750	100.0

Joint Committee on Taxation

Table 2

Medicare Catastrophic Coverage Act of 1988
Distribution of Medicare Enrollees
By Level of Supplemental Premium

(Calendar Year 1993)

in 1993

Supplemental Premium Per Enrollee	Medicare Enrollees (Thousands)	Percent Distribution
Not Subject To Premium........	18,387	52.4
Less than $100................	2,302	6.6
100 to 199................	2,555	7.3
200 to 299................	1,599	4.6
300 to 399................	1,648	4.7
400 to 499................	1,270	3.6
500 to 599................	1,187	3.4
600 to 699................	914	2.6
700 to 799................	744	2.1
800 to 899................	473	1.4
900 to 999................	240	0.7
1,000 to 1,049................	145	0.4
Maximum Premium ($1,050).......	3,612	10.3
TOTALS................	35,076	100.0

Joint Committee on Taxation

TABLE 3

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

(Calendar Year 1989)

JOINT RETURNS

Income Class (Thousands of Dollars)	Average Income Per Return[1]	Average Tax Liability Per Return	Supplemental Premium Per Enrollee[2]
$ 0 - $ 5...	$ 2,997	$ 0	$ 0.00
5 - 10...	7,701	-14	0.00
10 - 15...	12,556	-27	0.00
15 - 20...	17,614	13	0.00
20 - 25...	22,516	398	29.70
25 - 30...	27,545	930	69.75
30 - 35...	32,378	1,559	116.93
35 - 40...	37,599	2,281	171.08
40 - 45...	42,374	3,057	229.28
45 - 50...	47,516	4,147	311.03
50 - 55...	52,052	4,991	374.33
55 - 60...	57,527	6,883	501.23
60 - 65...	62,609	8,204	616.30
65 - 70...	67,491	9,849	738.80
70 - 75...	72,097	10,166	762.45
75 - 80...	77,757	10,239	767.93
80 - 100...	88,227	14,299	800.00
100 - 200...	136,677	25,315	800.00
200 and up...	643,830	139,278	800.00

NON-JOINT RETURNS

Income Class (Thousands of Dollars)	Average Income Per Return[1]	Average Tax Liability Per Return	Supplemental Premium Per Enrollee[2]
$ 0 - $ 5...	$ 3,071	$ 0	$ 0.00
5 - 10...	7,056	-1	0.00
10 - 15...	12,376	105	0.00
15 - 20...	17,196	576	[illegible].40
20 - 25...	22,210	1,410	[illegible].50
25 - 30...	27,274	2,036	309.25
30 - 35...	32,333	2,902	435.30
35 - 40...	37,254	4,773	715.95
40 - 45...	42,840	6,296	800.00
45 - 50...	47,076	7,637	800.00
50 - 55...	52,402	8,779	800.00
55 - 60...	56,636	9,932	800.00
60 - 65...	60,929	10,209	800.00
65 - 70...	67,280	9,603	800.00
70 - 75...	72,330	12,023	800.00
75 - 80...	76,882	13,422	800.00
80 - 100...	88,887	17,626	800.00
100 - 200...	156,036	30,208	800.00
200 and up...	[illegible],048	127,122	800.00

Joint Committee on Taxation
September 6, 1989

1/ Income is defined, solely for purposes of presenting distributional information, as adjusted gross income (AGI) plus untaxed income from: (1) untaxed social security benefits; (2) tax-exempt interest; (3) employer contributions for health plans and life insurance; (4) inside build-up on life insurance; (5) workers' compensation; (6) contributions to IRA and Keogh accounts; (7) minimum tax preferences; and (8) portion of passive losses in excess of minimum tax preferences to the extent the losses are allowed in the computation of AGI.

2/ Computed at average tax liability per return in income class.

P.5/8 SEP 12 '89 17:08 WASH RGNL OFFICE

TABLE 4

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

(Calendar Year 1993)

JOINT RETURNS

Income Class (Thousands of Dollars)	Average Income Per Return[1]	Average Tax Liability Per Return	Supplemental Premium Per Enrollee[2]
$ 0 - $ 5...	$ 2,357	$ -9	$ 0.00
5 - 10...	7,930	-12	0.00
10 - 15...	12,771	-32	0.00
15 - 20...	17,417	-21	0.00
20 - 25...	22,449	240	33.60
25 - 30...	27,456	554	77.56
30 - 35...	32,520	911	127.84
35 - 40...	37,453	1,592	222.88
40 - 45...	42,376	2,319	324.68
45 - 50...	47,445	3,099	433.86
50 - 55...	52,384	4,068	568.52
55 - 60...	57,230	4,958	694.12
60 - 65...	62,383	6,530	914.20
65 - 70...	67,341	7,807	1,050.00
70 - 75...	72,377	8,596	1,050.00
75 - 80...	78,037	9,598	1,050.00
80 - 85...	83,161	10,701	1,050.00
85 - 100...	91,765	13,676	1,050.00
100 - 200...	137,632	23,372	1,050.00
200 and up...	623,120	136,694	1,050.00

NON-JOINT RETURNS

Income Class (Thousands of Dollars)	Average Income Per Return[1]	Average Tax Liability Per Return	Supplemental Premium Per Enrollee[2]
$ 0 - $ 5...	$ 2,385	$ 0	$ 0.00
5 - 10...	7,548	-1	0.00
10 - 15...	12,158	39	0.00
15 - 20...	17,333	378	105.78
20 - 25...	22,380	1,020	285.60
25 - 30...	27,412	1,649	461.72
30 - 35...	32,373	2,295	647.60
35 - 40...	37,257	3,604	1,009.12
40 - 45...	42,631	4,856	1,050.00
45 - 50...	47,400	6,670	1,050.00
50 - 75...	60,696	9,044	1,050.00
75 - 100...	87,293	14,592	1,050.00
100 - 200...	130,153	28,074	1,050.00
200 and up...	634,697	113,030	1,050.00

Joint Committee on Taxation
September 6, 1989

1/ Income is defined, solely for purposes of presenting distributional information, as adjusted gross income (AGI) plus untaxed income from: (1) untaxed social security benefits; (2) tax-exempt interest; (3) employer contributions for health plans and life insurance; (4) inside build-up on life insurance; (5) workers' compensation; (6) contributions to IRA and Keogh accounts; (7) minimum tax preferences; and (8) portion of passive losses in excess of minimum tax preferences to the extent the losses are allowed in the computation of AGI.

2/ Computed at average tax liability per return in income class.

Senate Finance Committee

STAFF OPTIONS TO REFORM MEDICARE CATASTROPHIC
September 7, 1989 08:30 am

Option 1: Increase catastrophic cap on out-of-pocket expenses from $1370 in 1990 (which affects 7% of enrollees) to $1600 (benefits 5.5% of enrollees). Increase prescription drug deductible to assure that 16.8% of beneficiaries (instead of 27% currently estimated) would qualify for the benefit. Deductible would increase from $600 to $882 in 1991; from $652 to $984 in 1992; from $710 to $1092 in 1993). Under Part B opt-out, the decision to pay premiums and qualify for catastrophic benefits would be linked to the decision to enroll in Part B, which is currently voluntary.

Option 2: Increase catastrophic cap on out-of-pocket expenses from $1370 in 1990 (which affects 7% of enrollees) to $1600 (benefits 5.5% of enrollees). Delay phase-in of prescription drug benefit by one year, except for home intravenous therapy and immunosuppressives (and chemotherapeutics as under current law) which would become effective in 1990 as scheduled. Prescription drug benefit would begin on January 1, 1992 with 50% coinsurance and would be fully phased in on January 1, 1994 with 20% coinsurance (rather than 1991 and 1993 as currently scheduled). Drug utilization review requirements would be delayed another year (until January 1, 1993). Increase prescription drug deductible to assure that 16.8% of beneficiaries (instead of 27% currently estimated) would qualify for the benefit. Under Part B opt-out, the decision to pay premiums and qualify for catastrophic benefits would be linked to the decision to enroll in Part B, which is currently voluntary.

Option 3: Increase catastrophic cap on out-of-pocket expenses from $1370 in 1990 (which affects 7% of enrollees) to $1600 (benefits 5.5% of enrollees). Delay phase-in of prescription drug benefit by one year, except for home intravenous therapy and immunosuppressives (and chemotherapeutics as under current law) which would become effective in 1990 as scheduled. Prescription drug benefit would begin on January 1, 1992 with 50% coinsurance and would be fully phased in on January 1, 1994 with 20% coinsurance (rather than 1991 and 1993 as currently

scheduled). Drug utilization review requirements would be delayed another year (until January 1, 1993). Increase prescription drug deductible to assure that only enrollees who incur *catastrophic* drug costs would qualify (10% of beneficiaries). Deductible would increase to $1355 in 1992 and $1510 in 1993. Under Part B opt-out, the decision to pay premiums and qualify for catastrophic benefits would be linked to the decision to enroll in Part B, which is currently voluntary.

Option 4: The catastrophic cap on out-of-pocket expenses would be maintained at $1370 in 1990. The prescription drug benefit and associated premiums would be repealed (other than home intravenous and immunosuppressive therapy benefit (and chemotherapeutics as under current law) which would become effective in 1990 as scheduled. Under Part B opt-out, the decision to pay premiums and qualify for catastrophic benefits would be linked to the decision to enroll in Part B, which is currently voluntary.

Option 5: The catastrophic cap on out-of-pocket expenses would be eliminated. Delay phase-in of prescription drug benefit by one year, except for home intravenous therapy and immunosuppressives (and chemotherapeutics as under current law) which would become effective in 1990 as scheduled. Prescription drug benefit would begin on January 1, 1992 with 50% coinsurance and would be fully phased in on January 1, 1994 with 20% coinsurance (rather than 1991 and 1993 as currently scheduled). Drug utilization review requirements would be delayed another year (until January 1, 1993). Increase prescription drug deductible to assure that 16.8% of beneficiaries (instead of 27% currently estimated) would qualify for the benefit. Under Part B opt-out, the decision to pay premiums and qualify for catastrophic benefits would be linked to the decision to enroll in Part B, which is currently voluntary.

Option 6: Increase catastrophic cap on out-of-pocket expenses from $1370 in 1990 (which affects 7% of enrollees) to $1700 (benefits 5% of enrollees). Repeal prescription drugs except for home intravenous therapy and immunosuppressives (and chemotherapeutics as under current law). Request Prescription Drug Payment Review Commission study of "appropriate" catastrophic drugs and the means to finance them.

Option 7: Increase catastrophic cap on out-of-pocket expenses from $1370 in 1990 (which affects 7% of enrollees) to $1700 (benefits 5% of enrollees). Retain the prescription drug benefit with the following modifications:

a. The individual must have met the Part B catastrophic cap in order to be eligible for the drug benefit; and

b. Prescription drug benefit claims would not be processed until the individual incurred expenses equal to the drug deductible in that year.

OPTIONS TO REFORM MEDICARE CATASTROPHIC   September 7, 1989 08:30

	1989	1990	1991	1992	1993	Total
Option 1:						
Part B Cap at $1600	0	-0.4	-0.6	-0.7	-0.8	-2.5
Drugs at 16.8%	0	0	-0.5	-1.1	-0.7	-2.3
Part B opt-out	0	0.1	0.6	0.3	0.3	1.3
Total	0	-0.3	-0.5	-1.5	-1.2	-3.5
Option 2:						
Part B Cap at $1600	0	-0.4	-0.6	-0.7	-0.8	-2.5
Drugs at 16.8%, delayed	0	0	-1.4	-2.3	-1.4	-5.1
Part B opt-out	0	0.1	0.6	0.3	0.3	1.3
Total	0	-0.3	-1.4	-2.7	-1.9	-6.3
Option 3:						
Part B Cap at $1600	0	-0.4	-0.6	-0.7	-0.8	-2.5
Drugs at 10%, delayed	0	0	-1.4	-2.7	-2.2	-6.3
Part B opt-out	0	0.1	0.6	0.3	0.3	1.3
Total	0	-0.3	-1.4	-3.1	-2.7	-7.5
Option 4:						
Part B Cap at $1370	0	0	0	0	0	0
Repeal Drugs *	0	0.8	1	-0.7	-0.5	0.6
Part B opt-out	0	0.1	0.6	0.3	0.3	1.3
Total	0	0.9	1.6	-0.4	-0.2	1.9
Option 5:						
Eliminate Part B Cap	0	-1.8	-3.2	-3.8	-4.3	-13.1
Drugs at 16.8%, delayed	0	0	-1.4	-2.3	-1.4	-5.1
Part B opt-out	0	0.1	0.6	0.3	0.3	1.3
Total	0	-1.7	-4	-5.8	-5.4	-16.9

SEP 12 '89 17:09 WASH RGNL OFFICE P.7/8

Option 6:						
Part B Cap at $1700	0	-0.5	-0.8	-0.9	-1.1	-3.3
Repeal Drugs **	0	0	-1.4	-3.3	-3.8	-8.5
Total	0	-0.5	-2.2	-4.2	-4.9	-11.8
Option 7:						
Part B Cap at $1700	0	-0.5	-0.8	-0.9	-1.1	-3.3
Modified Drug Benefit	N/A	N/A	N/A	N/A	N/A	N/A
Total	N/A	N/A	N/A	N/A	N/A	N/A

Note: Estimates of Part B opt-out do not reflect any changes that might be made to supplemental premiums. Estimates take into account effects on Medicaid spending

* Assumes premium repeal. Repeal of benefits only is zero in FY90, -1.4B in FY91, -3.3B in FY92, -3.8B in FY93

** Assumes flat premium retained

	1990 Cost	1990 Percent of Total	1993 Cost	1993 Percent of Total	1989-93 Cost	1989-93 Percent of Total
Part A Benefits						
Hospital	1302	31.7%	1671	13.3%	6816	18.5%
Skilled Nursing Facility	381	9.3%	511	4.1%	2041	5.5%
Home Health	129	3.1%	208	1.7%	714	1.9%
Hospice	1	*	1	*	5	*
Part B Benefits						
Part B Copayment Cap	1838	44.7%	4326	34.5%	13162	35.8%
Respite Care	67	1.6%	418	3.3%	909	2.5%
Screening Mammography	75	1.8%	147	1.2%	483	1.3%
Prescription Drugs	76	1.8%	4254	33.9%	9646	26.2%
Administrative Expenses	244	5.9%	1000	8.0%	3035	8.2%
TOTAL MEDICARE BENEFITS	4113	100.0%	12536	100.0%	36811	100.0%

* Less than .1 percent

NOTE: These estimates are the latest available from CBO as of 28 August. They do reflect CBO's July reestimate of drug costs, but do not reflect recent reestimates of skilled nursing facility (SNF) costs, or other minor and technical reestimates of Part A benefits.

SEP 12 '89 17:09 WASH RGNL OFFICE P.8/8

MEDICARE Has Improved

Catastrophic Protection and Other New Benefits

An Official Notice To Medicare Beneficiaries Explaining Benefits Under The Medicare Catastrophic Coverage Act of 1988

"Let us remove a financial specter facing our older Americans— the fear of an illness so expensive that it can result in having to make an intolerable choice between bankruptcy and death."

President Ronald Reagan
1986 State of the Union Message

DEAR MEDICARE BENEFICIARY:

Beginning January 1, 1989, Medicare will be expanded to cover catastrophic health care costs.

This new plan meets President Reagan's call to protect the elderly and disabled against financial ruin in the event of a prolonged hospital stay or other high medical costs.

We are proud to provide this new coverage as part of our continuing commitment to affordable quality health care.

OTIS R. BOWEN, M.D.
Secretary
U.S. Department of Health and Human Services

MEDICARE EXPANDED TO INCLUDE CATASTROPHIC HEALTH INSURANCE

Medicare has been changed to better protect its 32 million elderly and disabled beneficiaries from "catastrophic" hospital, doctor and prescription drug bills. The changes, mandated by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), will be introduced beginning January 1, 1989.

The new law limits the amount you as a Medicare beneficiary must pay for hospital care, physician services, medical supplies, and outpatient drugs covered by Medicare. It increases home-health, skilled nursing facility, and hospice coverage, and adds breast-cancer screening and respite care benefits.

These new and improved benefits will be made available to you automatically if you are a Medicare beneficiary or when you become eligible for the program. You are not required to do anything to receive this coverage. If you are enrolled in Part A only and want to enroll in Part B so as to take advantage of all of the benefits, you will be given a chance to do so during the general enrollment period from January 1 through March 31 each year.

NEW HOSPITAL BENEFITS:

Medicare hospital insurance (Part A) helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility and hospice. It also pays for certain home health care.

Beginning January 1, 1989, you will be entitled to unlimited hospitalization for approved care after you pay a single annual deductible, estimated at $564 in 1989. (A deductible is an amount you must spend before Medicare begins paying for services and supplies covered by the program.) Medicare will pay for your hospital care only if you meet the following four conditions: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

Once you meet these conditions and pay the single annual deductible, Medicare pays 100 percent of the approved charges for your care. This is regardless of the costs, length of stay or number of times you are admitted to the hospital in any one year. And if you pay the deductible during December, you do not have to pay it again if you are still a patient in or are readmitted to the hospital in January of the following year.

While most hospital-related costs are covered by Medicare, you must pay for certain services and conveniences, such as a private room (unless it is a medical necessity), private duty nurses, a television, radio, or telephone in the room.

PSYCHIATRIC HOSPITAL BENEFIT:

The 190-day lifetime limit on inpatient psychiatric hospital services remains unchanged.

SKILLED NURSING FACILITY CARE:

The new law provides for 150 days of care per calendar year in a Medicare-certified skilled nursing facility *starting January 1, 1989*. If you are admitted to a skilled nursing facility, you will be responsible for copayments (a share of the costs) for the first eight days of care each year. The copayment is estimated at $22 per day in 1989. Medicare pays all other allowable charges for up to 150 days of covered care even if you are discharged and readmitted to a skilled nursing facility more than once during a calendar year. The requirement that you be hospitalized at least three days immediately before entering a skilled nursing facility to qualify for Medicare coverage will be eliminated for stays starting on or after January 1, 1989.

Skilled nursing facility care is not the same as custodial nursing home care. Skilled nursing facility care is acute care while custodial nursing home care is long-term care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation and other related health services. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. While Medicare does not cover custodial care in a nursing home, some insurance companies offer policies that do.

■ **HOME HEALTH CARE:** *Effective January 1, 1990*, if you qualify for home health care, reasonable and necessary skilled nursing care and/or home health aide care will be available to you for up to six days a week for as long as it is prescribed by a doctor. If you need such home health care seven days a week, you will be entitled to 38 consecutive days of care. The 38-day limit can be extended for a period of time under special circumstances.

■ **HOSPICE CARE:** Beginning in 1989, unlimited hospice care will be available to beneficiaries who are recertified as terminally ill after 210 days of care in a hospice.

■ **DOCTOR AND OTHER OUTPATIENT SERVICES (Part B):** Medicare Part B helps pay for medically necessary doctor services, outpatient hospital services, home health care, and various medical services and supplies not covered by the hospital insurance part of Medicare. It is voluntary, and enrollees pay a monthly premium.

Effective January 1, 1990, your share of approved charges for services and supplies covered by Part B will be limited to $1,370 a year. You will be required to pay the first $75 (deductible) of charges approved by Medicare and 20 percent of all approved charges after that until these out-of-pocket expenses total $1,370. It does not matter whether these expenses are paid directly by you or by your private insurance company. Once the $1,370 amount is reached, Medicare will pay 100 percent of all other approved charges under Part B for the remainder of the calendar year. (An approved charge is an amount Medicare has determined to be a reasonable price for physicians and other covered medical services.)

If a doctor or medical supplier charges more than Medicare's approved charge, you must pay the difference and it will not count toward the $1,370 limit. You will continue to be responsible for any charges over what Medicare allows even after you reach the $1,370 out-of-pocket limit. Some doctors and suppliers agree to not charge more than the Medicare-approved amount for services and supplies. They are called participating physicians and suppliers and their names and addresses may be obtained from the Medicare carrier for your area.

RESPITE CARE BENEFIT: This new benefit, *effective January 1, 1990,* pays for the temporary services of a home health aide to provide relief for an individual who normally helps a Medicare beneficiary who requires assistance with essential daily personal care. Medicare will pay for up to 80 hours per year of home health aide and personal care services. You can use this benefit only if you are chronically dependent and have met either the annual deductible for outpatient prescription drugs or the $1,370 Part B catastrophic limit for the year.

MAMMOGRAPHY: This new benefit, which goes into *effect January 1, 1990,* will pay up to $50 for X-ray screening for the detection of breast-cancer. Women 65 or older can use the benefit for a mammogram every other year, while certain younger disabled women covered by Medicare can use it for more frequent examinations.

NEW PRESCRIPTION DRUG BENEFIT: Medicare already pays for prescription drugs when you are in the hospital. *Beginning January 1, 1990,* the benefit will be expanded to cover a few outpatient prescription drugs in certain circumstances, and *in 1991 it will cover most prescription drugs as well as insulin.*

In 1990, Medicare will help pay for certain antibiotics and other drugs that are injected into the veins (intravenous) and can be safely used at home. Coverage also will be expanded in 1990 to include immunosuppressive drugs used in the second year and thereafter following a Medicare-covered organ transplant. Medicare already helps pay for immunosuppressive drugs taken the first year following a Medicare-covered organ transplant.

In 1990, you will have to pay the first $550 for these covered drugs. Medicare will then pay 80 percent of the cost of approved intravenous drugs and 50 percent of the cost of immunosuppressives used after the first year following a transplant. You will not have to pay the $550 deductible if your intravenous drug therapy began during a hospital stay and is continued at home, or for immunosuppressive drugs used in the first year after a transplant.

Effective January 1, 1991, Medicare will cover most other prescription drugs as well as insulin. You will be responsible for an annual deductible and copayments. In 1991 the deductible will be $600 and the copayment 50 percent. This means that after you pay the first $600 for covered outpatient prescription drugs,

Medicare will pay half of all other allowed drug charges for the remainder of the calendar year. In 1992 the deductible is estimated to be $652 and the copayment 40 percent. In 1993 and thereafter, if the new catastrophic coverage premiums have been sufficient to cover costs, Medicare will pay 80 percent of all the allowable drug charges in excess of the deductible. The deductible for 1993 is to be set at a later date.

PAYING FOR CATASTROPHIC HEALTH INSURANCE: Two new premiums are being added to pay for the catastrophic coverage. One will be an addition to the basic monthly Part B premium and the other will be a new annual income-tax-related premium. The extra charge to be added to the basic Part B premium will be $4 per month in 1989 and will gradually increase to $10.20 per month in 1993. It will be in addition to any increases in the monthly basic Part B premium which is $24.80 in 1988.

If you are a Social Security or Railroad Retirement beneficiary, any increase to you in the Part B premium cannot be greater than the cost-of-living adjustment in your monthly benefit for the year. In other words, if at sometime in the future the Part B premium were increased $6 per month and your cost-of-living adjustment for the year amounted to $5 a month, the increase in your monthly premium would be limited to $5.

While enrollment in Part B is still optional, you cannot buy Part B without also buying the new catastrophic benefits it provides. Everyone enrolled in Part B will be required to pay the new premium to be added to the basic Part B premium. Part B premium payments will not count toward the $1,370 out-of-pocket expense limit.

SUPPLEMENTAL PREMIUM: Besides the change in the basic premium, a supplemental premium based on your income tax liability is to be paid on Federal tax returns for 1989.

You must pay the supplemental premium if you are entitled to or eligible for Medicare Part A for more than six full months in the taxable year and your Federal income tax liability for the year is $150 or more.The only exceptions are for certain Medicare-eligible individuals living in a foreign country and those who pay a monthly premium for Part A coverage. You do not have to pay the premium if your tax liability for the taxable year is less than $150.

The supplemental premium rate is $22.50 for each $150 of Federal income tax liability for the 1989 tax year. This means that if you pay $150 in Federal income taxes for 1989, your supplemental premium will be $22.50. If your tax is $300, the premium will be $45. The premium rate for each $150 of tax liability will rise to $37.50 in 1990, $39 in 1991, $40.50 in 1992, and $42 in 1993. There is, however, a limit on the amount you must pay each year. For 1989, the maximum supplemental premium is $800. It will increase to $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

The maximum is double for a married couple as long as both were eligible for Part A for more than six full months during the taxable year.

Thus, a couple will pay a supplemental premium in 1989 at the rate of $22.50 for each $150 up to a maximum of $1,600. In the case of a joint return where only one spouse is eligible for Medicare, only one half of any tax liability is taken into account, and the $800 maximum applies. There are also special rules for governmental retirees to adjust for the fact that their government pensions are fully taxed while the pensions received by Social Security are not.

The supplemental premium will be administered through the Federal income tax system, with premium amounts computed from a table included with income tax forms and collected along with income tax payments. You will be receiving information from the Internal Revenue Service in your 1988 tax package. If you have a tax-related question about the supplemental premium, you should call or visit your local Internal Revenue Service office.

The supplemental premium does not count toward the $1,370 out-of-pocket expense limit for Part B benefits.

■ **PREPAYMENT PLANS:** If you are enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP), the new catastrophic coverage will be provided by your HMO or CMP. Additional information about this coverage and how it is to be provided by the plans will be mailed to you in the near future by the Health Care Financing Administration. If you are a federal retiree enrolled in the Federal Employees Health Benefits Program, special provisions of the new law may apply to you. The Office of Personnel Management will contact you directly regarding these provisions. If you are not contacted by mid-September, you should write to the Office of Personnel Management, P.O. Box 275, Washington, D.C. 20044-0275.

■ **MEDIGAP POLICIES:** The new law requires companies that issue insurance to supplement Medicare (Medigap policies) to send a letter to their policyholders who are entitled to Medicare explaining the changes in the Medicare law and how it affects their policies' benefits and premiums. The letter is to be mailed by January 31, 1989, to Medigap policyholders of record as of January 1, 1989. Medigap policies must be revised to avoid duplicating the new Medicare catastrophic benefits. Contact your State insurance commissioner or insurance agent for additional information about Medigap policies.

WHERE CAN I GET MORE INFORMATION?

If you require additional information about Medicare, contact the Medicare carrier that processes claims for your area. The carrier's telephone number is listed in *The Medicare Handbook*. Information, including the carrier's telephone number, also may be obtained by calling **1-800-888-1998.**

Questions about the supplemental premium should be directed to the Internal Revenue Service.

SUMMARY OF NEW BENEFITS

* **Hospital Benefit (Part A):** Effective January 1, 1989, beneficiary pays an annual deductible of $564 (estimated for 1989) and Medicare pays the balance regardless of the number of days of hospitalization or the costs.
* **Skilled Nursing Facility Care:** Effective January 1, 1989, 150 days of care per year with 20% copayment for first 8 days.
* **Hospice Care:** Effective January 1, 1989, beyond 210 days of care if recertified as terminally ill.
* **Home Health Care:** Coverage extended as of January 1, 1990, to provide for intermittent care up to 6 days a week; daily care for up to 38 consecutive days.
* **Medical Benefits (Part B):** Beginning January 1, 1990, beneficiary pays $75 deductible and 20% copayment up to $1,370. Medicare then pays all other allowable charges for the rest of the year.
* **Drug Benefit:** Certain drugs covered in 1990. Most prescription drugs, insulin covered in 1991 with Medicare paying 50% of allowable charges over $600. In 1992, Medicare pays 60% of allowable charges over $652 (estimated) deductible. If finances permit, Medicare pays 80% of allowable charges over yet-to-be set deductible in 1993.

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