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Medicare

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THE WHITE HOUSE
WASHINGTON

For: Mike McCurry

From: Chris Jennings

Important Medicare
Question that may
come up. Please
call w/ question.

MEDICARE SAVINGS IN THE MIDSESSION REVIEW

Q: **In 1995, the President vetoed the Conference Agreement in part because of CBO-scored Medicare cuts of $270 billion over 7 years. This year, the President's budget includes Medicare changes estimated by the Administration to total the exact same $270 billion over 7 years. Doesn't this mean that the President signed onto the very same level of savings that he said would wreak havoc on the Medicare program in the 1996 campaign?**

A: **Not at all. The 1995 bill contained a range of policies and a level of cuts that the President thought were wrong then and wrong now for Medicare and for older Americans.**

The savings are much smaller than the budget that the President vetoed.

An apples-to-apples comparison shows that CBO scores $200 billion over 7 years for the budget that the President signed into law. CBO scored the budget that he vetoed at $270 billion in savings -- 35 percent more than what he signed into law this year.

Second, the Administration has consistently produced savings estimates 20 to 30 percent higher than CBO for the exact same Medicare policies. Had the Administration scored the Republican proposal, it would likely have been well over $300 billion over seven years.

Third, the Republican budget that the President vetoed had combined Medicare and Medicaid reductions of over $430 billion over 7 years, according to CBO. The combined savings from these two program in this year's budget is about $220 billion over 7 years -- almost half of the vetoed bill's reductions.

There are major differences between the bill that the President signed and the one he vetoed.

The vetoed bill would have raised the Part B premium to 31.5% of costs immediately.

The vetoed bill allowed doctors to "balance bill" far above Medicare approved rates without any consumer protections.

The vetoed bill had an open-ended MSA that threatened to allow massive numbers of healthier and wealthier beneficiaries to leave Medicare.

And, moreover, the vetoed 1995 bill combined this provision with a proposal to block-grant Medicaid and eliminate the guarantee of health care for millions of children and older Americans.

4·25·97

MEDICARE TRUST FUND TALKING POINTS
April 23, 1997

THE UPCOMING MEDICARE REPORT WILL NO DOUBT CONFIRM WHAT THE PRESIDENT HAS CONSISTENTLY STATED -- THAT REPUBLICANS AND DEMOCRATS SHOULD COME TOGETHER AND ENACT MEDICARE REFORM THIS YEAR.

WE WELCOME CONCERNS ABOUT THE TRUST FUND. PRESIDENT CLINTON HAS BEEN ACTING TO ADDRESS THE PROBLEM SINCE HE TOOK OFFICE.

-- The President's 1993 Economic Plan extended the life of the Trust Fund by three years.

-- In 1994, the reforms included in the Health Security Act would have strengthened the Trust Fund by five years.

-- In 1995 and 1996, the President proposed a Medicare plan that would have extended the life of the Trust Fund for at least a decade.

THIS YEAR THE PRESIDENT'S BALANCED BUDGET GUARANTEES THE LIFE OF THE TRUST FUND FOR A DECADE.

-- HCFA's Chief Actuary confirms that the President's Medicare proposals would extend the life of the Trust Fund by at least ten years.

ACTION IS NEEDED -- REPUBLICANS AND DEMOCRATS SHOULD USE THIS OPPORTUNITY TO COME TOGETHER IN A BIPARTISAN MANNER TO ADDRESS THE NEED FOR REAL MEDICARE REFORM.

-- **The need for responsible intervention to improve the Trust Fund is real.** The President has a proposal that addresses this need in a responsible way, without imposing devastating provider cuts, increasing beneficiary costs, or enacting structural changes that devastate the program and the people it serves.

-- **This report should not be used irresponsibly.** The upcoming Trust Fund report should not be used to recklessly frighten the 38 million Medicare beneficiaries and their families into thinking that their benefits are in imminent danger. They simply are not.

-- **We have time to act this year. Over $120 billion remains in the Trust Fund** (as of March 1997). While incoming revenues are somewhat less than outgoing payments, the current balance in the Trust Fund means that there is no danger that claims will not be paid.

IT IS TIME TO PUT PARTISAN DIFFERENCES ASIDE AND AGREE ON MEDICARE REFORMS THAT WILL EXTEND THE LIFE OF THE TRUST FUND AND STRENGTHEN THE MEDICARE PROGRAM.

MA

MEMORANDUM

April 24, 1997

TO: Distribution List

FR: Chris Jennings

RE: Updated Medicare Trust Fund Talking Points

Attached are the updated Medicare Trust Fund talking points that were revised after the report was released. I have also attached a letter from HCFA's Chief Actuary confirming that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

We hope you find this information useful. Please call me at x6-5560 if you have any questions.

MEDICARE TRUST FUND TALKING POINTS
April 24, 1997

THE MEDICARE TRUSTEES REPORT CONFIRMS WHAT THE PRESIDENT HAS CONSISTENTLY STATED -- THAT REPUBLICANS AND DEMOCRATS SHOULD COME TOGETHER AND ENACT MEDICARE REFORM THIS YEAR.

-- The 1997 Trustees Report estimates that the Medicare Trust Fund will remain solvent until 2001.

WE WELCOME CONCERNS ABOUT THE TRUST FUND. PRESIDENT CLINTON HAS BEEN ACTING TO ADDRESS THE PROBLEM SINCE HE TOOK OFFICE.

-- The President's 1993 Economic Plan extended the life of the Trust Fund by three years.

-- In 1994, the reforms included in the Health Security Act would have strengthened the Trust Fund by five years.

-- In 1995 and 1996, the President proposed Medicare reforms in the context of his balanced budget that would have extended the life of the Trust Fund for at least a decade.

THIS YEAR THE PRESIDENT'S BALANCED BUDGET GUARANTEES THE LIFE OF THE TRUST FUND AT LEAST A DECADE.

-- An April 24, 1997 letter from HCFA's Chief Actuary confirms that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

ACTION IS NEEDED -- REPUBLICANS AND DEMOCRATS SHOULD USE THIS OPPORTUNITY TO COME TOGETHER IN A BIPARTISAN MANNER TO ADDRESS THE NEED FOR REAL MEDICARE REFORM.

-- **The need for responsible intervention to improve the Trust Fund is real.** The President has a proposal that addresses this need in a responsible way, without imposing devastating provider cuts, increasing beneficiary costs, or enacting structural changes that devastate the program and the people it serves.

-- **This report should not be used irresponsibly.** The upcoming Trust Fund report should not be used to recklessly frighten the 38 million Medicare beneficiaries and their families into thinking that their benefits are in imminent danger. They simply are not.

-- **We have time to act this year. Over $120 billion remains in the Trust Fund** (as of March 1997). While incoming revenues are somewhat less than outgoing payments, the current balance in the Trust Fund means that there is no danger that claims will not be paid.

IT IS TIME TO PUT PARTISAN DIFFERENCES ASIDE AND AGREE ON MEDICARE REFORMS THAT WILL EXTEND THE LIFE OF THE TRUST FUND AND STRENGTHEN THE MEDICARE PROGRAM.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date April 24, 1997

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for the HI Trust Fund under the Medicare Legislative Proposals in the President's 1998 Budget, Based on 1997 Trustees Report Assumptions

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare legislative proposals developed for the President's 1998 Budget. Based on the intermediate set of assumptions in the 1997 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in calendar year 2008 under the Budget proposals.

In the absence of corrective legislation, trust fund depletion would occur in calendar year 2001 based on the intermediate assumptions. Thus, the Budget proposals would postpone the year of exhaustion by about 7 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Budget proposals is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Medicare proposals in the President's 1998 Budget, we would be happy to provide it.

Richard S. Foster, F.S.A.

4.4.97

GUIDANCE ON IRS ACTION RELATING TO H.I. (MEDICARE) TAX
APRIL 4, 1997

* As I understand it, this is a technical issue that's been around for a long time, but nobody cared that much about it before 1991. Before 1991, the 2.9% H.I. tax, the Medicare portion of the payroll tax, applied only to the first $60,000 or so of wages, just like the FICA portion of the tax. In 1991, the cap was raised to $125,000.

* And in 1993, one of the steps we took to help shore up the Medicare Trust Fund was to make that portion of the payroll tax apply to the full amount of wages.

* As a result technical issues that had been hanging around, involving what partnership income is subject to the tax, suddenly got more interesting because they involved more money.

* I would recommend that you talk to Treasury about the technical issues, but the basic question here is when partnership income is subject to the H.I. payroll tax. They want to ensure that all taxpayers are being taxed on a level playing field. But some feel that this proposal raises concerns for some businesses, so it needs to be examined carefully.

* As I understand it, this proposal has a way to go before it's final. The comment period still has two more weeks to run, and a public hearing is planned for May 21.

* But I'm told that some of the comment Treasury has received is favorable. For example, the New York State Bar says that "the current proposals represent a major step toward rationalizing and simplifying the rules in this area."

* Nevertheless, there are some who disagree, and we would encourage everybody to get their comments in, pro and con, so Treasury can make the appropriate judgment.

Q: It appears that Speaker Gingrich doesn't want to give Treasury the chance to do that. He's threatening to enact legislation to prevent them from taxing partnership income in this way. What would the Administration's position be on such legislation?

A: Well, obviously, Congress has the authority to pass legislation. But Treasury hasn't even made a final decision as to whether it's proposed rule ought to be implemented. So it's a little premature to say what our position is on legislation that hasn't been written about a rule that hasn't even been finalized.

TOIV
Based on information from Treasury

Press Guidance
February 28, 1997

When will the President name the Advisory Commission on Health Care?

The President announced plans to create an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. While it has taken longer than any of us expected, we are currently going through final clearances on the individuals who will serve on this important panel and we expect to be able to announce the membership shortly. (Within the next month)

Per 2/19 guidance from Chris Jennings

New York Graduate Medical Education Waiver
February 21, 1997

Background: This morning's NY Times reports that the Health Care Financing Administration, led by Bruce Vladeck, has agreed to a demonstration project in New York that will save money for the Medicare system by giving financial incentives to NY hospitals which agree to train fewer specialists.

Currently, the Medicare program pays teaching hospitals training subsidies for each resident they employ -- this has led in some cases to hospitals increasing resident slots --- often in unneeded specialties -- in order to get the training subsidy money. This has been a particular problem in New York state, which trains more residents than any other state. This demonstration project is an attempt to reduce the number of residents trained, thus reducing the training subsidies and saving the Medicare system money. The financial incentives given back to the hospitals for reducing the number of residents trained will represent a part of the overall savings from reducing the original training subsidies.

FYI -- Hospital executives across the nation have endorsed the idea in general, but hospitals in other states are complaining that NY got a sweetheart deal and that they too should be compensated for training fewer doctors.

Q&A --

Q: Isn't this favoritism for New York?, How will paying subsidies save money?

A: No. New York has had significant increases in the number of specialists training. There is a broad-based consensus in the teaching community and elsewhere that we need to find ways to constrain that growth. This proposal simply provides incentives for New York's teaching facilities to work collaboratively with us in reducing the number of these slots. It also has the added benefit of actually achieving savings for the Medicare program. This will allow the hospitals in New York which are reducing slots to share in the savings that all taxpayers are getting.

New York got this project because the state trains more residents than any other state and they came to us first with the idea. If other states have demonstration proposals that meet the criteria of HHS' demonstration authority, the Administration is more than willing to review those proposals. It must be noted, however, that HHS does not have the authority to expand the demonstration nationwide. That would require a statutory change.

Q: Some in Congress have criticized the Administration for not consulting with them.

A: The administration consulted fully with Congress and in fact partly modified the demonstration to reflect recommendations made by the Ways and Means committee.

Q: Bruce Vladeck used to work for NYC. Why didn't he recuse himself from this matter?

A: There are many checks and balances on this demonstration project to ensure that it receives objective and ongoing evaluation. There was no reason for Dr. Vladeck not to be involved. (Refer to HHS).

KMcKiernan per Chris Jennings, 6-5560

TALKING POINTS ON MEDICARE SETTLEMENT
FEBRUARY 25, 1997

* The President has made it clear that we will not tolerate fraud and abuse, and the joint Justice/HHS probe illustrates that.

* This is the fourth in a series of investigations of laboratories that have overbilled Medicare and other Federal programs.

* The settlement of $325 million brings to over $800 million the total settlements based on these investigations.

* We worked with the Congress on a bipartisan basis last year to give the departments more power to conduct fraud investigations, and we have provisions in our current balanced budget proposal to achieve further savings from enforcement against fraud and abuse.

* This enforcement not only reduces health care costs but also helps reduce the deficit because of the collections from those who commit fraud.

TOIV
Conversation with Jennings

MEDICARE COMMISSION
FEBRUARY 13, 1997

* The President believes it is essential that we focus in the next several months on achieving a balanced budget and enacting Medicare changes that protect the Trust Fund into the middle of the next decade. The President's budget would ensure that the Trust Fund remains solvent through 2007, according to the professional career actuaries at the Health Care Financing Administration.

* The President believes that once we accomplish these goals, we need to move on to addressing the long-term financing issues of both Medicare and Social Security. And the President looks forward to working with Senators Roth and Moynihan and others on these issues.

* We need to do so in a bipartisan way, and the Medicare Trustees have also recommended that we engage in a bipartisan process as well. Certainly, a commission is one option for a bipartisan approach.

* We want to be sure, however, that do not let a discussion of how we address the long-term issues inadvertently distract us from the work of achieving an agreement on a balanced budget and addressing the short-term financing challenge confronting the Medicare program.

TOIV
Jennings

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

MMC
MEG
BT

Memorandum

1/24/97

Date January 21, 1997

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for the HI Trust Fund under the Medicare Legislative Proposals in the President's 1998 Budget

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare legislative proposals developed for the President's 1998 Budget. Based on the intermediate set of assumptions in the 1996 Trustees Report, we estimate that the assets of the HI trust fund would be depleted early in calendar year 2007 under the Budget proposals.

In the absence of corrective legislation, trust fund depletion would occur early in calendar year 2001 based on the intermediate assumptions. Thus, the Budget proposals would postpone the year of exhaustion by about 6 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Budget proposals is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Medicare proposals in the President's 1998 Budget, we would be happy to provide it.

Richard S. Foster

Richard S. Foster, F.S.A.

Brandenburg/Justice
202/616-2777
January 24, 1997

McCurry Talking Points: CHRISTIAN SCIENCE MEDICARE/MEDICAID LAWSUIT

Main Points to Stress

- In a suit filed against the federal government last year, longstanding Medicaid and Medicare exemptions that fund non-medical treatments in Christian Science Institutions were struck down by a District Court as unconstitutional. (Medicaid and Medicare typically pay only for medical services.)

- As the government's legal counsel, the Justice Department today notified the Appeals Court that the Department can not defend these special provisions, because the Constitution bars laws that favor a particular religious denomination or that delegate decision-making authority over federal programs to a religious institution.

- While the Christian Scientist Church defends the law on appeal, HHS will continue to provide reimbursement for Christian Science services unless a court prohibits it. The Justice Department has also offered to assist Congress in drafting legislation that would address the needs of Christian Scientists and meet the Constitution's standards.

- The Clinton Administration is committed to religious freedom, and worked hard to enact the Religious Freedom Restoration Act (RFRA). But to defend these special exemptions would undermine's RFRA's philosophy of not favoring one religious denomination over another.

Questions and Answers

Q: Why did the Justice Department decide not to defend the Christian Science provisions in Medicare and Medicaid?

A: There was simply no way under the Constitution to defend this provision. Though Medicaid and Medicare typically pay only for hospital and other medical services, there is an exception in the law providing special funding for nursing services that do not include medical treatment in institutions operated or certified solely by the Christian Scientist church. The Constitution's Establishment Clause, as interpreted by the Supreme Court, bars any statute that gives a preference to any particular religious denomination or that delegates decision-making authority over federal programs to a religious institution. Therefore, the Department has concluded that it cannot make any reasonable argument in defense of these special Medicare and Medicaid provisions.

Q: What is the impact of your decision on Christian Scientists -- are they going to be denied coverage?

A: The Church is continuing to defend the law on appeal. During that time, HHS will continue to provide reimbursement for Christian Science services, unless a court prohibits it. We have offered to assist Congress in drafting a legislation amendment that would address the needs of Christian Scientists and meet the Constitution's standards.

Q: This exemption was passed in the original Medicare statute in 1965. Why attack it now?

A: Since HHS is a defendant, we are required to decide whether the law can be defended. It was challenged for the first time last year in a Minnesota District Court, by a private child advocacy organization. That Court in August struck down the statute. The deadline to file before the 8th Circuit Court is today, and the Justice Department is filing a request for a 30-day extension and a notice that it will not defend those statutes.

Q: What are the specific problems with the provisions?

A: The provisions expressly call for special reimbursement exclusively for Christian Science nursing services received in Christian Science sanatoria that are operated or certified by the Christian Science Church headquarters in Boston, Massachusetts.

- As such, the provisions conflict with the fundamental rule that one religious denomination cannot be officially preferred over another.
- Second, the delegation of sanitoria certification authority to the Christian Science Church conflicts with the principle that government cannot cede to official religious hierarchies the power to determine the allocation of government benefits.
- Third, to characterize the provisions as accommodating religion would open to challenge most, if not all, state, local, and federal benefit programs nationwide to any group or individual that is unable, for religious reasons, to accept the benefits offered.

Q: Did the President approve this decision?

A: He was informed in advance of the proposed decision.

Q: How does the Department's decision square with the President's strong support of the Religious Freedom Restoration Act?

A: One of the factors that led us to decline to defend the Christian Science is that we concluded that a defense actually would undermine RFRA. Indeed, to defend the provisions as permissible accommodations arguably would require us to claim that they are compelled by RFRA. But in defending RFRA, we say that it is a permissible accommodation of religion because it is sect-neutral, and we distinguish it from laws that explicitly favor specific religions.

TALKING POINTS ON HUNT INTERVIEW
JANUARY 23, 1997

UPPER INCOME MEDICARE PREMIUMS/SOCIAL SECURITY RETIREMENT AGE

* Again, the President essentially said what he has said in the past. He has not opposed means-testing of Medicare premiums on principle. Indeed, there is already means-testing in current law, since Medicaid pays the premiums for low-income recipients. And there was a means-testing proposal in the President's health care reform plan.

* However, he has consistently said that higher premiums were not necessary for us to take the first step we need with regard to Medicare, protecting the Trust Fund through the middle of the next decade.

* The President does believe that this and a host of other proposals will need to be considered when we take on, in a bipartisan way, the long-term problem of securing the Medicare Trust Fund well into the future.

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* On the subject of raising the Social Security retirement age, the President has said in the past that this is an issue that will need to be considered under whatever bipartisan process he and the Congress settle on for addressing the long-term challenge facing the Social Security system. He did not endorse it in the interview, nor has he in the past. All he did was talk a little bit about the advantages and disadvantages.

TOIV

M.A.

MEMORANDUM

January 23, 1997

TO: Distribution

FR: Chris Jennings and Nancy-Ann Min

RE: Comparison of Medicare Proposals

Attached is a chart which compares the President's latest Medicare proposal to his 1996 proposal and the 1996 Republican proposal. The chart shows that the President has put forth a Medicare plan that meets the Republicans halfway, demonstrating his commitment to working in a bipartisan process to pass real Medicare reform.

The additional savings come from a range of policy changes, but the most notable increase in savings comes from managed care and home health care. We hope you find this information helpful. Please feel free to call 6-5560 with any questions or concerns.

THE PRESIDENT'S LATEST MEDICARE PROPOSAL DEMONSTRATES HIS COMMITMENT TO REAL REFORM AND MEETS THE REPUBLICANS HALFWAY.

	Republican 1996 Proposal[1]	President's Current Proposal[2]	President's 1996 Proposal[3]
6-YEAR	$158 Billion	$138 Billion	$116 Billion

[1] 1996 Proposal (April 1996 baseline). Six-year period is FY 1997-FY 2002. (Medicare savings stream as reported in the Senate Budget Resolution Report, 5/13/96).

[2] HCFA Actuaries' Estimates. Six-year period is FY 1998-FY 2003. **The additional savings come from a range of policy changes, but the most notable increase in savings comes from managed care and home health care.**

[3] 1996 Proposal (April 1996 baseline). Six-year period is FY 1997-FY2002. ("CBO's Estimates of the President's Budgetary Proposals" in "The Economic & Budget Outlook: FY 1997-2002").

MMC
MEG
BT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date January 21, 1997

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for the HI Trust Fund under the Medicare Legislative Proposals in the President's 1998 Budget

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare legislative proposals developed for the President's 1998 Budget. Based on the intermediate set of assumptions in the 1996 Trustees Report, we estimate that the assets of the HI trust fund would be depleted early in calendar year 2007 under the Budget proposals.

In the absence of corrective legislation, trust fund depletion would occur early in calendar year 2001 based on the intermediate assumptions. Thus, the Budget proposals would postpone the year of exhaustion by about 6 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Budget proposals is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Medicare proposals in the President's 1998 Budget, we would be happy to provide it.

Richard S. Foster, F.S.A.

1/13/97

HMO PAYMENT CUTS

Q. The managed care industry says that cuts to their payments, such as those reported in the *Post* yesterday, would be devastating and would force them to cut benefits to beneficiaries. Are you cutting HMO payment rates and, if so, aren't you concerned about their impact on beneficiaries?

A. I cannot comment on any specific proposals in the budget. However, I will say this:

(1) Clearly all providers and insurers who contract with Medicare are going to contribute savings necessary to strengthen the Medicare Trust Fund.

(2) As for HMOs, recent respected studies* have confirmed previous findings that Medicare is overpaying HMOs. In fact, on a national basis, the Medicare Trust Fund is actually losing money on every beneficiary who enrolls in a Medicare HMO.

(3) And while per person payments to Medicare managed care plans have grown by 16 percent over the past two years, private sector payments to these plans has been virtually flat.

(4) All parties -- inside and outside the industry -- recognize that we must have a better reimbursement system. The question is how best and when we can do this.

* Including Congress' own Physician Payment Review Commission (PPRC), the Mathematica Policy Research Study AND the Health Care Financing Administration Analysis, published in the HCFA *Review* (Summer 1996).

Updated: 1/13/97, 10:00 am

FOR INTERAL USE

MEDICARE and MANAGED CARE

- **Current Base Proposal.** Our current base proposal includes a proposal to decrease Medicare reimbursement to managed care plans from its current 95 percent of fee-for-service rates to 90 percent. Since every independent study we have seen over the last three years suggests we are overpaying these plans by at least this much, this proposal is more than defensible. In fact, the actuaries at HCFA (and the estimators at CBO) now score Medicare costs for every beneficiary opting for Medicare managed care.

- **Benefit of the HMO Proposal.** The reduction in reimbursement to HMOs does not start until 2000, but still achieves about $10 billion in savings over 5 years. (If we started the cuts earlier, HCFA tells me that our overall cuts in HMO payments -- we have other proposals too -- would be too deep.) This proposal has the added benefit that it allows us to reduce the overall hospital cut. It also contributes to our ability to pay for the Alzheimer's respite benefit to start in 1998, as well as some other modest beneficiary benefit improvements. If we go for this proposal, we will can say that we are giving the industry three years to prepare for it.

- **Potential Problem with this Proposal.** Clearly, however, as the Pear article from today illustrated, the managed care industry is ready to charge that such a reduction will force them to reduce the type of additional benefits (like prescription drug coverage, etc.) that they are now using to attract beneficiaries into managed care. They will undoubtedly cast our proposal as a benefit cut to millions of beneficiaries. The head of their industry trade group -- Karen Ignagni -- called me Friday evening to make clear this would be the case.

- **Department Response to HMO Criticism.** It is true that our overcompensation of managed care plans allows many plans to reinvest their overpayments in addtional benefits. It is also true that it enables them to earn significant profits. The Department (Bruce Vladeck in particular) believes that the reduction we are proposing, which they say is on the modest end of what their studies now say is defensible (85-90%), will still be sufficient for most of these plans to continue to provide additional benefits. Having said this, they do recognize that this will be the HMO industry response to our proposal.

- **Question.** Do we need to raise this up to higher levels before we lock this propsal in? Some in the Administration, like Larry Summers, have suggested that we may want to consider being overly generous for the short-term to get beneficiaries into managed care. I personally have mixed feelings on this one, but I believe the delay in the implementation of the cut and our likely characterization of it as a transition policy to a better reimbursement system should be a sufficient defense. However, I strongly believe that the principals should be aware of where another attack is likely to come from.

1/6/97

~~DRAFT~~ Final

TALKING POINTS ON *NY TIMES*' MEDICARE PREMIUM STORY

(General: We do not comment on any element of the budget before it is released by the President.)

PREMIUM INCREASES. It is no secret that the President reviews every Medicare option with a sensitivity to how proposals will affect beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than $25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care.

2/3rds older americans incomes less than $25K.

INTEGRITY OF PRESIDENT'S HOME HEALTH CARE AND BALANCED BUDGET PROPOSALS. The President's clear and overriding goal is to balance the Federal budget by 2002, extend the life of the Medicare Trust Fund until the middle of the next decade, and to protect our values. His upcoming budget proposal will achieve all of these goals. The home health policy mentioned in the *NY Times* is also consistent with these goals. It is good policy, has received bipartisan support, and makes it possible to strengthen the Trust Fund without indirectly harming beneficiaries through excessive hospital, doctor and other provider cuts. While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit.

- GOOD POLICY. **The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits – the most rapidly increasing part of the benefit – have no place in Part A side (the Hospital Insurance Trust Fund) of the program.** In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit.

- **BIPARTISAN SUPPORT. The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new.** Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.

- **PROTECTS AGAINST EXCESSIVE CUTS. The absence of the home health policy would necessitate excessive Medicare cuts that would threaten quality health care for millions of beneficiaries.** In addition to desire to focus attention on home health care, we advocated the home health proposal last year was because it enabled us to strengthen the Trust Fund without excessive cuts in hospital, physician, nursing home and other important provider payments.

~~DRAFT~~ Final

Q&As ON *NY TIMES'* MEDICARE PREMIUM STORY

Q. Isn't this home health care transfer just a gimmick that simply shifts dollars around and pushes out the needed tough medicine that Medicare requires?

A. No it is not. The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 – a proposal that virtually every Republican House Member voted for – including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.

Q. Regardless of past positions on this issue, Republicans now clearly oppose it on the grounds that it is a gimmick and is flawed policy. How can you defend it?

A. The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits -- the most rapidly increasing part of the benefit -- have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit. Such an intervention is long overdue.

Q. Even if it is defensible policy, if it is included in this year's budget, shouldn't it be included in the Part B premium – like every other service in the Part B side of the program?

A. I cannot comment on this year's budget before it is released. However, the President is clearly concerned about any proposal's impact on beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than $25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care.

Q. Doesn't this policy simply add to the deficit, which would require even greater contributions from taxpayers to support the program?

A. While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit. His last budget did just that and his next budget will do the same.

Clinton and G.O.P. Are Unlikely To Seek Medicare Premium Rise

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By ROBERT PEAR

WASHINGTON, Jan. 4 — Administration officials say that President Clinton has made a significant decision about budget strategy for 1997: he will not propose any increase in costs for Medicare beneficiaries, but will try to cut back payments to hospitals, doctors and others who provide health care to the elderly.

Congressional Republicans said that they too were unlikely to seek any increase in premiums or other charges for beneficiaries because, in last year's elections, they were pummeled by Democrats for having supported such proposals.

But another battle is looming this year over Mr. Clinton's proposal to solve some of Medicare's most conspicuous financial problems by shifting the cost of home health care from one account to another. The home health benefit is the fastest growing component of Medicare.

Mr. Clinton plans to send his budget to Congress early next month. If there is no change in current law, the Medicare trust fund that pays hospital bills will, by his estimate, run out of money in 2001. That is 10 years before the first baby boomers reach 65, the age of eligibility for Medicare.

A bipartisan group of experts summoned to the White House recently to advise the President's budget director, Franklin D. Raines, said Mr. Clinton's home health care proposal — one of his main proposals to keep the trust fund afloat — was little more than a bookkeeping gimmick.

Under Mr. Clinton's proposal, most of the cost of home health care for the elderly or disabled would be shifted from the Hospital Insurance Trust Fund to a separate Medicare account with unlimited access to general revenue.

Medicare spending on home health services has exploded in recent years, exceeding $18 billion and accounting for nearly 10 percent of Medicare benefit payments in 1996. Mr. Clinton wants to exclude these costs from the computation of Medicare premiums, so beneficiaries would not have to absorb the cost.

When Mr. Clinton suggested a similar change last year, Republicans said it was not a serious proposal. After the November election, they told him that they wanted a good-faith gesture on the budget, and that a repeat of his earlier recommendations would not do the trick.

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In an interview this week, Representative Bill Archer, the Texas Republican who oversees Medicare as chairman of the Ways and Means Committee, said: "We're looking for a signal from the President as to how real his budget will be. I want to work with him on a bipartisan basis, but this proposal on home health care is a shell game, an artificial solution. It may help the trust fund, but creates enormous problems in the general Treasury and for future generations."

Among the experts who met recently with Franklin D. Raines, the budget director for the Clinton Administration, were Charles L. Schultze, chairman of the Council of Economic Advisers under President Jimmy Carter; two former directors of the Congressional Budget Office, Rudolph G. Penner and Robert D. Reischauer, and Dan L. Crippen, a White House aide under President Ronald Reagan.

Mr. Schultze said the home health care proposal was "accounting shenanigans," and added: "It doesn't save the Government any money. It doesn't save any money for the Medicare program. It just shifts costs out of the hospital trust fund." Mr. Reischauer and Mr. Penner called it a "gimmick."

White House officials say that because many users of home health services have not been hospitalized recently, there is no reason for the Hospital Insurance Trust Fund to pay for those services. Increasingly, they say, Medicare's home health benefit is used by homebound people who have chronic illnesses or need long-term care for other reasons.

Medicare finances health care for 38 million people who are elderly or disabled. Its costs grew 10 percent a year in the last decade, reaching $191 billion in 1996.

Many Republicans and health policy experts say Medicare beneficiaries should pay more for their care, through premiums, deductibles or co-insurance, because such payments would generate revenue and curb the unnecessary use of services.

Chris Jennings, a White House aide who coordinates health policy for President Clinton, summarized the conventional wisdom: "In the eyes of a lot of people, we are not real men unless we hit beneficiaries with significant increases in out-of-pocket

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costs." But Administration officials note that the elderly already spend 21 percent of their family income, on average, for health care.

Medicare was a central issue in the Presidential election, as Mr. Clinton and Vice President Al Gore asserted that the Republicans' budget plan could force hundreds of hospitals to close. Now Mr. Clinton must explain why his plan to balance the budget will not have similar effects.

Bruce C. Vladeck, who heads the Federal Health Care Financing Administration, which runs Medicare, defended the decision to seek substantial savings from health care providers. Medicare, he said, has been less aggressive than private insurers in demanding discounts.

Savings will be sought from health-care providers.

"There are now many markets for many services in which Medicare is paying more than the most effective private purchasers." Mr. Vladeck said. "That is very hard to defend or justify."

Richard J. Pollack, executive vice president of the American Hospital Association, said that "it was pretty clear from last year's election campaign that most, if not all, of the savings in Medicare" would come from hospitals, doctors, nursing homes and suppliers of medical equipment. The savings sought by Congress and the President are so large, he said, that hospitals and doctors may face "real cuts, not just a reduction in the rate of increase," in their Medicare payments.

Mr. Pollack said that such cuts were inevitable as long as Congress focused on Medicare's immediate fiscal problems rather than on the long-term changes needed to finance the program for the baby boom generation. The hospital association espouses the idea of "shared responsibility," meaning that beneficiaries, especially those with higher incomes, should pay more, he said.

Some lawmakers have suggested that the Government increase Medicare premiums for beneficiaries with incomes above a certain level, like $75,000 a year. But Marilyn Moon, an economist at the Urban Institute who is a public trustee of the Medicare trust fund, said that such proposals would not raise much revenue because they would affect relatively few people. Census Bureau data show that fewer than 7 percent of the elderly have household incomes above $75,000 a year.

President Clinton, like many Republicans, wants to encourage the use of health maintenance organizations, in the hope that they will save money for Medicare. Nearly five million Medicare beneficiaries are in H.M.O.'s, and enrollment is growing by more than 80,000 a month.

But a summary of the President's budget proposal says that the use of H.M.O.'s "does not reduce Medicare costs" today because the Government's method of calculating payments is flawed. Medicare officials said they believed that their payments to H.M.O.'s were 5 percent to 7 percent too high, and they want Congress to correct the formula to eliminate such overpayments.

H.M.O.'s give comprehensive care for a fixed monthly premium. For each Medicare beneficiary in an H.M.O., the Government pays roughly 95 percent of the average cost for a patient in the traditional Medicare program. But Federal officials said that Medicare patients in H.M.O.'s tended to be healthier than the average beneficiary and therefore had lower medical expenses.

H.M.O. executives disagree. They say that many of their elderly members have chronic illnesses. And, they say, if the Government cuts Medicare payments to H.M.O.'s, it will reduce their ability to offer prescription drug coverage and other benefits that attract new members.

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Medicare
1-10-97

MEDICARE HOME HEALTH CARE TRANSFER

Q. Isn't this home health care transfer just a gimmick that simply shifts dollars around and pushes out the needed tough medicine that Medicare requires?

A. No it is not. The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.

Q. Regardless of past positions on this issue, Republicans now clearly oppose it on the grounds that it is a gimmick and is flawed policy. How can you defend it?

A. The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits -- the most rapidly increasing part of the benefit -- have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit. Such an intervention is long overdue.

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Medicare
1-8-97

MEMORANDUM

TO: Interested Parties January 8, 1997

FR: Chris J.

RE: Medicare Q&As and Breast Cancer Patient Protection Act

Attached is a one-page set of Q&As that was prepared for Erskine today. They were drafted (and cleared by Gene) to help respond to likely questions that will emerge from continuing leaks/speculation about our Medicare proposal.

As you will note, we are avoiding any discussion about specific provisions/numbers that will be in the budget. However, we are attempting to provide filler language to deal with Democrats' concerns about the aggregate number and a defense of the home health care proposal, based on our position on this issue in last year's proposal.

In addition, I am enclosing a stop-gap answer for "Drive-By-Deliveries" Part II legislation -- a bill aimed at preventing women who have undergone mastecomies from being prematurely being released. We are reviewing the legislation now to see if it has any budgetary impact before taking any final position.

Please call if you have any questions (6-5560).

MEDICARE QUESTIONS

Q. Will your budget have in excess of $124 billion over 6 years?

A. I will not go into specifics about particular Medicare savings numbers. Those figures are for the President to present. The savings number will not be exactly the same as last year's proposal. However, I can assure you that the proposal will be very consistent with the approach, policy, and values that were included in our last balanced budget proposal.

Q. Can you tell us whether the $100 billion in savings over 5 year number reported today is accurate? Have you ruled out a high income premium increase?

A. Once again, I will not go into specifics about numbers or policy. I will tell you that our entire Medicare proposal will meet four basic principals: First, it will extend the life of the Medicare Trust Fund until the middle of the next decade. Second, it will protect and be consistent with our fundamental commitment to the Medicare program and its beneficiaries. Third, whatever Medicare savings number we send up will be based on real, scorable reductions to the program. And fourth, as our proposal strengthens the Trust Fund, it will also make policy defensible contributions to balance the budget by 2002.

Q. Is the home health care transfer gimmick going to be in the budget? How can you possible defend it?

A. As you know, we -- and the Republicans in the House -- advocated for this proposal in recent budget proposals. Without commenting on our future proposal, I will say that the home health care initiative we proposed last year was good, defensible policy that focused on the portion of this benefit that is out-of-control -- home health services in excess of 100 visits. Payment for more than 100 visits should not be in Part A of the program, which is the part of Medicare that pays for acute -- not long-term -- services. In fact prior to 1980, that is how Medicare allocated the payment for these services. Finally, our home care proposal last year included a brand new prospective payment system for home health services, as well as a fraud and abuse component, which would reduce excess utilization and achieve scorable savings for the program.

Q. If you did this proposal again, would you include the new expenditures in the Part B side of the program in the calculation of the premium?

A. Neither the Republicans nor the Administration included this in the premium calculation previously. We were and always will be concerned about program changes that increase costs for beneficiaries. Having said this, I won't comment beyond this.

BREAST CANCER PATIENT PROTECTION ACT OF 1997

Q. Do you support the breast cancer patient protection act of 1997 introduced by Representative DeLauro?

A. We are extremely concerned about reports that some women who have received mastectomies may be prematurely discharged from the hospital. The President and his Administration has a long track record of challenging health plans to be accountable for coverage of medically appropriate services. We are reviewing the legislation introduced by Representatives DeLauro, Dingell, and Roukema. We look forward to working with Congress on this matter.