

Baseline Graph  
Charts

**MEDICARE SAVINGS**  
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	95-00	96-00	96-02	96-05
<b>ADMINISTRATION BASELINE</b>															
Gross Spending (Including Premiums) Growth	174.5	195.0	213.5	232.7	253.7	276.1	300.7	327.5	356.9	389.2	425.0	5.6%	9.1%	9.0%	9.0%
Net Spending (Excluding Premiums) Growth	154.4	174.8	191.8	208.6	228.1	249.4	272.7	298.3	326.5	357.4	391.7	10.1%	9.3%	9.3%	9.4%
<b>CBO BASELINE</b>															
Gross Spending (Including Premiums) Growth	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3	10.1%	9.7%	9.6%	9.7%
Net Spending (Excluding Premiums) Growth	158.0	178.7	197.5	215.0	237.4	260.8	286.5	315.2	347.3	383.2	423.9	10.5%	9.9%	9.9%	10.1%
<b>Administration Proposal (Admin. Baseline)</b>															
Gross Spending (Including Premiums) Growth	174.5	191.7	208.0	223.5	238.1	253.6	270.8	289.2	312.2	335.4	359.1	7.5%	7.2%	7.1%	7.2%
Net Spending (Excluding Premiums) Growth	154.4	171.5	186.3	199.4	212.6	226.9	242.8	260.0	281.7	303.5	325.5	8.0%	7.2%	7.2%	7.4%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66		-56	-124	-289
<b>Budget Resolution Spending (CBO Baseline)</b>															
Gross Spending (Including Premiums) Growth	178.0	191	202	214	226	239	255	274	291	309	328	6.1%	5.8%	5.2%	6.2%
Net Spending (Excluding Premiums) Growth	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8	6.0%	5.5%	6.1%	6.2%
Savings		8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130		-139	-270	-595
Savings per Beneficiary (50% w/extendrs)		100	-225	-350	-475	-600	-725	-875	-1050	-1275	-1525				

**MEDICARE SAVINGS**  
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02	96-05
<b>ADMINISTRATION BASELINE</b>														
Gross Spending (Including Premiums)	174.5	195.0	213.5	232.7	253.7	276.1	300.7	327.5	356.9	389.2	425.0			
Growth												9.1%	9.0%	9.0%
Net Spending (Excluding Premiums)	154.4	174.8	191.8	208.6	228.1	249.4	272.7	298.3	326.5	357.4	391.7			
Growth		13.2%	9.8%	8.7%	9.4%	9.3%	9.4%	9.4%	9.4%	9.5%	9.6%	9.3%	9.3%	9.4%
<b>CBO BASELINE</b>														
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3			
Growth												9.7%	9.6%	9.7%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9			
Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	9.9%	9.9%	10.1%
<b>Administration Proposal (Admin. Baseline)</b>														
Gross Spending (Including Premiums)	174.5	191.7	208.0	223.5	238.1	253.6	270.8	289.2	312.2	335.4	359.1			
Growth												7.2%	7.1%	7.2%
Net Spending (Excluding Premiums)	154.4	171.5	186.3	199.4	212.6	226.9	242.8	260.0	281.7	303.5	325.8			
Growth		11.1%	8.6%	7.0%	6.6%	6.7%	7.0%	7.1%	8.3%	7.7%	7.3%	7.2%	7.2%	7.4%
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66	-56	-124	-289
<b>Budget Resolution Spending (CBO Baseline)</b>														
Gross Spending (Including Premiums)	178.0	191	202	214	226	239	255	274	291	309	328			
Growth		7.3%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	5.8%	6.2%	6.2%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8	259.4	275.8	293.8			
Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	5.5%	6.1%	6.2%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-80	-107	-130	-139	-270	-595
Savings per Beneficiary (50%, w/extenders)		-100	-225	-350	-475	-600	-725	-875	-1050	-1275	-1525			

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**MEDICARE SAVINGS**  
(Dollars in billions, fiscal years)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	95-00	96-00	96-02	96-05	
<b>ADMINISTRATION BASELINE</b>																
Gross Spending (Including Premiums)	174.5	195.0	213.5	232.7	253.7	276.1	300.7	327.5	356.9	389.2	425.0					
Growth												9.6%	9.1%	9.0%	9.0%	
Net Spending (Excluding Premiums)	154.4	174.8	191.8	208.6	228.1	249.4	272.7	298.3	326.5	357.4	391.7					
Growth		13.2%	9.8%	8.7%	9.4%	9.3%	9.4%	9.4%	9.4%	9.5%	9.6%	10.1%	9.3%	9.3%	9.4%	
<b>CBO BASELINE</b>																
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3					
Growth												10.1%	9.7%	9.6%	9.7%	
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2	347.3	383.2	423.9					
Growth		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	10.2%	10.3%	10.6%	10.5%	9.9%	9.9%	10.1%	
<b>Administration Proposal (Admin. Baseline)</b>																
Gross Spending (Including Premiums)	174.5	191.7	208.0	223.5	238.1	253.6	270.8	289.2	312.2	335.4	359.1					
Growth												7.8%	7.2%	7.1%	7.2%	
Net Spending (Excluding Premiums)	154.4	171.5	186.3	199.4	212.6	226.9	242.8	260.0	281.7	303.5	325.8					
Growth		11.1%	8.6%	7.0%	6.6%	6.7%	7.0%	7.1%	8.3%	7.7%	7.3%	8.0%	7.2%	7.2%	7.4%	
Savings		-3	-6	-9	-16	-23	-30	-38	-45	-54	-66			-56	-124	-289
<b>Budget Resolution Spending (CBO Baseline)</b>																
Gross Spending (Including Premiums)	178.0	191	202	214	226	239	255	274	291	309	328					
Growth		7.3%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	6.2%	6.2%	6.2%	6.1%	5.8%	6.2%	6.2%	
Net Spending (Excluding Premiums)	158.0	170.7	179.0	189.3	200.2	211.6	226.5	243.8	259.4	275.0	293.0					
Growth		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	6.2%	6.2%	6.2%	6.0%	5.5%	6.1%	6.2%	
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-88	-107	-130			-139	-270	-595
Savings per Beneficiary (50%, w/extenders)		-100	-225	-350	-475	-600	-725	-875	-1050	-1275	-1525					
<b>House Resolution Spending (CBO Baseline)</b>																
Net Spending (Excluding Premiums)	158.0	172.2	182.1	191.2	200.6	209.7	219	228.8	239.0	249.7	260.9					
Growth		9.0%	5.7%	5.0%	4.9%	4.5%	4.4%	4.5%	4.5%	4.5%	4.5%	5.8%	5.0%	4.9%	4.7%	
Savings		-6.5	-15.4	-24.7	-36.7	-51.1	-67.6	-86.4	-108.2	-131.4	-162.9			-134.4	-288.4	-690.9
Savings per Beneficiary (50%, w/extenders)		-75	-200	-325	-450	-625	-825	-1050	-1300	-1550	-1900					
<b>Senate Resolution Spending (CBO Baseline)</b>																
Net Spending (Excluding Premiums)	158.0	166.5	175.9	188.4	201.8	216.4	233.8	253.5	271.8	291.3	312.3					
Growth		5.4%	5.6%	7.1%	7.1%	7.2%	8.0%	8.4%	7.2%	7.2%	7.2%	9.5-	6.8%	7.3%	7.2%	
Savings		-12.2	-21.0	-27.5	-35.5	-44.4	-52.8	-61.7	-75.5	-89.9	-111.6			-141.2	-265.7	-532.7
Savings per Beneficiary (50%, w/extenders)		-150	-275	-350	-450	-550	-650	-750	-900	-1050	-1300					



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NOTE: Estimates for 2003-2005 for the Budget Resolution were not available. The average growth rate was used to estimate the spending in those years.  
Medicare spending excludes discretionary spending.  
These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

INCLUDES '95-2000 GROWTH RATES

## MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
<b>CBO MEDICARE BASELINE</b>										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
<b>Administration Medicare Proposal (CBO Baseline: Administration savings estimates)</b>										
Gross Spending (Including Premiums)	178.1	195.7	213.9	230.9	247.9	265.6	285.3	307.0		
<i>Aggregate Growth</i>		9.9%	9.3%	8.0%	7.3%	7.1%	7.4%	7.6%	7.9%	7.8%
<i>Per Capita Growth</i>									6.5%	6.4%
Net Spending (Excluding Premiums)	158.0	175.4	192.0	206.7	221.9	238.3	256.6	276.9		
<i>Aggregate Growth</i>		11.0%	9.4%	7.7%	7.3%	7.4%	7.7%	7.9%	8.0%	7.9%
<i>Per Capita Growth</i>									6.5%	6.5%
Savings		-3	-6	-9	-16	-23	-30	-38	-56	-124
<b>Budget Resolution Medicare Proposal (CBO Baseline)</b>										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
<b>CBO PRIVATE GROWTH RATES</b>										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

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Growth Rate

## MEDICARE PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
<b>CBO MEDICARE BASELINE</b>										
Gross Spending (Including Premiums)	178.1	199.0	219.4	240.1	263.4	288.1	315.2	345.3		
<i>Aggregate Growth</i>		11.7%	10.3%	9.4%	9.7%	9.4%	9.4%	9.5%	9.7%	9.6%
<i>Per Capita Growth</i>									8.2%	8.2%
Net Spending (Excluding Premiums)	158.0	178.7	197.5	215.9	237.4	260.8	286.5	315.2		
<i>Aggregate Growth</i>		13.1%	10.5%	9.3%	10.0%	9.9%	9.9%	10.0%	9.9%	9.9%
<i>Per Capita Growth</i>									8.4%	8.5%
<b>Administration Medicare Proposal (CBO Baseline: Percent Reduction from Administration Baseline)</b>										
Gross Spending (Including Premiums)	178.1	195.7	213.7	230.6	247.3	264.6	283.8	304.9		
<i>Aggregate Growth</i>		9.9%	9.2%	7.9%	7.2%	7.0%	7.3%	7.4%	7.8%	7.7%
<i>Per Capita Growth</i>									6.4%	6.3%
Net Spending (Excluding Premiums)	158.0	175.4	191.8	206.4	221.3	237.3	255.1	274.8		
<i>Aggregate Growth</i>		11.0%	9.4%	7.6%	7.2%	7.2%	7.5%	7.7%	7.9%	7.8%
<i>Per Capita Growth</i>									6.4%	6.4%
Savings		-3	-6	-9	-16	-23	-31	-40	-58	-130
<b>Budget Resolution Medicare Proposal (CBO Baseline)</b>										
Gross Spending (Including Premiums)	178.1	191	202	214	226	239	255	274		
<i>Aggregate Growth</i>		7.2%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.8%	6.2%
<i>Per Capita Growth</i>									4.4%	4.9%
Net Spending (Excluding Premiums)	158.0	170.7	179.8	189.3	200.2	211.6	226.5	243.8		
<i>Aggregate Growth</i>		8.0%	5.3%	5.3%	5.8%	5.7%	7.0%	7.6%	5.5%	6.1%
<i>Per Capita Growth</i>									4.1%	4.8%
Savings		-8	-17.7	-26.6	-37.2	-49.2	-60	-71.4	-139	-270
<b>CBO PRIVATE GROWTH RATES</b>										
<i>Aggregate Growth</i>		6.6%	7.5%	7.8%	7.5%	7.5%	7.3%	7.1%	7.6%	7.4%
<i>Per Capita Growth</i>		6.2%	7.1%	7.4%	7.2%	7.2%	7.1%	6.8%	7.2%	7.1%

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

Medicare spending excludes discretionary spending. Administration estimates of unduplicated beneficiaries were used for the per capita growth rates.

These estimates DO NOT include any adjustment for the Republicans' proposed adjustment to the CPI. As a result, net spending is slightly lower than it would be after the adjustment.

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## MEDICAID PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
<b>CBO MEDICAID BASELINE</b>										
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8	614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%	10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9		
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%	3.3%	3.0%
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871		
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%	7.0%	7.0%
<b>Administration Medicaid Proposal (CBO Baseline: Administration Savings Estimates)</b>										
Spending	89.2	95.3	106	116.1	127.8	139.1	151.6	164.8		
		6.8%	11.2%	9.5%	10.1%	8.8%	9.0%	8.7%	9.9%	9.6%
Spending per Recipient	2,422	2,483	2,652	2,819	3,014	3,185	3,380	3,588		
		2.5%	6.8%	6.3%	6.9%	5.7%	6.1%	6.2%	6.4%	6.3%
Savings		-4	-4	-6	-7	-9	-11	-13	-30	-54
<b>Budget Resolution Medicaid Proposal (CBO Baseline)</b>										
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3		
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%	4.7%	4.5%
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705		
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%	1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54	-85	-182

The Administration savings were converted to the CBO baseline by subtracting the savings based on the Admin. baseline spending from the CBO baseline spending.

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## MEDICAID PROPOSALS & GROWTH RATES

(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	96-00	96-02
<b>CBO MEDICAID BASELINE</b>										
Spending	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8	614.3	954.7
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%	10.5%	10.2%
Recipients	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9		
		4.2%	4.1%	3.1%	3.0%	3.0%	2.7%	2.4%	3.3%	3.0%
Spending per Recipient	2,422	2,587	2,752	2,964	3,179	3,391	3,625	3,871		
		6.8%	6.4%	7.7%	7.2%	6.7%	6.9%	6.8%	7.0%	7.0%
<b>Administration Medicaid Proposal (CBO Baseline: Percent Reduction from Administration Baseline)</b>										
Spending	89.2	95.2	105.8	115.7	127.2	138.3	150.6	163.6	582.2	896.4
		6.7%	11.1%	9.4%	9.9%	8.7%	8.9%	8.6%	9.8%	9.5%
Spending per Recipient	2,422	2,479	2,646	2,810	2,999	3,166	3,358	3,562		
		2.4%	6.8%	6.2%	6.8%	5.6%	6.0%	6.1%	6.3%	6.2%
Savings		-4	-4	-6	-8	-10	-12	-14	-32	-58
<b>Budget Resolution Medicaid Proposal (CBO Baseline)</b>										
Spending	89.2	95.6	102.1	106.2	110.5	114.9	119.5	124.3		
		7.2%	6.8%	4.0%	4.0%	4.0%	4.0%	4.0%	4.7%	4.5%
Spending per Recipient	2,422	2,491	2,555	2,579	2,605	2,630	2,664	2,705		
		2.8%	2.6%	0.9%	1.0%	1.0%	1.3%	1.6%	1.4%	1.4%
Savings		-4	-8	-16	-24	-33	-43	-54	-85	-182

The Administration savings were converted to the CBO baseline by (a) converting the savings from the Administration baseline into a percent reduction from baseline spending; and (b) multiplying that percent reduction by the CBO baseline spending.

02-Sep-95

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**Estimated CBO pricing of GME, DSH and Medicaid Proposals that Affect  
Academic Health Centers and Teaching Hospitals  
(in billions, 7-year totals)**

<b>President's Package</b>		<b>Republican Conference</b>	
Indirect Medical Education (IME) Adjustment Reduction	-4.6	IME Reduction	-7.6
Graduate Medical Education (GME) Reform <sup>1</sup>	-5.7	Direct GME Reduction	-1.4
Disproportionate Share Hospital (DSH) Adjustment Reduction <sup>2</sup>	-1.0	DSH Reduction	-3.7
Estimated Impact of Medicaid Cuts	-5.4	Estimated Impact of Medicaid Cuts	-16.0
<b>Subtotal of Reductions</b>	<b>-16.7</b>	<b>Subtotal of Reductions</b>	<b>-28.7</b>
Payments for Medicare Managed Care discharges-- AAPCC giveback of DGME/IME/DSH <sup>3</sup>	+6.2	GME Trust Fund <sup>4</sup> (Questionable funding)	+13.5
<b>Aggregate Impact of President's Proposal on AHCs/Teaching Hospitals</b>	<b>-10.5</b>	<b>Aggregate Impact of Republican Conference Agreement on AHCs/Teaching Hospitals</b>	<b>-15.2</b>

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

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

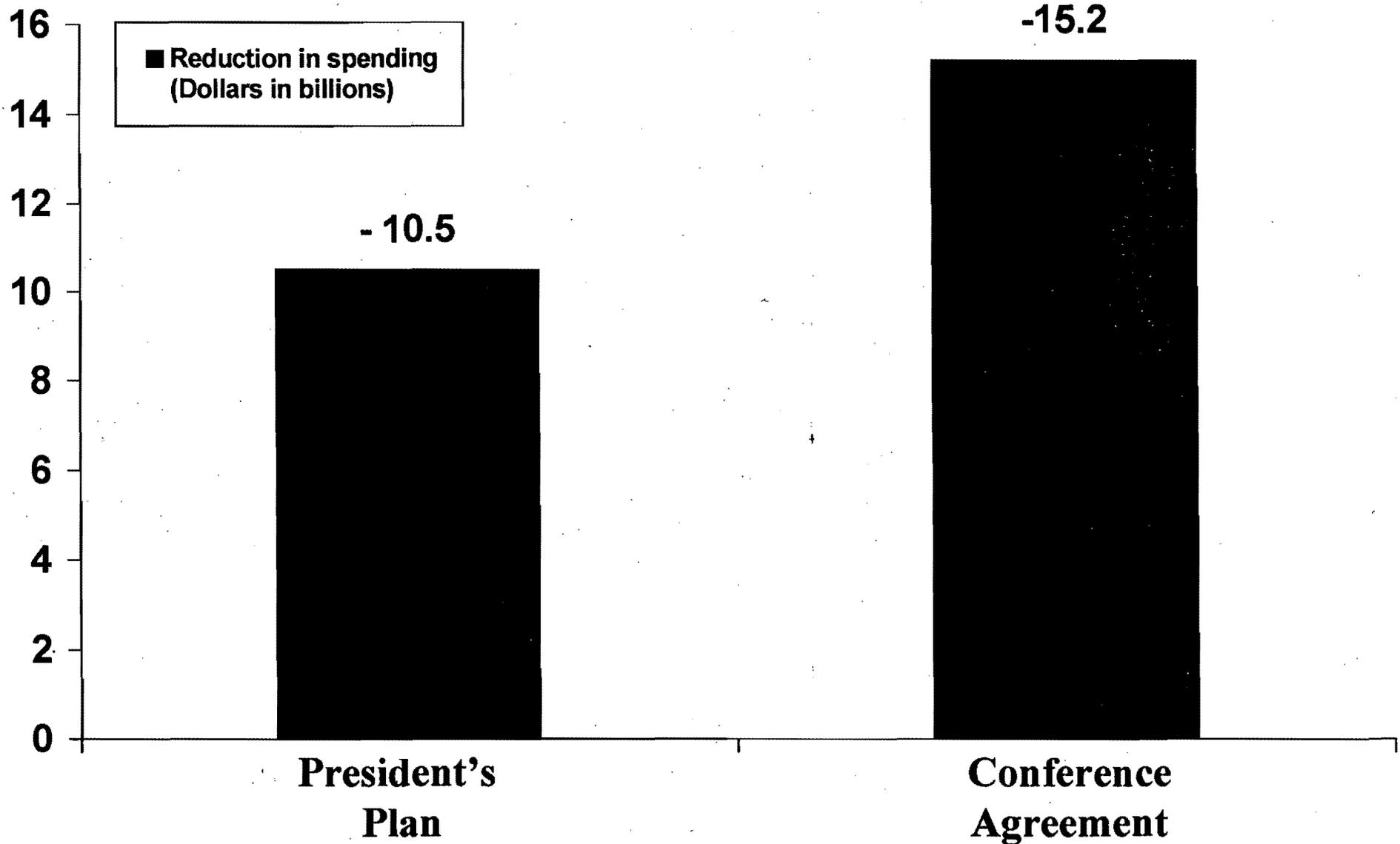
<sup>3</sup> Giveback based on OMB baseline would be \$6.9 billion.

<sup>4</sup> 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

(Estimated CBO Pricing, Dollars in billions, 7-yr Total)



Note: Includes impact of GME, IME and DSH reductions, Medicaid cuts, AAPCC payback, and the GME trust fund.

**Estimated CBO Pricing of Provisions Affecting Rural Hospitals  
(in billions, 7-year totals)**

<b>President's Package</b>		<b>Republican Conference</b>	
Update Reduction <sup>1</sup>	-1.9	Update Reduction	-3.9
Sole Community Hospital Rebasing /a	0.3	Medicare Dependent Hospital (rural) payment extension	0.2
Expand Rural Primary Care Hospital program /b	0.3	Critical Access Hospital Program	0.3
No Provision		Establish REACH Program; Rural Referral Center Bonus	0.2
Disproportionate Share Hospital (DSH) Adjustment Reduction <sup>2</sup>	-0.1	DSH	-0.2
<b>Impact of President's Plan on Rural Hospitals</b>	<b>-1.4</b>	<b>Impact of Republican Conference Agreement on Rural Hospitals</b>	<b>-3.3</b>

a/ Sole community hospitals will be rebased (payment base will be updated) with a hold-harmless provision so that no hospital's payments are lowered.

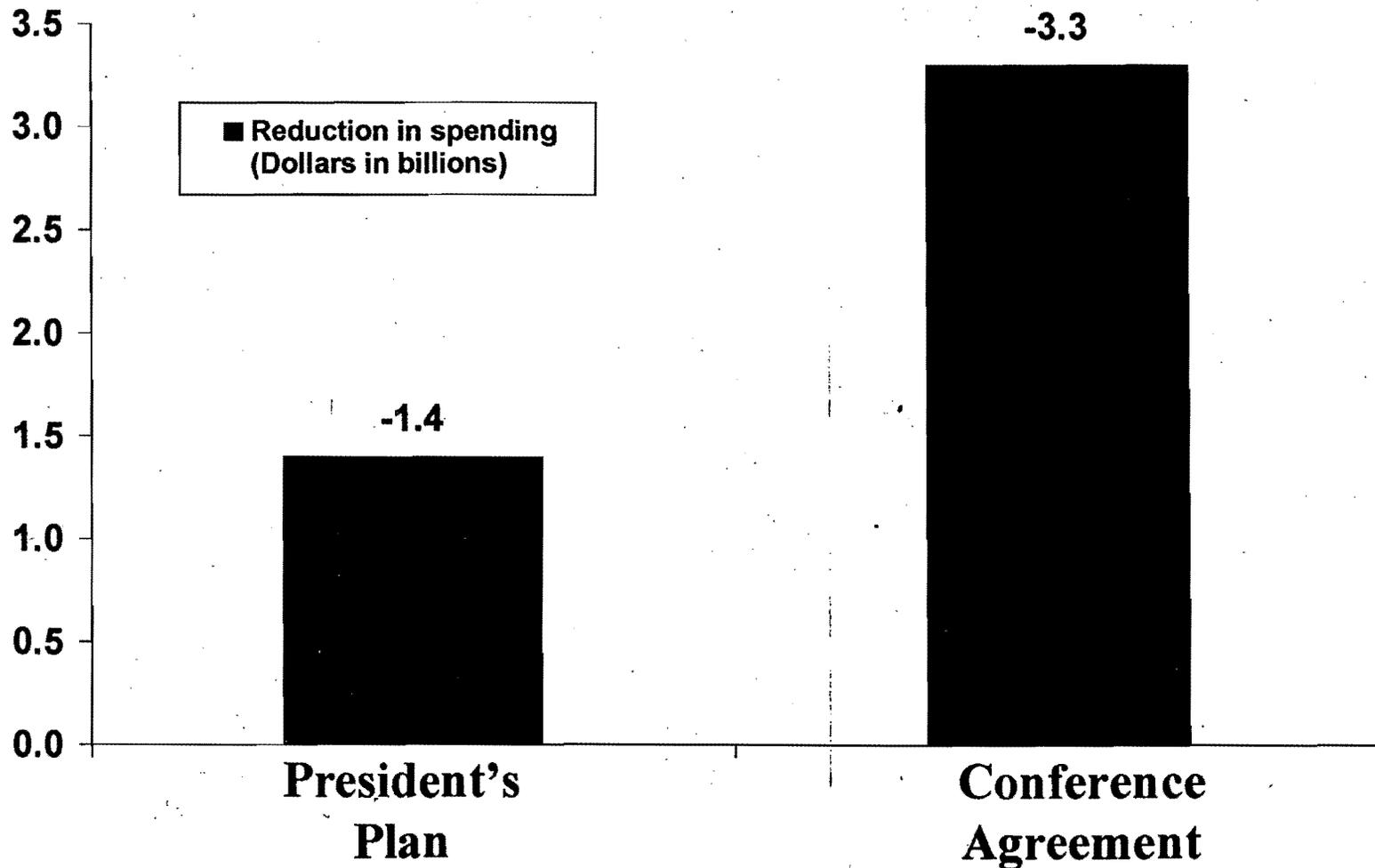
b/ The Rural Primary Care Hospital Program (RPCH) allows rural hospitals to downsize and offer limited services, as an alternative to closing. It currently operates in seven states. This proposal makes some improvements to the program and expands it to 50 states. The Republican Critical Access Hospital Program is quite similar to a nationwide RPCH program.

<sup>1</sup> Based on estimate of percentage of total payments that go to rural hospitals (13.5%).

<sup>2</sup> Based on estimate of percentage of DSH payments that go to rural hospitals (4%).

# Impact on Rural Hospitals

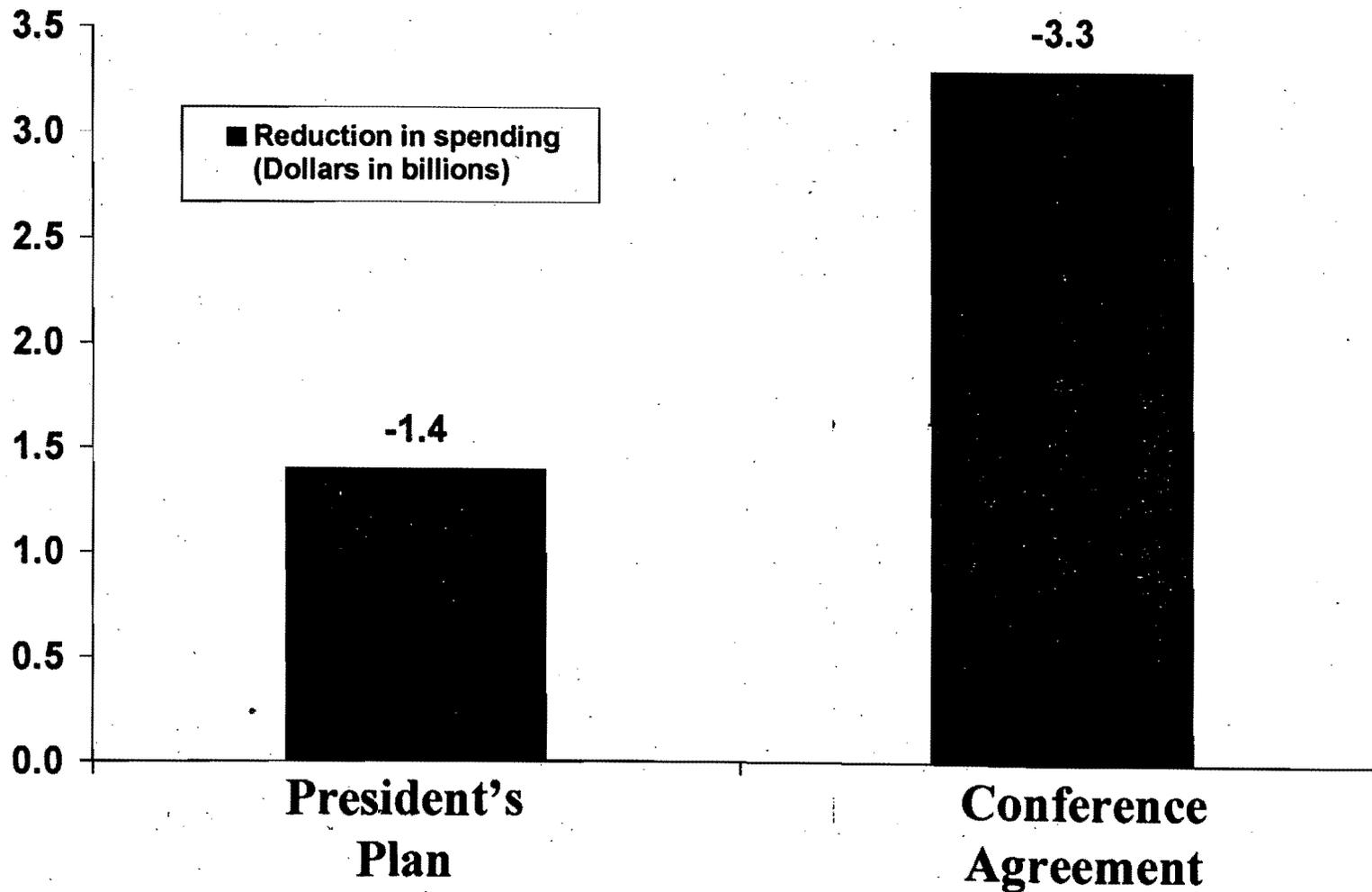
**President's Plan vs. Republican Conference Agreement**  
( Estimated CBO pricing, Dollars in billions, 7-yr Total)



Note: Includes impact of update reduction, DSH reduction, and new rural hospital programs.

# Impact on Rural Hospitals

**President's Plan vs. Republican Conference Agreement**  
( Estimated CBO pricing, Dollars in billions, 7-yr Total)



Note: Includes impact of update reduction, DSH reduction, and new rural hospital programs.

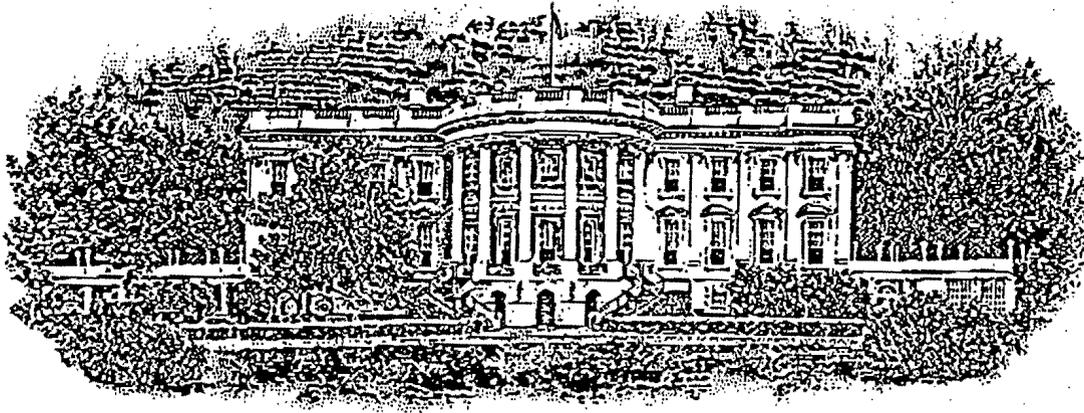
## FAX COVER SHEET



## Health Division



Executive Office of the President  
Office of Management and Budget  
OEOB, Room 262  
Washington, D.C. 20503



DATE: 6/26/95  
TO: Gene Sparling  
Chris Jennings  
AGENCY: \_\_\_\_\_  
FAX NO: \_\_\_\_\_

FROM: Nancy-Ann Min  
Associate Director for Health and Personnel

Phone number (202) 395-5178

Fax number (202) 395-7289

Number of pages (including cover) 2

COMMENTS: Does this help any?

**DRAFT**

**Medicare Outlays Under Proposed Budgets (Gross Outlays)**

Congressional budgets use CBO baseline and savings estimates; President's budget uses OMB baseline and savings estimates

(\$ in billions, by fiscal year)

	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>5-Yr Total 1996-2000</u>	<u>7-Yr Total 1996-2002</u>
<b>Conference Agreement</b>										
CBO Current Law Baseline	178.1	199.0	219.4	240.4	263.4	288.1	315.2	345.3	1,210.3	1,870.8
Growth	--	11.7%	10.3%	9.6%	9.6%	9.4%	9.4%	9.5%	9.7%	9.6%
Conf. Agreement Medicare Savings	--	-8.0	-18.0	-27.0	-37.0	-49.0	-60.0	-71.0	-139.0	<del>270.0</del>
Conf. Agreement Medicare Outlays	178.0	191.0	202.0	214.0	226.0	239.0	255.0	274.0	1,072.0	1,601.0
Growth	--	7.3%	5.8%	5.9%	5.6%	5.8%	6.7%	7.5%	5.6%	6.2%
Outlays as Percent of Baseline	100%	96%	92%	89%	86%	83%	81%	79%	89%	85%
<b>President's Balanced Budget Plan</b>										
OMB Current Law Baseline	174.5	195.0	213.5	232.7	253.7	276.1	300.7	327.5	1,170.9	1,799.0
Growth	--	11.7%	9.5%	9.0%	9.0%	8.8%	8.9%	8.9%	9.1%	9.0%
Medicare Savings with Expansions	--	-3.3	-5.5	-9.2	-15.5	-22.5	-29.9	-38.3	-56.0	<del>124.2</del>
Medicare Outlays with Expansions	174.5	191.7	208.0	223.5	238.1	253.6	270.8	289.2	1,114.9	1,674.9
Growth	--	9.9%	8.5%	7.4%	6.6%	6.5%	6.8%	6.8%	7.2%	7.1%
Outlays as Percent of Baseline	100%	98%	97%	96%	94%	92%	90%	88%	95%	93%

**Notes:**

CBO and OMB baseline estimates are different, consequently CBO and OMB savings estimates and revised baselines – including growth rates – are not directly comparable.

However, one could compare the outlays as a percent of baseline under the plans.

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Budget FY1

**Conference Agreement**

**Concurrent Resolution on the Budget -- Fiscal Year 1996**

**Early Highlights**

**June 23, 1995**

**Deficits and Spending**

- **Balance is achieved in seven years by first reducing the rate of growth in total spending.**
- **Total federal spending grows from \$1.5 trillion in 1995 to \$1.875 trillion in 2002. Annual growth rate of 3.0 percent.**
- **The federal deficit that would grow next year to nearly \$200 billion without changes in policy, will be reduced to \$170 billion and thereafter decline to a surplus of nearly \$7 billion in 2002.**
- **Total deficit reduction over the next seven years would reach nearly \$960 billion.**

**Tax Reductions**

- **Tax reductions cannot occur until Committees have first met their spending reduction instructions.**
- **Committees report to the Budget Committees their spending reduction legislation by mid-September and CBO certifies that balance has been achieved in 2002 and a fiscal dividend equal to \$170 billion over seven years, \$50 billion in 2002 has been created.**
- **Once certification occurs, tax writing committees**

would be instructed to report to the Budget Committees within five working days legislation that would reduce tax revenues up to but not to exceed \$245 billion over seven years, and not to exceed the fiscal dividend estimated to be \$50 billion in 2002.

- In no case can the tax cuts in 2002 result in the budget being out of balance.

### Select Spending Programs

#### Medicare

- Medicare will grow from \$178 billion this year to \$274 billion in 2002. Medicare spending will grow at an annual rate of 6.4 percent. Total Medicare spending over the next seven years will top \$1.6 trillion.
- Medicare solvency is insured through 2005.
- Relative to the unsustainable current spending path of Medicare, the conference agreement reduces spending \$270 billion over the next seven years.

#### Medicaid

- Conference agreement assumes a Medicaid block grant program that would reduce the rate of growth in the program from its current rate of 10.5 percent gradually over the next seven year period reaching about 4 percent in 2002.
- Medicaid spending grows from \$90 billion this year to over \$124 billion in 2002.
- Relative to a continuation of unsustainable growth in this program, savings of \$182 billion are achieved over the next seven years.

### Defense

- The conference agreement assumes that defense spending (outlays) will decline from \$270 billion this year to \$265 billion in 1998, and then return to annual spending levels of near \$271 billion in 2001 and 2002.
- Defense spending relative to President Clinton's request this year will increase nearly \$33.1 billion over the next seven years.
- In the Senate, firewalls between defense spending and other discretionary spending would be established for three years.

### Nondefense Spending

- Nondefense discretionary appropriations would decline from \$278 billion this year to \$244 billion in 2002.
- Relative to current law spending, these discretionary programs would be reduced \$190 billion over the next seven years through program terminations, consolidations, and returning their program management back to the states.
- The conference agreement assumes the termination of the Commerce Department, but leaves to the Committees of jurisdiction the determination of other Departmental closures.

### Other Programs

- The conference agreement assumes welfare reform such that programs are reformed and savings of nearly \$100 billion over the next seven years.
- The conference agreement assumes reform of agriculture price support programs totalling \$13.3 billion over the next seven years. Agriculture price support programs will still expend \$45 billion over the next seven years.
- The conference agreement assumes reform of federal student loan programs \$10 billion over the next seven years. Reforms, it is assumed would be targeted on graduate and professional students.
- The conference agreement assumes nearly full funding of the Violent Crime Reduction Trust Fund.



## CONFERENCE AGREEMENT COMPARED TO BASELINE

(Dollars in billions)

	1996	1997	1998	1999	2000	5-yr total	2001	2002	Grand total
<b>Current Law Deficit.....</b>	<b>198</b>	<b>215</b>	<b>211</b>	<b>225</b>	<b>238</b>		<b>226</b>	<b>229</b>	
<b>Discretionary:</b>									
<b>Defense.....</b>	<b>6</b>	<b>8</b>	<b>8</b>	<b>9</b>	<b>9</b>	<b>40</b>	<b>9</b>	<b>9</b>	<b>58</b>
<b>Nondefense.....</b>	<b>-10</b>	<b>-23</b>	<b>-27</b>	<b>-31</b>	<b>-31</b>	<b>-121</b>	<b>-34</b>	<b>-35</b>	<b>-190</b>
<b>Mandatory:</b>									
<b>Social Security.....</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Medicare.....</b>	<b>-8</b>	<b>-18</b>	<b>-27</b>	<b>-37</b>	<b>-49</b>	<b>-139</b>	<b>-60</b>	<b>-71</b>	<b>-270</b>
<b>Medicaid.....</b>	<b>-4</b>	<b>-8</b>	<b>-16</b>	<b>-24</b>	<b>-33</b>	<b>-85</b>	<b>-43</b>	<b>-54</b>	<b>-182</b>
<b>Other mandatory.....</b>	<b>-10</b>	<b>-19</b>	<b>-25</b>	<b>-26</b>	<b>-29</b>	<b>-108</b>	<b>-30</b>	<b>-36</b>	<b>-174</b>
<b>Revenues.....</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>3</b>
<b>Total policy changes.....</b>	<b>-26</b>	<b>-59</b>	<b>-86</b>	<b>-108</b>	<b>-132</b>	<b>-411</b>	<b>-158</b>	<b>-187</b>	<b>-756</b>
<b>Debt service.....</b>	<b>-1</b>	<b>-5</b>	<b>-9</b>	<b>-16</b>	<b>-24</b>	<b>-55</b>	<b>-35</b>	<b>-48</b>	<b>-137</b>
<b>Total deficit reduction.....</b>	<b>-27</b>	<b>-63</b>	<b>-95</b>	<b>-124</b>	<b>-156</b>	<b>-465</b>	<b>-192</b>	<b>-235</b>	<b>-958</b>
<b>Resulting deficit/surplus....</b>	<b>170</b>	<b>152</b>	<b>116</b>	<b>100</b>	<b>80</b>		<b>33</b>	<b>-7</b>	

NOTE: Details may not add to totals due to rounding. All totals shown on a unified budget basis.

Prepared by SBC Majority Staff, 22-Jan-95

SENT BY: Xerox Telecopier / 10/20 : 6-23-95 : 8:42AM : 202249/001

## CONFERENCE AGREEMENT COMPARED TO BASELINE

(Dollars in billions)

	1996	1997	1998	1999	2000	5-yr total	2001	2002	Grand total
<b>Current Law Deficit.....</b>	<b>198</b>	<b>215</b>	<b>211</b>	<b>225</b>	<b>238</b>		<b>226</b>	<b>229</b>	
<b>Discretionary:</b>									
<b>Defense.....</b>	<b>6</b>	<b>8</b>	<b>8</b>	<b>9</b>	<b>9</b>	<b>40</b>	<b>9</b>	<b>9</b>	<b>58</b>
<b>Nondefense.....</b>	<b>-10</b>	<b>-23</b>	<b>-27</b>	<b>-31</b>	<b>-31</b>	<b>-121</b>	<b>-34</b>	<b>-35</b>	<b>-190</b>
<b>Mandatory:</b>									
<b>Social Security.....</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Medicare.....</b>	<b>-8</b>	<b>-18</b>	<b>-27</b>	<b>-37</b>	<b>-49</b>	<b>-139</b>	<b>-60</b>	<b>-71</b>	<b>-270</b>
<b>Medicaid.....</b>	<b>-4</b>	<b>-8</b>	<b>-16</b>	<b>-24</b>	<b>-33</b>	<b>-85</b>	<b>-43</b>	<b>-54</b>	<b>-182</b>
<b>Other mandatory.....</b>	<b>-10</b>	<b>-19</b>	<b>-25</b>	<b>-26</b>	<b>-29</b>	<b>-108</b>	<b>-30</b>	<b>-36</b>	<b>-174</b>
<b>Revenues.....</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>3</b>
<b>Total policy changes.....</b>	<b>-26</b>	<b>-59</b>	<b>-86</b>	<b>-108</b>	<b>-132</b>	<b>-411</b>	<b>-158</b>	<b>-187</b>	<b>-756</b>
<b>Debt service.....</b>	<b>-1</b>	<b>-5</b>	<b>-9</b>	<b>-16</b>	<b>-24</b>	<b>-55</b>	<b>-35</b>	<b>-48</b>	<b>-137</b>
<b>Total deficit reduction.....</b>	<b>-27</b>	<b>-63</b>	<b>-95</b>	<b>-124</b>	<b>-156</b>	<b>-465</b>	<b>-192</b>	<b>-235</b>	<b>-958</b>
<b>Resulting deficit/surplus....</b>	<b>170</b>	<b>152</b>	<b>116</b>	<b>100</b>	<b>80</b>		<b>33</b>	<b>-7</b>	

NOTE: Details may not add to totals due to rounding. All totals shown on a unified budget basis.

Prepared by SBC Majority Staff, 22-Jun-95

(American Medical Association) AMA File

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 44-A-95

Subject: Medicare Transformation: Current Status

Presented by: P. John Seward, MD, Chair

Referred to: Reference Committee A  
(Ann Cea, MD, Chair)

### 1 BACKGROUND

2

3 Informational Board of Trustees Report 17 (A-95), before the House at this Meeting, identifies  
4 the need for fundamental transformation of the Medicare program. It also outlines AMA  
5 strategies on this critical issue, emphasizing that Medicare's current crisis follows from its  
6 open-ended promise. Although the program has had great success in securing universal access  
7 to high quality medical care for elderly Americans, it faces a dismal financial future.

8

9 This course, if uncorrected, portends accelerated instability and physician and provider payment  
10 cuts that exacerbate rather than remedy Medicare's problems. Ultimately, the program will fail  
11 in its fundamental objective of ensuring access to high quality medical care for elderly and  
12 disabled Americans. Medicare's public trustees have concluded that "... Medicare reform  
13 needs to be addressed urgently as a distinct legislative initiative." (April 3, 1995)

14

15 Past attempts to resolve this looming crisis have been fundamentally ineffective. At the same  
16 time, they have often increased program complexity and driven Medicare physician payment  
17 levels well below private payment levels, threatening access to care. Many policymakers and  
18 analysts now recognize that physician cuts are not the path to Medicare solvency.

19

20 Over the past several months, the Board of Trustees has utilized the AMA's extensive policy  
21 base to advance the case for fundamental Medicare transformation as reported in Report 17.  
22 This report updates Report 17 by reviewing the current status of the Medicare transformation  
23 debate, outlining the Board's current strategy and policy approach to this issue, and making five  
24 recommendations for policy changes needed to enhance AMA advocacy efforts.

25

### 26 HOW SHOULD MEDICARE BE TRANSFORMED?

27

#### 28 AMA Policy Directions

29

30 As Board Report 17 (A-95) outlines, Medicare must be transformed by reducing the growth  
31 rate of program expenditures and by fully funding its promise to beneficiaries. These goals  
32 cannot be met through the failed policies of the past. They must be achieved through shared  
33 sacrifice.

## B of T Rep. 44 - A-95 - page 2

1 Report 17 outlines elements of Medicare transformation, firmly grounded in AMA policy, that  
2 can guide development of specific AMA positions and proposals. These include:

- 3
- 4 • Enhance personal responsibility and cost consciousness. AMA policy (Policy 185.986,  
5 AMA Policy Compendium) encourages actions to identify, publicize and correct flaws  
6 in Medicare. One of Medicare's major flaws is the absence of beneficiary cost  
7 consciousness in consuming medical care, with Medigap coverage offsetting current  
8 cost sharing provisions for most beneficiaries. Possible responses include restructuring  
9 current cost sharing to be more efficient (Policies 165.960[4] and 165.989[13]) and  
10 offering Medical Savings Accounts (MSAs) (Policies 165.920[6] and 165.951).
  - 11
  - 12 • Enhance intergenerational equity in financing. The AMA has longstanding policy to  
13 place Medicare on a firmer and more equitable financial footing. These include the use  
14 of MSAs for the working population to accumulate savings for medical care needs in  
15 retirement and some level of linkage between beneficiary income and the Part B  
16 subsidy. (Board of Trustees Report 15, also before the House at this Meeting,  
17 summarizes and refines AMA policy on this latter issue.) It would also be appropriate  
18 to revise the arbitrary use of the age 65 for setting Medicare eligibility as has already  
19 been done for Social Security (165.993[2]).
  - 20
  - 21 • Enable and facilitate price competition among providers. AMA policy supports  
22 competitive approaches to health system problems from a number of standpoints,  
23 ranging from maintaining physicians' freedom to determine their own fees to  
24 encouraging the efficient provision and use of health care services. This policy  
25 suggests several approaches to integrating competition into Medicare pricing, including  
26 integrating the AMA's "new approach to fee-for-service" (Policy 400.960) with  
27 longstanding policy favoring use of the Medicare RBRVS in the context of allowing  
28 physicians to set their own conversion factor while Medicare sets its conversion factor  
29 based on budgetary and other considerations (Policy 400.994). In addition, MSAs  
30 would stimulate competition.
  - 31
  - 32 • Reduce regulatory and administrative complexity. The AMA seeks reduced hassles for  
33 physicians and patients and increased uniformity as needed to accomplish these goals.
  - 34

35 Implementation and Communication of AMA Medicare Strategy

36  
37 The AMA has been pursuing these Medicare policy goals in a variety of forums over the past  
38 several months. Lonnie R. Bristow, MD, president-elect of the AMA, outlined the AMA's  
39 broad approach in a speech to the Commonwealth Club on January 13, 1995. Since then, the  
40 AMA has also presented its views in formal testimony and in informal communications to  
41 relevant House and Senate Committees as well as to the Administration.

42  
43 The AMA also has embarked upon the necessary education of both Members of Congress and  
44 their staffs as well as the public and has encouraged opinion leaders and policy think tanks to  
45 study and advocate Medicare transformation. In addition, detailed information on AMA  
46 Medicare strategies and policy directions has been shared with the Federation.

## B of T Rep. 44 - A-95 -- page 3

1 Finally, we have held discussions with the leadership of the House of Representatives, as have  
2 other groups. At the Speaker's request, we have provided him with working draft proposals,  
3 incorporating the ideas and policies discussed in this Report, including those concepts for which  
4 we are requesting House of Delegates' action in this Report.

5  
6 Current Congressional and Administration Environment

7  
8 As expected, House and Senate Budget Resolutions have proposed unprecedented reductions in  
9 the rate of growth in Medicare spending. It appears that the savings target to emerge from  
10 conference committee will be about \$269 billion over seven years. Specific proposals released  
11 during these debates include major changes and sacrifices for providers and beneficiaries alike.  
12 In testimony before the Senate Finance Committee and the House Ways and Means Committee,  
13 AMA Trustees stated that a transformation of Medicare is needed, based on principles outlined  
14 in this report. They also emphasized that "[a] balanced budget cannot be 'balanced' on the  
15 back of one program and those who provide that program's services."

16  
17 Most recently, the Clinton Administration has released its plan for achieving a balanced budget.  
18 Although the projected Medicare reductions are below proposed Congressional levels, these  
19 outlined proposals rely solely on physician, hospital, and other provider cuts. Although  
20 complete details of the Administration proposal were not available at the time of this writing,  
21 the Board is pleased that the President is becoming actively involved in ongoing efforts to  
22 rescue the Medicare program. The AMA will engage the Administration actively, as it has the  
23 Congress, in pursuing the following fundamental AMA objectives:

- 24  
25 1. advocating the need for a complete Medicare transformation rather than continued  
26 reliance on the failed policies of continual physician and provider payment cuts;  
27  
28 2. enhancing patient and physician choice of delivery system; and  
29  
30 3. emphasizing the need to protect and enhance the quality of the medical care received by  
31 Medicare beneficiaries.

32  
33 THE AMA APPROACH TO MEDICARE TRANSFORMATION

34  
35 Given the current environment, the Board of Trustees believes that the following general  
36 advocacy approach will be effective for the AMA over the next several months. It has been  
37 developed to be consistent with the broad outlines and specific directives of AMA policy. In  
38 the discussion that follows, policies that do require change are identified and specific  
39 recommendations made for consideration by the House of Delegates.

40  
41 This transformation approach is a fundamental shift away from government control toward  
42 personal responsibility, choice, and an invigorated Medicare marketplace. It is simple in  
43 conception and execution, highly workable, and consistent with directions identified by many of  
44 the leading public and private sector Medicare experts. It will:

- 45  
46 • address fundamental beneficiary needs for a stable Medicare program, financial  
47 protection and predictability, choice, and consumer safeguards;

## B of T Rep. 44 - A-95 -- page 4

- 1 • meet the immediate and longer-term needs of the Congress and the Medicare Hospital  
2 Insurance Trust Fund for reductions in expenditure growth to sustainable levels; and  
3  
4 • enhance physicians' ability to provide services to Medicare beneficiaries in a stable and  
5 quality-promoting financial, clinical and practice environment.  
6

7 Transforming Medicare Benefits and Payment Methods  
8

9 The key elements of the Board's approach to Medicare transformation are simple. Beneficiaries  
10 should have the ability to remain in the current Medicare program, as appropriately modified,  
11 without undue financial penalty. Beneficiaries should also, however, have expanded choice of  
12 delivery system through a Medicare contribution to their health plan of choice. The choice of  
13 plans would include traditional health benefit plans, benefit payment schedule plans, managed  
14 care plans, physician sponsored networks, and MSAs. This option, which reflects AMA policy  
15 on privatizing Medicare (Policies 165.971, 165.987, 165.993, and 330.968), would operate like  
16 the successful, cost-effective Federal Employees Health Benefit Plan (FEHBP).  
17

18 To protect program solvency and financial stability, Medicare's contribution to purchase of an  
19 individual's health plan should be a "defined contribution" whose initial level and subsequent  
20 growth reflect the costs of providing current Medicare benefits as well as the requirements of  
21 Medicare solvency. Current AMA policy (Policies 165.985, 165.989, and 165.993) tends to  
22 focus on a benefits approach to developing the Medicare contribution to private health plans.  
23 With beneficiaries able to retain the traditional Medicare, however, the Board believes that  
24 defined contributions provide needed financial predictability and benefit design flexibility.  
25 Incorporation of this approach will require a clarifying change in AMA policy as recommended  
26 in the conclusion of this report.  
27

28 Traditional Medicare would be revised in two major ways to enhance beneficiary cost  
29 consciousness and provider competitiveness. First, current Medicare deductibles and co-  
30 insurance and beneficiary expenditures for Medigap coverage for cost sharing would be  
31 restructured and replaced by a single combined Part A and Part B deductible that would  
32 enhance the effectiveness of Medicare cost sharing, improve patient choice, maintain financial  
33 protection for beneficiaries, and reduce costs to both Medicare and beneficiaries stemming from  
34 separate Medigap coverage. This approach, although consistent with AMA support for  
35 effective cost-sharing, should be specified through a policy change supporting general  
36 restructuring of Medicare cost sharing.  
37

38 Second, Medicare should eliminate price and regulatory controls on charges and payments,  
39 including limiting charges for physicians' services (Policies 390.898, 390.958, 390.922, and  
40 400.994) and the flawed Medicare Volume Performance Standard (Policies 395.992, 395.999,  
41 400.965). These would be replaced by a competitive pricing system in which physicians would  
42 set and disclose to patients their own dollar conversion factor for the RBRVS. Medicare would  
43 set its conversion factor, considering both the budget and patient access to care, reflecting  
44 Policies 400.960 and 400.994. A similar approach should be implemented for Part A.  
45

46 Consistent with existing policies, patient and physician interests in high-quality care should be  
47 protected through non-intrusive regulatory approaches and existing or enhanced private sector  
48 efforts. These could include enrollment guidelines, disclosure and grievance procedures, and

## B of T Rep. 44 - A-95 - page 5

1 significant organized physician involvement in development of medical policies. There should  
2 be maximum flexibility in the means of achieving the requirements. To the greatest extent  
3 possible, accreditation by voluntary private sector bodies should be used instead of regulation.  
4

5 The Board also believes that a private sector partnership to enhance health care value should  
6 coordinate and focus efforts to develop medical and plan standards. It should include  
7 representatives from medical societies, hospital associations, insurers and national managed care  
8 companies, accrediting bodies, employers, consumer groups, and the federal government. It  
9 would marshal private sector resources devoted to development and application of medical  
10 standards, in cooperation with federal agencies such as the AHCPR, HCFA, and the NIH.  
11

12 Finally, consistent with Policies 165.951, 190.992, 190.983, 190.986, and 315.993, Medicare  
13 should implement, and expand to private sector plans treating Medicare beneficiaries, its efforts  
14 in administrative simplification, including uniform electronic and paper claim forms,  
15 computerized patient records and electronic patient records.

] Don't we  
have this?

16  
17 Transforming Medicare Funding of Graduate Medical Education

18  
19 In recent years, the AMA and other public and private organizations have devoted extensive  
20 attention to adequate funding of graduate medical education (GME). Medicare payment for  
21 direct medical education payments and indirect medical education adjustment has come under  
22 close scrutiny from the standpoint of both the federal budget and prudent workforce planning.  
23 The Council on Medical Education and the Council on Long Range Planning and Development  
24 have discussed these issues extensively in recent reports to the House (Policies 200.968 and  
25 305.981). One notable policy that has emerged from this process is the call for an all-payor  
26 funding pool for GME. The Board believes that, in the context of such a pool, the current  
27 exigencies of the Medicare program and current workforce requirements justify the following  
28 policy approaches that would rationalize the funding of GME.  
29

30 1. Consistent with Policies 165.987 and 200.968, Medicare's GME burden should be  
31 diminished over time and the private sector should play an enhanced role both in work force  
32 planning and in funding graduate medical education. As one means to implement this approach,  
33 in conjunction with an all-payor funding system, the Board believes that Policy 305.968, which  
34 calls for the "Congress to support the current level of direct and indirect costs of graduate  
35 medical education," should be revised to allow for changes in the funding formulas for these  
36 payments to halt the current steady increase in costs.  
37

38 2. The Board also believes that the time has come to restrict the number of residency positions  
39 funded through the Medicare DME adjustment. Its analysis suggests that this number should be  
40 reduced, over time, to 110% of the FY95 number of MD- and DO-graduates from medical  
41 schools in the United States. The reductions in the number of training positions not should be  
42 taken primarily from those positions filled by graduates of United States medical schools.  
43

44 CONCLUSIONS

45  
46 The Board will pursue the best possible outcome for physicians and their patients given current  
47 Medicare and federal budget realities. In advocating this approach to Medicare transformation,  
48 the Board has held extensive substantive discussions with the Administration and Congressional

## B of T Rep. 44 - A-95 - page 6

1 leadership. These discussions have been guided by the AMA's extensive Medicare policy base.  
 2  
 3 In pursuing Medicare transformation, the Board emphasizes that the changes outlined in the  
 4 previous section have been estimated to provide the Medicare program with substantial savings  
 5 that, while highly responsive to the budgetary priorities outlined by the Congress and the  
 6 Administration, would not sacrifice the ability of Medicare beneficiaries to obtain high quality  
 7 medical care. These savings are, in fact, a shared contribution by both beneficiaries and  
 8 providers through more efficient utilization, but without arbitrary provider payment cuts or  
 9 benefit reductions. They also reflect a rationalization of GME funding and workforce policies.

10  
 11 It is important to emphasize that enhanced cost consciousness does not mean substantial  
 12 increased beneficiary costs. Most beneficiaries could actually save money over what they  
 13 would have paid in deductibles, coinsurance, and Medigap premiums in a modernized approach  
 14 to cost sharing. Such an approach could include protections for low-income beneficiaries.

15  
 16 Finally, the Board emphasizes that the current Medicare Volume Performance Standard  
 17 (MVPS), if allowed to operate as under current law, is projected to reduce the Medicare  
 18 RBRVS conversion factor by 2-3% each year after 1996. This outcome results from the flawed  
 19 MVPS formula, which, as modified by the Omnibus Budget Reconciliation Act of 1993,  
 20 contains almost no allowance for increases in the volume of care provided to meet the needs of  
 21 Medicare beneficiaries. The AMA has testified before the PPRC and the Congress on the  
 22 pressing need to correct this grievously flawed formula. In advocating the proposal outlined  
 23 above, which would eliminate the limiting charge program and MVPS, the Board will, in the  
 24 context of current budget realities, vigorously pursue relief from these projected payment cuts.

25

26

27 RECOMMENDATIONS

28

29 The Board of Trustees recommends adoption of the following recommendations and that the  
 30 remainder of this report be filed:

31

32 1. That the AMA reaffirm that the fundamental goal of transforming Medicare should be  
 33 to assure the health of the elderly and disabled populations. Patients must have access  
 34 to high quality medical services. The best value in medical care can be achieved by  
 35 ensuring that the medical profession has a central role in the design and implementation  
 36 of a new Medicare program.

37

38 2. That, in the context of changes that enhance the fiscal solvency of Medicare, increase  
 39 beneficiary choice, and encourage program privatization, AMA policy should accept a  
 40 defined contribution by the federal government toward the purchase of private health  
 41 care coverage by Medicare beneficiaries. This defined contribution should equal the  
 42 actuarial value of the government Medicare contribution for individuals retaining  
 43 traditional Medicare coverage. The value of this contribution should reflect the cost of  
 44 access to needed health care and the need to establish the fiscal solvency of Medicare.

*Medicare  
 elimination program controls  
 means  
 limiting  
 charges*

## B of T Rep. 44 - A-95 -- page 7

## 1 Board of Trustees Suggested Clarifying Additions to Board of Trustees Report 44 (A-95)

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3. That AMA policy should include approaches that restructure Medicare beneficiary deductibles, coinsurance, premiums, and Medigap insurance to enhance the effectiveness of cost sharing, increase patient choice, maintain beneficiary financial protection, and reduce costs to Medicare and beneficiaries from Medigap coverage.
4. That, consistent with current AMA policy, Medicare should eliminate price and regulatory controls on charges and payments, including limiting charges for physicians' services (Policies 399.998, 399.998, 399.999, and 400.994) and the flawed Medicare Volume Performance Standard (Policies 395.992, 395.999, 400.965). Consistent with Policies 400.960 and 400.994, these controls would be replaced by a competitive pricing system in which physicians would set and disclose to patients their own dollar conversion factor for the RBRVS and Medicare would set its conversion factor, considering both the budget and patient access to care. A similar approach should be implemented for Part A of Medicare.
5. That Policy 305.968, in which the "[t]he AMA strongly urges Congress to support the current level of funding of direct and indirect costs of graduate medical education in Medicare legislation" should be replaced by policy stating that: "In the context of an all-payor funding pool for graduate medical education (Policy 165.897), Medicare contributions for direct and indirect costs of graduate medical education should be reduced consistent with the need to improve Medicare fiscal solvency and with the proviso that these funds be replaced, in aggregate, with contributions from the all-payor funding pool sufficient to maintain adequate funding for graduate medical education."
6. That AMA policy should accept a reduction in the number of first year residency positions funded through the Medicare direct medical education (DME) adjustment. Over time, this number should be reduced to 110% of the FY95 number of MD- and DO-graduates from medical schools in the United States. The reductions in the number of training positions should not be taken primarily from those positions filled by graduates of United States medical schools.

Fiscal Note: Within current budget.

# FAX

**American Hospital Association  
325 - Seventh Street, N.W.  
Suite 700  
Washington, D. C. 20004-2802  
202-638-1100**

**TO:** Marilyn Geager  
**FROM:** Herb Kuba  
**DATE:** 5-11-95  
**FAX #:** 456-6218  
**PAGES:** 4

**NOTES:**  
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American Hospital Association



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**Contacts:** William Erwin -- 202/626-2284  
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Alicia Mitchell -- 202/626-2339

## **AHA TO UNVEIL NEW DATA ON IMPACT OF MEDICARE REDUCTIONS**

Medicare is on the chopping block this week in the Senate and House Budget committees. These enormous spending reductions could devastate hospitals, health systems and the communities they serve. On May 11, American Hospital Association President Dick Davidson will be releasing new data prepared by Lewin-VHI illustrating the impact on hospitals of the Medicare budget numbers. The effect on different types of hospitals, along with impact by state, will also be available. Hospital representatives from key states will present perspectives of the impact on their hospitals.

**WHAT:** Press Conference on impact of proposed Medicare reductions

**WHEN:** Thursday, May 11  
9:00 - 9:30 a.m.

**WHERE:** Reserve Officers Association of the United States  
The Congressional Hall of Honor -- 5th Floor  
One Constitution Avenue, NE  
(directly across the street from the Senate Dirksen Building)

The American Hospital Association, a not-for-profit organization, serves as a national advocate for about 5,000 hospitals and health networks and the patients they serve; provides education and information for its members; and informs the public about hospitals, health systems and health care issues.

American Hospital Association



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

Office of the President

One North Franklin  
Chicago, Illinois 60606

May 10, 1995

The Honorable Bob Dole  
Majority Leader  
United States Senate  
S - 230 The Capitol  
Washington, DC 20510

(Identical letter sent to  
Speaker Newt Gingrich)

Dear Majority Leader Dole:

We fear that rhetoric and reality appear to be on a collision course on one of the most important issues ever to face Congress: the future of Medicare and Medicaid. In the past week, for example, the American people were told that Congress was about to "save the Medicare trust fund" from bankruptcy. Then, the Senate and House budget committees proposed the deepest spending reductions in the 30-year history of health insurance for the elderly. Do these spending reductions avert the trust fund's insolvency? No, -- only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question. On the Medicaid side, the senior citizens and children who make up most of the population that program serves could lose access to some kinds of care altogether, joining the growing ranks of the uninsured.

It is disappointing to discover that what last week sounded like a refreshing departure from the "business as usual" Medicare hammering of the past has this week become a gutting of the health care portion of the Social Security contract with America. Thirty years after its inception, Medicare must change and the decisions about that change will require sacrifice from all, including hospitals. It will also require the strong support of the public.

But that's not what's happening today. As long as Medicare is still part of the federal operating budget, and as long as trust fund balances and spending reductions are all part of the deficit equation, then it is impossible to give our citizens the assurances that Medicare is on the road to recovery. The American people must not be led to believe that the trust fund is secure when it is not. The enormous spending reductions contained in both the House and Senate budget committee proposals must not be portrayed as merely "rate of growth" reductions. They will lead inevitably to real cuts in services and resources available to take care of people.

Medicare cannot be strengthened just by cutting the growth in spending for hospital and physician care. The Medicare rolls will continue to grow; people will live longer and need more help. New medical technology will cost more. Inflation in the general economy -- always unpredictable -- will play a significant role.

**The Honorable Bob Dole**  
**Page two**

**There is no "silver bullet" fix for the serious problems confronting Medicare.**

**A wide range of options must be on the table and crafted into a long-term solution that is equitable to all. That means, considering not only reductions in the spending growth rate, but strong incentives for seniors to choose coordinated care, prudent increases in co-payments and deductibles, and fair means testing and eligibility criteria.**

**But the longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all.**

**Majority Leader Dole, we urge you to put Medicare back on the course outlined last week -- treating it as a real trust fund, not as a federal budget line item, and ensuring that "every penny saved" from the program is used to strengthen it for the future.**

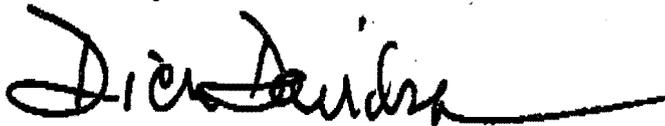
**Months ago, hospitals introduced the concept of a truly independent commission to sort out the choices about Medicare funding; benefits and recipient payments; eligibility; payments to hospitals, doctors, and others; and oversee a process to allow the Congress to make those choices in an open and accountable way.**

**The Senate Budget Committee and others have embraced the concept, but only as a short-term alternative in the current budget environment. In our view, that is too limited and too narrow to ensure the long-term viability of a program that clearly, in some form, is a permanent commitment to our citizens.**

**We stand ready to work with the leadership of the Congress to thoughtfully control the growth of Medicare, but only in a way that strengthens, not weakens, the program. We believe a permanent, independent commission can help provide that strength.**

**Let's get on with that important work now, but let it be driven by the goal of making Medicare affordable for the nation and accessible to those who rely on it. Those were among the founding principles of the program 30 years ago, and they should remain its bedrock today and in the future.**

Sincerely,



**Richard J. Davidson**  
**President**

**Courtesy Copy:**  
**The Honorable Newt Gingrich**



---

**Herb B. Kuhn**  
Vice President  
Congressional and  
Executive Branch Relations

American Hospital Association  
Liberty Place  
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## **Press Conference on the Impact of Medicare Reductions**

### **Participants**

**Dick Davidson**  
President  
American Hospital Association, Washington, D.C.

**Frances M. Hoffman**  
Continuous Quality Improvement Coordinator  
North Iowa Mercy Health System, Mason City, Iowa

**Carmela Dyer**  
Vice President for Policy Development  
American Hospital Association, Washington, D.C.



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## NEWS RELEASE

FOR IMMEDIATE RELEASE

CONTACT: William Erwin - (202) 626-2284  
Carol Schadelbauer - (202) 626-2342  
Alicia Mitchell - (202) 626-2339

### **UNPRECEDENTED SPENDING REDUCTIONS COULD JEOPARDIZE HEALTH CARE**

WASHINGTON, D.C. (May 11, 1995) -- Unprecedented reductions in Medicare spending proposed by Congressional budget committees could damage access to health care for the nation's senior citizens and the quality of care they receive, American Hospital Association President Dick Davidson said today in a letter to House Speaker Newt Gingrich (R-Ga.) and Senate Majority Leader Robert Dole (R-Kan.)

Davidson released the letter to reporters at a news conference on Capitol Hill. At the same time, he expressed disappointment about proposed massive Medicaid spending reductions and the effect these reductions would have on the older Americans and children who make up the bulk of Medicaid recipients.

"In the past week, the American people were told that Congress was about to 'save the Medicare trust fund' from bankruptcy," the AHA president said in the letter. "Do these spending reductions avert the trust fund's insolvency? No, only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question."

At the news conference, Davidson unveiled new estimates from the health consulting firm Lewin-VHI that illustrate the potential impact on hospitals of possible Medicare spending reductions. The estimates assume that Medicare spending will be reduced by \$250 billion over the next seven years. Senate and House budget committees have proposed even larger reductions.

(MORE)

## MEDICARE REDUCTIONS/2

The Lewin-VHI analysis assumes that a \$250 billion reduction could translate into an estimated \$94 billion less for hospitals over seven years in Medicare payments for hospitalized acute care patients than they would receive under present Medicare law. In addition, the analysis assumes that a series of specific policies would be enacted to achieve these reductions (see Exhibit 4 attached).

The study found that:

- By the year 2002, Medicare could pay hospitals only 89 cents on the dollar for the operating costs of delivering inpatient care to a Medicare patient. Today, hospitals barely break even under the Medicare Prospective Payment System.
- Every type of hospital would suffer under the reductions. Urban and rural hospitals would be almost equally hard hit. Likewise, large hospitals would be affected as seriously as small hospitals.
- The average hospital in 2002 could lose \$889 per Medicare inpatient.

In his letter to Gingrich and Dole, Davidson said: "The longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all."

As part of the long-range solution for Medicare, Davidson urged Dole and Gingrich to support the creation of an independent citizens' commission to balance Medicare spending with the benefits covered by the Medicare program. The commission would make recommendations to Congress on changes in the Medicare program to bring spending within a target budget set by Congress.

(MORE)

## MEDICARE REDUCTIONS/3

The recommendations would be considered under a "fast track" process, with Congress voting yes or no on the entire package of recommendations. Senate Republicans have proposed a somewhat similar commission, but with a life span of only a few months.

The commission proposed by the American Hospital Association, in contrast, would have an unlimited life, would be truly independent from day-to-day political battles in Congress and would have wide latitude to recommend changes in Medicare spending and benefits.

The AHA, a not-for-profit organization, is a national advocate for almost 5,000 hospitals and health networks, and the patients they serve; provides education and information for its members; and informs the public about hospitals, health systems and health care issues.

# **Exhibit 4: Assumptions for Modeling \$250 Billion in Medicare Spending Reductions: 1996 - 2002**

	1996-2000	2001-2002	7-Year Total
Medicare reductions 1996 - 2000 (billions)	\$150	\$100	\$250
Assumed reductions in PPS hospital payments a/	\$57	\$37	\$94
Assumed method of reduction			
IME add-on cut by: b/	27.3%	27.3%	NA
DSH payments reduced by: c/	20.0%	20.0%	NA
Update Factor set at:	MB-4.5%	MB+2.8%	NA

- a/ Figures based on inpatient operating revenues only and do not include share of reductions applicable to capital or DME.
- b/ The indirect medical education (IME) add-on factor is reduced from 7.7 percent for every 0.1 residents per bed under current law to 5.6 percent for 1996-2002.
- c/ Disproportionate share hospital (DSH) payments are now directed at hospitals which serve a high proportion of medically indigent patients.



## FACT SHEET

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The following analysis modeled the impact of Medicare spending reductions of \$150 billion over 5 years and \$250 billion over 7 years on hospitals and health systems. This is similar to the level of spending reductions proposed by Sen. Pete Domenici (R-NM), chairman of the Senate Budget Committee. Spending reductions proposed by the House Budget Committee are even greater. No specific details have been released about how the Senate spending reductions would be achieved. We have assumed, based on the pattern of reductions in previous proposals, that these overall Medicare reductions could translate into hospital Prospective Payment System (PPS) reductions of \$94 billion over 7 years.

Using this assumption and others detailed in Exhibit 4, Lewin-VHI estimated the potential impact on Medicare inpatient PPS operating margins. These estimates are not intended to predict future hospital financial status with certainty, but rather to illustrate financial pressures hospitals would face if reductions of this magnitude were enacted.

Reductions of this order are bigger than anything ever proposed. This could be devastating to the nation's hospitals, health systems and the communities they serve.

The Lewin-VHI findings show:

- Under this scenario, every hospital loses -- rural, urban, large, small, teaching, non-teaching.
- By the year 2000, Medicare PPS inpatient operating margins could fall to negative 20.6 percent. Because most of the reductions are made in the first five years, margins rise for the last two years, but still remain negative -- a negative 12.2 in the year 2002.
- By the year 2000, hospitals could lose \$1,300 in PPS payments for every Medicare patient. Hospitals could lose \$900 per Medicare patient in the year 2002.
- Hospitals' PPS costs last year grew at 2.1 percent -- the lowest rate ever. Lewin-VHI estimates use a very conservative number for hospital cost growth (slightly less than 4 percent annually), based on recent experience.

**Prospective Payment System (PPS)** - A payment system, implemented in 1983, in which the amount a hospital receives for treating a patient is fixed in advance by Medicare or an insurer.

**Medicare PPS Operating Margins** - Medicare inpatient operating revenue minus Medicare inpatient operating costs divided by Medicare inpatient operating revenue. These margins relate only to Medicare operating revenues and costs.

PROJECTED MEDICARE PPS INPATIENT OPERATING MARGINS:  
CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
MEDICARE BUDGET REDUCTION SCENARIO  
BY HOSPITAL GROUP (IN PERCENT)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	0.3	3.6	5.4	-20.6	-12.2
TEACHING STATUS						
ALL TEACHING	1,020	3.7	6.9	8.7	-18.6	-10.1
MAJOR TEACHING	224	11.4	15.3	17.2	-11.9	-3.7
MINOR TEACHING	796	-0.1	2.6	4.5	-21.8	-13.2
NON TEACHING	4,027	-3.3	0.0	1.8	-22.7	-14.3
GEOGRAPHIC LOCATION						
URBAN HOSPITALS	2,810	0.3	3.9	5.7	-20.6	-12.1
LARGE URBAN	1,530	1.8	5.8	7.7	-18.7	-10.3
OTHER URBAN	1,280	-2.0	0.9	2.8	-23.4	-14.8
RURAL HOSPITALS	2,237	0.5	1.5	3.0	-20.7	-12.7
SOLE COMMUNITY	603	-2.3	0.8	2.3	-21.5	-13.4
SOLE COMMUNITY/RR	53	6.4	6.3	7.8	-14.7	-7.0
RURAL REFERRAL CENTER	157	2.2	0.9	2.5	-22.1	-13.9
OTHER RURAL	1,424	-0.6	1.2	2.7	-20.7	-12.8
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	7.9	11.3	13.2	-14.8	-6.5
IME ONLY	494	-1.2	1.6	3.5	-23.0	-14.3
DSH ONLY	907	0.4	3.6	5.4	-19.8	-11.5
NO ADJUSTMENTS	3,120	-5.1	-1.7	0.1	-24.1	-15.6
MEDICARE UTILIZATION						
60% AND OVER	1,519	-2.0	0.8	2.6	-21.9	-13.4
UNDER 60%	3,528	0.9	4.2	6.0	-20.3	-11.9
BED SIZE						
1-49 BEDS	1,278	0.6	3.2	4.6	-18.2	-10.5
50-99 BEDS	1,139	-1.2	4.4	5.9	-16.9	-9.0
100-199 BEDS	1,198	-1.6	1.0	2.7	-22.2	-13.8
200-299 BEDS	682	-1.4	1.3	3.2	-22.4	-13.8
300 OR MORE BEDS	750	2.0	5.4	7.3	-19.8	-11.3
OWNERSHIP						
CHURCH	915	-0.0	3.2	5.0	-20.6	-12.1
VOLUNTARY	2,277	0.2	3.2	5.0	-21.4	-12.9
PROPRIETARY	701	0.9	5.8	7.7	-16.2	-8.0
GOVERNMENT	1,154	1.3	4.1	5.8	-21.3	-13.0

PROJECTED MEDICARE PPS INPATIENT NET INCOME PER CASE:  
CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
MEDICARE BUDGET REDUCTION SCENARIO  
BY HOSPITAL GROUP (IN DOLLARS)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	19	280	467	-1294	-889
TEACHING STATUS						
ALL TEACHING	1,020	271	666	936	-1415	-899
MAJOR TEACHING	224	1116	2022	2507	-1189	-434
MINOR TEACHING	796	-5	222	423	-1489	-1051
NON TEACHING	4,027	-163	1	128	-1207	-882
GEOGRAPHIC LOCATION						
URBAN HOSPITALS	2,810	18	329	540	-1400	-957
LARGE URBAN	1,530	124	531	776	-1362	-872
OTHER URBAN	1,280	-117	71	236	-1449	-1066
RURAL HOSPITALS	2,237	20	78	171	-866	-615
SOLE COMMUNITY	603	-83	37	121	-843	-609
SOLE COMMUNITY/RRC	53	304	383	522	-737	-407
RURAL REFERRAL CENTER	157	104	55	169	-1082	-788
OTHER RURAL	1,424	-20	58	139	-800	-571
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	636	1211	1557	-1223	-628
IME ONLY	494	-80	142	340	-1600	-1159
DSH ONLY	907	22	258	420	-1126	-761
NO ADJUSTMENTS	3,120	-241	-106	6	-1241	-932
MEDICARE UTILIZATION						
60% AND OVER	1,519	-97	49	183	-1143	-813
UNDER 60%	3,528	53	348	551	-1340	-912
BED SIZE						
1-49 BEDS	1,278	21	144	224	-659	-441
50-99 BEDS	1,139	-47	234	345	-730	-453
100-199 BEDS	1,198	-81	67	199	-1195	-864
200-299 BEDS	682	-82	102	273	-1383	-992
300 OR MORE BEDS	750	142	514	767	-1489	-989
OWNERSHIP						
CHURCH	915	-1	248	436	-1298	-886
VOLUNTARY	2,277	9	257	447	-1379	-967
PROPRIETARY	701	51	433	631	-974	-557
GOVERNMENT	1,154	67	296	457	-1209	-858

PROJECTED MEDICARE PPS INPATIENT REVENUE AS A PERCENT OF COST:  
CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
MEDICARE BUDGET REDUCTION SCENARIO  
BY HOSPITAL GROUP (IN PERCENT)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	100.3	103.7	105.7	82.9	89.1
TEACHING STATUS						
ALL TEACHING	1,020	103.9	107.4	109.6	84.3	90.8
MAJOR TEACHING	224	112.8	118.1	120.7	89.4	96.4
MINOR TEACHING	796	99.9	102.7	104.7	82.1	88.3
NON TEACHING	4,027	96.8	100.0	101.8	81.5	87.5
GEOGRAPHIC LOCATION						
URBAN HOSPITALS	2,810	100.3	104.0	106.1	82.9	89.2
LARGE URBAN	1,530	101.9	106.1	108.3	84.2	90.7
OTHER URBAN	1,280	98.0	100.9	102.9	81.0	87.1
RURAL HOSPITALS	2,237	100.5	101.5	103.1	82.8	88.8
SOLE COMMUNITY	603	97.8	100.8	102.4	82.3	88.2
SOLE COMMUNITY/RRC	53	106.8	106.7	108.4	87.1	93.4
RURAL REFERRAL CENTER	157	102.3	100.9	102.6	81.9	87.8
OTHER RURAL	1,424	99.4	101.3	102.8	82.8	88.7
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	108.6	112.7	115.1	87.1	93.9
IME ONLY	494	98.8	101.7	103.7	81.3	87.5
DSH ONLY	907	100.4	103.8	105.7	83.5	89.7
NO ADJUSTMENTS	3,120	95.1	98.3	100.1	80.6	86.5
MEDICARE UTILIZATION						
60% AND OVER	1,519	98.0	100.8	102.7	82.1	88.2
UNDER 60%	3,528	100.9	104.4	106.4	83.1	89.4
BED SIZE						
1-49 BEDS	1,278	100.6	103.3	104.8	84.6	90.5
50-99 BEDS	1,139	98.8	104.6	106.3	85.6	91.7
100-199 BEDS	1,198	98.4	101.0	102.8	81.8	87.9
200-299 BEDS	682	98.6	101.4	103.3	81.7	87.9
300 OR MORE BEDS	750	102.0	105.7	107.9	83.5	89.8
OWNERSHIP						
CHURCH	915	100.0	103.3	105.3	82.9	89.2
VOLUNTARY	2,277	100.2	103.3	105.3	82.4	88.6
PROPRIETARY	701	100.9	106.2	108.3	86.1	92.6
GOVERNMENT	1,154	101.3	104.3	106.1	82.4	88.5

PROJECTED MEDICARE PPS INPATIENT OPERATING MARGINS:  
CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
MEDICARE BUDGET REDUCTION SCENARIO  
BY STATE (IN PERCENT)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	-1.4	2.8	4.6	-20.9	-12.4
ALASKA	16	-8.1	-8.0	-5.8	-32.9	-23.4
ARIZONA	56	6.4	10.5	12.7	-11.2	-2.8
ARKANSAS	80	5.2	6.3	7.9	-15.4	-7.5
CALIFORNIA	424	3.7	10.4	12.3	-12.0	-4.0
COLORADO	65	-2.2	1.6	3.3	-21.8	-13.5
CONNECTICUT	34	-8.7	-8.0	-6.5	-36.2	-27.4
DELAWARE	7	-8.7	-2.9	-0.8	-28.8	-19.5
WASHINGTON DC	9	-6.5	0.1	2.1	-29.7	-20.4
FLORIDA	208	-3.7	0.9	2.9	-22.5	-13.7
GEORGIA	156	-0.9	4.2	5.8	-19.5	-11.4
HAWAII	18	-19.4	-17.3	-15.7	-46.6	-37.1
IDAHO	35	1.3	1.5	3.1	-20.4	-12.3
ILLINOIS	203	-4.5	0.7	2.8	-24.6	-15.7
INDIANA	115	-12.3	-9.2	-7.4	-35.1	-25.8
IOWA	121	-2.4	-2.0	-0.2	-25.8	-17.2
KANSAS	129	-3.3	1.2	3.0	-22.2	-13.7
KENTUCKY	103	-0.4	2.6	4.4	-20.9	-12.4
LOUISIANA	132	-7.9	-0.2	1.6	-25.0	-16.3
MAINE	39	-7.3	-3.1	-1.4	-28.0	-19.4
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	8.3	11.5	13.4	-12.1	-4.0
MICHIGAN	159	5.1	9.0	11.0	-14.9	-6.5
MINNESOTA	145	10.6	11.7	13.1	-10.8	-3.4
MISSISSIPPI	99	2.1	3.2	4.9	-20.4	-12.1
MISSOURI	131	-4.1	0.7	2.7	-23.6	-14.8
MONTANA	54	2.7	2.4	4.1	-19.3	-11.1
NEBRASKA	87	-7.5	1.1	2.9	-23.0	-14.5
NEVADA	22	3.4	7.0	9.0	-14.3	-6.0
NEW HAMPSHIRE	26	-13.9	-4.8	-3.1	-29.5	-20.8
NEW JERSEY	88	-8.4	-4.6	-3.0	-30.5	-21.8
NEW MEXICO	35	7.4	11.6	13.5	-9.4	-1.5
NEW YORK	208	13.4	11.4	13.3	-13.2	-5.0
NORTH CAROLINA	124	-1.3	-1.8	-0.4	-28.3	-19.9
NORTH DAKOTA	46	1.0	6.7	8.8	-14.2	-5.9
OHIO	183	-2.8	-1.0	1.1	-26.5	-17.5
OKLAHOMA	111	4.8	5.0	6.9	-17.5	-9.2
OREGON	61	10.5	11.2	12.8	-10.0	-2.4
PENNSYLVANIA	212	2.0	5.4	7.3	-19.1	-10.6
RHODE ISLAND	12	11.4	11.1	13.0	-11.5	-3.6
SOUTH CAROLINA	68	-8.2	-4.3	-2.7	-31.3	-22.5
SOUTH DAKOTA	52	-3.1	0.3	2.2	-22.3	-13.7
TENNESSEE	129	-10.4	-5.8	-4.0	-30.8	-21.8
TEXAS	386	-3.6	2.4	4.1	-21.8	-13.4
UTAH	39	5.2	4.6	6.0	-18.7	-10.7
VERMONT	15	-9.2	-8.6	-7.0	-36.1	-27.1
VIRGINIA	97	-2.5	1.3	3.1	-23.0	-14.5
WASHINGTON	89	5.5	7.6	9.0	-14.8	-7.2
WEST VIRGINIA	57	-1.3	-3.0	-1.4	-28.0	-19.4
WISCONSIN	127	2.4	3.0	4.8	-20.6	-12.2
WYOMING	26	-5.4	2.2	4.0	-19.4	-11.0

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association.

PROJECTED MEDICARE PPS INPATIENT NET INCOME PER CASE:  
CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
MEDICARE BUDGET REDUCTION SCENARIO  
BY STATE (IN DOLLARS)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	-70	183	338	-1109	-765
ALASKA	16	-528	-668	-536	-2225	-1840
ARIZONA	56	388	838	1121	-723	-212
ARKANSAS	80	232	372	515	-741	-422
CALIFORNIA	424	269	1038	1346	-955	-371
COLORADO	65	-129	122	277	-1363	-981
CONNECTICUT	34	-637	-765	-689	-2753	-2417
DELAWARE	7	-518	-236	-70	-1877	-1489
WASHINGTON DC	9	-564	8	278	-2721	-2175
FLORIDA	208	-212	68	256	-1430	-1014
GEORGIA	156	-48	302	455	-1122	-766
HAWAII	18	-1432	-1721	-1726	-3705	-3432
IDAHO	35	62	91	207	-1023	-716
ILLINOIS	203	-255	57	238	-1508	-1117
INDIANA	115	-643	-649	-571	-1993	-1708
IOWA	121	-115	-119	-14	-1276	-988
KANSAS	129	-155	78	210	-1141	-820
KENTUCKY	103	-20	166	315	-1089	-754
LOUISIANA	132	-401	-15	128	-1410	-1069
MAINE	39	-358	-203	-103	-1478	-1184
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	547	1001	1282	-830	-316
MICHIGAN	159	331	773	1045	-1011	-513
MINNESOTA	145	617	898	1100	-659	-242
MISSISSIPPI	99	84	171	286	-874	-605
MISSOURI	131	-222	52	219	-1395	-1019
MONTANA	54	123	139	266	-930	-618
NEBRASKA	87	-383	80	232	-1339	-983
NEVADA	22	232	637	900	-1051	-518
NEW HAMPSHIRE	26	-781	-385	-276	-1904	-1561
NEW JERSEY	88	-518	-382	-276	-2021	-1678
NEW MEXICO	35	368	768	984	-503	-92
NEW YORK	208	1047	1117	1438	-1011	-448
NORTH CAROLINA	124	-74	-134	-31	-1715	-1405
NORTH DAKOTA	46	50	463	670	-795	-386
OHIO	183	-165	-77	89	-1608	-1233
OKLAHOMA	111	234	312	473	-883	-538
OREGON	61	614	852	1072	-615	-171
PENNSYLVANIA	212	121	431	639	-1199	-778
RHODE ISLAND	12	748	936	1201	-772	-277
SOUTH CAROLINA	68	-449	-322	-220	-1853	-1553
SOUTH DAKOTA	52	-139	18	146	-1106	-794
TENNESSEE	129	-520	-394	-296	-1687	-1391
TEXAS	386	-201	183	350	-1347	-965
UTAH	39	322	370	541	-1219	-816
VERMONT	15	-499	-607	-542	-2034	-1772
VIRGINIA	97	-130	88	234	-1282	-938
WASHINGTON	89	332	611	793	-958	-542
WEST VIRGINIA	57	-64	-184	-94	-1372	-1104
WISCONSIN	127	130	207	366	-1157	-795
WYOMING	26	-237	131	270	-969	-640

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association.

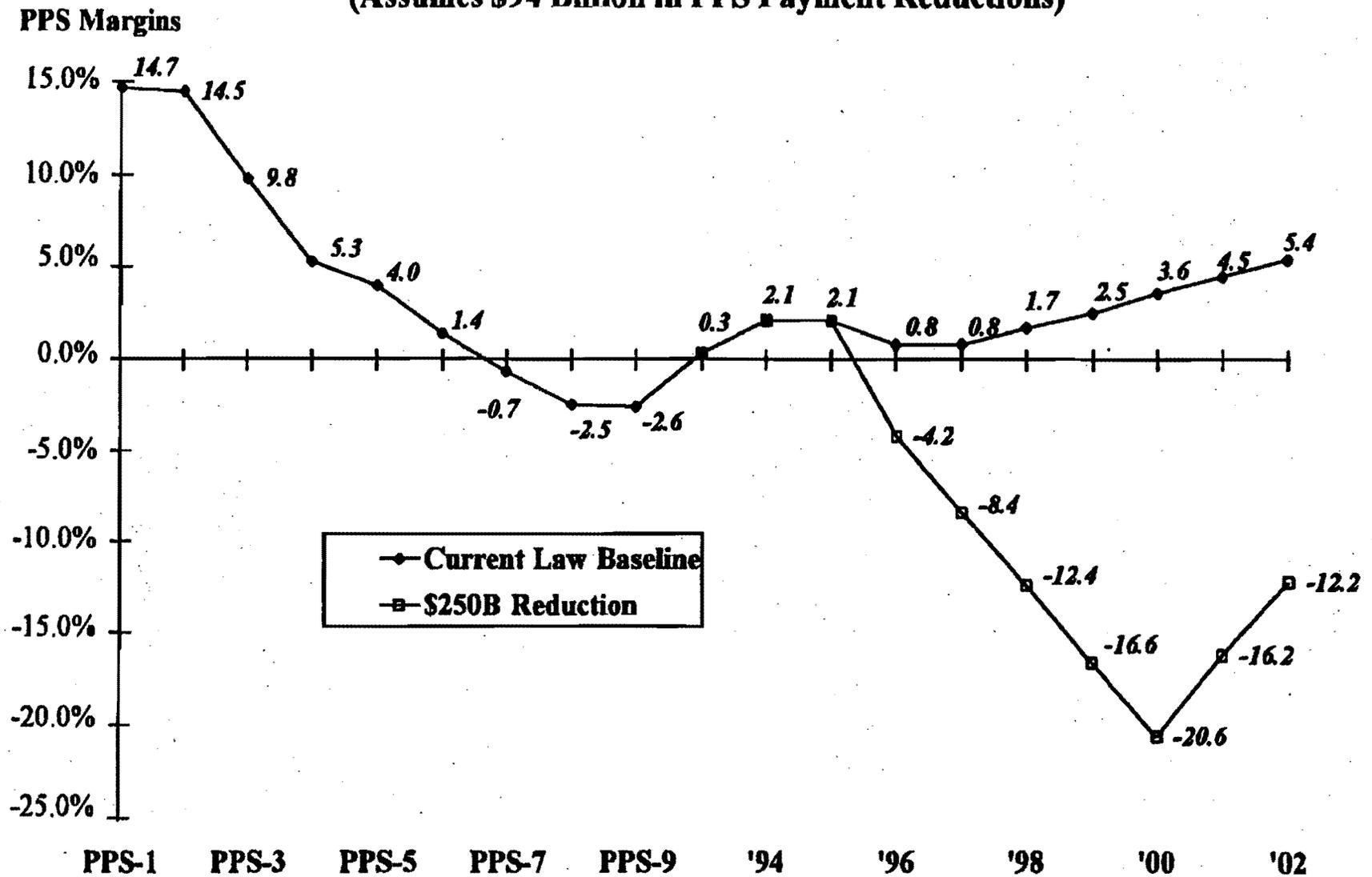
PROJECTED MEDICARE PPS INPATIENT REVENUE AS A PERCENT OF COST:  
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION  
 MEDICARE BUDGET REDUCTION SCENARIO  
 BY STATE (IN PERCENT)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	98.6	102.8	104.9	82.7	89.0
ALASKA	16	92.5	92.6	94.5	75.3	81.0
ARIZONA	56	106.9	111.7	114.5	89.9	97.3
ARKANSAS	80	105.4	106.7	108.5	86.7	93.0
CALIFORNIA	424	103.9	111.6	114.0	89.3	96.2
COLORADO	65	97.8	101.6	103.4	82.1	88.1
CONNECTICUT	34	92.0	92.6	93.9	73.4	78.5
DELAWARE	7	92.0	97.2	99.2	77.7	83.7
WASHINGTON DC	9	93.9	100.1	102.2	77.1	83.1
FLORIDA	208	96.5	100.9	103.0	81.6	88.0
GEORGIA	156	99.1	104.4	106.1	83.7	89.7
HAWAII	18	83.8	85.2	86.4	68.2	73.0
IDAHO	35	101.3	101.5	103.2	83.0	89.1
ILLINOIS	203	95.7	100.7	102.9	80.2	86.4
INDIANA	115	89.1	91.6	93.1	74.0	79.5
IOWA	121	97.6	98.1	99.8	79.5	85.3
KANSAS	129	96.8	101.2	103.1	81.8	87.9
KENTUCKY	103	99.6	102.6	104.6	82.7	89.0
LOUISIANA	132	92.6	99.8	101.7	80.0	86.0
MAINE	39	93.2	97.0	98.6	78.1	83.8
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	109.1	113.0	115.5	89.2	96.2
MICHIGAN	159	105.4	109.9	112.4	87.0	93.9
MINNESOTA	145	111.8	113.3	115.1	90.2	96.7
MISSISSIPPI	99	102.1	103.3	105.1	83.1	89.2
MISSOURI	131	96.1	100.7	102.8	80.9	87.1
MONTANA	54	102.7	102.4	104.3	83.8	90.0
NEBRASKA	87	93.0	101.1	103.0	81.3	87.4
NEVADA	22	103.6	107.6	109.9	87.5	94.3
NEW HAMPSHIRE	26	87.8	95.4	96.9	77.2	82.8
NEW JERSEY	88	92.2	95.6	97.1	76.6	82.1
NEW MEXICO	35	108.0	113.1	115.6	91.4	98.5
NEW YORK	208	115.5	112.9	115.3	88.3	95.2
NORTH CAROLINA	124	98.8	98.3	99.6	78.0	83.4
NORTH DAKOTA	46	101.0	107.2	109.7	87.6	94.4
OHIO	183	97.2	99.0	101.1	79.0	85.1
OKLAHOMA	111	105.1	105.3	107.4	85.1	91.6
OREGON	61	111.7	112.6	114.6	90.9	97.7
PENNSYLVANIA	212	102.1	105.8	107.9	84.0	90.4
RHODE ISLAND	12	112.9	112.5	114.9	89.7	96.6
SOUTH CAROLINA	68	92.4	95.9	97.4	76.2	81.6
SOUTH DAKOTA	52	97.0	100.3	102.2	81.8	87.9
TENNESSEE	129	90.5	94.5	96.2	76.5	82.1
TEXAS	386	96.5	102.4	104.3	82.1	88.2
UTAH	39	105.4	104.8	106.4	84.3	90.3
VERMONT	15	91.5	92.1	93.5	73.5	78.7
VIRGINIA	97	97.6	101.3	103.2	81.3	87.4
WASHINGTON	89	105.8	108.2	109.9	87.1	93.3
WEST VIRGINIA	57	98.7	97.1	98.6	78.1	83.7
WISCONSIN	127	102.5	103.1	105.0	82.9	89.1
WYOMING	26	94.9	102.2	104.2	83.7	90.1

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association,

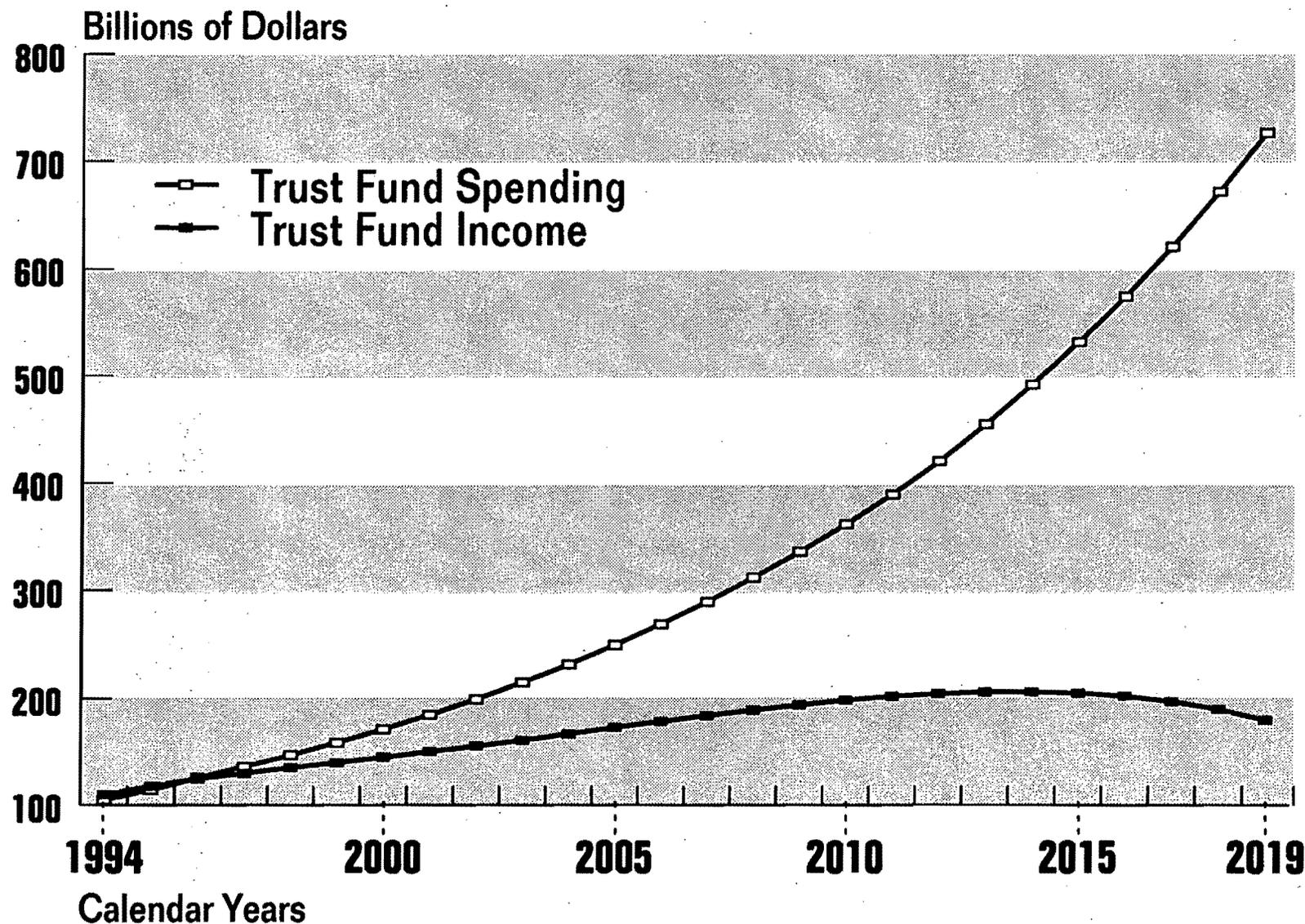
# Exhibit 7: Projected Medicare PPS Inpatient Operating Margins Under Current Law and Illustrative \$250 Billion 7-Year Budget Reduction Scenario

(Assumes \$94 Billion in PPS Payment Reductions)



# Spending Cuts Alone Won't Make Hospital Insurance Trust Fund Solvent

## Hospital Insurance Trust Fund Income and Spending 1994-2019



SOURCE: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund



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

Office of the President

One North Franklin  
Chicago, Illinois 60606

May 10, 1995

The Honorable Bob Dole  
Majority Leader  
United States Senate  
S - 230 The Capitol  
Washington, DC 20510

(Identical letter sent to  
Speaker Newt Gingrich)

Dear Majority Leader Dole:

We fear that rhetoric and reality appear to be on a collision course on one of the most important issues ever to face Congress: the future of Medicare and Medicaid. In the past week, for example, the American people were told that Congress was about to "save the Medicare trust fund" from bankruptcy. Then, the Senate and House budget committees proposed the deepest spending reductions in the 30-year history of health insurance for the elderly. Do these spending reductions avert the trust fund's insolvency? No, -- only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question. On the Medicaid side, the senior citizens and children who make up most of the population that program serves could lose access to some kinds of care altogether, joining the growing ranks of the uninsured.

It is disappointing to discover that what last week sounded like a refreshing departure from the "business as usual" Medicare hammering of the past has this week become a gutting of the health care portion of the Social Security contract with America. Thirty years after its inception, Medicare must change and the decisions about that change will require sacrifice from all, including hospitals. It will also require the strong support of the public.

But that's not what's happening today. As long as Medicare is still part of the federal operating budget, and as long as trust fund balances and spending reductions are all part of the deficit equation, then it is impossible to give our citizens the assurances that Medicare is on the road to recovery. The American people must not be led to believe that the trust fund is secure when it is not. The enormous spending reductions contained in both the House and Senate budget committee proposals must not be portrayed as merely "rate of growth" reductions. They will lead inevitably to real cuts in services and resources available to take care of people.

Medicare cannot be strengthened just by cutting the growth in spending for hospital and physician care. The Medicare rolls will continue to grow; people will live longer and need more help. New medical technology will cost more. Inflation in the general economy -- always unpredictable -- will play a significant role.

The Honorable Bob Dole  
Page two

There is no "silver bullet" fix for the serious problems confronting Medicare.

A wide range of options must be on the table and crafted into a long-term solution that is equitable to all. That means, considering not only reductions in the spending growth rate, but strong incentives for seniors to choose coordinated care, prudent increases in co-payments and deductibles, and fair means testing and eligibility criteria.

But the longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all.

Majority Leader Dole, we urge you to put Medicare back on the course outlined last week -- treating it as a real trust fund, not as a federal budget line item, and ensuring that "every penny saved" from the program is used to strengthen it for the future.

Months ago, hospitals introduced the concept of a truly independent commission to sort out the choices about Medicare funding; benefits and recipient payments; eligibility; payments to hospitals, doctors, and others; and oversee a process to allow the Congress to make those choices in an open and accountable way.

The Senate Budget Committee and others have embraced the concept, but only as a short-term alternative in the current budget environment. In our view, that is too limited and too narrow to ensure the long-term viability of a program that clearly, in some form, is a permanent commitment to our citizens.

We stand ready to work with the leadership of the Congress to thoughtfully control the growth of Medicare, but only in a way that strengthens, not weakens, the program. We believe a permanent, independent commission can help provide that strength.

Let's get on with that important work now, but let it be driven by the goal of making Medicare affordable for the nation and accessible to those who rely on it. Those were among the founding principles of the program 30 years ago, and they should remain its bedrock today and in the future.

Sincerely,



Richard J. Davidson  
President

Courtesy Copy:  
The Honorable Newt Gingrich



A member of Mercy Health Services

## OVERVIEW

### AFFILIATION

North Iowa Mercy Health Center is a Divisional Member of Mercy Health Services. Headquartered in Farmington Hills, Michigan, Mercy Health Services is the sixth largest employer in Iowa, owning five Iowa Hospitals. Because of our affiliation with Mercy Health Services, North Iowa Mercy and its staff are committed to carrying on the values and mission bestowed upon us by the founding Sisters of Mercy. Their example and inspiration translate to present and future needs. In a rapidly shifting health care environment, a compassionate, direct response to human need remains essential. North Iowa Mercy accepts that responsibility and has dedicated its human, technological and spiritual resources to meet that need.

Our affiliation with Mercy Health Services enables us to take advantage of other support services to enhance the delivery of quality health care in northern Iowa. Amicare Home Healthcare offers health-related services and equipment in the home to help individuals live as independently as possible. Amicare provides affordable options to lengthy hospital stays or nursing home placement. Nursing care, personal care, homemaking and live-in services are offered. A certified Medicare provider, Amicare also offers intermittent services in the home to speed recovery and rehabilitation. Such services include physical, occupational and speech therapies, and home health aide and social work services.

GNA is a rehabilitation service company which provides physical, occupational and speech therapy services to health care providers and employers. GNA works with North Iowa Mercy to provide comprehensive rehabilitation and occupational medicine services.

Mercy Health Plans provides leadership and consultative services for the development of insurance products, related services and negotiations with third party payers. Through its health plans, Mercy Health Plans provides responsible management of health care resources and contains costs while providing the highest quality of care.

### OVERVIEW

North Iowa Mercy operates two campuses in Mason City, is licensed for 350 beds, serves a 15-county region, and employs over 2000 people from northern Iowa and southern Minnesota. North Iowa Mercy has approximately 200,000 patient visits each year. It is designated by the State of Iowa as a Rural Referral Center and offers comprehensive medical and related services to the 340,000 residents in north central Iowa and southern Minnesota.

North Iowa Mercy Health Center's goal is to create the healthiest community and region in the United States through the development of a comprehensive community health care system.

### REGIONAL NETWORK

As the system of health care changes, North Iowa Mercy's mission has extended far beyond the patients who enter its doors. Our commitment to the future availability of quality health care throughout northern Iowa and southern Minnesota has resulted in the development of the North Iowa Mercy Regional Network. The Network includes the following programs and services:

- Contract affiliation with eight public rural hospitals, one community health center, and one Mercy Health Services hospital.
- Comprised of 32 physician clinics in Mason City and 21 rural communities
- Clinical/support services contracts
- Support of rural emergency medicine services
- Mercy Regional Laboratory

AARP

Medicare  
valuation

## The Dole/Packwood Proposals to Cut Medicare Would Hurt Older Americans

In recent weeks Senate leaders -- Majority Leader Robert Dole and Finance Committee Chairman Robert Packwood -- have outlined deficit reduction plans that would make unprecedented reductions in Medicare over the next 5-7 years. Senators Dole and Packwood have indicated that Medicare spending would have to be cut by \$150 to \$175 billion between 1996 and 2000 and by \$250 and \$300 billion over 7 years (1996-2002) in order to achieve the goal of a balanced budget by 2002. These suggested cuts are three times larger than any made in previous budget bills. The largest Medicare reduction to date was \$56 billion over 5 years in OBRA '93. (Chart 1)

While the Senators have not indicated exactly how they would make these cuts, it seems likely that they would distribute the impact equally between providers and beneficiaries. This would mean that over the next 5 years older Americans would pay at least \$2,000 more out-of-pocket than they would pay under current law. (Chart 2)

Rather than reducing the total cost of Medicare services, the Senators appear to be proposing to simply shift costs onto Medicare beneficiaries -- asking them to pay more through higher premiums, deductibles and coinsurance.

Older Americans already pay almost three times as much out-of-pocket, as a percent of income, as the non-elderly, yet median household income of the elderly is half that of those under 65. (Charts 3,4,5)

- Under the Dole/Packwood proposals, likely increased costs to Medicare beneficiaries include (Chart 9):
  - \* **A 30% Medicare Part B Premium.** Currently the Part B premium is intended to approximate 25% of Part B costs. The remaining 75% of Part B costs are paid from general revenues. In 1995 the Part B premium is \$46.10 per month (\$553.20 annually). With cuts of \$150 billion in Medicare over the next 5 years (total in Parts A & B), the Medicare premium would probably be increased to at least 30% -- approximately \$67.00 per month (\$804 annually) in the year 2000.

**An Income-related Part B Premium.** The Dole/Packwood proposals could mean that a new income-related premium would be imposed on individuals with incomes above \$50,000 and on couples with incomes above \$100,000. This would nearly triple what these beneficiaries would otherwise pay in premiums and, in fact, asks this groups to pay more than the actuarial value of their Part B benefit. At the same time, however, subsidies for private sector premiums for those under age 65 would continue. This means that taxpayers would continue to subsidize corporate

executives or members of Congress, while subsidies to Medicare beneficiaries with much lower incomes would be eliminated. (Charts 10, 11)

- \* ***A \$200 Part B Deductible, Indexed to the Growth in Part B Program Costs.*** Currently Medicare beneficiaries pay a \$100 annual deductible for Part B services; the deductible is not indexed. The Dole/Packwood proposals could require increasing the Part B deductible to \$200 and indexing it to the growth in the Part B program. The indexing would mean that in just 5 years, from 1996-2000, this deductible would grow from \$200 to \$275, (assuming roughly an 8% Medicare Part B growth rate). The total out-of-pocket increase over this 5-year period would be \$680 per beneficiary.
- \* ***A New 20% Home Health Coinsurance.*** Currently Medicare beneficiaries do not pay coinsurance for home health care. This was done to encourage the use of home health rather than nursing home care. A new 20% coinsurance would force the average home health user to pay an additional \$1,200 out-of-pocket in the year 2000. Those who use home health care the most – primarily lower income women over the age of 75 – would pay over \$3,800 in 2000. This is a “sick tax” on the most frail and vulnerable elderly and disabled Americans – those who can least afford it. In addition, this cutback in Medicare’s very modest long-term care coverage would almost certainly be coupled with cuts in the nursing home, home health, and spousal impoverishment protection now provided in the Medicaid program.
- \* **For poor and low-income Medicare beneficiaries the Medicaid program currently pays deductibles and coinsurance (for those up to 100% of poverty) and premiums (for those up to 120% of poverty). The Dole/Packwood proposals would probably require cutbacks or elimination of this protection, leaving low-income people without the dollars to buy access to basic health care.**

Thirty-six million older Americans depend on the benefits and insurance protection they get from Medicare. AARP believes that Medicare’s promise for current and future generations must be protected. This will require careful stewardship so Medicare can continue to provide quality, affordable health care; so choice is maintained; so fraud and abuse do not rob the program of dollars and the public’s confidence; and so Medicare beneficiaries do not have to pay more and more because Medicare pays less and less.



# CENTER ON BUDGET AND POLICY PRIORITIES

Budget FIG

February 7, 1995

## THE CLINTON BUDGET

By Robert Greenstein, Richard Kogan, and Pauline Abernathy

The Clinton Administration budget issued today marries middle-class tax cuts with a strong dose of austerity in the domestic non-entitlement side of the budget. It would reduce domestic non-entitlement spending by fiscal year 2000 to its lowest level, measured either as a percentage of the economy or as percentage of the total federal budget, since 1958.

Compared to the budget paths set forth in the two previous Clinton budgets, this budget contains substantially less for domestic non-entitlement programs — including lower levels for investment initiatives. It also contains more for defense and sizable tax cuts that total \$157 billion over 10 years.

Overall expenditures for the three major domestic investment categories — research and development, education and training, and physical investments such as infrastructure — would *decline* between fiscal year 1995 and fiscal year 1996, when inflation is taken into account. Expenditures in these three areas would total \$137.9 billion in fiscal year 1996, up less than one percent from their fiscal year 1995 level despite the budget's forecast of a 3.2 percent inflation rate.

A number of individual investment areas would receive increases above the inflation rate, including biomedical research, commercial technology research, lifelong learning programs, Head Start, the Job Corps and the WIC program.

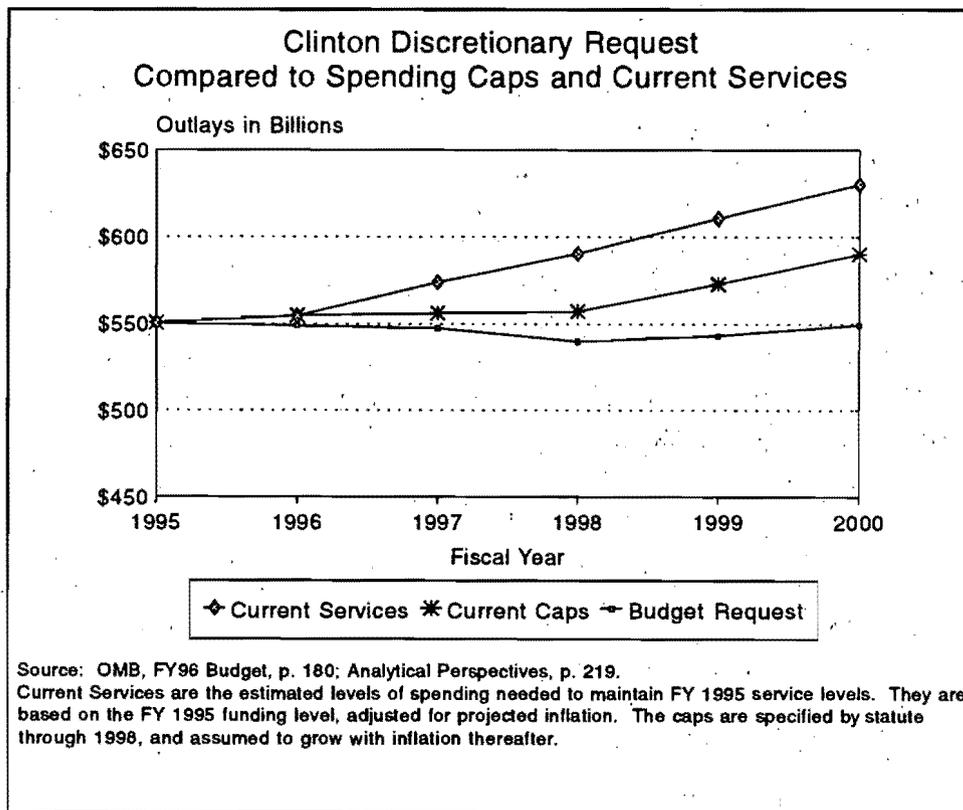
Most of the budget's fiscal year 1996 spending cuts represent sound ways to reduce the deficit. Proposals to accelerate the shift to direct student loans, institute royalty fees or additional auction authority for use of the radio spectrum, deny the earned income credit to those with more than \$2,500 in interest and dividend income, sharply scale back impact education aid, and extend provisions of current law that save money in Medicare and veterans program but are scheduled to expire in the next few years, among others, constitute reasonable ways to achieve needed deficit reduction.

### Large Reductions in Non-Entitlement Programs Lie Ahead

Future budgets, however, will need to identify tens of billions of dollars in additional cuts in non-defense discretionary (i.e., non-entitlement) programs to meet

the austere discretionary spending caps the Administration is proposing for fiscal years 1997 through 2000. For these years, the budget assumes across-the-board reductions in nearly all non-defense programs that are not entitlements. The budget assumes that in 1997, funding for most such programs will fall three percent below the funding levels requested for 1996, without any adjustment for inflation. The decline would grow to five percent in 1998, seven percent in 1999, and nine percent in 2000.

When inflation is taken into account, this would represent a 20 percent across-the-board appropriations cut below the 1996 levels for much of the federal government except for defense and entitlement programs. The Administration apparently plans, through its "Reinventing Government II" initiative and through proposals to be included in future budgets, to replace this large, indiscriminate across-the-board cut with an array of deeper cuts and program eliminations in some areas and lesser cuts or no cuts in other areas viewed as having greater merit. By proposing to lower sharply the spending caps governing non-entitlement spending, the Administration would compel itself and Congress to produce these additional cuts in the next few years.



### Clinton Proposes Lower Discretionary Spending Caps

	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	TOTAL
	(in billions of dollars)					
Current Spending Caps Extended Through 2000	554.9	556.2	557.2	573.0	590.2	2,831.5
Clinton Discretionary Request (Proposed New Caps)	549.0	547.7	540.4	543.3	549.6	2,730.0
Clinton Cuts Below Capped Baseline	-5.9	-8.5	-16.8	-29.7	-40.6	-101.4

Source: OMB, Budget of the U.S. Government, Fiscal Year 1996, p. 180. The caps are specified by statute through 1998 and assumed to grow with inflation thereafter.

### Health Care and Other Entitlements

While the budget proposes to pare non-entitlement programs substantially, it touches entitlements lightly. Entitlements and other mandatory spending would be reduced \$29 billion over the next five years, compared with a \$101 billion reduction in the non-entitlement side of the budget.

Rising costs for health care entitlements represent the single major reason the long-term deficit forecast is so adverse, and data from the Administration's budget underscore the necessity of reforming the U.S. health care system if our long-term deficit problems are to be surmounted. OMB calculations show the budget would be balanced by fiscal year 2003 if per capita Medicare and Medicaid expenditures grew in tandem with the general rate of inflation and per capita output, rather than at the higher rates at which health care costs in both the public and private sectors have been mounting and are expected to continue to grow. (See box on next page.)

Simply exacting large cuts from Medicare and Medicaid, in the absence of larger-scale health care reform, will not satisfactorily address this problem. As Congressional Budget Office director Robert Reischauer told the bipartisan Entitlement Commission last summer, imposing deep cuts on Medicare and Medicaid without system-wide health care reform would cause substantial shifting of health care costs to the private sector, adversely affecting employers and employees, and also would likely reduce the quality of health care for the elderly and the poor. At the earliest possible point, Congress and the Administration should return to the tough job of reforming the health care system in ways that reduce the rate of growth in both public and private health care costs.

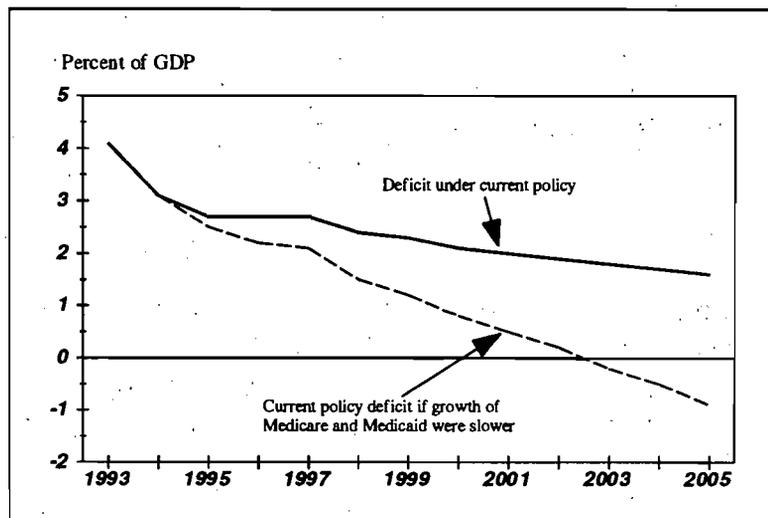
## Deficit Reduction And Tax Cuts

The “middle class bill of rights” — a series of tax cuts targeted largely on those with incomes between \$20,000 and \$100,000 — is central to the Clinton budget. These Clinton tax cuts are preferable to those in the Contract with America, in large part because the Contract tax cuts would lose more than four times as much revenue over the next 10 years and provide four times as large a proportion of their benefits to those with incomes exceeding \$100,000.

### Health Care and the Budget

The President’s budget demonstrates once again that the rapid growth of Medicare and Medicaid is the primary cause of stubbornly high deficits. Medicare growth is projected to average 9.1 percent per year and Medicaid 9.3 percent. The attached chart, taken from the budget, shows that if Medicare and Medicaid grew at more normal rates, the deficit would disappear by 2003.\*

Expanded use of managed care might produce noticeable reductions in Medicare and Medicaid costs. But absent broad measures to control the costs of the nation’s overall health care system, major reductions in the long-term *growth rates* of Medicare and Medicaid costs are difficult to achieve without (1) requiring Medicare beneficiaries to pay an increasingly large share of their health care costs out of pocket, (2) providing steadily poorer quality health care for beneficiaries than the rest of society enjoys, or (3) steadily reducing Medicare and Medicaid reimbursement rates, which is likely to lead doctors and hospitals to pass unreimbursed costs on to employers and employees through added growth in health insurance premiums, a hidden but growing tax.



\* NOTE: OMB projected a slower level of health care growth by assuming that, starting in 1994, per-beneficiary costs grew only as rapidly as general inflation plus overall U.S. productivity.

A more fiscally prudent course would have been to forgo tax cuts at this time. The savings achieved from the Administration's spending cuts would better be devoted primarily to deficit reduction, and to a lesser degree to increased financing for selected public investments likely to have long-term economic payoffs.

With the economy growing at a healthy pace, increased consumption spurred by tax cuts isn't needed. More private investment spurred by long-term deficit reduction — and more public investment in critical areas — is likely to be of greater benefit in generating long-term economic growth and long-term income growth for the middle class.

### **Paying for Tax Cuts**

While more deficit reduction would be preferable to tax cuts, the Clinton budget does pay for its tax cuts over the next 10 years. There is a risk, however, that tax cuts approved on Capitol Hill later this year might not meet this test.

Some House leaders recently indicated they need produce only \$200 billion in spending cuts over the next five years to pay for the tax cuts in the Contract with America, ignoring the much larger revenue losses the Contract tax proposals would generate in years after that. Both Treasury and Senate Budget Committee Republican staff estimates indicate that the revenue loss from the Contract tax proposals would equal or exceed \$500 billion in the succeeding five-year period, from 2001 to 2005.

A tax cut package not paid for over the long term would enlarge the long-term deficit. While the Clinton budget can be criticized for not reducing the deficit more, some of its Congressional critics themselves risk making the long-term deficit problem worse if they do not restrain the exploding long-term costs of the Contract's tax cuts.

Moreover, had the Administration proposed additional spending cuts in its budget, these proposals would likely be used by Congress primarily to finance larger tax cuts rather than for deficit reduction. For this reason, additional spending cut proposals probably should be reserved until the bidding war on tax cuts that threatens to overtake Capitol Hill has run its course. Presenting proposals for additional spending reductions after action on tax cuts is completed, rather than advancing such proposals now, should increase the chances that further program cuts are used for deficit reduction and not for overly large tax cuts that are likely to provide the lion's share of their benefits to those at higher income levels.

### **Comparing the Clinton and Contract Tax Cuts**

The Clinton tax proposals and the portion of the Contract that contains its middle-class tax cuts bear some similarities. Both feature a \$500-per-child tax credit; the Contract's tax credit covers children to age 18, while the Clinton credit extends through age 12. Both also expand Individual Retirement Account tax benefits. In

addition, the Clinton budget would provide a large deduction for tuition expenses, which families could use regardless of whether they itemize deductions.

While the total size of the middle-class tax cut is somewhat larger under the Contract than under the Clinton budget, the principal differences between the Clinton tax cuts and the Contract tax cuts lie elsewhere — in the large tax cuts the Contract includes for upper-income individuals and large corporations. These provisions are the primary reason that, as noted, the Contract tax cuts lose more than four times as much in revenue over the next 10 years as the Clinton tax cuts and confer four times as large a proportion of their benefits on the top 10 percent of the population, those with annual incomes over \$100,000.

**COST OF CLINTON AND CONTRACT TAX CUTS**  
(in billions of dollars)

	1996-2000	2001-2005	10-Year Total
Clinton <sup>1</sup>	\$56	\$101	\$157
Contract <sup>2</sup>	\$205	\$520	\$725

**DISTRIBUTION OF TAX BENEFITS UNDER CLINTON AND CONTRACT TAX PLANS**

Income Group	Percentage of Families in each Income Group	Percentage of Benefits Going to Each Group Under Clinton Tax Cuts	Percentage of Benefits Going to each Group Under Contract Tax Cuts
< 50,000	65%	29%	19%
50,000 - 100,000	25%	58%	30%
100,000 - 200,000	8%	12%	22%
Over 200,000	2%	1%	28%

Source: Office of Tax Analysis, Department of the Treasury

<sup>1</sup> This estimate of the cost of the Clinton tax cuts was issued by the Treasury Department on February 6, 1995. It includes the "middle class bill of rights" and a series of small revenue-raising measures in the Administration's budget. It reflects revenue savings only and does not include \$6 billion in outlay savings over 10 years associated with the revenue changes the Administration is proposing. The "middle class bill of rights" itself costs \$63 billion over the first five years and \$171 billion over 10 years.

<sup>2</sup> This is the Treasury Department estimate of the cost of the Contract tax cuts, released January 10, 1995. On February 1, 1995, the Joint Tax Committee released a similar estimate of the cost of the Contract tax cuts in the first five years, \$196 billion. The Joint Tax Committee has not issued an estimate of the cost in the second five years.

The Clinton budget demonstrates that sizable middle-class tax cuts can be paid for without making major cuts in benefits for the middle-class or the poor. The Clinton budget does not contain sharp increases in Medicare premiums and deductibles, higher interest payments on student loans, or deep cuts in basic cash, food, and health care benefits for poor children and elderly people. If Members of Congress decide to add to the Clinton budget cuts a series of steep reductions in benefits for poor and middle-class families and elderly people to pay for the much larger tax cuts in the Contract, these benefit reductions will primarily be used to finance tax cuts for those at high income levels, not the middle class.

### **Proposed Change in Budget Procedures Unwise**

In a little noticed budget development, both the Administration and Republican Congressional leaders are proposing to alter the budget procedures established in 1990 and allow reductions in non-entitlement programs to be used to pay for tax cuts (and for entitlement increases, if proposed in the future). This development raises concerns.

Under the 1990 budget agreement, tax cuts and entitlement increases must be paid for through offsetting tax increases or entitlement cuts. Since tax increases and entitlement cuts are difficult to pass, this requirement has restrained Congress and the executive branch from adopting fiscally imprudent tax cuts and entitlement expansions in recent years.

Cutting non-entitlement programs is much easier than raising taxes or cutting entitlements because doing so initially entails simply lowering the cap governing non-entitlement spending. The details of which non-entitlement programs to cut generally come much later, often in a subsequent Congress. Thus, the procedural change advocated by the Administration and Republican leaders would make it easier both to enact overly large tax cuts this year and to enact fiscally imprudent tax cuts or entitlement expansions in subsequent years.

This approach is made more problematic by the fact that the domestic non-entitlement portion of the budget is the part of the budget where most public investment spending is found. Under the Clinton proposals, this part of the budget would already be reduced to 2.8 percent of the Gross Domestic Product by fiscal year 2000, the smallest proportion since 1958. As a proportion of the total federal budget, domestic non-entitlement expenditures would fall to 13.7 percent. This, too, is the smallest proportion since 1958.

### **Difficult to Assess Impact on Programs Serving Low-Income Americans**

The budget includes both increases and decreases in non-entitlement programs serving low-income families and individuals. Few changes are proposed in low-income entitlements. Among the low-income non-entitlement programs slated for

### Domestic Discretionary Spending in the Clinton Budget

President Clinton's proposed budget squeezes domestic discretionary spending to a greater degree than is commonly realized. For example:

- Domestic discretionary spending in fiscal year 2000 will be limited to \$261 billion, about the same level as at present. Since spending will hardly grow but prices will, the purchasing power of this part of the budget will decline 14 percent.
- In fiscal year 2000, domestic discretionary spending will comprise less than one-seventh of the budget. At 13.7 percent of total spending, this is the *lowest share since 1958*, well below the post-war peak of 23 percent reached in 1978.
- In fiscal year 2000, domestic discretionary spending will total 2.8 percent of the nation's economy (Gross Domestic Product, or GDP). This will be the *lowest percentage since 1958*, well below the post-war peak of 4.9 percent reached in 1980.

*NOTE: Discretionary programs exclude entitlements or other mandatory programs, net interest, deposit insurance, and offsetting receipts. They are controlled through the annual appropriations process rather than by permanent law (such as permanent benefit formulas). In recent years, slightly more than half of all discretionary spending has been for defense and international programs. This box discusses the other half, covering such programs as infrastructure, scientific research, education, veterans' hospitals, natural resources and the environment, job training, assisted housing, WIC and Head Start, law enforcement and the judiciary, and the daily operations of such agencies as the Treasury Department.*

reductions are a number of the low-income housing programs and job training grants for youth. The budget includes funding increases for such low-income programs as Head Start, WIC, and the Job Corps.

It is difficult to assess immediately the net effect of the budget's proposals in the low-income area because the Administration proposes to consolidate many programs serving low- and moderate-income Americans into larger program groupings. Some of these consolidations would merge programs now targeted at low-income households with programs also serving people at other income levels.