

## SIMILAR LETTER DELIVERED TO ENTIRE CONGRESS



*Bringing lifetimes of experience and leadership to serve all generations.*

December 19, 1995

The President  
The White House  
Washington, DC 20500

Dear Mr. President:

Throughout 1995 one of the most perplexing problems confronting policymakers and the public has been the need to reform and constrain the cost growth in Medicare, and at the same time maintain the program's commitment to provide affordable, quality health care to older and disabled Americans. The dual challenge of constraining cost and continuing to provide quality care has led to a continuing debate over the appropriate growth rate for the Medicare program.

The Medicare reductions proposed in the budget reconciliation conference agreement and in the President's proposal are without precedent in their magnitude and potential effects on the program. In an attempt to understand what a fair and appropriate growth rate for Medicare would be, AARP has compared the Medicare growth rates in the budget reconciliation conference agreement and in the President's December 7, 1995 package to growth rates in the private sector and in current-law Medicare (see enclosed chart). If done accurately, comparisons to the private sector can provide a useful benchmark against which to assess alternative Medicare spending proposals. Unless a proposal permits Medicare spending to grow at least in tandem with growth in the private sector, it seems unlikely that the program will be able to hold its own -- either in payments to providers or in quality of care -- when compared to the coverage available through other payers.

Under current law, the average annual rate of growth in the cost of Medicare benefits is projected to be 9.2 percent over the next seven years, while the average annual rate of growth in health care benefit costs for those under 65 in the private insurance market is estimated to be 7.4 percent. Under the conference agreement, Congress would reduce the average annual rate of growth of Medicare benefits to 7.0 percent. The President's plan would reduce Medicare's growth rate to 7.8 percent. However, looking at these aggregate growth rates can be misleading, and could lead to very serious mistakes.

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Regina J. Lehmann, President

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It is only when one looks at the components of health spending that it is possible to accurately assess whether reductions of the magnitude being proposed will sustain basic benefits and quality health care for Medicare enrollees now and in the future.

Health spending increases are composed of several factors:

1. general price inflation as measured by the Consumer Price Index (CPI);
2. population growth;
3. aging of the population; and
4. "health-specific costs," including
  - medical-specific price inflation over the CPI, such as the hospital market basket or the Medicare Economic Index (MEI),
  - medical technology,
  - medical research, and
  - the increased use and complexity of services.

To understand the impact of spending reductions in Medicare as compared to the private sector, we need to focus on the reductions in the only area -- health-specific costs -- where these cost reductions could fall.

The enclosed chart -- which is based upon projections by the Congressional Budget Office (CBO) using the new economic assumptions -- shows that general price inflation applies consistently across all populations. Increases in population and aging of the population are different for those under and over 65, but nonetheless, are determined by demographics; they will not change as the result of any budget legislation.

Health-specific costs, however, are different for those over and under 65. This category can be viewed as the projected *need* for the increased use of health care services, the complexity of these services, and advances in technology. For example, as people grow older they often need a greater number of health care services and more complex types of services than those under 65.

Thus, the reductions in Medicare's rate of growth will not come from general price inflation<sup>1</sup>, or from the categories that reflect the growth and aging of the population. These categories reflect factors that are beyond our control and cannot be "legislated away." Rather, changes will come from health-specific costs. In this category, the chart shows that both the Congressional proposal and the President's proposal reduce Medicare's growth rate substantially below the private sector.

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<sup>1</sup> Even if Congress and the President make a change -- or assume one -- in the CPI, it will apply equally across all populations and programs.

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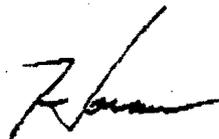
Health-specific costs are currently projected to account for 4.1 percent of spending growth in the Medicare program, and 4.0 percent of spending growth for those under 65. However, Congress would dramatically reduce Medicare's rate of growth in this area to 2.0 percent, and the President's proposal only permits 2.8 percent growth.

It is essential that Medicare's cost growth -- and health cost growth, in general -- be cut back. In fact, the current growth rate is unsustainable. Efficiencies can and must be found, and ways to provide quality health care for less must be identified and put into practice. But, if Medicare is to continue to provide an acceptable level of quality care, it cannot be constrained significantly more tightly than private-sector health care. If the disparity between the two is too large, then we risk turning Medicare into a second class health program. Medicare's future growth in health-specific costs should be at least comparable to private sector growth, especially as technology improves, the population ages, and people live longer.

Older Americans and their families look to the Medicare program to provide reliable, affordable health insurance and financial security against the cost of health care. Deep reductions in Medicare spending over 7 years will place tremendous pressure on the program and on the beneficiaries who depend on it. If costs in the overall health care system continue to grow -- as they inevitably will -- but the rate of growth in Medicare is held down, who will pay the difference? Will Congress begin cutting benefits from Medicare to keep costs low? Will health care plans and providers "cut corners" to reduce costs? Will beneficiaries pay more out-of-pocket (e.g., balance billing)? Will individuals in the private sector pay more due to cost-shifting by providers? Will quality suffer?

AARP is concerned about the answers to these questions. If you would like to discuss this further, please do not hesitate to call me, or have your staff call Marty Corry (434-3750) or Tricia Smith (434-3770) of our Federal Affairs Department.

Sincerely,

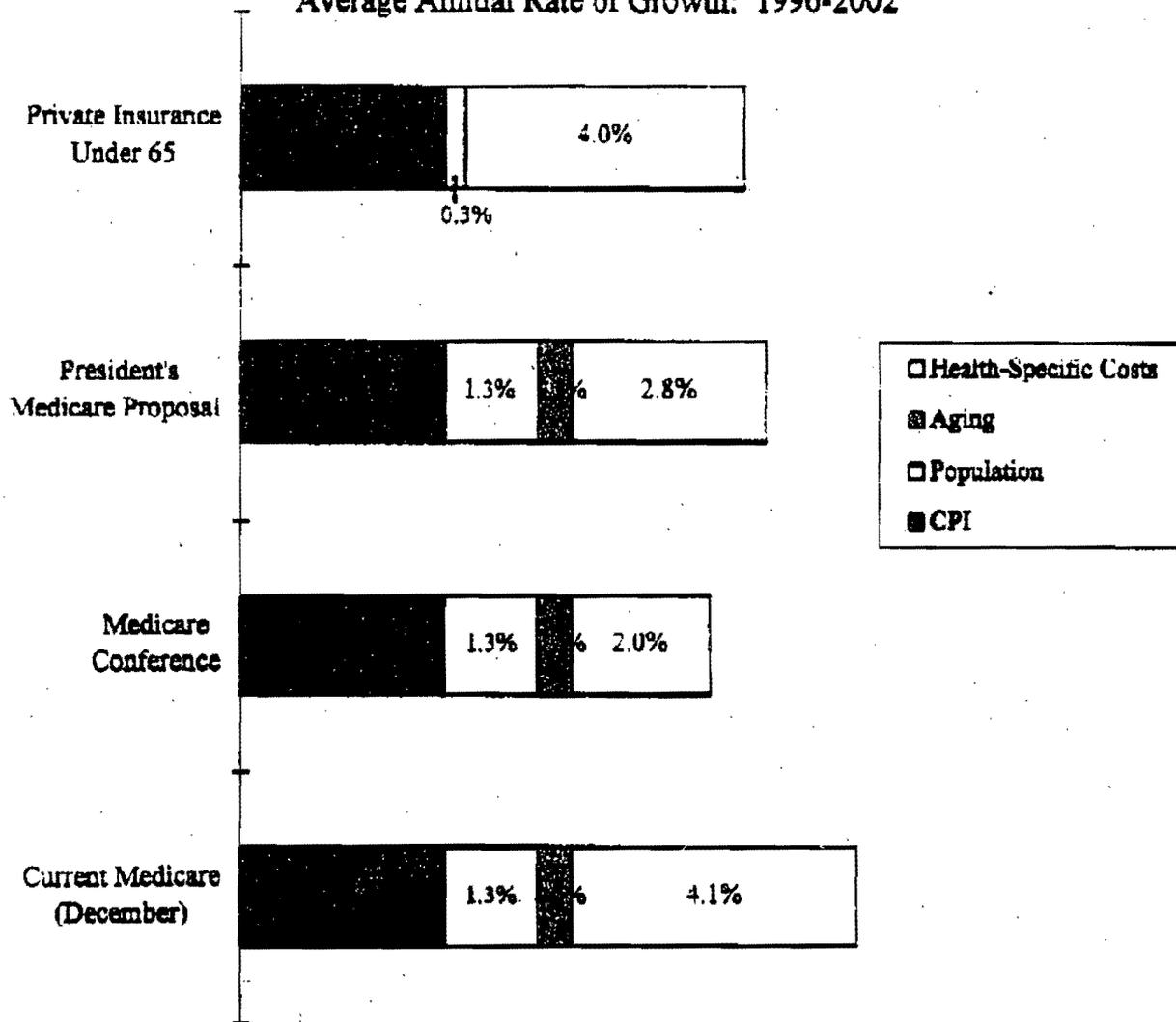


Horace B. Deets

Enclosure

## Components of Health Spending Growth

Average Annual Rate of Growth: 1996-2002



*Note: The percentages do not add to the total growth rates. To get to the total growth rates, add "1" and multiply. For example, current Medicare = (1.030)x(1.013)x(1.005)x(1.041)=(1.092)=9.2%.*

Source: Based on CBO preliminary December projections, except for the private insurance forecast, which was based on earlier CBO projections.

November 27, 1995

## **The Graduate Medical Education Reform Proposal in the Balanced Budget Act of 1995: How the Teaching Hospital and GME Trust Fund Works**

**Summary:** Beginning FY 1997 (October 1, 1996), the federal government would create a trust fund called the Teaching Hospital and Graduate Medical Education Trust Fund. The trust fund would derive its funding from two basic sources: \$13.5 billion in appropriated general revenues from the U.S. Treasury and transfers from the Medicare program. The trust fund would be subdivided into five separate and distinct accounts, each with its own funding level and payment methodology. The five accounts are: 1) the General MedicarePlus Incentive Account; 2) the General Indirect Costs Medical Education Account; 3) the General Direct Costs Medical Education Account; 4) the Medicare Indirect Costs Medical Education Account; and 5) the Medicare Direct Costs Medical Education Account.

In FY 1997, \$1.1 billion in general revenues would be appropriated to the trust fund. In subsequent years, the following general revenues would be appropriated: \$1.3 billion in FY 1998; \$2.0 billion in FY 1999; \$2.6 billion in FY 2000; \$3.1 billion in FY 2001; and \$3.4 billion in FY 2002. Over the six-year period, a total of \$13.5 billion would be appropriated to the trust fund, excluding transfers from the Medicare program. Starting FY 2003, the general revenues in the trust fund would be increased by an inflation factor.

The general revenues would be allocated among the three general (non-Medicare) accounts. The General MedicarePlus Incentive Account would receive an increasing share of the total revenue appropriated to the trust fund until FY 2000, when it would receive one-half of the appropriated dollars. The remaining amount would be allocated between the General Indirect Costs and the General Direct Costs Medical Education Accounts.

Prior to FY 1997, teaching hospitals would continue to receive the two Medicare payments with an education label: the indirect medical education (IME) payment and the direct graduate medical education (DGME) payment. Beginning October 1, 1996, the Secretary of HHS would estimate annually what the Medicare program would have paid to teaching hospitals for IME and DGME and would transfer those amounts to the appropriate accounts in the trust fund. The estimates would be made subject to specified payment policy changes, and also would be affected by the extent to which Medicare beneficiaries enroll in MedicarePlus plans or choose other options and leave the fee-for-service payment system.

To receive payments from the five accounts in the trust fund, hospitals would submit payment documents to the Secretary of HHS through the Health Care Financing Administration (HCFA). Qualifying graduate medical education consortia (not described in detail in this summary) could receive payments from three accounts: the General MedicarePlus Incentive Account; the General Direct Costs Medical Education Account; and the Medicare Direct Costs Medical Education Account.

This analysis describes for each of the five accounts comprising the trust fund how funding would be provided to the account in each Federal fiscal year and how payments would be made from the account to the recipients.

## 1. The General MedicarePlus Incentive Account

### How this Account Would Be Funded

FY 1996: No account exists.

FY 1997: This account would be funded entirely with general revenues from the U.S. Treasury. In the first year, this account would receive 20 percent of the appropriation, or \$220 million (20 percent of \$1.1 billion). The Medicare program makes no transfer to this account.

FY 1998: This account would receive 30 percent of the \$1.3 billion appropriation, or \$390 million.

FY 1999: This account would receive 40 percent of the \$2.0 billion appropriation, or \$800 million.

FY 2000: This account would receive 50 percent of the \$2.6 billion appropriation, or \$1.3 billion.

FY 2001: This account would receive 50 percent of the \$3.1 billion appropriation, or \$1.55 billion.

FY 2002: This account would receive 50 percent of the \$3.4 billion appropriation, or \$1.7 billion.

*Note: This account receives its funding "off the top." The remainder of the general revenue dollars would be allocated between the General Indirect Costs Medical Education Account and the General Direct Costs Medical Education Account.*

### How the Money in this Account Would Be Distributed

FY 1996: No account exists.

FY 1997-FY 2002: Teaching hospitals would receive a percentage of the money in this account. A hospital's percentage would be calculated annually as the hospital's share of inpatient discharges attributable to individuals enrolled in the MedicarePlus program relative to the number of MedicarePlus discharges for the fiscal year at all teaching hospitals. Qualifying graduate medical education consortia could receive payments from this account.

*Note: Unlike the IME adjustment in the fee-for-service prospective payment system, this payment would be unrelated to the number of residents and beds in teaching hospitals, or to the operating cost structures of teaching hospitals with differing levels of involvement in graduate medical education. The hospital-specific percentage would change annually. This methodology would favor teaching hospitals in locations with high Medicare managed care penetration.*

## 2. The General Indirect Costs Medical Education Account

### How this Account Would Be Funded

FY 1996: No account exists.

FY 1997: This account would be funded entirely with general revenues from the U.S. Treasury. After the General MedicarePlus Incentive Account receives its funding, a portion of the remainder is allocated to this account based on the percentage that Medicare IME payments constituted relative to total combined IME and Medicare DGME payments in FY 1994. In FY 1997, this account would be funded at \$634 million (see note below). The Medicare program makes no contribution to this account.

*Note: First, the General MedicarePlus Account would be funded at \$220 million or 20 percent of \$1.1 billion. The remaining \$880 million would then be allocated between the General Indirect Costs and the General Direct Costs Medical Education Accounts. For example, in FY 1994, IME payments were \$3.8 billion and DGME payments were about \$1.5 billion, or IME spending was 72 percent of the total of the two Medicare payments with an education label. Therefore, the General Indirect Costs account would get 72 percent of \$880 million in FY 1997, or \$634 million. The remaining 28 percent, \$246 million, would be transferred to the General Direct Costs Medical Education Account.*

FY 1998: This account would receive 72 percent of \$910 million (\$1.3 billion less 30 percent of \$1.3 billion), or \$655 million.

FY 1999: In this fiscal year, this account would receive 72 percent of \$1.2 billion (\$2.0 billion less 40 percent of \$2 billion), or \$864 million.

FY 2000: This account would receive 72 percent of \$1.3 billion (\$2.6 billion less 50 percent of \$2.6 billion), or \$936 million.

FY 2001: In this year, the account would receive 72 percent of \$1.55 billion (\$3.1 billion less 50 percent of \$3.1 billion), or \$1.116 billion.

FY 2002: This account would receive 72 percent of \$1.7 billion (\$3.4 billion less 50 percent of \$3.4 billion), or \$1.224 billion.

### How the Money in this Account Would Be Distributed

FY 1996: No account exists.

FY 1997-FY 2002: Teaching hospitals would receive a fixed percentage of the funds in the new General Indirect Costs Medical Education Account. A hospital's percentage would be calculated as the mean average of the percentages of total IME that the hospital received in Fiscal Years 1992, 1993, and 1994. The percentage in each fiscal year would be calculated as the hospital's total Medicare IME payment for the year divided by total IME payments in that year to all teaching hospitals. Payment would be made on an institution, not discharge,

basis. Graduate medical education consortia would not receive payments from this account.

*Note: The hospital's percentage would remain fixed through FY 2002; only the amount available in the account for distribution would vary (see above). As currently defined, this payment would be uncoupled from the number of residents training at the hospital in FY 1997 and beyond and from the teaching hospital's operating cost structure. Because Medicare would not contribute to this account, the available funding in this account would be unaffected by the trend toward enrollment in managed care or choice of other non-fee-for-service options.*

### 3. The General Direct Costs Medical Education Account

#### How this Account Would Be Funded

FY 1996: No account exists.

FY 1997: This account would be funded entirely with general revenues from the U.S. Treasury. After the General MedicarePlus Incentive Account receives its funding, a portion of the remainder is allocated to this account based on the percentage that Medicare DGME payments constituted relative to total combined Medicare DGME and IME payments in FY 1994. In FY 1997, this account would be funded at \$246 million (see note below). The Medicare program would make no contribution to this account.

*Note: For example, in FY 1994, Medicare DGME payments were approximately \$1.5 and IME payments were \$3.8 billion. DGME payments were 28 percent of the total of the two Medicare payments with an education label. Therefore, after the General MedicarePlus Account receives its funding (described earlier), the General Direct Costs Medical Education Account would be allocated 28 percent of \$910 million, or \$246 million in FY 1997.*

FY 1998: This account would receive 28 percent of \$910 million (the residual after the General MedicarePlus Account is funded), or \$255 million.

FY 1999: This account would receive 28 percent of \$1.2 billion, or \$336 million.

FY 2000: This account would receive 28 percent of \$1.3 billion, or \$364 million.

FY 2001: This account would receive 28 percent of \$1.55 billion, or \$434 million.

FY 2002: This account would receive 28 percent of \$1.7 billion, or \$476 million.

#### How the Funds in this Account Would Be Distributed

FY 1996: No account exists.

FY 1997-FY 2002: Hospitals would receive a fixed percentage share of this account. The hospital-specific percentage would be based on the mean average of the percentages of total Medicare DGME payments that the hospital received each year in Fiscal Years 1992, 1993

and 1994. The percentage in each fiscal year would be calculated as the hospital's total Medicare DGME payment for the year divided by total DGME payments in that year to all teaching hospitals. Qualifying graduate medical education consortia could receive payments from this account.

*Note: This percentage would remain fixed through FY 2002; only the amount available for distribution would vary (see above). As currently defined, this payment would be uncoupled from the number of residents training at the hospital in FY 1997 and beyond. Because Medicare would not contribute to this account, the available funding in this account would be unaffected by the trend toward enrollment in managed care or choice of other non-fee-for-service options.*

#### 4. The Medicare Indirect Costs Medical Education Account

##### How this Account Would Be Funded

FY 1996: The Medicare program continues to make IME payments to hospitals using the prospective payment system's IME formula at the rate of 6.7 percent for every 10 percent increment in a hospital's resident-to-bed ratio (IRB).

FY 1997: The Medicare program would transfer funds to this account. The Secretary of HHS would make an estimate of what the program would have spent nationwide during this year if it were still making IME payments for discharges under the prospective payment system during the applicable year. In FY 1997, the IME rate would be lowered to 6.0 percent. If the Secretary determines that the amount transferred is insufficient for making payments, the Secretary must make additional transfers for the year between the funds and accounts involved as appropriate.

FY 1998: The Medicare program's transfer is calculated using the IME formula at 6.0 percent.

FY 1999: The Medicare program's transfer is calculated using the IME formula at 5.6 percent.

FY 2000: The Medicare program's transfer is calculated using the IME formula at 5.3 percent.

FY 2001: The Medicare program's transfer is calculated using the IME formula at 5.0 percent.

FY 2002: The Medicare program's transfer is calculated using the IME formula at 5.0 percent.

*Note: The projected annual Medicare IME transfer for its fee-for-service patients would be directly related to the extent to which national MedicarePlus enrollment increases. That is, each year the Medicare program would make its transfer to the Medicare Indirect Costs Medical Education Account based on the number of enrollees who remain in the fee-for-*

*service payment system and who receive inpatient hospital services that are paid under the prospective payment system. As Medicare beneficiaries leave the fee-for-service system and join MedicarePlus plans or participate in Medical Savings Accounts, which would pay hospitals for inpatient services using methods other than the prospective payment system, the Medicare program's transfer to this account and to the Medicare Direct Costs Medical Education Account would diminish.*

#### **How the Money in this Account Would Be Distributed**

FY 1996: Hospitals receive Medicare IME payments for their fee-for-service discharges using the 6.7 percent rate and the current methodology in the prospective payment system.

FY 1997-FY 2002: Hospitals would receive Medicare IME payments using the IME formula in effect for the applicable fiscal year.

### **5. The Medicare Direct Costs Medical Education Account**

#### **How this Account Would Be Funded**

FY 1996: The Medicare program makes DGME payments subject to the payment policy changes described below.

FY 1997: The Medicare program would make a transfer to this account each fiscal year. Beginning in FY 1997, the transfer would be based on what the Secretary estimates the program would have paid hospitals in that year for direct graduate medical education (DGME). If the Secretary determines that the amount transferred is insufficient for making payments, the Secretary must make additional transfers for the year between the funds and accounts involved as appropriate. The estimated amount would be based on each hospital's per resident payment amount, but rules for counting full-time equivalent (FTE) residents would be subject to the following policy changes:

- FY 1996-FY 2002: The number of residents would be capped at the number of full-time equivalent (FTE) residents in approved medical residency training programs (allopathic and osteopathic) as of August 1, 1995. The Secretary must adjust the total payment each fiscal year so that the total payment does not exceed the amount that would have been paid if the number of residents had not exceeded the number of residents as of August 1, 1995. Programs that reduced or did not expand the number of FTE residents would not be subject to the payment reduction.
- FY 1998-FY 2002: Beginning in FY 1998, payments for residents who have completed the initial residency period, or five years (whichever occurs first), would be reduced from 0.5 to 0.25. There would be an exception of up to two additional years for residents in geriatrics and preventive medicine.

*Note: As in determining the Medicare program's transfer to the Medicare Indirect Costs Medical Education Account, the transfer amount to this account depends on the number of beneficiaries who remain in the fee-for-service payment system and who receive inpatient*

*care. This occurs because the Medicare Direct Costs transfer calculation is based on the program's fee-for-service patients' share of total inpatient days. As Medicare beneficiaries leave the fee-for-service system and join Medicare Choice Plans or participate in Medical Savings Accounts, which would pay hospitals for inpatient services using other methods, the Medicare program's transfer to this account would diminish.*

#### **How the Money in this Account Would Be Distributed**

**FY 1996:** Hospitals would receive DGME payments based on the payment policy changes described above.

**FY 1997-FY 2002:** Each hospital would receive a payment from this account. Qualifying graduate medical education consortia also could receive payments from this account. Payments to hospitals would be based on the Secretary's annual estimate of what would have been paid to hospitals under the new payment policies (see above).

*Note: The Secretary would estimate payment rates for a consortium using a per resident cost methodology that would take into account its direct costs in carrying out graduate medical education.*

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Prepared by Linda E. Fishman, Associate Vice President, AAMC. November 27, 1995.



# NEWS

*For further inquiry, contact American Association of Retired Persons • Communications Division  
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**AARP STATEMENT  
ON THE BUDGET RECONCILIATION ACT OF 1995  
November 16, 1995**

The American Association of Retired Persons (AARP) remains very concerned about the magnitude of reductions to Medicare and Medicaid contained in the conference report to the Budget Reconciliation Act. While the report includes some further improvements, Congress still has a long way to go.

The Association is pleased that the Medicare Part-B deductible remains at \$100 a year, as in the House bill. But the total cuts to Medicare and Medicaid over seven years are still too much, too fast, and enforcement of nursing home quality standards has been further weakened in the report.

Four hundred billion dollars in cuts from these two major health care programs that serve older and low-income Americans do not meet the fairness test. Reductions in Medicare called for in the conference report are much more than is necessary to keep the program solvent into the next decade.

Millions of American families depend on Medicare and Medicaid for their basic health care coverage, for protection against the high cost of long-term care and for financial security. These protections, for Americans of all ages, are now at risk.

Cutting \$164 billion from Medicaid over the next seven years is far more than the program can shoulder. Frail, older Americans, most of whom are single, elderly women who have worked hard all of their lives, and children from low-income families would be the hardest hit by such drastic cuts.

At this juncture in the budget debate, it's a shame that a veto is necessary, but unfortunately, there is no other alternative. AARP will continue to work with Congress and the Administration to get fair legislation that ensures future Medicare solvency and reduces the federal budget deficit.

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For additional information, please contact Susan Schauer at 202/434-2560.