/* As with the remainder of the Health Security Act and its supporting documentation, HIV and AIDS are not mentioned often by name. For example, HIV is only specifically mentioned once in this document, under preventible diseases. However, it is still a significant document in the evaluation of the entire proposal. */

December 9, 1993

ESTIMATING THE IMPACT OF HEALTH REFORM ON FEDERAL RECEIPTS

Executive Summary

The Treasury Department's Office of Tax Analysis (OTA) is responsible for preparing revenue estimates of proposals which affect Federal receipts. In general, OTA analyzes legislative proposals that change the Internal Revenue Code. OTA also analyzes the effects of certain legislative changes which do not amend the Internal Revenue Code but nonetheless affect Federal receipts. For example, changes in the laws concerning employer provision of certain fringe benefits can affect receipts because of the favorable tax status of such benefits.

The tax code also provides preferential treatment for certain types of health insurance expenditures. Health insurance contributions receive preferential tax treatment under several different provisions. Employer contributions for health insurance are deductible as a business expense by the employer and are excluded from the income of employees. Through their employers, some employees may have the option of contributing to tax-preferred cafeteria plans, enabling them to pay for their portion of health costs with pre-tax dollars. Self-employed individuals can deduct 25 percent of health insurance costs from adjusted gross income. Taxpayers can also deduct qualifying medical expenses which exceed 7.5 percent of their adjusted gross income. As a consequence, changes in the financing of health insurance will have implications for Federal receipts.

Estimating the effects of health reform on Federal receipts has required a cooperative effort among many agencies. The undertaking has demanded a broad understanding of the provisions contained in the proposal. Estimating the revenue impact of the proposal has required many data inputs from other Federal agencies involved in this process. To maintain consistency while estimating the costs of the health reform plan, the estimates of the revenue impact of the plan rely on certain inputs from other Federal agencies involved in this process. Because of the interaction among the provisions, a change in one or two of the

basic underlying policy parameters could trigger significant changes in the revenue estimates.

The health reform plan contains many non-tax provisions which may affect Federal receipts by changing the financing of health care. Each of these provisions may have very different effects on revenues, but in combination the Administration's plan results in a net increase in Federal receipts over the budget period. An alternative plan with similar features could yield very different revenue results, even if it differed from the Administration's plan in only a few key non-tax aspects.

This technical note provides background as to the methods and assumptions underlying Treasury's estimates of the impact of health reform on Federal receipts. In preparing these estimates, Treasury followed long-standing estimating conventions accepted by both Administration and Congressional agencies responsible for producing estimates of the budgetary impact of legislative proposals. In analyzing the revenue impact of non-tax changes in the financing of health insurance, Treasury has used the same methodology and models which are used to estimate the effects of changes in Internal Revenue Code provisions on receipts.

Individual Tax Model

The Individual Tax Model (ITM) is one of the most powerful tools developed by OTA to aid in estimating changes in Federal receipts. The ITM is a large microdata simulation model. The microdata aspect of the model refers to the fact that it contains data on the income, deductions, health expenditures, and other characteristics of individual tax filing units and families. The model can simulate the taxes paid under both current law and proposed changes in law.

Professional economists in OTA construct, maintain, and utilize the ITM. OTA economists share a broad background in applied microeconomics, particularly in public finance. In addition, OTA economists are also specialists in other fields, such as econometrics, health economics, labor economics, statistics, and computer programming. These skills are used to develop the inputs to the model and for examining its outputs.

Interactions with Other Agencies with Interests in Tax and Health Policy Questions

OTA economists communicate regularly with their counterparts at the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), who also use large microsimulation models. Such contacts are useful both for identifying differences among

the models as well as for developing consensus among the agencies responsible for analyzing the receipts effects of proposals.

In the health area, OTA staff maintains regular contact with numerous specialists. Members of OTA staff routinely discuss health modeling issues with staff from several agencies in the Department of Health and Human Services, including the Agency for Health Care Planning and Research (AHCPR), the Office of the Assistant Secretary of Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). In addition, OTA consults with health policy staff at the Council of Economic Advisers (CEA), the Office of Management and Budget (OMB), and the CBO.

OTA's extensive contacts with the staffs of other government agencies and outside experts provide additional access to data, research, and other techniques which are generally useful for model development. In many cases, these contacts are long-standing.

Description of the Individual Tax Model

[For a more detailed discussion of the Individual Tax Model, see James Cilke and Roy A. Wyscarver, The Treasury Individual Income Tax Simulation Model. Department of the Treasury, Office of Tax Analysis, March 1990.]

Data: The current version of the ITM was constructed from a sample of 110,000 individual income tax returns filed in 1989. The data base is a stratified probability sample of tax returns prepared by the Internal Revenue Service's Statistics of Income (SOI) Division.

[Under Section 6103 of the Internal Revenue Code, OTA and JCT have access to tax return data, including the complete SOI file. A public-use computer tape file is available to other analysts, but it has fewer data items and taxpayer records and does not contain information which might violate the confidentiality of taxpayers. In particular, the public use file blurs information on high-income taxpayers.]

This is the same sample employed by the SOI to produce the tabulations published in the Statistics of Income - 1989 Individual Income Tax Returns. When weighted, these data represent the total population of taxpayers in the United States.

Tax returns contain extensive information on the components

of taxable income. In addition, tax returns provide information about taxpayers' marital status and family size. However, tax returns do not contain information on other demographic characteristics, on non-taxable forms of income such as welfare benefits or earnings on pension and other retirement savings, or on expenditures made by the taxpayer. Nor do tax returns provide any information on families outside the tax system.

[Nonfilers are predominantly low-income persons who do not have an income tax liability and do not file a return to claim a refund.]

More comprehensive information than is provided on tax returns is needed to analyze the impact of proposals which extend the current income tax base and to analyze payroll, excise and other taxes.

To add more information, the SOI tax return data are first matched to age data from Social Security records and then statistically merged with records from the Current Population Survey (CPS) conducted annually by the Bureau of the Census. The records in the ITM are grouped into family units as well as income tax return units, and are weighted to represent the entire filing population and noninstitutionized nonfiling population. The SOI file is also statistically merged with records from the Bureau of Labor Statistics' Consumer Expenditure Survey. In addition, imputations of other critical income, asset, expenditure, employment, and demographic measures are made using a variety of sources (e.g., the Federal Reserve Board's Survey of Consumer Finances).

The data sources described above contain only limited information on expenditures on health care. From tax returns, information is available on the amount of health insurance purchased by self-employed persons who claim a 25 percent deduction. Tax returns also contain information on certain health expenditures, but only for those filers who itemize deductions and whose expenditures exceed 7.5 percent of their adjusted gross income. The Current Population Survey provides information on the insured status of individuals, including whether the insurance is provided through private or public sources. Lacking from these surveys is information on a family's total expenditures (including any employer contributions) on health insurance, characteristics of their insurance policy, and the health status of family members.

To supplement these data sources, OTA statistically matched the data from the 1987 National Medical Expenditure Survey (NMES) to the ITM. The NMES is an extensive survey of approximately 14,000 households representing the civilian, noninstitutionalized population of the United States. It was conducted under the auspices of the Department of Health and Human Services' Agency for Health Care Planning and Research (AHCPR). The 1987 survey updates and expands previous surveys conducted in 1977 and 1980. The surveys collected information about participants' utilization and expenditures for health services, health insurance coverage, health status, and employment and income. Data from the household survey are supplemented by information from medical providers, employers, and insurers.

Extrapolation: The complete data file is then extrapolated to future years based on the economic forecasts used in the Budget.

[At the time of the release of the Administration's health reform plan, the estimates were based on the Administration's economic assumptions contained in the 1993 mid-session review. The economic assumptions were extended through the year 2000 by OMB for purposes of determining the longer-term budgetary impact of health reform.]

The extrapolation is done in two stages. The first stage adjusts for anticipated economic growth and inflation. This is accomplished by multiplying the various income, deduction, and credit items on each return by forecasts based on per-capita growth rates estimated from the economic forecasts. In the second stage, the weights assigned to the records in the file are changed to hit separately determined targets for key variables, including the size distribution of adjusted gross income.

The growth rates for health data are generally based on projections contained in the Federal Budget or the National Health Accounts. Where relevant, the targets reflect significant changes in participation or expenditures since 1987 (the base year for the NMES) or 1989 (the base year for the CPS). For example, a major expansion in Medicaid will affect participation rates during the mid-nineties. To ensure consistency with the Administration's Budget estimates, the Health Care Financing Administration's projections for persons insured by Medicaid are used to estimate targets in the extrapolation of these items in the ITM.

Tax Calculator: Using the extrapolated files, the tax laws for each year in the Budget period are simulated. In

combination, these simulation programs are referred to as the "tax calculator" or simply, the "calculator." The calculator takes information from each potential tax filing unit in the data file, and using a set of specified tax parameters, computes that unit's Federal individual income tax liability under the proposed change in law.

Two basic revenue estimating assumptions are embedded in the calculator for computing tax liabilities. First, all filers are assumed to choose tax options which minimize their tax liabilities. Second, variables such as the level and distribution of total pre-tax income or total expenditures are held constant when simulating a tax policy change.

The calculator computes the values of a number of variables that are endogenous to the model -- that is, these are tax variables, in addition to liabilities, which may be affected by a proposal and which, in turn, can affect the calculation of tax liabilities. In general, the ITM can trace through most of the interactions between any income source and the various provisions of the Internal Revenue Code.

Appropriate behavioral responses have been incorporated into the tax model. In addition, as will be discussed further below, off-model adjustments are often made by the analysts to incorporate other anticipated behavioral changes in response to a proposed tax change.

Uses and Limitations of Model Output

As noted above, the ITM is a powerful tool which enables OTA economists to better analyze the effects of various proposals. There are several important distinctions, however, between the output of the tax model and the final analyses prepared by OTA.

First, even in the simplest case, output from the ITM does not go unexamined. Output is subject to a reality check. Users of the ITM check carefully the results to determine if they appear reasonable. For example, users may compare the extrapolation of a particular variable with data which has become available since the initial construction of the tax model. Such information may include data from more recent samples of tax returns (e.g., the 1991 SOI sample of tax returns), other government organizations (e.g., the Bureau of Labor Statistics' Surveys of Employee Benefits; the Census Department's Survey of Income and Program Participation), trade associations (e.g., surveys conducted by the Health Insurance Association of

America), and independent consulting organizations.

Second, the ITM is best utilized to analyze the effects of changes in the tax code that affect broad groups of taxpayers and involve current law tax rules. The tax model cannot be relied upon exclusively to estimate changes in the tax code which affect narrow populations or introduce new income tax rules. In these instances, OTA economists may rely on "spreadsheet" models to produce estimates of tax changes. Often, these spreadsheet models are, themselves, quite extensive and sophisticated. In many cases, information from the ITM (e.g., the marginal tax rate faced by a comparable group of taxpayers) may be used as input into these spreadsheet models. The ITM is also not used to analyze proposals affecting tax units other than individuals. For these purposes, OTA maintains several other tax models, including a corporate model, a depreciation model, and an estate model.

Third, subject to certain budget estimating conventions, estimates of the revenue effects of tax changes include assumptions about changes in taxpayers' behavior induced by changes in tax policy. Given the set of macroeconomic assumptions used to prepare the Budget, major GDP components -- such as real and nominal GDP -- are assumed to be fixed for purposes of estimating the deficit impact of a proposed change in legislation. Thus, for revenue estimates, behavioral effects are constrained by this "fixed GDP" assumption. Behavioral assumptions which affect the composition of GDP, but not its level, are integral to the revenue estimates. Off-model adjustments are generally necessary to account for the full range of potential behavioral effects.

Fixed GDP Assumption

The "fixed GDP" budget estimating convention is a long standing rule and is followed by the Office of Management and Budget, Treasury, and all other Executive Branch agencies. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) follow a similar convention, using the economic assumptions contained in CBO's budget analyses. The "fixed GDP" assumption allows policymakers to view the effects of proposed change in law on the deficit, as forecasted in the most recent Budget.

[Under the Budget Enforcement Act of 1990, the estimates of legislative proposals are based on the economic assumptions contained in the President's Budget. At the time of the

introduction of the Administration's health reform bill in the fall of 1993, it did not seem likely that the legislative action would be completed by the end of the year. As a consequence, there was an Administration-wide decision to use the recent economic assumptions contained in the Mid-session review.]

Without such a convention, dozens of analysts in each agency could derive their own independent forecast of GDP each time they estimated the deficit impact of a proposed change in legislation.

[The fixed GDP assumption is discussed in detail in Howard W. Nester, "A Guide to Interpreting the Dynamic Elements of Revenue Estimates." Compendium of Tax Research 1987, C. Eugene Steuerle and Thomas Neubig, eds. Washington, D.C.: Government Financing Office, 1987, pp. 13 - 41.]

As a consequence of the fixed GDP assumption, Treasury, CBO, and JCT assume that total employee compensation remains unchanged in response to a requirement that employers provide a new fringe benefit to their workers. This identity is derived from the Census Bureau's National Income Accounts (NIA). Under these assumptions, if employer contributions for health insurance increase, then other forms of labor income -- wages or other fringe benefits - must decline in order for GDP to remain constant.

[Some benefits -- such as employer contributions for social insurance -- are linked by law to wages and thus change as wages change.]

However, if wages and salaries decline, income taxes and employment taxes must decline as well. This effect is sometimes referred to as the "income offset."

[For a discussion of the "income offset," see George Tolley and C. Eugene Steuerle, "The Effects of Excises on the Taxation and Measurement of Income," 1978 Compendium of Tax Research. Washington, D.C.: Government Printing Office, 1978, pp. 67 - 78; and Sonia Conly and Linda Radey, "Changes in Excise and Payroll Taxes and Their Effect on Total Budget Receipts," paper presented at the 1988 Eastern Economic Association Meetings, Boston, Massachusetts.]

Federal income and employment tax liabilities are affected by these compositional changes, as the allocation between taxable cash wages and non-taxable compensation (including the employer portion of payroll taxes) shifts. Based on observable relationships within the NIA, wages and salaries would appear to

fall by almost the full amount of an increase in employer contributions for health insurance. Wages and salaries do not fall by the full amount for several reasons. First, the reduction in wages automatically causes employer contributions for social insurance (another form of labor compensation) to decline. Further, to some extent, employer contributions for other fringe benefits, such as pensions and life insurance, will also fall.

Estimating the Effect of Required Employer Contributions for Health Insurance, Premium Discounts, and Cost Containment on Federal Receipts

Under the health reform plan, employers would be required to contribute towards the purchase of a comprehensive health insurance benefit plan for their workers. This package may cost either more or less than the health insurance plan currently provided by the firm, and its scope may also differ markedly from the firm's current plan. Employers' response to a requirement that they contribute toward their employees' health insurance will depend, in large part, on how the guaranteed comprehensive benefit package differs both in costs and generosity from their current plans and the extent to which they may be entitled to premium discounts under the proposal.

[The health reform plan affects revenues largely through its impact on the allocation between taxable wages and non-taxable health benefits. The plan can affect revenues in other ways as well. As insurance coverage expands as a consequence of the plan, some taxpayers will not incur large out-of-pocket expenditures for uncovered medical expenses, and deductible medical expenditures will also fall. Expansion of the Medicare benefit package to include prescription drugs may also reduce deductions for medical expenses.]

Five key pieces of information are necessary to evaluate the impact of the health reform proposal on Federal receipts. These include:

* Initial cost of the comprehensive benefit package;

* Rate of growth in the cost of the comprehensive benefit package;

* Degree to which employers' costs are offset by premium discounts;

* Employees' demand for health insurance in excess of the comprehensive benefit package; and

* Employees' ability to negotiate with employers to obtain tax-preferred methods of paying for supplemental coverage and the employee share of the cost of the comprehensive benefit plans.

The data sources and the key underlying assumptions for each of these items are described briefly below.

Costs of the Benefit Package: The Health Care Financing Administration (HCFA) provided estimates of the costs of the benefit package at 1994 levels, assuming that the plan was fully effective in that year. Their estimates included the effects of moving to a system of universal coverage.

Rate of Growth in the Costs of the Benefit Package: All agencies involved in estimating the budgetary impact of the health reform plan used the same assumptions regarding the rate of growth in the cost of the benefit package. Under these assumptions, the basic benefit package was assumed to grow at a rate consistent with private health insurance between 1994 and 1996. Beginning in 1996, the costs of the plan were assumed to grow at the targeted rates of growth specified in the health reform plan (CPI+1.5 percentage points in 1996, CPI+1.0 percentage points in 1997, CPI+0.5 percentage points in 1998, and CPI in 1999 and 2000). These rates of growth are based on the assumption that the cost containment initiatives contained in the plan are effective.

Premium Discounts: Under the plan, premium discounts are provided to ease the burden for some employers. First, small firms with fewer than 75 employees and average wages below $24,000 will be entitled to significant premium discounts. Second, the Federal government will provide premium discounts for other firms within the regional alliance if the cost of providing the comprehensive benefit package exceeds 7.9 percent of their payroll. Some employers will receive premium discounts even though they provided health insurance in the past. These employers are expected to pass the discounts back to workers in the form of higher wages and other benefits. Receipt of premium discounts, then, could affect the estimates of the plan on Federal receipts.

HCFA is responsible for producing the official estimates of the costs of the premium discounts. Using Treasury's Individual Tax Model, it is also possible to simulate the receipt of the premium discounts by individuals (as passed back to them by their

employers). Treasury's estimates of the premium discounts were used solely as an input into the analysis of the effect of the plan on Federal receipts. As a check, OTA's estimates of the premium discounts are reconciled to those produced by HCFA.

Demand for Supplemental Coverage: Workers' demand for supplemental coverage is estimated largely as a function of expenditures on medical services for items not within the scope of the comprehensive benefit package. Data on reimbursable expenditures on health insurance, as well as current health insurance expenditures, are used to determine the value of supplemental health insurance coverage. Estimates of the costs of administering health insurance (the "load factor") under the current system were provided by HCFA. The estimates also account for changes in the price and demand for supplemental coverage following health reform.

Cafeteria Plans and Other Tax-Preferred Arrangements with Employers: Under the Administration's health plan, individuals may be responsible for a portion of the cost of the comprehensive benefit package. They may be liable for the difference between the cost of the plan which they select and eighty percent of the weighted average cost of a plan within their region. As under current law, workers are generally required to pay for health insurance premiums out of after-tax income. However, the current system provides workers with several opportunities to reduce their health insurance costs by paying with pre-tax dollars. To the extent that workers can take advantage of these options, tax receipts will fall.

[As will be discussed further below, the Administration's plan would restrict contributions to cafeteria plans. The estimates of the effects of the required employer contribution do not reflect these proposed restrictions. The effects of these restrictions are estimated separately, under the assumption that employee behavior has changed in the ways described in this section.]

The estimates of the required employer contribution (with premium discounts and cost containment) took into account the likelihood that individuals may seek ways to shelter, on net, more of their health insurance premiums through cafeteria plans and other informal arrangements with employers. The estimates also took into account other offsetting factors (such as some reductions in contributions which, under the current system, cover out-of-pocket reimbursements).

Estimating the Effect of Restricting Contributions for Health Insurance

Under the plan, employer contributions for the comprehensive (i.e., standard) benefit package (up to 100 percent of the costs of the package) would be excluded from income for purposes of calculating individual income and employment taxes. Employer-paid premiums on supplemental plans would now be included in employees' taxable income.

While this provision would generally become effective January 1, 2004, contributions for health benefits through cafeteria plans would be disallowed, effective January 1, 1997. As a consequence, the seven-year estimates of the revenue impact of health reform only show the impact of the restrictions on employer contributions through cafeteria plans.

OTA's estimates of the effects of the restrictions on cafeteria plans are "stacked" after the combined effects of the required employer contribution, cost containment, and subsidies have been taken into account. In other words, the baseline for cafeteria plans, in these estimates, assume that individuals have already made certain adjustments to other aspects of health reform. Thus, for example, the baseline would reflect changes in the utilization of the cafeteria plans in response to the required employer contribution.

When contributions to cafeteria plans are restricted, individuals may have alternative opportunities to shelter income through other tax-preferred arrangements with their employers (e.g., the employer may agree to pay the full amount of the employee contribution and, in turn, explicitly reduce wages by an offsetting amount). These alternatives for sheltering income are taken into account in the revenue estimates for restricting cafeteria plans.

The Health Security Act of 1993
Documentation of Federal Budget Effects

December 1993

/* Due to the fact that persons can change the page length or margin length within their word processors, we have retained the page numbers, but eliminated page breaks. Your mileage may vary <smile>. */

Table of Contents

BACKUP DOCUMENTATION

This document provides a description of policies in the Health Security Act which involve Federal costs or savings, the line-by-line numerical estimates, and a brief description of key assumptions or methodologies used to derive the estimates. The estimates are consistent with the Congressional testimony presented by the Director and Deputy Director of OMB. A few minor variances with the final bill language remain. Revised estimates will be provided with the President's FY 1995 Budget.

Backup Documentation
(Savings negative, costs positive)
(outlays in $ millions)

Budget Category
Medicaid: Providing Coverage for Medicaid Non-Cash Recipients through Alliances

Budget Projections

Fiscal Years	1995	1996	1997	1998	1999	2000	95-2000
Guaranteed benefit package	0	-1,900	-6,500	-18,500	-24,700	-27,900	-79,500
Wrap: non-cash	0	-100	-600	-1,600	-2,300	-2,600	-7,200
Wrap: cash kids	0	-100	-300	-900	-1,200	-1,300	-3,800
Emergency svcs for undocumented persons	0	100	200	400	500	600	1,800
Net Medicaid Savings	0	-2,000	-7,200	-20,600	-27,700	-31,200	-88,700

Policy Description

Current non-cash recipients of Medicaid (individuals under age 65 who do not receive AFDC or SSI payments) will receive a comprehensive package of benefits through the health alliances, like everyone else. Medicaid will not pay their premiums. In addition, Medicaid will no longer pay for wraparound benefits on behalf of non-cash recipients integrated into alliances or cash recipient children. (Cash and non-cash children will receive wraparound benefits through a new Federal program, as described in a separate backup document.)

Key Technical Assumptions

Estimates are based on projected Medicaid acute care spending for services covered in the guaranteed benefit package as well as Medicaid wraparound benefits. Pricing based on August 1993 Medicaid estimates. The percentage of aggregate acute care spending allocated to non-cash recipients is based on data from HCFA-64 and 2082 forms. DSH spending is not included in the estimates. Assumes that states with 15% of Medicaid spending implement by FY 1996, 40% by FY 1997, and 100% by FY 1998. Estimates based on assumption that new Federal program is created to cover wrap benefits for both cash and non-cash children. Net Medicaid savings includes estimate for continued Medicaid coverage of emergency services for undocumented persons.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Long-term care: Medicaid offset from new community LTC program.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
community LTC offset	0	-1,500	-2,200	-2,700	-3,100	-3,600	-13,100

POLICY DESCRIPTION

The new community LTC program for people with severe disabilities will serve eligible individuals who were previously covered under Medicaid.

KEY TECHNICAL ASSUMPTIONS

Estimates are from ASPE/Lewin-VHI (see "New Programs/Long-Term Care"), based on the assumptions that roughly 50% of baseline Medicaid home and community-based spending will be offset by the new program. Data from the National Medical Expenditures Survey and the Medicaid program support an estimate that 50% of Medicaid home and community-based expenditures are for individuals meeting the severely disabled criteria of the new community LTC program. ASPE assumed that States will move these individuals to the new LTC program, where a higher Federal matching rate and increased program flexibility will be available. Medicaid baseline spending projected by Lewin-VHI.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Effect of Capitated Payment for Cash Recipients

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-300	-1,200	-3,900	-6,700	-10,200	-22,300

POLICY DESCRIPTION

Under the Health Security Act, a comprehensive benefits package will be provided to cash AFDC recipients through the Alliances. States will contribute to the Alliances a premium for cash recipients equal to 95% of baseline spending on benefits for cash recipients in the year prior to implementation of reform. Baseline spending in the year prior to implementation is computed by trending forward spending in FY 1993 by the projected national average Medicaid growth rate for benefits for cash recipients. Beginning with the first year of implementation, premiums grow at the budgeted premium growth rate for the private sector. Separate premiums will be computed for AFDC and SSI recipients. States are to vary premiums across Alliances within a State so that the weighted average premium across all Alliances is equal to the premium as calculated on a uniform, Statewide basis.

OACT'S KEY TECHNICAL ASSUMPTIONS

To calculate the premium, actuaries used annual growth rates derived from historical and baseline data. States were assumed to implement health reform on a Federal fiscal year basis in 1996 (15%), 1997 (25%), and 1998 (60%). It was assumed that full-year cash recipients would total roughly 18 million by FY 1996. The baseline data used to calculate the savings listed above incorporates State spending estimates from August, 1993.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ hundreds of millions)

BUDGET CATEGORY
Medicaid: Disproportionate Share Hospital Payments and Vulnerable Populations Adjustment

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Disprop Share	0.0	-1.4	-4.7	-13.0	-16.8	-18.6	-54.6 *
Vulnerable Pop Adj	0.0	0.2	0.4	1.0	1.0	1.0	3.6 *
Net	0.0	-1.2	-4.3	-12.0	-15.8	-17.6	-51.1 *

* Totals do not add due to rounding.

POLICY DESCRIPTION

Medicaid disproportionate share hospital (DSH) payments are supplemental payments for hospitals that serve large numbers of low-income, undercompensated, or non-paying patients. The Federal share of DSH payments totalled about $9 billion in FY 1993, over 12% of medical assistance payments. Hospitals that currently serve a disproportionate share of Medicaid and uncompensated patients will receive large inflows of new revenue when universal coverage is phased in with health reform. Providers will be compensated for all patients and rates for current and former Medicaid recipients will be determined through negotiations with health plans. As a result, Medicaid DSH payments are to be eliminated as Sates implement health care reform in CY 1996 (15%), CY 1997 (25%), and CY 1998 (60%). New Federal payments of $3.55 billion will be targeted to hospitals serving a high percentage of low-income individuals through the Vulnerable Populations Adjustment.

OACT'S KEY TECHNICAL ASSUMPTIONS

The baseline data used to calculate the savings listed above incorporates State spending estimates from August, 1993. August State estimates were not included in HCFA's mid-session review (MSR) estimates. HCFA actuaries estimated that Federal DSH outlays in FY 1994 will total roughly $10.3 billion -- up from an MSR estimate of $9.5 billion. Actuaries assumed that a three-month payment lag would lower potential first-year savings in each

State by 25%. Savings were calculated assuming that States would implement health reform on a Federal fiscal year basis as follows: FY 1996 (15%), FY 1997 (25%), and FY 1998 (60%).

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BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Long-term care: Liberalized LTC eligibility

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Liberalized LTC elig.	0	500	500	500	500	500	2,500

POLICY DESCRIPTION

Under the Health Security Act, States will establish a medically needy program for all residents of nursing homes and intermediate care facilities (ICFs-MR). The personal needs allowance (PNA) for nursing home residents may be raised to $50 per month. (Current PNA levels vary across States, but the national average is $35 per month.) The costs of raising the PNA are financed with 100% Federal dollars. States have the option to allow unmarried nursing home and ICF-MR residents to retain up to $12,000 in assets (up from the current $2,000) in determining Medicaid eligibility.

KEY TECHNICAL ASSUMPTIONS

Approximately 1.2 million residents of nursing homes and ICFs-MR are Medicaid recipients. PNA levels would increase for these individuals in 45 States. 5 States already have PNAs at or above $50 per month.

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BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Cost-Sharing Discounts Provided in Some Alliances

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	100	200	600	700	700	2,300

POLICY DESCRIPTION

If a low-cost sharing plan is not available at or below the weighted average premium, AFDC and SSI recipients (as well as other low-income beneficiaries) will receive discounts to reduce their cost-sharing to the level they would have incurred if they had enrolled in a low cost-sharing plan. Medicaid pays for these cost-sharing (out-of-pocket) discounts as part of payments to the alliances.

KEY TECHNICAL ASSUMPTIONS

The total number of Medicaid cash enrollees (non-aged and disabled) was estimated by HCFA at 18.4 million in FY 96 and grows to 20.2 million in FY 2000.

The percentage of Medicaid cash enrollees eligible for low cost-sharing discounts is estimated at 5.0%, yielding 990,000 enrollees receiving discounts in FY 1999. The average discount cost was estimated at $1050 in FY 96, 57% of which is Federal, yielding an average Federal discount cost of $599. Average discount costs were assumed to increase by 5% per year. State phase-in schedule

assumes States with 15% of Medicaid spending implement 10/1/95; States with 25% implement 10/1/96; and States with the remaining 60% of spending implement 10/1/97. Estimate of cost-sharing discounts calculated on fiscal year basis.
Act provides Medicaid premium (in addition to out-of-pocket) discounts to AFDC and SSI recipients (1371 (c)(1)) who reside in alliance areas in which a health plan at or below the average weighted premium is not available. This estimate only reflects costs associated with these out-of-pocket (not premium) discounts.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Costs associated with paying unpaid Medicaid claims for cash recipients ("Payment lag").

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	1,040	1,960	5,310	0	0	8,310

POLICY DESCRIPTION

States generally pay Medicaid costs (claims) retrospectively. Thus, in the year of implementation, States will be responsible for "lagged" claims from the previous year in addition to prepaid capitation payments to plans.

KEY TECHNICAL ASSUMPTIONS

States are, on average, a quarter behind in payments. In the year in which a State implements reform, the State (and the Federal government) must make up for this lag, which constitutes 25% of spending for cash recipients for services in the standard benefit package. The costs are incurred in FY96 through FY98 due to staggered State implementation of 15%/25%/60%. States are assumed to phase-in on fiscal year basis.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Administrative Savings Due to Program Reduction and Simplification.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-100	-300	-800	-1,100	-1,400	-3,700

POLICY DESCRIPTION

Under the Health Security Act, as under current law, State expenditures for administering the Medicaid program will be matched by the Federal government. State Medicaid programs will include far fewer enrollees, however. Payment for services included in the comprehensive benefits package will be made via a fixed, pre-paid monthly premium, rather than through direct, fee-for-service provider reimbursements -- significantly reducing the volume of claims and the need for provider contracts, reimbursement specialists, and other State oversight personnel.

Thus, with enactment of the Health Security Act, States will have an opportunity to reduce Medicaid administrative expenses substantially.

KEY TECHNICAL ASSUMPTIONS

It is assumed that States would be able to reduce administrative expenses by about one-third in response to reduced responsibilities in enrollment, oversight, rate-setting, and claims processing. Because administrative savings depend on discretionary State action, potential savings were discounted by 25%. Savings totals assume that States implement health reform on a Federal fiscal year basis in FY1996 (first 15%), FY97 (next 25%) and FY98 (last 60%), and that full administrative savings are reached 2 years after implementation.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: Impact of Medicare Drug Benefit on Medical Spending

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	-700	-1,000	-1,200	-1,300	-1,500	-5,700

POLICY DESCRIPTION

The Health Security Act extends a drug benefit to Medicare Part B beneficiaries. Low-income beneficiaries will receive the same out-of pocket discounts for the drug benefit as they do for other

Medicare services. Individuals eligible for both Medicaid and Medicare who currently receive Medicaid drug benefits will now be served by the Medicare drug benefit when reform is implemented. Federal and State Medicaid expenditures will reduced by the portion of the Medicare drug benefit financed through Federal Medicare revenues.

OACT'S KEY TECHNICAL ASSUMPTIONS

OACT assumed that the net Federal per-beneficiary cost of the Medicare drug benefit, together with beneficiary premiums and cost-sharing, would be equivalent to net Federal per-beneficiary costs for prescription drugs under Medicaid. Actuaries also assumed that Federal outlays from the Medicare drug benefit would reduce current Medicaid spending on dual eligibles (approximately 3.5 million beneficiaries) by 50%, since Medicaid will continue to pay the premium and cost sharing. Conversely, in a shorthand way, the actuaries assumed that Medicaid would incur additional costs equal to 50% of the net Federal per-beneficiary cost of the Medicaid drug benefit for Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs), for whom Medicaid pays Part B premiums (approximately 1.5 million beneficiaries). The baseline data used to calculate the offset savings listed above incorporates State spending estimates from August, 1993.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ hundreds of millions)

BUDGET CATEGORY
Medicare/Medicaid: Effect on Qualified Medicare Beneficiary (QMB)/Selected Low-Income Medicare Beneficiary (SLMB) participation and Medicaid payments

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Net effects	0.0	0.1	0.1	0.1	0.2	0.3	0.8

on Medicaid of Medicare savings proposals (Drug benefit cost-sharing and premiums assumed in Medicare drug estimates.)

POLICY DESCRIPTION

Under the Health Security Act, working individuals of Medicare-eligible age and their spouses will receive health coverage by enrolling in Alliances, with the employer as primary payor in those cases when a Medicare enrollee works at least 40 hours in each of the last two months of each year. Those eligible for Medicare and Medicaid coverage of cost-sharing and/or benefits will retain Medicaid benefits. Medicare is primary payor for all Medicare services under current law, including drugs for non-working dual eligibles, with Medicaid paying Part B premiums and, in some cases, cost-sharing for poor Medicare Part B enrollees.

KEY TECHNICAL ASSUMPTIONS

Full FY 1996 implementation of relevant policies; approximately 3.5 million QMBs and 750,000 SLMBs in 1996, extrapolated from HCFA data reports for 1993. Assumed no QMBs/SLMBs are working aged. Medicare is primary payor of drugs for dual eligibles. Drug cost-sharing for QMBs is not in the MOE calculation, but will be required of States. QMBs and dual eligibles who work would receive coverage through the Alliance and may continue to receive Medicaid wrap-around coverage. Medicaid cost-sharing for drugs assumed in Medicare estimates. Assumed 57% of total additional Medicaid costs would be borne by Federal government. Effect of package on Part A premium is not calculated and, as a result, effects on qualified working disabled individuals (QDWIs) are not included in the estimates. This calculation is, therefore, sensitive to the following variables: Percentage of QMBs working; whether Medicaid pays the 20% premium for working QMBs/SLMBs; whether Medicaid pays QDWIs' 20% premium in Alliance; effect on Part A premium for QDWIs of Medicare savings package; effect of final Medicare savings package on coinsurance liabilities (Medicaid pays the Part A premium for QDWIs).

BACKUP DOCUMENTATION
(savings negative, costs positive)

(outlays in $ millions)

BUDGET CATEGORY
Medicare: Part B Prescription Drug Benefit

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Drug Benefit	0	6,600	13,500	14,200	15,200	16,200	65,800

POLICY DESCRIPTION

Under the Health Security Act, Medicare Part B will be expanded for all beneficiaries to include a prescription drug benefit on January 1, 1996. Beneficiaries will pay for their prescriptions out-of-pocket up to $250 each year and 20% of drug costs between $250 and $1000, and will not incur out-of-pocket costs for prescriptions above $1000 each year. Manufacturers will be required to pay a rebate for each non-generic prescription sold to a beneficiary equal to at least 17% of the average manufacturer's price to the retail class of trade. The Part B premium is calculated to equal 25% of the Federal costs of the drug benefit (net of rebate revenue). Reimbursement to pharmacists will be capped at 93% of the average wholesale price for ingredient costs plus $5 per script for the dispensing fee (indexed to inflation). Pharmacists will be expected to answer questions from beneficiaries on recommended usage, side-effects, interactions, etc. The HHS Secretary is authorized to require those administering the benefit to operate a utilization review program for pharmacists and physicians similar to that required under Medicaid.

OACT'S KEY TECHNICAL ASSUMPTIONS

Listed costs are net of rebate revenue. It was assumed that each dollar of the new Medicare drug benefit would induce an additional 60 cents of drug spending by beneficiaries. Induced demand is estimated to be about $10 billion annually. Administrative costs account for about $1 billion per year of gross Federal expenditures. Monthly Part B premiums would rise between $10 and $11 in CY 1996 to cover 25% of Federal program costs. It was assumed that, after implementation of the drug benefit in 1996, over 36 million Part B beneficiaries would obtain a total of about 1 billion prescriptions per year. It was also assumed that 500,000 high-income beneficiaries would disenroll from Part B due to the combined effect on the Part B premium of the drug benefit and the proposal in the Health Security Act to income-relate the Medicare Part B premium. Working beneficiaries in the Alliance (see separate description of working policy) were included in the

beneficiary population used to estimate the costs listed above. An offset for working beneficiaries for all Medicare expenditures, including Part B drug costs, is listed separately.

[Pages 15 - 16]

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicare: Part B Prescription Drug Benefit Administrative Costs(non-add)

Administrative costs are displayed separately for illustrative purposes only and are included in the cost estimate of the Part B prescription drug benefit.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Drug Benefit	13	600	900	1,000	1,000	1,100	4,613

POLICY DESCRIPTION

Under the Health Security Act, Medicare Part B will be expanded for all beneficiaries to include a prescription drug benefit on January 1, 1996. Beneficiaries will pay for all prescriptions out-of-pocket up to $250 each year, 20% of drug costs between $250 and $1000, and will not incur out-of-pocket costs for prescriptions above $1000 each year. Manufacturers will be required to pay a rebate for each non-generic prescription sold to a beneficiary equal to at least 17% of the average manufacturer's price to the retail class of trade. Pharmacists will be expected to answer questions from beneficiaries on recommended usage, side-effects, interactions, etc. The Secretary is authorized to require those administering the benefit to operate a utilization review program for pharmacists and physicians similar to that required under Medicaid.

OACT's KEY TECHNICAL ASSUMPTIONS

Actuaries assumed that, beginning in 1996, over 36 million Part B beneficiaries would obtain a total of about 1 billion prescriptions per year. It was assumed that electronic claims would account for 90% of all prescriptions and would cost 73cents each in 1993. Remaining claims would be filed on paper, averaging 1.5 prescriptions per claim, and would cost about $1.00 each to administer. It was assumed that the weighted average cost per prescription, 72.4 cents, would increase 3% annually through FY 2000. Fixed costs of $100 million annually were also included in the cost estimates.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlay in $ millions)

BUDGET CATEGORY
Medicare payments to VA health plans

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Medicare payments to VA plans	--	--	--	200	300	300	800

POLICY DESCRIPTION

Under the Health Security Act, Medicare will reimburse VA health plans for services to higher-income veterans for non-service-connected conditions, as defined in 38 USC 1722 (b), eligible for Medicare. VA and HHS will negotiate application of rules and payment rates.

KEY TECHNICAL ASSUMPTIONS

VA estimates approximately 55,000 veterans that are enrolled in Medicare and that are above the "higher-income" threshold received VA care in FY 1992. Assumes 1/1/98 start-up date. VA health facilities must meet Medicare conditions of participation and reporting requirements.

This calculation is sensitive to the following variables: which Medicare payment methodology will be used if VA health plans are considered Medicare HMOs; interaction with working aged policy; whether VA health plans will also cover spouses of veterans; rate of increase/decrease in eligible population; whether Medicare pays for a spouse who enrolls in a VA plan; phase-in schedule used in pricing; whether premiums have been netted out of Medicare

expenditures, including drug premium add-on; whether Medicare will be primary payor for prescription drugs purchased by the VA; the date of commencement of Medicare payments to VA health plans; additional administrative costs, if any.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlay in $ millions)

BUDGET CATEGORY
Medicare payments to DoD health plans

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Medicare payments to DoD health plans	--	200	500	1,300	1,400	1,400	4,800

POLICY DESCRIPTION

Under the Health Security Act, the Secretary of HSS has the discretion to disregard the exclusion in the Social Security Act on Medicare payments to DoD health facilities. Medicare will pay a capitated amount to military health plans for services equivalent to SMI benefits for those Medicare beneficiaries who enroll in military plans. The payment will equal the payment to an organization with a risk-sharing contract under Section 1876 of the Social Security Act.

KEY TECHNICAL ASSUMPTIONS

DoD estimates it will provide $1.268 billion in services to individuals over 65 in 1993. Assumes revised phase-in schedule of 15% in FY 1996, 40% in FY 1997, and 100% in FY 1998. Estimate only accounts for currently projected services to over-65 population and assumes no induced utilization for inpatient or outpatient services. DoD used the DRG workload for the over-65 population to calculate total services provided Medicare beneficiaries. Assumes Medicare paid for 90% of costs. Used CPI-U to inflate estimates in the out-years.

This calculation is sensitive to the following variables: method of calculation of the capitated amount; inpatient induced utilization would appear to be negligible, but there may be an

inducement effect on the outpatient (Part B) side; effective date for Medicare payment -- phase-in schedule for such payments not specifically outlined.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicare: New liabilities for ex-FEHB retiree beneficiaries

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
New Medicare costs, net of premium penalty	--	0	0	300	300	300	900
Medicare offsetting receipts from monthly premium	--	0	0	-100	-100	-100	-300

POLICY DESCRIPTION

Under the Health Security Act, retiree health benefits for Federal retirees are covered by Medicare as primary payor. Federal retirees could then have first-dollar coverage, with OPM filling in the cost-sharing as the secondary payor. OPM is assumed to be responsible for payments to cover late enrollment fees assessed against the Part B premium. OPM will offer a Medigap-like policy to protect Federal retirees from cost-sharing.

KEY TECHNICAL ASSUMPTIONS

Assume all Federal employees and annuitants join beginning January 1, 1998. Assume cohort equals 115,000 individuals (OPM estimates). New enrollment is only under Part B, since almost all have Part A coverage now. Assumed average Part B benefits for aged Part B enrollees. Assumed OPM pay 100% of the Part B late enrollment penalty, including new drug premium (Beneficiaries who do not enroll in Medicare during their initial enrollment period are subject to a penalty in the monthly premium). Assumes all new enrollees pay Part B premium of 25%, including new drug premium. Assumes no drop-outs as the result of the working aged policy or the income-related Part B premium. Assumes no balance billing; assumes drug rebate amounts (15%) into net new Medicare outlays.

This calculation is sensitive to the following variables: Effect of wrap-around coverage on utilization; whether wrap-around policies will cover the Part B deductible; how many will opt to purchase FEHB supplemental coverage; average number of years subject to penalty; relative health status of this cohort of individuals; PAYGO consequences; what effect the final policy on working aged will have on these estimates; interaction effect with income-related Part B premium; design of OPM's supplemental policies; receipts from drug add-on amount to Part B premium (Estimates do not account for working aged, long-term care policies).

[Page 20 and 21]

BACKUP DOCUMENTATION
(savings negative, costs positive)

BUDGET CATEGORY

Medicare Working Policy. Offset for Medicare-Eligible Employed Beneficiaries, and Medicare-Eligible Spouses and Dependents of Working Individuals

BUDGET PROJECTIONS

Fiscal Yrs	1995	1996	1997	1998	1999	2000	1995-2000
	-1,000	-3,000	-8,000	-8,000	-8,000		-28,0000

POLICY DESCRIPTION

Policy is described in detail in the attached specifications.

KEY TECHNICAL ASSUMPTION

HCFA actuarial estimate is based upon the attached specifications. The Office of the Actuary assumes the Medicare working policy would result in about 5.4 million beneficiaries obtaining primary coverage in FY 1996 through their employment (or as a dependent or spouse of an employee) -- up from about 2.2 million who would have primary coverage from group health insurance under current law. All 5.4 million would retain Medicare Part A for secondary coverage; about 5 million out of the 5.4 million beneficiaries are projected to retain Medicare Part B secondary coverage. The remaining 400,000 who would not enroll in Part B are largely high-income beneficiaries who would be required to pay a higher, income-related premium to receive Part B wrap-around coverage.

Pricing assumes 15% phased into alliances in FY 96, 40% in FY 97, and fully phased-in FY 98. Includes Medicare as Secondary Payer (MSP) savings associated with the drug benefit. Does not include savings from the MSP proposals in the $124 billion Medicare savings package. Interactions with the income-related Part B premium and savings proposals in the $124 billion Medicare savings package are taken into account within the $124 billion package.

MSP POLICY

o Medicare beneficiaries who are working or have a spouse that is working or who are a dependent of someone who is working would be required to enroll in the alliance if the individual working worked forty or more hours in each of the previous two calendar months and would be working in the third month. (An exception would be provided in the case of a person who retired in the month prior to the month in which Medicare coverage begins.) Coverage in the alliance would begin on the first day of the third month.

This policy is a variation on the coverage rules for non-Medicare beneficiaries under which the employer is required to make a payment on behalf of an individual if the individual worked more than 40 hours in a month.

o Medicare would make the following payments on behalf of beneficiaries enrolled in alliances:

+ Medicare would fill in all cost sharing if the individual was enrolled in Part B or cost sharing only for Part A covered services if the individual did not enroll in Part B.

+ Medicare would pay the remainder of the employer share that would otherwise be the responsibility of the worker, if the employment was for less than 30 hours per week. (Discounts that would otherwise apply if the individual was paying part of the employer share would not apply.)

o If the tie to employment is terminated prior to the end of the year, the individual would stay in the alliance and Medicare would pay the entire employer share for the remaining months. At the end of the year, the individual would have the option of Medicare coverage or opting to remain in the alliance under the opt-in rules.

o Existing limitations on the working aged provisions to firms with at least 20 employees and on the disabled provisions to large group health plans would be eliminated. The ESRD MSP provisions would be conformed to the revised aged and disabled provisions. The existing limitation of 18 months for ESRD MSP would be eliminated. (Savings from extension of the authority for the disability provision, reduction of the employer threshold from 100 to 20, and extension of the 18-month provision for ESRD are included as part of the Medicare savings, rather than under this proposal.)

BACKUP DOCUMENTATION
(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY
Medicare. Reimbursements to physician assistants, nurse practitioners, and clinical nurse specialists (Sec. 4022)

BUDGET PROJECTIONS

Fiscal Yrs	1995	1996	1997	1998	1999	2000	1995-2000
	0	250	450	500	600	650	2,450

POLICY DESCRIPTION

Sec. 4022 of HR 3600 would expand the sites and areas in which services from Medicare's physician fee schedule could be furnished by physician assistants, nurse practitioners, and clinical nurse specialists. Separate billings for these services (i.e., fee-for-service payment) would be more widely available to these non-physician practitioners or their employers.

Effective January 1, 1996, services furnished by the specified non-physician practitioners would be separately reimbursable as follows: physician assistants -- services furnished in all settings and all areas; nurse practitioners -- services furnished in all settings except to inpatients of hospitals located in urban areas; clinical nurse specialists -- services furnished in all settings except to inpatients of hospitals, nursing facilities, and skilled nursing facilities located in urban areas.

KEY TECHNICAL ASSUMPTIONS

HCFA actuary pricing assumes that outlays would increase because of greater beneficiary access to these non-physician practitioners' services (predominantly primary care) in more settings and more areas of the country. The actuary also assumes that some substitution for higher-cost physician-furnished services would occur, reducing the net costs of the provision.

Interactions with other relevant provisions of the Health Security Act, e.g., Medicare savings provisions, Medicare incentives for provision of primary care services, and between Health Alliances and the Medicare beneficiary population still being considered.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(Outlays in $ millions)

BUDGET CATEGORY
Medicare savings proposals

BUDGET PROJECTIONS

Fiscal Yrs	1994	1995	1996	1997	1998
Medicare savings proposals	-150	-2,480	-9,875	-14,373	-22,815

BUDGET PROJECTIONS (continued)

Fiscal Yrs	1999	2000	1994-2000
Medicare savings proposals	-33,000	-41,721	-124,414

POLICY DESCRIPTION

HR 3600 contains a package of provisions to reduce the rate of growth of Medicare program costs that will result in seven-year savings of over $124 billion. The provisions include changes to payment rates, enrollee cost-sharing, and other changes to current law. These changes will be made in the context of both universal coverage and slower growth in private sector health costs, reducing the likelihood of cost-shifting and adverse effects on beneficiaries. A significant portion of these savings would come from reducing payments originally intended to ease financial pressures created by uncompensated care, the rationale for which is virtually eliminated under the universal coverage ensured by the Health Security Act. The provisions will also strengthen the Medicare Trust Funds and ease upward pressure on beneficiary cost-sharing.

KEY TECHNICAL ASSUMPTIONS

Provides back-up documentation for estimates in the 1994-2000 window. See attached document. Estimates are sensitive to interaction with other provisions affecting Medicare; effect and magnitude of Medicare enrollees opting into managed care plans; net effect of all relevant provisions on Medicare spending.

($ in millions)

PART A PROPOSALS

Reduce the Hospital Market Basket Index (HMBI) Update by 2% in FY 1997-2000. Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input cost changes and Congressional direction. OBRA 93 reduced the HMBI in FYs 94 - 97 by 2.5, 2.5, 2, and 0.5 percentage points respectively, to reflect greater efficiencies in hospitals. This proposal would reduce the market basket updates by 2% for FY 1997 - FY 2000. Since the market basket is projected to increase 5% annually, and case mix is projected to increase 2% per year, hospitals can still expect an overall 5% increase per year.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	930	2,870	5,610	8,750	$18,160

Reduce Indirect Medical Education (IME) Adjustment to 3.0% in FY 1996. A portion of the IME is intended to compensate hospitals for uncompensated care. Universal coverage, however, will ensure payment for all patients and essentially eliminate uncompensated care. In 1996, the IME adjustment will be lowered to 3.0% under this proposal. Beginning in FY 1997, the aggregate amount of IME payments will be increased by the projected national average increase in premiums for the under-65 population for those States that opt into the reformed system; by 1998, all Medicare IME payments will be made in this fashion. These payments will be appropriated to a national pool to finance the higher costs of academic health centers. The cash flow effect for IME payments is built into these estimates.

Savings

1996	1997	1998	1999	2000	1996-2000
2,470	3,110	3,470	4,130	4,660	$17,840

Adjust Inpatient Capital Payments to Reflect Better Cost Data.

This proposal combines three inpatient capital payment adjustments

to reflect more accurate base year data and cost projections. The first piece would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system (PPS) by 15% for FY 1996 - 2000. PPS-excluded hospitals, currently paid at full costs, do not have an incentive for efficiency. The second piece would reduce PPS Federal capital payments by 7.31 percent and hospital-specific amount by 10.41 percent to reflect new data on the FY 1989 capital cost per discharge and the increase in Medicare inpatient costs from FY 1990 to FY 1992. The last piece would reduce payments for hospital inpatient capital through a 22.1% reduction to the FY 1996 - 2000 updates of the capital rates. Current data indicate that Medicare inpatient capital cost per discharge increased 77.5% during the years immediately before the introduction of prospective payment for capital-related costs (FY 1986 - FY 1991). The identifiable variables for capital costs only increased 38.2% over the same period. This proposal would reduce the update to the capital rates by 4.9% each year during FY 1996 - 2000 to recover excess capital spending.

Savings					
1996	1997	1998	1999	2000	1996-2000
$995	1,400	2,005	2,610	3,315	$10,325

Revise the Disproportionate Share Hospital (DSH) Adjustment. Hospitals that treat a disproportionate share of low-income patients receive an additional payment. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income Medicare patients. In the reformed system with universal coverage, DSH can be reduced. This proposal would replace the current DSH program with a new program as States come into the new system. The new program would assist hospitals serving the largest share of low-income patients.

Savings					
1996	1997	1998	1999	2000	1996-2000
$430	1,330	3,670	4,390	4,810	$14,630

Moratorium on PPS-Exempt Long-Term Care Hospitals. Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to a rate-of-increase limit. This proposal would pay new long-term care hospitals under the PPS

system. Alternatively, these hospitals could seek reclassification as psychiatric or rehabilitation hospitals, or become certified as skilled nursing facilities (SNFs), for example, and be paid under the SNF cost limit structure.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
$20	40	70	100	130	170	$530

Extend OBRA 93 Provision: Eliminate Catch-Up after SNF Freeze Expires. OBRA 93 established a two-year freeze on updates to the cost limits for skilled nursing facilities (SNFs). A "catch-up," however, is allowed after the SNF freeze expires on October 1, 1995; new cost limits would be established that do not reflect the effects of the freeze. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

Savings

1996	1997	1998	1999	2000	1996-2000
$80	160	180	200	210	$830

Graduate Medical Education: Effect of National Pool.

Under the legislation, Medicare would pay into two national pools: one for direct medical education, and one for academic health centers. The projected Medicare spending for direct and indirect medical education would be transferred to the Secretary for those States that have opted into the reformed system; by 1998, all States will be folded into the new system. These funds will be transferred out of the Trust Funds faster than they are currently paid to hospitals. This will result in a slight cost to Medicare. The costs displayed here are the cash flow effect for direct graduate medical education.

Costs

1996	1997	1998	1999	2000	1996-2000
-30	-60	-150	-20	-20	-$280

Interaction Costs

PART A INTERACTION					
$0	-110	-300	-510	-730	-$1,650

PART A REVENUE PROPOSAL

Subject All State and Local Employees to Hospital Insurance Tax. State and local jurisdictions can opt to pay the HI payroll tax for State and local workers hired before April 1, 1986, but are not required to do so. The proposal would extend the payroll tax to all remaining exempt State and local workers, who would thus be treated like all other covered workers. Additional revenues would exceed benefit payments for a long time, since 90% of retired State and local workers already receive Medicare benefits through other covered jobs or spousal employment; only about 70%, however, worked in State or local government jobs on which HI taxes were paid.

Savings

1996	1997	1998	1999	2000	1996-2000
$1,535	1,518	1,470	1,420	1,366	$7,309

(Estimates for this proposal were calculated by Treasury Department staff.)

PART B PROPOSALS

Base MVPS on Real GDP Per Capita. This proposal would change the statutory formula that is used to determine the Medicare Volume Performance Standard (MVPS), a target for the rate of growth in Medicare physicians expenditures. Currently, the MVPS is based on the average annual growth in the volume and intensity of physicians' services over the preceding five fiscal years. This proposal would substitute the five-year average growth in real GDP per capita for this volume and intensity factor and the

performance standard factor. This change would directly connect MVPS to the growth rate of the national economy. The MVPS for all three categories of physician services (surgical, primary care, and all other) would continue to be adjusted for projected increases in physicians' fees, beneficiary enrollment, and changes resulting from regulatory and legislative activity. The MVPS for primary care services would be given an additional 1-1/2 percentage point upward adjustment. Under current law, there is no upper limit on physician fee increases, but fees cannot decrease by more than five percentage points. This proposal would eliminate the floor on physician fee reductions.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	275	1,075	1,975	2,775	$6,100

Establish Cumulative Growth Targets for Physician Services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays, without regard to the prior year's target rate of growth in outlays. This process weakens the ability of the MVPS to serve as a meaningful target for sustainable growth in Medicare physician spending. Under this proposal, the MVPS for each category of physician services would be built on a designated base-year MVPS (FY 1995). This initial target would be updated annually for changes in the beneficiary enrollment and inflation, but not for actual outlay growth above or below the target. Essentially, physician fee changes in any one year would no longer distort the MVPS for the following years. The annual process for calculating physician fee updates would not change from current law.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	(85)	1,825	2,475	1,600	$5,815

Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services. The conversion factor is a dollar amount that converts the fee schedule's relative value units (RVUs) into a payment amount for each physician service. This proposal would reduce the conversion factor by 3% in CY 1995 to account for the excessively high FY 1992 target and 1994 update that is anticipated, except that primary care services would not be reduced.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$250	475	525	550	575	600	$2,975

Eliminate Formula-Driven Overpayment in Hospital Outpatient Departments. Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal would eliminate the flaw in the payment methodology and the resulting overpayments, effective July 1, 1994. In addition, the current payment method gives hospitals strong incentives to increase charges for these services, thus raising beneficiary coinsurance liabilities. Fixing the formula-driven overpayment would mitigate the hospital incentive to raise the charges to Medicare enrollees.

Savings

1994	1995	1996	1997	1998	1999	2000	1996-2000
$150	1,050	1,300	1,690	2,190	2,750	3,480	$12,610

Contract Competitively for All Part B Laboratory Services. The Secretary would be required to establish the same kind of competitive acquisition system for Medicare laboratory services as for other selected Part B items and services beginning January 1, 1995. Pricing assumes that competitive contracting will reduce the price of laboratory services by 10%. Medicare laboratory payments currently are projected to grow by 15% to 18% per year. This proposal seeks to curtail the growth rate by lowering the price of tests and reducing the profit incentive for physicians to order unnecessary tests. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$140	220	260	290	320	360	$1,590

Competitively Bid Selected Medicare Part B Items and Services. This proposal would require the HHS Secretary to contract competitively for Medicare services and supplies, based on quality and other standards. The initially planned items for competitive procurement are MRIs, CAT scans, oxygen services, and enteral nutrients. Pricing assumes a 10% reduction in price for these services and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$110	190	210	240	270	300	$1,320

Income-Related Part B Premium, Fully Phased-in to 75%.

Currently, all Medicare enrollees pay the same Part B premium, regardless of income. This premium is set at approximately 25% of program costs, beginning in 1996; the balance is paid by general revenues. This proposal would charge high-income enrollees a premium up to 75% of program costs. The increase in the premium for single individuals would begin at modified adjusted gross incomes (plus taxable Social Security benefits) of $90,000 and phase up to 75% for those individuals with incomes equal to or above $105,000. The increase for couples would begin at $115,000, with the maximum 75% premium being paid by couples in which both are eligible for Medicare with a combined income of over $130,000.

Savings (includes interaction)

1996	1997	1998	1999	2000	1996-2000
$350	935	900	985	1,070	$4,240

Re-establish 20% Coinsurance for Laboratory Services.

This proposal would re-establish a 20% coinsurance on all physician office, outpatient, and independent laboratory tests under Medicare Part B, effective January 1, 1995. Congress eliminated the required coinsurance on laboratory services for independent labs and those in hospital outpatient departments in 1984. In 1985, Congress eliminated coinsurance for physician office laboratory services. Clinical laboratory services are the only services provided under Medicare Part B for which no coinsurance is now required.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$650	1,070	1,230	1,380	1,540	1,720	$7,590

Extend OBRA 93 Provision: 25% SMI Premium.

OBRA 93 established the Part B premium collections at 25% for program costs for 1996-1998. This proposal would extend the OBRA 93 provision requiring that Part B premium collections cover an estimated 25% of program costs.

Savings

	1996	1997	1998	1999	2000	1996-2000
	0	0	0	1770	4310	$6080
Interaction	(710)	(1090)	(2140)	(2770)	(3180)	($9,890)
NET	(710)	(1090)	(2140)	(1000)	1130	($3,810)

Limit Payments to High-Cost Medical Staffs.

This proposal would establish limits on Medicare physician payments per inpatient hospital admission, similar to limits used in other parts of Medicare. The proposal would take effect in 1998. Payment limits would be established based on the median of hospital-specific case-mix adjusted relative value units per admission. For urban hospitals, the limit would be 125% of the national median in 1998 and 1999, and 120% in 2000 and thereafter. For rural hospitals, the limit would be 140% of the national median in 1998 and thereafter. Annually, a hospital-specific per admission relative value would be projected for the upcoming year for each hospital. This projection would be adjusted for each hospital's teaching status and disproportionate share. At the beginning of each year, Medicare would establish a 15% withhold for medical staffs projected to be over the national limit. After the end of each year, Medicare would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. For medical staffs below the limit, the entire withhold would be returned.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$0	0	0	500	780	1,040	$2,320

Prohibition on Balance Billing.

Physicians and other providers of Part B services are said to "accept assignment" on Medicare claims when they accept the Medicare approved amount as payment in full for covered services. Balance-billing (also called extra-billing) occurs when providers charge more than the Medicare-approved amount -- Medicare pays 80% of the approved amount and the beneficiary or other payor (e.g. Medigap insurance) is responsible for paying the balance. Balance-billing is prohibited under current law for most Part A and B services. Physicians may not charge more than 15% over the Medicare approved amount for their services, and only about 6% of all physician dollars are billed on an unassigned basis. Elimination of balance-billing remaining in Medicare will make for

consistent treatment of all services with Medicare and between Medicare and the health alliance-approved plans serving the under-65 population. It will also reduce beneficiary confusion, enhance beneficiaries' financial protection, and simplify carrier administration. This proposal will mandate assignment and prohibit all balance-billing by providers of Part B services effective January 1, 1996. The costs from this proposal arise largely from elimination of the participating physician payment differential.

Costs

1996	1997	1998	1999	2000	1996-2000
($130)	(250)	(260)	(270)	(290)	($1,200)

PARTS A AND B PROPOSALS

Extend OBRA 93 Provision: Eliminate Catch-Up after Home Health Freeze Expires. OBRA 93 eliminated the inflation adjustment to the home health limits for two years, FY 1994-1995. This proposal would eliminate the inflation "catch-up" -- currently allowed after the freeze expires on July 1, 1996 -- by recalculating the percent of the mean that would produce the same amount of savings as if the freeze continued. HCFA actuaries estimate this to be 100% of the mean.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	480	600	650	690	$2,420

Lower Home Health Limits to 100% of Median.

Home health is projected to rise over 10% a year through 1998, including 33% growth in 1994. This proposal would lower the cost limits to 100% of the median for cost reporting periods beginning on or after July 1, 1997. In other words, Medicare would reimburse home health agencies at a rate no higher than the costs encountered by half of the agencies.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	10	160	230	250	$650

Require a 10% Copayment on All Home Health Visits other than Those Occurring 30 Days after a Hospital Discharge. Home health is one of the fastest growing benefits in Medicare, with a projected increase in home health outlays of nearly 33% in 1994. Medicare enrollees do not currently pay cost-sharing on home health care. This provision would charge a copayment on all home health visits except those received within 30 days of an inpatient hospital discharge; these visits are less discretionary and more intensively rehabilitative. Enrollees who receive home health without an inpatient stay would pay 10% copayment on all services. The copayment would be equal to 10% of the average cost per visit.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$230	1,400	1,560	1,680	1,800	1,920	$8,590

Expand Centers of Excellence.

HCFA has initiated two bundled payment demonstration projects that show potential for Medicare savings. These projects involve contracting with "Centers of Excellence" that perform coronary artery bypass graft (CABG) surgery and cataract surgery. By expanding this concept to all urban areas, contracting with individual centers using a flat payment rate for all services associated with the cataract or CABG surgery, Medicare would be able to reduce costs. The Secretary also would be granted the authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so through rebates representing 10% of the government's savings from the center. Pricing assumes a 10% discount in the price of services for the 20 percent of beneficiaries who are assumed to use the centers.

Savings

	1996	1997	1998	1999	2000	1996-2000
Part A	60	70	70	70	70	$340
Part B	40	40	40	40	40	$200

Extend OBRA 93 Provision: Medicare Secondary Payor (MSP) Data Match with SSA and IRS. OBRA 93 included an extension of the data match between HCFA, IRS, and the Social Security Administration to identify the primary payers for Medicare enrollees with health care coverage in addition to Medicare. This proposal would extend that provision beyond its scheduled expiration date of 1998.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	0	0	195	330	$525

Establish a Threshold of 20 Employees for MSP for the Disabled.

OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled employees with employer-based health insurance. The provision is applicable to all employers with 100 or more employees. This proposal would lower the employee threshold from 100 to 20 employees beginning on January 1, 1998. With community rating under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would eliminate the employee threshold. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996-2000
0	0	150	240	260	$650

Extend OBRA 93 Provision: MSP for Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. This proposal would extend this provision permanently.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	0	0	990	1,340	$2,330

Extend OBRA 93 Provision: Medicare Secondary Payor Provisions for ESRD Patients. OBRA 93 extended through FY 1998 a provision that makes Medicare the secondary payor for individuals with end stage renal disease (ESRD) enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. This provision permanently extends the MSP provision for individuals with ESRD. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would provide coverage of all individuals with end stage renal disease for as long as the individual requires care. The provision would require all employer-sponsored plans to cover workers, dependents of workers, and workers' spouses who are eligible for Medicare.

Savings

1996	1997	1998	1999	2000	1996-2000
$0	0	0	75	150	$180

HMO Payment Improvement.
Medicare pays 95% of the average adjusted per capita cost (AAPCC) for Medicare enrollees in Medicare-contracted HMOs. This proposal would establish a range around the Part A and Part B components of the AAPCC that would presumably encourage HMOs to participate in Medicare while establishing reasonable limits on reimbursement for high-cost counties. The ceiling would be 150% of the national average Part B component of the AAPCC and 170% for the Part A component of the AAPCC, with a floor established at 80%. The range would be phased-in over a four-year period, beginning in 1995.

Savings

1995	1996	1997	1998	1999	2000	1996-2000
$30	90	165	250	350	400	$1,285

TOTAL SAVINGS

1994	1995	1996	1997	1998	1999	2000	1996-2000
$150	2,480	9,875	14,373	22,815	33,000	41,721	$124,414