

HOUSE

Items Contrary to the Bipartisan Budget Agreement

- **Immigrants** -- Ways and Means bill fails to cover legal immigrants who were in the U.S. when the welfare law was signed but who become disabled after that date and falls \$.7 billion short of the amount agreed to in the Budget Agreement.
- **Medicaid Investments** -- Commerce bill fails to include the Medicaid investments in the agreement (a higher Federal match for the D.C. Medicaid program and inflation adjustments for the Medicaid programs in Puerto Rico and the territories).
- **Assistance for Low-Income Medicare Beneficiaries** -- Commerce proposal for the Federal government to pay 100 percent of the "extra" amount of premium due to the home health reallocation is too administratively complex for the value of the benefit provided and spends only one-third of the \$1.5 billion investment included in the Agreement.
- **Medicaid benefits for disabled children** -- Commerce fails to include the proposal in the Budget Agreement to restore Medicaid for approximately 30,000 disabled children who will lose SSI benefits under the new definition of childhood disability.
- **Home Health Reallocation** -- Ways and Means bill phases in the home health transfer from Part A to Part B, which takes two years away from the additional years of Part A Trust Fund solvency that would result from policies in the Agreement. (The Commerce Committee provision is consistent with the Agreement.)
- **Food Stamps** -- Agriculture Committee creates approximately 190,000 work slots, significantly less than the 350,000 in additional work slots for individuals facing the time limit in the Administration's proposal because it does not include any performance standards, as are included in the Administration and Senate proposals, and does not satisfactorily target the money to work slots for the targeted individuals.
- **Spectrum** -- The Commerce Committee-reported bill would save \$9.7 billion, or \$16.6 billion short of the level in the agreement. Major objectionable provisions include lack of reimbursement authority for Federal users forced to relocate and lack of hard cut-off date for analog broadcasting. In addition, the bill does not include two proposals agreed to in the agreement: (1) auction of vanity toll free telephone numbers; and (2) spectrum penalty fee. (Since the agreement, CBO has changed its scoring methodology to require specificity in the directed reallocation, which is causing reductions of several billion dollars in scoring.)
- **Welfare to work** -- Ways and Means proposal fulfills the terms of the Budget Agreement by targeting funds to urban areas through its split between formula (50 percent) and competitive (50 percent) grants; its formula grant sub-State allocation factors and method of administration; and its reservation of 65 percent of competitive grants for cities.

Education and Workforce proposal does not adequately fulfill the agreement because it reduces the competitive funding share from 50 percent to 5 percent. The Administration strongly prefers the Ways and Means proposal.

- **051/053** -- The House National Security Committee moves \$2.6 billion in 1998 budget authority intended to fund environmental privatization projects and to forward fund specific Department of Energy programs (subfunction 053) to Department of Defense military programs (subfunction 051) in HR 1119, the National Defense Authorization Act. The House Appropriations Committee shifts \$1.8 billion in BA to the Defense Subcommittee and \$.8 billion to the Military Construction Subcommittee. The Budget Agreement assumed that subfunction 053 would be funded at the President's request level, and that the additional spending in the agreement would go to Defense military activities.
- **Land Acquisition** -- The House Appropriations Interior Subcommittee has approved their FY 1998 bill without any of the \$700 million for priority land acquisition.
- **International Affairs funding** -- The House 602 (b) allocation appears to reduce international affairs funding by \$.5 billion below the FY 1998 level for function 150.

HOUSE

Other Major Objectionable Items

- **Minimum Wage and Workfare** -- Ways and Means and Education and the Workforce proposals deny the minimum wage to workfare participants by allowing States to either reduce hours of work requirements or count Medicaid/child care/housing/ etc. as income for calculating the minimum wage.
- **MEWAs** -- Education and the Workforce has adopted a proposal that would allow business members of multiple employer welfare associations (MEWAs) to form "association health plans," as provided for in H.R. 1515, the Expansion of Portability and Health Insurance Coverage Act of 1997. The Administration opposed a version of these provisions last year. The bill as drafted has inadequate consumer protections and has the potential to result in premium increases for small businesses and employees who may bear the burden of adverse selection.
- **Privatization** -- The Commerce bill allows all States to privatize Medicaid eligibility and enrollment determination functions. The Agriculture bill allows privatization of parallel Food Stamp functions. The Administration strongly opposes privatization of welfare eligibility determination and related functions.
- **Children's Health (direct services)** -- The Commerce bill spends a portion of the children's health investment funds on direct services. The Administration is concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and children would not necessarily get meaningful coverage. The Administration is also concerned that direct services may not be the most cost-effective way to expand coverage to children, as stated in the Budget Agreement.
- **Children's Health (abortion)** -- Commerce bill extends the Hyde amendment to the \$16 billion children's health investment. The Administration opposes the Hyde Amendment.
- **Medicare Medical Savings Accounts** -- Commerce and Ways and Means Committee bills include an MSA demonstration that is too large, too expensive, and exposes beneficiaries to any additional charges providers choose to levy without limitation. The Administration strongly believes that the current law limits on balance billing should be applied to this demonstration and that it should be limited geographically for a trial period.
- **Medical Malpractice** -- Commerce and Ways and Means Committees have adopted the same medical malpractice provisions that the Administration opposed in the vetoed Balanced Budget bill and the House version of the Health Insurance Portability and Accountability Act (HIPAA).

- **Student Loans** -- Education and the Workforce has adopted an objectionable provision regarding administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan Program (FFELP). The provision would mandate ACAs to be paid at a rate of 0.85% of new loan volume from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA), up to a cap of \$170 million in FY 1998 and 1999 and \$150 million in FY 2000-2002. This provision represents a new entitlement to these agencies not included in the Budget Agreement.
- **Welfare-to-Work Performance Fund** -- Ways and Means and Education and the Workforce proposals do not include a performance fund, which the Administration supports so that welfare to work funds generate greater levels of placement in unsubsidized jobs than States will achieve with TANF and other funds.
- **Repeal of Maintenance of Effort Requirement on State Supplementation of SSI Benefits** -- The Ways and Means Committee repeals the MOE which would let States significantly cut, or even eliminate, benefits to nearly 2.8 million poor elderly, disabled, and blind persons. The proposal also could put at risk low-income elderly and disabled individuals who could lose SSI entirely and thereby lose Medicaid coverage as well. The Administration opposed this proposal during last year's welfare reform debate.
- **Welfare to Work Worker Displacement** -- Ways and Means and Senate Finance adopt worker displacement language that is taken from HR 1385, the House-passed bill on job training reform. These committees apply worker protection/anti-displacement provisions only to the \$3 billion welfare to work program. The Education and the Workforce committee adopts virtually the same language, but applies it to all of TANF. The Education and the Workforce provisions are preferable.
- **Debt Limit extension should be included in the spending bill.** Currently it is only in the revenue bill reported by Ways and Means.
- **Expect consideration of two bills in the House.**

SENATE

Items Contrary to the Bipartisan Budget Agreement

- **Immigrant Benefit Restorations** -- The Finance bill fails to fully restore coverage for legal immigrants who were in the United States when the welfare law was signed but who become severely disabled after that date as called for in the Budget Agreement. The Committee adds SSI disability benefits for immigrants who were in the country before August 23 1996 who become severely disabled and who apply for benefits before September 30, 1997. This has a total cost of \$10.4 billion. It still falls short of the coverage under the Budget Agreement.
- **Medicaid Investments** -- The Finance bill includes the Medicaid investments (a higher Federal matching payment for the Medicaid program in the District of Columbia and inflation adjustments for the Medicaid programs in Puerto Rico and the territories), but at spending levels below those in the Budget Agreement. In the case of the District of Columbia the investment is for only three years.
- **Assistance for Low-Income Medicare Beneficiaries** -- The Finance Committee bill fails to include the proposal in the agreement to spend \$1.5 billion over five years to ease the impact of increasing Medicare premiums on low-income Medicare beneficiaries.
- **Medicaid Benefits for Disabled Children** -- The Finance bill fails to include the proposal in the Budget Agreement to restore Medicaid for approximately 30,000 disabled children who will lose SSI benefits under the new definition of childhood disability.
- **Home Health Reallocation** -- The Finance bill phases in the home health transfer from Part A to Part B, which takes two years away from the additional years of Part A Trust Fund solvency that would result from policies in the Agreement. (The Commerce Committee provision is consistent with the agreement.)
- **Spectrum** -- The Commerce Committee bill is estimated to save approximately \$16.8 billion, or \$9.5 billion short of the level in the agreement. While Senate bill is much improved over the House bill, the Senate bill does not include a hard date for analog termination. In addition, the bill does not include two proposals agreed to in the agreement: (1) auction of vanity toll free telephone numbers; and (2) spectrum penalty fee. (Since the agreement, CBO has changed its scoring methodology to require specificity in the directed reallocation which is causing reductions of several billion dollars in scoring.)
- **Welfare to Work Grants to Cities** -- House Ways and Means fulfills the terms of the Budget Agreement by targeting funds to urban areas through its split between formula (50 percent) and competitive (50 percent) grants; its formula grant sub-State allocation factors and method of administration; and its reservation of 65 percent of competitive grants for cities. The Finance bill reduces the competitive funding share from 50 percent to 25

percent. The Finance Committee bill would provide for local administration of funds only through the TANF agency, rather than mayors and other chief local elected officials working with private industry councils (PICs) and in the bill, HHS rather than DOL acts as the federal Administrating agency. The Administration strongly prefers the Ways and Means proposal.

- **Unemployment Insurance Integrity** -- Senate Finance does not include the provision of the budget agreement that achieves \$763 M in mandatory savings over 5 years through an increase in discretionary spending for unemployment insurance "program integrity" activities of \$89 M in 1998 and \$467 M over five years. The House Ways and Means proposal includes this language.
- **State SSI Administrative Fees** -- Finance Committee bill does not include a provision in the Budget Agreement to increase the administrative fees that the Federal Government charges States for administering their State supplemental SSI payments and to make the increase available, subject to appropriations, for SSA administrative expenses. This proposal saves approximately \$375 million over 5 years.

SENATE

Other Major Objectionable Items

- **Privatization** -- The Finance Committee bill allows the State of Texas to privatize functions for all federal and state health and human services benefit programs -- including Medicaid, Food Stamps, and WIC. The Administration opposes privatization of the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors).
- **Medicare Medical Savings Accounts** -- Although an improvement over the House version, the Finance Committee bill includes an MSA demonstration that exposes beneficiaries to any additional charges providers choose to levy. The Administration strongly believes that the current law limits on balance billing should be applied to this demonstration and that it should be limited geographically for a trial period.
- **Balance Billing Protections** -- Finance includes an objectionable provision that would allow private fee-for-service plans to participate in Medicare Choice without any balance billing protections. The Administration opposed this provision in the vetoed Balanced Budget bill.
- **Student Loans** -- Labor and Human Resources includes an objectionable provision regarding administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan Program (FFELP). The provision would mandate ACAs to be paid at a rate of 0.85% of new loan volume from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA), up to a cap of \$170 million in FY 1998 and 1999 and \$150 million in FY 2000-2002. This provision represents a new entitlement to these agencies not included in the Budget Agreement.
- **Children's Health** -- The provisions in the Finance bill are a starting point for expanding health insurance coverage for low-income children. The Administration would like to work with the Congress to improve the Finance proposal to better reflect the bipartisan Chafee/Rockefeller/Jeffords/Hatch proposal.
- **Children's Health (abortion)** -- The Finance bill extends the Hyde amendment to the \$16 billion children's health investment. The Administration opposes the Hyde Amendment.
- **Medicaid Cost Sharing** -- The Finance bill allows States to require limited cost sharing for certain Medicaid beneficiaries. The Administration is concerned that this proposal may compromise beneficiary access to quality care. The Administration believes that the President' Budget language to allow States to charge nominal copayments for HMO enrollees is much preferable.

- **Welfare to Work Worker Displacement** -- Ways and Means and Senate Finance adopt worker displacement language that is taken from HR 1385, the House-passed bill on job training reform. These committees apply worker protection/anti-displacement provisions only to the \$3 billion welfare to work program. The Education and the Workforce committee adopts virtually the same language, but applies it to all of TANF. The Education and the Workforce provisions are preferable.

The following provisions should be considered in the context of long-term reforms to Medicare:

- **Home Health Copayments** -- Finance imposes a Part B home health copayment of \$5 per visit, capped at an amount equal to the annual hospital deductible. These savings are not necessary to balance the budget.
- **Medicare Eligibility Age** -- Finance raises the eligibility age for Medicare from 65 to 67. These savings are not necessary to balance the budget.
- **Means Testing the Medicare deductible** -- Finance includes a new income-related deductible provision for Part B services. These savings are not necessary to balance the budget and introduce significant administrative complexities.

June 19, 1997

CBO VS. OMB

Q. THE CONGRESSIONAL BUDGET OFFICE SAYS THAT THE ADMINISTRATION'S NUMBERS ARE WAY OFF WHEN THEY USE THE CBO BASELINE. ISN'T THIS JUST ANOTHER ROSY SCENARIO?

A. Absolutely not. We have a solid balanced budget plan based on numbers that are consistent, conservative and professional. Indeed, using the assumptions of the top private sector forecasters, our plan would get to balance.

There are some small differences between CBO and OMB in growth estimates and the health care baseline that get magnified over a 10 year period. We believe that our baseline is superior. Even CBO admits that our growth estimates are more consistent with the Blue Chip than theirs are. And our health care estimates are done by top, career health professionals at the Health Care Finance Administration, who have the best and most current information.

Indeed, CBO acknowledges that the Administration is closer to the Blue Chip than the CBO on the key economic assumptions that affect the deficit, including growth, interest rates and the GDP deflator.

Yet, while we believe our baseline is the best and they clearly believe that their baseline is the best, the key thing is that neither side should let honest accounting differences be an excuse to not work together to avoid a train wreck and to come up with the type of balanced budget plan that the American people could support.

FOLLOW UP: BUT DIDN'T YOU PROMISE IN 1993 TO USE CBO PROJECTIONS?

In his first budget, the President wanted to take away any disputes over numbers. Remember, Administration projections didn't have the best reputation after 12 years of magic asterisks and smoke and mirrors. Our accurate projections and success on the budget over the past two years have restored faith in an Administration's ability to put forward reasonable, fair budget projections. Indeed, we have been more on target than CBO in projecting the deficit so far. So particularly when the Administration numbers are exactly in line with the top private sector forecasters, it is appropriate and necessary for the President to rely on OMB for his budget projections.

BACKGROUND INFORMATION ON THE OMB/CBO BASELINE DIFFERENCES

- By our best estimates, using the economic assumptions of the Blue Chip forecasts and the career professionals at HCFA (Health Care Finance Administration), the President's economic plan gets to a small surplus in the year 2005.
- *Indeed, CBO acknowledges that the Administration is closer to the Blue Chip than the CBO on three key economic assumptions that affect the deficit, including growth, interest rates and the GDP deflator.*
- A Federal Reserve Board of Philadelphia study of 59 top economists projected average real GDP growth of 2.6% over ten years. The Administration has projected average growth of slightly under 2.5%. Therefore, the Administration's numbers are somewhat conservative compared to many top private sector economists.
- There are differences between the OMB and CBO baselines, but they are based on very small differences in two areas that appear more significant when they are extended over a 10 year period.
- Indeed, after the House takes into account its economic assumptions based on the CPI, growth and interest rates, 60% of the baseline differential is already evaporated. So the baseline difference between the Administration and the House is actually not so significant.
- The record has proved that OMB was more accurate in its deficit forecast than CBO when it presented the Administration's 1993 economic plan.

GROWTH RATES:

- **Very Small Differences:** We assume growth at slightly under 2.5% over the next several years. CBO is a little lower, around 2.3%. Yet, with the growth dividend that the House Budget Committee is taking with its plan -- and we are not -- the difference is virtually non-existent. CBO stated that "the economic assumptions of the Clinton Administration and the Congressional Budget Office are similar," and that our assumptions actually lead to more conservative deficit estimates in the first two years of our forecast.
- **Consistent with Outside Forecasters:** Our proposals are consistent with those of the top outside forecasters. Our growth forecasts are virtually identical to the Blue Chip between 1997-2001, and indeed, in both 1999 and 2000, the Blue Chip forecasts .4 and .3 higher growth than the Administration does. Meyer & Associates calls for higher growth than the Administration in 1999, 2000, 2001 and the same in 2002. DRI is higher than we are for two years, lower than we are for two years and the same two years. Ray Fair has higher growth forecasts every year between 1998 and 2001. So it is clear that we have conservative growth estimates that are consistent with the top private sector forecasters.

Indeed, the April, 1995 CBO document that compares CBO and OMB states that *"the Administration is generally closer than the CBO to the Blue Chip's long-range projections. The Blue Chip indicates the same average growth over the 1997-2000 period as the Administration and has similar projections for interest rates and the GDP deflator."*

- **This is Very Different from the Rosy Scenarios of the Past:** The Administration's growth forecast is only about .1% higher than CBO's. This is very different from the rosy scenarios that characterized Republican Administrations. For example, Stockman's FY1982 budget predicted growth a whopping 1.3% higher than the CBO. The next year, he came back again with a budget that predicted growth an average of 1.0% higher on average each year for his plan. The first two years of the Bush Administration called for budgets with growth rates that were on average .83% higher every year than the CBO projection. So when you see the differences of .1% or .2% in the CBO and OMB growth rates, you can see that most years they are 1/10th to 1/7th the degree of differential that we saw during the Bush/Reagan years.
- **"Wedge Factor" Differences are Narrow:** The CBO indicates the difference between the estimates for the CPI and the GDP deflator has an important effect on the estimates of the deficit. This difference is called a "wedge factor." The Administration's estimate of wedge is similar to the Blue Chip's estimate [assuming that both CBO and the Blue Chip make the adjustment for re-benchmarking the CPI that CBO has already announced it will do in its summer update.]

HEALTH CARE:

- One of the two main reason for the difference in the CBO and OMB baselines is that the Administration assumes slightly less growth in Medicare and Medicaid.
- We should recall that these numbers come from the same HCFA actuaries that the Republicans frequently use as authorities when discussing the need to strengthen the Medicare Trust Fund. Certainly, they could not be questioning their credibility now.
- It is important to understand that the Medicare and Medicaid numbers are prepared by the Office of Actuary in the Health Care Financing Administration. The actuaries are career professionals who have been doing these same numbers through the last two Republican Administrations. Any notion that their estimates were affected by anything other than their professional judgment cannot be justified.
- The whole difference comes from the fact that on Medicaid the Administration projects 9.3% growth and the CBO projects 9.9% and on Medicare the Administration projects 9.1% growth and CBO projects 9.7%
- While we believe these are the differences of honorable career professionals on both sides, we do believe that our numbers are more accurate.

- On Medicaid, the Administration has higher beneficiary growth rates, yet they end up with slightly higher overall growth assumptions because the Administration's estimates of per beneficiary costs are lower than CBO's 5.3% and 7.0%. *Yet, the HCFA estimates are based on more up-to-date Social Security numbers regarding disabled beneficiaries in Medicaid and up-to-date Treasury information on Medicaid outlays -- which catches current changing trends.*

- On Medicare, the Administration and CBO baselines for inpatient hospital services (which represent half of Medicare costs) are virtually identical. The only real difference is that while both believe the high growth rates in home health and skilled nursing facility costs will come down, the Administration projects them coming down somewhat faster.

ADMINISTRATION'S GROWTH NUMBERS VS. BLUE CHIP'S: The chart below shows that the Administration's projection over five years comes to the same average growth as the Blue Chip, while the CBO's is somewhat pessimistic relative to the consensus of private forecasters.

**LONG-RANGE FORECASTS OF GDP GROWTH
1997 THROUGH 2001**

	1997	1998	1999	2000	2001
Blue Chip (March)	2.0	2.3	2.9	2.8	2.4
Administration	2.5	2.5	2.5	2.5	2.4
CBO	2.4	2.3	2.3	2.3	2.3

ATTACHMENT #1

TALKING POINTS FOR CONGRESSIONAL HEALTH BUDGET MEETING

- **HISTORICAL OPPORTUNITY.** This budget offers an unprecedented opportunity to pass the most significant health care reforms since Medicare and Medicaid were enacted over 30 years ago. If we succeed, we will:
 - Modernize and reform Medicare, extending the life of the Medicare Trust Fund for well over a decade, and lay the foundation for addressing the long-term financing challenges facing the program;
 - Offer states unprecedented flexibility to efficiently administer Medicaid; and
 - Extend health care coverage to millions of uninsured American children.
- **BIPARTISAN PROCESS.** We are at this point because of your cooperation and diligence in putting the interests of good policy ahead of partisan politics. This occurred both in the negotiations leading up to the budget agreement, and in the preparation for the upcoming mark-ups.
- In particular, Chairman Archer, Chairman Bliley, Subcommittee Chairman Thomas, and Subcommittee Chairman Bilirakis deserve great praise for how you have integrated our Democratic colleagues in the drafting of the respective mark-ups. I believe the final budget and the country will be all the better for the process you have established.
- **COMMON GROUND.** The result of this bipartisan work is a foundation of policies that we all agree will help reform the entitlement programs. These include:
 - Modernizing the program by offering more plan choices to Medicare beneficiaries. Mr. Thomas, you have been a leader in this area.
 - Reforming the fee-for-service program through prospective payment systems for home health, skilled nursing facilities, outpatient departments, and other fee-for-service providers. Mr. Thomas and Mr. Stark, you have been working on these issues for years.

- Assuring that beneficiaries have adequate consumer and quality protections in both Medicare and Medicaid. Mr. Stark and Mr. Dingell, you have led the way here; and
- Providing new Medicare preventive benefits, such as screening for cancer and diabetes self-management. Mr. Thomas, Mr. Bilirakis and Mr. Stark have worked diligently on these issues.

• **PRIORITIES.** At the beginning of the Congressional mark-up process, I would like to emphasize several of my priorities.

MEDICARE

- **Prudent purchasing reform.** I share your belief that Medicare will survive only if we take from the private sector its best lessons in competition and negotiation. Real reform requires taking steps such as the proposals that give the Secretary the authority to negotiate lower prices through competitive bidding and other similar market oriented mechanisms.
- **Immediate home health reallocation.** The immediate reallocation of long-term home health care to Part B is good policy and is needed to extend the trust fund. There is no reason to phase it in over time. Doing so will reduce how much we extend the life of the Trust Fund by at least two years.
- **Carving out academic health center payments from managed care.** I believe we should make it a priority for medical schools and other teaching facilities to be directly compensated for their unique additional costs -- and not dependent on whether managed care plans pass on the payment we give them for this purpose.
- **Medical Savings Accounts (MSAs).** Everyone in this room knows I have concerns about a new Medicare Medical Savings Account. Such an approach will -- according to CBO -- cost the Trust Fund money and could adversely select healthy populations away from the traditional program. I don't believe we should move in an untested and full-scale way.

MEDICAID

- **Disproportionate Share Hospital (DSH) reductions.** After major objections from Governors, among others, we agreed to drop the per capita cap proposal from our savings package. Now the Governors want to reduce the DSH reductions. Our savings are achievable if DSH funds can be better targeted and are critical if we are to balance the budget.
- **Medicaid investments.** Our investments -- for low income beneficiaries, DC and Puerto Rico -- were explicitly referenced in the budget agreement. If we can maintain our DSH savings -- as I believe we can, we must honor the agreement on the investments.

CHILDREN'S HEALTH INITIATIVE

- **Efficient investment for children's coverage.** One issue that I feel the most strongly about is the opportunity to expand children's coverage. I look forward to working with you on the most efficient way to provide meaningful coverage for up to 5 million children.

However, I have concluded that tax incentive approaches are not the best mechanisms to most efficiently target our limited \$16 billion children's health budget investment. I have become convinced that these approaches are administratively burdensome, costly and would not most efficiently pick up uninsured children. Therefore, I believe that the \$16 billion should be used through Medicaid or a capped mandatory grant option. If, however, you propose tax incentive options in the context of your tax cut proposals, I am open to reviewing them to determine their priority relative to other tax cut proposals.

- **CLOSING.** While we will not agree on everything at the beginning of this process, I am confident that we can build upon the strong bipartisan working relationship that we have developed, and finalize this historic agreement in a way that is acceptable to all.

American Hospital Association

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TO: Chris Jennings
Sara Bianchi

FROM: Lisa Potetz

DATE: 8/14

NUMBER OF PAGES TO FOLLOW: 9

COMMENTS:

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AHA SW

TABLE 2

Highly Vulnerable Group*

	Number	Percent
Total	692	100%
Urban	302	44%
City	141	20%
Rural	390	56%
Sole Community Provider	110	16%
Negative patient margin	487	67%
Negative total margin	224	32%

* Hospitals with more than 2/3 of their net patient revenue came from Medicare/Medicaid

Source: 1993 AHA Annual Survey; Medicare Provider Specific file

This letter was sent to the U.S. House of Representatives and the U.S. Senate.

December 19, 1995

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

Dear Senator Dole:

As hospital trustees from around the nation and as Republicans, we are writing to share our concerns with the budget conference report recently passed by the House and Senate. Further, we want to set forth our priorities for a bipartisan compromise that leads to a balanced budget.

Hospital trustees strongly support the stated goals of the Balanced Budget Act of 1995 -- a balanced budget, a strengthened Medicare trust fund and restructured, more efficient Medicare and Medicaid programs. These goals must be accomplished through shared responsibility among all stakeholders -- providers and beneficiaries alike. Hospitals have offered several concrete and reasonable alternatives to achieve these goals without significantly diminishing the quality or availability of patient care. For the most part, our alternatives have been rejected and the conference report fails to address our concerns.

Hospital trustees have unique responsibilities. We are, of course, responsible as fiduciaries for the financial health of the institutions we serve. But we also have a responsibility to our communities to provide high quality care for all patients and ensure access to this care for our most vulnerable citizens: the elderly, the disabled and millions of children, many of whom lack health insurance of any kind. Regrettably, the magnitude of the reductions in Medicare and Medicaid included in the conference report, combined with the failure to include the broad restructuring of the Medicare program promised, requires that hospitals, health systems and their trustees oppose the plan.

Hospital trustees, chief executive officers and administrators remain committed to working with all parties to achieve the goals we and the congressional leadership share. We believe those goals are both important and achievable. However, we will measure every proposal against the tests of both quality and access; that is, will these proposals in any way diminish the quality of care we provide, and will they reduce the ability of those who need our help most to get the care they need.

We believe the President and the Congress should achieve a balanced budget that includes the following elements:

- A continued federal entitlement to health care for our most vulnerable populations -- the elderly, the poor, the disabled and millions of children.

- Federally licensed, substantially integrated community-based provider sponsored organizations (PSOs) as defined in the original House-passed Medicare Preservation Act.
- Shared responsibility among all stakeholders -- hospitals, physicians and beneficiaries -- for Medicare reductions and the minimum reductions possible for both Medicaid and Medicare, while still achieving a balanced budget.
- An independent citizens commission for Medicare to take the budget politics out of health care that requires congress to act quickly on the commission's recommendations.
- Medical malpractice reform and the elimination of unnecessary barriers to the development of integrated delivery systems.

As hospital trustees and as citizens, we stand ready to work with you to achieve our shared goal of a responsible balanced federal budget.

Sincerely,
(see attached)

M. John Ashton
University of Utah Hospital and Clinics
Salt Lake City, UT

Paul Avery
St. Mary's Medical Center
Saginaw, MI

William Ayers, Jr.
Aspen Valley Hospital
Aspen, CO

Ed Bartlet
Candler Hospital
Savannah, GA

James H. Bates
Sharon Hospital
Sharon, CT

Kay Bennett
Carson-Tahoe Hospital
Carson City, NV

Stan Berry, FACHE
Hanford Community Medical Center
Hanford, CA

Sam Bettis
Bradley Memorial Hospital
Cleveland, TN

Don Bierle
Presentation Health System
Yankton, SD

Richard E. Bird
Bulloch County Hospital Authority
Satesboro, GA

Mardian J. Blair
Florida Hospital
Orlando, FL

William P. Bowersox
Leesburg Regional Medical Center
Leesburg, FL

Willard Bridwell, M.D.
Hanford Community Medical Center
Hanford, CA

Conley Brooks, Sr.
Allina Health System
Minneapolis, MN

Christopher H. Brown
Niagara Falls Memorial Medical Center
Niagara Falls, NY

Eric Brown
Tri County Hospital
Lexington, NE

Colonel Russel L. Bryant
Bon Secours-St. Joseph Hospital
Port Charlotte, FL

Charles Bundy
Springs Memorial Hospital
Lancaster, SC

Lynn Burnsed
Leesburg Regional Medical Center
Leesburg, FL

Vince Caponi
St. Vincent's Hospital
Birmingham, AL

Nicholas Carosi, III
Potomac Hospital
Woodbridge, VA

Phyllis J. Cobb
Sarasota County Public Hospital Board
Sarasota, FL

Arnold Cogswell
Albany Medical Center Hospital
Albany, NY

John Collier
Cross County Hospital
Wynne, AR

Arthur Comstock
Eastern Maine Medical Center
Acadia Hospital
Bangor, ME

Joan S. Conboy
Little Falls Hospital
Little Falls, NY

Ted Couch
Moffitt Cancer Center, Inc.
Tampa, FL

Barry Couch
King's Daughters Hospital
Temple, TX

Michael H. Covert
Sarasota County Public Hospital Board
Sarasota, FL

Bruce Dean
Mercy Medical Center
Mt. Shasta, CA

L. Patrick Deering
Harbor Hospital Center
Baltimore, MD

Gerald W. Dominick
Sun Coast Hospital, Inc.
Largo, FL

T. O'Neil Douglas
Baptist - St Vincent's Health System
Jacksonville Beach, FL

Harry R. Duncanson
Memorial Healthcare System, Inc.
Hollywood, FL

Hogan Dunlevy
Sun Health Corporation
Del E. Webb Memorial Hospital
Sun City West, AZ

Vick Edwards
Rice County District
Hospital Number One
Lyons, KS

Wes Finch
Grinnell Regional Medical Center
Grinnell, IA

Herbert Fitch
Soldiers & Sailors Memorial Hospital of Yates
County
Penn Yan, NY

Robert D. Francisco
Converse County Memorial Hospital
Douglas, WY

James Frank
Delta Memorial Hospital
Antioch, CA

Robert Gabrielson
Holy Infant Hospital
Hoven, SD

James E. Gardner
Memorial Health Systems, Inc.
Ormond Beach, FL

Donna C. Gatch
Healthmark of Quincy, Inc.
Gadsden Memorial Hospital
Quincy, FL

Blake Gerard
Socorro General Hospital
Socorro, NM

Carole A. Green
Lee Memorial Health System, Inc.
Fort Myers, FL

Willis Gregory
Carolina's Hospital System
Florence, SC

Bradley K. Grover
Columbia Northside Medical Center
St. Petersburg, FL

Francis Guess
Seton Health Corporation
Nashville, TN

Calvin Hagan
Baptist Medical System
Little Rock, AR

Richmond M. Harman
Martin Memorial Health Systems, Inc.
Stuart, FL

Robert M. Harrell
Orlando Regional Healthcare System, Inc.
Orlando, FL

James D. Harvey
Hillcrest Medical Center
Tulsa, OK

Geri Herbert
Wood River Medical Center
Sun Valley, ID

David A. Herf, M.D.
North Okaloosa Medical Center
Cresview, FL

Gloria S. Hope, RN, Ph.D.
Tarpon Springs Hospital Foundation, Inc.
Helen Ellis Memorial Hospital
Tarpon Springs, FL

Mary-Jo Horton
Martin Memorial Health Systems, Inc.
Stuart, FL

John K. Humphress
Tallahassee Memorial Regional Medical Center
Tallahassee, FL

Georgia Jeter
Columbus Regional Healthcare System, Inc.
Columbus, GA

Drew Johnson
Bryan W. Whitfield Memorial Hospital
Demopolis, AL

William E. Karnatz, Sr., Esq.
University Hospitals of Cleveland
Cleveland, OH

Rodney S. Ketcham
Health First, Inc.
Melbourne, FL

Stephen Kiley
St. Joseph Hospital
Kokomo, IN

Guy King, III
St. Joseph's Hospital, Inc.
Tampa, FL

Jane Kitching
Columbia Clearwater Community Hospital
Clearwater, FL

Shirley Klens
Lock Haven Hospital
Lock Haven, PA

Lanny A. Kope
PMH Health Resources, Inc.
Phoenix Memorial Hospital
Phoenix, AZ

Michael Kremin
Seton Health Corporation
of East Central Michigan
Saginaw, MI

Charles Lanham
Pleasant Valley Hospital
Pt. Pleasant, WVA

Roger A. Larson
Sun Coast Hospital, Inc.
Largo, FL

Owen Lawless
Eastern Health Systems, Inc.
Birmingham, AL

R. Daryl Libby, DDS
Hanford Community Medical Center
Hanford, CA

Omar K. Lightfoot, Jr.
University Community Hospital, Inc.
Tampa, FL

Duane L. Lipps
Lake Hospital System, Inc.
Painesville, OH

Thad Lowrey
Columbia New Port Richey Hospital
New Port Richey, FL

Donald V. Mahony, M.D.
St. John's Hospital and Nursing Home
Jackson, WY

J. Christopher Manners
Saint Luke's Medical Center
Cleveland, OH

Gino Marconi
Mercy Medical Center
Mt. Shasta, CA

David Marley
Mercy Hospital of Miami, Inc.
Miami, FL

Ralph Martin
Rankin Medical Center
Brandon, MS

Betty Massey
White River Medical Center
Batesville, AR

Ted Matney
Randolph Hospital
Asheboro, NC

Jack McConnell
Volunteers in Medicine Clinic
Hilton Head Island, SC

Sister Martin McEntee
St. Joseph Hospital
Kokomo, IN

J. Stewart McLaughlin, Esq.
Southside Hospital
Bay Shore, NY

David McMahon
Hanford Community Medical Center
Hanford, CA

Robert T. Meade, M.D.
Leesburg Regional Medical Center
Leesburg, FL

Robert Meisel
Seton Health Corporation
of East Central Michigan
Saginaw, MI

C. R. Merolla

Good Samaritan Hospital Medical Center
West Islip, NY

Paul E. Meas, CPA

Shands Hospital at the University of Florida
Gainesville, FL

A. J. Miller

Lutheran Medical Center
Wheat Ridge, CO

John Milton, V

Jackson Hospital
Marianna, FL

Elizabeth Molina

Gritman Medical Center
Moscow, ID

Marian B. Monroe

Martin Memorial Health Systems, Inc.
Spartanburg, SC

Jan Moore

Nacogdoches Memorial Hospital
Nacogdoches, TX

Richard Moses

Tuomey Regional Medical Center
Sumter, SC

Herb Mosher

Rehoboth-McKinley Christian Hospital
Gallup, NM

Thomas H. Nimick, Jr.

Shadyside Hospital
Pittsburgh, PA

Jane Oehm

Lutheran Medical Center
Wheat Ridge, CO

M. Benson O'Kelley, Jr.

Leesburg Regional Medical Center
Leesburg, FL

Robert Ourisman

National Rehabilitation Hospital
Washington, DC

John Pacowia

Waterbury Hospital
Waterbury, CT

John Peracchino

Mercy Medical Center
Mt. Shasta, CA

Marshall Pickens

Anderson Area Medical Center
Anderson, SC

Henry Pollak, II

White Plains Hospital Medical Center
The Jewish Home and Hospital for the Aged
New York, NY

Vicki Robinson

Breckinridge Hospital, Inc.
Hardinsburg, KY

Sandra Rogers-Tracy

St. Joseph's Hospital
Parkersburg, WVA

Sister Renee Rose

St. Mary's Hospital
Milwaukee, WI

Edward Rongione

Glades General Hospital
Belle Glade, FL

Ted Ruta

Parrish Medical Center
Titusville, FL

Don Salter

Santa Rosa Medical Center
Milton, FL

Paul Salter, Jr., M.D.

Shelby Medical Center
Alabaster, AL

William Saltonstall

New England Medical Center
Boston, MA

James Shearer

St. Joseph Hospital
Kokomo, IN

Curtis Shipley

Washington Regional Medical Center
Fayetteville, AR

Rodney R. Smith

North Okaloosa Medical Center
Crestview, FL

Judith Stoffer

St. Joseph Hospital
Eureka, CA

Leonard P. Stewart, II

National Rehabilitation Hospital
Washington, DC

James H. (Jed) Suddeth, Jr.
Richland Memorial Hospital
Columbia, SC

Don Yarger
Craig General Hospital
Vinita, OK

Joseph M. Sullivan
Catholic Medical Center of Brooklyn & Queens
Brooklyn, NY

Roland Sutton
Stephens Memorial Hospital
Norway, ME

George Thomas, M.D.
Manatee Memorial Hospital, LP
Bradenton, FL

Larry Unkrich
Jefferson County Hospital
Fairfield, IA

Conrad Utts
St. Joseph Hospital
Kokomo, IN

Colleen Van Nostran
Memorial Hospital
Manhattan, KS

John Van Zanten
Corning Hospital
Corning, NY

John Vihinen
Rutland Regional Medical Center
Rutland, VT

Bruce L. Warwick
Greenwich Hospital
Greenwich, CT

James S. Watkinson
Health Corporation of Virginia
Richmond, VA

Ralph W. Weeks
Lakeland Regional Medical Center, Inc.
Lakeland, FL

David Whitworth
Breckinridge Hospital, Inc.
Hardinsburg, KY

Sister Clarise Winter
St. Joseph Hospital
Kokomo, IN

Alan Johnson Woodruff
Martin Memorial Health Systems, Inc.
Stuart, FL

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.

AMERICA'S HOSPITALS AND HEALTH SYSTEMS

May 16, 1996

Dear Senator:

On behalf of the undersigned organizations representing hospitals and health systems, we strongly urge your support of any amendment to S. Con. Res. 57 (the FY 1997 Budget Resolution) which lowers reductions to Medicare. We cite in particular an amendment to be offered by Sen. Jay Rockefeller (D-WV) to restore \$50 billion to the Medicare program.

While it appears that the overall Medicare budget reductions of \$165 billion included in S. Con. Res. 57 are roughly the same as those in the last Republican offer in January, the budget drastically changes how the reductions would be allocated within the program. The FY 1997 budget proposal achieves the total reduction by saving \$124 billion from Part A Medicare (the Hospital Insurance Trust Fund) and \$44 billion from Part B.

The net result is that in S. Con. Res. 57, the reductions in Part A have increased by approximately \$25 billion. Not only are these unprecedented reductions, but they would have a disproportionate adverse impact on hospitals. To achieve reductions of this magnitude, Congress may need to adopt policies that would freeze or actually reduce payment rates per beneficiary.

Hospitals and health systems support a reasonable deficit reduction package, and believe that changes in Medicare are sorely needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare. However, we are gravely concerned about the level of Medicare Part A reductions proposed in S. Con. Res. 57.

Again, we ask you to support any amendments that temper the level of reductions to Medicare Part A, including Sen. Rockefeller's amendment to restore \$50 billion to the Medicare program, and seek a more balanced approach to achieving savings.

Sincerely,

American Hospital Association
American Association of Eye and Ear Hospitals
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Public Hospitals and Health Systems
Premier, Inc.
VHA Inc.

Letter also sent to Chairman Archer
and Chairman Bliley

May 10, 1996

The Honorable William Roth, Jr.
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Roth:

The undersigned organizations representing hospitals and health systems have reviewed the Fiscal Year 1997 (FY 97) House and Senate Budget Committee proposal, particularly with respect to the Medicare and Medicaid programs.

While it appears that the overall Medicare budget reductions of \$167 billion are roughly the same as those in the last Republican offer in January, the Budget Committees have significantly changed the allocation of reductions within the program. While it is difficult to assess the overall impact of the budget resolution in the absence of greater detail, now larger Medicare Part A reductions mean hospitals are likely to experience actual reductions in payment rates under the committees' proposal.

The budget resolution now includes lower budget reductions in Part B of Medicare, while the reductions in Part A have increased by approximately \$25 billion since the January offer. While the FY 97 budget resolution offers a milder overall approach to deficit reduction compared to last year's resolution, its impact on hospitals appears worse. To achieve reductions of this magnitude, Congress may need to adopt policies resulting in payment rates per beneficiary that would be frozen or actually reduced.

We also have serious concerns about the Budget Committees' Medicaid reductions. We would like to take this opportunity to reiterate our support for maintaining the entitlement nature of the Medicaid program to ensure that those who have coverage today will continue to have coverage tomorrow. Furthermore, we support maintaining current law provider assessment restrictions and Boren amendment payment safeguards. While the overall reductions are somewhat lower than the January offer, if combined with corresponding state reductions through lower state matching requirements or new provider assessments, these reductions could be quite significant for providers.

Hospitals and health systems support the need to adopt a reasonable deficit reduction package, and believe that changes in Medicare are needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare and Medicaid. However, we are gravely concerned about the level of reductions proposed by the Budget Committees in these programs.

Chairman Roth
May 10, 1996
Page 2

We strongly urge you to reconsider both the overall level of Medicare and Medicaid reductions included in the budget resolution and, in your capacity as chairman of the authorizing committee, adjust the allocation between Parts A and B proposed by the Budget Committees.

American Association of Eye and Ear Hospitals
American Hospital Association
American Osteopathic Healthcare Association
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Children's Hospitals
National Association of Public Hospitals and Health Systems
Premier

Association of American Medical Colleges
Catholic Health Association of the United States
InterHealth
National Association of Children's Hospitals
and Related Institutions
National Association of Public Hospitals

May 24, 1995

The Honorable Richard Gephardt
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gephardt:

Our five national health care associations -- Association of American Medical Colleges, Catholic Health Association, InterHealth, National Association of Children's Hospitals and Related Institutions, and National Association of Public Hospitals -- strongly oppose proposals that would eliminate federal minimum standards for Medicaid eligibility.

Medicaid is the joint federal/state program that pays for the health care of more than 31 million mothers and children of low income families as well as elderly and disabled Americans of low and moderate incomes. Medicaid has become increasingly important as the number of uninsured Americans continues to grow. From 1992 to 1993, the number of uninsured Americans grew from 40.1 million to 41.2 million. Children accounted for eight in ten newly uninsured Americans. Without Medicaid, 28% of all Americans and 40% of all children would be uninsured.

Currently, however, several Congressional leaders and governors are proposing major cuts in the future level of federal Medicaid funding and replacing the federal Medicaid entitlement for eligible individuals with a block grant that would give each state a fixed sum of funds plus flexibility to set its own eligibility standards.

Depending on how they were defined, block grants could end Medicaid as a program which entitles eligible individuals to health care regardless of the state in which they reside. Instead, Medicaid could become a program that entitles states to federal funds regardless of the level of health coverage the state provides. If the annual growth rate in federal Medicaid spending were cut in half and the funds were turned into block grants, it would be virtually impossible for many states to absorb the funding cuts without using their new flexibility to limit Medicaid eligibility and services.

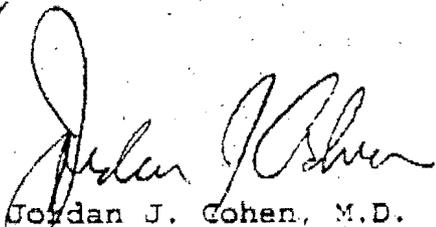
According to the most recent available data, Medicaid covered 12 percent of the U.S. population in 1993 -- separate from the 16 percent of Americans who were uninsured. Medicaid plays an even larger role for specific populations. For example, in 1993, Medicaid

covered nearly one in four children and one in three infants, regardless of family income. It covered nearly one in three non-elderly Americans with family incomes below 200% of the federal poverty standard and more than three in five non-elderly Americans with incomes below 100% of poverty.

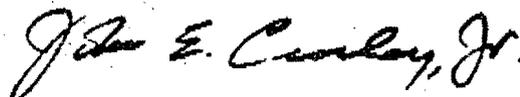
Since the 1980s, when Congress delinked Medicaid eligibility from welfare eligibility, Medicaid has become a health care program that fosters employment. For example, children represent half of all Medicaid recipients, and nearly three in five Medicaid covered children live in low income families with working adults.

Instead of ending federal minimum eligibility standards for Medicaid, our five associations believe the nation must take steps to achieve universal health coverage, beginning with steps to expand and adequately finance coverage, while avoiding deterioration of current coverage in public programs such as Medicaid. Our five associations believe that, at a minimum, federal law should maintain current national Medicaid eligibility requirements and look to the future to expand coverage for uninsured Americans.

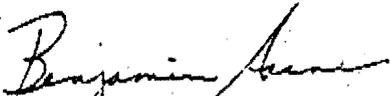
Sincerely,



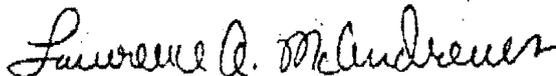
Jordan J. Cohen, M.D.
President
Association of American
Medical Colleges



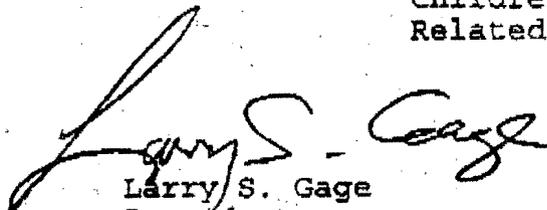
John E. Curley, Jr.
President/CEO
Catholic Health Association
of the United States



Benjamin Aune
President and CEO
InterHealth



Lawrence A. McAndrews
President and CEO
National Association of
Children's Hospitals and
Related Institutions



Larry S. Gage
President
National Association
of Public Hospitals

**InterHealth
AmHS Institute
American Hospital Association
American Medical Association
The Cleveland Clinic Foundation
American Health Care Association
Federation of American Health Systems
National Association of Public Hospitals
Association of American Medical Colleges
American Osteopathic Hospital Association
American Society of Health-System Pharmacists
National Association of Psychiatric Health Systems
National Association of Children's Hospitals and Related Institutions
American Association of Eye and Ear Hospitals
Healthcare Financial Management Association
Volunteer Trustees of Non-Profit Hospitals
National Council of Community Hospitals
American Society of Internal Medicine
American Rehabilitation Association
American Diabetes Association
Catholic Health Association
VHA Inc**

May 17, 1995

The Honorable
United States Senate
Washington, DC 20510

Dear Senator

On behalf of the organizations listed above, we are writing to express our serious concern for the Medicare and Medicaid programs as the Senate begins consideration of its fiscal year (FY) 1996 budget resolution.

From the outset, let us say that we understand that changes are necessary in Medicare and Medicaid... programs that provide health care to millions of elderly, disabled, women and children. We share your goal of restructuring these programs to bring to them the same types of cost-effective health care delivery that are holding down costs in the private sector. Many of our organizations have proposed significant and far-reaching solutions to the problems facing these two important programs. We know that savings in the system can be achieved, and we are willing to accept some reductions through this restructuring.

May 17, 1995
page 2

The proposals put forward by the Senate Budget Committee, however, go too far too fast. The Senate Budget Committee plan, for instance, calls for unprecedented savings in the Medicare program of \$141 billion over five years and \$236 billion over seven years. It is important to note that these numbers are almost three times larger than the level of savings achieved as part of the five-year package in OBRA '93. In addition, the Senate Budget Committee proposes Medicaid spending reductions of \$175 billion over seven years. Such dramatic reductions will seriously jeopardize the ability of doctors, hospitals and others to continue providing high-quality health care to our nation's elderly, disabled, women and children. Furthermore, reductions of this magnitude will undermine efforts to restructure the health care system.

While we pledge to work with you to find workable solutions to the problems facing these programs, we urge you to moderate the level of proposed reductions in Medicare and Medicaid recently approved by the Senate Budget Committee.

Sincerely,

The Above-Listed Organizations

Letter also sent to Chairman Archer
and Chairman Bliley

May 10, 1996

The Honorable William Roth, Jr.
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Roth:

The undersigned organizations representing hospitals and health systems have reviewed the Fiscal Year 1997 (FY 97) House and Senate Budget Committee proposal, particularly with respect to the Medicare and Medicaid programs.

While it appears that the overall Medicare budget reductions of \$167 billion are roughly the same as those in the last Republican offer in January, the Budget Committees have significantly changed the allocation of reductions within the program. While it is difficult to assess the overall impact of the budget resolution in the absence of greater detail, now larger Medicare Part A reductions mean hospitals are likely to experience actual reductions in payment rates under the committees' proposal.

The budget resolution now includes lower budget reductions in Part B of Medicare, while the reductions in Part A have **increased by approximately \$25 billion** since the January offer. While the FY 97 budget resolution offers a milder overall approach to deficit reduction compared to last year's resolution, its impact on hospitals appears worse. To achieve reductions of this magnitude, Congress may need to adopt policies resulting in payment rates per beneficiary that would be frozen or actually reduced.

We also have serious concerns about the Budget Committees' Medicaid reductions. We would like to take this opportunity to reiterate our support for maintaining the entitlement nature of the Medicaid program to ensure that those who have coverage today will continue to have coverage tomorrow. Furthermore, we support maintaining current law provider assessment restrictions and Boren amendment payment safeguards. While the overall reductions are somewhat lower than the January offer, if combined with corresponding state reductions through lower state matching requirements or new provider assessments, these reductions could be quite significant for providers.

Hospitals and health systems support the need to adopt a reasonable deficit reduction package, and believe that changes in Medicare are needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare and Medicaid. However, we are gravely concerned about the level of reductions proposed by the Budget Committees in these programs.

Chairman Roth
May 10, 1996
Page 2

We strongly urge you to reconsider both the overall level of Medicare and Medicaid reductions included in the budget resolution and, in your capacity as chairman of the authorizing committee, adjust the allocation between Parts A and B proposed by the Budget Committees.

American Association of Eye and Ear Hospitals
American Hospital Association
American Osteopathic Healthcare Association
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Children's Hospitals
National Association of Public Hospitals and Health Systems
Premier

BUDGET AND ECONOMIC FAX

Steve E.

415 202 7496

FAX COVER PAGE

RBO Baseline FY

Pages Including Cover: 8

TO: Chris Jennings

Phone: 456-5560

Fax: 456-5542

Medicare (Medicaid)

FROM: Glen Rosselli

Deputy Assistant Secretary for Policy Analysis

Phone: 622-0090

Fax: 622-2633

Message:

Please deliver to Chris Jennings upon receipt.

Note: Thomas held a press conference and blasted the Administration.

I had someone there staking it out and will have someone at the hearing tomorrow.

Let's talk tomorrow.

CBO April 1996 Baseline: MEDICARE

17-Apr

Outlays by fiscal year,
in billions of dollars.

PART A: HOSPITAL INSURANCE (HI)

	1996	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
TOTAL HI OUTLAYS /1	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
Annual Growth Rate		10.7%	9.5%	9.0%	8.2%	7.6%	7.6%	7.4%	7.5%	7.7%	7.7%	7.9%
TOTAL HI MANDATORY /2	113.6	125.0	138.0	150.5	162.9	175.6	189.0	203.0	218.2	235.0	253.2	273.4
TOTAL HI BENEFITS /3	113.4	125.7	137.8	150.2	162.8	175.3	188.7	202.8	217.8	234.6	252.9	273.0
Annual Growth Rate		10.8%	9.6%	9.1%	8.2%	7.8%	7.6%	7.4%	7.5%	7.7%	7.8%	8.0%
Hospitals	79.8	84.1	88.5	93.7	99.2	104.7	110.1	115.3	120.8	126.6	132.5	138.8
Annual Growth Rate		5.4%	5.2%	5.9%	6.0%	5.5%	5.2%	4.7%	4.7%	4.8%	4.7%	4.7%
IMOs	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Annual Growth Rate		38.5%	29.9%	24.0%	17.7%	17.2%	17.0%	16.8%	16.9%	17.0%	17.1%	17.0%
Hospice	1.9	2.5	3.1	3.7	4.2	4.7	5.2	5.7	6.2	6.7	7.3	7.9
Annual Growth Rate		32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%	8.5%	8.5%	8.5%	8.5%
Home Health	14.9	17.5	20.1	22.5	24.6	26.7	28.9	31.3	33.8	36.5	39.4	42.4
Annual Growth Rate		17.7%	15.0%	11.7%	9.3%	8.6%	8.4%	8.2%	8.1%	8.0%	7.8%	7.8%
Skilled Nursing Facilities	9.1	11.0	12.4	13.6	14.7	16.0	17.3	18.6	20.0	21.4	22.9	24.6
Annual Growth Rate		20.6%	12.9%	9.3%	8.5%	8.4%	8.1%	7.7%	7.4%	7.3%	7.1%	7.1%

PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)

TOTAL SMI OUTLAYS /1	65.2	71.9	79.3	87.8	96.5	106.0	116.4	127.9	141.3	156.5	173.4	192.4
Annual Growth Rate		10.2%	10.4%	10.7%	9.9%	9.8%	9.8%	9.9%	10.5%	10.8%	10.9%	10.9%
TOTAL SMI BENEFITS /3	63.5	70.1	77.5	85.9	94.5	103.9	114.2	125.6	138.8	153.9	170.8	189.6
Annual Growth Rate		10.4%	10.5%	10.9%	10.0%	9.9%	9.9%	10.0%	10.6%	10.9%	11.0%	11.0%
Benefits paid by Carriers /4	41.7	44.6	47.6	51.3	54.8	58.3	61.9	65.6	69.9	74.8	80.1	85.7
Annual Growth Rate		6.9%	6.9%	7.6%	6.8%	6.4%	6.2%	5.9%	6.6%	7.0%	7.1%	7.1%
Physician Fee Schedule	33.0	35.1	37.0	39.3	41.3	43.1	44.8	46.3	48.3	50.7	53.4	56.2
Annual Growth Rate		6.2%	5.6%	6.2%	5.0%	4.4%	4.0%	3.4%	4.3%	5.0%	5.2%	5.3%
Benefits paid by Intermediaries /5	15.4	17.3	19.4	21.9	24.6	27.7	31.2	35.0	39.1	43.4	47.9	52.7
Annual Growth Rate		12.5%	12.4%	12.4%	12.7%	12.6%	12.4%	12.2%	11.7%	11.1%	10.4%	9.9%
Group Plans	6.4	8.2	10.4	12.8	15.2	17.9	21.2	25.1	30.0	35.9	42.9	51.4
Annual Growth Rate		28.0%	26.6%	23.0%	18.6%	18.1%	18.3%	18.5%	19.4%	19.6%	19.7%	19.6%

Includes discretionary administration.

Includes mandatory administration.

Includes the impact of PL 104-121, enacted on March 29, 1996. This impact is not distributed to the components of Medicare benefits.

Includes all services paid under the physician fee schedule, durable medical equipment, independent and physician in-office lab services, ambulance services paid by carriers, and other services.

Includes outpatient hospital services, lab services in hospital outpatient departments, hospital-provided ambulance services and other services.

CBO April 1996 Baseline: MEDICARE

26-Apr

Outlays by fiscal year,
in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Part A Information:												
HI Trust Fund Income	114.8	119.9	126.0	129.7	134.3	138.8	142.8	147.3	151.4	155.1	159.2	163.0
HI Trust Fund Outlays	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
HI Trust Fund Surplus	-0.0	-7.2	-13.3	-22.1	-30.0	-38.2	-47.6	-57.1	-68.3	-81.5	-95.8	-112.2
HI Trust Fund Balance (end of year)	129.5	122.3	109.0	86.9	56.9	18.7	-28.9	-86.0	-154.3	-235.8	-331.6	-443.8
Part A FY Enrollment (in millions)												
	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
HI Deductible (calendar year, in dollars)												
	\$716	\$736	\$764	\$796	\$832	\$868	\$904	\$940	\$980	\$1,020	\$1,064	\$1,108
Monthly Premium (calendar year, in dollars)												
	\$261	\$269	\$311	\$334	\$356	\$378	\$402	\$426	\$451	\$480	\$510	\$538
Premiums collected												
	\$1.0	\$1.1	\$1.2	\$1.4	\$1.5	\$1.6	\$1.7	\$1.9	\$2.0	\$2.2	\$2.4	\$2.6
PPS Market Basket Increase												
	3.6%	3.5%	3.3%	3.5%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
PPS Update Factor (average)												
	1.9%	1.5%	2.8%	3.6%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
Part A Hospital Inpatient Payments:												
PPS Hospitals												
	69.2	72.6	75.5	78.7	82.3	86.0	89.5	92.9	96.3	99.9	103.4	107.2
Non-PPS Hospitals/Units												
	10.6	11.5	13.0	14.9	16.9	18.6	20.6	22.4	24.4	26.7	29.0	31.5
Disproportionate Share Payments												
	3.9	4.6	4.8	5.0	5.2	5.4	5.6	5.8	6.0	6.3	6.5	6.7
Indirect Medical Ed. Payments (for patient care)												
	4.9	5.2	5.5	5.9	6.3	6.7	7.2	7.7	8.2	8.8	9.3	9.9
Inpatient Capital Payments												
	7.9	9.6	10.4	11.1	11.8	12.6	13.0	13.3	13.7	14.1	14.4	14.8
Part A and Part B Hospital Inpatient Payments:												
Direct Medical Ed. Payments (for teaching program)												
	2.3	2.4	2.5	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.7
Part B Information: (In calendar years, except as noted)												
Deductible (in dollars)												
	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
MEI percentage change												
	2.1%	2.0%	2.2%	2.1%	2.0%	2.0%	1.8%	1.8%	1.9%	1.8%	1.7%	1.7%
Physician Update (weighted average)												
	7.4%	0.4%	1.2%	0.0%	-3.0%	-2.6%	-3.2%	-2.9%	-0.6%	0.0%	1.2%	1.7%
Conversion Factor												
	\$36.11	\$36.28	\$36.75	\$36.74	\$35.65	\$34.75	\$33.66	\$32.68	\$32.49	\$32.51	\$32.91	\$33.50
Primary Care Update												
	7.9%	-2.7%	2.5%	7.2%	-3.0%	-1.0%	-3.2%	-3.2%	-0.5%	-0.5%	1.5%	2.5%
Conversion Factor												
	\$36.38	\$35.42	\$36.31	\$38.93	\$37.77	\$37.40	\$36.22	\$35.08	\$34.89	\$34.71	\$35.24	\$36.13
Surgical Update												
	12.2%	3.4%	2.2%	-2.9%	-3.0%	-3.0%	-3.2%	-3.1%	-0.6%	0.7%	1.7%	2.2%
Surgery Conversion Factor												
	\$39.45	\$40.80	\$41.60	\$40.48	\$39.27	\$38.07	\$36.87	\$35.73	\$35.62	\$35.76	\$36.37	\$37.15
Anesthesia Conversion Factor												
	\$14.77	\$15.28	\$15.61	\$15.16	\$14.71	\$14.26	\$13.81	\$13.38	\$13.31	\$13.39	\$13.62	\$13.92
Other Physician Update												
	5.2%	0.0%	0.3%	-1.3%	-3.0%	-3.0%	-3.2%	-2.7%	-0.6%	-0.0%	0.9%	1.2%
Conversion Factor												
	\$34.62	\$34.63	\$34.74	\$34.30	\$33.28	\$32.26	\$31.24	\$30.39	\$30.21	\$30.21	\$30.47	\$30.84
Laboratory Update												
	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
XME Update												
	3.2%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
XO Update												
	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
ISC Update												
	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
Monthly Premium (in dollars)												
	\$46.10	\$42.50	\$44.40	\$48.70	\$50.20	\$51.70	\$53.20	\$54.70	\$56.30	\$58.00	\$59.70	\$61.50
MI Premium Receipts (fiscal years, in billions) #												
	19.2	18.8	19.4	21.2	22.5	23.5	24.5	25.5	26.6	27.8	28.7	29.5
fiscal Year Enrollment (in millions)												
	35.5	38.0	36.5	38.9	37.3	37.7	38.2	38.6	39.0	39.5	40.0	40.6

Includes the impact of PL 104-121, enacted on March 29, 1996.

CBO April 1996 Baseline: MEDICARE

17-Apr

*Outlays by fiscal year,
in billions of dollars.*

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
RISK HMO SPENDING AND ENROLLMENT												
Part A Risk HMO Outlays (FY)	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Part B Risk HMO Outlays (FY)	5.4	7.3	9.5	11.9	14.3	17.1	20.4	24.3	29.2	35.1	42.2	50.7
Total	13.1	17.8	23.2	28.8	34.2	40.4	47.7	56.2	66.5	78.7	93.2	110.3
Part A Risk HMO Outlays (CY)	8.4	11.3	14.5	17.7	20.8	24.3	28.4	33.2	38.8	45.4	53.2	62.2
Part B Risk HMO Outlays (CY)	5.9	7.8	10.1	12.5	14.9	17.8	21.3	25.4	30.5	36.7	44.1	52.9
Total	14.3	19.1	24.6	30.2	35.7	42.1	49.7	58.6	69.4	82.1	97.3	115.1
Part A Enrollment (FY)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
Part A Enrollment (CY)	37.1	37.7	38.2	38.7	39.2	39.7	40.2	40.7	41.2	41.8	42.4	43.1
FY Risk HMO enrollment March '96 baseline	2.7	3.4	4.1	4.7	5.1	5.7	6.2	6.8	7.5	8.3	9.1	10.0
Year to Year Change		25.0%	20.0%	15.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
CY Risk HMO enrollment	2.9	3.6	4.2	4.8	5.3	5.8	6.4	7.0	7.7	8.5	9.3	10.3
Year to Year Change		23.6%	18.6%	13.6%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Mem: FY HMO penetration rate /1	7.3%	9.0%	10.7%	12.1%	13.2%	14.3%	15.5%	16.9%	18.3%	19.9%	21.6%	23.3%
Mem: CY HMO penetration rate /1	7.8%	9.4%	11.0%	12.4%	13.4%	14.6%	15.9%	17.2%	18.7%	20.3%	22.0%	23.8%

/ Risk HMO enrollment as a percent of Part A enrollment.

Revised
09-Apr

CBO March 1996 Baseline: MEDICAID

<i>Outlays by fiscal year, in billions of dollars</i>	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Federal share of Medicaid payments												
Benefits	74.5	80.8	88.9	98.6	108.4	119.0	131.1	144.6	159.7	176.3	194.6	214.8
Disproportionate share	10.7	10.7	11.2	11.8	12.4	13.0	13.7	14.3	15.1	15.8	16.6	17.4
Administration	3.9	4.3	4.7	5.1	5.7	6.3	6.9	7.6	8.4	9.2	10.2	11.2
TOTAL	89.1	95.7	104.9	115.5	126.5	138.3	151.6	166.6	183.1	201.3	221.4	243.4
Percentage Change	8.6%	7.5%	9.5%	10.2%	8.5%	8.3%	9.7%	9.9%	9.9%	10.0%	10.0%	9.9%
State Share	87.2	72.2	79.1	87.2	95.4	104.3	114.4	125.7	138.1	151.9	167.0	183.6
Total State and Federal	156.3	168.0	184.0	202.7	221.9	242.6	266.0	292.2	321.2	353.2	388.4	427.0
Benefits by type of spending												
Acute care	46.8	50.7	56.1	62.3	68.5	75.3	83.0	91.8	101.5	112.2	123.9	136.9
Long term care	27.7	30.1	32.8	36.3	39.8	43.7	48.1	52.8	58.2	64.1	70.7	77.9
Total	74.5	80.8	88.9	98.6	108.4	119.0	131.1	144.6	159.7	176.3	194.6	214.8
Benefits by Recipient Category												
Aged	23.9	25.7	28.1	30.9	33.8	36.9	40.5	44.4	48.7	53.4	58.7	64.5
Blind and Disabled	26.4	29.2	32.3	36.2	40.4	44.7	49.4	54.8	60.9	67.6	75.0	83.1
Children	14.2	15.3	17.1	18.9	20.6	22.6	24.9	27.5	30.3	33.4	36.8	40.6
Adults	9.9	10.5	11.4	12.6	13.6	14.9	16.4	18.0	19.8	21.8	24.0	26.6
Recipients (millions of people)												
Aged	4.2	4.3	4.5	4.8	4.7	4.9	5.0	5.1	5.2	5.4	5.5	5.7
Blind and Disabled	5.8	6.0	6.3	6.6	6.8	7.1	7.3	7.6	7.8	8.1	8.3	8.5
Children	17.7	18.2	19.0	19.4	19.9	20.4	20.8	21.3	21.7	22.2	22.6	23.1
Adults	7.5	7.4	7.5	7.7	7.9	8.0	8.2	8.4	8.6	8.7	8.9	9.1
Others	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Total	36.0	36.8	38.1	39.1	40.1	41.1	42.1	43.1	44.1	45.2	46.1	47.1

NEWS

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE

April 29, 1996

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New CBO Report Shows Medicare Declining Far Faster than the Clinton Administration Projected

Thomas Calls on President to Submit New Plan to Save Medicare

CBO Projects \$444 Billion Medicare Deficit in 2006, with Deterioration Accelerating

Washington -- Congressman Bill Thomas, Chairman of the Health Subcommittee of the Committee on Ways and Means, today released a new report by the Congressional Budget Office showing that the Medicare trust fund balance is declining far faster than the 1995 report issued by the Clinton Administration's Medicare Board of Trustees.

"This new report," Thomas said, "confirms the worst fears about the Medicare Trust Fund. Medicare is in worse shape than we were told last year and its balance is declining every day. Medicare must be saved from bankruptcy and I urge the Clinton Administration to heed this urgent new warning by submitting an updated plan to the Congress on how to save Medicare, without increasing taxes. The President should submit his plan along with the 1996 Medicare Trustee report."

The CBO figures released today by Thomas are the first official confirmation that the Medicare Hospital Insurance Trust Fund, also known as Medicare part A, will be bankrupt in 2001, one year earlier than the Trustee's 1995 report projected. The deficit will then drop exponentially over the next five years to \$444 billion, according to the CBO, far in excess of the projections made in 1995 by the Clinton Administration Board of Trustees.

"Based on this new information, President Clinton's existing Medicare proposal is out of date and it appears to be a band-aid on a severely hemorrhaging patient. The President should submit to the Congress an updated plan on how to save Medicare. We must work together to save Medicare and Republicans are committed to preserving and strengthening Medicare so it will always be there for those who need it. In 1993, President Clinton raised taxes to boost Medicare and it obviously didn't work. His new plan should contain no tax increases."

Thomas added that today's CBO numbers are more stark than the 1995 Medicare Trustee's Report.

"If the 1995 Medicare Trustees report was a 6.0 earthquake, this new report is an 8.0 earthquake," Thomas said. The 1995 Trustee report said Medicare would suffer a \$6.7 billion deficit in 2002. CBO shows that the Medicare deficit will actually be \$86 billion, surging to a \$444 billion deficit in 2006, blowing the overall federal deficit totally out of control. "This dramatic difference clearly shows that Medicare is in worse shape than we were told," Thomas said.

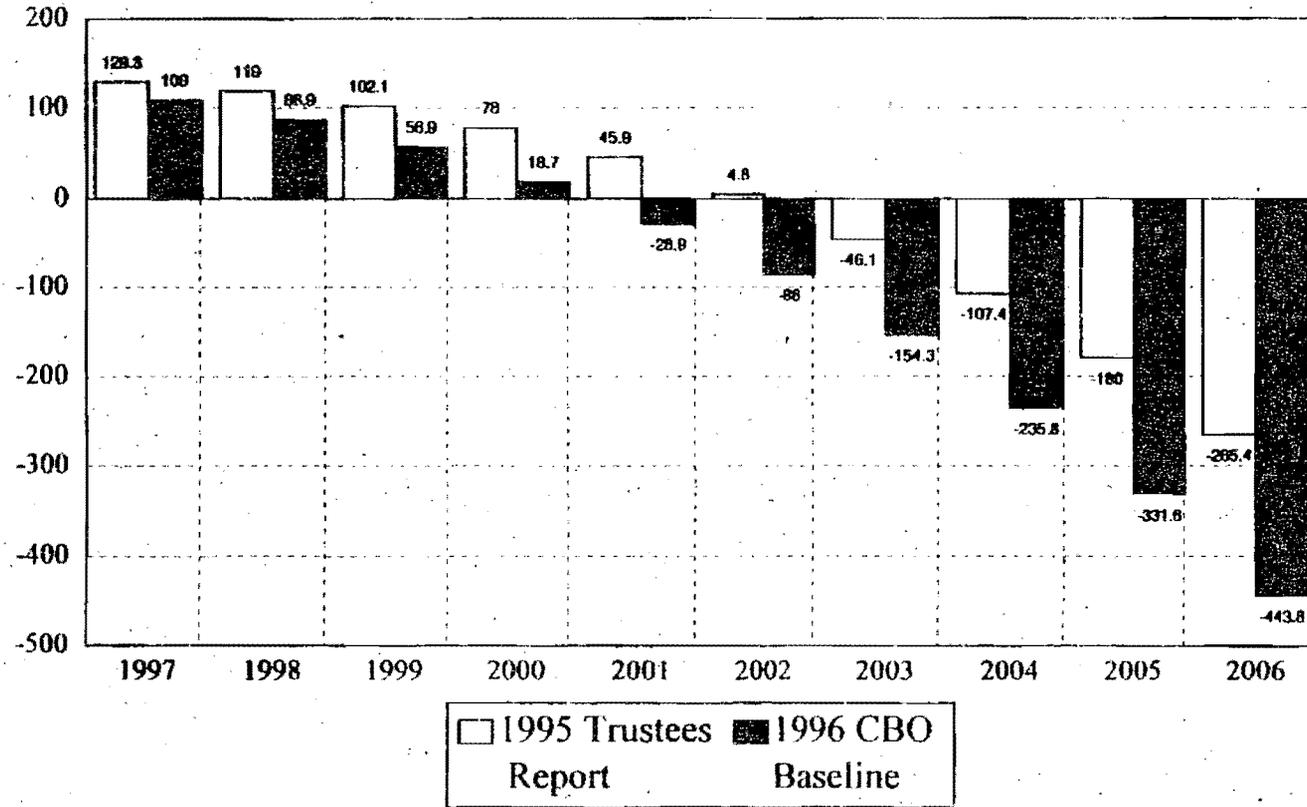
The CBO report, part of the April 1996 baseline, also indicates that the accelerating Medicare crisis is not caused by demographic changes. According to their analysis, approximately 37 million senior citizens will be enrolled in Medicare in 1997, increasing to 41 million seniors by 2006, a increase of just 1.2% annually.

"Before the baby boomers even retire, Medicare is severely out of balance and both parties must work together and rethink how to save this important program," Thomas said.

"This would not have happened if President Clinton hadn't vetoed the Republican plan to save Medicare," Thomas said. "Instead of working together to save Medicare, the President unfortunately chose to play partisan politics by scaring senior citizens and demagoging the issue. The time has come to save Medicare. I urge the President to submit a new plan to the Congress that can achieve strong bi-partisan support."

New CBO Report Shows Medicare Declining Far Faster Than Clinton Administration Projected

Medicare Trust Fund Balance at Fiscal Year End
(billions of dollars)



Sources: Federal Hospital Insurance Trust Fund Report, 1995 and Congressional Budget Office, 1996

Medicare: 2002 and Beyond
Statement of Robert D. Reischauer*

Subcommittee on Health
Committee on Ways and Means
February 13, 1996

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to discuss the future of the Medicare program with you. My statement addresses three issues:

- The need for structural reform of Medicare and the challenge such reform will represent.
- The contribution Medicare might make to the effort to balance the budget by 2002, and
- The Medicare proposals contained in the President's fiscal 1998 budget.

The need for structural reform

From a fiscal, an institutional, or a political perspective, the Medicare program is not sustainable as it is currently structured. There is no immediate crisis; rather there are problems that will grow in severity over time. While there may be no need for precipitous action, the sooner the nation begins the inevitable process of restructuring Medicare, the less disruptive or wrenching the changes will be and the more options policymakers will be able to consider.

The fiscal problem is straightforward. Spending by Medicare, as it is currently structured, is projected to grow at a faster pace than the economy is expected to expand. The Administration expects that, over the next 5 years, spending on an unchanged

* Senior Fellow, The Brookings Institution. The views expressed in this statement are those of the author and should not be attributed to the staff, officers or trustees of the Brookings Institution.

Medicare program will grow at an annual rate of 8.9 percent while the economy will expand by 4.9 percent a year.² The Congressional Budget Office's (CBO) projections show Medicare growing by 8.8 percent annually and the economy expanding by 4.7 percent annually over the next 10 years. The Board of Trustees of the Medicare Trust Funds estimates that Medicare's disbursements will grow about 2.8 percentage points a year faster than the economy over the course of the next four decades. This somewhat more sanguine but still unsustainable projection rests on an optimistic assumption that there will be a sharp slowdown in the growth of spending per capita.³ A program of Medicare's size can not grow significantly faster than the economy expands for a sustained period of time without requiring either drastic reductions in other government activities or significant tax increases.

The institutional problem arises because rapid changes are taking place in the non-Medicare insurance marketplace. Medicaid, employer-sponsored plans, and individual insurance are becoming, for the most part, capitated systems involving panels of providers and some management of care. Medicare, on the other hand, remains largely an unmanaged indemnity insurance program open to virtually any licensed provider of services. The institutional infrastructures needed to support these two very distinct types of insurance are different. The information requirements, regulatory needs, and management procedures of

² Net of part B premiums.

³ The *1996 Annual report of the Board of Trustees of the Federal Hospital Insurance Fund* (pages 8 and 71) states that HI program costs are based on an assumption that the growth rate of costs per unit of service will decline over the next 25 years until it reaches the rate of growth of average hourly earnings. The growth of per enrollee SMI costs is assumed to decline gradually after 2008, reaching the rate of growth of GDP per capita by 2020 where it is assumed to remain. Both of these assumptions represent a sharp slowdown from recent experience.

the two approaches will increasingly diverge, creating a certain amount of complexity, confusion, and inefficiency. The existence of two very different approaches may create incentives that affect, in a positive or negative way, the access to or quality of care available to Medicare participants. Incentives that increase cost pressures on Medicare could also develop.

If the Medicare and non-Medicare portions of the health insurance market continue to evolve along different paths, the strong political support Medicare has enjoyed since its inception could begin to erode. As originally conceived, Medicare was to provide the elderly, and later the disabled, with insurance coverage similar in structure and scope to that enjoyed by members of the working population and their dependents. In recent years, increasing numbers of those covered by Medicaid, employer-sponsored plans, and individual insurance policies have found their choice of providers limited, their access to specialists controlled, their selection of prescription drugs confined to those available through a formulary, and their ability to obtain certain expensive procedures constrained. These restraints have not been greeted with enthusiasm. If Medicare costs continue to escalate necessitating tax increases or reductions in other programs, some may begin to wonder why the elderly and disabled enjoy more in the way of unrestrained access to providers and services than that which is available to the balance of the population. If this happens, Medicare's support among taxpayers could begin to wane.

While these developments imply that Medicare will not be able to avoid restructuring, it would probably be unwise for policymakers to attempt at this point to specify all of the details of a restructured Medicare program. As a general principle, the health insurance system that government provides for the elderly and disabled should be

similar to, or at least compatible with, that available to the balance of the population. In recent years, the structures of Medicaid, individual insurance, and employer-sponsored plans have been changing at warp speed. This change could continue at a breakneck pace along the same path, come to an abrupt halt, or veer off in an entirely new direction. It would be unwise for policymakers to assume that they can forecast now where the private marketplace will settle when the convulsions cease. This suggests that restructuring Medicare should be viewed as an evolutionary process rather than a "big bang" event.

The fact that the ultimate destination is uncertain should not be taken as an excuse for delaying the journey. The general direction in which Medicare must move is fairly clear. Market incentives must be incorporated into Medicare. Participants will have to be given greater choice of plan types and incentives that encourage them to obtain their care from those providers who are both efficient and high quality. Institutions will have to be developed that can measure and monitor the quality of competing plans, disseminate information on the services offered by and performance of the different plans, enroll and disenroll participants, adjudicate disputes, and regulate the financial soundness of plans. It takes time to build such institutions, to get the kinks out of their systems, and to get participants, providers, and plans comfortable with the new structure. It would be best if this were done gradually and not when the new institutional infrastructure is required to bear the burden of fiscal restraint, which will be the situation a decade from now. In short, the time to begin the structural reforms that Medicare will have to undergo is now.

Current demographic and market conditions, which suggest that the risks and dislocation associated with restructuring are much lower now than they will be later, reinforce this point. For the next decade the nation will experience something of a lull

before the demographic storm. The population that is 65 and over is projected to grow by 0.9 percent a year between 1997 and 2007 (or from 12.7 percent of the total population to 12.8 percent). This is less than the growth experienced during the previous decade. This suggests that any nascent institutional structures that are created will have a period to take root before being faced with the rapid expansion in number of participants that will take place after 2010. In addition, providers--particularly hospitals, physicians and other health professionals--are currently in excess supply. Furthermore, in contrast to previous periods, Medicare payment levels are not far below those of most private payers. Taken together, these conditions suggest that there is little likelihood that the introduction of structural reforms, even with a few slips and stumbles, will adversely affect access or compromise the quality of care received by Medicare participants. This was not the case a decade ago and may not be the case a decade hence.

Medicare's Contribution to the Balanced Budget Effort

With respect to Medicare, the 105th Congress should focus its efforts on initiating the structural reforms that will be needed to ensure that the program remains viable over the long-run. Unfortunately, most of the recent debate has centered on the contribution that Medicare might make to balancing the federal budget by 2002 rather than on structural reforms. Of course, restraining Medicare spending must be an important component of the deficit reduction effort because Medicare is such a large and rapidly growing program. The extent of these savings is limited only by the nation's commitment to providing the elderly and disabled with access to high quality, affordable health care and its concern about excessive disruption of the health care infrastructure.

Some notion of the amounts that Medicare might be expected to contribute to deficit reduction can be obtained by examining the various budget balancing plans that have been proposed during the past two years. These plans called for Medicare savings that ranged from \$100 billion to \$270 billion. (Chart 1) These amounts constituted between one-fifth and one-third of the non-interest outlay reductions proposed by the various plans. (Chart 2A) Medicare spending would have been between 11 and 22 percent below baseline levels by 2002 under these proposals. (Chart 2B)

One can not make simple comparisons of the numbers in the charts because some involve seven year's worth of savings, some six years, and one five years. In addition, the baselines against which the savings are measured are different. In fact, between March 1995 and January 1997, CBO lowered its estimate of baseline Medicare spending during the 1996 to 2002 period by \$104 billion. (Chart 1)

The current Medicare budget debate is likely to revolve around savings that range from \$90 billion to \$140 billion over the 1998 to 2002 period. Spending restraint in this range is achievable and should not be too disruptive of the provider community. Ultimately, the magnitude of the savings that Medicare might realize from restraining the growth of payments to providers and instituting certain efficiencies depends crucially on what happens in the private insurance marketplace. If employer-sponsored health plans continue to hold down the annual rate of growth of their per-capita costs to under 4 percent, larger Medicare savings might be possible. On the other hand, if the growth of private health care costs rebounds to the rates experienced during the last half of the 1980s, even \$90 billion in savings would prove difficult to realize.

The Medicare proposals in the President's fiscal 1998 budget

The Medicare proposals in the President's 1998 budget constitute a good foundation upon which to build. The President calls for restraining the growth of payments to providers through many of the mechanisms that have been used effectively in the past. Most of the short-run savings are realized from these devices. While the savings proposed by the President are quite large relative to those that have been adopted in previous reconciliation acts, conditions are quite different now. It is likely that the restraints proposed in the President's budget could even be increased somewhat without risking any serious adverse consequences for participants.

The President's budget also proposes a number of new benefits and cost reducing measures for participants. The former include coverage of colorectal screening, a diabetes self-management benefit, annual mammograms, respite relief for families of Alzheimer's patients, and improved availability of preventive injections. The latter include eliminating cost-sharing for mammography services, reducing the cost-sharing for hospital outpatient services, lowering the premium surcharge for late enrollment in Part B, and changing the rules governing Medigap to make the premiums charged those leaving HMOs for the traditional fee-for-service system more affordable.

There are sound reasons for each of these benefit expansions and cost reduction measures. Nevertheless, the President's proposal sends an inappropriate message to Medicare participants. It tells them that they can expect to get more for less even in an era of fiscal austerity, even when the Hospital Insurance Trust Fund is spending more than it is taking in, and even when Medicare faces severe fiscal problems in the not-too-distant future. Under these circumstances, it would be appropriate to ask participants to bear the

cost of the proposed Medicare expansions. These costs could be added to the Part B premium. This would raise premiums by about \$10 a month in 2002. At that time, premiums would represent roughly 28.8 percent of costs, which is still below the 1995 level. Increasing premiums to their 1995 level and adopting an income-related surcharge on participants whose incomes are over twice the median would represent a responsible way of requiring Medicare participants to contribute to the efforts to balance and preserve the program for future retirees. For some this could represent a hardship, but many of the most needy would be shielded by Medicaid, which must pay the premiums of beneficiaries whose incomes are below 120 percent of the poverty threshold.

The President's budget proposal also contains a number of nascent structural reforms, some of which would affect the traditional fee-for-service component of Medicare and some of which would affect the capitated component. While the President's structural reforms are a positive step, they are too timid and tentative. On the fee-for-service side, the President proposes to replace the cost-based reimbursement of home health care, nursing home care, and outpatient hospital services with new prospective payment systems. The effort to move to prospective payment for post-acute care is commendable but fraught with technical difficulties which were discussed in a recent CBO study.⁴ Unless movement to a PPS system is done with great care, costs could increase, individuals with heavy service needs could have difficulty obtaining care, and quality could deteriorate. Nevertheless, it is important to accept the fact that any measures which successfully curb the explosive growth in post-acute care spending will lead to some reduction and redistribution of

⁴ Congressional Budget Office, *Medicare Spending on Post-Acute Care Services: A Preliminary Analysis*, January 1997.

services.

The President's budget also proposes that the Health Care Financing Administration (HCFA) be given greater authority to use negotiated prices and competitive bidding to set payments for non-physician Part B services. Such a procedure, which the President has proposed before, is long overdue. However, giving this authority to HCFA does not mean that it will be used. HCFA will be under intense political pressure to delay or make only very limited use of this authority. A bolder initiative would could promise more significant savings. One option would be to include minimum thresholds in the legislation. For example, Congress could require that at least 30 percent of the laboratory services paid for by Medicare in 2002 be purchased through competitive bids or negotiated prices unless HCFA provides evidence that such procedures would not be cost effective.

The structural changes the President proposes for the capitated portion of Medicare are more modest than those suggested for the fee-for-service program. The President would expand the choices available to participants to include Preferred Provider Organizations (PPOs) and Provider-Sponsored Organizations (PSOs) that meet certain standards as well as HMOs. While other plan types might be included, the President is prudent to expand the range of choice very cautiously. Until we are confident that HCFA can risk-adjust the capitated payments paid to plans sufficiently to avoid serious adverse selection problems, the expansion of options must be done very deliberately.

The budget also calls for the dissemination of comparative information on the plans available to Medicare participants. From the information available, it is not clear whether a new entity would be established to collect, evaluate, and disseminate this information or

whether the enrollment and disenrollment functions would be handled centrally by Medicare or would be decentralized to the plans. There are good reasons to establish a new entity to perform these responsibilities.

The budget also calls for significant changes in the way HMOs and the new types of capitated plans would be paid in the future. Rather than having payments strictly related to the local costs of fee-for-service Medicare, payments would be a blend of national and local fee-for-service costs. Local costs would still be calculated on a county basis, which does not make a great deal of sense when health market areas are much larger. The local cost component of the President's proposal should be based on multi-county averages. This would reduce some of the random year to year variability in payments and make payments more equitable. Why, for example, should a Medicare HMO operating within the Washington metropolitan area receive about \$2,200 less a year for an enrollee living in Fairfax County, Virginia than for an enrollee residing in Prince Georges County, Maryland?

The President's plan would also place a floor beneath capitated payments in rural counties to encourage expansion of managed care into these areas. On the surface, this proposal seems both equitable and efficient. Under certain circumstances, however, it could result in less not more choice. If the capitated payment for the area were considerably above the average fee-for-service Medicare expenditure in the area, providers would have an incentive to band together and see Medicare patients only through their PSN, PPO, or HMO. In this way providers could maximize their Medicare incomes.

The President's proposal also calls for gradually reducing the average payment made to capitated plans from 95 percent of the AAPCC to 90 percent starting in 2000. This

initiative responds to research evidence that suggests that if those selecting Medicare HMOs had remained in fee-for-service Medicare, they would have incurred costs somewhat below 95 percent of the average fee-for-service costs. If this is true and there is any positive correlation between the proclivity to enroll in an HMO and health status, the gap between the capitated payments received by HMOs and the costs of providing services to HMO enrollees is likely to grow as HMOs increase their market share.

Charts 3 and 4 provide an admittedly extreme and unrealistic illustration of this point. Chart 3 provides a picture of the distribution of per beneficiary Medicare costs in 1996. As is well known, costs are highly skewed with the most expensive one percent of the enrollees accounting for roughly 14 percent of the program's costs and over half of costs being incurred by the most expensive five percent of beneficiaries. Chart 4 depicts what would happen if Medicare participants enrolled in HMOs strictly according to their health status. The HMOs' costs to care for these individuals would rise as an increasing share of the population joined HMOs but the AAPCC would rise even faster because of the skewed nature of Medicare costs. When only the healthiest individual in the Medicare population, one who would incur no Medicare costs, participated in an HMO, the HMO would receive 95 percent of the AAPCC—or about \$4,500 a year—and the individual might not use any of the HMO's services. If all but the most expensive one percent of the Medicare population joined HMOs, the capitated payment made to HMOs would be over \$50,000 per participant, but the costs incurred per member by the HMOs might be only around \$4,000.

Medicare HMO enrollment has been growing by leaps and bounds. In 1996 enrollment expanded by 36 percent and CBO projects Medicare HMO enrollment to grow

by 30 percent in 1997 and 25 percent in 1998. Evidence suggests that Medicare HMO enrollees are younger and healthier than other Medicare participants. It is reasonable to expect that the dynamic illustrated in its most extreme form in Chart 4 is occurring and will grow in significance until the Medicare HMO population stabilizes and ages. If this is the case, policymakers should not wait until 2002 to begin ratcheting down the capitated payments made to HMOs. A gradual phasedown of possibly two percentage points a year should begin in 1998. As this reduction in capitated payments takes place, a substantial and continuous research effort should be mounted to measure the extent to which HMO participants are (or are not) less costly than their fee-for-service comparison groups. Congress should also instruct HCFA to devote more resources to developing risk adjustment mechanisms that could be used to modify capitated payments in an environment in which the payments made to capitated plans are decoupled from fee-for-service costs.

In addition to the analytical, there is a political reason for moving expeditiously to reform the capitated payment mechanism. In part because of the generous level of capitated payments, many HMOs have been able to provide their Medicare members with additional services at little or no additional costs. Low cost sharing, vision services, prescription drug benefits, and routine check-ups are among the most common of these benefits. As HMO enrollment grows and more and more Medicare beneficiaries come to regard these benefits as an entitlement, it will be increasingly difficult to reduce HMO payments. Plans will tell their members that actions being considered by Congress threaten their prescription drug benefit or their vision care. The pressure will be intense. This suggests that moving soon and in small steps is preferable to waiting and taking larger

leaps.

A final element of the President's proposal that merits some attention is his proposal to shift a significant portion of the costs of home health services from Part A, which is funded by the payroll tax, to Part B, three-quarters of which is supported by general revenues. Conceptually, the services the Administration would shift do not fit in the Part A hospital insurance program. However, the Administration's motive for this shift does not appear to be a quest for conceptual purity. Rather, it reflects political expediency--the need to make good on the promise to keep the wolves of insolvency from the trust fund's door for a decade without raising payroll taxes or imposing too much of a burden on Part A providers. The President's refusal to either increase Part B premiums to reflect the transferred costs or to subject transferred home health services to the deductible or coinsurance that most other Part B services face underscores the impetus behind the proposal. So too does the apparent failure to limit the home health services available to those beneficiaries who have only Part A coverage to the services that would be paid for from the Hospital Insurance Trust Fund.

But the real issue is not the motive behind this proposal but rather its consequences. The shift of home health expenditures to Part B will place an even larger portion of Medicare spending in direct competition with other programs for scarce budgetary resources. In a constrained environment, this inevitably will mean that discretionary and other mandatory programs will be cut more deeply in the effort to balance the budget. Equally important, the shift will serve to delay consideration of the types of fundamental structural reforms needed to preserve Medicare for the babyboom generation. Anachronistic as the Part A trust fund mechanism is, it serves the important function of

forcing reluctant policymakers to restrain this popular program when Part A spending outpaces payroll tax receipts and the trust fund's solvency is threatened. Shifting a portion of the fastest growing component of Medicare into Part B, which can dip into the Treasury's bottomless well for funds, will only delay the unavoidable and make the needed adjustments all the more wrenching when they occur. The longer we wait to make these changes, the more constrained our options will be and the more prominent a role tax increases will have to play in the solution. If the political pressures are great now, they will be even more intense in a decade when the babyboom generation is facing the realities of retirement.

CHART 1 Reduction in Medicare Spending

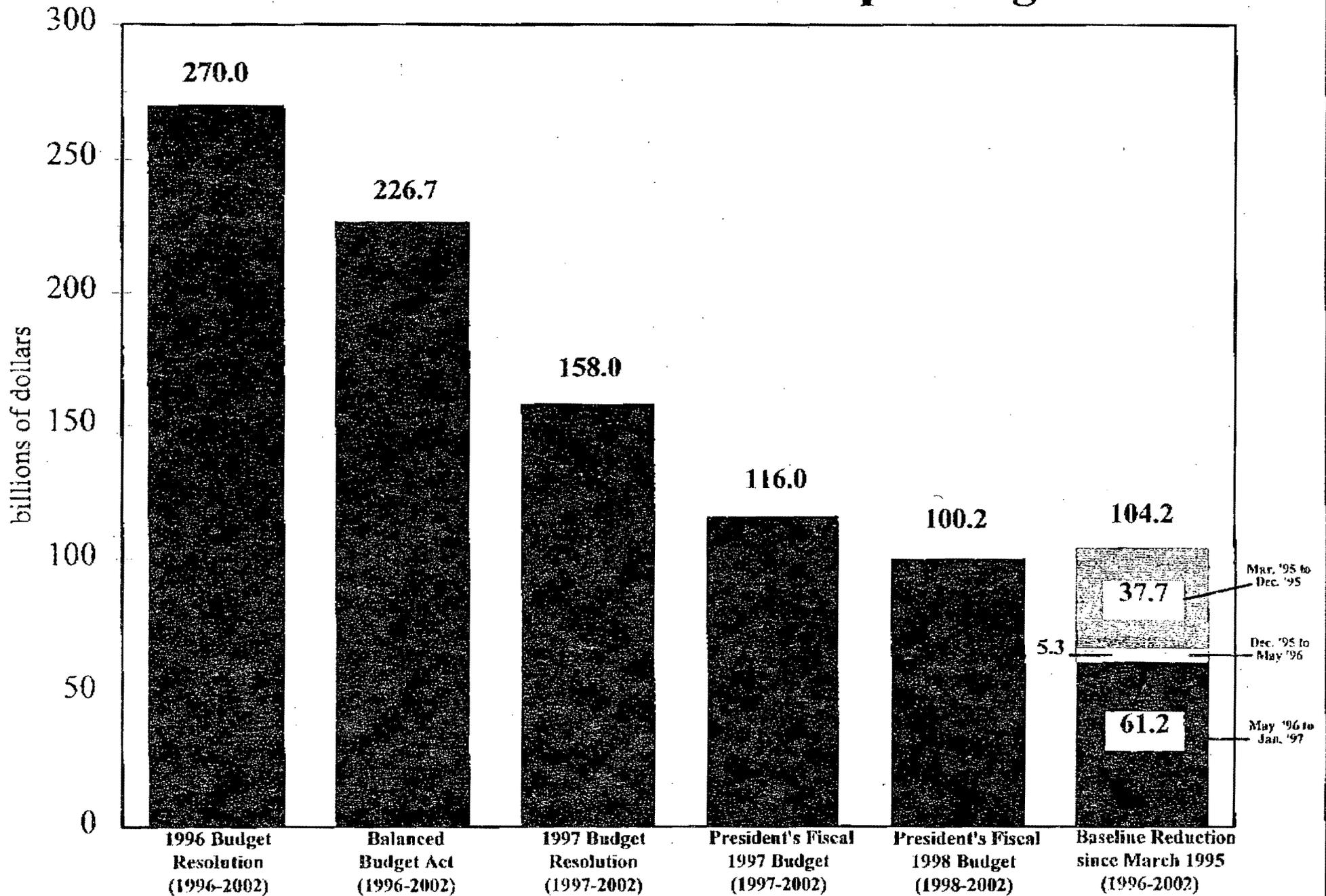


CHART 2A
Percent of Non-Interest Outlay Savings from Medicare

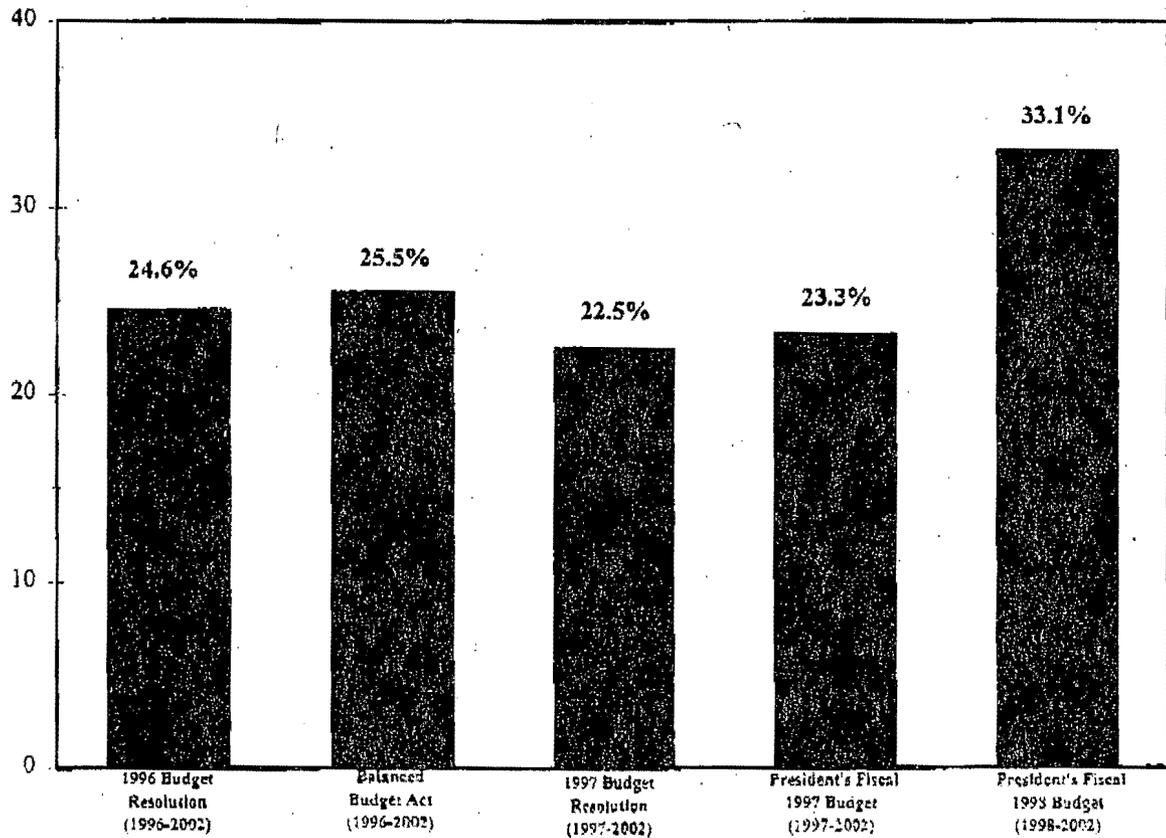


CHART 2B
Medicare Spending in 2002
Percent Reduction from Baseline

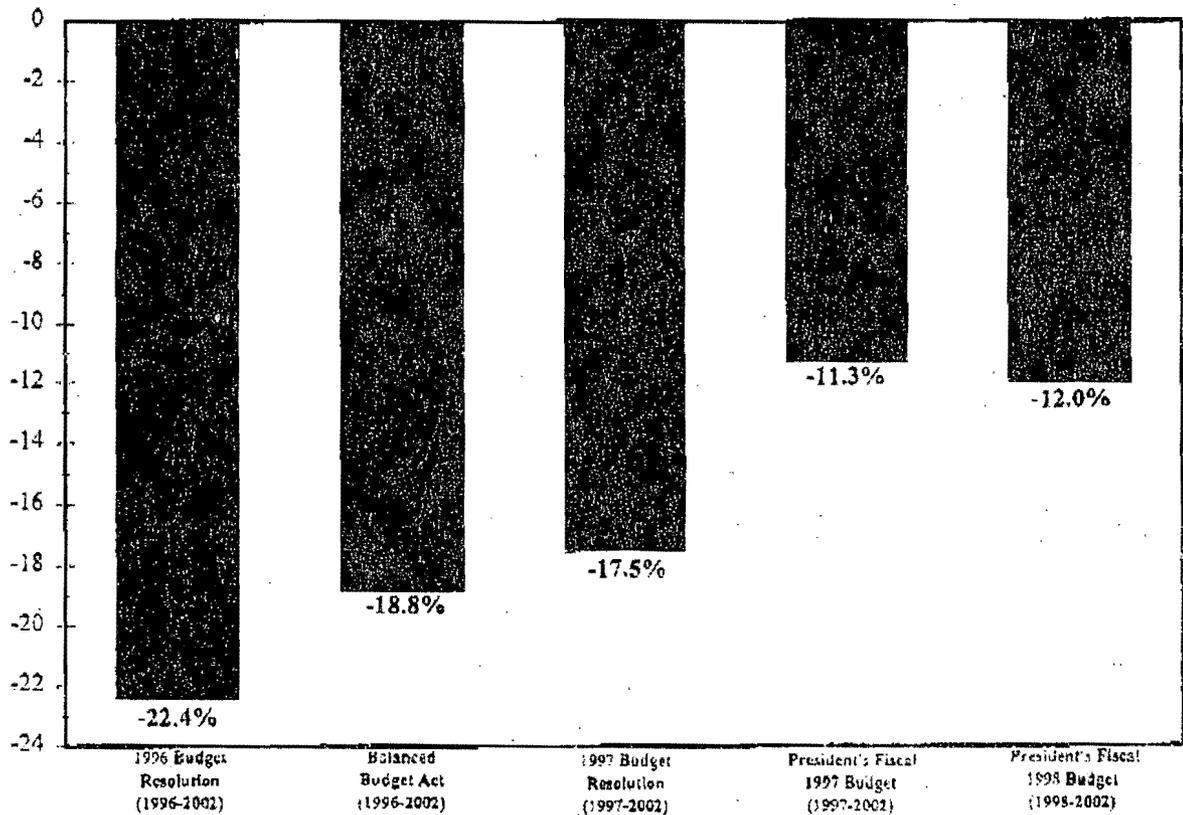


CHART 3

Distribution of Medicare Expenditures per Beneficiary

1996 (\$4,753 mean)

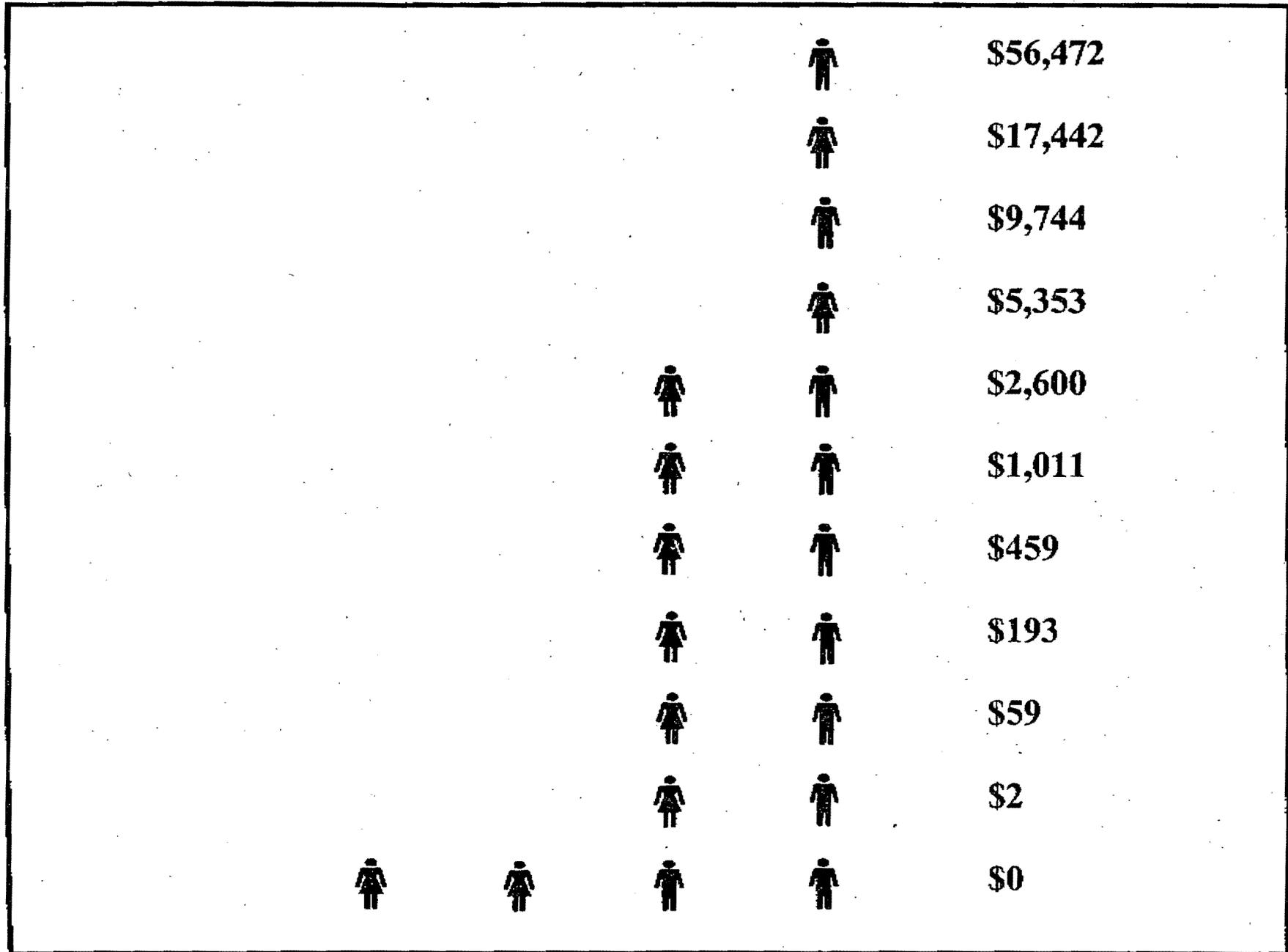
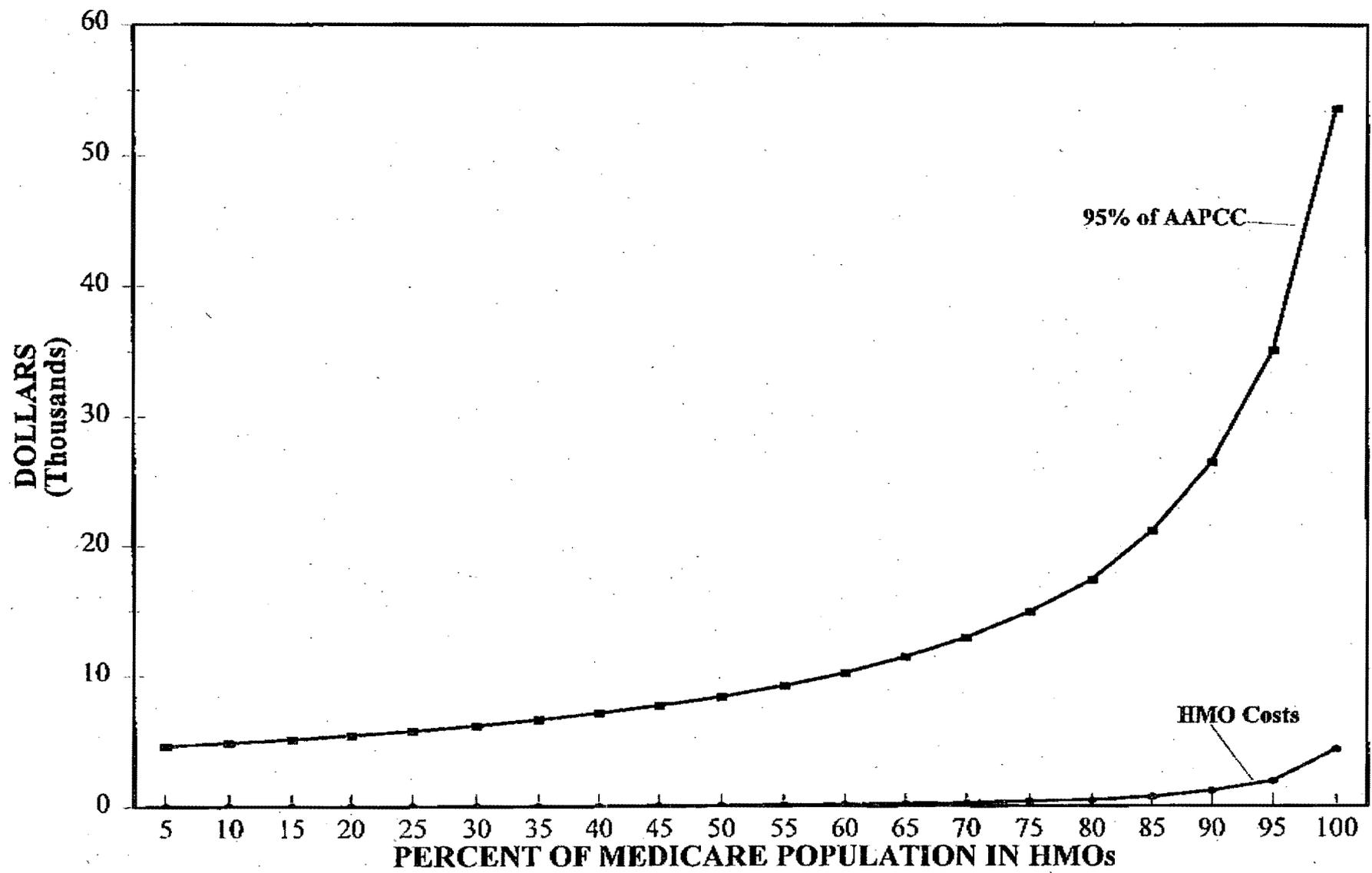


CHART 4

Extreme Illustration of HMO Revenues and Costs per Beneficiary as HMO Participation Increases



• Assumes that the beneficiaries with the lowest health expenditures join HMOs first.

This letter was sent to all Senators and Representatives of the US Congress

AMERICA'S HOSPITALS AND HEALTH SYSTEMS

November 17, 1995

Dear:

The undersigned national, state and metropolitan organizations, representing more than 5,000 hospitals and health systems nationwide, cannot support the conference report on H.R. 2491, the budget reconciliation bill. Our reason is straightforward: as it stands, this legislation, viewed in its entirety, is not in the best interest of patients, communities and the men and women who care for them.

Hospitals and health systems support the stated goals of the conference report -- a balanced budget, a strengthened Medicare trust fund and restructured, more efficient Medicare and Medicaid programs. In fact, we have offered several concrete and reasonable alternatives to achieve these goals without significantly reducing the quality or availability of patient care. For the most part, these alternatives were rejected.

In this long budget debate, America's hospitals and health systems have been guided by principles based on ensuring good patient care now and in the future:

- The health care protection for our nation's most vulnerable populations -- the elderly, the poor, the disabled and millions of children -- is inadequate.
- The tools which could enable hospitals and health systems to continue to provide high quality care to beneficiaries in the new Medicare marketplace are insufficient. The necessary tools were included in the House-passed Medicare Preservation Act, but were significantly diluted during the conference process.
- We have consistently stated that the budget reductions in Medicaid and Medicare remain too deep and happen too fast. Hospitals and health systems are willing to shoulder a fair share of the reductions needed for a balanced budget. But the reductions in the conference report will jeopardize the ability of hospitals and health systems to deliver quality care, not just to those who rely on Medicare and Medicaid, but to all Americans.

Although we cannot support the conference report, we stand ready to work with Congress and the Administration on a fair approach to reducing spending, balancing the budget and protecting the availability and quality of patient care.

Sincerely,
(see attached)

Alabama Hospital Association	Metropolitan Hospital Association of New Orleans	North Dakota Hospital Association
American Hospital Association	Maine Hospital Association	Ohio Hospital Association
AmHS/Premier	The Maryland Hospital Association	Akron Regional Hospital Association
Arizona Hospital and Healthcare Association	Massachusetts Hospital Association	Greater Cleveland Hospital Association
Arkansas Hospital Association	Michigan Health and Hospital Association	Hospital Association of Central Ohio
California Association of Hospitals and Health Systems	Greater Flint Area Hospital Assembly	Oklahoma Hospital Association
Healthcare Association of Southern California	Hospital Council of East Central Michigan	Greater Oklahoma City Hospital Council
Hospital Council of Northern and Central California	North Central Council of the Michigan Health and Hospital Association	Oregon Association of Hospitals and Health Systems
Hospital Council of San Diego and Imperial Counties	South Central Michigan Hospital Council	American Osteopathic Healthcare Association
Catholic Health Association	Southeast Michigan Hospital Council	The Hospital Association of Pennsylvania
Colorado Hospital Association	Southwestern Michigan Hospital Council	The Delaware Valley Hospital Council
Connecticut Hospital Association	Minnesota Hospital and Healthcare Partnership	Hospital Council of Western Pennsylvania
Association of Delaware Hospitals	Mississippi Hospital Association	South Carolina Hospital Association
District of Columbia Hospital Association	Missouri Hospital Association	South Dakota Hospital Association
Florida Hospital Association	Kansas City Area Hospital Association	SunHealth
South Florida Hospital Association	Montana Hospital Association	Tennessee Hospital Association
Tampa Bay Hospital Association	National Association of Public Hospitals	Texas Hospital Association
Georgia Hospital Association	Nebraska Association of Hospitals and Health Systems	Greater Houston Hospital Council
Healthcare Association of Hawaii	New Hampshire Hospital Association	Greater San Antonio Hospital Council
Idaho Hospital Association	New Jersey Hospital Association	Utah Association of Healthcare Providers
Illinois Hospital and Health Systems Association	New Mexico Hospitals and Health Systems Association	Vermont Hospital Association
Metropolitan Chicago Healthcare Council	Hospital Association of New York State	Virginia Hospital and Healthcare Association
Indiana Hospital Association	Nassau-Suffolk Hospital Council	VHA Inc.
InterHealth	Northeastern New York Hospital Council	Volunteer Trustees of Not-for-Profit Hospitals
Kansas Hospital Association	Northern Metropolitan Hospital Association	Washington State Hospital Association
Kentucky Hospital Association	Rochester Regional Hospital Association	West Virginia Hospital Association
Louisiana Hospital Association	Western New York Healthcare Association	Wisconsin Hospital Association
	North Carolina Hospital Association	Hospital Council of Greater Milwaukee
		Wyoming Hospital Association

American Hospital Association



Advocacy Action Plan

Liberty Place
121 Seventh Street, N.W.
Washington, DC 20004-2802
Telephone 202.638.1100

An advocacy strategy to help hospitals
serve their communities.

November 16, 1995

To: Allied Association Chief Executive Officers
Allied Association Government Relations Officers
Healthcare System Government Relations Officers

From: Rick Pollack, Executive Vice President
Federal Relations

Subject: Opposition to Budget Reconciliation Conference Report/
Post Veto Strategy

ISSUE

House and Senate conferees have agreed on a balanced budget reconciliation conference report. The House is likely to consider the measure as early as Friday, November 17 and the Senate as soon as Saturday.

It is anticipated that President Clinton will veto this budget reconciliation package when it reaches his desk. Negotiations between the congressional leadership and the president will likely follow.

Despite the best efforts of allied associations and hospitals and health systems, this conference report falls short of our requirements in a number of its provisions:

- ✓ The conference significantly compromised the House-passed provider sponsored organization (PSO) language, which the AHA had supported.
- ✓ The conference report dropped important medical malpractice reforms that were included in the House bill.
- ✓ The agreement significantly weakened Medicaid coverage for the disabled, allowing states to determine how the disabled are to be defined.
- ✓ The "Failsafe" provision remains in the bill and is effectively a permanent capped entitlement for Medicare.

CAPPING THE "FAILSAFE" BUDGET MECHANISM

Amendment:

To provide that the maximum aggregate reduction in fee-for-service expenditures under the "failsafe" budget mechanism may not exceed the \$36.6 billion needed to achieve the \$270 billion budget target.

Rationale:

- o This amendment would guarantee that the \$270 billion in savings required by the budget resolution are completely achieved while limiting providers' liability for further budget reductions.
- o Hospitals already are targeted for \$78 billion in traditional Medicare spending reductions, and could absorb the lion's share of the \$36.6 billion estimated by CBO to be needed and sequestered through a "failsafe" or "lookback" budget mechanism.
- o The "failsafe" or "lookback" mechanism was originally crafted as a means of assuring scorable savings reasonably expected to be achieved through increased use of managed care.
- o Without limiting the annual dollar amount that can be taken from providers through a "failsafe" budget mechanism, additional reductions could be made in hospital payments for reasons beyond hospitals' control:
 - General inflation, while at an all-time low, could speed up again causing budget targets to be exceeded.
 - Any errors or underestimates in CBO scoring of the reconciliation bill would cause budget targets to be exceeded.
 - CBO current projections expect a slowdown in nursing home and home health spending. If they are wrong, budget targets could be exceeded.
- o Without a cap, providers are held liable and could be exposed to unlimited amounts of additional payment reductions.