

THE DOLE-GINGRICH BUDGET PUT HOSPITALS AT RISK

AARP:

- In June, 1995, AARP wrote: "Spending cuts could limit access to providers. [M]any hospitals across the country -- particularly in rural areas -- would be forced to close." [AARP, 6/29/95]
- In June, 1995, AARP wrote: "[The] Congressional Budget Resolution Could Devastate Medicare Beneficiaries." Dole voted for this budget resolution which cut Medicare by \$270 billion -- same as the vetoed budget. [AARP, 6/29/95]
- In November, 1995, AARP wrote that the Dole-Gingrich \$400 billion cuts from Medicare and Medicaid "[D]o not meet the fairness test." [AARP, 11/16/95]
- In November, 1995, AARP wrote that under the Dole-Gingrich budget, existing Medicare and Medicaid protections against the high cost of long-term care, "are now at risk" [AARP, 11/16/95]

AHA:

- In summer, 1995, the AHA ran newspaper advertisements saying "Medicare is being reduced... But not only seniors -- everyone will feel the impact... Needed hospitals in rural or inner-city communities could be forced to shut their doors, period."
- In October, 1995, AHA wrote a letter to Senator Dole saying the Dole Medicare cuts would mean: "[R]educations of that magnitude would result not in a reduction in the rate of growth, but in a real cut. That means per beneficiary spending for hospital care grows less than the rate of inflation." [AHA, 10/16/95]
- In November, 1995, AHA wrote: "Reductions of this magnitude represent a real cut in payments to hospitals, not simply a reduction in the rate of increase. Quality and availability of care will be adversely affected....Particularly hard hit will be communities with hospitals serving a large proportion of Medicare and Medicaid patients....Almost 700 of the most vulnerable hospitals derive two thirds or more of their net patient revenue from Medicare and Medicaid." [AHA, 11/95]



Liberty Place
325 Seventh Street, N.W.
Washington, DC 20004-2802

Office of the President

One North Franklin
Chicago, Illinois 60606

October 16, 1995

The Honorable Bob Dole
United States Senate
141 Hart Senate Office Building
Washington, DC 20510

Dear Senator Dole:

You and your Senate colleagues are about to make public policy decisions of truly historic proportions. Your debate and action on the Fiscal 1996 budget reconciliation bill, particularly where Medicare is concerned, will affect the lives of all Americans.

That's why the American Hospital Association, on behalf of its 5,000 members in the community delivering care every day, wants to make you aware of a report by Lewin-VHI, a respected research firm. It analyzes the effect of Medicare spending reductions on hospitals.

The bill now before the U.S. Senate calls for reductions of \$86 billion in hospital services. The principal finding of this analysis is that reductions of that magnitude would result not in a reduction in the rate of growth, but in a real cut. That means per beneficiary spending for hospital care grows less than the rate of inflation.

Repeatedly, the American people have been assured that the Medicare program would not suffer real cuts. This is a promise that must be kept. Eighty six billion dollars in reductions will seriously jeopardize the ability of the hospital community to continue to provide high quality care, not only to seniors, but to all our citizens. This is the potential impact of the current Senate proposal.

In its conclusion, Lewin-VHI, Inc., states: "The potential for payment reductions to result in real decline in hospital spending over the next seven years should indicate to policymakers the need to carefully consider the impacts of potential Medicare changes on the different categories of health care providers."

This is what the nation's hospitals ask of you and your colleagues in the critical days ahead.

Sincerely,

John Davidson

MEDICARE AND MEDICAID ARE IMPORTANT TO HOSPITALS

- For nearly one in four hospitals, 60% of patient days are Medicare patient days.
- More than 2,300 hospitals (nearly half) have large Medicaid patient loads (15% or more of their inpatient days).
- ^{//} Almost 700 most vulnerable hospitals derive two thirds or more of their net patient revenue from Medicare and Medicaid -- about 300 of these hospitals derive three quarters or more of their net patient revenue from Medicare and Medicaid.
 - ✓ Nationally, these hospitals represent 13 percent of all hospitals, providing 9 percent of hospital stays including all patients not just Medicare and Medicaid, and contributing 11 percent of all emergency room visits.
 - ✓ 56 percent of these highly vulnerable hospitals are rural; 20% are inner-city hospitals.

Source:

American Hospital Association analysis based on data from the 1993 AHA Annual Survey and the Medicare Provider Specific file.

DEAR MEMBER OF CONGRESS

WHAT WILL YOU TELL YOUR VOTERS IF YOU TAKE \$250 BILLION OUT OF THEIR MEDICARE?

*Some in Congress want to reduce Medicare by more than
\$250 billion over seven years.*

With the largest Medicare reductions in history on the table, now might be a good time to consider how you're going to explain a vote to damage the Medicare system.

Who will be hurt the most? Certainly seniors will be harmed, because their Medicare is being reduced — again. But not only seniors — *everyone* will feel the impact if community hospitals have to reduce their services or close their doors.

A new study by Lewin-VHI, one of the nation's top research firms, finds that with reductions of \$250 billion, Medicare could be paying less than 89 cents on the dollar of an elderly patient's stay in the hospital seven years from now.

WHAT WILL HAPPEN TO HEALTH CARE?

These reductions will mean:

- Money-losing but crucial services like trauma care, burn units and ICUs may have to be closed.
- Senior citizens will find it harder to receive the level of care they need as they grow older.

- New life-saving technology that people need could be delayed.
- Innovative community outreach programs that help millions of Americans could get trimmed.
- Needed hospitals in rural or inner-city communities could be forced to shut their doors, period.

Hospitals are successfully controlling costs, but these reductions go beyond what is reasonable. They're going to hurt—not just folks on Medicare, but anyone who may need the high quality care that only a hospital can give. And that will leave some very important people—your voters—looking for answers.

What will you say? We urge you to tell them that you Reject proposals to reduce Medicare!

Dick Davidson

Dick Davidson, President

AHA American Hospital Association

TOO MUCH, TOO FAST

The Impact on Older Americans of Medicare and Medicaid
Reductions in the FY'96 Budget Resolution

Prepared by the
American Association of Retired Persons
June 29, 1995

For further information contact:

Tricia Smith

AARP Federal Affairs Department Health Team
(202)434-3770

- At the highest income categories, beneficiaries would pay triple the amount they now pay for the Part B premium. If the income thresholds for the proposed high-income premium are not indexed, each year a greater percentage of Medicare beneficiaries would be required to pay the new, higher premium. In the future, Congress could simply choose to lower the income threshold, thereby increasing revenues.
- At the same time that an income-related premium would be imposed on Medicare beneficiaries, federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies come in the form of the tax deduction for employer-provided health insurance. As a result of the savings target under the Budget Resolution, Congress could impose higher health costs on higher-income older Americans but would continue federal subsidies for corporate executives, middle-aged millionaires, and Members of Congress. A May, 1994 Price Waterhouse analysis estimated that reducing federal subsidies for higher-income individuals under age 65 in the same manner as for Medicare beneficiaries would result in federal budget savings that are four times as large as the Medicare income-related premium savings.

7) *Beneficiary Access to Care could be Jeopardized*

Medicare beneficiaries' access to needed health care could be seriously hurt by the unprecedented reductions in Medicare spending included in the FY 96 Budget Resolution. For the average older American, the \$270 billion in Medicare spending reductions will mean:

- **Increased Out-of-Pocket Costs That Could Limit Access to Services:** For the average beneficiary, the proposal to reduce Medicare spending could cost about \$3,400 more out-of-pocket over the next seven years in the form of higher premiums, coinsurance and deductibles. For many beneficiaries — particularly those with low incomes — the additional costs are on top of the \$2,750 they already pay out-of-pocket for health care in 1995. Older Americans spend roughly 20 percent of their income on health care — nearly three times as much as those under age 65. Increasing out-of-pocket costs could mean that fewer beneficiaries would be able to afford the care they need and many would be forced to wait until a condition worsens and care is even more expensive.
- **Spending Cuts That Could Limit Access to Providers:** As physician payments are reduced, many doctors will try to shift more costs onto Medicare beneficiaries. One likely way for this to happen is through the elimination of the Medicare balance billing limits. This change would allow doctors to charge beneficiaries significantly more than what Medicare approves. If this happens, many older Americans would no longer be able to afford to see their doctors. In other

cases, physicians may find that it is no longer profitable to treat Medicare patients, leaving beneficiaries without access to a doctor. Still other beneficiaries may have to travel long distances for hospital care since many hospitals across the country — particularly in rural areas — would be forced to close.



- **Spending Cuts That Could Limit Access to Health Plans:** The level of spending reductions included in the Budget Resolution could result in substantially higher premiums for beneficiaries who choose to remain in traditional fee-for-service Medicare. Some beneficiaries might no longer be able to afford to stay in fee-for-service and would be forced into managed care.

8) *Medicare Caps could be Imposed*

- **Structure**

Members of Congress are considering a Medicare spending "cap" as one method for achieving budget savings. Under this approach, yearly spending limits or targets would be established for the Medicare program. This cap could take one of several forms: a total spending limit for the program, a limit on the annual growth rate in the program; or a per capita spending limit. The cap could be fixed in law or determined on a yearly basis.

Annual Medicare spending would then be measured against the cap. Under one approach, known as a "look-back," actual Medicare spending would be compared with the target at the end of each year. If actual spending exceeded the target, then Medicare spending for the following year would be reduced by the amount exceeding the target.

- **Impact on Beneficiaries**

A Medicare cap would have a direct bearing on Medicare beneficiaries. If Medicare spending exceeds the yearly cap, automatic cuts in Medicare spending would likely translate into higher out-of-pocket costs for Medicare beneficiaries — in the form of higher premiums, coinsurance or deductibles — as well as reductions in payments to hospitals and doctors which would affect beneficiary access to services.

Advocates of a Medicare cap claim that this kind of target is necessary to keep program spending in check. However, for the average beneficiary — who has little control over Medicare program spending — this would mean an even greater out-of-pocket burden for Medicare services.

⁽¹⁾ This analysis is based on the June 22, 1995 Budget Resolution Conference Agreement.

⁽²⁾ Increased out-of-pocket costs are averaged across all Medicare beneficiaries.

⁽³⁾ Out-of-pocket health costs include all health care expenses of non-institutionalized older individuals except those paid by Medicare. Medicare and private premiums, and prescription drugs, for example, are considered out-of-pocket costs. Data are based on December, 1993 CBO projections of population subgroups and National Health Accounts data by type of service and payer.

MEMORANDUM

October 15, 1996

TO: Evelyn Lieberman
Ron Klain
Greg Simon

FROM: Chris Jennings

SUBJ: AARP on Republican Medicare Cuts

Attached is background material (provided to Leon and Gene) to respond to AARP's intention to write a letter to the Vice President about his comments on Medicare on "Meet the Press."

Enclosed please find:

- AARP's characterization of the Republican Medicare cuts;
- AARP's explicit use of the word "devastate";
- RNC press release in which Haley Barbour suggests that AARP affirmed the Republicans' contention that there were no cuts in their Medicare proposal;
- Transcript from "Meet the Press"; and a
- Memorandum to Leon Panetta on this issue.

I hope this information is helpful. If you have any questions, please call me.

AARP QUOTES ABOUT REPUBLICAN MEDICARE CUTS

- "Congressional Budget Resolution Could *Devastate* (emphasis added) Medicare Beneficiaries." [Source: AARP Impact Analysis: "Too Much, Too Fast," June 29, 1995].
- "This Fiscal Year 1996 (FY96) Budget Resolution proposes to take nearly half of the deficit reduction of the next 7 years out of Medicare and Medicaid. In both programs these are the largest cuts ever proposed, and in Medicare the proposed cuts are far more than what is needed to keep the program solvent for the next decade." [Source: AARP Impact Analysis: "Too Much, Too Fast," June 29, 1995].
- Congress has proposed unprecedented reductions in Medicare spending as part of the FY 96 Budget Resolution. The proposal would reduce Medicare by \$270 billion over the next seven years. These reductions are nearly three times as large as the reduction enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). [Source: AARP Impact Analysis: "Too Much, Too Fast," June 29, 1995].
- "Spending Cuts That Could Limit Access to Providers: ...beneficiaries may have to travel long distances for hospital care since many hospitals across the country -- particularly in rural areas -- would be forced to close." [Source: AARP Impact Analysis: "Too Much, Too Fast," June 29, 1995].
- "The Senate voted to cut approximately \$440 billion from Medicare and Medicaid over the next seven years. Such cuts from the two major health programs that serve older and low income Americans are too much too fast....The proposal passed by the Senate would cut approximately \$270 billion from Medicare, much more than is necessary to keep the program solvent. AARP believes that less drastic changes are needed to assure solvency and stability in Medicare for the next decade." [Statement by Horace B. Deets on Senate vote to balance the budget, October 27, 1995].
- "...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..." [Source: "AARP Statement on the Budget Reconciliation Act of 1995," November 16, 1995].
- "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." [Source: "AARP Statement on the Budget Reconciliation Act of 1995," November 16, 1995].
- "Four hundred billion dollars in cuts from these two major health care programs (Medicare and Medicaid) 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." [Source: "AARP Statement on the Budget Reconciliation Act of 1995," November 16, 1995].

TOO MUCH, TOO FAST

The Impact on Older Americans of Medicare and Medicaid
Reductions in the FY'96 Budget Resolution

Prepared by the
American Association of Retired Persons
June 29, 1995

For further information contact:
Tricia Smith
AARP Federal Affairs Department Health Team
(202)434-3770

Introduction

Older Americans support deficit reduction and they want a strong economy for their children and grandchildren. But they also understand that financial security — for themselves and their families — is dependent upon adequate and affordable health care coverage.

AARP believes that deficit reduction should be fair and balanced. We should strive to keep our economy on a steady path of deficit reduction, but we should not jeopardize the Medicare and Medicaid programs and the financial security they provide in the process.

The Fiscal Year 1996 (FY96) Budget Resolution proposes to take nearly half of the deficit reduction of the next 7 years out of Medicare and Medicaid. In both programs these are the largest cuts ever proposed, and in Medicare the proposed cuts are far more than what is needed to keep the programs solvent for the next decade.

As Congress struggles to meet its arbitrary deficit reduction deadlines and targets, hasty and ill-considered policy decisions are almost inevitable. Medicare and Medicaid beneficiaries will end up paying out-of-pocket what the programs will no longer pay.

The Medicare and Medicaid programs are not perfect. Changes are appropriate. Indeed, they must begin this year. A better approach recognizes that the Medicare and Medicaid programs will need to adapt to changing needs and budgetary constraints. But these changes should be carefully thought out, with considerable input from beneficiaries who understand fully what these changes will mean for them and for their children and grandchildren.

CONGRESSIONAL BUDGET RESOLUTION COULD DEVASTATE MEDICARE BENEFICIARIES

Congress has proposed unprecedented reductions in Medicare spending as part of the FY96 Budget Resolution. The proposal would reduce Medicare by \$270 billion over the next seven years. These reductions are nearly three times as large as the reduction enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA93).⁽¹⁾

This document describes illustrative increases in beneficiary out-of-pocket costs under the resolution and the impact these cuts would likely have on the average older American.

How Much More Will Beneficiaries Pay?

- AARP estimates that these proposals to reduce Medicare spending would mean that the average Medicare beneficiary would pay approximately \$3,400 more out-of-pocket over the next seven years (see Chart 1).⁽²⁾ Estimates are based on the assumption that one-half of proposed Medicare spending reductions come from beneficiaries.

What Are Beneficiaries Paying Already?

- In 1995, the average older beneficiary will spend about \$2,750 out-of-pocket to cover the cost of Medicare premiums, deductibles, coinsurance and the cost of services not covered by Medicare — like prescription drugs and preventive care. This does not include the enormous cost of nursing home care, which is nearly \$40,000 a year. Even without any changes in Medicare, these older beneficiaries are already projected to spend more than \$25,500 out-of-pocket for health care costs over the next 7 years.⁽³⁾ Under the Budget Resolution, an average beneficiary would end up spending a total of about \$29,000 over seven years — an increase of about \$3,400.

How Will Beneficiaries Be Affected?

- To achieve the Medicare spending reductions in these proposals, costs that are currently paid by the Medicare program would probably be shifted to Medicare beneficiaries in the form of higher premiums, deductibles and coinsurance.

RNC News Release

Clinton Debate Strategy?
When cornered, don't tell the truth
Statement By RNC Chairman Haley Barbour

October 7, 1996

After watching the debates last night, it's clear why polls show the American people don't trust Bill Clinton. Time and again, Clinton tried to deceive the voters with charges that were just plain false. Here are two examples:

Clinton claimed Dole and Speaker Gingrich had "cut" Medicare when, in fact, even the AARP (American Association of Retired Persons) says that's not true. In a letter to Clinton dated 12/19/95, the AARP wrote that the balanced budget Congress passed and Clinton vetoed "would reduce the average annual rate of growth of Medicare benefits to 7.0 percent." The letter went on to state "the president's plan would reduce Medicare's growth rate to 7.8 percent." For Bill Clinton to claim that a 7 percent increase in Medicare is a devastating "cut", while a 7.8 percent increase in Medicare spending allows him to "protect" the program is not only absurd, it shows Clinton has no regard for the truth.

Yet it's not enough for Clinton to scare seniors with his falsehoods. He went on to claim Bob Dole had "voted against student loans." Wrong again. The balanced budget Congress passed and Clinton vetoed *increased* funding for student loans from \$24 billion today to \$36 billion in 2002 -- a 50 percent increase. According to the Congressional Budget Office, these are the exact same levels that would occur under President Clinton's student loan policies.

Somehow Bill Clinton seems to get away with these deliberate deceptions. As Senator Bob Kerrey (D-Neb.) has said; "Clinton's an unusually good liar. Unusually good" (*Esquire*, Jan., 1996). But the American people are a lot smarter than Bill Clinton gives them credit for. The truth will out, and come this election day, November 5, the American people will choose a leader whom even Democrats describe as a "man of his word" --that man is Bob Dole.

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Marty - As far as I know, you disagree w/ Barbour -- we both have

cats

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Now, you've got three things here. You've got the Dole-Gingrich plan, you've got this plan, which is a retreat from that, and then you've got the Dole plan, which is much, much worse.

When they had \$270 billion cuts, they had to have very large increases in premiums. Senator Dole's Senate plan originally proposed a doubling of the deductible and benefit cuts.

Now that they have gone to a \$550 billion tax scheme, the results for Medicare would be absolutely devastating, and you don't have to take my word for it. The American Hospital Association, the Catholic Health Association, the Concord Coalition, "Business Week," "Time," "Newsweek," "U.S. & World Report," they've all said the consequences of this Dole plan for Medicare would be extreme.

MR. RUSSERT: But the Concord Coalition has also said that the Clinton campaign has demagogued this issue, that you, in fact, are going to, quote, "cut Medicare" as well.

VICE PRESIDENT GORE: No.

MR. RUSSERT: Recipients would be getting 7,100 (dollars); under your plan, it goes down to 57 (hundred dollars). Recipients are going to pay 42-50 a month --

VICE PRESIDENT GORE: (Inaudible, crosstalk.)

MR. RUSSERT: The fact is, something must be done about Medicare, and you're trying to make the Republicans the bogeymen, when, in fact, you are doing something very similar.

VICE PRESIDENT GORE: Not true. Not true.

First of all, there are no premium increases, there are no deductible increases, and no cuts to recipients. There are cost constraints put on providers within the context of a larger plan that does extend the life of the Medicare trust fund 10 years out into the future.

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The difference is in their approach, they've raised premiums, and they've cut benefits to recipients. And they've also proposed -- and we talked about this the last time I was on your program --

MR. RUSSERT: Right.

VICE PRESIDENT GORE: -- they have proposed a two-tier approach to Medicare that would cause it to wither on the vine. That's the speaker's phrase.

MR. RUSSERT: But you are limiting the growth of Medicare. It's now growing at 10 percent and you want to reduce that to 7 percent a year, the Republicans about 6.8 percent --

VICE PRESIDENT GORE: Through constraints on providers. On providers, not on recipients.

MR. RUSSERT: Let me show you something the president said last year, speaking to the American Association of Retired People.

(Begin taped segment.)

PRES. CLINTON: Only in Washington do people believe that no one can get by on twice the rate of inflation. (Laughter.) So when you

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hear all this business about cuts, let me -- let me caution you that that is not what is going on. 71993

(End taped segment.)

MR. RUSSERT: "That is not what's going on." That's the president's own words, and yet, if you watch a Clinton/Gore commercial, you hear "cut, cut, cut." In fact, both parties are trying to say, "Medicare can't grow at 10 percent a year. We will go bankrupt. We have to do something," you're both trying to do something, and the differences are incremental --

VICE PRESIDENT GORE: That's not correct, Tim --

MR. RUSSERT: -- and the president just said we shouldn't use the word "cuts."

VICE PRESIDENT GORE: With all due respect, it's not correct. Where our plan is concerned -- that's what he was talking about. You're trying to make it appear that there are minuscule differences between the two approaches, and there are huge differences between the two approaches.

We want to save Medicare. We will save Medicare. They're -- Senator Dole has bragged this year about the fact that he was one of only 12 people to vote against creating Medicare in the first place. He said he knew that it wouldn't work. Well, it has worked and it will continue to work.

.ETX

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He has proposed, along with Speaker Gingrich, a fundamental redesign of Medicare that would have one system for those who are well off and another one for the rest of the country that would wither on the vine. He proposed doubling the deductible.

If the Dole plan had been enacted, if their shutdown scheme had worked, the average couple on Medicare would have already, today, been paying an extra \$268 per year. Also, over the life -- over the course of their plan, an extra \$1,700 per year.

The American Hospital Association raised the question of whether it could have caused the closing of 700 hospitals around the country. The AARP, which supported our plan -- supported our plan -- said their plan would devastate Medicare.

Now, there's all the difference in the world in these two approaches, and the fundamental reason for it -- there are two reasons. Number one, Senator Dole doesn't believe in Medicare -- I personally don't believe that. I know that in a political season, they will try to soften that, but he's bragged about voting against its creation in the first place, and the second reason is they are wedded to this \$550 billion risky tax scheme that would mandate deep, deep cuts in Medicare and in defense.

MR. RUSSERT: Bottom line, Mr. Vice President. If you're re-elected, you will have to do something about Medicare. You cannot let it continue to grow at 10 percent. You may have to raise the retirement age, you may have to increase premiums, you may have to reduce benefits, correct?

VICE PRESIDENT GORE: Tim, we have put out a budget plan, a balanced budget plan, that protects the investments in the future and that extends the life of Medicare out 10 years into the future --

MR. RUSSERT: But you shift money from one account to another and increase the deficit \$50 billion by doing it.

VICE PRESIDENT GORE: No, no, absolutely -- look, it's a balanced budget plan, verified, certified by the Congressional Budget Office, that protects Medicare, also Medicaid and investments like education and the environment, and extends the life of the trust fund.

October 15, 1996

MEMORANDUM FOR LEON PANETTA

FROM: GENE SPERLING, CHRIS JENNINGS, BILL WHITE
CC: ALEXIS HERMAN
SUBJECT: PHONE CALL TO AARP'S HORACE DEETS (202) 434-2305

BACKGROUND:

On Sunday, the Vice President was being questioned about Medicare on "Meet the Press" and said, "The AARP, which supported our plan -- supported our plan -- said their (GOP) plan would devastate Medicare." AARP, which never explicitly supported our plan, raised objections with the VP's remarks and his use of the word devastate. Yesterday, AARP stated they would be sending a letter to the VP objecting to the mischaracterization, and forwarding a copy of the letter to the Dole/Kemp campaign.

Last night, Chris had a number of frank conversations with AARP's Marty Corry. We reminded AARP that they had used the word devastate (attached). As a result, they have dropped their critique of the VP's use of devastate, and have backed away from releasing a letter until after Horace Deets (AARP's Executive Director) and you have had a conversation.

TALKING POINTS:

- o I am calling regarding the Vice President's remarks on "Meet the Press" on Sunday.
- o We regret the Vice President appeared to mischaracterize AARP's position on the President's Medicare plan. We understand your concerns, but we want you to know the reference was unintentional.
- o The VP was simply trying to say that AARP -- like us -- strongly opposed the Republicans' seriously flawed policy changes AND \$270 billion in Medicare cuts, BUT had not opposed our Medicare reforms in the Health Security Act. In fairness, your past policy statements have used words like "devastate, unfair, and drastic." [Leon: They did not oppose the Health Security Act -- and in fact supported the Mitchell plan we endorsed -- because our Medicare savings were reinvestment in prescription drug and long-term care coverage].
- o I do realize that his comments were not clear, and I assure you that I will talk with the President and the Vice President to make certain that future statements do not misstate your position.
- o Horace, it would be extremely upsetting to us if you sent out a letter on this issue. If you release a letter a day before the debate, the GOP will use AARP's good name to defend the Republicans' political rhetoric. The way to handle concerns such as those you raise are through conversations like these.

NOTE: If AARP insists on issuing a letter, you should demand that a similar and simultaneously sent letter goes to Haley Barbour to critique his distortion of AARP's position on "cuts." (See attached).

**POINTS ON THE CONCORD COALITION'S STATEMENT ON THE VICE PRESIDENT'S
REMARKS ON MEDICARE ON NBC'S "MEET THE PRESS, OCTOBER 11, 1996**

THE VICE PRESIDENT SAID THE FOLLOWING ON MEET THE PRESS:

- "When they had \$270 billion cuts, they had to have very large increases in premiums. Senator Dole's Senate plan originally proposed a doubling of the deductible and benefit cuts. Now that they have gone to a \$550 billion tax scheme, the results for Medicare would be absolutely devastating, and you don't have to take my word for it. The American Hospital Association, the Catholic Health Association, the Concord Coalition, *Business Week*, *Time*, *Newsweek*, *US News & World Report*, they've all said the consequences of this Dole plan for Medicare would be extreme." [Meet the Press, 10/13/96]

**THE CONCORD COALITION HAS REPEATEDLY STATED THAT DOLE'S UNSPECIFIED
DISCRETIONARY CUTS ARE NOT CREDIBLE AND THAT HE WOULD HAVE TO CUT
ENTITLEMENTS (SUCH AS MEDICARE) MORE:**

While it is true the Concord Coalition did not explicitly mention Medicare as one of the programs Senator Dole would have to cut further to pay for his risky \$550 billion tax scheme, the Concord Coalition has repeatedly made clear that Dole's cuts in discretionary spending are not credible, and would therefore require additional cuts in entitlement programs, explode the deficit, or both:

- **The Concord Coalition Stated That Dole Would Not Tell Voters About His Painful Cuts Until After The Election.** "The Dole people will maintain with straight faces from now until November that the necessary cuts will be anonymous, painless reductions that will not affect you or anyone you know." [Martha Phillips, Executive Director, The Concord Coalition, *New York Times*, 8/20/96]
- **The Concord Coalition Clearly Wrote That Dole's Plan Would Not Work Without Deeper Entitlement Cuts.** "Can't we offset any revenue loss by cutting federal spending? Possibly, but not by following the Dole Plan's strategy, which promises to derive nearly all the needed savings from unspecified cuts in "discretionary" outlays." [Concord Coalition, Facing Facts Alert #21, 8/16/96]
- **The Concord Coalition Wrote That Dole's Plan Couldn't Work Without Deeper Entitlement Cuts.** "Congress would have to slash this [domestic discretionary] spending while phasing in large tax cuts and while leaving the vast and still-growing senior-citizen entitlement edifice (in Dole's words) 'off the table.' It's hard to see how leaders like Dole and Jack Kemp...could square this circle." [Concord Coalition, Facing Facts Alert #21, 8/16/96]
- **The Concord Coalition Stated That Dole's Plan Will Not Work.** "This will not work. *It will blow a gigantic hole* in the budget and it will set us back rather than lead us forward." [Martha Phillips, ABC News, 8/4/96]
- **The Concord Coalition Labeled Dole's Spending Cuts "Impossible"** "[The Dole plan's] proposed outlay cuts are politically if not mathematically impossible." [Concord Coalition, Facing Facts Alert #21, 8/16/96]
- **The Concord Coalition Wrote That Under The Dole Plan:** "most public services to the young and poor will have to be defunded entirely." [Concord Coalition, Facing Facts Alert #21, 8/16/96]

OTHER EXPERTS AGREE THAT DOLE'S PLAN WOULD REQUIRE DEEPER MEDICARE CUTS:

- **The Economist.** 83% of Economists polled by the *Economist* magazine said that Dole's plan would not work without deeper cuts in Medicare and defense. [*Economist*, 10/5/96]
- **Dole Campaign Steering Committee Co-Chair, Republican Senator Al D'Amato.** "You can't just be cutting all of discretionary spending.... I think we're gonna have to look at -- for example the COLA increases that we automatically give to people who retire and (the) federal retirement system.... You're gonna have to look at Medicare.... I would never say it if I were him [Dole] until after the election. No way. No way. Absolutely I mean I'm not running this year so I can say it and tell the truth." [Don Imus Show, 8/12/96]
- **Business Week:** "Where on earth does he come up with that kind of dough...? From popular programs, such as Medicare and environmental protection. But candidate Dole knows it's bad politics to admit that now." [8/19/96]

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WIRE SLUG STORY FROM MOVED TIMING
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NBC "MEET THE PRESS"
WITH HOST: TIM RUSSERT
GUESTS:
VICE PRESIDENT AL GORE
SUNDAY, OCTOBER 13, 1996

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PLEASE CREDIT ANY QUOTES OR EXCERPTS FROM THIS NBC PROGRAM TO "NBC'S MEET THE PRESS."

MR. RUSSERT: Mr. Vice President, welcome back to "Meet the Press."

VICE PRESIDENT GORE: Good morning. Good to be here.

MR. RUSSERT: Here are the headlines this morning: "Kemp shifts tax, slams half-truth; he lists scandals in radio address."

I want you to listen to, and our viewers listen to, Jack Kemp on the radio yesterday.

(Begin taped segment.)

MR. KEMP: The words that seem to characterize the ethics of this administration are words like "Travelgate," "Filegate," "independent counsels," and "possible presidential pardons." These problems add up to a pattern that is sad and troubling to all Americans, Democrat, Republican, and independents, an arrogance of power, the avoidance of responsibility, the habit of half-truths.

(End taped segment.)

MR. RUSSERT: Your reaction to Mr. Kemp?

VICE PRESIDENT GORE: Well, I think it's unfortunate that he would succumb to the intrigues of the camp within the Dole campaign which has been urging him to take this kind of low-road attack. I think that's unfortunate. They pledged they would not do that, and they just flip-flopped on that, and that's characteristic, incidentally, of what Senator Dole has done on supply-side economics, what Jack Kemp did on affirmative action.

The large questions such as the economic policy our country should pursue are ones that Senator Dole has just completely flip-flopped on, and, of course now, you're seeing his advisers just pushing both Jack Kemp and Bob Dole to do what you saw and heard --

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MR. RUSSERT: Is this a sign of desperation, do you think?

VICE PRESIDENT GORE: Yes, I do. I really do. I think that -- I think he wouldn't be doing that otherwise.

MR. RUSSERT: But isn't -- isn't character a fair issue to bring up? Why can't the Republicans say, "Listen, Bill Clinton promised, quote, 'the most ethical administration in history,' and it hasn't been that. Filegate. Travelgate. Whitewater." What's wrong with those as legitimate issues?

VICE PRESIDENT GORE: Well, first of all, what Jack Kemp said was that these kinds of attacks are beneath Bob Dole and they ought to be beneath Jack Kemp also. Senator Dole was asked by Jim Lehrer during the first presidential debate, okay, here's your chance in front of a hundred million people, are there any of these things that you have the guts to bring up in the debate? And Senator Dole said, "Oh, no. No, no. I'm not comfortable talking about that kind of thing."

And the reason is the American people want to hear about the

Clinton: Do you believe that?

VICE PRESIDENT GORE: Well, we've tried to just cooperate fully with everything that his investigation has asked for. We'll continue to do that, and we've tried to kind of stay arm's length from the criticism of that institution. Instead, we've tried to cooperate with it.

But let me repeat, overall this is a politically motivated investigation by Senator Dole with his campaign chairman put in charge of it. 60 hearings on Whitewater compared to one hearing on Medicare.

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The general counsel was brought into the campaign. It's really outrageous.

MR. RUSSERT: Is Kenneth Starr, the independent counsel, politically motivated?

VICE PRESIDENT GORE: Well, I tried to say just a moment ago that we believe that the best approach to that investigation is to try to cooperate fully, give them everything they ask for, and then, you know, try to keep kind of arm's length from that.

MR. RUSSERT: There have been, in your opinion, no ethical lapses in the Clinton administration?

VICE PRESIDENT GORE: In every administration in history there have been problems that have cropped up. There's been no exception to that.

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I will say that I think that the ethical standards established in this White House have been the highest in the history of the White House.

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You have a tougher code of ethics, tougher requirements strictly abided by.

And look at all this Whitewater stuff. What's come out of it? Absolutely nothing, after five years, tens of millions of taxpayers' dollars, absolutely nothing, and nothing will.

MR. RUSSERT: What if there were indictments before the election by Mr. Starr? How would that play politically?

VICE PRESIDENT GORE: Well, you know, you're talking about a hypothetical that I would reject from the get-go there. That's not going to happen. But I, you know, I can't tell you what they might -- what somebody might try to do, but that's not going to happen.

MR. RUSSERT: Let me raise another issue regarding ethics that has been in "The Wall Street Journal," Knight-Ridder newspapers, "The Washington Post," "The LA Times," "The New York Times," and that is contributions of foreign nationals to the Clinton/Gore campaign.

One of the examples cited is a fellow named John Wong (sp), who was -- he worked for Lippo (sp) Company. Then he went to work for the Commerce Department. Then he went to the Democratic National Committee. He is now raising money, close to \$4 million from foreign nationals for your campaign. One of these groups, the Lippo (sp) Company and some individuals, gave \$425,000, even though they live in Indonesia. And they are saying -- and Newt Gingrich just yesterday said that same Lippo (sp) Company got a billion-dollar power plant in China, coincidentally, because of (sic) the Commerce Department had lobbied on their behalf.

Why is the Clinton/Gore campaign taking money from Lippo (sp) Company and individuals associated with it when, in fact, it was an individual who had worked for them, who worked for the Commerce Department, and is now a fundraiser for the DNC?

VICE PRESIDENT GORE: Well, some of the facts as you have strung them together there give an incorrect impression. Number one, we have strictly abided by all of the campaign finance laws, strictly. There've been no violations. Senator Dole's campaign has already been cited a couple of times.

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MR. RUSSERT: But you have to return a \$250,000 from some South Koreans because it was illegal.

VICE PRESIDENT GORE: In every campaign, when you look at, you know, every single contribution that comes in, I'm sure you couldn't find a single campaign where there wasn't a time where the treasurer said, "Wait a minute, you know, this one has to be sent back" or whatever.

There've been no violations of law, no violations of the regulations. We've strictly complied with every single one of them.

Now, the -- there is a difference between a legal resident of the United States who complies with all the laws, lives here, works here, et cetera. Under the law, as it exists, that is perfectly legal.

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Now -- now, let me follow this up by saying that we have fought hard for campaign finance reform. The president supported the McCain-Feingold bill, authored -- co-authored by Senator John McCain, who is a strong supporter of Senator Dole. Senator Dole stopped that legislation. There was some bipartisan support for it. I will acknowledge that there was some opposition in both parties, but the Democratic Party was prepared to go forward and tried to go forward under President Clinton's leadership. The Republicans in the United States Senate held up campaign finance reform.

And in the House of Representatives, of course, President Clinton went to New Hampshire to debate Newt Gingrich a year ago, and they shook hands publicly in front of a crowd there, at the suggestion of a resident who recently passed away up there, who said, "Why don't you have a bipartisan commission on this?" They shook hands. The president appointed his individuals to the commission, said, "Let's go forward," and the speaker stonewalled, held back, and played political games with it.

And so this whole issue is one that we have tried to address in a responsible and vigorous way, and they have filibustered it.

MR. RUSSERT: But what about the appearance, Mr. Vice President, of a gentleman, John Wong, working for a company, Lippo (sp) Company, then joining the Commerce Department, where he works on their behalf, lobbies on their behalf, then goes over to the DNC and raises money from them -- I mean, there's an appearance there that does not set well with the American public.

VICE PRESIDENT GORE: Well, again, there have been absolutely no violations of any law or regulations, and there -- there is nothing that has been done that's wrong.

MR. RUSSERT: Knight-Ridder said that you visited a representative of the Lippo (sp) Company in a hospital room on behalf of the president. Did you?

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VICE PRESIDENT GORE: No, that's not true.

MR. RUSSERT: Never happened?

VICE PRESIDENT GORE: Never happened.

MR. RUSSERT: Did you --

VICE PRESIDENT GORE: What did they say --

MR. RUSSERT: -- did you have any meetings with the Lippo (sp) Company officials --

VICE PRESIDENT GORE: No.

MR. RUSSERT: -- or investors in Lippo (sp) Company --

VICE PRESIDENT GORE: No.

MR. RUSSERT: -- who were involved in this?

VICE PRESIDENT GORE: I remember when that thing came out. I said, "What in the world is this?" There's absolutely no truth to that whatsoever. I don't know.

MR. RUSSERT: If you could change the law, would you ban foreign nationals from giving contributions to American political campaigns?

VICE PRESIDENT GORE: I think there are a lot of changes in the campaign finance laws that ought to be examined. I think that a bipartisan commission is a good idea. We have fought for it and we've fought for our own campaign finance reform bill, and all these ideas ought to be considered.

MR. RUSSERT: Now, Newt Gingrich yesterday said that based on some of the policies of the Clinton administration -- this is a quote. "Under the Clinton administration, you can come to America illegally, sneak into the country, announce that you're HIV positive, be declared

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a political refugee, and be eligible for \$120,000 in health benefits."

VICE PRESIDENT GORE: Well --

MR. RUSSERT: Is that factually true?

VICE PRESIDENT GORE: I don't believe it is. The -- but, you know, Speaker Gingrich has -- when he got his chance to run the Congress, he shut down the government, tried, along with Senator Dole, to push past the American people an agenda that included many extremist measures that would have devastated Medicare, that would have ended the nursing home standards, would have eliminated the guarantee of health care to poor children.

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Then he came on your program several months ago, after the Dole-Gingrich budget was transformed into Senator Dole's campaign proposal -- the central issue facing the country, where is the economy going -- and he said that he and Senator Dole would have that budget verified by the Congressional Budget Office. They called upon us to do that last year, and we complied with their request, and the Congressional Budget Office, nonpartisan, said, "Your budget is in balance while it protects these important investments.

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Then, when he put out his proposal, Senator Dole has refused to verify it. They keep saying, "We trust the American people." Ronald Reagan used to say, "Trust, but verify."

Now, I would like to, on this program today, formally call upon Senator Dole to submit his budget plan to the Congressional Budget Office and ask for a response before the election.

Speaker Newt Gingrich said -- "absolutely," was the word he used -- that he would do that, on this program.

Now, Mr. Kemp is on one of the other programs this morning. I hope that he will accept this challenge to verify their budget plan. Mr. Gingrich is on one of the other programs this morning. I hope he will be asked why has he broken his pledge to submit Senator Dole's budget plan to the Congressional Budget Office to have it verified.

MR. RUSSERT: Why don't the Democrats introduce his plan, the Dole plan, as a formality and ask for a CBO estimate?

VICE PRESIDENT GORE: Well, Mr. Gephardt, Congressman Gephardt and Senator Daschle, asked the CBO, and the CBO said that it would have to be introduced as a plan by somebody who supported it so that it would be eligible to be verified.

And you asked Speaker Gingrich, "Will you do that?" Speaker Gingrich said, "Absolutely. We'll do that. You can count on it." Well?

You know, remember this, Tim: The reason the government was shut down twice was partly because of their demand that the president's budget plan be verified by the CBO, the Congressional Budget Office, as being in balance. They did not reopen the government until the CBO said, "Yes, the president's plan is in balance."

Now that their plan is presented, they're refusing to take their own advice, refusing to live up to their own pledge.

Now, let me cut through this. There's no secret why they have refused to try and verify it, because their numbers do not add up. They do not even come close to adding up.

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Senator Dole's plan would blow a hole in the deficit, a huge hole in the deficit, driving up interest rates, driving up car payments, driving up home mortgage payments, stalling out the recovery, throwing us back into recession, raising unemployment, and causing much, much deeper cuts in Medicare and Medicaid, education, and the environment than were caused even by the Dole-Gingrich plan of a year ago.

MR. RUSSERT: I want to get to Medicare and the budget, but let me just close up this whole ethical question. It's not just Republicans who have been concerned about it. I want to show you a tape of Ross Perot earlier this week in San Francisco, making a comment.

(Begin videotaped segment.)

MR. PEROT: Can you believe that we have a president who has a

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number of associates who have gone to jail on financial issues that he was allegedly connected to, and he will not look the American people in the eye and say, "If you re-elect me as president, I will not use that power to pardon my friends, because if I don't, they're going to talk about me and do a plea bargain"?

Now, is it -- let me ask you, is it asking too much of the president to promise that he won't do that? I hope not. I hope not. (Applause.)

(End videotaped segment.)

MR. RUSSERT: Is it asking too much of the president to say, "Listen, no pardons for anyone who could possibly implicate me in these matters"?

VICE PRESIDENT GORE: Senator Dole suggested on national television that the only proper response by President Clinton to that question would be, "No comment," and that's -- and the president took him up on that suggestion.

The president feels that it's improper to say yea or nay before a question of that kind is even presented --

MR. RUSSERT: But there's a perception the president is dangling pardons --

VICE PRESIDENT GORE: Well, that's why he said, "No comment."

MR. RUSSERT: -- in order to silence people.

VICE PRESIDENT GORE: He said, "No comment" -- well, that's not true. He said, "No comment."

MR. RUSSERT: Are you concerned that, if re-elected, the second term will be just riddled or saddled with ethical problems and investigations?

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VICE PRESIDENT GORE: Absolutely not, because what you're seeing with this five-year, politically motivated investigation by the D'Amato committee and Senator Dole and this whole cottage industry, you would see them lose their motivation to continue spending millions of dollars on this. The whole purpose of it has been their effort to try to defeat Bill Clinton for re-election. That's been the whole purpose of it. Once the election is over, if we are successful -- knock on wood -- then they will lose that motivation, and you'll see the whole thing just wither on the vine, as Speaker Gingrich said he wanted to do to Medicare.

MR. RUSSERT: We have to take a quick break. We'll be back and talk about Medicare, education, and some other issues. We'll be back with more of Vice President Al Gore, right after this.

(Announcements.)

MR. RUSSERT: And we're back on "Meet the Press" talking with the vice president of the United States, Al Gore.

Mr. Vice President, a big debate in this campaign about Medicare, and we've talked about it a lot on this program. I want to show our viewers a comparison between the Clinton plan and the Republican plan. Let me put it up on the screen here.

Currently, the average Medicare recipient gets \$4,400. In the year 2002, under the GOP plan, the Republican plan, they get 5,800 (dollars); under the Clinton plan, 6,300 (dollars). If nothing was done, the average recipient would get 7,100 (dollars).

Monthly premiums, money out of the pocket, they now pay 42-50 (\$42.50), under the Republican plan, 85-90, under the Clinton-Gore campaign -- plan, \$77.

My purpose in showing that is that there has been a similarity, in effect, between Clinton and Gingrich and the Republicans in trying

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to deal with Medicare. You both are going to limit the growth, you both are going to increase premiums, but to the public at large, all they have heard from the Clinton/Gore campaign is, "Republicans want to cut Medicare, and we want to save it."

The fact is you're both trying to limit the growth in Medicare, as evidenced so clearly by those numbers.

VICE PRESIDENT GORE: No, those numbers are unintentionally misleading, Tim. Let me explain to you why.

What you have put up there is not Senator Dole's Medicare plan. What you put up there was the Domenici budget that emerged after the negotiations, after the shutdowns, their final offer --

MR. RUSSERT: Supported by Senator Dole.

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VICE PRESIDENT GORE: Well, no, because -- here's the difference. You know, what's the size of the tax cut in the budget plan that those numbers come out of? One hundred and twenty-two billion dollars. See, Senator Dole has a budget plan that has a combination of cuts and raises -- call it a risky tax scheme; I think that's an accurate description. But instead of \$122 billion, he's proposing \$550 billion, four and a half times as much.

Those premium increases and benefits cuts that are associated with the final thing that they put on the table in the Senate, that's not representative at all of what Senator Dole is proposing.

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Now, you've got three things here. You've got the Dole-Gingrich plan, you've got this plan, which is a retreat from that, and then you've got the Dole plan, which is much, much worse.

When they had \$270 billion cuts, they had to have very large increases in premiums. Senator Dole's Senate plan originally proposed a doubling of the deductible and benefit cuts.

Now that they have gone to a \$550 billion tax scheme, the results for Medicare would be absolutely devastating, and you don't have to take my word for it. The American Hospital Association, the Catholic Health Association, the Concord Coalition, "Business Week," "Time," "Newsweek," "U.S. & World Report," they've all said the consequences of this Dole plan for Medicare would be extreme.

MR. RUSSERT: But the Concord Coalition has also said that the Clinton campaign has demagogued this issue, that you, in fact, are going to, quote, "cut Medicare" as well.

VICE PRESIDENT GORE: No.

MR. RUSSERT: Recipients would be getting 7,100 (dollars); under your plan, it goes down to 57 (hundred dollars). Recipients are going to pay 42-50 a month --

VICE PRESIDENT GORE: (Inaudible; crosstalk.)

MR. RUSSERT: The fact is, something must be done about Medicare, and you're trying to make the Republicans the bogeymen, when, in fact, you are doing something very similar.

VICE PRESIDENT GORE: Not true. Not true.

First of all, there are no premium increases, there are no deductible increases, and no cuts to recipients. There are cost constraints put on providers within the context of a larger plan that does extend the life of the Medicare trust fund 10 years out into the future.

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The difference is in their approach, they've raised premiums, and they've cut benefits to recipients. And they've also proposed -- and we talked about this the last time I was on your program --

MR. RUSSERT: Right.

VICE PRESIDENT GORE: -- they have proposed a two-tier approach to Medicare that would cause it to wither on the vine. That's the speaker's phrase.

MR. RUSSERT: But you are limiting the growth of Medicare. It's now growing at 10 percent and you want to reduce that to 7 percent a year, the Republicans about 6.8 percent --

VICE PRESIDENT GORE: Through constraints on providers. On providers, not on recipients.

MR. RUSSERT: Let me show you something the president said last year, speaking to the American Association of Retired People.

(Begin taped segment.)

PRES. CLINTON: Only in Washington do people believe that no one can get by on twice the rate of inflation. (Laughter.) So when you.

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hear all this business about cuts, let me -- let me caution you that that is not what is going on.

(End taped segment.)

MR. RUSSERT: "That is not what's going on." That's the president's own words, and yet, if you watch a Clinton/Gore commercial, you hear "cut, cut, cut." In fact, both parties are trying to say, "Medicare can't grow at 10 percent a year. We will go bankrupt. We have to do something," you're both trying to do something, and the differences are incremental --

VICE PRESIDENT GORE: That's not correct, Tim --

MR. RUSSERT: -- and the president just said we shouldn't use the word "cuts."

VICE PRESIDENT GORE: With all due respect, it's not correct. Where our plan is concerned -- that's what he was talking about. You're trying to make it appear that there are minuscule differences between the two approaches, and there are huge differences between the two approaches.

We want to save Medicare. We will save Medicare. They're -- Senator Dole has bragged this year about the fact that he was one of only 12 people to vote against creating Medicare in the first place. He said he knew that it wouldn't work. Well, it has worked and it will continue to work.

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He has proposed, along with Speaker Gingrich, a fundamental redesign of Medicare that would have one system for those who are well off and another one for the rest of the country that would wither on the vine. He proposed doubling the deductible.

If the Dole plan had been enacted, if their shutdown scheme had worked, the average couple on Medicare would have already, today, been paying an extra \$268 per year. Also, over the life -- over the course of their plan, an extra \$1,700 per year.

The American Hospital Association raised the question of whether it could have caused the closing of 700 hospitals around the country. The AARP, which supported our plan -- supported our plan -- said their plan would devastate Medicare.

Now, there's all the difference in the world in these two approaches, and the fundamental reason for it -- there are two reasons. Number one, Senator Dole doesn't believe in Medicare -- I personally don't believe that. I know that in a political season, they will try to soften that, but he's bragged about voting against its creation in the first place, and the second reason is they are wedded to this \$550 billion risky tax scheme that would mandate deep, deep cuts in Medicare and in defense.

MR. RUSSERT: Bottom line, Mr. Vice President. If you're re-elected, you will have to do something about Medicare. You cannot let it continue to grow at 10 percent. You may have to raise the retirement age, you may have to increase premiums, you may have to reduce benefits, correct?

VICE PRESIDENT GORE: Tim, we have put out a budget plan, a balanced budget plan, that protects the investments in the future and that extends the life of Medicare out 10 years into the future --

MR. RUSSERT: But you shift money from one account to another and increase the deficit \$50 billion by doing it.

VICE PRESIDENT GORE: No, no, absolutely -- look, it's a balanced budget plan, verified, certified by the Congressional Budget Office, that protects Medicare, also Medicaid and investments like education and the environment, and extends the life of the trust fund.

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Since Medicare was enacted in 1965, February of 1965, there have been 23 times when there have had to be adjustments to keep it on track. That will happen again. We have 10 years in which to do that. Will a bipartisan commission play a role in helping to keep it on track? Of course, and we've said that.

But you can't have this kind of commission approach in the context of a \$550 billion tax scheme that would tie the commission's hands and give them no realistic options for making the kind of sensible adjustments that have always been necessary to keep Medicare on track.

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MR. RUSSERT: Medicare will go broke in five years, and something must be done. Social Security --

VICE PRESIDENT GORE: No, no, let me correct you on that. The president's plan extends it out into the future for 10 years.

MR. RUSSERT: That hasn't been passed.

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VICE PRESIDENT GORE: Well, we --

MR. RUSSERT: Something must be done.

VICE PRESIDENT GORE: I predict that it will be.

MR. RUSSERT: Social Security is also going to be a problem as we retire, our generation, in about 20 years -- more and more people entering that system, limited resources. The president gave a little small, sneak preview of what might happen on Social Security in an interview in "Money" magazine. Let me show you that graphic there.

He said, "We're going to have to do something" -- this is about Social Security -- "we've made a minor adjustment in lowering the annual cost-of-living increases for Social Security benefits about 3/10 of a percent. There might be some agreement on whether we could accelerate the planned increase in the retirement age a little or whether it would be raised more for the people who are younger, like me."

VICE PRESIDENT GORE: Well, you'll notice --

MR. RUSSERT: What's going to happen to Social Security?

VICE PRESIDENT GORE: You'll notice in the quotation, you had three dots in the middle of that quotation. That's the universal symbol for identifying large chunks of the quotation that are left out --

MR. RUSSERT: Oh, that was not taken out of context. That's a very accurate representation.

VICE PRESIDENT GORE: Well, let me tell you what's -- one thing that's missing, and I know it's not an intentional misrepresentation; I'm not saying that. But one thing that is missing is the president was asked about this idea of a commission and was asked to speculate on what kinds of subjects would be fit subjects for such a commission to look at.

The retirement age on Social Security has already been increased by action taken back in the early 1980s --

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 MR. RUSSERT: But it's fair game to say it could be accelerated, in light of longer life expectancy.

VICE PRESIDENT GORE: What a commission might consider is a purely hypothetical question. The fact is that Social Security is on a sound footing for almost 30 years into the future. We have plenty of time to make -- and, again, just as with Medicare, over the lifetime of the Social Security system, there have regularly been adjustments that take into account demographic changes and other things that change from time to time.

The retirement of the baby-boom generation, you and me and our cohorts, will cause changes in the demographics of the people paying in versus the people drawing out. Some of the changes to account for that have already been programmed into Social Security, and if more are needed 20 years from now, 30 years from now, we'll do it.

MR. RUSSERT: Ten years from now, every nickel, every nickel in

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the federal Treasury will go to Medicare, Social Security, Medicaid, and pensions, if we do nothing. You are willing to acknowledge that we are going to have to change Medicare and Social Security for those two systems to survive?

VICE PRESIDENT GORE: Well, first of all, the president has put forward a balanced budget plan. We have reduced the deficit for four years in a row. We promised to cut it by 50 percent. We've cut it by 60 percent. We are going to balance the budget, and we will do so in a way that protects Medicare and Medicaid and the important investments we have emphasized, which are so important to building that bridge to the 21st century that we talk about so much. We think that is important, and we'll do so in a way that makes certain that the entitlement issue is addressed responsibly and that the Social Security and Medicare systems are protected.

MR. RUSSERT: We have to take another quick break. We'll be back with more of our discussion here with Vice President Al Gore, the Democratic candidate for vice president, after this.

(Announcements.)

MR. RUSSERT: More on "Meet the Press" right after this station break. More of Al Gore.

(Announcements.)

MR. RUSSERT: Mr. Vice President, in the last presidential debate, a lot of people were confused about President Clinton's comments on education. He had always said he was against vouchers, he was against providing people a choice of going to public -- public or private school and funded by the government. Let me show you a tape from President Clinton's debate performance.

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(Begin videotaped segment.)

PRES. CLINTON: If we're going to have a private voucher plan, that ought to be done at the local level or at the state level. If a local school district in Cleveland or any place else wants to have a private school choice plan like Milwaukee did, let them have at it.

(End videotaped segment.)

MR. RUSSERT: So if a city or a state wants to have a voucher system where people would go to a private or public school and it would be funded by the government, you have no problem, according to the president.

VICE PRESIDENT GORE: Well, what he meant was that local governments that have submitted this to a referendum have seen them defeated every time the voters have had a chance to vote on it and to speak on it. In some communities, you have seen totally private, nongovernmental funds used to set up a voucher system. That is fine. There's no constitutional problem, there's no problem with it.

But we are opposed -- let me make it clear -- we are opposed to siphoning public funds away from public schools in order to finance private schools.

MR. RUSSERT: That's not the impression the president left.

VICE PRESIDENT GORE: Well, if you got a different impression from that, it was not intended. We do not support the use of public funds in ways that siphon them away from public schools.

And the reason why is 90 percent of the schoolchildren in America go to public schools, and we need to strengthen and lift up our public school system, respecting and highly valuing the private schools that exist in the country and play a tremendous role.

But where public funds are concerned, they ought to be going to public schools, the education budget that comes from public funds.

jdonaldson

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MR. RUSSERT: Minister Louis Farrakhan is having a million-man march again in New York on Wednesday. He has been, over the last few months, to Iraq, Iran --

VICE PRESIDENT GORE: Mm-hmm (acknowledgement).

MR. RUSSERT: -- Libya, Cuba. He's announced he's going to North Korea.

VICE PRESIDENT GORE: 87.

MR. RUSSERT: No other American citizen could get away with that. He's going to these countries without permission, and yet the administration does nothing.

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VICE PRESIDENT GORE: Mm-hmm (acknowledgement).

MR. RUSSERT: He keeps his passport.

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Why is Mr. Farrakhan allowed to visit these kinds of terrorist nations without permission and nothing is done?

VICE PRESIDENT GORE: Well, it's my understanding that there is an ongoing investigation that was announced by the appropriate agencies some time ago. I think that is under investigation --

MR. RUSSERT: But he continues to travel.

VICE PRESIDENT GORE: Well, personally, I believe that what he has done and said is just completely outrageous. He has promoted anti-Semitism, he has promoted division between people of different racial and ethnic groups. That's un-American --

MR. RUSSERT: You believe he's anti-Semitic?

VICE PRESIDENT GORE: I believe that he's made comments over the years that are clearly anti-Semitic. He has attacked me for allegedly being in a conspiracy with Abraham Foxman of the Anti-Defamation League to attack him, and I -- I -- I've said over the years that I think his rhetoric is highly inflammatory and, really, he promotes hatred.

MR. RUSSERT: Why not revoke his passport? Why allow him to do something no other American citizen can do? The suggestion is the Clinton/Gore campaign is afraid of alienating black voters --

VICE PRESIDENT GORE: Oh, no --

MR. RUSSERT: -- so you're going soft on Mr. Farrakhan.

VICE PRESIDENT GORE: -- no, no, no. If I took the opposite tack in answering your question and called for some legal measure to be imposed, you would say, "Well, that's improper because this is a legal proceeding where the investigation has to occur and you have to have due process and all that."

There was an investigation announced. I believe the proceeding is still under way within the appropriate agencies, and it would be improper to have somebody in the middle of the campaign say, you know, "We're going to impose this penalty." That's for the -- that's to be handled in the proper -- but I assure you, there's no hesitancy based

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on a fear of alienated Mr. Farrakhan. I've attacked him for years -- or attacked his rhetoric for years, and what he represents.

MR. RUSSERT: But you don't think American citizens going to Libya or Iran, Iraq, and Cuba is appropriate behavior?

VICE PRESIDENT GORE: No, I don't.

MR. RUSSERT: Let me turn to foreign policy quickly. Bosnia. We have been promised by President Clinton that on December 20, American troops would be out of Bosnia. Secretary of Defense Perry announced last week in fact there'll be 7,500 American troops at least on the ground spring of '97.

Now, you can say there are two different missions, but the bottom line is the president promised American troops out of Bosnia, and now they're going to be in Bosnia well into next year.

VICE PRESIDENT GORE: Well, there are two different missions, and

the second mission hasn't been accepted yet. The NATO -- NATO has a study under way right now of the possibility of a successor mission. We have said that we will review the results of the NATO study with an open mind when it is completed, but our mission is going to be completed by roughly the end of the year. We always said it would be about a year.

Look at what's happened there. They've had elections. The war has ended. There's encouraging movement toward reconciliation. There are remaining problems, of course. Nobody ever thought it would be easy. But there has been a remarkable absence of violence, remarkably little trouble during this mission, and remember, President Clinton showed the courage to lead not only this country but, by leading this country, create movement in the whole rest of the world to bring that war in Bosnia to an end, brought the parties to Dayton, Ohio, and citizens of different faiths in Ohio formed a prayer circle, a chain, all the way around the negotiating site. Only in America could this happen, and it succeeded.

MR. RUSSERT: Before we go, last week I teased Vice President (sic) Kemp about his football career. When I was in Florida, the local paper --

VICE PRESIDENT GORE: Oh, no --

MR. RUSSERT: -- did an analysis of your athletic career -- "This VP is no MVP."

VICE PRESIDENT GORE: (Laughs.)

MR. RUSSERT: This is what your basketball coach said: "I could never get him to throw it up there nice and easy."

VICE PRESIDENT GORE: (Laughs.)

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MR. RUSSERT: John Halverson (sp), a former teammate, said, "He didn't have a jump. He launched it." Richard LaBelle (sp) said, "Al was nothing special on the court, just another body."

They concluded if he didn't have a career in politics, he would make a pretty good bricklayer.

VICE PRESIDENT GORE: (Laughs.)

MR. RUSSERT: Why? Because when the ball left Gore's hands, it bounced off the basket, was quite often like a brick playing off the rim.

How do you plead?

VICE PRESIDENT GORE: These kinds of personal attacks are characteristic of a Sunday talk show in desperation. (Laughter.)

MR. RUSSERT: Are you going to be stiff for the rest of this campaign?

VICE PRESIDENT GORE: Well, Tim, how could I be but otherwise?

MR. RUSSERT: Mrs. Clinton said if you are re-elected, you will do the macarena the day after the election. True?

VICE PRESIDENT GORE: Well, my version of the macarena has been spreading like wildfire. As a matter of fact, I've been expanding my repertoire. With a group of friends who are Asian-Americans, I've performed the Chinese long ribbon dance, very similar to my macarena. With some Dominican-American friends, I did the marenque recently, and at the right time, I'll demonstrate that for you.

MR. RUSSERT: As we go out, Mr. Vice President, we thank you, but let's go out with Al Gore doing the congo.

VICE PRESIDENT GORE: Oh, no! (Laughs.) (Cheers and applause.)

END

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Medicare Alert
601 E Street, N.W.
Washington, DC 20049

Forwarding & Address Correction Requested

**URGENT ACTION
MEDICARE ALERT**
See Page 3 for Toll Free
Phone Number

Mr. John Q. Sample VAF 012345678
123 Main Street
Ames, IA 50010-1234



Dear Mr. Sample:

As we enter a new year, the President and the Congress are still locked in a major debate over the federal budget, particularly Medicare. At stake is how much you will pay in Medicare premiums, your choice of doctor, and the quality of your health care. By speaking up now, you can still affect the outcome of this debate.

Like Social Security, Medicare is a linchpin of financial security for older Americans and their families. It is irreplaceable -- the only really affordable health insurance plan for millions of older Americans.

But some in Washington still want to make cuts in the program -- as much as \$227* billion -- that are too much, too fast!

While we do need to slow the growth of Medicare -- as well as health care generally -- the level of cuts being considered is unprecedented and more than is needed. In fact, the most recent report of the bipartisan Medicare Trustees points out that only \$110 billion -- not \$227 billion -- is needed to keep Medicare solvent for the next decade.

Why then has Congress cut twice as much from Medicare than is necessary?

AARP agrees that changes in Medicare are needed if we want to strengthen the program and keep its promise of affordable, quality health care for today's beneficiaries as well as our children and grandchildren. But, cutting \$227 billion over the next seven years will put an unfair burden on older Americans and on the program. Here's what it would mean to you:

Higher premiums: The proposal would double the \$42.50 monthly premium you now pay to about \$84.60 a month by the year 2002. The income of most beneficiaries won't rise this quickly.

And, beneficiaries with incomes above \$60,000 would pay a much higher monthly Part B premium.

How long will it be before Congress lowers this to \$40,000 or even \$30,000? No one knows, but some have already proposed it.

* The Congressional Budget Office has reestimated the reductions needed to reach a balanced budget by 2002, based on new economic projections which reflect a healthier economy. The budget bill's cuts in Medicare have come down as a result, but many of the same policy changes that were proposed earlier -- higher premiums, "extra billing", reductions in payments to providers -- would still take place.

Higher doctor charges or "extra billing": While the proposal maintains the current limit on how much doctors can charge Medicare patients in regular Medicare, it doesn't extend this protection to all new managed care plans. This means you could be paying even more out-of-pocket for physician care.

Higher costs for basic Medicare benefits: On top of increased premiums and balance billing charges, the proposal also allows health care plans to charge Medicare beneficiaries an even greater amount for the same Medicare benefits you receive now. This is a triple out-of-pocket hit for most older persons.

Less protection for low-income older persons: Right now, Medicare beneficiaries with incomes below about \$625 per month -- mostly older women living alone -- have their Medicare premiums, deductibles and coinsurance paid by the Medicaid program. The proposal would eliminate this valuable protection, meaning that these individuals might not be able to afford basic Medicare services.

AARP believes that there is a more responsible way to strengthen the Medicare program.

- First, we need to act this year to save the \$110 billion that's needed to keep Medicare strong for the next decade.
- And second, we need to begin now to consider the long-term direction of Medicare. But we can't afford to rush the process. We need time for public debate. Medicare beneficiaries and their families have to be part of this process.

I am writing to urge you to contact your Representative, Senators and the President immediately and let them know that \$227 billion in Medicare cuts is not acceptable. When millions of Medicare beneficiaries speak out to defend Medicare, the U.S. Congress has to listen.

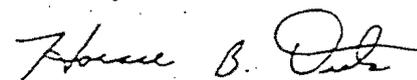
AARP has set Wednesday, January 10 as "Medicare Defense Day." On that day, thousands of Americans will tell Congress and the President not to make cuts in Medicare that are too much, too fast.

Your direct line to action is as near as your phone, and AARP has set up a special toll-free 800 line for your call to your Senators. On "Medicare Defense Day," I hope you'll call Senators Charles E. Grassley and Tom Harkin, and urge them to stand firm for quality, affordable health care in the Medicare program, not a plan that shifts costs to elderly Americans.

On the next page is an AARP "Medicare Defense Action Alert" with the addresses and the toll-free phone number you need to make yourself heard.

Please remember to phone your Senators on "Medicare Defense Day," Wednesday, January 10. If you can't call then, or can't get through, please try again the next day. Your action -- and the action of other citizens -- will open the doors of Senate offices to the sound of people like you proclaiming the message that blindly cutting Medicare is bad medicine for America.

Sincerely,



Horace B. Deets

MEDICARE ACTION ALERT

The largest Medicare cuts ever could soon be enacted.
Congress and the President need to hear from you:

These cuts are too much, too fast!

1. Please mark your calendar today to call your Representative and Senators on Wednesday, January 10, "Medicare Defense Day." If you can't call then, or can't get through, try again the next day. We've set up a special toll-free 800 line for you to place your call to Senators Charles E. Grassley and Tom Harkin. For calls to your Representative use the number below.
2. Reinforce your phone calls by writing letters to your Senators and the President. Mail those letters now so they will arrive as close as possible to "Medicare Defense Day."
3. Share this Action Alert with three friends or relatives who don't want the Congress to shift more health care costs to elderly Americans.

Here are the phone numbers and addresses you need:

Senator Charles E. Grassley
U.S. Senate
Washington, DC 20510
1-800-667-6412

Senator Tom Harkin
U.S. Senate
Washington, DC 20510
1-800-667-6412

Representative Jim Ross Lightfoot
U.S. House of Representatives
Washington, DC 20515
1-(202) 225-3806
or call your local Congressional District office

The President
The White House
Washington, D.C. 20500
1-202-456-1414

Make Your Voice Heard. When you contact your Senators and the President:

- Tell them you do not support \$227 billion in Medicare spending cuts -- it's too much, too fast. Ask why they are supporting \$227 billion when the Medicare Trustees Report shows that \$110 billion is all that is necessary to save the Trust Fund. Tell them there is a better way to fix Medicare.
- Tell them you do not want to pay more out-of-pocket for health care. Urge them not to support doubling Medicare's premiums and raising what physicians can charge you.



NEWS

*For further inquiry, contact American Association of Retired Persons • Communications Division
601 E Street, N.W. • Washington, D.C. 20049 • (202) 434-2560*

STATEMENT BY HORACE B. DEETS
ON SENATE VOTE TO BALANCE THE BUDGET
OCTOBER 27, 1995

The American Association of Retired Persons (AARP) believes today's vote by the U.S. Senate to balance the budget by the year 2002 needlessly endangers the health and well-being of our nation's elderly and vulnerable. The Association supports efforts to balance the budget that are fair and reasonable. The Senate bill is neither.

The Senate voted to cut approximately \$440 billion from Medicare and Medicaid over the next seven years. Such cuts from the two major health care programs that serve older and low-income Americans are too much too fast. American families look to Medicare and Medicaid for health care coverage, for a long term care safety net, and for financial security. These protections are now at risk.

However, the Senate made the right choice and deleted several harmful provisions. The Association applauds the Senate for maintaining federal requirements for nursing home standards. Repeal of this legislation could result in a return to the dark days of nursing home care when residents were subjected to physical restraints and over-medication. The Senate was right to maintain these requirements.

The Senate also eliminated a provision that would have raised the eligibility age for Medicare and eliminated a provision allowing corporations to raid pension funds. We congratulate the Senate on these actions.

Unfortunately, the Congress still has a long way to go. The proposal passed by the Senate would cut approximately \$270 billion from Medicare, much more than is necessary to keep the program solvent. AARP believes that less drastic changes are needed to ensure solvency and stability in Medicare for the next decade.

The bill also reduces Medicaid spending by \$170 billion over the next seven years. Although we congratulate the Senate on reducing the figure from \$187 billion, the magnitude of this reduction is still high. The Senate package also turns over to the states virtually all decisions about eligibility, coverage and quality of care. Together, these changes have the potential to jeopardize the health care safety net upon which millions of Americans of all ages depend.

Overall, the Senate bill will hurt older Americans. We urge House and Senate negotiators who must hammer out the final budget agreement to protect the access and quality of our health care system. The Medicare and Medicaid cuts are too large. The numbers must be lowered.

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AARP **NEWS**

*For further inquiry, contact American Association of Retired Persons • Communications Division
601 E Street, N.W. • Washington, D.C. 20049 • (202) 434-2560*

STATEMENT BY EXECUTIVE DIRECTOR HORACE B. DEETS ON THE MEDICARE, SOCIAL SECURITY TRUSTEES' REPORTS

June 5, 1996

The Medicare and Social Security Trustees' reports released today make it clear that immediate action is needed on Medicare, and the long-term solvency of Medicare and Social Security must also be addressed.

As expected, the Medicare report indicates that the Medicare Trust Fund will run out of money in 2001, one year earlier than previously predicted. AARP is concerned about this, but believes there is no cause for alarm. Meanwhile, the Social Security report highlights, once again, that the Social Security Trust Fund is solvent through 2029, but that modest adjustments in the program must be made to ensure its long-term solvency.

Elected officials and candidates for office should not use these findings to politicize Medicare and Social Security and frighten Americans about the future of these vital family programs. Such partisan approaches are counterproductive. And there is no reason to panic. Instead, AARP has two specific recommendations based on today's reports.

First, the President and the Congress must act immediately to protect Medicare for today's older and disabled Americans. They must go back to the bargaining table now and hammer out a short-term agreement to ensure Medicare's solvency through 2006. Any workable agreement to fund Medicare for the next ten years must fairly spread the burden between doctors, hospitals, and Medicare beneficiaries. What's more, the current Medicare program does not need to be jeopardized to do this. The President and the Congress have an obligation to finish the job this year. But they can't stop there.

Second, as a nation, we must start an inclusive dialogue that should begin immediately, lead us into next year, and ultimately, identify pragmatic solutions for Medicare and Social Security for the next century. We must start this debate now and keep it centered on the issues. Medicare and Social Security demand our nation's best thinking, not distortions, partisan posturing, or simplistic answers.

The response to today's reports should be cooperation, not confrontation. AARP calls upon lawmakers to stop the partisan finger pointing and start working together to find lasting solutions to ensure Medicare and Social Security will be there for our children and grandchildren. Politics as usual is unacceptable. It's time for a solutions approach.

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For additional information, please contact Christine Kirby at 202/434-2560.



Bringing lifetimes of experience and leadership to serve all generations.

October 26, 1995

Dear Senator:

As the Senate debates the 1995 budget reconciliation bill, the American Association of Retired Persons (AARP) urges you to consider several issues of critical importance to older Americans and their families.

Older Americans believe that the deficit must be reduced. And, as they have so many times before, they are willing to do their part. It is this view, held by the vast majority of older Americans, that has led AARP to support every deficit reduction bill since 1982 except one (the 1993 Act, which we neither opposed nor supported).

The vast majority of older Americans, including our members, are prepared to share in the sacrifice needed to reduce the deficit, and restore Medicare's solvency, if they see the bill as fair. But this bill would produce \$467 billion in savings from Medicare and Medicaid over the next seven years -- 44 percent of the net savings in the bill. Older Americans and their families look to Medicare and Medicaid for health care coverage, for a long-term care safety net, and for financial security. As the Senate considers legislation saving \$280 billion in Medicare and \$187 billion in Medicaid over the next seven years, AARP remains deeply concerned that these changes will put affordable, quality health care at risk for millions of older Americans, and remove the health, and long-term care safety net for millions more of our most vulnerable citizens and their families. In short, the bill that is before the Senate does not meet the test of fairness.

Moreover, the reduction in Medicare spending is far more than the Trustees indicate is needed to ensure solvency and stability in Medicare for the next decade. AARP believes that we must ensure a stronger, healthier Medicare -- for older persons, their children and grandchildren. Repeatedly, in testimony and elsewhere, we have called for changes this year in Medicare to ensure Medicare Part A solvency for the next decade and reduce the rate of growth in Part B. As a second step, we have also recommended that the Congress move promptly to establish a bipartisan approach to guide the long-term direction of the Medicare program. Attempting to accomplish all or even part of this second step in the few remaining months of 1995 sells the American public and the Medicare program short.

The bill also would reduce Medicaid spending by \$187 billion over the next seven years and turn over to the states virtually all decisions about eligibility, coverage and quality of care in the Medicaid program. These changes would have extremely serious implications for Americans, young and old, for whom Medicaid is a critical health care safety net.

American Association of Retired Persons 601 E Street, N.W., Washington, D.C. 20049 (202) 434-2277

Eugene I. Lehrmann *President*

Horace B. Deets *Executive Director*

Unfortunately, the bill that is before the Senate shares many of the same problems as the House bill, and compounds some of them.

- The bill nearly doubles the Part B premium over the next seven years, and more than doubles the Part B deductible -- taking it from its current \$100 annually to \$150 next year, and to \$210 by 2002. As a result, older Americans will be forced either to pay a higher deductible or be pushed into another coverage option such as managed care.
- While doubling premiums and deductibles, the bill repeals Medicaid's Qualified Medicare Beneficiary (QMB) program that today pays for Medicare's premiums, deductibles and coinsurance for low-income seniors -- rolling back the clock to a time when low-income older Americans could not afford to participate in Medicare.
- While the Senate proposal wisely maintains the current 15 percent limit on physician balance billing in traditional Medicare fee-for-service, it does not seem to extend this critical out-of-pocket protection to the new Medicare coverage options. As a result, beneficiaries who opt for the new Medicare Choice options could be subject to any fee the physician charges.
- The bill increases the age of Medicare eligibility from 65 to 67, beginning to phase in this change in 2003. Proponents base their support of this change on a false analogy to Social Security. But, in fact, Social Security's eligibility for early retirement will remain at the current age 62, even when the age for full benefits is increased to 67. Medicare does not offer early eligibility, meaning that millions more Americans could find themselves uninsured as a result of this provision.
- The deep cuts in provider reimbursement proposed in the Medicare and Medicaid sections could cause hospital closures and would create serious disincentives for physicians to treat Medicare patients.
- Like the House bill's "fail-safe" provision, the Senate's "BELT" would penalize those beneficiaries who choose to or have no alternative but to remain in traditional fee-for-service.
- The bill imposes a new "affluence test," in effect a surtax, on Medicare beneficiaries, with incomes as low as \$50,000 for singles, but it imposes no such penalty on receipt of the health care tax subsidies for those under 65 with similar or higher incomes, including Members of Congress.
- The bill repeals Medicaid and takes away the promise of a long-term care safety net from millions of American families who have no option but to turn to this program after they have exhausted their means.

October 26, 1995

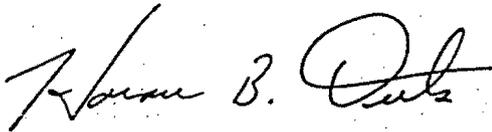
Page 3

- The bill also repeals successful quality of care standards that have significantly reduced the use of physical and chemical restraints in nursing homes and increased the detection and resolution of resident abuse.
- And, at a time when many members of the Senate are calling for increased savings, the Senate bill, similar to the House bill, enables companies to raid pension plans, thereby converting savings for investment to current consumption.

I am attaching more specific analyses of the bill's Medicare, Medicaid, and corporate pension reversion provisions. It is our hope that Senators will resist the call to rush this bill through. Even with a limit on the time for debate, these issues can be examined and votes taken. Over the coming days the Senate can improve upon the current bill, making it fairer; or it can endorse the current bill, sending a message that few will mistake.

If you would like to discuss any of these issues further, please do not hesitate to call me or have your staff call Marty Corry (434-3750), Tricia Smith (434-3770), or David Certner (434-3760) of our Federal Affairs Department.

Sincerely,



Horace B. Deets

Attachments

Medicare

The Senate Finance Committee's Medicare proposal produces \$280 billion in Medicare savings over the next seven years. AARP is deeply concerned that the reductions in Medicare spending coupled with significant program changes, will jeopardize beneficiaries' access to the coverage they choose, the affordability of their care and the overall quality of medical care.

Access

Eligibility for Medicare: Finding affordable, adequate health insurance poses a greater problem for the pre-Medicare population than for any other age group because of the likelihood of pre-existing conditions. The Senate bill would raise the eligibility age for Medicare from 65 to 67, beginning in 2003, in an attempt to link Medicare and Social Security eligibility. However, unlike raising the age for Social Security eligibility -- which provides early retirees benefits at age 62 -- there would be no "early option" for health care coverage. Raising Medicare's eligibility age would leave many retirees without Medicare protection for an even longer period, at the time in their lives when they need it most, in effect adding millions more to the ranks of the uninsured.

Beneficiary Access to Physician Services: The Medicare spending reduction in the bill would mean deep cuts in provider reimbursement. This could create serious disincentives for physicians to treat Medicare patients. In some areas of the country, rural hospitals are already closing and beneficiaries are having problems finding physicians willing to treat them. Deep cuts would only exacerbate these problems.

Budget Expenditure Limit Tool (BELT): The Senate Medicare proposal would create a Budget Enforcement Limiting Tool (BELT) that would reduce fee-for-service provider reimbursements if Medicare spending in a fiscal year is projected to exceed the targets set in the bill. Formula-driven approaches to budget cutting have always concerned AARP, in part, because of the rigidities they build into the system and their inherent potential for error and misestimation.

In addition, we believe the current structure of the "BELT" contains silent beneficiary costs. For instance, under the Senate proposal, the Part B premium is intended to cover 31.5 percent of Part B annual spending. However, because the Senate has specified the actual amount of the premium in the law, rather than the percentage, when the BELT is tightened and Part B program spending is lowered, the premium would actually account for more than 31.5 percent of annual spending. This silently shifts more costs onto beneficiaries.

The same problem occurs with the Part A hospital deductible. The deductible is based, in part, on Medicare's payment to PPS hospitals. If the deductible is calculated before the "BELT" reduces Part A spending, it would be based on a higher payment amount and would, in turn, shift more costs onto Medicare beneficiaries.

Affordability

Increase in the Part B Deductible and Premium: The Senate proposal would essentially double the Part B annual deductible by 2002, requiring the average beneficiary to pay \$210 out-of-pocket before Medicare's Part B coverage would even begin. It would also increase the Part B premium -- nearly doubling the \$46.10 monthly premium beneficiaries now pay -- to \$89 by the year 2002. Given that the average Medicare beneficiary already spends \$2,750 out-of-pocket for health care costs -- not including the costs associated with long-term care -- these additional costs would add significantly to this out-of-pocket burden.

Low-Income Protection: Under current law, Medicaid pays for the cost of Medicare premiums, deductibles and coinsurance for low-income Qualified Medicare Beneficiaries (QMBs). Under the Senate proposal, this protection would be lost because states would no longer have to pay any Medicare out-of-pocket costs for low-income seniors -- primarily single, older women who live on less than \$625 a month. Governors have long sought to eliminate this responsibility, supporting a federal takeover of the entire QMB program. Therefore, it is not reasonable to expect that states would continue providing these essential protections. As a result, low-income Medicare beneficiaries would be at great risk of not receiving needed health care services.

Higher-Income Premium: The Senate proposal singles out older persons to pay a new income-related premium, while at the same time allowing federal subsidies for health care costs for those under 65 -- including Members of Congress -- to continue, regardless of income.

Choice

Balance Billing Protection: Although the Senate plan offers Medicare beneficiaries a wide range of coverage options, the apparent lack of balance billing protection in these plans could act as a barrier to choice. The Senate proposal wisely maintains the current 15 percent limit on physician balance billing in traditional Medicare fee-for-service, but does not seem to extend this critical out-of-pocket protection to all new Medicare coverage options. As a result, beneficiaries who opt for new Medicare Choice options -- like point-of-service, preferred provider organizations, provider service networks or medical savings accounts -- could be subject to any fee the physician charges. Ironically, the potential for significant out-of-pocket costs for

physician care could well drive beneficiaries away from the new coverage options, keeping many in traditional fee-for-service.

Quality of Care

Quality Standards and Oversight: The Senate proposal repeals existing quality standards and oversight requirements for managed care plans, but gives the Secretary authority to establish new standards for all Medicare Choice plans. The proposal also requires that all plans be accredited by the Secretary (or by an independent organization deemed by the Secretary) and that plans contract with an approved independent quality improvement and review organization, which will conduct specified ongoing performance review and an alternative enrollee grievance procedure. Plans will also be required to comply with consumer protections, including an appeals process that includes expedited appeals and judicial review. Each of these protections is vitally important and should be retained at the federal level in order to ensure that Medicare Choice plans provide quality care. If beneficiaries are to be offered a vast array of plans, including some with no prior experience, those plans must be required to meet federal standards, federally enforced. These provisions of the Senate proposal will encourage beneficiaries to try the new options under Medicare choice and should not be diluted.

Medicaid

The Senate Finance Committee Medicaid proposal reduces Medicaid spending by \$187 billion over the next seven years and turns over to the states virtually all decisions about eligibility, coverage and quality of care in the Medicaid program. These changes would have extremely serious implications for Americans, young and old, for whom Medicaid is a critical health care safety net. Some think that the Medicaid program is not important to older Americans, but they are mistaken.

- About two-thirds of nursing home residents rely on Medicaid.
- Medicaid pays for a major portion of long-term care at home.
- Over 5 million older Americans rely on Medicaid for their care.

In fact, Medicaid is the only long-term care safety net for frail, elderly people who need home care or have to enter a nursing home. In our view, \$187 billion in Medicaid savings is far more than the program can shoulder and continue to provide this safety net for millions of Americans.

- By the year 2002, the Senate Medicaid proposal would require a cut of about 30 percent in projected federal funding for the program. Additional reductions in state spending are also likely.
- According to a recent study conducted for AARP by Lewin-VHI, over 2 million Americans could lose their Medicaid coverage for long-term care in the year 2002, primarily for home care, as a result of the proposed reductions.

Block granting Medicaid would not only eliminate the guarantee of coverage that holds the safety net together, it would also eliminate minimum federal consumer protections that help older Americans. The size of the Medicaid reductions, coupled with many states' historic reluctance to maintain strong beneficiary protections, make it unlikely that states would pick up where the federal government leaves off. Clearly, this proposal puts our most vulnerable citizens at unacceptable and unnecessary risk. Of particular concern are two protections that had bipartisan support when enacted they were signed by President Reagan, but would be eliminated under the Senate Medicaid proposal.

Protections for Qualified Medicare Beneficiaries (QMBs): Under current federal law, Medicaid pays the Medicare deductibles and coinsurance for QMBs with incomes below the federal poverty line (about \$7,500 for singles and \$10,000 for couples) and premiums for those with incomes under 120 percent of poverty. Under the proposed block grant, states would no longer have to pay Medicare premiums, deductibles or coinsurance for low-income seniors -- primarily women who live on less than \$625 a month. Governors have long sought to eliminate this responsibility, supporting a federal takeover of the entire QMB program. In our view, it is highly unlikely that

states would continue providing any protection against Medicare's out-of-pocket costs. As a result, millions of low-income Medicare beneficiaries would be at great risk of not receiving needed services.

Nursing Home Quality Standards: Block granting Medicaid would also eliminate current national nursing home quality standards. Over the last decade, quality of care in nursing homes has improved in a variety of specific, measurable ways as a result of the law. In fact, the record shows that, since the 1987 nursing home quality law was enacted, there has been a 25 percent decline in discharges from nursing homes to hospitals, a decrease of over 40 percent in the use of restraints, as well as a tenfold increase in the detection and resolution of resident abuse.

Some will argue that the states can be trusted to maintain nursing home quality without any federal oversight. This argument ignores history. States were doing a poor job prior to the law's enactment. The nursing home industry -- which, because of its historical dependence on Medicaid, is much more powerful at the state level than at the federal level -- will almost certainly urge governors and state legislators to deregulate the industry at a time when unprecedented cuts in Medicare and Medicaid budgets are likely to be passed in the Congress and nursing home reimbursement is likely to be cut. Too many have forgotten the conclusion of the respected National Academy of Sciences in its landmark 1986 report: "A stronger federal leadership role is essential for improving nursing home regulations because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government."

The Association is deeply dismayed that repeal of this legislation is even being considered. We must not turn our backs on America's oldest, most frail and vulnerable citizens.

Corporate Pension Reversions

The Senate Finance Committee tax package would permit employers to gain access to pension funds by permitting transfers of funds above 125 percent of "current" liability and eliminating the existing excise taxes that discourage companies from recapturing pension assets. AARP opposes this rollback of the 1990 law that halted the pension raids of the 1980's.

The proposal is contrary to the fundamental and well established rule that pension assets should be used solely for the benefit of plan participants. Permitting employers to transfer pension assets undermines the concept of a pension trust. In addition, transfers of pension funds based on current liability will result in plans falling below what is necessary to meet long-term pension commitments. In short, the proposal would encourage employers to reduce plan funding to insufficient levels.

The pension transfer proposal will further erode our nation's savings. An estimated \$19 billion of pension savings will be consumed, a result directly at odds with the need to improve the nation's savings rate.

The proposal produces a short-term revenue gain as pension funds are spent. However, the pension assets must eventually be replaced in order to meet pension commitments, thus resulting in a revenue loss over the long term. Also, we should not encourage employers to put money into plans, benefit from the tax break for pensions, and then pull the money out for non-pension purposes.

The proposal will increase the risk to pension beneficiaries and the Pension Benefit Guaranty Corporation (PBGC). The minimal "cushion" of pension assets required to be left in the plan is insufficient to pay benefits should a plan terminate. In addition, such levels do not take into account the potential economic downturn that a company, or its investments, may face. A drop in interest rates or a stock market correction will turn a barely funded plan into an underfunded plan very quickly. Stripping plans of assets in good times will inevitably lead to benefit losses and higher risk for the PBGC -- and thus taxpayers -- in bad times.

Current law permits a limited exception for the transfer of benefits to pay for health benefits for retirees. This current exception was part of the compromise package in 1990 to end "pension raiding." Dramatically opening up pension funds to enormous transfer options will once again result in the type of pension raids experienced in the past decade and will reduce pension security as well as our nations savings.

Consumer Price Index

The Consumer Price Index (CPI) determines the annual level for Cost-of-Living Adjustments (COLAs) for Social Security and other federal benefits, as well as for provisions in the tax code. The CPI is determined by the Bureau of Labor Statistics (BLS). Some in Congress have suggested that the CPI be lowered by as much as one percentage point.

The Association believes Congress should not legislate a change to the CPI but should leave to the Bureau of Labor Statistics the authority to make any adjustments that might be needed. The BLS, which is responsible for objectively calculating the CPI, has an ongoing procedure to reevaluate the index and make adjustments as warranted. Any congressionally-mandated adjustment to the CPI prior to the completion of BLS's anticipated "rebenchmarking" would be premature, and would politicize an issue best left to these technical experts.

An accurate CPI is important because it is used to adjust many federal programs, particularly Social Security COLAs. Millions of Social Security recipients rely on annual cost-of-living adjustments to help ensure that their purchasing power is not eroded by inflation. Any COLA reduction would create serious hardships for low to middle income beneficiaries who rely on Social Security as their primary income source and who will be hardest hit by proposed changes in Medicare. For example, a CPI that is one percentage point lower would mean that today's average retired worker would lose almost \$5,500 in Social Security benefits over 10 years. Social Security does not contribute one penny to the deficit. Any changes in Social Security COLAs within the context of deficit reduction would break the commitment both parties made prior to and after last November's election to leave Social Security "off the table".

The CPI is also used to adjust the annual indexation of tax brackets, exemptions and other provisions in the income tax code. Thus, if the CPI is lowered, most moderate and middle income taxpayers would also pay more in taxes.

AARP urges Congress to leave decisions regarding the CPI to the research technicians at BLS. In fact, economists disagree about whether, and to what extent, the CPI may be overstated. We have not yet heard from the BLS. If Congress reduces the CPI at this stage of the budget debate, the American people would rightfully regard it as a thinly disguised effort to cut COLAs and raise taxes.

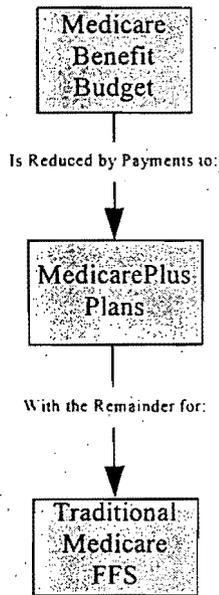


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CAPPING THE MEDICARE PROGRAM: The Impact on Medicare Beneficiaries

How does the Conference Agreement Cap the Medicare Program?

The Medicare reform plan approved by Congress in 1995 includes a cap on total program spending. Known as the "Medicare benefit budget" (MBB), this cap would limit aggregate annual spending to dollar amounts spelled out in the statute, regardless of the actual costs that may be incurred:



	1996	1997	1998	1999	2000	2001	2002
MBB (billions)	\$194.2	\$206.3	\$217.8	\$229.2	\$247.2	\$266.4	\$289.0
Growth Rate		6.2%	5.6%	5.2%	7.9%	7.8%	8.5%

In subsequent years, the MBB would be the previous year's MBB increased by 5 percent and by beneficiary enrollment.

The cap would be enforced by a mechanism called the "fail-safe" in the traditional Medicare fee-for-service program, and by another device to limit growth in the new MedicarePlus plans. Under the fail-safe, provider payments in traditional, fee-for-service Medicare would be reduced automatically in any year for which total program spending -- including payments to MedicarePlus plans (private health plans enrolling Medicare beneficiaries) -- was projected to exceed the cap. In MedicarePlus, the conference agreement would limit the percentage by which a Medicare payment to a MedicarePlus plan could increase annually.

The Fail-Safe. The complicated fail-safe mechanism would ensure that Medicare outlays in any year would not exceed the cap specified for that year. After estimates of MedicarePlus spending are subtracted from the MBB, the fail-safe would apply to the remaining fee-for-service expenditures on a sector-by-sector basis. Specific limits, based on a formula in the bill, would be determined for each of nine non-MedicarePlus sectors: inpatient hospital, home health, skilled nursing facilities, hospice, physicians, outpatient hospital, durable medical equipment, labs, and other. The cap would then reduce provider payments in each sector accordingly. However, individual sector caps would only be triggered if the total fee-for-service expenditure limit were exceeded.

The fail-safe looks both forward and backward if the total cap is exceeded. For instance, beginning in 1998, if the Secretary of HHS estimated that a sector's expenditures in the next year would exceed its allotment, she would reduce payment rates in that sector for fiscal year 1999. In addition, in 1999, the Secretary would look back at 1997. Based on actual expenditure data for 1997, she would review the fee-for-service budget and spending limits for that year. If actual spending for a sector had exceeded its limit, then the sector's allotment for the fiscal year 1999 would be reduced accordingly.

The National Average Per Capita Growth Percentage. While MedicarePlus expenditures are excluded from the fail-safe, the Conference Agreement limits them through another mechanism: the National Average Per Capita Growth Percentages (NAPCGP). These growth rates limit payments to MedicarePlus plans in each year. Currently, payments to Medicare managed care plans are based on a capitated payment. That amount is set annually and based on Medicare fee-for-service spending. The Conference Agreement would replace that annual payment methodology with one that is not tied to fee-for-service spending and specify the actual growth rates in the legislation, as follows:

	1996	1997	1998	1999	2000	2001	2002	Subsequent Years
Medicare Plus	8.0%	3.8%	4.6%	4.3%	3.8%	5.5%	5.6%	5.0%

AARP Analysis:

Formula driven approaches to budget cutting have always concerned AARP. The fail-safe and the NAPCGP are very rigid; and the fail-safe has potential for error and misestimation. Moreover, the public knows very little or nothing about these *caps* on Medicare spending and their long-term effects on the program that they look to for affordable health care coverage.

In the Budget Reconciliation Conference Agreement, Congress has structured a bill that would make fewer providers willing to participate in the traditional Medicare fee-for-service program. Likely outcomes include:

- Specific reductions in provider payments included in the legislation.
- Additional reductions in future fee-for-service provider payments under the cap imposed by the fail-safe mechanism, thereby making traditional fee-for-service Medicare less attractive than MedicarePlus and Medicare less-and-less attractive in relation to other payers.
- The beneficiaries most likely to leave the traditional program are those who are healthier and more willing to experiment with new types of coverage. If Medicare misestimates how many beneficiaries will "migrate" to MedicarePlus plans or the cost of these beneficiaries, this will place more pressure on the fail-safe mechanism, and ultimately on the older and frailer Medicare beneficiaries who remain in fee-for-service.
- Beneficiaries make up the difference in the inadequate payments through higher out-of-pocket payments, as is currently happening for outpatient hospital services (Medicare beneficiaries now pay up to 50 percent for these services under Medicare), or by paying higher MedicarePlus premiums.

AARP is concerned about what kind of coverage will be available by the turn of the century. Will providers still be willing to see Medicare patients in a fee-for-service setting? Will the quality, cost, and availability of care in MedicarePlus plans be upheld as payments are limited arbitrarily? By squeezing both fee-for-service and MedicarePlus plans, the Budget Reconciliation Conference Agreement poses the question of whether Medicare -- in a few short years-- will still be able to meet the health needs of older Americans. AARP continues to believe that reductions in the Medicare Part A program of \$110 billion (as suggested in the Medicare Trustees report) represent a more reasonable level of cuts. But, the deep reductions that would be imposed by the Budget Reconciliation Conference Agreement cut back Medicare program spending too much, too fast. In addition, the cap on Medicare spending could result in dramatic changes in future years in the benefits and quality of care Medicare provides, and in the out-of-pocket costs beneficiaries must pay.

AARP NEWS

*For further inquiry, contact American Association of Retired Persons • Communications Division
601 E Street, N.W. • Washington, D.C. 20049 • (202) 434-2560*

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.

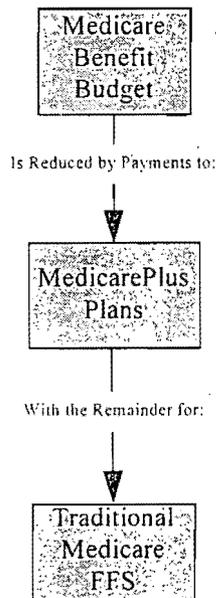


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AARP Supports Maintaining Premium Caps in MedicarePlus Plans

Medicare Beneficiaries Should Not Be Exposed to Greater Out-of-Pocket Costs In MedicarePlus than in Fee-for-Service

AARP and its members strongly support the language in the budget reconciliation conference agreement that protects beneficiaries in MedicarePlus plans from being charged more out-of-pocket, on average, for Medicare-covered benefits than beneficiaries in Medicare fee-for-service. This is an important protection that assures comparability of the basic Medicare benefit package throughout the Medicare system. However, some in Congress are saying that this provision was placed in the bill mistakenly, and that it will be removed at the first opportunity. **AARP urges that this basic beneficiary protection remain in place.**

Background

Under current law, there are several ways a health care provider or plan may collect payment (beyond what Medicare reimburses) from a Medicare beneficiary for Medicare-covered services. In fee-for-service, the provider may collect specified coinsurance and deductibles, and strictly limited balance billing amounts. In managed care, the plan can collect coinsurance, copayments and deductibles, and the plan can charge a premium. Generally, managed care plans charge nominal copayments (e.g., \$5 for a physician visit) and premiums, in lieu of deductibles and coinsurance (e.g., 20%). **Regardless of the different ways of collecting from the beneficiary, current law protects the beneficiary by stating that the managed care plan cannot cost the beneficiary more, on average, than Medicare fee-for-service.** This is a significant protection because beneficiaries may have difficulty comparing their potential out-of-pocket liability among plans that have different means of collecting beneficiary contributions. Therefore, the average out-of-pocket liability under Medicare fee-for-service becomes the ceiling. Since the expectation is that managed care will cost less than fee-for-service, the limit has not been seen as a problem.

This **premium "cap"** has been carried over into the reconciliation legislation creating the MedicarePlus plans. However, the managed care industry is urging Congress to remove this cap and hold them accountable to a looser standard. Their preferred standard would peg any premium cap to the rate they are able to charge in the commercial markets (known as the "adjusted community rate" or ACR). In particular, they would be able to charge premiums comparable to their commercial rates, in case the government payment does not keep up with the private marketplace.

(over)

American Association of Retired Persons 601 E Street, N.W., Washington, D.C. 20049 (202) 434-2277

Eugene I. Lehrmann *President*

Horace B. Deets *Executive Director*



Issue

The problem with this approach is that it exposes the beneficiary to liability for inadequate government payment to the plan. The argument is made that the commercial marketplace will pay the lowest price at which the services can be delivered; thus, the argument continues, if the government is paying less, then the government payment is not enough to cover the cost of the services. Therefore, if the cap is pegged at commercial rates, and if managed care providers believe that the government payment is not sufficient to cover the cost of the Medicare services, these providers will want to be free to make up the difference from the beneficiary.

AARP Response

AARP believes this is the wrong way to address a potential problem. There are several reasons why the industry's proposal is flawed. First, if Congress is interested in promoting greater use of MedicarePlus (managed care and other options) then it should not create financial disincentives for beneficiaries to exercise these choices. Consumer groups will certainly point out the potential financial risk to beneficiaries. Second, it deceives the beneficiary who makes the reasonable assumption that going into a managed care plan will cost less, not more. Third, it makes it impossible for the beneficiary to make an apples-to-apples comparison among the options available, because there is no longer any assurance that out-of-pocket costs are subject to comparable limits. Fourth, ultimately, it erodes the basic guarantee that Medicare will cover a specific set of benefits.

Lawmakers have said that the MedicarePlus payments are sufficient to deliver Medicare benefits. If so, then plans have nothing to fear from a cap that limits their charges to beneficiaries to the level of Medicare fee-for-service beneficiary charges.

Solution

Leave the premium cap language, Sec. 1855(e), as it is. If Medicare's payments to plans are sufficient to cover the cost of services, there is no need to allow plans the opportunity to increase premiums beyond the Medicare fee-for-service exposure. If payments are insufficient, the issue will surface in the unavailability of MedicarePlus plans and should be addressed by the Congress at that time.



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AARP Supports Extending Medicare Balance Billing Protection to New Coverage Options

AARP and its members strongly support extending the statutory limit on physician balance billing to all of the new MedicarePlus coverage options now being considered in the budget reconciliation legislation. The limit on balance billing reinforces three of the basic objectives of Medicare reform -- restraining the growth of health care costs, reducing the out-of-pocket burden on beneficiaries, and protecting choice.

Background

Two categories of physicians currently treat Medicare patients: participating and non-participating. A participating physician agrees to accept Medicare's designated payment amount and the beneficiary's 20 percent coinsurance as total payment for services. Non-participating physicians collect Medicare's payment, the beneficiary's coinsurance, and may also collect an additional fee from the beneficiary known as *balance billing*. Current law limits the amount a non-participating physician may balance bill a beneficiary to 15 percent of Medicare's payment amount.

This limit on balance billing was one of the key beneficiary financial protections enacted as part of the 1989 physician payment reform law. Prior to the establishment of the limit, Medicare beneficiaries spent over \$2 billion a year out-of-pocket for physician balance billing charges.

The Conference Agreement Weakens Balance Billing Protection

While the Conference Agreement retains the 15 percent Medicare balance billing limit in traditional Medicare fee-for-service and for most out-of-network emergency services, it severely weakens the program's balance billing protection in general by not extending the limit to all of the new Medicare coverage options. This means that beneficiaries who enroll in MedicarePlus options could pay significantly more out-of-pocket for physician care.

Extending the Limits to New Medicare Coverage Options is Important

- ***Encouraging beneficiaries to choose new coverage options:*** Extending the balance billing limit to the entire MedicarePlus system would help to ensure that these plans become real options for beneficiaries. For the average older person who already pays \$2,750 out-of-pocket for health care, failure to extend the balance billing limit to MedicarePlus plans would mean that beneficiaries who enroll in these plans may have to pay even more for physician care, **creating a serious disincentive to leave fee-for-service** and try new coverage options.

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- ***Controlling out-of-pocket costs:*** Failure to extend balance billing protection to MedicarePlus will mean that those beneficiaries who opt for new plans in order to retain their physician, or for any other reason, will have no protection against **significant out-of-pocket costs**.
- ***Choice of provider:*** Failure to extend balance billing protection to new coverage options would also put beneficiaries in the vulnerable position of having to negotiate for their care. Beneficiaries who could not afford to pay any amount a physician charges would **not have access to the doctor of their choice**.
- ***Cost-shifting:*** Failure to extend the balance billing limit to all new coverage options would be a step backwards -- **allowing doctors to simply shift costs to beneficiaries** when they want to charge substantially more than what has been established as reasonable reimbursement.



UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF THE UNDER SECRETARY

Benefits
EPSDT

To: Ken Apfel
Nancy Ann Min
Jennifer Klien
Diana Fortuna
Chris Jennings

From: Marshall Smith
Undersecretary

Judith Heumann
Assistant Secretary for Special Education and Rehabilitative Services

Re: Medicaid

Date: December 7, 1995

We are pleased that the President's new Medicaid proposal retains the basic framework of Title XIX, particularly in the areas of eligibility and benefits, including EPSDT. As you know, Medicaid plays a key role in ensuring that we meet the nation's first education goal: all children be ready to learn. Moreover, schools have undertaken an increasing role in providing access to health services -- much of which are reimbursable through Medicaid -- particularly for low-income and disabled students. In the case of students with disabilities, schools are required by law to provide health services that are necessary for the child to benefit from their education. This requirement under the Individuals with Disabilities Education Act (IDEA) has been critical in ensuring both the health and education of children with disabilities.

We hope that regardless of any changes within Medicaid, children will receive health services within a coherent, accountable system that continues to ensure that appropriate services are available in home- and community-based settings, including schools. For children with special needs, providing services in appropriate settings can prevent more costly hospital or institutional care, and eliminate or reduce later primary or secondary illness or disability that are likely to result in conditions more costly to treat in the future.

However, as we move to a new Medicaid framework, we have several fears. First, if it becomes impossible to maintain the current EPSDT entitlement, services to the most vulnerable populations may be threatened. Second, access to care may be compromised because managed care providers will have insufficient incentives to work with existing home- and community-based providers -- including schools -- that are currently effective in ensuring

access for children. Third, schools which have come to rely on Medicaid as an important source of financing for health services may be less able to access Medicaid to support the provision of health services that students need and that schools are required to provide under the IDEA.¹ Finally, as states have more flexibility in designing home- and community-based options, there may be insufficient incentives to provide services in noninstitutional settings.

For these reasons, we have particular concerns about the outcome of forthcoming negotiations on the ultimate Medicaid legislation. This memorandum lays forth some preliminary ideas about how to address these concerns in the context of continuing negotiations with Congress.

I. LEVELS OF COVERAGE AND SERVICES FOR CHILDREN

In the event that it becomes necessary to consider alternatives to the current EPSDT entitlements, we have several thoughts that we would like to discuss further.

Issue #1: Consider keeping EPSDT available to all eligible children but restrict the mandatory treatment services to children and youth who are:

- below a certain age or,
- are disabled or,
- need services to prevent or ameliorate a primary or secondary illness or disability likely to result in an exacerbation of the condition in the future.

Since entitlement to treatment services is a major issue of contention, it would be worth pursuing how to protect the availability of these services for those populations that need it the most. That cut could be by age, disability status or effect of failure to receive services.

Issue #2: Maintain a guaranteed basic health benefit that meets the needs of all eligible children aged 21 and under. This benefit should include preventive services; primary care services; and other health services needed to maintain or stabilize health outcomes, or to prevent or mitigate an adverse change in health outcome.

¹ For example, last year the school districts in New York City, Chicago and Houston billed Medicaid \$85 million, \$40 million and \$14.9 million, respectively.

This definition could be implemented in conjunction with EPSDT or some modified "menu" of required services and would act as a limitation on the services that must be provided. Alternatively, the definition could be used in lieu of a "menu" approach to defining the benefits package.

II. STRENGTHENING HEALTH OUTCOMES

If the entitlement to EPSDT is significantly reduced or eliminated, strengthening health outcomes will be critical to ensuring adequate services for children. Quality assurance parameters will help guide: (1) the provision of care and services, and (2) access to care in the most appropriate setting. Moreover, even if EPSDT remains in its present form, it may be worth considering pressing for child-specific health outcomes (which could be identified by states in their plans) in the negotiation process because they could improve the effectiveness of the EPSDT program in the managed care environment.

Issue #1: Require that state plans include child health outcome performance standards that ensure appropriate services. Examples of outcomes might be:

- o children receive the complete immunization series recommended by the American Academy of Pediatrics;
- o uncorrected vision, hearing or other preventable health problems are treated;
- o lower rates of adolescent substance abuse, school-age parenting, and mental health problems.

Issue #2: Require that state plans include minimum standards of access that help to ensure that services are reasonably accessible to recipients. Such a requirement would provide incentives for managed care providers to work with existing community-based providers, including schools and early intervention programs, because those providers are more often located in the child's community.

This requirement would also benefit disabled adults by encouraging that services be delivered in a manner that allows them to remain at home and in their communities and maintain gainful employment.

Issue #3: Require that state plans include performance standards to ensure that disabled

children receive necessary services in appropriate settings. Such a requirement would help children get the services they need to avoid institutionalization and would encourage managed care providers to work with existing community-based providers. An example of such a requirement might be:

- o disabled children receive health services necessary to maintain functional capability in school, at home, and in their community rather than being hospitalized or institutionalized.

III. MAINTAINING CURRENT LAW ON RELATION OF MEDICAID AND IDEA: PAYOR OF FIRST RESORT

Issue: Retain provision in Title XIX, that makes Medicaid the payor of first resort for those services deemed medically necessary, even though they are an entitlement to the child under IDEA.

Currently, Medicaid is prohibited from refusing to pay for medically-necessary health services solely because they are entitled under IDEA. Thus, current law ensures that Medicaid is the "payor of first resort" with regard to the medically-necessary health-related services provided under IDEA.

If at any time Title XIX ceases to be the negotiating document, we want to highlight the importance of maintaining this provision. The effect of eliminating it would be that schools and other entities would lose medicaid reimbursement for health services provided under IDEA to medicaid-eligible disabled children. Since schools are legally required to provide health related services to children with disabilities, local education budgets would have to assume full financial responsibility for the costs and delivery of medically-necessary health services to medicaid-eligible children receiving services under the IDEA.

IV. ADDITIONAL MECHANISMS FOR STRENGTHENING THE RELATION OF MEDICAID AND SCHOOLS

Because of the important role schools play in providing access to services for children, and because of the importance Medicaid has assumed in financing some of those services, we also put forward some specific ideas about how to improve the position of schools as providers which might be pursued if it becomes appropriate in the negotiations.

Issue #1: Require states to define their relationship with schools and other community-based providers in the provision of health services to medicaid-eligible children

This would require the state medicaid agency to consider the role of schools without mandating any particular relationship with them. We believe that this would encourage states and managed care providers to consider the benefits of providing services in a cost-effective and accessible manner through schools and other community based providers.

Issue #2: Encourage States to make available a "supplemental insurance package" to schools districts and other agencies to pay for health-related services under IDEA.

This package, at a minimum, would cover the medically-necessary related services in a child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and the evaluations related to those services. Additional options could include the remaining benefits under the State's Medicaid program for children with disabilities.

This package could be purchased from: (1) the State Medicaid Agency (as a discounted fee-for-service option, if the State carves out school services); or, (2) purchased from managed care organizations or provider groups through partial or full risk contracts.

This would allow State educational and early intervention agencies to be part of the managed care system by using their existing IDEA dollars (aggregate Federal, State, and local), along with a share of the child's per capita amount under Medicaid to pay for the supplemental insurance package.

This approach would also address the concerns of the individual school districts about: (1) the burden of children's health expenditures when the costs are not evenly distributed; (2) coordinating any continued State's children mandates. The ability to group or pool risk across when purchasing this plan would decrease overall costs to the school districts.

Issue #3: Prohibit states from excluding payments to schools or other qualified entities that provide health services to medicaid-eligible children under other Federal laws.

Schools are eligible for reimbursement, under both current Title XIX and under the Republican proposal. However, for the reasons discussed above, schools may well have difficulty obtaining reimbursement -- even though they are required to provide related services to students with disabilities under IDEA.

DM

FAX



Health Division



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Organization:

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Number of Attached Pages: 3

Notes:

Academic Med. Ctr. Chart

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*Health Division Front Office
Health & Human Services Unit
Health Programs & Services Branch
Health Financing Branch*

Why we should not use or distribute the attached table and chart.

These documents rely on estimates of the effect of Medicaid cuts on academic medical centers that are based on faulty assumptions.

They are based on the assumption that the Medicaid cuts in the Administration and Conference plans are distributed among providers in the same way that HHS estimates current Medicaid are distributed. (Please note that HHS' estimates of current Medicaid spending for teaching hospitals are based on very tenuous assumptions that are not supported by data or research.) Because we do not know the distribution of Conference agreement Medicaid cuts, this assumption may be as valid as any other. **This is not true, however, of the Administration plan. HHS staff estimate that 30% of current Medicaid spending goes to hospitals, but the Administration's plan relies heavily on DSH cuts (almost 90% of total savings are from the DSH cut), which only go to hospitals.**

Assuming that HHS is correct about the current distribution of Medicaid spending, applying their methodology to the *portion of the Administration's Medicaid cuts impacting hospitals* -- which includes **the entire DSH cut** -- yields a cut of approximately \$16 billion (as opposed to the \$5.4 billion now in the table) to teaching hospitals. Using this new estimate, the table shows the Administration's plan as cutting more from academic medical centers than the Conference agreement.

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**Estimates of Impacts of GME, DSH and Medicaid Proposals on
Academic Health Centers and Teaching Hospitals
(in billions, 7-year totals)**

President's Package	Administration Scoring	Republican Conference	CBO Scoring
Indirect Medical Education (IME) Adjustment Reduction	-6.9	IME Reduction	-7.6
Graduate Medical Education (GME) Reform ¹	-4.5	Direct GME Reduction	-1.4
Disproportionate Share Hospital (DSH) Adjustment Reduction ²	-1.6	DSH Reduction	-3.7
Estimated Impact of Medicaid Cuts	-5.4	Estimated Impact of Medicaid Cuts	-16.0
Subtotal of Reductions	-18.4	Subtotal of Reductions	-28.7
Payments for Medicare Managed Care discharges-- AAPCC giveback of DGME/IME/DSH	+6.8	GME Trust Fund ³ (Questionable funding)	+13.5
Interactions	+0.4		
Aggregate Impact of President's Proposal on AHCs/Teaching Hospitals	-11.2	Aggregate Impact of Republican Conference Agreement on AHCs/Teaching Hospitals	-15.2

¹ The elements of the GME reform package result in savings from both direct GME (35%) and indirect GME (65%).

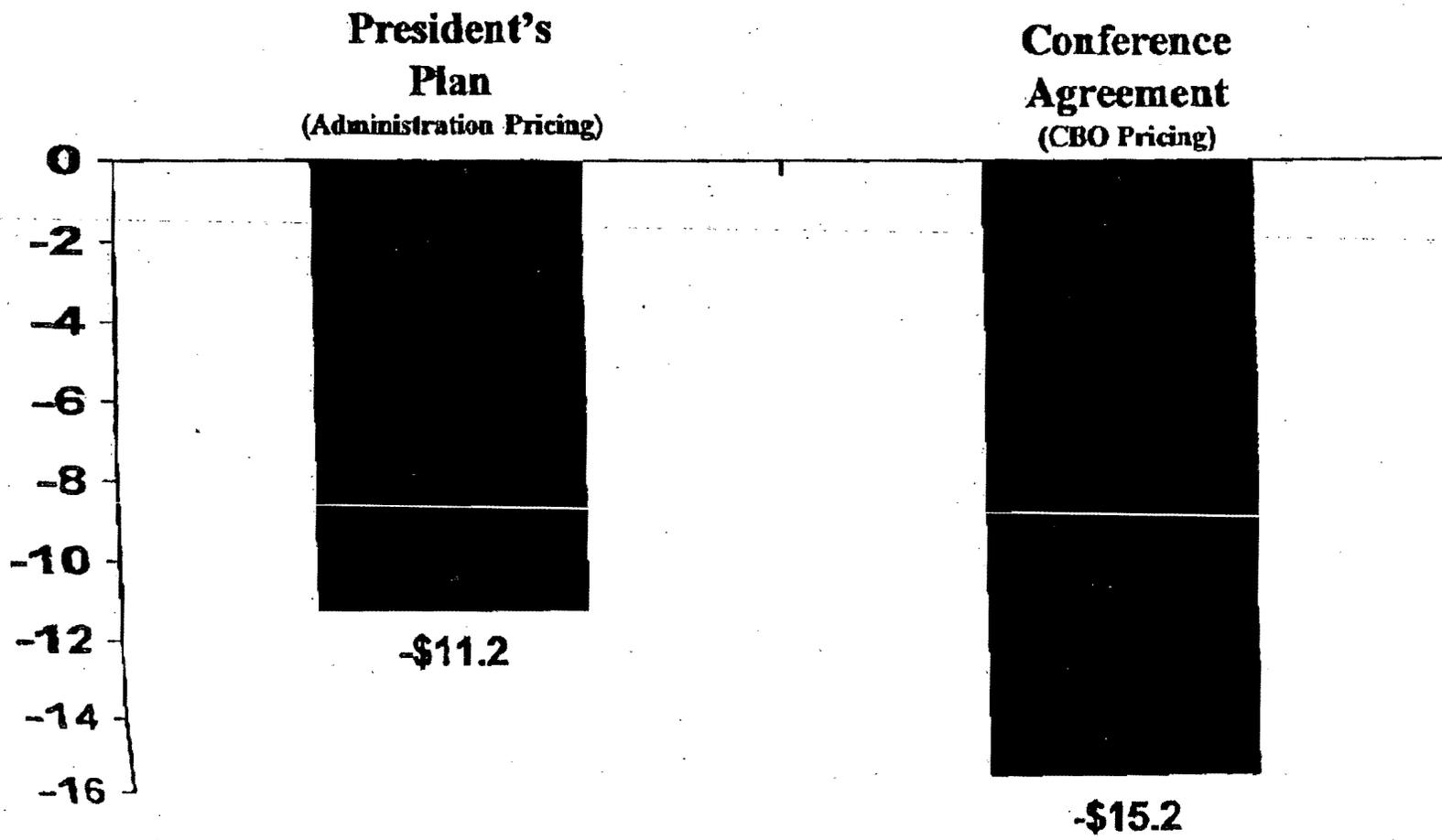
² Based on proportion of DSH payments that go to teaching hospitals (68%).

³ The GME Trust Fund is funded through general revenues that are questionable and may not be permanent.

Impact on Academic Health Centers and Teaching Hospitals

President's Plan vs. Republican Conference Agreement

(Dollars in billions, 7-yr Total)



Impact of CBO, DME and DSH reductions, Medicaid cuts, AAPCC payback, and the GME trust fund.