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# FOIA MARKER

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**Record Group/Collection:** George H.W. Bush Presidential Records  
**Collection/Office of Origin:** Policy Development, White House Office of  
**Series:** Kuttner, Johannes, Files  
**Subseries:**

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**OA/ID Number:** 06970  
**Folder ID Number:** 06970-008

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**Folder Title:**  
Health Care Reform - 92 Proposal - Final Papers

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Stack:	Row:	Section:	Shelf:	Position:
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MEMORANDUM  
OF CALL

Previous editions usable

TO:

*Hans*

YOU WERE CALLED BY--

YOU WERE VISITED BY--

OF (Organization)

PLEASE PHONE ►

FTS

AUTOVON

WILL CALL AGAIN

IS WAITING TO SEE YOU

RETURNED YOUR CALL

WISHES AN APPOINTMENT

MESSAGE

*Hans*

*This has suddenly become sensitive, so please don't circulate it. - D. Bizer*

RECEIVED BY

DATE

TIME

63-110 NSN 7540-00-634-4018

STANDARD FORM 63 (Rev. 8-81)  
Prescribed by GSA  
FPMR (41 CFR) 101-11.6

\* U.S. GPO: 1990 - 262-080

Office of Management and Budget

TO: Dr Bradford  
FROM: Steve Bandman

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Date: 1/21/92 Time:

Number of attached pages: 3

Fax Destination

Place:

Phone number:

Notes:

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FAX Number: 202/395-3910

Voice Confirmation: 202/395-3844

## Summary of Market Reform Discussions

### 1. Small Group Market Reforms (excluding HINs)

- Follows "mainstream" approach on interim basis, as outlined in previous documents: e.g., guaranteed issue, guaranteed renewability, limitation on preexisting condition exclusions, interim premium variation limit and interim reinsurance or assigned risk pooling. Premium bands and other requirements (?) [would]/[could] be phased-out with full implementation of risk pooling system.
- Phased-in implementation of health risk pooling, as described in previous papers over a five year period, starting in third year.
- Health risks would be pooled within age categories to prevent a transfer from younger to older workers.

### 2. Pooling for Tax Credit Recipients

- A health risk pool for tax credit recipients would be implemented simultaneously with initial implementation of the health tax credit system. The pool would be administered by the state.
- The pool would cover all credit recipients, including those receiving partial credits and including coverage provided through employment based plans, possibly with an exception for coverage provided through firms employing over 100 workers.
- Each insurer providing coverage to a credit recipient would pay a flat per capita amount into the pool for each credit recipient.
- On an annual basis, each credit recipient would be assigned to a unique health status category. (Age could be included as an explicit basis for categorization, though this is not necessary.)
- Each insurer would receive a transfer from the pool for each credit recipient with higher than average expected health care costs.

- The transfer would equal the difference between the average expected cost for all credit recipients and the expected cost for the health status category involved.
- The pooling for credit could result in some transfer from young to old.

### 3. **Federal State Relations**

- See attached table which indicated proposed method for implementing various reforms.
- Reforms can be implemented through direct Federal preemption (through ERISA or otherwise) or through incentives for states to enact laws that comply with Federal standards.
- Under the incentive approach, if a state's health insurance laws do not meet Federal minimum standards, then insurance sold in-state would be certified through Federal back-up mechanism and a non-complying state's Medicaid administrative grant funding would be frozen at base year levels.

## Summary of Market Reform Discussions

### 1. Small Group Market Reforms (excluding HINs)

- 50%  
wi = 1.5 low
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  - Phased-in implementation of health risk pooling, as described in previous papers, over a five year period, starting in third year.
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- On an annual basis, each credit recipient would be assigned to a unique health status category. (Age could be included as an explicit basis for categorization, though this is not necessary.)  
  
{The public write-up would be modified to down play the mechanics, including attribution of credit recipients to health status categories. The public-write up would talk about adjustments being made in the aggregate, based on aggregate differences in the populations insured by different carriers.}
- Each health category would have a corresponding weight based on expected health care costs, assuming a "core" benefit package with a weight of 1.0000 equal to average costs.

- Each insurer would calculate an average weight for all credit recipients covered by the insurer. Insurers with an average of more than 1.000 would receive net transfers from the pool while insurers below 1.000 would be net losers.
- As is the case for any broad-based health insurance pooling which includes individuals of all ages, this scheme would result in significant transfers from young to old.

### 3. Federal State Relations

- See attached table which indicates proposed method for implementing various reforms. Table is for discussion purposes today and will not be included in public paper.
- Reforms can be implemented through direct Federal preemption (through ERISA or otherwise) or through incentives for states to enact laws that comply with Federal standards.
- Under the incentive approach, if a state's health insurance laws do not meet Federal minimum standards, then insurance sold in-state would be certified through Federal back-up mechanism and a non-complying state's Medicaid administrative grant funding would be frozen at base year levels.

## **Examples of How the Health Risk Pool Would Operate in Practice:**

### **Pool for Credit Recipients**

#### **Example 1:**

- Credit recipient -- 55 year old single male with diabetes and heart disease applies for "core" coverage. Income below poverty, receives a full \$1,250 credit.
- Carrier is free to charge any premium for this individual. Without the pooling system, carrier A would have charged \$8,000, because the individual is in a high risk category.
- With the pooling system, carrier A will charge a premium closer to \$1250 because carrier A will receive a transfer from the pool to make up the difference between average cost and expected cost for the individual involved. (Competition among insurers participating in the program will drive premiums down to the \$1250 level.)

#### **Example 2:**

- Credit recipient is healthy 20 year old male.
- Without the pooling system, carrier would have charged \$500, because recipient is in a low risk category.
- With the pooling system, carrier will charge a premium closer to \$1250 because as a result of covering this individual, the carrier will pay into the pool an amount equal to the difference between the average cost for credit recipients and expected cost for the low-risk individual involved.

### **Small Business Pool for Individuals Not Eligible for Credit**

#### **Example 1A -- Same individual as example 1, but not a credit recipient.**

- Insurer will charge premium equal to average cost for 55 year old men.

#### **Example 2A -- Same individual as example 1, but not a credit recipient.**

- Insurer will charge premium equal to average for 20 year old men.

**Market Reform -- Federal State Relations**  
(for discussion purposes only)

	State Mandated Benefit Laws	State Premium Taxes	State AntiManaged Care Laws	State Solvency Standards	Market Reforms*
<b>Current Law</b>					
Self-insured employers	ERISA preemption	ERISA preemption	Not protected	ERISA preemption	n/a
Fully insured coverage purchased by employers	Not protected	Not protected	Not protected	State regulation applies	n/a
Individual coverage	Not protected	Not protected	Not protected	State regulation applies	n/a
<b>Proposal</b>					
Self-insured employers	No change; ERISA preemption	No change; ERISA preemption	Preempt or discourage through Federal standards	No change; ERISA preemption	n/a
Coverage purchased by employer or individuals through HIN	Extend ERISA preemption	Extend ERISA preemption	Preempt or discourage through Federal standards	State regulation applies	State regulation encouraged by Federal standards and incentives
Other fully insured coverage purchased by employers	?	?	? <i>See pre-empt</i>	State regulation applies	State regulation encouraged by Federal standards and incentives
Individual coverage purchased by credit recipient	?	?	? <i>↓</i>	State regulation applies	State regulation encouraged by Federal standards and incentives
Other coverage purchased by individuals	?	?	? <i>↓</i>	State regulation applies	State regulation encouraged by Federal standards and incentives

*stu*

\* "Market reforms" include guaranteed issue, guaranteed renewability, limitation on preexisting conditions, premium bands, and health risk pooling.

## Modification of Market Reform Proposal

**Problem:** To promote competition, credit-eligible individuals should have choice and be able to buy coverage from one of a number of competing health plans. However, providing this choice could lead to severe risk selection problems.

**Proposed Solution:** There would be no limit on choice. Small group market reforms would be extended to the individual insurance market, with the inclusion of age as an explicit basis for health risk adjustment. This would extend broad risk pooling to unemployed or self-employed credit recipients.

### Specifics:

- Each state would define a "core" benefit package with an estimated actuarial value equal to the value of the health tax credit.
- Any health plan in a given state could offer the state-defined "core" benefit package to credit recipients and to others. Health plans would be free to charge a market price (e.g., there would be no requirement that the package be sold at a price equal to the credit amount).
- To ensure that credit recipients have a variety of options available, the insurance commissioner could require two or more health plans with a substantial market share to offer the "core" benefit plan.
  - In this case, the health plan would be required to offer "core" benefit coverage to any one receiving a full or partial credit or anyone not offered coverage through an employer group.
  - Insurers would be free to charge a market price for the package.
- The small group market reforms would be extended to "core" benefit insurance sold on an individual basis.
  - Specifically, such insurance, would be subject to premium bands, on an interim basis, and to the health risk adjustment system on a permanent basis. As a result, such insurance would be subject to a mandatory reinsurance premium and pooling mechanism.
  - Moreover, any insurance sold to a credit recipient would be subject to the mandatory reinsurance premium, though, in the case of non-core coverage sold on an individual basis, the health plan would not receive net positive transfers from the pool.

- For both the small group and for "core" benefit coverage sold on an individual basis, the health risk adjustment system would be implemented immediately. Initial implementation would be limited to use of age as a health risk adjustment factor.
  - Within four years after this initial implementation, diagnosis-based health risk adjustment would be implemented as well.
  - Implementing an age adjustment would help to ensure affordability of coverage to older credit-recipients.
- In an emergency, [random]/[rotating] assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice.
- States would be [required]/[encouraged] to implement outreach programs with the goal of securing 100% participation among credit eligibles.
  - Broader participation would help prevent unnecessary and costly emergency care by encouraging primary and preventative care.
  - Moreover, for the \$1250 credit to be adequate to purchase basic coverage, healthy people must be paying premiums to offset the higher health care costs generated by sick people.

## Cost-Containment Measures

**Tax Cap:** Conceptually, the most important part of the proposal package, because for the first time consumers will assess insurance benefits at the margin relative to other goods and services.

**Medicaid Reform:** Contains costs through two features: (1) increased reliance on managed care (10-15% savings initially) and (2) increased State flexibility for innovation and cost-effective approaches. *FFS → Capitation - alone an incentive*

**Medicare Reform:** Contains costs through two features: (1) increased reliance on coordinated care initiatives, and (2) re-investment in Medicare HMO-risk contract program. Increased market penetration of 10% for Medicare enrollees in HMOs could produce up to 7% lowered growth in costs relative to FFS.

**Medicare Budget Savers:** Targets providers, not beneficiaries; impact on private costs unclear. *- D - Average -- min cost shifting*

**Self-Referrals:** Recent evidence indicates self-referrals can increase (inappropriate) diagnostic testing by 300-400 percent.

**Insurance Market Reforms:** Several aspects help contain costs:

- (1) reduced administrative costs (due to larger pooling by small employers);
- (2) reduced "churning" in market generally of companies underwriting/dropping coverage/marketing to new groups;
- (3) decreased role for brokers (and broker fees of typically 20%) who identify and market to low-risk groups.
- (4) strengthens price competition based on quality of care provided rather than risk selection;
- (5) requiring broader availability of group coverage (increasing risk pools will lower average costs);
- (6) ending State mandated benefits;
- (7) ending State anti-managed care laws;
- (8) HINs increase market power for small employers and reduce administrative costs by increasing risk pools and negotiating discounts.

**Consumer Information:** Plans and providers that demonstrate equivalent or superior outcomes at lower premium cost would gain a competitive edge. Service utilization and costs could be cut appreciably with no deterioration in outcomes. *invest in outcomes research*

*Malpractice*

## **Administrative Costs Savings**

- o HHS Secretary's initiatives --
  - (1) encourage expedited development of data standards for electronic claims processing;
  - (2) explore possible application of electronic medical record and/or "smart card" for health insurance enrollees;
- o Encourage electronic billing under Medicare Part B through differential payment rates
- o Small market reform initiatives -- reduces churning, broker fees and other marketing practices, and larger pooling for coverage.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Paper	Certification of Health Insurance Credit for Working Poor (6 pp.)	01/07/92	P-5	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

**Open on Expiration of PRA  
(Document Follows)  
By JRD (NLGB) on 1/5/2005**

<b>Date Closed:</b> 1/5/2005	<b>OA/ID Number:</b> 06970-008
<b>FOIA/SYS Case #:</b> 1999-0118-F	<b>Appeal Case #:</b>
<b>Re-review Case #:</b> 2005-0296-S	<b>Appeal Disposition:</b>
<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
<b>AR Disposition Date:</b>	<b>MR Disposition Date:</b>

### RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P-1 National Security Classified Information [(a)(1) of the PRA]
- P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P-3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

**Freedom of Information Act - [5 U.S.C. 552(b)]**

- (b)(1) National security classified information [(b)(1) of the FOIA]
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- (b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- (b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- (b)(9) Release would disclose geological or geophysical information

1-7-92

## Certification of Health Insurance Credit for Working Poor

1. Employers certify workers as eligible for advance payments of the Health Insurance Credit (HIC). Under one option, employees would submit an application (a Schedule HIC) to the employer. The employer would verify information concerning wages paid to the worker and contributions to health insurance plans. Employers would be required to perform some due diligence in verifying other information needed to determine eligibility for the credit (for example, eligibility for Medicaid, VA-CHAMPUS; other income sources; number of dependents).

### Effects of Proposal:

Administrative costs are passed to employers (many of whom likely to be small businesses). To the extent that employers are unlikely to bear administrative costs, compliance costs are likely to be high.

In computing the credit, the employer will immediately become aware of the advantages to him of substituting the credit for any contribution he may be making which is less than or equal to the amount of the credit for the which the employee qualifies, thus hastening the "buying out of the base."

Employers have access to relevant information only to the extent of wages and contributions to employer health insurance plans. Employers do not have personal knowledge of workers' incomes (other than wages), their family living arrangements, or their eligibility for other Federal health programs.

- A. As part of due diligence, employers could be required to collect additional information to verify eligibility:
  - This raises privacy concerns. Employees will not want to share personal information with employers.
  - Employers have neither superior ability nor incentive to discern whether workers, in fact, meet criteria. Indeed, in cases where employers are self-insured, they will keep the credit even if the worker is not eligible.
- B. Workers would determine if they were eligible and provide a Schedule HIC to their employers, who would not be subject to due diligence requirements. Alternatively, employers could certify eligibility for those workers who voluntarily provide information necessary to determine eligibility.
  - Employers have no incentive to monitor workers' eligibility.

- Workers must be both willing and able to determine that they meet eligibility criteria.
- This approach is similar to current withholding practices, where individuals can claim additional exemptions, or the advance payment system for the EITC. However, experience with the advance payment system for the EITC demonstrates the difficulties in allowing this practice among low-income recipients.
  - Less than one percent of EITC claimants receive the credit in advance.
  - Many who do receive advance payments do not have a tax liability and are unaware that they are supposed to file a return at the end of the year and reconcile actual annual income with advance credit payments.
  - GAO estimates that about 45 percent of those who, according to W-2 records, may have received the advance payment never filed a tax return.
  - GAO also estimates that about 49 percent of workers who both received advance payments and filed a tax return did not report payments of the advance credit on their final tax return. Since the IRS automatically calculates the credit based on information on the tax return and sends eligible workers a refund, these persons probably received excessive payments for the entire year. In many cases, these workers were not eligible for the credit at all.
  - Given normal processing delays in matching returns and W-2's, the IRS is not able to begin to detect these problems until nearly a year after the filing of the final return (or as much as two years after the advance payments may have been made).

Recommendation:

Oppose. Administrative and compliance costs too high, because employers will not have incentives or ability to make correct certifications. In cases where employer is self-insured, he may have incentives to claim credits for ineligible persons. In view of GAO data, it will be extremely difficult to recapture overpayments.

2. Insurers could certify workers as eligible for the credit. The insurer could receive the completed HIC from the employee, on which the employer has certified the wage or salary income paid to the employee and the amount, if any, of the employer's contribution to health insurance. Otherwise the certification process would be similar to that required of the employer.

Effects of Proposal:

There would be no neutral party between the two groups who benefit from the certification (the recipient worker and the recipient insurer).

The insurer does not have easy access to information confirming participation by the employee or members of his family in other Federal government health programs.

The insurer has no incentive to be diligent in certifying the information on the HIC. If the individual is not eligible, the insurer receives the full credit.

Some liability scheme for insurers could be devised so that they are no longer held harmless for errors. However, such a scheme will cut down eligibility for the credit.

Requiring disclosure by the applicant to the insurer of family income and structure may violate an individual's privacy. In some cases, insurance companies may be able to infer from this information other characteristics of the worker (such as propensity to test positive for HIV). Using such information, insurers might deny eligibility for the credit.

The Federal government would still bear sizable administrative costs for determining fraud.

Recommendation:

Oppose. Administrative and compliance costs too high, because insurers will not have ability to make correct certifications and will only have incentives to certify any plausible applicant. It will be extremely difficult to recapture overpayments.

3. For 1993 through 1995, the state welfare agencies would certify workers as eligible for the credit. During these years, applicants for the maximum credit amounts must have income of between 50 and 75 percent of the tax thresholds, and applicants in the phase-down range have incomes of between 100 and 125 percent of the tax thresholds. These income ranges roughly approximate the income eligibility ranges for poverty programs, including the Food Stamp program.

Applicants would obtain and complete a Schedule HIC ("HIC") which would require certain information necessary to establish eligibility for the credit. If employed, workers would obtain certification by their employer of their wages and the amount, if any, of the employer contribution. They would present the completed HIC to state welfare office, along with evidence of income and dependents. The state welfare office will verify HIC information for a six-month period and compute the six-month credit based on tables provided by the IRS. These verification procedures would be subject to periodic quality control review by HHS. Certifications would be made effective January 1 and July 1. Information gathering necessary for semi-annual recertification could be spread over some period prior to the certification date to avoid unacceptable bunching of the workload. Persons receiving the credit system prior to a certification date would receive prorated credits.

After certification of the credit, the state welfare office will file a copy of the HIC with the IRS. The claimant will transfer the certified HIC to the insurer or employer, as appropriate, in payment for insurance coverage.

For 1996 and beyond, the IRS, HHS, and the Social Security Administration will develop a comprehensive database and computer system that will permit timely and semi-automatic verification of applicants. The database will contain up-to-date information on eligibility criteria. Coordination between the agencies will be critical because the database will contain information from tax returns, IRS information reports, and participation data in other Federally-subsidized health programs. Implementation of this verification system will coincide with the expansion of eligibility for credits, in excess of the basic minimum amount, to the non-poverty population.

#### Effects of Proposal:

Unlike employers and insurers, the welfare agencies have much less incentive to certify ineligible applicants.

Government agencies have superior access to information concerning certain eligibility criteria, and their staffs are familiar with the processes for determining eligibility for low-income programs.

In addition, many of those eligible for the credit would have contact with welfare offices. Despite being operated at the national level by the Agriculture Department, the Food Stamp program is administered at the state and local levels by the same welfare offices and personnel that operate AFDC and general assistance. Moreover, many of those eligible for the Health Insurance Credit will also be eligible for Food Stamps. Food Stamps are available to families (including those with workers) with incomes up to 130 percent of poverty.

Recommendation:

Support. Welfare agencies have superior ability to verify eligibility for the credit among the low-income population and fewer incentives to certify ineligible. Quality control studies, following common practices, will serve as a check on compliance. This option also provides the IRS, HHS, and SSA time to construct the type of dataset which would be necessary for large-scale, semi-automatic certifications. Construction of this dataset should coincide with the expansion of the credit to the non-poverty population, which currently has little contact with the welfare offices.

A counter-argument made be made against a proposal to transfer certification responsibilities to the state welfare agencies. States may have incentive to move persons off Medicaid (a program which is partially funded with state funds and also administered by state welfare offices) and enroll them, instead, in the fully Federally funded health tax credit.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
02. Memo	From Hanns Kuttner to Tom Scully Re: Medicaid Option #2, Integration with Tax Credit [2 copies] (4 pp.)	01/07/92	<del>P-5</del>	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
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By JRD (NLGB) on 10/28/2005

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<b>FOIA/SYS Case #:</b> 1999-0118-F	<b>Appeal Case #:</b>
<b>Re-review Case #:</b> 2005-0296-S	<b>Appeal Disposition:</b>
<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
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THE WHITE HOUSE

WASHINGTON

January 7, 1992

MEMORANDUM FOR TOM SCULLY

FROM:

HANNS KUTTNER *Hanns*

SUBJECT:

Medicaid Option #2: Integration with Tax Credit

Our thinking about Option #2, "Unified Program," has been contorted by an anarchistic view of how it would operate. You have focused on how states would find this option attractive because they could drop the cumbersome Medicaid eligibility process. However, we could not allow complete anarchy and drop all eligibility determination processes. It is this fact, it would seem to me, that saves the day.

I would suggest the following scenario for making Option #2 workable:

- At present the Medicaid paper says, "States would be required to provide a core benefit package and to cover everyone up to the poverty level who filed for coverage."

This assumes some kind of eligibility process. (There is no way to get away from this burden on the state, including some quality assurance mechanism that has penalties on states for overcertifying people for the credit. Otherwise we face something worse than Medicaid scams: states could station eligibility workers in hospitals who could give out \$1250 certificates to anyone who could not produce an insurance card.)

- A determination would be made at the beginning of the year of a state's estimated payment. The estimated amount would cover (A) the Medicaid per capita payments, based on the method discussed for estimating Medicaid eligibles and (B) the estimated number of Health Tax Credit (HTC) eligibles multiplied by \$1250/\$3125. States would continue to follow the same financial arrangements as for Medicaid: periodic drawdown from the Treasury, quarterly estimates, etc.
- The state would capture Social Security numbers and family unit size (is anything else required?) from individuals made eligible for the Unified Program (UniPro.)
- The state would allow individuals to opt out of UniPro if they chose, giving them the same certificate under the same terms as people get their certificates in non-UniPro

states.

- At the end of the year, the state would mail 1099s to all UniPro eligibles. Those people would include the credit amount on their tax returns. (This does not distinguish between those who would be eligible for Medicaid and those are part of the newly insured tax credit crowd. It is the only approach possible without maintaining a shadow Medicaid eligibility process. It has the unfortunate consequence of causing those people who would have been in the old Medicaid program and who have upward income shifts -- into the phase out range or beyond -- to have a tax consequence, something they would not have had in traditional Medicaid or in any of the Option 1 states.)
- The state provides the IRS with a tape providing social security numbers of UniPro participants for the past year and also those who opted out. The IRS, working with HCFA, then settles up with the state for the relevant year in the following process:
  1. Subtract the number opted out from the original estimate of UniPro participants.
  2. Subtract the estimated number of Medicaid eligibles from the number of UniPro participants.
  3. Compare the remaining number. If greater than the estimated number of full credit persons, the state's payment is adjusted upward. If lower than the estimated number of UniPro participants, adjust future payments downward.

copies: OMB - Bandeian  
Treasury - Hubbard, Leonard, Holtzblatt  
HCFA - Hudson, Gustafson, Johnson

THE WHITE HOUSE  
WASHINGTON

January 7, 1992

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I would suggest the following scenario for making Option #2 workable:

- At present the Medicaid paper says, "States would be required to provide a core benefit package and to cover everyone up to the poverty level who filed for coverage."

This assumes some kind of eligibility process. (There is no way to get away from this burden on the state, including some quality assurance mechanism that has penalties on states for overcertifying people for the credit. Otherwise we face something worse than Medicaid scams: states could station eligibility workers in hospitals who could give out \$1250 certificates to anyone who could not produce an insurance card.)

- A determination would be made at the beginning of the year of a state's estimated payment. The estimated amount would cover (A) the Medicaid per capita payments, based on the method discussed for estimating Medicaid eligibles and (B) the estimated number of Health Tax Credit (HTC) eligibles multiplied by \$1250/\$3125. States would continue to follow the same financial arrangements as for Medicaid: periodic drawdown from the Treasury, quarterly estimates, etc.
- The state would capture Social Security numbers and family unit size (is anything else required?) from individuals made eligible for the Unified Program (UniPro.)
- The state would allow individuals to opt out of UniPro if they chose, giving them the same certificate under the same terms as people get their certificates in non-UniPro

states.

- At the end of the year, the state would mail 1099s to all UniPro eligibles. Those people would include the credit amount on their tax returns. (This does not distinguish between those who would be eligible for Medicaid and those are part of the newly insured tax credit crowd. It is the only approach possible without maintaining a shadow Medicaid eligibility process. It has the unfortunate consequence of causing those people who would have been in the old Medicaid program and who have upward income shifts -- into the phase out range or beyond -- to have a tax consequence, something they would not have had in traditional Medicaid or in any of the Option 1 states.)
- The state provides the IRS with a tape providing social security numbers of UniPro participants for the past year and also those who opted out. The IRS, working with HCFA, then settles up with the state for the relevant year in the following process:
  1. Subtract the number opted out from the original estimate of UniPro participants.
  2. Subtract the estimated number of Medicaid eligibles from the number of UniPro participants.
  3. Compare the remaining number. If greater than the estimated number of full credit persons, the state's payment is adjusted upward. If lower than the estimated number of UniPro participants, adjust future payments downward.

copies: OMB - Bandeian  
Treasury - Hubbard, Leonard, Holtzblatt  
HCFA - Hudson, Gustafson, Johnson

## II. Brief Summary of Proposal for States

(\$ in billions, Federal Share)	1992	1993	1994	1995	1996	1997	93-97
<b>Current Law:</b>							
Total Medicaid	72.8	84.5	98.3	113.8	131.2	150.9	578.7
Acute Care	31.0	36.5	42.9	50.2	58.5	67.9	255.9
Dual-Eligibles	12.3	14.5	17.1	20.0	23.3	27.1	114.3
DSH 1/ - Non-add	8.4	9.8	11.4	13.2	15.2	17.2	75.5
Long-term Care	26.6	30.5	34.9	39.8	45.2	51.1	189.4
Administration	2.6	3.0	3.4	3.8	4.2	4.8	19.1

<b>Medicaid Reform Proposal:</b>							
Acute Care Payment	31.0	35.3	39.5	43.6	47.7	51.7	540.0
Add-on to CPI 2/	N.A.	5%	5%	4%	3%	2%	N.A.
<b>Savings:</b>							
Acute Care	0.0	1.2	3.4	6.6	10.8	16.2	38.2
Administration	0.0	0.0	0.0	0.1	0.1	0.2	0.5
<b>Total Savings 3/</b>	<b>0.0</b>	<b>1.2</b>	<b>3.4</b>	<b>6.7</b>	<b>10.9</b>	<b>16.4</b>	<b>38.7</b>

<b>Additional Savings Proposals:</b>							
Capitating Dual-Elig. 4/	0.0	0.5	1.4	2.6	4.3	6.6	15.4
Phase-down DSH Spend. 5/	0.0	1.0	2.3	5.3	10.6	12.6	31.8

- 1/ These amounts for disproportionate share hospital (DSH) payments under current law are included in the other numbers; they do not add into yearly totals.
- 2/ The percentage add-on is part of the per capita annual update adjustment that includes the CPI(u) and a population growth factor.
- 3/ Total savings from the reform capitated program exclude the dual-eligibles (those eligible for both Medicare and Medicaid), and assume the continuation of the DSH program.
- 4/ An additional \$15.4 billion could be saved if spending for dual eligibles were included in the reform capitated program.
- 5/ Additional savings of \$31.8 billion could be achieved if DSH spending were phased-down over five years -- reduced, for example, by 10% in year one, 20% in year two, 40% in year three, 70% in year four, and 80% in year five.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
03. Paper	Medicaid Reform Options (7 pp.)	01/06/92	P-5	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
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**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
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<b>AR Disposition Date:</b>	<b>MR Disposition Date:</b>

### RESTRICTION CODES

<p><b>Presidential Records Act - [44 U.S.C. 2204(a)]</b></p> <p>P-1 National Security Classified Information [(a)(1) of the PRA]        P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]        P-3 Release would violate a Federal statute [(a)(3) of the PRA]        P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]        P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]        P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]</p> <p>C. Closed in accordance with restrictions contained in donor's deed of gift.</p> <p>PRM. Removed as a personal record misfile.</p>	<p><b>Freedom of Information Act - [5 U.S.C. 552(b)]</b></p> <p>(b)(1) National security classified information [(b)(1) of the FOIA]        (b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]        (b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]        (b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]        (b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]        (b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]        (b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]        (b)(9) Release would disclose geological or geophysical information</p>
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January 6, 1992

## MEDICAID REFORM OPTIONS

### I. Background

Medicaid is a joint Federal/State program to provide health insurance to certain low-income individuals. Medicaid eligibility rules follow certain categorical requirements (age, disability, dependent children) and exclude able-bodied singles and childless couples. Mandatory Medicaid eligibility has historically been linked to receipt of cash assistance under AFDC and SSI, but in recent years, mandatory eligibility has been extended to a certain groups based on poverty status, e.g., poor and near-poor pregnant women and children. Optional eligibility extends to a variety of groups including the "medically needy," whose high medical expenses cause them to "spend down" their income to within Medicaid limits in order to qualify for benefits. Medicaid also pays the Medicare cost sharing for poor Medicare beneficiaries, the so-called dual eligibles.

Mandatory Medicaid services include hospital (inpatient and outpatient), physician and nursing home care. Optional services include prescription drugs among other benefits.

Provider payments are established by the States within broad Federal parameters. Based on recent legislation, hospital disproportionate share payments for hospitals serving large numbers of Medicaid or low-income patients are limited to 12 percent of total Medicaid benefit payments.

States set most program rules within broad Federal guidelines, determine beneficiary eligibility, and pay provider claims.

The program is funded jointly by the Federal and State governments. The Federal share varies by State per capita income from 50 to 83 percent for program expenditures and from 50 to 90 percent for program administration.

Continued reliance on fee-for-services payment, limited use of coordinated care, low provider participation, and over-reliance on emergency room care are symptomatic of perverse incentives in the current program.

## II. Brief Summary of Proposal for States

(\$ in billions, Federal Share)	1992	1993	1994	1995	1996	1997	93-97
<b>Current Law:</b>							
Total Medicaid	72.5	84.5	98.3	113.8	131.2	150.9	578.7
Acute Care	31.0	36.5	42.9	50.2	58.5	77.9	255.9
LTC/Dual-Elig.	38.9	45.0	52.0	59.8	63.5	68.2	303.7
Administration	2.6	3.0	3.4	3.8	4.2	4.8	19.1

<b>Medicaid Reform Proposal:</b>							
Per-capita Payment	31.0	35.3	39.5	43.5	47.6	61.5	540.0
Add-on to CPI <u>1/</u>	N.A.	6%	5%	4%	3%	2%	N.A.
<b>Savings:</b>							
Acute Care	0.0	1.2	3.4	6.6	10.8	16.2	38.2
Administration	0.0	0.0	0.0	0.1	0.1	0.2	0.5
<b>Total Savings <u>2/</u></b>	<b>0.0</b>	<b>1.2</b>	<b>3.4</b>	<b>6.7</b>	<b>10.9</b>	<b>16.4</b>	<b>38.7</b>

<b>Additional Savings Proposals:</b>							
Additional Savings by Including Dual-Eligibles	0.0	0.5	1.4	2.6	4.3	6.6	15.4
<b>Total DSH Spending <u>3/</u></b>	<b>8.4</b>	<b>9.8</b>	<b>11.4</b>	<b>13.2</b>	<b>15.2</b>	<b>17.5</b>	<b>75.5</b>

1/ The add-on factor is part of the per capita adjustment factor includes the CPI(W), which also includes a population growth factor.

2/ Total savings assumes the exclusion from the per capita program of the dual-eligibles, both Medicare and Medicaid eligible, and assumes the continuation of the current disproportionate share hospital (DSH) program.

3/ These amounts are included in the Medicaid baseline based on the recently passed legislation on donations and taxes.

**General:** Federal payments to States for acute care services under Medicaid would be shifted from the current open-ended entitlement approach to an indexed per capita payment.

In order to continue to afford their current programs in future years, States would be required to deliver all acute care services through coordinated care.

**Medicaid and Health Tax Credit (HTC):**

States would have two options to deal with the interaction between the acute care services under Medicaid program and the HTC.

**Option 1 - Separate Medicaid and Tax Credit Programs:** States would retain responsibility for the current acute care benefits under the Medicaid program. The benefit structure, eligibility, and provider payment rules would remain basically the same as under the current Medicaid program.

States would serve as "program administrators" and "brokers" for a HTC program for certain low-income individuals for the purchase of private insurance coverage. As program administrators, the States would be required to certify eligibility for and amount of the HTC program for those who wish to obtain their tax credit prospectively. As brokers, States would be required to contract with at least one private health plan to provide "core benefits" and at least one plan that offers major medical coverage, each at a cost no greater than the amount of the tax credit.

**Option 2 - Unified Program:** States would be allowed to establish a unified program under which they would receive a lump sum payment from the Federal government, equal to the sum of per capita payments for those who meet Medicaid eligibility requirements and HTC payments for those who are eligible for them. When the program is fully phased-in, States would be required to provide a core benefit package and to cover everyone up to the poverty level who filed for coverage.

States would be required to contract with at least one private plan to offer coverage at a cost no greater than the maximum amount of the tax credit.

States would be expected to continue to pay their share of the unified program, with amounts indexed to their share of the 1992 per capita Medicaid spending.

All eligible individuals would be allowed to opt-out of the unified program and obtain the HTC to purchase insurance on the same basis as individuals above the poverty line.

### III. Detailed Description of Options

#### OPTION 1 - Separate Medicaid and Tax Credit Programs

States would retain responsibility for the current Medicaid program. However, for the acute care portion of the program, the Federal payment would be converted to a indexed per capita payment. The expenditures for dual-eligibles, covered by both Medicare and Medicaid, and those receiving long-term care services would not be covered in this program. Their expenditures would continue to be matched by the Federal government as they have previously been.

States would serve as "program administrators" and "brokers" for the HTC program under which the Federal government would provide tax credits to certain low-income individuals.

**Benefits:** At a minimum, States would be required to continue to provide the same package of acute care benefits under Medicaid, in the same amount, duration and scope they did as of January 1, 1992. However, States would have the option to alter the package of acute care services, provided the resulting package was actuarially equivalent.

**Eligibility:** States would be required to continue to cover all current mandatory eligibility groups under Medicaid, as well as any optional groups they covered as of January 1, 1992, including the medically needy, i.e., those with high medical expenses compared to their incomes who would be allowed to spenddown into Medicaid eligibility.

**Provider Payment:** Current Medicaid payment policies that require providers to accept Medicaid rates as full payment with no significant cost sharing or balance billing would apply.

**Federal Payments to States:** Different Medicaid per capita amounts would be calculated for different age-sex or other groupings. States would receive a "pro-rated" per capita payment for those covered under Medicaid for a part of a year.

**Private Insurance Option under Credit Program:** States would be required to contract with at least one private health plan to provide "core benefits" at a cost no greater than the amount of the tax credit and at least one plan that offers major medical coverage at a reasonable price. Also, States could "buy-out" -- purchase private insurance for Medicaid eligibles. Where private insurance offers fewer benefits than Medicaid, Medicaid would provide wrap-around coverage.

**Maintenance of Effort (MOE):** MOE concerns would be largely addressed by the requirement that States maintain their

existing benefit and eligibility provisions. In addition, a Federal "look-behind" function would be established to assure State compliance.

**Coordinated care:** In order to continue to afford their current programs in future years, States would be required to deliver all acute care services through coordinated care. To facilitate this, existing impediments to coordinated care (e.g., the rule requiring no more than 75 percent of the enrollment be Medicaid or Medicare beneficiaries) would be relaxed. As the HTC program is phased in, more thorough Federal standards for coordinated care would be prescribed, and the direct Federal role in quality enforcement would expand.

**State Program Administration:**

Medicaid: States would continue their current administration of their Medicaid programs.

HTC: In addition, States would be required to determine eligibility for the HTC program for those non-workers who wish to obtain their tax credit prospectively. Individuals would have to file for the tax credit and have their eligibility determined by the State welfare/Medicaid office. There would be no asset/resource test for eligibility for the HTC program. Eligibility for the HTC for non-workers would be redetermined by the State every six months.

Insurers would do all the claims processing for those eligible for the HTC. Insurers would be guaranteed premiums for prospective eligibles for six months.

Federal look-behind or quality control efforts would be conducted to assure proper program administration, e.g., proper eligibility determination, and fraud and abuse monitoring.

Treasury/IRS would administer all other aspects of the HTC program.

## OPTION 2 -- Unified Program

States would be allowed to establish a unified program, combining their current Medicaid program with the HTC program.

The Federal Medicaid payment would be converted to an indexed per capita payment and combined with a tax credit amount for those under 100 percent of poverty who file for the tax credit. Individuals would have the freedom to choose between coverage under the State program and private insurance coverage.

Many Federal rules governing Medicaid would be relaxed.

**Core Benefits:** States would be required to provide a core benefit package, defined as all mandatory Medicaid services, on a Statewide and comparable basis. However, States would have the flexibility to modify the amount, scope and duration of these services (as they can now). Prescription drugs would not be covered in this core benefit package.

**Eligibility:** When the reform is fully phased in, States would be required to cover everyone under 100 percent of the poverty level who filed for coverage.

**Provider Payment:** Current Medicaid requirements that providers accept Medicaid rates as full payment, with no balance-billing or significant cost-sharing, would continue to apply.

**Federal Payments to States:** States would receive a lump sum payment from the Federal government, which would be the sum of per capita payments for those who meet Medicaid eligibility requirements and HTC payments for those who are eligible for them and who do not opt-out. The Federal payment to the States would be reduced by the amount of tax credits for individuals who opt out of the program.

The Federal government would estimate both the Medicaid and HTC populations, and base its lump sum payment to the State on this estimate. While States might wish to retain some ability to verify eligibility for the Medicaid and HTC payments in order to assure more accurate payment from the Federal government, they could choose to simplify their eligibility determination processes, easing their administrative burdens substantially.

**Maintenance of Effort (MOE):** States would be expected to continue to pay their share of the Medicaid program (i.e., indexed 1992 per capita spending). In a State that kept existing Medicaid eligibility determination, claims processing and reporting requirements in place, State spending should be readily verifiable.

In order to assure that States are not encouraging the sickest individuals to opt out, the States would be required to report certain information on these individuals to enable the Federal government to assess the actuarial cost of health care for those individuals. If the actuarial cost of those individuals exceeded the amount of the tax credit, in addition to the routine deduction of the tax credit amount from the Federal payment to the State, there would be a further reduction by the amount that the actuarial cost exceeded the tax credit amount.

**Private Insurance Option under the Credit Program:** States would be required to contract with at least one private plan to offer coverage at a cost no greater than the maximum amount of the tax credit. Individuals eligible for the HTC would have the freedom to choose between coverage under the State program or private insurance coverage.

**Coordinated care:** In order to continue to afford their current programs in future years, States would be required to deliver all acute care services through coordinated care. To facilitate this, existing impediments to coordinated care (e.g., 75 percent rule on public enrollment and voluntary enrollment) would be relaxed. As the HTC program is phased in, more thorough Federal standards for coordinated care would be prescribed and the Federal role in quality enforcement would expand.

**State Program Administration:** States would operate their unified program including eligibility determination and claims processing for everyone below 100 percent of poverty. Federal look-behind or quality control efforts would be conducted to assure proper program administration, e.g., proper eligibility determination, and fraud and abuse monitoring.

States and Treasury/IRS would split administrative responsibilities for the HTC program for those whose incomes were above 100 percent of poverty in the same manner as under Option 1.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04. Paper	Medicaid Reform Proposal - Issues [2 copies] (14 pp.)	01/06/92	-P-5	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
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<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
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### RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P-1 National Security Classified Information [(a)(1) of the PRA]
- P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P-3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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Freedom of Information Act - [5 U.S.C. 552(b)]

- (b)(1) National security classified information [(b)(1) of the FOIA]
- (b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- (b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- (b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- (b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- (b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- (b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- (b)(9) Release would disclose geological or geophysical information

January 6, 1992

## MEDICAID REFORM PROPOSAL -- ISSUES

### STATES' OPTION 1 - Separate Medicaid and Tax Credit Programs

States could choose to keep their current Medicaid programs. Those doing so would be required to serve as "program administrators" and "brokers" for a tax credit program for certain low-income individuals for the purchase of private insurance coverage.

#### Issue: Disproportionate Share Hospital (DSH) Payments.

Should a State's payments to disproportionate share hospitals be subtracted from its expenditure base before the State's per capita payments are calculated?

- o Savings estimates assume that DSH payments will be included in a State's expenditure base. Subtracting these payments from the base would increase estimated savings by \$75.5 billion over five years.
- o However, subtracting DSH payments would appear to abrogate the agreement which the Administration recently negotiated with Congress to enact legislation to limit a State's DSH payments to no more than 12 percent of total Medicaid expenditures.
- o DSH payments are used by States for a combination of purposes -- covering uncompensated care for the uninsured and low Medicaid payments -- to hospitals that serve a large number of Medicaid and low-income patients.
- o In most States, DSH are the hospitals that serve the majority of the poor population. Many are under severe financial distress.

Suggested resolution. To be identified.

#### 2. Issue: Dual Medicare-Medicaid eligibles.

Should this group be included in the per capita payment to States or continued as under current law?

- o Savings estimates assume that Federal payments to States for dual eligibles continue on an open-ended basis as currently. Putting dual eligibles under the per capita payment program would increase total savings by \$15.4 billion over five years.
- o Dual eligibles are different from other Medicaid

eligibles in two fundamental ways. First, Medicare is the primary payer of acute care services. Consequently States have minimal opportunities to serve this population in coordinated care arrangements. Second, dual eligible are heavy users of care, especially care care related to long-term, chronic medical conditions.

Suggested resolution. To be identified.

3. Issue: Administrative costs.

Would State administrative costs for the tax credit program be fully Federal or shared with the States?

- o HCFA assumes 15 to 20 million credit individuals will qualify for tax credit program. (Treasury has not provided their own estimates.) Preliminary estimates of average annual cost for determining eligibility are \$150-350. Hence, the total administrative cost would range from a low of \$2.25 billion to \$7 billion per year.
- o Administrative costs would be less if States were allowed to use existing methods of counting income and family members, rather than being required to implement a whole new set of IRS-based methods.

Suggested resolution. To be identified.

4. Issue: Limits on Federal payments.

Should the Federal payment be based on a per capita amount or the lesser of the per capita amount or the amount actually spent by the State?

- o If the Federal payment to a State is a per capita amount determined without regard to the State's actual spending, then it would be possible for the State to "win," i.e., reduce its relative share of total Medicaid spending, particularly if coordinated care becomes widespread and is successful at limiting per capita costs.
- o Without the possibility of "winning" under this payment scheme, States could be reluctant to support this approach.

Suggested resolution. To be identified.

*Option 1  
only  
issue*

5. Issue: Defining "coordinated care".

Who should define "coordinated care" -- the Federal government or each State?

- o If States had complete flexibility, then they could choose to deliver all coordinated care through public hospital/health clinic networks. On the other hand, they might adopt a limited version of coordinated care, to provide only outpatient care through a primary care case management network, leaving inpatient hospital care on its present basis.
- o If the Federal government wished coordinated care to be more encompassing and uniform, then the Federal government could develop a list of options for coordinated care from which the States could choose, or the Federal government could narrowly define coordinated care. (Exceptions for rural areas could be devised.)

Suggested resolution. To be identified.

STATES' OPTION 2 - Unified Program

States could choose to establish a unified program under which they would receive a lump sum payment from the Federal government, equal to the sum of per capita payments for those who meet Medicaid eligibility requirements plus tax credit payments for those who are eligible for them. When fully phased-in, the unified program would cover everyone up to the poverty level who filed for coverage. Many Federal rules governing Medicaid would be relaxed.

6. Issue: Prescription drugs.

Should prescription drugs be included as a mandatory (core) benefits? Should recipient copayments be required or allowed?

- o Currently, prescription drugs are an optional Medicaid benefit, but all States cover it, often with nominal cost-sharing.
- o The tax credit amount, as initially calculated, did not explicitly account for the cost of prescription drugs.
- o If States are required to cover drugs as a core benefit, the cost could be reduced by requiring recipients to cost-share. Should cost-sharing be Federally mandated? Left to each State? Limited to nominal amounts as currently or substantially raised?

Suggested resolution. To be identified.

7. Issue: Ensuring State maintenance of effort (MOE).

What measures are necessary to prevent States from encouraging low-income people to opt out of the State program and into the Federal tax credit program, thus shifting costs from the State to the Federal government?

- o States will be expected to continue to pay their share of the Medicaid program (i.e., indexed 1992 per capita spending). The Federal government must have a mechanism for enforcing this requirement.
- o Stringent Federal enforcement mechanisms (e.g., requiring extensive reporting by States, extensive Federal quality control activities, severe financial penalties) involve significant administrative effort and Federal involvement, diminishing the attractiveness of the option to have a unified program.
- o Looser enforcement mechanisms, though less costly and burdensome, could lead to uneven implementation of maintenance of effort requirements and shifting of persons to the Federal tax credit program.

Suggested resolution. To be identified.

## ADMINISTRATION OF THE HTC -- ISSUES

1. Issue: Prospective eligibility certification for workers.
  - o Treasury's proposal. States would determine eligibility for anyone wishing an advance tax credit, whether they are employed or not.
  - o Problems. Employed people might be reluctant to apply at a welfare office because of the stigma associated with welfare programs.
  - o Possible solutions. Applications could be processed by the States (which in all cases have to determine whether an HTC applicant is eligible for Medicaid) but applicants could have the choice of submitting them at other sites, e.g., Social Security District Offices or employers. However such an arrangement could lead to administrative delays and mistakes and, in the case of employers, could lead to potentially serious privacy concerns.
  
2. Issue: Treasury administration through the tax code.
  - o Treasury proposal. The HTC would be administered by Treasury and reconciled through the tax system.
  - o Problem. States, in option 1, would be performing the eligibility determination for all HTC recipients. States, in option 2, would be operating the entire program for those under 100 percent of poverty. Both options assume that the States would perform their functions in a prospective manner. The Treasury operates in a retrospective manner. The reconciliation of these two approaches by its nature must put someone at financial risk. The Treasury approach under Medicaid State option 1 would put the individual at risk. Under option 2, the State appears to be at risk.
  - o Possible solutions. None yet identified.
  
3. Issue: qualified dependents and size of credit.
  - o Treasury proposal. Size of the credit would depend on the number of qualified dependents in the tax filing unit.
  - o Problem. States, which will determine eligibility for the advance credit, cannot know how many qualified dependents will be claimed for any filing unit. Treasury will not know this either until the unit files its income tax return the year following the tax year.

- o Possible solutions. None yet identified.

4. Issue: Tax credit-subsidized insurance and other Federally subsidized health benefits.

- o Treasury proposal. Other Federal programs - IHS, PHS, and VA - would be required to bill insurers for the cost of medical care they provide to persons insured under the tax credit program.
- o Problems. Health care providers cannot distinguish between insured persons who are and are not eligible for the tax credit.

Most Federal programs seek reimbursement from patients' insurance, though with mixed level of effort and mixed success. More stringent requirements could be imposed, although it is not clear whether these would be cost-effective.

- o Possible solutions. Other Federal programs could be encouraged to seek payment from insurers of all their patients with insurance coverage of any sort.

5. Issue: Participation in the tax credit program by persons whose employers now pay part or all of the insurance premiums.

- o Treasury proposal. Employers would receive the benefit through reduced tax liability.
- o Problems. Individuals eligible for the tax credit have little or no incentive to apply for it.

Employers have every incentive to encourage their employees to apply. The incentive would be especially pronounced for employers paying low wages.

The proposal does not specify the disposition of the credit in cases where the employer and employee each pay a share of the premium.

- o Possible solutions. None yet identified.

6. Issue: Certification for users of emergency room care.

- o Treasury's possible resolution. Hospitals could assist the individual to apply. Immediate but temporary certification of eligibility could be made.

- o Problems. Insurers are generally unwilling to immediately enroll someone who will plainly incur high costs and whose temporary eligibility certification may soon be withdrawn. For this proposal to work, all insurers (employer-based, small group, State-contracted programs) would have to be required to modify or drop enrollment and coverage restrictions on persons with pre-existing conditions.
- o Possible solutions. None yet identified.

January 6, 1992

MEDICAID REFORM PROPOSAL -- ISSUES

STATES' OPTION 1 - Separate Medicaid and Tax Credit Programs

States could choose to keep their current Medicaid programs. Those doing so would be required to serve as "program administrators" and "brokers" for a tax credit program for certain low-income individuals for the purchase of private insurance coverage.

Issue: Disproportionate Share Hospital (DSH) Payments.

Should a State's payments to disproportionate share hospitals be subtracted from its expenditure base before the State's per capita payments are calculated?

- o Savings estimates assume that DSH payments will be included in a State's expenditure base. Subtracting these payments from the base would increase estimated savings by \$75.5 billion over five years.
- o However, subtracting DSH payments would appear to abrogate the agreement which the Administration recently negotiated with Congress to enact legislation to limit a State's DSH payments to no more than 12 percent of total Medicaid expenditures.
- o DSH payments are used by States for a combination of purposes -- covering uncompensated care for the uninsured and low Medicaid payments -- to hospitals that serve a large number of Medicaid and low-income patients.
- o In most States, DSH are the hospitals that serve the majority of the poor population. Many are under severe financial distress.

Suggested resolution. To be identified.

2. Issue: Dual Medicare-Medicaid eligibles.

Should this group be included in the per capita payment to States or continued as under current law?

- o Savings estimates assume that Federal payments to States for dual eligibles continue on an open-ended basis as currently. Putting dual eligibles under the per capita payment program would increase total savings by \$15.4 billion over five years.
- o Dual eligibles are different from other Medicaid

eligibles in two fundamental ways. First, Medicare is the primary payer of acute care services. Consequently States have minimal opportunities to serve this population in coordinated care arrangements. Second, dual eligible are heavy users of care, especially care care related to long-term, chronic medical conditions.

Suggested resolution. To be identified.

3. Issue: Administrative costs.

Would State administrative costs for the tax credit program be fully Federal or shared with the States?

- o HCFA assumes 15 to 20 million credit individuals will qualify for tax credit program. (Treasury has not provided their own estimates.) Preliminary estimates of average annual cost for determining eligibility are \$150-350. Hence, the total administrative cost would range from a low of \$2.25 billion to \$7 billion per year.
- o Administrative costs would be less if States were allowed to use existing methods of counting income and family members, rather than being required to implement a whole new set of IRS-based methods.

Suggested resolution. To be identified.

4. Issue: Limits on Federal payments.

Should the Federal payment be based on a per capita amount or the lesser of the per capita amount or the amount actually spent by the State?

- o If the Federal payment to a State is a per capita amount determined without regard to the State's actual spending, then it would be possible for the State to "win," i.e., reduce its relative share of total Medicaid spending, particularly if coordinated care becomes widespread and is successful at limiting per capita costs.
- o Without the possibility of "winning" under this payment scheme, States could be reluctant to support this approach.

Suggested resolution. To be identified.

*Option 1  
only  
issue*

5. Issue: Defining "coordinated care".

Who should define "coordinated care" -- the Federal government or each State?

- o If States had complete flexibility, then they could choose to deliver all coordinated care through public hospital/health clinic networks. On the other hand, they might adopt a limited version of coordinated care, to provide only outpatient care through a primary care case management network, leaving inpatient hospital care on its present basis.
- o If the Federal government wished coordinated care to be more encompassing and uniform, then the Federal government could develop a list of options for coordinated care from which the States could choose, or the Federal government could narrowly define coordinated care. (Exceptions for rural areas could be devised.)

Suggested resolution. To be identified.

STATES' OPTION 2 - Unified Program

States could choose to establish a unified program under which they would receive a lump sum payment from the Federal government, equal to the sum of per capita payments for those who meet Medicaid eligibility requirements plus tax credit payments for those who are eligible for them. When fully phased-in, the unified program would cover everyone up to the poverty level who filed for coverage. Many Federal rules governing Medicaid would be relaxed.

6. Issue: Prescription drugs.

Should prescription drugs be included as a mandatory (core) benefits? Should recipient copayments be required or allowed?

- o Currently, prescription drugs are an optional Medicaid benefit, but all States cover it, often with nominal cost-sharing.
- o The tax credit amount, as initially calculated, did not explicitly account for the cost of prescription drugs.
- o If States are required to cover drugs as a core benefit, the cost could be reduced by requiring recipients to cost-share. Should cost-sharing be Federally mandated? Left to each State? Limited to nominal amounts as currently or substantially raised?

Suggested resolution. To be identified.

7. Issue: Ensuring State maintenance of effort (MOE).

What measures are necessary to prevent States from encouraging low-income people to opt out of the State program and into the Federal tax credit program, thus shifting costs from the State to the Federal government?

- o States will be expected to continue to pay their share of the Medicaid program (i.e., indexed 1992 per capita spending). The Federal government must have a mechanism for enforcing this requirement.
- o Stringent Federal enforcement mechanisms (e.g., requiring extensive reporting by States, extensive Federal quality control activities, severe financial penalties) involve significant administrative effort and Federal involvement, diminishing the attractiveness of the option to have a unified program.
- o Looser enforcement mechanisms, though less costly and burdensome, could lead to uneven implementation of maintenance of effort requirements and shifting of persons to the Federal tax credit program.

Suggested resolution. To be identified.

## ADMINISTRATION OF THE HTC -- ISSUES

### 1. Issue: Prospective eligibility certification for workers.

- o Treasury's proposal. States would determine eligibility for anyone wishing an advance tax credit, whether they are employed or not.
- o Problems. Employed people might be reluctant to apply at a welfare office because of the stigma associated with welfare programs.
- o Possible solutions. Applications could be processed by the States (which in all cases have to determine whether an HTC applicant is eligible for Medicaid) but applicants could have the choice of submitting them at other sites, e.g., Social Security District Offices or employers. However such an arrangement could lead to administrative delays and mistakes and, in the case of employers, could lead to potentially serious privacy concerns.

### 2. Issue: Treasury administration through the tax code.

- o Treasury proposal. The HTC would be administered by Treasury and reconciled through the tax system.
- o Problem. States, in option 1, would be performing the eligibility determination for all HTC recipients. States, in option 2, would be operating the entire program for those under 100 percent of poverty. Both options assume that the States would perform their functions in a prospective manner. The Treasury operates in a retrospective manner. The reconciliation of these two approaches by its nature must put someone at financial risk. The Treasury approach under Medicaid State option 1 would put the individual at risk. Under option 2, the State appears to be at risk.
- o Possible solutions. None yet identified.

### 3. Issue: qualified dependents and size of credit.

- o Treasury proposal. Size of the credit would depend on the number of qualified dependents in the tax filing unit.
- o Problem. States, which will determine eligibility for the advance credit, cannot know how many qualified dependents will be claimed for any filing unit. Treasury will not know this either until the unit files its income tax return the year following the tax year.

- o Possible solutions. None yet identified.

4. Issue: Tax credit-subsidized insurance and other Federally subsidized health benefits.

- o Treasury proposal. Other Federal programs - IHS, PHS, and VA - would be required to bill insurers for the cost of medical care they provide to persons insured under the tax credit program.
- o Problems. Health care providers cannot distinguish between insured persons who are and are not eligible for the tax credit.

Most Federal programs seek reimbursement from patients' insurance, though with mixed level of effort and mixed success. More stringent requirements could be imposed, although it is not clear whether these would be cost-effective.

- o Possible solutions. Other Federal programs could be encouraged to seek payment from insurers of all their patients with insurance coverage of any sort.

5. Issue: Participation in the tax credit program by persons whose employers now pay part or all of the insurance premiums.

- o Treasury proposal. Employers would receive the benefit through reduced tax liability.
- o Problems. Individuals eligible for the tax credit have little or no incentive to apply for it.

Employers have every incentive to encourage their employees to apply. The incentive would be especially pronounced for employers paying low wages.

The proposal does not specify the disposition of the credit in cases where the employer and employee each pay a share of the premium.

- o Possible solutions. None yet identified.

6. Issue: Certification for users of emergency room care.

- o Treasury's possible resolution. Hospitals could assist the individual to apply. Immediate but temporary certification of eligibility could be made.

- o Problems. Insurers are generally unwilling to immediately enroll someone who will plainly incur high costs and whose temporary eligibility certification may soon be withdrawn. For this proposal to work, all insurers (employer-based, small group, State-contracted programs) would have to be required to modify or drop enrollment and coverage restrictions on persons with pre-existing conditions.
- o Possible solutions. None yet identified.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
05. Paper	Medicare Coordinated Care Initiative (8 pp.)	12/17/91	<del>P-5</del>	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
 (Document Follows)  
 By JRD (NLGB) on 10/28/2005

<b>Date Closed:</b> 1/5/2005	<b>OA/ID Number:</b> 06970-008
<b>FOIA/SYS Case #:</b> 1999-0118-F	<b>Appeal Case #:</b>
<b>Re-review Case #:</b> 2005-0296-S	<b>Appeal Disposition:</b>
<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
<b>AR Disposition Date:</b>	<b>MR Disposition Date:</b>

### RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P-1 National Security Classified Information [(a)(1) of the PRA]
- P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P-3 Release would violate a Federal statute [(a)(3) of the PRA]
- P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

**Freedom of Information Act - [5 U.S.C. 552(b)]**

- (b)(1) National security classified information [(b)(1) of the FOIA]
- (b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- (b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- (b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- (b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- (b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- (b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- (b)(9) Release would disclose geological or geophysical information

12.27.91

## MEDICARE COORDINATED CARE INITIATIVE

**Concept:** Coordinated care is the best way to ensure that cost-effective and high quality medical care is provided under the Medicare program. Currently, however, the only coordinated care alternative to a la carte fee-for-service is the HMO option. In some areas, beneficiaries don't even have that limited choice. Although Medicare enrollment in coordinated care plans grew on average by 9 percent for the past two years, enrollment as a percentage of the total Medicare population is still only 6.6% relative to the 40% enrolled in the under 65 population.

If significant strides are to be made in expanding the percentage of Medicare beneficiaries receiving coordinated care, a two-prong approach is required. The Administration needs to:

- o create new options, as alternatives to the most structured form of coordinated care (HMOs), that would provide beneficiaries with greater provider choice while introducing them to the benefits of coordinated care; and
- o take steps to strengthen the existing HMO option.

### 1.0 NEW COORDINATED CARE OPTIONS

#### 1.1 Point of Service (POS) Option

##### Background

- [full scale version of CAPA to discuss?]
- o Under current law, a beneficiary who wants to receive benefits through an HMO must enroll with that plan. Beneficiaries enrolling in HMOs with risk contracts are required to receive all of the Medicare covered services through the HMO.
  - o In recent years, employers have been moving toward health plans where individuals make a choice at the point of service of whether or not to receive care through the plan's network of providers or outside of that network. These plans have both been popular with employees and have achieved the desired results of moving a significant percentage of services into the preferred provider network.

##### Proposal - Create a Medicare Point-of-Service Option

- o HCFA would enter into multi-year contracts with entities (POS contractors) to create comprehensive preferred provider networks (primary care physicians, specialists, hospitals, labs, etc) for beneficiaries not enrolled in risk plans.

- o POS contractors would negotiate discounts for bundled Part A and Part B payments for high cost/high volume surgical procedures. They would also negotiate other discounts from providers and suppliers. POS physicians would have incentives to make referrals only within the POS network.
- o No enrollment would be required for the option: beneficiaries would make the choice on a service-by-service basis whether or not to use the POS network.
- o Beneficiaries would receive incentives for receiving services through the POS network. These could include:
  - o rebates from Medicare for each physician service provided by the POS network, equal to 50% of the coinsurance amount (In any year, total rebates would be limited to 30% of the Part B premium.).
  - o a package of preventative services (i.e. immunizations, screening for colon cancer) that would be available only through the POS network.
- o There would be one POS contractor in a given area. The contractor would receive incentive payments based on performance in restraining expenditure growth.
- o Availability of the POS option would be constrained by the limited number of entities that would be capable of providing the POS product envisioned. In addition, POS may never be feasible in some isolated rural areas.

*splitting -  
no enrollment,  
how financial?*

## 1.2 Employer POS

### Background

- o About 40% of Medicare beneficiaries have employer-based supplemental benefits.
- o Employers have been leading the way in the use of new coordinated care options such as point of service. However, because of various problem in coordinating their benefit packages and their coordinated care systems with Medicare, they have generally not be including Medicare-eligible retirees in these new programs.

Proposal - Contract with employer or union-sponsored plans to provide medical review/utilization review for Medicare covered services for retirees.

*Amn want  
more →  
control over  
claims  
- how do we make  
enrollment possible  
where and how  
PPO?*

- o This proposal would enable employers and Taft-Hartley trusts to coordinate benefits to retirees through the same administrative structure used to coordinate care for active employees and/or under-65 retirees.
- o The employer or union could provide the MR/UR directly or subcontract with an insurer or another entity to provide the service. The MR/UR performed under the contract would have to be as stringent as review performed by Medicare carriers; they would also follow national HCFA coverage guidelines.

## 2.0 STRENGTHEN EXISTING COORDINATED CARE PROGRAM

### 2.1 Increased Investment in Current Program

#### Background

- o HMOs contracting with Medicare on a risk basis compete directly with the Medicare program -- a large insurer with substantial monopsony power. By virtue of this power, Medicare is able in effect to obtain deep price discounts from fee-for-service providers. These price discounts may overwhelm potential savings that HMOs can achieve from negotiated discounts and better control over utilization.
- o In addition, HMOs are paid only 95% of comparable fee-for-service costs (because of presumed efficiencies). Nevertheless, HMOs face marketing and enrollment costs unlike government.
- o Critics of the Medicare risk contract program argue that the current AAPCC methodology results in "favorable selection" -- greater numbers of healthy persons enrolling in HMOs relative to the fee-for-service sector, thus providing overpayment for care. Evidence, while mixed, offers some support for this selection bias argument. Nevertheless, other measures (e.g., lack of market entry) raise questions about the extent of this problem.
- o Recent research (Scheffler, 1989; Welch, 1991; Robinson, 1991) has found that growth in HMO market penetration may result in lower overall Medicare costs since it is correlated with a reduction in the rate of increase of fee-for-service costs. According to Welch, if enrollment in risk plans increases by 10 percentage points, Medicare expenditures would decrease by 1.2% in the short term and by as much as 3.9% in the long run.

Proposal - Increase payments to HMOs with risk contracts.

**Option 1 - Increase Payments from 95 to 100% of the AAPCC**

The additional 5% could encourage the entry into the Medicare market of HMOs who currently are not participating. Existing plans could use the additional 5% to improve their competitive edge against Medigap plans by offering additional benefits or providing rebates to beneficiaries.

This proposal has been put forward in the past and was not well received by the Congress.

**Option 2 - Increase Payments to 100% through Outlier Payments and Beneficiary Rebates**

Under this proposal, Medicare would make additional payments to HMOs for a portion of the costs of high cost cases above a predetermined threshold. For example, if Medicare paid for 60% of the costs for cases that exceeded \$61,000 in 1993, payments to HMOs would increase on average by 2.5 percent.

In addition to outlier payments, Medicare could provide rebates to beneficiaries enrolled in HMOs as a concrete sign of the support of the risk contract program. The rebate could equal 30% of the Part B premium.

The approximate cost of the two options, taking into account payment lags but without accounting for the potential impact of reduced fee-for-services costs would be:

(dollars in millions)

	1993	1994	1995	1996	1997
Option 1	250	420	515	600	685
Option 2					
Outlier	60	190	230	260	300
Rebates	0	225	280	330	370
Total	60	415	510	590	670

[Actuary's estimate]

Full budget - rebates only to plans that charge a premium]

**2.2 Reform of Current Payment Methodology**

**Background**

- o Although the AAPCC methodology is accurate in predicting the costs for an HMO's total enrollment, its predictive power in regard to individual enrollees is extremely low.

- o Even though enrollment in risk plans as a percent of total Medicare enrollment is low, in some counties enrollment is greater than 25%. Over the past few years the increases in the AAPCCs for these counties has lagged behind the national average increase (USPCC).
- + For example, while the national average increase in rates for the past three years was 22.6%, in one county with 34% enrollment the increase was 15.5%. In another county with 27% enrollment the AAPCC actually decreased over the past three years.
- + The industry's response to these developments, building on the research results cited above, is to argue that the rewards for a plan decrease to the extent that it is successful in enrolling significant numbers of Medicare beneficiaries.

### Proposals

A) Break the Link with Fee-for-Service - Index current rates based on the growth in the USPCC or a blend of the USPCC and the AAPCC. This would be done immediately for high penetration areas and would be studied for the program as a whole.

B) Experiment with Competitive Bidding To Establish Payment Rates

- o The premium contribution for beneficiaries in a defined market area could be set equal to the lowest price for the Medicare benefit package submitted by a qualified plan. The contribution could be adjusted by risk-specific categories.
- o Annual updates could be accomplished through successive iterations of same process or indexed by some mutually agreed-upon update factor.

## **2.3 Increase Flexibility of HMO option**

### Background

- o HMOs with risk contracts currently cannot deal exclusively with employer groups but must be open to all enrollees in their services area.
- o HMOs cannot currently enter into multi-year contracts with Medicare with fixed rates for the term of the

contract. Instead, they are limited to contracting on a year-to-year basis.

- o Although Medicare is encouraging beneficiaries to enroll in HMOs upon entering the program, enrollment may not be possible because of the timing of open enrollment periods.

### Proposals

A) Establish a new risk contracting option that allows for provision of coordinated care services to Medicare group retirees only.

- o If a group is 1,000 or more, payment to the plan could be either the current HMO payment rate, or an experience rate based on the projected health care utilization of the specific Medicare group retirees enrolled.
- o The proposal would eliminate problems under current law which deter employers from offering an HMO option to their Medicare-eligible retirees, by allowing (a) coordinated enrollment with the employer's schedule, (b) geographic boundaries based on residence of employer's group retirees, and (c) flexibility of benefits offered (subject to minimum requirements).
- o Unlike the Medicare Insured Group (MIG) demonstration, the HMO rather than the employer would be at-risk.

B) Establish a multi-year based contracting option, for up to three years.

- o Each year AAPCC projections would be developed for the subsequent two years. Plans exercising the multi-year option could lock-in these rates rather than the AAPCCs applicable for one-year contracts.
- o A long-term contract with stable rates would constitute a commitment on the part of Medicare and the HMO to the risk contract program.

C) Permit HMOs/CMPs to conduct continuous open enrollment exclusively for new beneficiaries.

- o As a result of this proposal, more newly entitled beneficiaries would have a coordinated care option available to them upon enrollment.

## 2.4 Refine Current Payment Methodology

### Background

- o Plans argue that the payment rates are slightly depressed because of the treatment of Medicare beneficiaries for whom Medicare is the secondary payor -- working aged. The working aged depress per capita ratios because these beneficiaries incur no or significantly reduced Medicare costs yet are included in the total number of beneficiaries. Medicare payment are accurate only if the working aged enroll in plans in a proportion equal to their presence in fee-for-service. Since this enrollment balance is difficult to achieve, some plans are underpaid while other are overpaid.
- o Another payment issue is the lack of a health status adjustor. Experience with what was believed to be the most promising adjustor (DCGs) indicated that it further exacerbated the current problems with favorable selection rather than improving the accuracy of payment.

### Proposal

- A) Include "Working Aged" Adjustor in the 1993 rates
  - o This would slightly increase payment for non-working aged enrollees and significantly reduce payment for the working aged. The net result will be more accurate payment.
- B) Continue Research to Develop a Health Status Adjustor

## 2.5 Reform Cost Contract Options

### Background

- o In addition to the risk contract option, coordinated care plans currently have two cost-based options under Medicare.
  - + There is a cost contract option for which plans have to meet many of the same requirements as for a risk contract.
  - + Under a second cost option, plans can enter into agreements to become Health Care Prepayment Plans (HCPPs).

- o Neither of these cost options provide incentives for the efficient delivery of care. In 1989, payments for beneficiaries enrolled in these plans exceeded 100% of the AAPCC in 13 out of 34 cost contracts and 19 out of 42 HCPPs. Payments above 100% of the AAPCC totaled more than \$35 million.
- o In addition, in recent years, HMOs that previously had risk contracts have converted to HCPPs since there are fewer requirements for such an agreement. The requirements that they thus avoid cover such areas as fiscal soundness, beneficiary appeals and the prohibition against health screening.

Proposals

A) Modify cost contract provisions to: establish an absolute limit on payments at 100% of the AAPCC; require plans to process claims for out-of-plan services; provide plans with tools for controlling out-of-plan utilization; and provide incentive bonuses to efficient plans equal to 25% of the savings below 95% of the AAPCC, up to 2% of the AAPCC.

B) Eliminate the Health Care Prepayment Plan Option (HCPP) for HMOs and CMPs, and impose requirements on remaining HCPPs.

**2.6 Strengthen Oversight of HMO Program**

Background

In addition to contract termination, HCFA can move to freeze enrollment or impose civil monetary penalties in certain situations.

Proposal - Expand the intermediate sanction/CMP authority to allow these enforcement tools to be used against plans that:

- o engage in prohibited marketing practices;
- o distribute marketing material without obtaining the required prior approval; and
- o do not cooperate with quality review.

**TABLE 1. 1993 COST PROJECTIONS FOR PLAN OPTION A: THE UNINSURED POOR**

SINGLE PERSONS:	MARRIED ADULTS - NO CHILDREN; <small>24,391.5</small>	MARRIED ADULTS WITH CHILDREN*; <small>935</small>	SINGLE ADULT WITH CHILDREN*; <small>1071</small>
Person - \$1,960 1666	Person - \$2,870 Family - \$5,740 <small>4879</small>	Person - \$1,100 Family - \$5,280 <small>4488</small>	Person - \$1,260 Family - \$4,100 <small>3485</small>
Inpatient hospitalization up to 15 days  Person - \$1,100	Inpatient hospitalization up to 15 days  Person - \$1,700 Family - \$3,400	Inpatient hospitalization up to 15 days  Person - \$560 Family - \$2,690	Inpatient hospitalization up to 15 days  Person - \$660 Family - \$2,150
Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 10% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits  Person - \$860	Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 10% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits	Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 10% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits	Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 10% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits

*85% - discount for managed care.*  
*-10% for no cost shift*  
*+9% Admin*

\*Family size for married with children is 4.8; for single persons with children is 3.25.  
 Source: 1987 National Medical Expenditure Survey, Household. Agency for Health Care Policy and Research.

1993 Cost Projections for Insurance Plans for  
the Uninsured Poor

	Premium
<p>PLAN A Includes Inpatient Hospital up to 15 days, Inpatient Physician, lab, emergency room, and ambulatory physician visits covered for \$5 fee per visit for the first three physician visits, then a 10 percent co-pay up to a \$500 out-of-pocket limit.</p>	\$1,256
<p>PLAN B Includes all services under PLAN A, but requires a 20 percent co-pay on physician visits after 3 visits.</p>	\$1,200
<p>PLAN C Includes unlimited Inpatient Hospital, and Inpatient Physician care.</p>	\$1,057
<p>PLAN D Includes all services under PLAN C, with an addition of 3 ambulatory physician visits and associated lab fees with a \$10 co-pay per visit.</p>	\$1,183
<p>PLAN E Includes all services under PLAN C, with an addition of 5 ambulatory physician visits and associated lab fees with a \$10 co-pay per visit.</p>	\$1,225
<p>PLAN F Includes all services under PLAN C, with an addition of 10 ambulatory physician visits and associated lab fees with a \$10 co-pay per visit.</p>	\$1,267

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Premiums are based on the 1987 National Medical Expenditure Survey, Household Survey, trended to 1993 using HCFA growth factors. Estimates of expenditures for the Poor, Uninsured are based on an AHCPR, two stage regression analysis. Prices reflect private market rather than Medicaid fees.

Premiums include 15 percent offset for managed care savings, a 10 percent offset for savings from no cost-shifting, and an addition of 9 percent for administrative costs. These adjustments are estimated, and may require further refinement.

**TABLE 1. 1993 COST PROJECTIONS FOR INSURANCE PLANS FOR THE UNINSURED POOR, PLANS A, B, AND C**

PLAN OPTION A: \$1,495	PLAN OPTION B: \$1,428	PLAN OPTION C: \$1,258
<p>Inpatient hospitalization up to 15 days</p> <p style="text-align: center;">\$ 800.00</p> <p>Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 10% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits</p> <p style="text-align: center;">\$ 695.00</p>	<p>Inpatient hospitalization up to 15 days</p> <p style="text-align: center;">\$ 800.00</p> <p>Inpatient physician, lab, emergency room, and ambulatory physician visits covered with a 20% copay on services up to \$500 out-of-pocket and \$5 fee per visit for the first three physician visits</p> <p style="text-align: center;">\$ 628.00</p>	<p>Unlimited inpatient hospitalization and inpatient physician care</p> <p style="text-align: center;">\$ 1,258</p>

Source: 1987 National Medical Expenditure Survey, Household Survey. Agency for Health Care Policy and Research.

**TABLE 2. 1993 COST PROJECTIONS FOR INSURANCE PLANS FOR THE UNINSURED POOR, PLANS D, E, AND F**

PLAN OPTION D: \$1,408	PLAN OPTION E: \$1,458	PLAN OPTION F: \$1,508
<p>Unlimited inpatient hospitalization and inpatient physician care</p> <p>\$ 1,258.00</p>	<p>Unlimited inpatient hospitalization and inpatient physician care</p> <p>\$ 1,258.00</p>	<p>Unlimited inpatient hospitalization and inpatient physician care</p> <p>\$ 1,258.00</p>
<p>Three ambulatory physician visits and associated lab fees with a \$10 copay per visit</p> <p>\$ 150.00</p>	<p>Five ambulatory physician visits and associated lab fees with a \$10 copay per visit</p> <p>\$ 200.00</p>	<p>Ten ambulatory physician visits and associated lab fees with a \$10 copay per visit.</p> <p>Note, approximately 90 percent of persons would have 10 or fewer visits.</p> <p>\$250.00</p>

Source: 1987 National Medical Expenditure Survey, Household Survey. Agency for Health Care Policy and Research.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
06. Paper	Health Tax Credit - Administrative Issues (8 pp.)	12/27/91	<del>P-5</del>	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
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 By JRD (NLGB) on 10/28/2005

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<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
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December 27, 1991

## HEALTH TAX CREDIT -- ADMINISTRATIVE ISSUES

### BRIEF SUMMARY OF PROPOSAL

The health tax credit (HTC) would be available only to individuals who are not eligible for Medicaid, Medicare, VA and CHAMPUS, or other Federal health subsidies and have modified adjusted gross income (defined as the sum of adjusted gross income, nontaxable Social Security payments, nontaxable Railroad Retirement Social Security equivalent payments, and tax-exempt interest) below certain thresholds. The amount of the credit depends on the size of the filing unit and the individual's modified adjusted gross income. In 1993, the maximum credit would be \$1,250 for filers claiming one exemption, \$2,300 for filers claiming two exemptions, and \$3,125 for filers claiming three or more exemptions.<sup>1</sup> The credit would phase down to a minimum credit of \$125/\$230/\$313 between 50 percent and 100 percent of the tax threshold (defined as the sum of the standard deduction and personal exemptions). The minimum credit would phase out over modified adjusted gross income levels of \$30,000 - \$40,00 for single filers, \$40,000 - \$50,000 for heads of households and \$60,000 - \$70,000 for married filers filing jointly. Income thresholds for phasedown of the full credit to the minimum credit would rise to 100 percent and 150 percent of the tax threshold over a 5-year period.

There would be offered a combined credit/deduction alternative for use by credit recipients who have taxable income. If an individual participates in an employer-sponsored health care plan to which the employer makes contributions (a contributory plan), the deduction would be reduced by the amount of the employer's contribution.

The HTC would be transferable to an insurance company or, in the case of a person <sup>whose employer offered a health plan</sup> covered by a contributory plan, to the employer. Insurance companies would be required to offer a basic health insurance coverage ("Plan A") at a price not in excess of the amount of the full credit. Credits would be transferable to employers only if they provide coverage equivalent to Plan A.

To demonstrate eligibility for the credit, individuals would be required to fill out a new Schedule HIC (Health Insurance Credit). The schedule would show the individual's modified adjusted gross income, the number of qualified dependents, and eligibility for other forms of subsidized insurance.

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<sup>1</sup> All credit and income threshold amounts would be indexed for inflation (using the CPI(U) index).

ADMINISTRATIVE ISSUES

Summarized below are a number of administrative issues that will have to be resolved before the HTC can be instituted. Although the administrative problems are numerous, the one issue that dwarfs most of the others is the fact that for the foreseeable future, it will not be feasible to issue credits on the basis of income information that has been verified through the IRS matching programs. As a consequence, credits will be issued on the basis of unverified information reported by applicants for the HTC. This is the same unverified information on which EITC eligibility has been based. Serious compliance concerns have been raised about the EITC. Although the EITC compliance problems have been eased by legislative modifications to the credit, these modifications would not be readily adaptable to the HTC. It is therefore likely that the use of this unverified information would result in serious compliance and collection problems. Only slightly less troublesome is the mismatching of credits and the need for credits during periods of fluctuating income that arises from the administrative necessity of basing credit amounts on prior year income. These issues and others are discussed below.

1. Determining income eligibility.

a. Should the HTC be based on projected current year income, or last year's income?

Basing the credit on current year income would require estimates of income, which are likely to be inaccurate, resulting in an erroneous credit amount determination. If an individual underestimates income, the IRS would have to recapture the excess, either from the individual or from the insurer or employer to which the credit was transferred. Recapturing the excess from the insurer or employer would raise costs and would discourage providing coverage to credit holders. Recapturing the excess from the individual would be costly and would work a serious hardship on low-income persons who do not have cash to repay the excess.

SUGGESTED RESOLUTION: To avoid these compliance and collection problems, base the HTC on the prior year's income. Related issues arise in connection with other eligibility criteria, such as the number of dependents claimed on the return. This information would also be based on prior year returns for similar reasons.

verified info -  
IM program

b. How does prior year income rule affect persons with transitory declines in income?

POSSIBLE RESOLUTION: The resolution to Issue 1.a. will not help a person whose income drops in the current year (e.g., someone who becomes unemployed and loses health insurance or a divorced woman no longer covered under her ex-husband's policy). One possibility would be to allow such persons to estimate income and make up the difference at the end of the year. This solution brings with it the compliance and collection problems raised above. It would also mean that if the individual went on the prior year income system described in 1.a. in the year following the drop in income, the first low income year would be the basis for two credits rather than one. If the individual remains on the current year system, the problems of the current year income system are perpetuated.

NOTE: For such persons, the mere availability of Plan A may be a substantial benefit, even if they do not receive the credit.

2. Verifying income eligibility.

a. Where does the individual file the Schedule HIC?

The individual could file the Schedule HIC with the IRS, which would then provide a certification for the credit, which could be taken to the insurance company or the employer for the purchase of health insurance. The processing of these forms would probably take several months and would add to the IRS administrative burden, because many persons submitting a Schedule HIC would not otherwise be filing a return. This would require additional IRS resources, or the reallocation of resources now deployed elsewhere.

*what happens if there is no insurance?  
[value?]*

Alternatively, the individual could be required to submit the Schedule HIC to the insurer (or to the employer, in the case of an individual covered by a contributory plan). The insurer (or employer) could verify against the IRS database the information submitted by individuals who file tax returns. The insurer could also provide information submitted by non-filers to the IRS, which could be matched against information returns.

*All employees will offer.*

PROPOSED RESOLUTION: Subject to the limitations discussed in d.2., below, have Schedule HIC filed with the insurer or employer. Insurers and employers would be required to exercise some due diligence before submitting the Schedule HIC information to the IRS.

b. When is the IRS database available for confirming Schedule HIC information?

The IRS can provide a database containing information

provided on timely filed returns by August of the year following the relevant taxable year. (Information from returns on extension and amended returns would not be available in August. Information on non-filers would not be available on this database at all.) This information has been checked only for internal consistency. The IRS does not run its matching programs until spring of the following year, so that true verification of Schedule HIC income information is not possible until that time. (Under the IRS modernization program, it is expected that the time at which matching runs can be done will move closer to the August date, but no date for that development has been established.) Although the use of verified information would be extremely desirable from a compliance standpoint, it would require that income eligibility be based on two year old information, which would unacceptably exacerbate the problems described in 1.b.

SUGGESTED RESOLUTION: Base eligibility verification on information available on the IRS database in August, or, in the case of non-filers, on the unconfirmed information provided by the individual on Schedule HIC.

NOTE: With its current capacity, the IRS database can provide quick responses only with respect to a limited number of returns (typically, those showing a balance due). Other requests require a 24 hour response time. The IRS would require additional capacity to be able to respond on a same-day basis to eligibility checks.

c. Will eligibility checks done before August reflect the proper year's income on which to base the HTC?

If the IRS database is available for use year-round, eligibility checks done prior to August will be based on aging information.

SUGGESTED RESOLUTION: To assure that all individuals receive credits based on information of comparable age, we could adopt a "plan year" that runs from August through July and provide an open season beginning in August during which applicants come into the system. Pro-rated credits would be issued for partial years beginning after the end of the open season and ending in July.

d. May the IRS disclose return information to insurers or employers?

Disclosure of the return information needed to confirm the Schedule HIC would almost certainly violate section 6103. Even if the legal impediment were eliminated by amending section 6103, the IRS would have to develop a system that could (1) limit the insurer's or employer's access to items necessary for an

eligibility determination, (2) identify the persons dialing in as authorized, and (3) protect the larger system against inadvertent or intentional transmission of computer viruses.

POSSIBLE RESOLUTION: Disclosure of information can be minimized if the insurer or employer supplies only the individual's name and TIN to the IRS, which would determine the necessary information and compute the credit. Although insurers and employers could still infer certain taxpayer characteristics from the amount of the credit, this system might be less offensive than the direct disclosure of line item information. It would also reduce the risk of erroneous credit calculations by the insurer or employer.

POSSIBLE INTERIM RESOLUTION: Since privacy and security issues are a function of an electronic verification system, they can be avoided by having individuals file their Schedule HICs with the IRS and obtaining an IRS certification. Although paper filing with the IRS results in the delays and administrative burdens described in 1.a., it may be a necessary stopgap system until the IRS can provide a system that alleviates its privacy and security concerns.

e. Should automatic recertification be permitted?

PROPOSED RESOLUTION: Providing automatic recertification until the IRS determines that the recipient is no longer eligible would eliminate the need to go through the process of demonstrating eligibility on an annual basis. Nevertheless, given the interval that would elapse between the time eligibility lapses and the time the IRS can verify eligibility (i.e., after the matching programs are run), there could be a lot of revenue loss that would be difficult to recoup. Therefore, annual recertification should be required.

f. Should coverage be extended for some period after an individual loses certification?

Although it should be possible for a recipient to know he is no longer eligible when he files his tax return, it is unlikely that much of the population receiving the credit will be sensitive to all the factors that could terminate eligibility. Dropping people without warning could create hardship.

POSSIBLE RESOLUTION: (1) Require that access to the group in which the recipient was covered remain available at the same cost despite termination of the subsidy, or (2) if the recipient can't afford to continue his coverage immediately, provide a grace period of perhaps 30 days during which coverage continues after loss of certification.

g. How will the eligibility verification procedure work for emergency care?

When an apparently poor and uninsured person is admitted to the hospital, the hospital will then have an incentive to procure insurance for the person through the HTC program.

SUGGESTED RESOLUTION: An eligible individual could (assisted by the hospital) submit a Schedule HIC. If eligibility were confirmed by the IRS database, the individual could get a pro-rated credit and purchase insurance that would cover the emergency care.

3. Eligibility criteria not shown on income tax return.

a. How will the insurer know whether an individual receives other federal health subsidies?

At this point, neither the IRS nor any other Federal agency has comprehensive information. Nevertheless, insurers will need to confirm this information before granting coverage.

PROPOSED RESOLUTION: Insurance companies could call affected state and Federal agencies for confirmation. State and Federal agencies would also be required to send tapes containing this information to the IRS to confirm eligibility. [NOTE: Forty states currently provide the IRS with data identifying AFDC recipients. Ten states, including New York, refuse to provide such information without a legislative mandate.] The IRS would need information on the availability, compatibility, and timing of the tapes.

Related questions remain regarding the time at which receipt of other subsidies is tested. Presumably the resolution of these questions depends on the time when the information can be made available for confirmation.

b. Will individuals eligible for other benefits for part of the year be eligible for partial credit?

PROPOSED RESOLUTION: The pro-rated credits available under the plan year/ open season program should permit the issuance of partial year credits.

c. If one member of a filing unit is ineligible, is the entire unit disqualified?

PROPOSED RESOLUTION: Eligibility should be determined on an individual by individual basis. For example, the fact that a dependent grandparent is eligible for Medicare should not leave the remaining parents and children without coverage. The amount of the credit would be based on the number of eligible members in

the filing unit. There are related issues concerning the treatment of the income of ineligible members as well as the inclusion of income of dependents that is reported on separate returns (such as the kiddie tax).

4. Transferability of credits.

a. Should credits be refundable?

The HTC is available to be used only for the purchase of health insurance. If the individual claims the credit on his return, the IRS will have to verify the purchase.

PROPOSED RESOLUTION: Require that individuals transfer credits. An information return would be required on which the transferee would report the name and TIN of the transferor, the amount of the credit transferred and the policy number associated with the credit to assure that only one credit per TIN per year was awarded and the credit was used to purchase insurance. Credits would be nonrefundable to the insurer or employer, although a carryover would be permitted, either indefinitely or for some specified period of time. It may be necessary to make the credit refundable for transferees that are tax-exempt employers or state programs.

b. Should the credit be available to offset payroll taxes?

For some insurers and employers without tax liability, an offset against payroll taxes would provide an immediate benefit from the credit. The HTC proposal was estimated assuming an offset against income taxes only. New numbers would have to be run for a payroll tax offset.

c. How does the transfer of credits to the employer work? UNRESOLVED ISSUES:

If two members of a filing unit are covered by a contributory plan, must one member claim it or can it be split?

Administration would be simplified if one member claimed and transferred the credit awarded to the filing unit. However, a filing unit may include dependents that would not be covered under an employer-sponsored family plan. It may be necessary to allow the credit to be divided to permit coverage of all eligible members of the family unit.

What happens when an individual transfers a credit to the employer and then leaves her job? Can the individual recover a pro rata portion of the credit to take to a new employer or to buy insurance privately? If so, and if the employer has already claimed the full credit, there would have to be a recapture

mechanism to avoid doubling up the prorated portion of the credit recovered by the individual.

6. Recapture of overpaid credits.

a. Should recapture be formally limited to persons with income above a certain level?

SUGGESTED RESOLUTION: If an individual qualifies for the HTC on the basis of prior year's income but experiences an increase in income during the current year, it may be appropriate to recapture all or a portion of the credit. Nevertheless, a recapture mechanism may discourage persons from claiming the credit out of fear they may owe additional tax at the end of the year and may also be a disincentive for taking employment near the end of the year. In the case of overpaid credits resulting from erroneous information on the Schedule HTC that is discovered on audit, collection of the overpaid amounts may be difficult because the recipients lack cash to pay and also creates the image of the IRS extracting dollars from the destitute.

Recapture should therefore probably be limited to cases in which the individual's income is substantial. Following this as a formal policy rather than an administrative practice would provide comfort for individuals fearful of taking a job or claiming the credit but would at the same time eliminate the incentive for persons expecting to be below the recapture threshold to report information accurately on the Schedule HIC.

7. Credit/deduction alternative.

a. How will the IRS know the amount of the employer contribution? PROPOSED RESOLUTION: Employers would be required to report amounts contributed to health plans on the Form W-2.

b. What will the form look like? We should soon be preparing a mock-up of the form for determining the credit/deduction, since it promises to be complex.

# Withdrawal/Redaction Sheet (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
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## Health Insurance Market Reform Proposal

### I. Introduction

There is widespread agreement that the market for private health insurance is in need of reform. Problems are most severe in the health insurance market for small business. Workers at small firms are much more likely to be uninsured than workers at medium and large size firms.

Number of Uninsured Workers and Dependents By Firm Size -- 1987					
Firm Size	Number of Workers & Dependents	Percent of Workers & Dependents	Number Uninsured	Percent Uninsured	Percent of All Working Uninsured
<25	74.2 m	44%	17.2 m	23.1%	68%
26 - 100	34.6 m	21%	4.3 m	12.3%	17%
>100	59.2 m	35%	3.9 m	6.6%	15%
Totals	168.0 m	100%	25.4 m	15.1%	100%

A key problem is that the market for health insurance for small business is in turmoil due to intense competition based on risk selection. A single small business cannot serve as a stable risk pool. One or two sick workers can greatly increase average per employee health benefit costs. Insurers originally combined many small businesses into a single risk pool and charged all members of the insured group a uniform (or age-adjusted) premium that did not vary based on health risk. In today's market, however, some insurers are "cherry picking" low risk business -- while other businesses are left with unaffordably high premiums.

Broad insurance pooling helps make coverage affordable for individuals with chronic illness. However, current marketing methods provide an opportunity for aggressive insurers to make a quick profit by (i) offering low premiums to attract healthy groups and (ii) discontinuing coverage (or increasing premiums to a prohibitive level) once a group becomes more costly. An aggressive insurer can also use medical information to exclude coverage groups, individuals, or preexisting conditions. Further, as the aggressive insurer succeeds in attracting low-risk groups and avoiding high-risk groups, conservative insurers face a premium spiral. This makes it difficult for conservative insurers to spread risk among a broad pool of companies and forces them to shift to narrower pools to compete.

While there is no definitive information concerning the extent of current problems, the market for small business is unstable. As a result, the insurance industry is supporting corrective legislation. A number of bills have been introduced on Capital Hill. These bills follow the general outlines of model state legislation developed by

the National Association of Insurance Commissioners (NAIC). They include bills introduced by Senators Durenberger, Chafee, and Mitchell in the Senate and by Representatives Nancy Johnson and Rostenkowski in the House. The Health Insurance Association of America (HIAA) and Blue Cross Blue Shield (BCBS) have similar proposals.

The proposal described below also follows the NAIC model, but differs in three basic respects. First, the proposal relies on regulatory oversight of premium setting methods only as a temporary measure, pending implementation of a risk equalization pool (a less regulatory approach that will be more stable in the long term). Second, the proposal encourages small employers to form groups to purchase health insurance. Finally, the proposal provides Federal incentives to encourage states to enact the proposed reforms.

## **II. Availability of Coverage for the General Market**

The reforms specified in subparagraphs (A) - (E) apply broadly to all private health insurance coverage provided within a state.

### **A. Prohibition on Exclusion from Coverage Due to Health**

1. All insurers wishing to sell group health insurance in a state would be required as a condition of doing business to (i) accept every employer group in the state that applies for coverage and (ii) provide coverage to all members of the employer group. [Similar to NAIC, HIAA, BCBS, Johnson, Rostenkowski, Chafee, Durenberger, Mitchell, Bentsen]
2. All employers (regardless of size) wishing to do business in a state would be prohibited from excluding any individual from health insurance coverage for reason of health status. [Note: would require ERISA amendment.] [Similar to Bentsen and Rostenkowski]

**B. Guaranteed Renewability** Insurers wishing to sell group coverage in a state would be required to renew coverage (though not necessarily at on the same terms) for a group except in the case of nonpayment of premiums, fraud or misrepresentation by the insured, and certain other exceptions following the NAIC model. [Similar to NAIC, HIAA, BCBS, Johnson, Rostenkowski, Chafee, Durenberger, Mitchell, Bentsen]

**C. Portability** Use of preexisting condition exclusions would be limited for all insurers and employers. In 1993, the maximum duration for a preexisting condition exclusion would be 5 months. This would phase

down to zero by 1997. Thus, by 1997, a worker could move from job to job without fear of losing coverage. Prior to 1997, preexisting conditions would only affect the typical worker's first entrance into the work force. [Note: this needs to be clarified; also need to indicate that portability would apply to individuals leaving Medicaid for private insurance and vice versa.] [Similar to Bentsen and Rostenkowski]

#### **D. Access to Group Coverage for Workers and Dependents**

1. All employers would be required to offer access to health insurance with individual and family coverage to all employees working more than 17.5 hours a week -- but would not be required to pay for it. [Similar to Johnson]
2. The coverage offered must cover at least a "core" benefit package equal in value to the maximum refundable health credit. The core benefit package would be defined by the states.
3. The employer need not make any contribution towards the cost of coverage under such a plan but would be required to arrange for enrollment and deduction of premiums from paychecks. A penalty would be imposed for non-compliance.

#### **E. Access to Group Coverage for College Graduates**

1. All colleges and universities that provide group coverage (most do) would be required to extend group coverage to new graduates for 6 months after graduation from under graduate and post-graduate programs. This could fill a significant uninsured gap for new work force entrants.
2. The college or university need not make any contribution towards the cost of coverage under such a plan.

### **III. Small Group Market Reforms**

All insurers wishing to sell small group coverage within a state must be in compliance with the premium standards specified in subparagraph (A) and must participate in a risk spreading system as specified in subparagraph (B). The mechanism for state implementation is discussed in section VI (page 7).

## A. Premium Standards

These standards limit variation in premiums within each insurance company's overall set of offerings. They would not constrain premium variation between insurers. The premium standards would be temporary and would be phased-out with full implementation of a system to equalize risk among insurers. (See below)

1. Premium Standards Across "Blocks of Business" Premiums could vary by up to 20% across different blocks of business. A carrier may establish different blocks of business: (i) for business acquired from another carrier, (ii) for business obtained through a distinct system of marketing (e.g., brokers vs. associations), and (iii) for business obtained through a different associations. Carriers could establish three different blocks of business for each of the three reasons, for a total of nine different blocks of business.
2. Premium Standards Across Age/Sex Categories Insurers could vary premiums without limit by age and sex. This means that younger workers would not directly subsidize older workers.
3. Premium Standards Within Age/Sex Categories Insurers would be limited in their ability to vary premiums based on health status or prior use of care. Premiums could not differ by more than 50% within age/sex categories in the first year decreasing to 35% by the third year. [Same as Bentsen proposal].
4. Rate of Increase for Renewal Premiums --same as Bentsen.
5. Enforcement An independent actuary would certify compliance. Failure to have a valid certification would trigger a violation. The enforcement agency could conduct a look-behind investigation to verify certifications.

Maximum Allowed Variation in Premiums Across and Within Demographic Categories (highest premium allowed to be xx% above lowest)								
	NAIC	HIAA	Duren- berger	Chafee	Bentsen	Mitchell	Johnson	Rosten- kowski
Across Age/Sex	No limit	No limit	No limit	No limit	No limit	10% phased- in	No limit	70%
Within Age/Sex	70%	110%	50%	50%	50% phased to 35%	50% phased to 0%	70%	0%

## B. Spreading Risks Among Insurers (Long Term Stability)

Because of guaranteed issue/renewability requirements and premium limits, an insurer that enrolls a disproportionate share of high-risk groups would be forced to charge higher premiums than competing insurers. Some method is needed to spread risks among insurers to prevent this unfair competitive disadvantage.

1. Interim Measures -- States would be required on an interim basis to implement a prospective reinsurance<sup>1</sup> or risk allocation system.<sup>2</sup> States would have flexibility regarding the details of these systems, [but could follow the NAIC model].
2. Health Risk Adjustment/Risk Equalization Pool Starting in the third year, states would phase-in a risk equalization pool for small group carriers. The Secretary of Health and Human Services would be authorized to phase-out premium limits and interim risk pooling measures as minimum Federal standards if the Secretary determines that the risk adjustment system is sufficient to make these limits and interim measures unnecessary.
  - a. All participating small group carriers would pay a flat per enrollee premium to cover the risk of enrolling a disproportionate share of high risks.
  - b. At the beginning of each year, each insurer would assign each insured individual to a unique health risk category based on diagnosis.<sup>3</sup>

- c. Each category would have a weight corresponding to a different level of expected health care use with a weight of 1.000 for average expected utilization (a weight of 2.000 would reflect an expected cost of two times average).
- d. The insurer would calculate an average weight for the entire insured group. Insurers with an average of more than 1.000 would receive net transfers from the pool while insurers below 1.000 would be net losers.
- e. A random sample audit of claims and medical records would be used to verify the accuracy.
- f. Pilot tests could be conducted either through FEHBP or Medicare.

This approach reduces incentives for "cherry picking and refocuses insurers' incentives on pooling risk efficiently while competing to provide services at low cost.

#### IV. Health Insurance Networks For Small Employers

Cleveland's Council of Smaller Enterprises (COSE) operates a successful health insurance group purchasing program for small firms. By pooling purchasing power, COSE is able to negotiate better rates with insurers. In addition, COSE is able to reduce overhead and marketing costs, which otherwise can amount to 40% of benefit costs for groups with fewer than 6 employees. While COSE has been successful, surprisingly little of this type of group purchasing is going on nationwide. The reforms described in section III will spur group purchasing by protecting against some of the abusive practices that have daunted some local purchasing groups.

- A. **Incentives for Group Purchasing** The Federal preemption of state regulation of self-insured health benefit plans under ERISA that benefits virtually all large employers would be extended to small businesses that purchase coverage on a group basis through a health insurance network (HIN). This would protect against (i) state mandated benefit laws that require firms to provide certain costly services, (ii) state health insurance premium taxes, (iii) and state anti-managed care laws. HINs could self-insure, but in this case, state insurance solvency standards would apply.

- B. **Group Purchasing** HINs would contract with insurers to provide coverage to members. As noted above, HINs could also self-insure, but would be subject to state solvency regulation. All HINs would be required to offer at least one managed care/HMO option, and at least one fee-for-service or other alternative option. Managed care and fee-for-service alternatives would include a "core" package priced at the amount of the refundable health credit.
- C. **Organization** HINs would be structured as non-profit voluntary membership corporations with a board of directors elected by the membership. HINs would be required to have a full-time staff to manage benefits. HINs would be registered and qualified, as applicable, by a state or Federal agency. A HIN would be required to have a "significant" share of the small employment market in the State to assure effective purchasing power in the market. HINs could be established along the lines of professional societies, industry or trade associations and would be subject to the market reforms listed in sections II and III.

#### V. **Mandated Benefit and Anti-Managed Care Laws**

The following provisions of state law would be prohibited:

- A. **Requirements for state mandated benefits.** These include laws that require insurers to cover services such as chiropractors and podiatrists. These mandated benefits drive up costs and are enacted solely because of intense interest group lobbying in state legislatures.
- B. **Provisions that restrict managed care.** Many provider groups, including physicians, lobby state legislatures to impose restrictions which prevent the development of managed care -- and the competitive pressure it imposes on fee-for-service providers. Anti-managed care laws include --
  1. Restrictions on reimbursement rates or selective contracting: laws that restricts the ability of a carrier to negotiate reimbursement rates with providers, or to contract selectively with one provider or a limited number of providers.
  2. Restrictions on differential financial incentives: laws that limit the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

3. Restrictions on utilization review: laws that (a) prohibit utilization review of any or all treatments and conditions, (b) require that such review be made by an in-state physician or by a physician in a particular specialty, (c) require the use of specified standards of health care practice in such reviews, (d) require the disclosure of the specific criteria used in such reviews, (e) require payment to providers for the expense of responding to utilization review requests, (e) imposes liability for delays in performing such review.

[Similar to Johnson, Chafee]

## VI. How To Structure Federal and State Roles

To be more than symbolic, the Administration's proposal must include some mechanism to ensure that the proposed reforms take effect. Because health insurance traditionally has been regulated by the states,<sup>4</sup> this mechanism must affect state laws in some way. Options could range from modest incentives for states to enact appropriate reforms to outright Federal preemption. Two options are presented.

**Option A:** If a state's health insurance laws do not meet Federal minimum standards, then insurance sold in-state must be certified through Federal back-up mechanism with Federal penalty for non-complying insurance plans. Further, a non-complying state's Medicaid administrative grant funding will be frozen at base year levels. [Similar to Bentsen, Mitchell, Johnson, Rostenkowski; but none have the Medicaid link.]

**Option B: Direct Preemption** Health insurance would be directly regulated by a Federal agency. All applicable state laws would be preempted. [Similar to Durenberger]

### Recommendation:

- Incentives for States (Option A) would apply to all requirements specified in Sections II (Availability of Coverage), III (Small Group Reforms), and V (Mandated Benefit and Anti-Managed Care Laws).
- Direct Preemption (Option B) would apply to protect health insurance networks from state mandated benefit laws, premium taxes, and anti-managed care laws.

## VII. Definition of Small Group Coverage:

**Option A: Limited to 50 or fewer employees.** [Similar to Chafee, Durenberger, Bentsen, Rostenkowski].

Pros: Does not impose unnecessary burden on industry and on state regulators. Extending reforms above group size 50 is unlikely to have any appreciable effect on encouraging insurance coverage -- since risk selection problems are unlikely to affect premiums for these workers.

Reduces risk that reforms could put undue financial strain on insurers with a sicker client base.

Cons: Extending reforms to include all firms, regardless of size, may be a political selling point.

**Option B: Limited to 100 or fewer employees.** [Similar to Mitchell]

**Option C: Not limited by firm size.**

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<sup>1</sup> Under NAIC's prospective reinsurance model, an insurer could obtain optional reinsurance for any employer group or any newly eligible group member. The primary insurer would be liable for an individual's costs up to \$5000. Above \$5000, the primary insurer would be responsible for 10% while the reinsurance program would be responsible for 90% of costs. Above \$10,000 the program would be fully responsible. Group reinsurance premiums would be set at 5 times a base rate set by the board, while individual reinsurance premiums would be set at 1.5 times the base rate. The program would be funded by (i) reinsurance premiums, (ii) a mandatory assessment on all small group insurers set at a maximum of 5% of overall revenues, and (iii) other broad based funding if needed.

<sup>2</sup> Under NAIC's risk allocation model, guaranteed issue would not apply -- insurers could refuse to provide coverage based on health risk. However, the rejected group or individual would have a right to receive coverage from an insurer pursuant to an allocation system. Under this system, the state would maintain a list with quotas of assigned risks for each insurer. Each carrier's quota would generally reflect the carriers market share. A rejected group or individual could select one of the insurers on the list, provided that the insurer had not already received a disproportionate share of allocated risks. Each carrier's quota would be readjusted on an annual basis if the actual cost of the allocated risks to the insurer differ significantly from the norm.

<sup>3</sup> This would be done by running the insurer's previous year claims data basis through a computer algorithm that makes health risk category assignments based on routinely collected diagnostic codes. Two health risk adjusters are available today -- the Diagnostic Cost Groups (DCGs) which reflect inpatient hospital diagnoses and the Ambulatory Cost Groups which reflect ambulatory diagnoses.

<sup>4</sup> In recent years, the Federal government has assumed a greater role. Self-insured health benefit plans are subject to Federal regulation through ERISA with a total preemption of state law, and Medicare supplemental (Medigap) coverage is subject to a joint federal-state regulatory system.

# Withdrawal/Redaction Sheet

## (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
08a. Memo	From C. Boyden Gray to Richard Darman Re: Medicare Health Care Reform (1 pp.)	12/20/91	P-5	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
(Document Follows)

By JRD (NLGB) on 10/28/2005

<b>Date Closed:</b> 1/5/2005	<b>OA/ID Number:</b> 06970-008
<b>FOIA/SYS Case #:</b> 1999-0118-F	<b>Appeal Case #:</b>
<b>Re-review Case #:</b> 2005-0296-S	<b>Appeal Disposition:</b>
<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
<b>AR Disposition Date:</b>	<b>MR Disposition Date:</b>

### RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P-1 National Security Classified Information [(a)(1) of the PRA]
- P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P-3 Release would violate a Federal statute [(a)(3) of the PRA]
- P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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- (b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
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- (b)(9) Release would disclose geological or geophysical information

THE WHITE HOUSE  
WASHINGTON

December 20, 1991

MEMORANDUM FOR RICHARD DARMAN

FROM: C. BOYDEN GRAY *CBG*  
COUNSEL TO THE PRESIDENT

SUBJECT: Medicare Health Care Reform

As we discussed many months ago, attached are some suggestions from the Antitrust Division regarding ways to move away from the expensive fee-for-service system toward a more competitive approach for providing Medicare benefits.

Of course, this does not represent a general plan for health care reform, but a building block for any plan you may develop. The paper was produced in conjunction with Gail Wilensky and her staff and is consistent with what I understand to be Alain Enthoven's approach to health care reform.

cc: Roger Porter  
Michael Boskin

# Withdrawal/Redaction Sheet

## (George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
08b. Memo	From James Rill, DOJ to C. Boyden Gray Re: Medicare Cost Containment (4 pp.)	12/19/91	<del>P-5</del>	

**Collection:**

**Record Group:** Bush Presidential Records  
**Office:** Policy Development, Office of  
**Series:** Kuttner, Johannes  
**Subseries:**  
**WHORM Cat.:**  
**File Location:** Health Care Reform - 92 Proposal - Final Papers

Open on Expiration of PRA  
 (Document Follows)  
 By JRD (NLGB) on 10/28/2005

<b>Date Closed:</b> 1/5/2005	<b>OA/ID Number:</b> 06970-008
<b>FOIA/SYS Case #:</b> 1999-0118-F	<b>Appeal Case #:</b>
<b>Re-review Case #:</b> 2005-0296-S	<b>Appeal Disposition:</b>
<b>P-2/P-5 Review Case #:</b>	<b>Disposition Date:</b>
<b>AR Case #:</b>	<b>MR Case #:</b>
<b>AR Disposition:</b>	<b>MR Disposition:</b>
<b>AR Disposition Date:</b>	<b>MR Disposition Date:</b>

### RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

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- (b)(9) Release would disclose geological or geophysical information

**U.S. Department of Justice****Antitrust Division**

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*Office of the Assistant Attorney General**Washington, D.C. 20530***December 19, 1991****Memorandum****TO: C. Boyden Gray**  
**White House Counsel****FROM: James F. Rill**  
**Assistant Attorney General**  
**Antitrust Division****RE: Medicare Cost Containment****Background**

Medicare is one of the largest spending programs within the federal budget. In 1990, Medicare spending exceeded \$100 million. Moreover, Medicare costs are escalating rapidly. Despite these significant expenditures, there are persistent questions concerning the quality of care delivered through the system. Medicare cost containment and quality improvement must be key features of any effort to reform the American health care delivery system, and various proposals for fundamental reform of the Medicare program are being evaluated in that broad context.

A significant part of the Medicare cost problem stems from the overutilization of health care resources by beneficiaries who lack incentives to consider cost-effective health care delivery systems and forms of treatment. A related problem is the absence of effective competition among providers of health care services. Both problems could be addressed to a substantial degree by reforms that would encourage greater utilization of competitive coordinated care delivery stems. By correcting the incentive structure facing both beneficiaries and providers, significant costs savings -- perhaps approaching \$2 billion per year -- could be achieved.

## Elements of Reform

1. Promote competition through socially more responsible pricing of health care benefits to the Medicare beneficiaries.

The existing Medicare reimbursement system favors expensive fee-for-service health care delivery. This is because beneficiaries themselves pay substantially the same price regardless of whether they select the most expensive or the least expensive health care plan. Not surprisingly, beneficiaries usually select the most expensive fee-for-service approach. (Moreover, Medigap insurance creates additional incentives to over-utilize health care services.)

In order to move toward a more competitive approach, Medicare's contribution to the beneficiary's health plan must be made independent of the actual health plan selected by the beneficiary.

Under this approach, if a beneficiary chooses a plan that actually costs less than the amount of the Medicare contribution then the beneficiary would be able to keep the difference. By the same token, the beneficiary would have to bear the full cost of a plan that costs more than the fixed contribution level. It is only through such a benefit scheme that the beneficiary will have incentives to seek out less expensive health plans that offer an appropriate mix of price and quality. Health care providers will have strong incentives to compete against each other on price, quality, and scope of coverage, because the reform makes beneficiaries sensitive to price and quality differences among the various health plans. The government's contribution to each beneficiary, however, will be based on the beneficiary's health status and expected health care costs. Thus, the government's contributions for a very sick beneficiary will be larger than its contribution for a very healthy beneficiary. This adjusted-contribution method ensures that no beneficiary is unable to obtain high-quality health insurance because of pre-existing conditions. Moreover, adjusted-contributions promote equity across all Medicare beneficiaries by ensuring that all beneficiaries face similar out-of-pocket expenses for health insurance.

If the government's fixed contribution for each beneficiary is pegged to the lowest cost health plan available to the beneficiary, beneficiaries can obtain complete health coverage with virtually no additional out-of-pocket expenses. This approach will allow Medicare beneficiaries to reduce significantly their health care expenses, if they so choose.

2. Create incentives for HMOs to compete for Medicare beneficiaries.

Reform contemplates that HMOs that are most efficient in serving Medicare beneficiaries should also have incentives to compete vigorously for potential enrollees. Firms are motivated by profits to provide products and services. But HMOs that serve our elderly are not allowed to realize those same benefits from lowering costs or increasing enrollment. Instead, HMOs' profits on Medicare enrollees are restricted, leaving HMOs with incentives to increase costs by providing low-value, but costly services. This restriction on HMO profits also reduces HMOs' incentives to enroll Medicare beneficiaries, thereby reducing the opportunity to treat Medicare beneficiaries in a low-cost environment and for Medicare beneficiaries to share in the cost-savings that HMOs allow.

Market-oriented reform requires that efficient HMOs be allowed to retain some share of the profits that superior efficiency generates. Market competition for price sensitive Medicare beneficiaries will put a constraint on the profits that will ultimately flow to the HMOs.

3. Contracting.

Medicare program is already experimenting with promoting centers of excellence where Medicare beneficiaries can obtain certain high volume services, such as coronary bypass at reduced rates. Medicare is constrained in its ability to enter contracts with such centers. Contracting would allow Medicare to take advantage of its ability to purchase some common procedures for beneficiaries at reduced rates. Such procedures are those that the elderly require most frequently. These discounts can reduce health care costs of those beneficiaries that are not participating in managed care programs, which already contract for discounted rates from providers.

4. Increasing information to beneficiaries.

Increasing reliance on market forces to allocate health care resources requires informed consumers. Medicare beneficiaries should be provided cheaply with information about managed care options. Limited standardization of health plans will also intensify competition because consumers will be in a better position to compare products. However, markets are innovative in constructing new packages. We encourage such innovation and the new Medicare program will not stifle it.

**Conclusion**

Market forces are the most powerful constraint on Medicare health care costs. For such forces to operate, Medicare beneficiaries must benefit from selecting lower cost managed care health care options and managed care providers must be allowed to benefit from cost reductions and from offering more attractive insurance products. Competition among managed care providers for beneficiaries will also exert pressure on fee-for-service providers, thus reducing aggregate health care costs.