

MEMORANDUM

June 10, 1997

TO: John Hilley, Gene Sperling, Rahm Emanuel, Maria Echaveste, Bruce Vladeck,
Rich Tarplin, Gary Claxton

FR: Chris Jennings

RE: AARP letter supporting the Budget Agreement

cc: Bill White, Nancy-Ann Min

On Friday, senior leadership at AARP met with the Vice-President and gave him a letter for the President which indicates their support for the Budget Agreement. As you will note, the letter states that the size of the Medicare savings and increase in premiums are fair. They sent a similar letter to Congressional leadership.

We are planning to not go out of our way to use this letter publicly, but to refer to it if the situation arises that our base Democrats raise problems with our Medicare package. This is consistent with Gene's recommendations. It is also in line with AARP's preference for us not to use the letter as unnecessary propaganda.



Bringing lifetimes of experience and leadership to serve all generations.

June 6, 1997

The President
The White House
Washington, D.C.

Dear Mr. President:

Medicare beneficiaries have much at stake in the decisions that the Congress will make on Medicare and Medicaid as part of the FY98 budget reconciliation bill. AARP is very pleased by the action taken so far in the budget agreement, the Budget Resolution, and in the first steps of the reconciliation process to extend Medicare solvency in a manner that protects Medicare beneficiaries and the promise of the Medicare program.

The \$115 billion in Medicare reductions established in the budget agreement and included in the budget resolution are projected to extend the solvency of the Hospital Insurance (HI) Trust Fund to at least 2007. The budget agreement would achieve solvency through shared sacrifice from all who participate in Medicare -- providers and beneficiaries alike. It asks Medicare beneficiaries who today pay a monthly premium of \$43.80 to increase their monthly payment to about \$67.00 by 2002. It also includes several welcome improvements in Medicare preventive benefits.

We applaud the fact that the budget has been crafted in a bipartisan process and we urge the same kind of bipartisanship in the further deliberation of the FY98 reconciliation package. This letter and attachment outline several major issues and concerns that AARP urges you to consider as your Administration works with the Congress to move this legislation to your desk.

In summary, we urge that the final legislation achieve the following outcomes:

- protect low-income beneficiaries against the cost of the higher Medicare Part B premium that will come about from this legislation;
- correct the inequity in hospital outpatient coinsurance so that beneficiaries will, over time, be asked to pay no more than 20% of Medicare's approved payment in coinsurance;
- ensure quality of care in Provider Service Organizations and other Medicare managed care plans;

American Association of Retired Persons 601 E Street, NW Washington, DC 20049 (202) 434-2277

Margaret A. Dixon, Ed.D. *President*

Horace B. Deets *Executive Director*



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- reform Medicare supplemental insurance rules to make medigap more “portable,” so that beneficiaries can exercise a true choice between fee-for-service and managed care;
- avoid provisions, such as MSAs, that would jeopardize the Medicare risk pool and put at risk the promise of affordable health care for all Medicare beneficiaries; and
- repeal the criminal penalty for transfer of assets to qualify for Medicaid.

As the Congress continues its deliberations over this legislation, we hope you will champion these issues and use your influence to urge the Congress to adhere to the strong and balanced framework provided by the budget agreement. This framework affords both you and the Congress an opportunity to say to the American people that we can and will take the steps necessary to begin to lead the Medicare program to a position of strength for today’s and tomorrow’s beneficiaries.

The Association stands ready to help you in this endeavor.

Sincerely,



Horace B. Deets

attachment

AARP Medicare and Medicaid Priorities in FY98 Budget Reconciliation

Protecting Low-Income Beneficiaries

Low-income beneficiaries need adequate protection from the additional costs that they will incur from the changes in this bill. Currently, the law provides that Medicare's premiums, deductibles and coinsurance may be paid by Medicaid for those with incomes below the poverty level (\$7,890 in 1997), and that Medicaid may pay the premium of those with incomes between 100% and 120% of the poverty level. But individuals whose incomes are just above these levels will be faced with significantly higher premiums over the next several years and very limited resources with which to pay them.

The majority of such beneficiaries are women, and their economic status can be particularly precarious. Almost one-third of all older women have incomes below 150 percent of poverty. Moreover, almost 10 percent of all Medicare beneficiaries have incomes between 120 and 150 percent of poverty. The impact of a monthly premium that is projected to climb to between \$65.00 and \$70.00 per month by 2002 would mean that these older persons, many of them women who live alone, would have to make painful choices among necessities like health care and groceries or housing.

The budget agreement includes \$1.5 billion over five years to defray the costs of the premium for lower-income beneficiaries--those with incomes just above 120 percent of poverty (\$9,468 in 1997). Maintaining this commitment in the final legislation will be critical to many of those Medicare beneficiaries who are most vulnerable. The promise of Medicare is nothing less than the promise of affordable, quality health care for older and disabled Americans. This bill should maintain that promise by assuring that the higher Medicare premium does not force low-income beneficiaries to make unacceptable choices about the bare necessities in life.

Correcting the Inequity in Hospital Outpatient Coinsurance

Medicare beneficiaries pay significantly more than the usual 20 percent coinsurance for most hospital outpatient services. In fact, on average, beneficiaries pay 47 percent of the total amount the hospital is actually paid for the service. A "glitch" in the law allows hospitals to base beneficiary coinsurance on the amount the hospital actually charges for the service, rather than on the amount that Medicare determines is appropriate. This results in beneficiaries paying significantly more for hospital outpatient services than they should. As hospitals continue to increase their charges, the amount that beneficiaries pay in coinsurance will continue to skyrocket.

Some argue that this really is not a direct out-of-pocket cost because most Medicare beneficiaries have Medigap coverage. While it is true that most beneficiaries have some form of supplemental coverage, this glitch in the law should not result in beneficiaries being pushed into the Medigap market as a way of finding relief from exorbitant outpatient costs. Moreover, even with supplemental coverage, beneficiaries are still vulnerable to greater costs passed directly on to them through higher Medigap premiums. A portion of the increase in 1996 premiums for some supplemental plans was directly attributable to rising outpatient costs.

While we recognize that this is not an inexpensive correction to make, it is currently a very expensive predicament for Medicare beneficiaries that should be corrected before it gets worse. The Ways and Means Health Subcommittee's proposal begins to solve the outpatient coinsurance problem by freezing the current level of coinsurance and, over time, phasing it back down to the appropriate level of 20 percent of Medicare's approved payment for hospital outpatient services. We urge the Committee to look favorably on this proposal and to improve upon it if possible.

Ensuring Quality of Care in Provider Service Organizations (PSOs) and Other Medicare Managed Care Plans

AARP believes that it is the responsibility of the Medicare program to assure that all coverage options are financially sound and offer Medicare's high standard of consumer protection. To this end, we believe that the consumer protections provided under section 1876 must be maintained and must be the basis for quality and consumer protections in all new Medicare coverage options. In particular, any PSO legislation enacted by Congress must also have the following consumer protections in place.

First, except for the specific areas described below, all of the requirements that apply to current Medicare managed care must continue and be applied to PSOs and other new Medicare managed care options. This includes such important protections as the Medicare appeals system and prohibitions on balance billing, as well as all of the requirements that have been developed under section 1876 of the Social Security Act. Second, exceptions to current Medicare risk requirements must contain protections to mitigate the potential for abuse of PSO legislation and be limited to the following:

- 1) a time-limited exemption from state licensure that is conditioned on the creation of the necessary federal administrative structure for certification and oversight and adequate federal funding for enforcement;
- 2) solvency standards established by the Secretary of HHS, with advice from the NAIC, that explicitly limit the percentage of net worth that could be satisfied by physical assets and that require PSOs to have a specific plan to protect consumers in the event of insolvency;

3) an easing, rather than elimination, of the 50/50 rule and minimum enrollment requirements by giving credit for enrollment through contractual arrangements; and

4) allowing private accreditation to substitute only for duplicative federal accreditation of a plan's internal quality assurance when it is comparable, but maintain the requirement for independent external quality review.

Reforming Medigap

AARP supports changes that will make Medigap insurance "portable," so that Medicare beneficiaries can exercise a true choice between fee-for-service and managed care. Portability is even more important if Medicare is expanded to include PSOs. If Medicare beneficiaries are to be expected to turn their health care over to these relatively inexperienced entities, they must have assurance that they can not only return to fee-for-service Medicare, but also obtain Medigap coverage if the PSO fails to meet their needs.

Congress should provide opportunities for beneficiaries to change from fee-for-service/Medigap to managed care and back on a guaranteed issue basis. In addition, Medigap carriers also should be required to community rate their premiums, just as managed care plans are required to community rate beneficiary premiums. This would create a level playing field in the medigap marketplace and fair and affordable choices for beneficiaries.

Medical Savings Accounts in Medicare

AARP has very serious concerns about introducing medical savings accounts into the Medicare program. They pose a serious risk to Medicare's risk pool and to the program's future ability to provide affordable health care to all beneficiaries. In that regard, a program such as has been proposed by the Ways and Means Health Subcommittee proposal to establish a 500,000 person Medicare MSA demonstration project goes beyond the standard demonstration project level.

Supporters of MSAs claim that beneficiaries make wiser health care choices if they have a greater stake in the actual cost of their care. Yet an MSA could actually prove costlier for both beneficiaries and the program because it encourages adverse selection. Since Medicare would likely finance MSAs on the basis of an average per person payment amount, the program could end up making payments for healthy individuals that it would not otherwise make, leaving fewer funds available for the older, frailer and more costly patients left in traditional Medicare.

MSAs could also leave beneficiaries vulnerable to higher out-of-pocket costs and inadequate consumer protections. If the government's payment is not enough to cover the total costs of both the catastrophic premium and the high deductible, or if the payment diminishes over time, beneficiaries could find themselves having to make up a significant difference out-of-pocket. Older persons could also find themselves vulnerable for the costs of services that insurance companies decide are not reimbursable or do not count towards satisfying the deductible.

We are also very concerned about the potential for Trust Fund dollars being used for things other than health care. An August, 1996 advertisement for Golden Rule MSAs in the Wall Street Journal cited an example of an Ohio woman who used her medical savings account funds to pay for property taxes. At a time when the Medicare Hospital Insurance Trust Fund is facing bankruptcy, we do not believe it is in the best interest of the program or beneficiaries to use Medicare dollars for things other than health care. The imposition of a penalty will not necessarily prevent the misuse of funds. In fact, the Joint Tax Committee has found that a minimal penalty tax does not serve as a strong deterrent to withdrawals from individual retirement accounts.

Given all of the potential problems with MSAs we believe that Medicare should not be expanded to include this coverage option. If a demonstration is incorporated in the final legislation, then it must be tightly drawn to reduce the program's exposure and protect beneficiaries.

Repeal of the Criminal Penalty for Transfer of Assets to Qualify for Medicaid

Older Americans who need long-term care and qualify for assistance should not be deterred from applying for Medicaid. Section 217 of the Health Insurance Portability and Accountability Act of 1996 contains a provision that criminalizes the transfer of certain assets to qualify for Medicaid. This provision makes it a federal crime for people who knowingly and willingly transfer their assets for less than fair market value within three years of applying for Medicaid. As written, Section 217 could subject older nursing home residents to prosecution or prison. A more likely scenario is that destitute, ill older people--the exact people for whom Medicaid benefits were intended--will be scared away from applying for Medicaid.

The apparent aim of the amendment is to discourage transfers of property that are abusive manipulations of the Medicaid eligibility rules. However, Section 217 presents several problems:

- Many people are unaware of the nuances of Medicaid eligibility rules, including Section 217 and its implications. Unknowingly, they may transfer some of their assets. For example, they may wish to help their grandchild with college expenses. If they apply for Medicaid within three years, they may be subject to criminal prosecution.

- The law does not define “knowingly and willingly.” As a result, it is unclear how these terms would be measured objectively.
- Estate planners and others with the resources to “game” the rules will still be able to do so. In fact, some people have speculated that the provision could increase the demand for counseling on Medicaid planning.

AARP believes that the Medicaid program must be protected from abusive manipulation of its asset rules by people with significant resources. We have always opposed such activities as contrary to the spirit, if not the letter, of the law. If a problem exists with the Medicaid rules, a more direct solution would be to tighten current eligibility loopholes. It remains unclear how a criminal penalty added to an already existing civil penalty solves the problem. We urge the repeal of this provision as called for in H. R. 216.

If you have any questions or need additional information, please feel free to have your staff contact Marty Corry or Tricia Smith of our Federal Affairs Department at (202) 434-3770.

June 6, 1997

Differences between the Republicans' \$270 Billion Medicare Plan and the Balanced Budget Agreement's Medicare Plan

- **The total Medicare savings are still billions less than the \$270 billion package that the President vetoed. There are many other important differences as well:**
 - 1) **Vetoed Budget had premiums that were about \$18 more per month than in the 1997 Balanced Budget Agreement.** The monthly premium under the Budget Agreement will be about \$69 in 2002. If the policy were a 31.5% premium instead of 25%, this premium would be about \$87. On an annual basis, this difference is about \$215 for a single beneficiary, \$430 for a couple.
 - 2) **Vetoed Budget would have raised the percent of the program funded by beneficiaries by over one fourth.** The 1997 Balanced Budget Agreement keeps the Medicare Part B premium at its current level of 25% of program costs — far below 31.5% the 1995 Republican Budget that the President vetoed.
 - 3) **Vetoed Budget's investments are only 1% of the 1997 Balanced Budget Agreement's investments.** The Budget Agreement includes critical investments:
 - **Preventive services: \$3 to 4 billion**, including services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.
 - **Protection against excessive hospital outpatient coinsurance: \$4 billion**
 - **Premium assistance for low-income beneficiaries: \$1.5 billion**

In contrast, the vetoed Budget included extremely modest investments, **\$100 million** for coverage of oral breast cancer drugs.

 - 4) **Vetoed Budget had larger provider reductions.** The vetoed Budget had policies that put much tighter constraints on provider payment growth. For example, under the vetoed plan, hospital payment update reductions would be twice as big as is needed in the 1997 Budget Agreement. This translates into savings of \$22 billion over five years under the vetoed plan versus \$11 billion under the Agreement.
 - 5) **Vetoed Budget included flawed structural reforms.** The 1997 Balanced Budget Agreement does not sanction the use of balance billing, association plans, and other ideas that put beneficiaries at risk.

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American Medical Association

Physicians dedicated to the health of America



News Release

FOR IMMEDIATE RELEASE

December 4, 1996

AMA: PROTECT AND PRESERVE MEDICARE -- NOW

Leaders of the American Medical Association today urged Congress and the Administration to enact fundamental Medicare reforms within the next 12 months to fix the troubled program "once and for all."

"Protect Medicare for our patients. Save it for our kids. And do it now," AMA board chair Nancy W. Dickey, MD, told a national press briefing at the AMA's Washington office.

AMA ads running the same day in Washington and Capital Hill newspapers repeated the "do it now" Medicare theme. "The problem is too big and the time to act is too short to wait," said Dr. Dickey.

Appearing with Dr. Dickey was AMA president Daniel H. Johnson Jr., MD. They briefed the media on the AMA's four-point plan to transform Medicare by:

1. Modernizing traditional Medicare, so patients can remain in Medicare without fearing they will lose the security, services or quality they receive now.
2. Creating a broader menu of health plan choices for Medicare patients to select on their own.
3. Shoring up the nearly bankrupt Hospital Trust Fund.
4. Ensuring that a healthy Medicare is available for future generations.

The AMA plan is based on more than decade of policy development. Dr. Dickey said the AMA plan "will put Medicare back on its fiscal feet. The quality of care will not be diminished. Spending will continue at a responsible rate of growth, with a reasonable and reliable contribution from the government."

- more -

Dr. Johnson noted that the rate of growth in spending on physician services is only 6.5 percent, far below other categories of Medicare spending. "We are willing to accept reasonable limits on the rate of growth," he said.

The AMA leaders also expressed concern that decision makers would delay making needed long-term, fundamental changes in Medicare and would rely instead on short-term cuts in payments to providers.

"That's the kind of penny-wise and pound-foolish quick fix" that "won't stop the bleeding any longer," said Dr. Johnson.

Access to care could be jeopardized, he added, unless Congress adopts recommendations endorsed by both parties and the administration's own Physician Payment Review Commission to correct a flawed payment formula that impacts physicians unfairly.

Under the faulty current formula, Medicare payments to some physicians are dropping below what medical services actually cost. As a result, some physicians are unable to accept new Medicare patients.

The answer, Dr. Johnson said, is to stop relying annually on stop-gap cuts and to pass "meaningful, long-term transformation of Medicare now so the program works well without anyone, patients or physicians, being sacrificed."

The AMA plan, said Dr. Dickey, "makes for good fiscal policy and good medical policy, and we urge Congress and the Administration to turn it into reality within the next 12 months."

Dr. Dickey is a family physician in College Station, Texas, and a professor at the College of Medicine at Texas A&M University in College Station. Dr. Johnson is a radiologist from Metairie, Louisiana.

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For more information, please contact:

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Brenda Craine	202/789-7447

American Medical Association

Physicians dedicated to the health of America



Backgrounder

AMA's '96-'97 Medicare Repair Proposal

What's Wrong and How to Fix It

As the recent presidential and congressional campaigns made abundantly clear, Medicare is in trouble, and everyone wants to save it. The tough question is -- "how"? As the nation's physicians, we are particularly concerned that any Medicare reform maintains high standards for the quality of care, and guarantees access for everyone who is Medicare-eligible.

Our Top Priority

Preserving the Patient-Physician Relationship

We have a comprehensive reform proposal that, **above all else**, recognizes the sanctity of the relationship of trust between patients and their physicians that makes medicine unique. By that we mean:

- * All patients should have the opportunity and the responsibility to choose the plan or physician they feel is best qualified to treat them or individually elect any restrictions on choice;
- * All patients, including those with chronic conditions and special health or financial needs, must have access to any needed service covered by Medicare;
- * No restrictions on information about treatment options and no financial incentive program can be allowed to interfere with physicians' role as patient advocate.
- * Both patients and physicians must have complete, easily understood information about the Medicare program, and a right to raise questions, voice grievances, and to have them responded to in a fair, effective process; and
- * Patients must be protected from unscrupulous or inept health plans, physicians, and other providers.

Introduction

How did we get here?

When Medicare started back in 1966, a promise was made to Americans of all ages that they would have the security of health insurance in their retirement. Thirty years later, the promise remains -- but Medicare is in serious financial trouble. Thirty years ago, Medicare cost about \$5 billion. Right now, the tab is closer to \$180 billion -- and rising!

A growing elderly population, increased longevity, expanded medical capabilities, and innovative -- but costly -- new technologies have pushed Medicare to the verge of bankruptcy.

We propose shifting Medicare away from its current emphasis on government control toward a system of personal choice and an invigorated Medicare marketplace that fosters competitive pricing for covered medical services.

We are willing to open up to competition this massive, single-payer, fee-for-service system. Moreover, physicians are willing to accept limits on the rate of growth.

Our proposal would offer Medicare beneficiaries two basic options:

Stay in Improved Medicare System

* Beneficiaries who want to retain the security embodied in a plan they know and trust could remain in a restructured traditional Medicare system much as it is today; or

Choose "Medichoice"

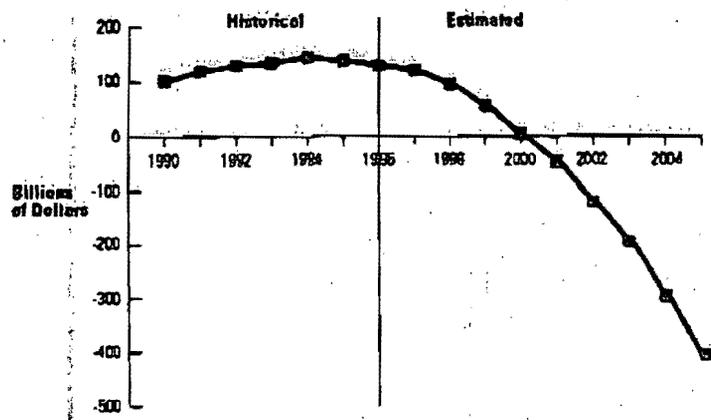
* Beneficiaries could join a new system, which we call "Medichoice," that is similar to the successful, cost-effective Federal Employee Health Benefits Plan (FEHBP) -- in which the government makes a defined contribution to the cost of coverage, while beneficiaries have the choice of a wide range of competing insurance plans.

All Medicare-eligible individuals would be able to choose between the more traditional Medicare system or "Medichoice" on a periodic basis.

The Specific Problems
What Must be Fixed

Medicare is Almost Broke

Part A Trust Fund Assets at End of Year 1990-2005

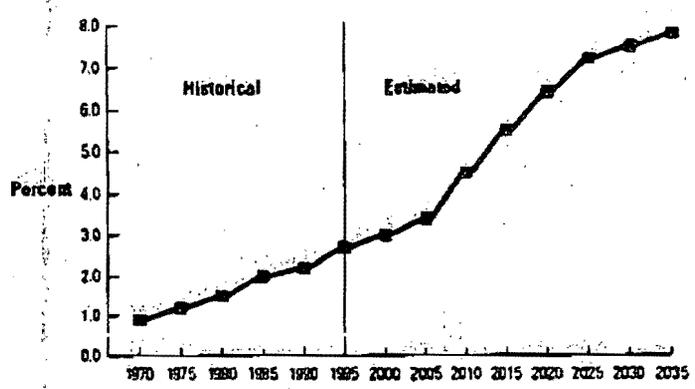


Source: 1996 Annual Report of Trustees of Federal HI Trust Fund

The Medicare hospital trust fund (Part A) will be empty by 2000 or 2001. Current law does not allow deficit spending from the Part A trust fund; unless the law is changed and other sources of funds are tapped, payments to hospitals for services provided to Medicare beneficiaries will cease.

Medicare's Growth Rate is Outstripping Our Ability to Pay

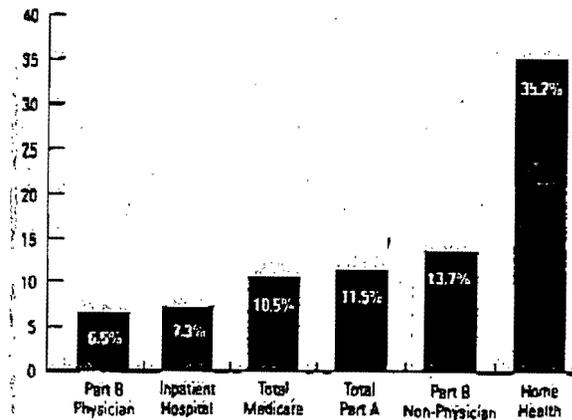
Medicare Expenditures as a Percentage of GDP



Source: Congressional Budget Office

Medicare expenditures grew from 3.7% of the federal budget in 1970 to 13% in 1995. If the rates of spending in both parts of Medicare are not slowed, spending is projected to grow rapidly from 2.6% of Gross Domestic Product in 1995 to 7.8% in 2035. Medicare's expenditure growth cannot be sustained at current levels while government continues to struggle to meet other commitments.

Average Annual Growth Rate 1991-1995

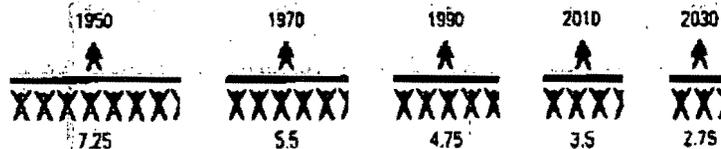


Payments for physician services are not responsible for Medicare's escalating growth rate. Part B physician spending growth was 6.5% from 1991-95. This is well below the rate for other categories of Medicare spending, and well below overall Medicare growth.

The methods used by government to try to control the growth have not worked. Price controls have been one of the main approaches; they have been used since 1983 in part A, and since 1975 in various forms in Part B. Reductions in payments to physicians and hospitals have been another heavily-used attempt to control growth. Seventy distinct reductions in Medicare payments to physicians have occurred since the program began.

The Baby Boomers are Coming

Number of Working Americans per Retiree 1950-2030



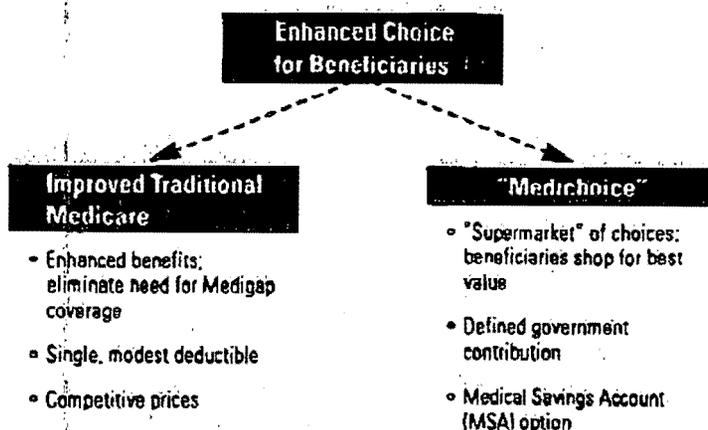
Source: The Bipartisan Commission on Entitlement and Tax Reform (Kerry Commission)

The number of workers contributing payroll taxes to finance the hospital trust fund is declining. In 1965 when Medicare was enacted, there were 5.5 working-age Americans

for every individual over 65. Today, there are only 3.9. In the coming decades, as the "baby boom" generation continues to age, the number will fall more rapidly. By the year 2030 there will be only 2.2 working-age Americans for each individual over age 65. By that time, 20% of the population will be covered by Medicare, compared with 12.8% now.

AMA's Medicare Repair Proposals

The Two Paths



Enhance Choice for Medicare Beneficiaries

We believe the traditional Medicare program should continue to be an option for Medicare beneficiaries. To do otherwise is too threatening to America's elderly. Because most beneficiaries are likely to remain in the traditional program for many years, it is necessary to restructure the program to make it more efficient.

And, as an alternative, we recommend the establishment of a structured private health insurance offering modeled on the Federal Employees Health Benefits Program (FEHBP) using a defined contribution. The value of this subsidy for the purchase of private health insurance plans would be equal to the amount that would be spent by Medicare on the enrollee's behalf if the person had remained in the traditional Medicare program. Patients would have a broader array of choices of plans and would be provided with better comparative information to purchase coverage that provides the greatest value.

Reconfigure Medicare Beneficiary Cost-Sharing to Reduce Cost to Both Beneficiaries and Medicare

We propose Medicare modify its benefits to encompass Medigap benefits, and at the same time fold all current cost-sharing requirements into a single, modest deductible. We

also propose methods to assure that economically disadvantaged beneficiaries maintain access to the Medicare program.

Foster Economic Efficiency with a Competitive Price System for Physician and Hospital Services

Price controls for Medicare services should be transitioned out and Medicare beneficiaries should be rewarded for choosing the most personally economical health services in the market. Providers should be rewarded for offering competitively priced services. Price competition can coexist with protections for beneficiaries.

Redesign Graduate Medical Education Funding

Graduate medical education is partially paid for by Medicare payments to hospitals. This method of financing needs updating. We recommend the financing of graduate medical education based on contributions from all payers of health care -- an "all payer" fund -- which would include not only the federal government but also health plans and other providers.

Update Medicare's Regulatory Structure

a/ Fraud and Abuse in the Medicare Program

Billions of dollars are stolen from the Medicare program each year in a wide variety of fraud schemes. While the exact nature and scope of these problems are not known, estimates are that up to 10% of health care expenditures is lost to fraud and abuse.

The incidence of misconduct can be greatly reduced by setting standards of appropriate behavior, disseminating this information widely, and designing and implementing programs to facilitate compliance.

The Federal Bureau of Investigation (FBI) says physicians are least likely to be involved in health care system fraud. In fact, doctors are playing an important role in detecting and reporting fraud. An AMA/FBI partnership has strengthened the successful prosecution of health care fraud.

b/ Professional Liability

An estimated \$45 to 90 billion per year of medical costs are related to health care liability. We simply recommend adoption of the reforms that have been successful in the most populous state in the union, California. These reforms include a limit on non-economic damages and a sliding scale limit on attorney contingency fees.

c/ Facilitating Provider-Sponsored Networks and Provider-Sponsored Organizations

Research identifies physicians as best able to identify and implement efficiency in the delivery system. We recommend giving physicians the opportunity to establish successful organizations to help solve Medicare's cost problems.

Prepare for Future Generations

We support gradually increasing the age of eligibility to 67, the same as Social Security. We support reducing the subsidy for high income beneficiaries using income-related premiums. We believe that private savings during working years, for health care in retirement (medical savings accounts), should be part of the solution to Medicare's financial health over the long-term.

More on Medichoice

How Would It Work?

For beneficiaries electing the Medichoice program, a more varied set of preventive and essential health care services would be available as options. Beneficiaries electing Medichoice would be credited with the amount it would have otherwise cost Medicare to insure them. They would then be free to seek services from an individual physician or group, as they see fit.

Medichoice is a defined contribution system designed to control the open-ended entitlement that is a major contributor to Medicare's budgetary instability. Many analysts recommend the Federal Employees Health Benefit Plan (FEHBP) as a model for providing choices under a defined contribution plan. The FEHBP is a "supermarket" through which dozens of private plans are offered to millions of federal employees, retirees, and dependents. Economic incentives in this plan are powerful and Federal employees avidly shop for the best value.

Any insurance plan could participate in Medichoice provided it complies with certain minimum standards adapted to Medichoice from the legislative and regulatory provisions governing the FEHBP. Medichoice would also offer MSAs as an option.

Before the periodic enrollment period, Medicare-eligible individuals would receive:

1/ notification of the premium and deductible for the next year for traditional Medicare coverage;

2/ the amount of the government contribution to the cost of Medichoice plans for which the individual is eligible in the coming year;

3/ comprehensive information on participating Medichoice options in the individual's geographic area, together with rates.

Beneficiaries will either pay the difference when the cost of the chosen plan exceeds the government contribution or keep the balance when the government contribution exceeds the plan cost. Beneficiaries choosing the MSA option could purchase a high-deductible catastrophic medical plan and deposit the premium savings in their MSA accounts.

The AMA Plan in the Real World

Three Examples

Joe Carter -- Heavy User

About 15% of enrollees use \$10,000 or more a year of medical care

Joe Carter has experienced mild symptoms of heart disease for several years. Recently, while working in his backyard, Joe suffered a heart attack that left him hospitalized for several weeks. After initial treatment, he met with several cardiologists and revisited the hospital twice for treatment of coronary artery obstruction.

Under the current system, Joe's medical expenses for doctor care and two hospital visits totaled \$10,000. His total medical spending, however, was only \$1625 because of Medicare and his Medigap policy (which paid the Medicare co-insurance and deductibles). In other words, the \$533 Joe spent on his Medicare Part B premium and the \$1092 he spent for his Medigap policy insured him against the financial risks of his extended illness.

Under the AMA proposal, Joe would receive the same doctor care and hospital treatment for his heart condition. But, instead of paying a Medicare and Medigap premium, he would pay a single Medicare premium for the same coverage. Joe Carter would spend the same total amount for health care that he does now.

Delores Evans -- Low User

Roughly 30% of Medicare enrollees spend \$300 or less on medical care

Delores Evans is 66 and works part-time as a middle school counselor. Delores enrolled in Medicare when she turned 65 because her employer did not offer insurance

benefits. In 1993, Delores was diagnosed with a non-cancerous breast tumor. On the advice of her physician, she receives an annual mammogram and breast examination.

Under the current system, Delores decided to buy a Medigap policy for \$1092 to cover Medicare co-insurance and deductibles. She also pays the Medicare Part B premium of \$533, so her annual out-of-pocket cost for medical care is \$1625. An additional \$300 worth of tests (mammogram and breast examination) are covered by Medicare, because they are considered medically necessary.

Under the AMA proposal, Delores would continue to visit her physician twice a year. Instead of paying a premium for Medigap and Part B coverage, she would pay a single Medicare premium. Delores' total health care bill would be about \$200 less than she currently pays.

Ruth Hudson -- average user

About 11% of enrollees have no supplemental coverage

Ruth Hudson is widely known in the small southern town where she was born, working as a caretaker for her neighbors, relatives and friends. Ruth had to curtail her caretaking activities about the time she turned 80. For years, her diabetes had shown only mild symptoms, but it began to affect her more seriously. Her eyesight, for example, deteriorated significantly, becoming apparent to her only after she missed her bus stop several times in one week. The swelling in her knee joints also began to make walking and climbing stairs more difficult. Ruth began to visit her doctor more frequently for relief from her diabetes, though her condition had not advanced enough to require hospitalization.

Under the current system, Ruth has not purchased Medigap coverage because she can't afford it. She and her husband saved a small nest egg which she uses along with her Social Security to pay her increasing medical expenses. In the past year, her medical bills totaled \$1433, which includes a \$533 Medicare Part B premium and \$900 in deductibles and co-insurance for physician care.

Under the AMA proposal, Ruth Hudson would pay a single Medicare premium of \$1625, which is \$192 more than she currently pays. However, she would now be insulated from the likelihood of increased co-insurance if her condition required more extensive care or hospitalization.



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October 16, 1996

The Honorable John Boehner
U.S. House of Representatives
1121 Longworth Building
Washington, DC 20515

Dear John:

Thank you for your October 15 letter. The American Hospital Association always has been free of partisanship in relation to presidential campaigns and 1996 is no exception.

That's why we understand your concern about how public statements are characterized. When we heard the reference to the AHA in the first presidential debate, we immediately contacted officials at the White House to make clear what our public statements have been on the matter. Upon hearing another reference in the vice presidential debate, we again took action with the White House by providing them with documents outlining AHA's public statements. What we said was that 700 hospitals derive two thirds or more of their net patient revenue from Medicare and Medicaid, and that large Medicare reductions mean needed hospitals in rural and inner-city communities could be forced to shut their doors.

And when requested by your staff to clear up the situation, we informed them of the actions we already had taken and sent documentation to them--the same information that we sent to President Clinton and Vice President Gore.

We value our important working relationship with you and the Republican Conference. Your leadership on key issues, such as delivery system restructuring, has been deeply appreciated. We look forward to working with you when the 105th Congress convenes in January. That is why we acted promptly to set the record straight on our public statements about the effect of Medicare changes on hospitals.

Sincerely,

A handwritten signature in black ink, appearing to read 'Dick', written over a horizontal line.

Richard J. Davidson
President

- o **House GOP seeks rebuttal of Clinton-Gore debate statements on Medicare.** House GOP Conference Chair John Boehner is urging the American Hospital Association to refute statements made by President Clinton and Vice President Gore during their recent televised debates. In a letter to AHA President Richard Davidson, Boehner said Clinton and Gore both "repeatedly cited a 'study' from your organization, contending the Medicare Preservation Act would result in 700 hospitals closing nationwide. As you know, the AHA has never produced such a study — only an estimate of the total number of hospitals that are 'Medicare dependent.'" Added Boehner: "I am sure you realize the Clinton-Gore campaign is manipulating your position for partisan gain."

Boehner said Republicans and the AHA "have been working together to save Medicare from bankruptcy," while "for 18 months, the Democrats and their Washington-based special interest allies have demonized the Medicare Preservation Act, running million-dollar ad campaigns against House Republicans. At every opportunity, the Clinton-Gore ticket echoes this message, further distorting the record of the Republican Congress." Boehner's letter pressed the AHA for a "public correction" of "the White House's repeated misuse of your figures and your organization's good name" before tonight's debate. Concluded Boehner's letter: "I would deeply regret it if this incident were to sour relations between the AHA and House Republicans as we look toward efforts to save Medicare from bankruptcy."

Meanwhile, On Fox television last night, President Clinton said: "I will never accept my opponents' devastating cuts in Medicare for the elderly, or revoking Medicaid's guarantees for poor people, the elderly, people with disabilities. I vetoed them last year." Asked about plans for health care policy, Clinton also said: "We should help provide health coverage for those between jobs; stop health plans from penalizing doctors who tell their patients all treatment options, not just the cheapest ones; and fully fund cutting-edge research to fight problems like breast cancer, AIDS, spinal cord injuries." Concluded Clinton: "Medical science is making great strides today — unlocking the secrets of DNA that cause cancer and Alzheimer's. We must make sure every family benefits from that progress — to build a bridge to a healthier 21st century."

- o **Stiglitz to lay out Administration's economic growth policy.** Council of Economic Advisers Chairman Joseph Stiglitz is expected today to lay out the framework for the Clinton Administration's economic growth policy at an early afternoon speech to the National Economists Club. According to a copy of Stiglitz's prepared remarks, the Administration's policy rests on three pillars: "investments in capital, investments in people, and improvements in the efficiency of the economy."

Under the heading of investment, Stiglitz is expected to say that "the key is reducing the budget deficit without slashing public investment," and therefore, "deficit reduction is...a fundamental component of the Clinton Administration's growth agenda." Stiglitz is expected to cite a 38 percent increase in real investment since 1993, which he says is a result of the Administration's emphasis on deficit reduction.

Stiglitz also lists a litany of Clinton Administration education initiatives which satisfy the "investment in people" pillar. Among the initiatives expected to be cited are \$1500 Hope Scholarships for the first year of higher education; \$10,000 tuition tax credits for families; GI Bill for American workers for job training; and \$1000 college honors scholarships for the top 5 percent of high school graduates.

Under the heading of improving efficiency, Stiglitz is expected to emphasize four areas of Administration priority: R&D, promoting economic competition at home, expanding markets abroad, and improving the efficiency of the public sector. Arguing that "the payoff to society as a whole from R&D substantially exceeds that to the individual firm," Stiglitz concludes, "a government role is warranted." Discussing deregulation, Stiglitz is expected to say that while "we are often told of the high costs imposed on the economy by regulations," and "many regulatory schemes are indeed inefficient," regulations "usually have benefits as well as costs." Stiglitz's speech continues: "Many of the benefits — such as clean air and water — are not directly included in conventional GDP measures. So comparisons of the costs of regulations to GDP are misleading, since the benefits are not included in the GDP. Ideally, a broader measure of economic activity — such as Green GDP accounts — would measure both the costs and benefits accurately, and allow us to make informed choices about different regulatory structures. ... The fundamental point is that we should be interested in the net social benefit, not the gross cost, of any specific regulation."

THE IMPACT OF THE BUDGET BILL ON HOSPITALS

- Under the conference agreement, reductions in Medicare payments to hospitals would total about \$96 billion--\$78 billion in "traditional" reductions in Medicare payments to hospitals and an additional \$18 billion from the "failsafe" provision.
 - ✓ On average, hospitals would be paid \$1,025 less per admission over the 1996-2002 period than they would under current law, a reduction of roughly 13 percent.
- Reductions of this magnitude represent a real cut in payments to hospitals, not simply a reduction in the rate of increase. Quality and availability of care will be adversely affected.
 - ✓ According to a study by Lewin-VHI, 7-year reductions of more than \$75 billion result in a real cut in Medicare payments to hospitals--not simply a reduction in the rate of growth.
 - ✓ The September 1995 Lewin-VHI report states that with 7-year reductions of \$100 billion--only slightly more than the conference agreement--payments to hospitals would rise only 2.4 percent per beneficiary per year. This is almost a full percentage point less per year than general inflation, expected to rise at 3.3 percent per year.
 - ✓ While politicians may choose to ignore the effects of inflation, hospitals don't have the freedom to do so. Prices of food, drugs, heat and air conditioning, x-ray film and other items that hospitals purchase go up each year, and nurses and other employees expect pay increases that keep up with inflation.
 - ✓ Moreover, the 3.3 percent forecasted increase in general inflation does not include the additional costs of innovations in medical technology which often add to expenses as hospitals upgrade and add equipment in order to provide the most advanced medical care. If these price increases were taken into account, the cuts would be even deeper.
- The Congressional leadership has asserted that under the budget bill, Medicare spending overall would grow from \$4,800 per beneficiary in 1995 to \$6,700 per beneficiary in 2002; an increase of 40 percent.
 - ✓ According to the Lewin-VHI study, with reductions of \$100 billion, Medicare hospital spending would grow from \$2,420 per beneficiary in 1995 to only \$2,860 per beneficiary in 2002.
 - ✓ That is, per beneficiary spending for hospital services would grow only 18 percent compared to a 25 percent increase in inflation during the same years.

■ In combination with the Medicaid reductions included in the bill, hospitals will have a difficult time meeting the needs of the community. Particularly hard hit will be communities with hospitals serving a large proportion of Medicare and Medicaid patients.

- ✓ For nearly one in four hospitals, 60 percent of patient days are Medicare patient days.
- ✓ More than 2,300 hospitals (nearly half) have large Medicaid patient loads (15 percent or more of their inpatient days).
- ✓ Almost 700 most vulnerable hospitals derive two thirds or more of their net patient revenue from Medicare and Medicaid--about 300 of these hospitals derive three quarters or more of their net patient revenue from Medicare and Medicaid.

■ Nationally, the most vulnerable hospitals (those that derive two-thirds or more of their net patient revenue from Medicare and Medicaid) represent 13 percent of all hospitals, provide 9 percent of all hospital stays, not just Medicare and Medicaid, and treat 11 percent of all emergency room visits.

- ✓ 56 percent of these highly vulnerable hospitals are rural; 20 percent are inner-city hospitals.

■ In many States, these most vulnerable hospitals play an even greater role in their communities.

- ✓ In New York: the most vulnerable hospitals provide nearly one in four of all hospital stays and 29 percent of all emergency room visits.
- ✓ In Texas: they represent 35 percent of all hospitals, treat one in four emergency room visits, and provide 21 percent of all hospital stays.
- ✓ In Oklahoma: they provide 15 percent of all hospital stays and treat nearly 20 percent of all emergency room visits.
- ✓ In California: they provide 12 percent of all hospital stays and treat 15 percent of emergency room visits.
- ✓ In West Virginia, Missouri, Kansas, and Oklahoma: 22 percent of all hospitals derive two-thirds or more of their net patient revenue from Medicare and Medicaid.

American Hospital Association

AHA

✓ 190838
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October 15, 1996

Honorable William J. Clinton
President of the United States
The White House
Washington, DC 20500

Dear Mr. President:

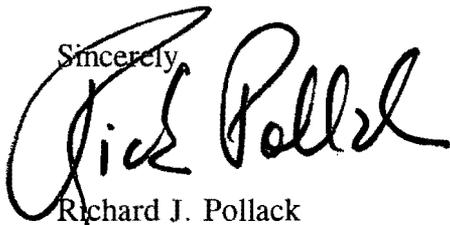
A number of questions have been raised regarding statements attributable to the American Hospital Association (AHA) with respect to the impact on hospitals of proposed Medicare budget reductions. We are pleased to provide the following official statements by the association in regard to this matter during the past legislative session:

- Testimony before the Senate Finance Committee on May 17, 1995 on the "Medicare Hospital Insurance Trust Fund."
- Testimony before the House Ways and Means Committee on September 22, 1995 on "Saving Medicare."
- An AHA fact sheet entitled "Medicare and Medicaid are Important to Hospitals."

If you have any further questions regarding this matter, please feel free to contact me.

Best Regards.

Sincerely,



Richard J. Pollack
Executive Vice President



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**Statement
of the
American Hospital Association
before the
Committee on Finance
of the
United States Senate
on
The Medicare Hospital Insurance Trust Fund**

May 17, 1995

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. I am pleased to testify today on behalf of AHA's 4,600 institutional and 50,000 individual members.

The Medicare budget issues under consideration will touch the lives of almost all Americans: the 37 million people who rely on Medicare benefits for their health care; the families of those beneficiaries; the millions of baby boomers who are edging closer to retirement; and the young workers who are paying into the system and rightfully expect Medicare to be there for them when they grow older and retire.

America's hospitals and health systems are proud of the high-quality care they've provided for Medicare beneficiaries over the first 30 years of the program. It hasn't always been easy

-- Medicare on average pays hospitals just 89 cents for each dollar of care delivered, a figure that is certain to drop if the spending proposals being considered are adopted. But we've kept our promise to deliver high-quality health care to the millions of Americans covered by the Medicare program. We're here today because we want to be able to keep that promise well into the next century.

I'd like to present my testimony in three parts:

The crisis in Medicare Part A -- the Hospital Insurance (HI) Trust Fund

The effects of further Medicare spending reductions

Some long-term answers to make the Medicare program stronger

The current crisis in the Hospital Insurance Trust Fund

The number of Medicare enrollees is increasing exponentially: When Medicare became law 30 years ago, 19.1 million people were covered; today's 37.5 million Medicare-insured Americans will swell to more than 40 million in five years. The average one-earner couple retiring in 1995 will use an estimated \$126,700 more in Medicare benefits than they paid in taxes and premiums. In just 15 years, the nation's 77 million baby boomers will start turning 65. And not too long after that, there will be only two workers supporting each enrollee, instead of the four supporting each enrollee today.

All of these facts are contributing to the HI trust fund's financial fragility. The trust fund's board of trustees recently reported that the fund will be insolvent by 2002. They also

reported that program costs are expected to far exceed revenues over a 75-year long-range period under any reasonable set of assumptions.

But Medicare is, like the rest of Social Security, a contract with America's seniors, and the HI trust fund is the centerpiece of that promise. The HI trust fund is the financial backing that keeps the Medicare contract from becoming just a bill of goods. Something must be done to fulfill the contract. But, contrary to current political rhetoric, the business-as-usual approach of simply cutting HI trust fund spending will do little or nothing to solve the problem.

That rhetoric has shifted in recent weeks. Many in Congress are now saying they want to cut Medicare to save Medicare. Unfortunately, no proposal currently on the table shores up the long-term viability of the trust fund. Behind all the rhetoric about shoring up the trust fund lurks the business-as-usual approach of more and more cuts to Medicare -- this time in order to balance the budget.

It's clear why this shift in rhetoric occurred: National polls and focus groups conducted by the American Hospital Association and others suggest that Americans believe deeply that Medicare is Social Security -- an earned annuity, paid for over a lifetime of payroll deductions. A member of Congress who votes to erode Medicare is seen as violating a promise not to touch Social Security. That sentiment cuts across all age, income, geographic, and gender boundaries.

And they are right. Medicare is part of the Social Security law. Medicare Part A is funded through payroll deductions; Medicare Part B premiums -- which, with general revenues, fund physician, ambulatory, and other services -- are deducted from beneficiaries' Social Security checks.

These proposed Medicare spending reductions may, in fact, be reductions in the rate of growth and not cuts in spending, but let's be clear: To people who rely on Medicare for their care and to people who provide their care, the spending proposals being considered are very likely to translate into cuts -- cuts in services and cuts in personnel. To the people to whom we provide care, these slowdowns in the rate of spending translate into real cuts.

Even the fund's trustees acknowledge that further legislation to limit payment increases to providers or extend prospective payments to other providers would only postpone insolvency for five to 10 years. In fact, the \$256 billion in overall Medicare savings over seven years proposed by the Senate Budget Committee would delay insolvency of the HI Trust Fund for only about four years. Adding four years to the solvency of the trust fund is not worth the price these reductions would extract from the millions of Americans who rely on Medicare. And even if the drastic reductions in spending do delay insolvency, solvency is not the only issue. Even if solvent, the trust fund must contain enough dollars to provide quality care for seniors.

In order to fully address the long-term problems of the Medicare program, all ingredients must be on the table -- the program structure, the level of benefits, and program revenues, as well as spending. Unfortunately, current proposals look only at slowing the rate of spending, a business-as-usual approach that ignores much of the problem.

The effects of Medicare spending cuts.

There's no question that Medicare spending is growing. But it's important to take a closer look at why. The AHA commissioned a study by Price-Waterhouse that revealed some interesting things:

- Enrollment growth and medical and general inflation accounted for nearly 89 percent of Medicare spending growth since 1980.
- Growth in Medicare enrollment between 1980 and 1993 was double the rate of growth in the general population. At the same time, enrollees over 75 years old as a percentage of all elderly (over 65) grew to 43 percent in 1993 and are expected to reach nearly half by 2005.
- The proportion of Medicare spending on hospital care has declined from 70.2 percent in 1980 to 60.1 percent in 1993.

- Since 1980, Medicare hospital spending growth has been lower than growth in Medicare spending for other services.

Since the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) was enacted, Medicare hospital spending reductions of at least \$48 billion have had significant impact on hospitals and health systems. So have Prospective Payment System (PPS) payment rates that haven't kept up with inflation. On Medicare inpatient and outpatient care combined, 1993 Prospective Payment Assessment Commission data show hospitals losing 11 cents on the dollar.

The effects of the Senate Budget Committee's proposed cuts of \$256 billion over seven years can be illustrated by a new impact analysis AHA commissioned from Lewin-VHI, a health care consulting firm. We asked Lewin-VHI to model the impact on hospitals and health systems of overall Medicare spending reductions totalling \$150 billion over five years and \$250 billion over seven years.

Based on historical patterns of previous Medicare spending reductions, the Lewin-VHI analysis assumes that a \$250 billion reduction could translate into hospital PPS reductions of \$94 billion over seven years.

The Lewin-VHI findings show:

- Under this scenario, every type of hospital loses -- rural, urban, large, small, teaching, and non-teaching.
- By the year 2000, Medicare PPS inpatient operating margins 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 will lose \$1,300 in PPS payments for every Medicare patient. Hospitals will be paid \$900 less 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, based on last year's experience. If actual cost growth is higher than projected, hospitals could face substantially lower margins than those illustrated here.

In the past, hospitals have coped with Medicare spending reductions by shifting costs -- by passing the difference on to other payers, like non-Medicare patients and their employers. But those days are fast disappearing -- and these reductions are unprecedented. Simply put, the market is shutting down the cost-shift option. Managed care contracts and a growing number of private insurers who negotiate discounted prices are making cost-shifting a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or both. Either action takes us farther from our mission of providing the highest-quality health care to all the people we serve, including America's elderly.

AHA's vision for the future of Medicare

To deal with the trust fund problem constructively, and for the long term, we need to make fundamental, structural changes in the Medicare program -- like moving it toward coordinated care -- and create an independent citizen's commission on Medicare.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a survey by the consulting firm of Frederick/Schneiders found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those in traditional fee-for-service.

Most importantly, coordinated care networks can bring Medicare beneficiaries closer to a better vision of health care for the future: a connected health system, with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Coordinated care works better than the old-fashioned, fragmented system we must pull away from. And it can bring better, more efficient care to older Americans who entrust their health to Medicare. There are a number of options Congress could consider that would help move Medicare into coordinated care. Here are a few:

- **Fix the current methodology used to pay Medicare risk contractors** -- There is general agreement that the current payment system is flawed, and Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local area, which affects costs and the calculation of the AAPCC.
- **Model the Medicare program after the Federal Employees Health Benefit Program** -- For federal employees, the government makes a fixed contribution and the employee chooses from a wide variety of plans. Medicare could do the same on behalf of its beneficiaries if they choose to enroll in a coordinated care plan in the private sector.
- **Provide financial incentives for Medicare beneficiaries** who choose coordinated care options that are available in their area. These plans, offering comprehensive

services at lower than current fee-for-service prices, give seniors better value for their Medicare dollars.

- **Explore new ways of paying coordinated care organizations that contract with Medicare** -- a new approach would allow plans in the same market area to bid competitively for Medicare contracts, for example. Bidding would have the effect of setting different market prices in local areas for Medicare coordinated care enrollees in a way that takes into account local costs and health care needs.
- **Expand the types of plans that Medicare beneficiaries can choose** -- Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or traditional fee-for-service providers. Medicare should also contract with the growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New types of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.
- **Provide seniors with more information on coordinated care plans** -- send a list of local coordinated care plans directly to beneficiaries and give them an annual report that compares coordinated care and fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.

- **Allow for an open enrollment period each year, during which Medicare beneficiaries can elect to receive services from a coordinated care plan -- and make their choice of a managed care plan valid for one year instead of the current 30-day period, to enable the plan to better manage beneficiary needs and practice preventive care.**

We are already seeing the beginnings of a transition to coordinated care for many seniors. In the longer-term, this can bring lower costs and more efficient health care to seniors, and ultimately restructure the Medicare program itself. But, what about the process under which Medicare budget decisions are made? That process has to change as well.

True restructuring of the program can only come by removing its funding process from the stifling politics of "business-as-usual." The American people have a right to know that what their nation spends on Medicare is buying the best benefits and the most efficient care. They should rest assured that federal budget pressures won't get in the way of providing good health services for older Americans. AHA urges Congress to create an independent citizens' commission to do this job -- and put the "trust" back in the trust fund.

Senators Domenici and Dole, and Speaker Gingrich, have talked about a commission. But their idea is to have a commission on a short-term basis to address short-term budget questions. We believe a bipartisan, citizens' commission on Medicare should be permanent, with a life expectancy beyond the current crisis.

Unless an independent, national citizens' commission is formed to make the tough calls on Medicare, older Americans will continue to be caught in the political crossfire obscuring the real issue: how to provide quality, cost effective health care to a growing number of beneficiaries.

Those political pressures have led to congressional, back-room, middle-of-the-night Medicare cuts of \$100 billion under the past two budget bills. And they could lead to cuts of nearly three times that amount if the current proposal is adopted.

An independent commission would get the process out of the political back rooms and into the sunshine. The commission would do an independent study on the spending needed to maintain current commitments. Then, Congress can set a target for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations -- which would then be voted up or down as a package.

With an independent commission, we can have an open and honest discussion about how much we want to spend -- and what we can buy for that money. The commission would also provide an annual report to Congress on the quality of care and access to care under the Medicare program.

Creating an independent commission to make recommendations on Medicare spending and benefits doesn't mean that we won't constrain growth. It does mean that we'll do it rationally, in the full light of day.

CONCLUSION

There is a responsible way and an irresponsible way to achieve reasonable reductions in Medicare and to shore up the Hospital Insurance Trust Fund. The irresponsible way is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors. The responsible way is to restructure the program by providing seniors more choice and encouragement to participate in a broader range of coordinated health plans.

And the responsible way is to establish an independent national commission to make the tough choices that will be needed to keep services and benefits in line with available money -- and to keep Medicare from being a "cash cow" that continually finances other policy initiatives and legislative agendas.

Mr. Chairman, America's hospitals and health systems understand the need to lower the federal deficit. We understand that to accomplish this monumental task, all federal programs will have to contribute their fair share. That's why we were willing to discuss a responsible alternative offered by Senator Judd Gregg (R-NH) that would have saved billions and reduced the rate of growth. Unfortunately, the budget committees have chosen a more

extreme approach. It is an approach that hospitals simply cannot support if we are to keep our promise to the millions of Americans who rely on Medicare funding for their health care

We look forward to working with this panel to create constructive change in the Medicare program -- and to protect a program that in some way touches almost every American life.

American Hospital Association



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**Statement
of the
American Hospital Association
before the
Committee on Ways and Means
of the
United States House of Representatives
on
Saving Medicare**

September 22, 1995

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit, Michigan, and chairman of the American Hospital Association. AHA includes in its membership 5,000 hospitals, health systems, networks and other providers of care. I am pleased to testify today on their behalf.

America's hospitals and health systems are at the forefront of change in the way health care is being delivered. In communities all across the country, hospitals and health systems are looking for new and better ways to do their job. They are forming partnerships and creating integrated systems of care that are designed not just to treat illness and injury, but to make the communities they serve healthier.

This is health care reform at its finest -- and Congress should be commended for recognizing that it is time for Medicare to take part in this progress. There has been a lot said about restructuring the Medicare program, and we understand there are some positive steps being considered that move toward that goal in the Medicare Preservation Act. That's the good news. The bad news is that the plan apparently does not go far enough to help us continue those reforms. More importantly, we have to question the Congress' commitment to those reforms when, in the same plan, it appears that a level of spending reductions in Medicare is proposed that could affect quality and access to care for millions of Americans.

THE BAD NEWS -- MEDICARE SPENDING REDUCTIONS

Although the proposed reductions have been referred to as a slowdown in the rate of growth of Medicare spending -- from 10 percent annually to 6.4 percent annually -- the fact is that for hospitals and health systems, they could translate into real cuts if payments don't keep up with general inflation.

How could this happen when the budget resolution would allow per-beneficiary spending to increase 40 percent over the next seven years, from \$4800 to \$6700? Because Medicare spending for hospital services is growing much more slowly than the rest of the program. CBO projects that, under current law, Medicare spending for hospital services will grow 6.9 percent a year over the 1996-2002 period, compared with about 10 percent for the Medicare program overall. On a per-beneficiary basis, under current law, payments to hospitals are

projected to grow by only 5.5 percent each year, compared with more than 8 percent for the program overall.

The deep reductions in payments for Medicare hospital services that are being considered could, therefore, lead to such small rates of increase for hospitals that they do not even cover general inflation -- which is projected to average 3.3 percent annually, as measured by the Consumer Price Index. Payments that do not at least cover inflation will force hospitals to try and provide the same range and quality of services with fewer and fewer resources, an extremely difficult if not impossible task -- and one that most hospitals are already struggling with in the current market.

Based on a quick estimate of the Medicare Preservation Act, the specific hospitals reductions are in excess of \$75 billion over seven years -- and we're still counting. This does not include further reductions that would be made in hospital payments as a result of the fail-safe, or "look-back," mechanism.

What do these reductions mean to the typical 150-bed hospital?

- \$11 million less revenue between 1996 and 2002.

What do these reductions mean to the typical 250-bed hospital?

- \$17 million less revenue between 1996 and 2002.

What do these reductions mean to the typical hospital with 300 or more beds?

- \$49 million less revenue between 1996 and 2002.

While this committee deals with Medicare and not Medicaid, I must point out that proposed Medicaid reductions, when added to the Medicare reductions being considered, will increase these losses substantially.

For all types of hospitals, these reductions could:

- Threaten the very future of hospitals in the neediest communities. Large cuts in Medicare spending hit the most financially vulnerable hospitals hardest, often the ones that need to remain open to ensure access and coverage to underserved populations.
- Restrict access or availability of important services often offered at a financial loss -- including trauma care, burn units and neonatal intensive care.
- Limit the ability of hospitals to focus on the health of their community. Prevention, health promotion, community outreach and education may be scaled back or sacrificed in cost-cutting efforts.
- Jeopardize the local economy through forced layoffs and cutbacks in purchasing. As major employers and purchasers of goods, hospitals are a vital part of the economic fabric of their communities.
- Stymie their efforts to collaborate within the community to provide cost-effective and patient-friendly networks of care.

Shared responsibility

America's hospitals and health systems have urged throughout this budget process that shared responsibility should be the guiding principle behind any reductions in Medicare spending. It has been our understanding that Congress agreed. However, the reports that we are getting about the realities of the Medicare Preservation Act concern us. Hospitals face a double-whammy: a disproportionate share of the overall Medicare reductions would be borne by providers -- including hospitals and health systems; and a disproportionate share of provider reductions would be borne by hospitals and health systems. In fact, we estimate that hospitals face in excess of \$75 billion in reductions through traditional means -- a figure that does not include potential reductions from a look-back mechanism, but is already disproportionately higher than reductions to others with a stake in Medicare.

Hospitals and health systems are willing to work to both reduce the budget deficit and ensure that the Hospital Insurance Trust Fund remains solvent. But both goals must be arrived at through shared responsibility.

Initiatives that move Medicare toward our vision of coordinated health care can serve patients better *and* save money. But, saving the current goal of \$270 billion over seven years should mean a financial effect on everyone with a stake in Medicare -- hospitals and health systems, physicians, other providers, and beneficiaries. Doing business the old-fashioned way -- just cutting provider payments -- is not the answer. To address Medicare's long-term problems,

everything must be on the table: program structure, benefits, beneficiary cost-sharing, eligibility, and program revenues, as well as provider payments.

In the past, hospitals coped with Medicare spending reductions by passing the difference on to other payers, like non-Medicare patients and their employers. That's called cost-shifting. But those days are fast disappearing, and these reductions are unprecedented. The market is shutting down the cost-shift option. Managed care contracts and a growing number of employers and private insurers who negotiate discounted prices are making it a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or, ultimately, shut their doors altogether. Any one of these options takes us further from our mission of providing the highest-quality care to the people we serve, including America's elderly, poor and disabled. At the same time, deep reductions to provider payments could stifle the local innovation and progress that are key to restructuring the Medicare program.

THE GOOD NEWS: EXPANDING COORDINATED CARE OPTIONS

Hospitals and health care systems have a great deal at stake in expanding coordinated care options under the Medicare program. First and foremost, we believe that locally based coordinated care systems hold great promise in improving the quality and continuity of care,

as well as improving the efficiency of health care delivery. The document released yesterday suggests that the Medicare Preservation Act recognizes that promise, at least conceptually.

However, we need to ensure that Congress provides the specific tools needed to make coordinated care options available to beneficiaries, and to encourage beneficiaries to select those options.

Provider-Sponsored Networks

Medicare beneficiaries who want to choose coordinated care rather than fee-for-service coverage have just two choices: a health maintenance organization (HMO) or a competitive medical plan (CMP). These plans are important elements in a restructured health care delivery system, but Medicare must look beyond these two options.

The Medicare Preservation Act recognizes the benefits and savings that can be achieved through locally based networks of care — what we call provider-sponsored networks. PSNs are formal affiliations of health care providers, organized and operated to provide health care services. These networks commonly take the form of physician-hospital organizations or independent practice associations, and are often called integrated delivery systems.

Many PSNs have formed HMOs, or have become partners with insurers to do so. But still more have not become HMOs. Some serve populations that are too small or too sick to support the full risk of an HMO. Some are in states where it reportedly takes up to two

years to get an HMO license. Others are in areas where Medicare's HMO payment is simply too low to provide adequate care. Others are in areas where it could be economic suicide to compete with local insurers for private enrollees.

The Medicare program should take full advantage of the health care innovations and efficiencies offered by PSNs by allowing them to contract directly with Medicare. Medicare will need many new entrants into the coordinated care market in order to give seniors a wide range of health plan choices.

We agree that any entity delivering care to Medicare beneficiaries must meet high standards. But current regulatory thinking could limit the ability of PSNs to serve Medicare beneficiaries.

We propose that PSNs would have to meet all the same consumer protection standards as currently required by Medicare for other risk contractors, except that PSNs would meet higher quality standards and different but comparable solvency standards, and they would not be required to have at least as many private enrollees as Medicare and Medicaid enrollees (Medicare's so-called "50/50" rule).

A modified solvency standard is important because PSNs directly provide, not buy, most of the services that are covered. As a result, the standard should recognize that most of a PSN's assets need to be invested in its capacity to deliver health care services, not in the

more liquid assets needed by insurers to pay claims to providers. It is their receipt of capitated payment that many insurance regulators equate with an insurance function, which triggers the perceived need for insurer-like solvency requirements. PSNs are actually paid in many ways, not just capitation, so it is important to put this in context with the rest of their operation. The solvency standard we have proposed is generally equivalent to the national model HMO act (which is actually higher than some state HMO requirements), with changes to reflect the primary PSN function of health care delivery and avoid any unreasonable financial barrier for rural PSNs.

A key difference between our proposed PSN direct contracts and other Medicare risk contractors is that PSNs would not be required to directly enroll private individuals. In the private sector, PSNs contract to deliver coordinated care to enrollees of HMOs, self-insured employers, and other health plans. They do not generally engage in enrolling individuals. Medicare's current "50/50 requirement" forces PSNs to directly compete for the private enrollees of the same plans with whom they have contracts to deliver services -- a step that generally disrupts those contractual relationships.

PSNs, while required to meet federal standards, should not also be required to be licensed by the state in order to direct contract with Medicare. State HMO licensure is a process that can be burdensome, slow and unsuitable for PSNs -- blocking the availability of a broader range of options for America's seniors. And we fear that the state regulatory process will

become more problematic, as state insurance regulators try to force new and evolving health care delivery structures into existing regulatory structures.

Thus far, we have seen only a conceptual description of the budget plan's approach to provider-sponsored networks. We greatly appreciate that PSNs are included in the Medicare Preservation Act, but we continue to have real concerns that the promise of provider-sponsored networks may not be realized under the Medicare program.

For example:

- **Timeline that provides a jump start for insurers.** The description indicates that insurers would be allowed to offer expanded options to Medicare beneficiaries well before PSNs would be allowed to do so (as much as 11 months), allowing them to corner the market before PSNs are allowed to compete. To ensure a level playing field, all new Medicare private plan options should be required to become available simultaneously to Medicare beneficiaries.

- **Timing of PSN standards.** In an earlier draft document made available to AHA, the framework of regulatory deadlines and effective dates indicated that PSNs would be subject to a set of transitional standards that would take six months to issue, even though they are based predominantly on the current HMO/CMP standards, and another six months to apply in the certification process -- only to be supplanted two years later by a permanent set of standards, the development of which would be

turned over to state insurance regulators under the auspices of the National Association of Insurance Commissioners (NAIC). The secretary of Health and Human Services (HHS) would not have any authority to reject or modify NAIC's standards. This would tie up PSNs in a process of constantly changing regulatory requirements for the first three to four years. PSNs need a lengthy period of stable federal oversight (preempting state regulation) to ensure substantial PSN participation in markets around the country; NAIC's role should be limited to an advisory one. PSN standards should be issued on a fast-track basis (by April 1, 1996).

- **Solvency standard.** The description also indicated that the American Academy of Actuaries (AAA) would be given the open-ended task of developing a PSN solvency standard, again without any apparent ability on the part of the HHS secretary to reject or modify it. The provision that AAA develop the PSN solvency standard should be significantly altered. AAA should modify the current NAIC model HMO solvency standard only to the extent necessary to conform to the provider service delivery environment of a PSN, and to avoid any unreasonably high financial hurdle for rural PSNs. It also should be clarified that the role of AAA is advisory to the HHS secretary.

- **Shared-risk payment arrangements.** We understand that some in Congress may be unwilling to allow a shared-risk as well as full-risk payment option for PSNs. We believe that is unfortunate, because shared risk may be the only means of bringing

coordinated care arrangements to some rural and chronic care Medicare populations. If Congress insists on excluding shared-risk arrangements for PSNs at the outset, we urge that HHS be given explicit demonstration authority to develop and demonstrate such arrangements.

Barriers to integration

There are other barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation -- the heart of coordinated care.

For instance:

- The provision of health care services has long been considered a charitable and, therefore, tax-exempt activity. However, current tax exemption guidelines for non-profit providers have not kept pace with the trend toward coordinated care. Tax policy should create opportunities for non-profit health care providers to integrate and provide coordinated care services. Not-for-profit HMOs currently enjoy tax exemption, and should continue to do so. In addition, we support including in the budget plan a provision giving statutory tax exemption to provider-sponsored networks that meet vigorous community benefit requirements.
- We are pleased to see modifications to the physician self-referral law, which prohibits referrals when a financial relationship exists between the physician and the entity to which the physician refers a patient. For example, the Medicare Preservation Act

removes from the law's jurisdiction referrals based on compensation arrangements, which are already covered under anti-kickback law, and pares back the list of services to which the law applies. However, it is unclear whether the modification that expands the exception for prepaid plans would cover the variety of risk-sharing arrangements, including PSNs, that can be developed with incentives to prevent excessive and inappropriate utilization of services. This issue needs to be addressed.

- Modifications to the "anti-kickback" law, which prohibits payment in exchange for referrals of Medicare and Medicaid patients, are heartily welcomed. The federal government is actively--and properly--working to ferret out waste, fraud and abuse. However, a vague law, broad interpretations, and expansion of the law's reach and sanctions without clarification, have combined to create confusion over what kinds of arrangements providers may establish. We're very pleased that the Medicare Preservation Act provides for an advisory opinion process and calls for various clarifications in the enforcement of the anti-kickback law. Again, however, we need to be certain that the exemption for certain managed care arrangements adequately covers the variety of risk-sharing arrangements, like PSNs, that ensure appropriate utilization.
- The Medicare Preservation Act indicates that current antitrust law is a barrier to the formation of PSNs. Because we do not know the details of how PSNs will be defined, we cannot speak to whether the proposed relief is necessary, adequate or

anti-competitive. However, we continue to believe that a process for getting specific approval for appropriate provider arrangements could offer protection from expensive and time-consuming antitrust challenges.

- Although it may not necessarily be a barrier to integration, the threat of liability lawsuits is felt heavily by hospitals and health systems and can certainly be a barrier to the efficient delivery of health care. We are very pleased to see that a number of liability reforms are planned in the budget proposal. These include limiting a defendant's liability for non-economic damages to its proportionate share of fault; limiting non-economic damages to \$250,000; modification of the collateral source rule to allow defendants to introduce evidence of insurance payments to a claimant; modifying the statute of limitations so that claims can not be filed more than two years after an injury is discovered or five years after the initial injury occurred; and allowing non-economic damages of more than \$50,000 to be paid periodically rather than in a lump sum.

The look-back

If the budget plan provides the tools we feel are necessary, then we are confident that the program will save money by moving Medicare toward coordinated care. That is why we supported the concept of a "look-back" mechanism during deliberation of the budget to ensure the savings anticipated from moving more Medicare beneficiaries into coordinated care. But the "look-back" should not be used to overpromise savings that can be reasonably

achieved through coordinated care in seven years. The specific amount of targeted savings we had suggested from a look-back mechanism is \$60 billion through 2002. However, we are concerned that the budget plan may go well beyond this. All Medicare spending in excess of specified target amounts would be recaptured through the look-back, triggering future reductions in payments to providers. This would effectively turn the entire Medicare program into a capped entitlement.

Under this approach, factors beyond the control of hospitals and other providers could cause budget targets to be exceeded and trigger a look-back sequester: unanticipated inflation in the prices of goods and services hospitals must purchase (inflation is currently projected to average a relatively low 3.3 percent over the next seven years); unanticipated admission increases (for example, as the result of a flu epidemic); and errors by the Congressional Budget Office in estimating the savings associated with specific proposals.

The look-back should be limited to its original purpose: guaranteeing savings that can be reasonably achieved by moving Medicare beneficiaries into coordinated care plans.

Therefore, the total amount that can be recaptured from hospitals and other providers in a look-back should be limited and capped at the targeted savings -- our suggestion of \$60 billion over seven years. All stakeholders should play a role in contributing to the look-back if it becomes necessary. And an independent commission -- like the one proposed by Rep. Phil English (R-PA) in his Commission to Save Medicare Act of 1995 (HR 2152) -- would

be best-suited to objectively and efficiently determine how to allocate among the various stakeholders the automatic spending reductions a look-back would call for.

CONCLUSION

Mr. Chairman, America's hospitals and health systems share this committee's goal of restructuring Medicare. But the current budget plan as we understand it won't bring some of the key changes needed to achieve this result. We urge you to consider the very important changes we've outlined in this statement as the plan is debated in committees and on the floor.

We continue to be concerned about the impact of reductions of \$270 billion on quality and access. At the same time, given the right tools, America's hospitals and health systems are confident that the Medicare program can be restructured in a way that increases efficiency and improves access and quality. The millions of Americans who rely on Medicare, and those who will rely on it in the future, deserve no less.

###

MEDICARE AND MEDICAID ARE IMPORTANT TO HOSPITALS

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

Source:

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



Advocacy Action Plan

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An advocacy strategy to help hospitals
serve their communities.

March 29, 1995

To: Allied Hospital Association Chief Executive Officers
Allied Hospital Association Government Relations Officers

Subj: April Recess Advocacy Activity

ISSUE

Both the House and Senate will be taking a lengthy recess during the month of April. The House will adjourn on April 7 and reconvene on May 1, while the Senate will adjourn on April 7 and reconvene on April 24. Many organizations will use this time to deliver their advocacy message at the local level.

Debate on the Fiscal Year 1996 budget resolution, including potential Medicare and Medicaid spending reductions, is likely to begin in earnest when Congress returns. The April recess is the perfect time to deliver an additional grassroots message prior to the beginning of that debate.

TARGETS

We continue to focus our efforts on the Republican majority in both the House and Senate: We are targeting Republicans on the House Ways and Means, Commerce, and Budget Committees; the Senate Finance and Budget Committees; and the moderate Republicans we have identified as key targets since the beginning of the 104th Congress (see attachment 1).

ACTION REQUESTED

During the recess, we are asking that you set up either a visit to a local hospital for each of our targets, or a meeting between local hospital representatives and the targeted official. As mentioned above, since we are about to begin an arduous budget debate, the recess is a prime opportunity to get as many Representatives and Senators into local hospitals as we can.

MESSAGE

- ✓ **Hospital Visits:** If the meeting is to take place in a hospital setting, the focus should be on services and programs that are critical to the health of the community, but would be harmed as a result of massive Medicare and Medicaid reductions.
- ✓ **Impact on Communities:** By the beginning of the congressional recess, we will have compiled, whether through Lewin-VHI or through internal AHA calculations, the estimated impact on hospitals and health systems of five-year Medicare spending reductions of \$100, \$150, \$200, and \$250 billion. From these overall Medicare savings estimates, we will make some reasonable

assumptions about the likely hospital contribution to the overall reductions. We will then calculate the impact of these reductions by hospital type, by state, and by congressional district. It is important to remember that these estimates will be illustrative of the impact we might expect. We still have few specific budget proposals in hand, so we have to make assumptions based on projected and rumored reductions in order to make our case. Information will be sent to you during the week of April 3.

- ✓ **Rate of Growth Myth:** It appears that the principal argument of the Republicans will be that they are not cutting Medicare and Medicaid, but only slowing the rate of growth. As you know, this argument often fails to take into consideration the reasons for valid increases in costs. AHA commissioned Price-Waterhouse to study why such increases are occurring. Attached please find two charts which present the arguments that costs are increasing for reasons beyond hospitals' control, and that hospital spending has grown more slowly than other health care services (see attachment 2). We need to make the point to all of the Republican targets that a reduction in the rate of increase will have an adverse impact on hospitals and health systems, and that slowing growth is not as simple a concept as it appears.
- ✓ **Right Way vs. Wrong Way:** We must continue to deliver our overall message on both Medicare and Medicaid: We are not arguing that there should be no reductions in these programs, but that there is a right way to achieve spending reductions -- moving beneficiaries into coordinated care and, for Medicare, establishing an independent commission to properly balance benefits with payments; and a wrong way -- ratcheting down on provider payments. (We can provide further specifics on these proposals upon request.) This is not a new message, but it remains the foundation for dealing credibly with the new Republican majority, while not accepting massive reductions in payments to hospitals.

CONCLUSION

This will be our last opportunity to influence these critical Republican votes before they return to Washington to seriously debate the budget. We appreciate your efforts in setting up these meetings, and in making the case from the grassroots level. The Regional Directors will be following up with you regarding the meetings and any feedback that results.

As we have previously discussed, we will also inform our general membership that you, our allied associations, will be setting up meetings with targeted Republican members during the April recess. If you have any questions, please feel free to call your Regional Director or any of the Federal Relations staff. Thank you for your help.

Rick Pollack
Executive Vice President
Federal Relations

AHA APRIL RECESS TARGETS BY REGION

REGION	MEMBER	TYPE	DIRECTOR
1	Christopher Shays (R/CT-4)	Mod Rep/Bdgt	Barry
1	Gary Franks (R/CT-5)	Com.	Barry
1	Nancy Johnson (R/CT-6)	GOP Ldr.	Barry
1	<i>Olympia Snowe (R/ME-SEN)</i>	<i>Bdgt</i>	<i>Barry</i>
1	Peter Blute (R/MA-3)	Mod Rep	Barry
1	Peter Torkildsen (R/MA-6)	Mod Rep	Barry
1	<i>Judd Greg (R/NH-SEN)</i>	<i>GOP Ldr/Bdgt</i>	<i>Barry</i>
1	Charles Bass (R/NH-2)	Bdgt	Barry
1	<i>John Chafee (R/RI-SEN)</i>	<i>Finance</i>	<i>Barry</i>
2	Marge Roukema (R/NJ-5)	Mod Rep	Christenson
2	Bob Franks (R/NJ-7)	Bdgt	Christenson
2	Bill Martini (R/NJ-8)	Mod Rep	Christenson
2	Rod Frelinghuysen (R/NJ-11)	Mod Rep	Christenson
2	Dick Zimmer (R/NJ-12)	Mod Rep/W+M	Christenson
2	<i>Alfonse D'Amato (R/NY-SEN)</i>	<i>Finance</i>	<i>Christenson</i>
2	Rick Lazio (R/NY-2)	Mod Rep/Bdgt	Christenson
2	Dan Frisa (R/NY-4)	Com	Christenson
2	Susan Molinari (R/NY-13)	GOP Ldr/Bdgt	Christenson
2	Sue Kelly (R/NY-19)	Mod Rep	Christenson
2	Ben Gilman (R/NY-20)	Mod Rep	Christenson
2	Sherwood Boehlert (R/NY-23)	Mod Rep	Christenson
2	Bill Paxon (R/NY-27)	GOP Ldr./Com	Christenson
2	Jack Quinn (R/NY-30)	Mod Rep	Christenson
2	Amo Houghton (R/NY-31)	Mod Rep/W+M	Christenson
2	Bill Clinger (R/PA-5)	Mod Rep/Com	Christenson
2	Jim Greenwood (R/PA-8)	Mod Rep	Christenson
2	Joe McDade (R/PA-10)	Mod Rep	Christenson
2	John Fox (R/PA-13)	Mod Rep	Christenson
2	Bob Walker (R/PA-16)	F.O.N./Bdgt	Christenson
2	Phil English (R/PA-21)	Mod Rep/W+M	Christenson

KEY:

Bdgt	Senate or House Budget Committee
Com	House Commerce Committee
<i>Finance</i>	Senate Finance Committee
F.O.N.	Friend of Newt
GOP Ldr	Senate or House Republican Leader
Mod Rep	Moderate House Republican
W+M	House Ways and Means Committee

REGION	MEMBER	TYPE	DIRECTOR
3	<i>William Roth (R/DE-SEN)</i>	<i>Finance</i>	<i>Simpson</i>
3	Mike Castle (R-DE-AL)	Mod Rep	Simpson
3	Ed Whitfield (R/KY-1)	Com	Simpson
3	Jim Bunning (R/KY-4)	W+M/Bdgt	Simpson
3	Wayne Gilchrist (R/MD-1)	Mod Rep	Simpson
3	Connie Morella (R/MD-8)	Mod Rep	Simpson
3	Richard Burr (R/NC-5)	Com	Simpson
3	Sue Myrick (R/NC-9)	Bdgt	Simpson
3	Tom Bliley (R/VA-7)	GOP Ldr/Com	Simpson
3	Tom Davis (R/VA-11)	Mod Rep	Simpson

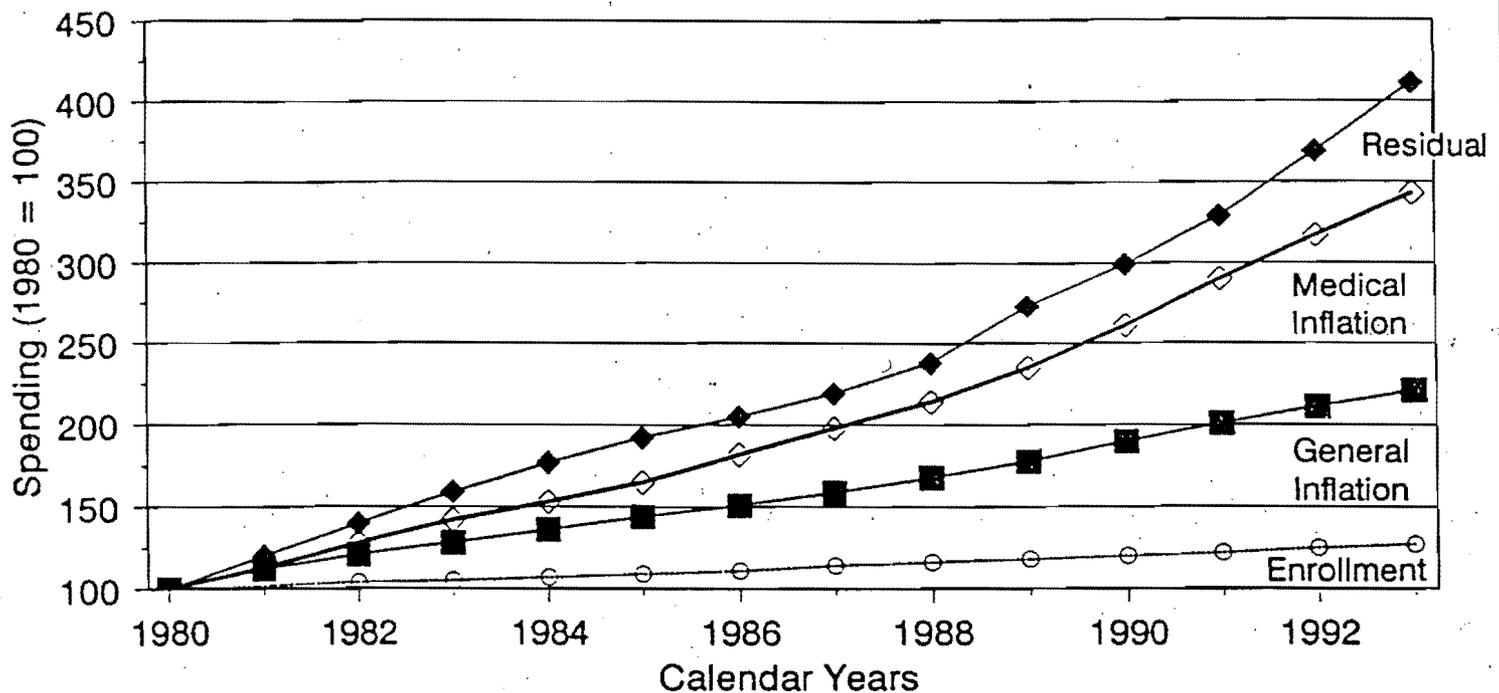
4	Cliff Stearns (R/FL-6)	Com	Bolster
4	Mike Bilirakis (R/FL-9)	GOP Ldr/Com	Bolster
4	Dan Miller (R/FL-13)	Bdgt	Bolster
4	Clay Shaw (FL-22)	W+M	Bolster
4	Mac Collins (GA-3)	W+M	Bolster
4	John Linder (R/GA-4)	F.O.N.	Bolster
4	Newt Gingrich (R/GA-6)	GOP Ldr	Bolster
4	Charlie Norwood (R/GA-10)	Com	Bolster
4	<i>Trent Lott (R/MS-SEN)</i>	<i>GOP Ldr/Bdgt</i>	<i>Bolster</i>
4	Bob Inglis (R/SC-4)	Bdgt	Bolster
4	<i>Bill Frist (R/TN-SEN)</i>	<i>Bdgt</i>	<i>Bolster</i>

Bdgt	Senate or House Budget Committee
Com	House Commerce Committee
<i>Finance</i>	Senate Finance Committee
F.O.N.	Friend of Newt
GOP Ldr	Senate or House Republican Leader
Mod Rep	Moderate House Republican
W+M	House Ways and Means Committee

REGION	MEMBER	TYPE	DIRECTOR
5	Phil Crane (R/IL-8)	W+M	Shlaes
5	John Porter (R/IL-10)	Mod Rep	Shlaes
5	Dennis Hastert (R/IL-14)	GOP Ldr./Com	Shlaes
5	Ray LaHood (R/IL-18)	Mod Rep	Shlaes
5	<i>Spencer Abraham (R/MI-SEN)</i>	<i>Bdgt</i>	<i>Shlaes</i>
5	Peter Hoekstra (R/MI-2)	Bdgt	Shlaes
5	Vern Ehlers (R/MI-3)	F.O.N.	Shlaes
5	Dave Camp (R/MI-4)	W+M	Shlaes
5	Fred Upton (R/MI-6)	Mod Rep/Com	Shlaes
5	Nick Smith (R/MI-7)	Bdgt	Shlaes
5	Rob Portman (R/OH-2)	W+M	Shlaes
5	Michael Oxley (R/OH-4)	Com	Shlaes
5	Paul Gillmor (R/OH-5)	Com	Shlaes
5	David Hobson (R/OH-7)	Mod Rep/Bdgt	Shlaes
5	John Boehner (R/OH-8)	GOP Leader	Shlaes
5	Martin Hoke (R/OH-10)	Mod Rep/Bdgt	Shlaes
5	John Kasich (R/OH-12)	GOP Ldr/Bdgt	Shlaes
5	Deborah Pryce (R/OH-15)	Friend of Newt	Shlaes
5	Ralph Regula (R/OH-16)	Mod Rep	Shlaes
5	Bob Ney (R/OH-18)	Mod Rep	Shlaes
5	Scott Klug (R/WI-2)	Com	Shlaes
5	Steve Gunderson (R/WI-3)	Mod Rep	Shlaes
6	<i>Charles Grassley (R/IA-SEN)</i>	<i>Bdgt/Finance</i>	<i>Shickich</i>
6	Jim Leach (R/IA-1)	Mod Rep	Shickich
6	Jim Nussle (R-IA-2)	FON/W+M/Bdgt	Shickich
6	Greg Ganske (R/IA-4)	Com	Shickich
6	<i>Bob Dole (R/KS-SEN)</i>	<i>GOP Ldr/Financ</i>	<i>Shickich</i>
6	<i>Nancy Kassebaum (R/KS-SEN)</i>	<i>Mod Rep</i>	<i>Shickich</i>
6	Pat Roberts (R/KS-1)	Mod Rep	Shickich
6	Sam Brownback (R/KS-2)	Bdgt	Shickich
6	Jan Meyers (R/KS-3)	Mod Rep	Shickich
6	Jim Ramstad (R/MN-3)	Mod Rep/W+M	Shickich
6	<i>Kit Bond (R/MO-SEN)</i>	<i>Bdgt</i>	<i>Shickich</i>
6	Mel Hancock (R/MO-7)	W+M	Shickich
6	Doug Bereuter (R/NE-1)	Mod Rep	Shickich
6	Jon Christensen (R/NE-2)	W+M	Shickich
6	<i>Larry Pressler (R/SD-SEN)</i>	<i>Finance</i>	<i>Shickich</i>

REGION	MEMBER	TYPE	DIRECTOR
7	Bob Livingston (R/LA-1)	F.O. N.	Becker
7	Jim McCreary (R/LA-5)	W+M	Becker
7	<i>Don Nickles (R/OK-SEN)</i>	<i>Bdgt/Finance</i>	<i>Becker</i>
7	Steve Largent (R/OK-1)	Bdgt	Becker
7	Tom Coburn (R/OK-2)	Com	Becker
7	<i>Phil Gramm (R/TX-SEN)</i>	<i>Bdgt</i>	<i>Becker</i>
7	Sam Johnson (R/TX-3)	W+M	Becker
7	Joe Barton (R/TX-6)	Com	Becker
7	Bill Archer (R/TX-7)	GOP Ldr	Becker
7	Jack Fields (R/TX-8)	Com	Becker
7	Lamar Smith (R/TX-21)	F.O.N./Bdgt	Becker
7	Tom DeLay (R/TX-22)	GOP Ldr	Becker
7	Dick Arney (R/TX-26)	GOP Ldr	Becker
8	John Shadegg (R/AZ-4)	Bdgt	Desmond
8	Jim Kolbe (R/AZ-5)	Mod Rep/Bdgt	Desmond
8	<i>Hank Brown (R/CO-SEN)</i>	<i>Bdgt</i>	<i>Desmond</i>
8	Wayne Allard (R/CO-4)	Bdgt	Desmond
8	Dan Shaefer (R/CO-6)	Com	Desmond
8	Michael Crapo (R/ID-2)	Com	Desmond
8	<i>Pete Domenici (R/NM-SEN)</i>	<i>GOP Ldr</i>	<i>Desmond</i>
8	<i>Orrin Hatch (R/UT-SEN)</i>	<i>Finance</i>	<i>Desmond</i>
8	<i>Alan Simpson (R/WY-SEN)</i>	<i>Finance</i>	<i>Desmond</i>
9	<i>Frank Murkowski (R/AK-SEN)</i>	<i>Finance</i>	<i>Giardina</i>
9	Wally Herger (R/CA-2)	W+M/Bdgt	Giardina
9	George Radanovich (R/CA-19)	Bdgt	Giardina
9	Bill Thomas (R/CA-21)	GOP Ldr/W+M	Giardina
9	Carolos Moorhead (R/CA-27)	Com	Giardina
9	David Dreier (R/CA-28)	F.O.N.	Giardina
9	Steve Horn (R/CA-38)	Mod Rep	Giardina
9	Christopher Cox (R/CA-47)	Com	Giardina
9	Brian Bilbray (R/CA-49)	Com	Giardina
9	John Ensign (R/NV-1)	W+M	Giardina
9	<i>Bob Packwood (R/OR-SEN)</i>	<i>GOP Ldr/Financ</i>	<i>Giardina</i>
9	<i>Slade Gorton (R/WA-SEN)</i>	<i>Bdgt</i>	<i>Giardina</i>
9	Rick White (R/WA-1)	Com	Giardina
9	Jennifer Dunn (R/WA-8)	F.O.N./W+M	Giardina

Increase in Inflation and Enrollment Account for Most of Medicare's Growth



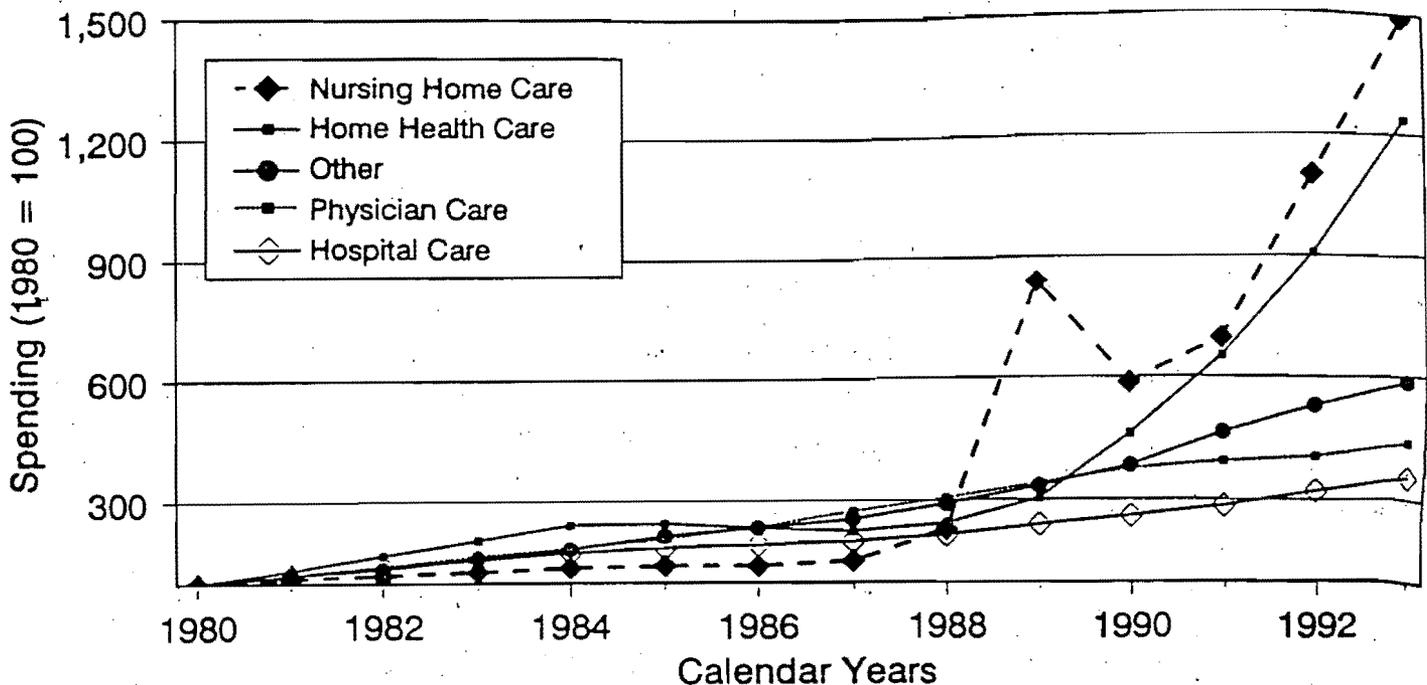
Source: Calculations by Price Waterhouse LLP, Health Policy Economics Group, based on Health Care Financing Administration, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-1993*, and *Projections of National Health Expenditures: Factors Accounting for Growth and Unpublished Data and Economic Report of the President*, February 1994, Table B-3.

Inflation and greater numbers of Medicare enrollees account for nearly 89% of growth in Medicare spending since 1980.

- ◆ Enrollment, general inflation and medical inflation accounted for 15.6 percent, 41.6 percent and 31.5 percent of the growth in Medicare respectively between 1980 and 1993.
- ◆ The "residual" growth of 11.2 percent includes increased use of services by enrollees, new technology, aging of the Medicare population and any errors in measuring the other three components.

Note: The GDP deflator was used to calculate general inflation.

Medicare Hospital Spending Growth is Lowest Compared to Spending for Other Services



Source: Calculations by Price Waterhouse LLP, Health Policy Economics Group, based on Health Care Financing Administration, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-1993*, and *Projections of National Health Expenditures: Factors Accounting for Growth and Economic Report of the President*, February 1994, Table B-3.

- ◆ Medicare hospital spending increased 10.2 percent annually from 1980 to 1993 compared with 12.0 percent annually for physician care, 21.3 percent annually for home health care and 23.1 percent annually for nursing home care.
- ◆ Medicare hospital spending has already been contained to a great extent by Medicare's Prospective Payment System (PPS) which no longer pays most hospitals on the basis of their costs.
- ◆ Growth in Medicare hospital spending has also been slowed by hospitals' efforts to provide care more efficiently. Hospitals are working in communities with physicians, other providers, senior centers and churches to coordinate care for seniors and provide care in the most appropriate and cost effective way possible.

DEAR VOTER

WHAT WILL YOU TELL YOUR MEMBER OF CONGRESS IF HE TAKES \$250 BILLION OUT OF YOUR MEDICARE?

Congress has been busy lately—so maybe your Member of Congress, Congressman Graham, hasn't focused attention on a particularly painful Congressional proposal that would devastate Medicare. Maybe *he* hasn't—but *you* should.

This proposal would squeeze hundreds of billions of dollars from Medicare at a time

when more and more Americans are relying on it for their health care.

Medicare is a Contract with America. Senior citizens have kept their part of that contract and working Americans honor that contract with every paycheck deduction for Medicare. Now it's time for Congress to keep their part of the deal.

✂
Dear Congressman Graham,

Drastic Medicare reductions will hurt senior citizens who have paid all their working lives and need to know the program will be there to provide health care when they need it most. Don't break the Medicare promise. Vote against irresponsible Medicare reductions. Please help to preserve affordable care for seniors and access for all Americans to essential, but costly, hospital services such as burn units, trauma care and intensive care units.

Medicare matters to me. Medicare matters to every American.

Mail to: Congressman Lindsey Graham, Washington, DC 20051

Or call Congressman Graham at (202) 225-5301 and let him know you expect him to honor the Medicare contract by voting against Medicare reductions.

The South Carolina Hospital Association

The American Hospital Association

SOME IN CONGRESS WANT TO REDUCE MEDICARE BY MORE THAN \$250 BILLION

This is more than 3 times the largest Medicare reduction in history.

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

A new study by Lewin-VHI, one of the nation's top research firms, finds that with reductions of \$250 billion, *every hospital* will lose money treating Medicare patients.

WHAT WILL HAPPEN TO HEALTH CARE?

These reductions will mean:

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

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

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

Hospitals and Congress should work together to reform, restructure and save money in Medicare—but let's not gut it.





[79 STAT.]

PUBLIC LAW 89-97—JULY 30, 1965

TITLE I—HEALTH INSURANCE FOR THE AGED AND
MEDICAL ASSISTANCE

SHORT TITLE

SEC. 100. This title may be cited as the "Health Insurance for
the Aged Act".

PART I—HEALTH INSURANCE BENEFITS FOR THE AGED

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 101. Title II of the Social Security Act is amended by adding
at the end thereof the following new section:

MEDICARE: THE REAL CONTRACT WITH AMERICA

*30 years ago, Congress entered into a Contract with America
that still stands: Medicare*

Medicare is one of Congress's most important promises. Americans have paid into this program throughout their lives in the belief that Medicare would be there for them in their later years. Over the decades, the names and faces on Capitol Hill have changed, but the promise to older Americans hasn't: when you need health care, you will have it.

Now this long-honored contract is in danger. Some in Congress want to slash Medicare and break their promise to 32 million Americans—to all those who depend on Medicare now and to the tens of millions nearing retirement age.

Call your members of Congress at (202) 224-3121, and let them know you expect them to honor the Medicare contract by voting against Medicare reductions.

Washington State Hospital Association

American Hospital Association



PUBLIC LAW 89-97—JULY 30, 1965

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TITLE I—HEALTH INSURANCE FOR THE AGED AND
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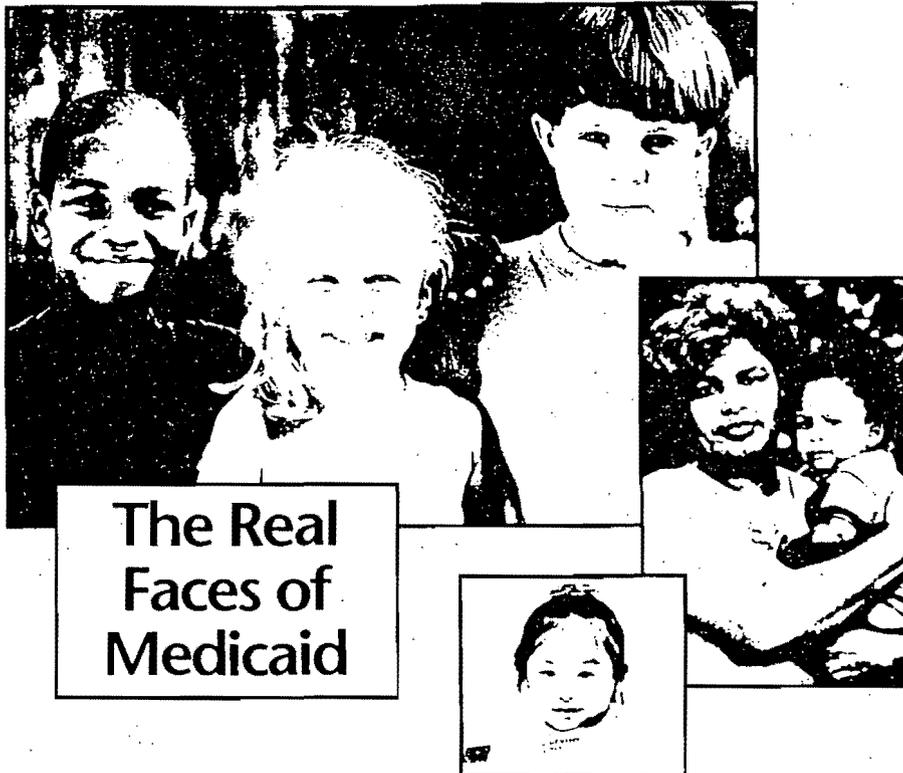
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Illinois Hospital & HealthSystems Association

American Hospital Association



Dear United States Senator:

Your smallest constituents are our biggest responsibility

Close to 17 million children — almost 1 in 4 — rely on Medicaid.

They're America's most vulnerable citizens, and when they become ill many of these children must turn to hospitals and health systems and the professionals who staff them.

Day in and day out, for everything from routine problems to emergency care, children on Medicaid and their families come to us for the full range of services we provide.

Taking care of these children and *all* of the people we serve is a serious responsibility. That's why we know the importance of keeping a guaranteed benefits package as part of Medicaid reform. While we understand the need for states to have

some flexibility in managing Medicaid, we believe that all children should be guaranteed a basic level of health care.

Children covered by Medicaid are your smallest constituents. They can't vote. But we care for them, and we hope you will too.

Dick Davidson

Dick Davidson, President, American Hospital Association

Virginia Trotter Betts

Virginia Trotter Betts, President, American Nurses Association

Call your Senators today at (202) 224-3121, and tell them to guarantee that Medicaid covers our most vulnerable citizens.

ANA

ANA



The Real Faces of Medicaid

The vast majority of Medicaid dollars—two-thirds—goes to providing care for blind, disabled and older Americans

Before Congress reduces Medicaid, we should take a closer look at the program, face-to-face. Who really depends on Medicaid?

The truth is, two-thirds of Medicaid's budget is devoted to caring for America's blind, disabled and elderly. These are Americans who deserve to live

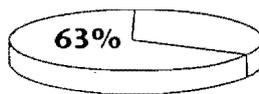
out their lives with dignity. With the help of Medicaid and the quality care it pays for, they will.

Sadly, Medicaid is a mystery to many Americans. Maybe that's why some

mistakenly believe that we can squeeze Medicaid without any cost to our communi-

ties. America's care-givers know better. Hammering down on Medicaid will hurt—not just the millions of elderly who rely on it, but also anyone who may need a hospital or health care system.

WHAT MEDICAID PAYS FOR

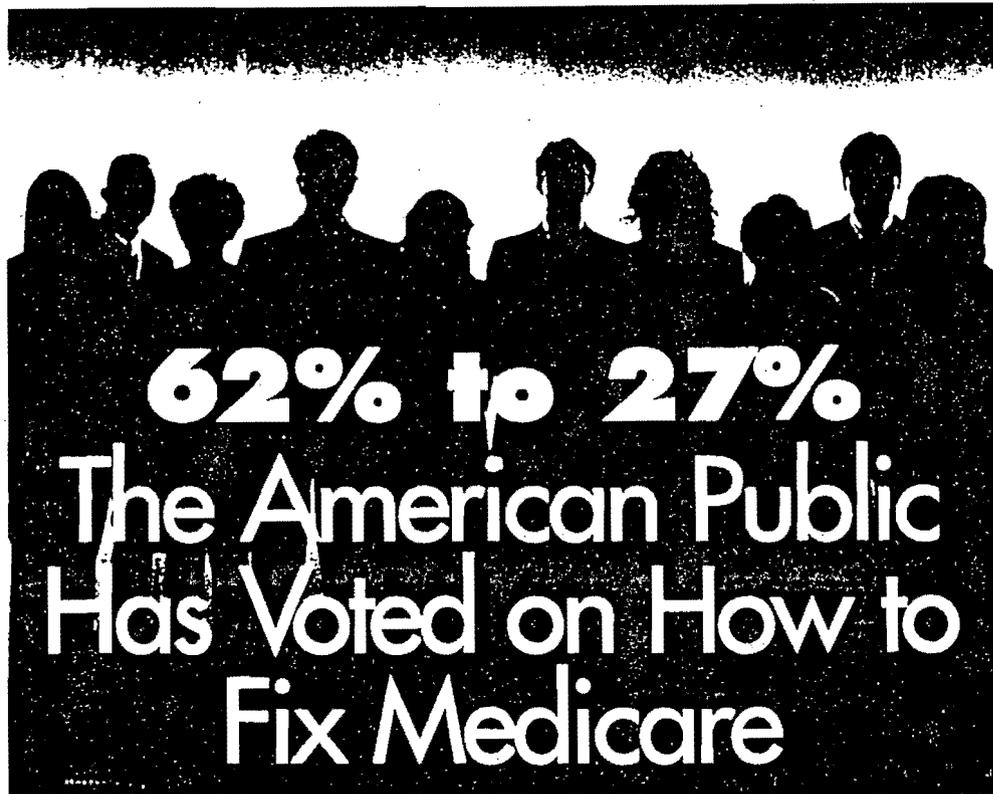


Percentage of Medicaid budget that goes to pay for care for the elderly, blind and disabled

Who benefits from Medicaid? Four million blind, disabled and older Americans do.

Dick Davidson

Dick Davidson, *President*



62% to 27%

The American Public Has Voted on How to Fix Medicare

An Independent Commission for Medicare Has Built-in Support

Sometimes the most difficult political problems have simple solutions. That's the case as Congress and the President wrestle with ways to balance the cost of Medicare against the vital coverage Medicare provides to the American people.

A recent public opinion survey of American voters shows overwhelming support for a blue ribbon Independent Citizens Commission on Medicare.* The survey, conducted by leading Republican and Democratic polling firms, found that two out of three American voters prefer a blue ribbon Independent Commission to decide how to fix the Medicare program.

Now, Rep. Phil English has offered H.R. 2152 which will create such an Independent Commission. This Independent Commission would be able to help

Congress make the tough choices needed to balance the health care needs of American seniors against the resources available to meet them.

THE QUESTION

Assuming there will be Medicare cuts, who would you prefer to make the decision about how Medicare is changed to keep the system from going bankrupt while providing quality care:

An independent blue ribbon commission	62%
Congress	27%
Don't know	10%

The result will be a fair and thoughtful assessment of Medicare's needs and not just another quick fix. Such an on-going process will insulate long-term concerns from short-term political calculations.

The nation's hospitals strongly support H.R. 2152. We believe an Independent Commission for Medicare is a courageous first step by the Congress toward lasting reform of Medicare and the health delivery system.

Dick Davidson
Dick Davidson, President

*Poll of 800 registered voters conducted June 23-27, 1995 by the Mellman Group and the Warshaw Group.

FINALLY, A WAY TO TAKE THE POLITICS OUT OF MEDICARE

Representative English has a way to save Medicare and keep the promise to senior citizens.

The Medicare crisis needs a long-term solution, not just political slogans. That's why Congressman Phil English's proposal for an Independent Citizens Commission on Medicare makes so much sense. It takes the politics out of Medicare.

If we want Medicare to be there when our children and grandchildren need it, we must make tough decisions now. Thinking long-term is hard enough in the superheated atmosphere of Washington politics. It's next to impossible with an election year coming.

Congressman English believes an independent blue-ribbon group of citizens would do the best job of ensuring that the health services older Americans rely on don't take a back seat to back room federal budget politics. He's right.

We congratulate Congressman English for taking a courageous first step toward lasting reform of Medicare and you should too. Call him at (814) 456-2038. Tell him you support his plan for an Independent Citizens Commission on Medicare.

 American Hospital Association

 Hospital Association of Pennsylvania



American Hospital Association

To the U.S. House of Representatives:

The Medicare reforms you enacted on Oct. 26 set the stage for the most sweeping changes in that program since its inception 30 years ago. By any measure, you acted boldly. Now, in the conference phase of reconciliation, one of your most important achievements may be at risk.

While the nation's hospitals remain deeply concerned about the size of the Medicare spending reductions, we strongly support one action in particular you took which holds enormous potential to bring better health and health care to millions of Americans:

In the language of legislation, they're called "provider-sponsored organizations." In fact, they are people in your community — hospitals, physicians, nurses, and others — who will come together and work with Medicare to take care of the people in your community. By making these networks a major part of Medicare reform, you're ensuring that senior citizens and others served by Medicare — in communities large and small — will be able to choose the caregivers they already know and trust as their neighbors. And they are absolutely essential to Medicare cost containment in the future.

Powerful forces in the insurance industry are worried about what Americans would do if the choice was between hometown, community-based care and something else.

Speaker Gingrich and your House leaders have been valiant supporters of provider-sponsored organizations. This good work must be preserved in the conference committee deliberations. Stand with them and with the communities you and we serve together as we support these House-passed provisions.

Sincerely,

Dick Davidson, *President*
American Hospital Association