

Dec. 16 / Administration of Ronald Reagan, 1981

National Commission on Social Security Reform

*Executive Order 12335.
December 16, 1981*

By the authority vested in me as President by the Constitution of the United States of America, and to establish, in accordance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. App. 1), the National Commission on Social Security Reform, it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the National Commission on Social Security Reform. The Commission shall be composed of fifteen members appointed or designated by the President and selected as follows:

(1) Five members selected by the President from among officers or employees of the Executive Branch, private citizens of the United States, or both. Not more than three of the members selected by the President shall be members of the same political party;

(2) Five members selected by the Majority Leader of the Senate from among members of the Senate, private citizens of the United States, or both. Not more than three of the members selected by the Majority Leader shall be members of the same political party;

(3) Five members selected by the Speaker of the House of Representatives from among members of the House, private citizens of the United States, or both. Not more than three of the members selected by the Speaker shall be members of the same political party.

(b) The President shall designate a Chairman from among the members of the Commission.

Sec. 2. Functions. (a) The Commission shall review relevant analyses of the current and long-term financial condition of the Social Security trust funds; identify problems that may threaten the long-term solvency of such funds; analyze potential solutions to such problems that will both assure the financial integrity of the Social Security System and the provision of appropriate benefits; and provide appropriate recommendations to the Secretary of Health and

Human Services, the President, and the Congress.

(b) The Commission shall make its report to the President by December 31, 1982.

Sec. 3. Administration. (a) The heads of Executive agencies shall, to the extent permitted by law, provide the Commission such information as it may require for the purpose of carrying out its functions.

(b) Members of the Commission shall serve without any additional compensation for their work on the Commission. However, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the government service (5 U.S.C. 5701-5707), to the extent funds are available therefor.

(c) The Commission shall have a staff headed by an Executive Director. Any expenses of the Commission shall be paid from such funds as may be available to the Secretary of Health and Human Services.

Sec. 4. General. (a) Notwithstanding any other Executive Order, the responsibilities of the President under the Federal Advisory Committee Act, as amended, except that of reporting annually to the Congress, which are applicable to the Commission, shall be performed by the Secretary of Health and Human Services in accordance with the guidelines and procedures established by the Administrator of General Services.

(b) The Commission shall terminate thirty days after submitting its report.

Ronald Reagan

The White House,
December 16, 1981.

[Filed with the Office of the Federal Register, 2:22 p.m., December 16, 1981]

National Commission on Social Security Reform

*Appointment of the Membership.
December 16, 1981*

The President today announced his intention to appoint/designate the following indi-

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viduals to serve on a 15-member bipartisan National Commission on Social Security Reform. Alan Greenspan will serve as Chairman.

Establishment of the Commission fulfills a pledge made by the President in September to create a bipartisan task force to work with the President and Congress to reach two specific goals:

- To propose realistic, long-term reforms to put social security back on a sound financial footing, and
- To forge a working, bipartisan consensus so that the necessary reforms can be passed into law.

Robert A. Beck, chairman of the board and chief executive officer, Prudential Insurance Co. of America, Newark, N.J. He is a member of the President's Export Council.

Mary Falcey Fuller, vice president, finance, Shaklee Corp., San Francisco, Calif. Previously she was senior vice president and director, Blyth Eastman Dillon & Co., Inc., New York, N.Y.

Alan Greenspan, chairman and president, Townsend-Greenspan and Co., Inc., New York, N.Y. He is a member of the President's Economic Policy Advisory Board.

Alexander B. Trowbridge, president, National Association of Manufacturers, Washington, D.C. He is a member of the President's Task Force on Private Sector Initiatives.

Joe D. Waggoner, Jr., consultant, Bossier Bank & Trust Co., Plain Dealing, La. He represented the Fourth Congressional District of Louisiana during the 87th to 95th Congresses.

Senate Majority Leader Howard Baker, in consultation with Senate Minority Leader Robert Byrd, selected the following individuals to serve on the Commission:

William Armstrong, United States Senate (R-Colo.), chairman of the Subcommittee on Social Security of the Senate Finance Committee.

Robert Dole, United States Senate (R-Kans.), chairman of the Senate Finance Committee.

John Heinz, United States Senate (R-Pa.), chairman of the Senate Special Committee on Aging.

Lane Kirkland, president of the American Federation of Labor-Congress of Industrial Organizations.

Daniel Patrick Moynihan, United States Senate (D-N.Y.), ranking minority member of the Subcommittee on Social Security of the Senate Finance Committee.

House Speaker Thomas P. O'Neill, in consultation with House Minority Leader Robert Michel, selected the following individuals to serve on the Commission:

William Archer, United States House of Representatives (R-Tex.), ranking minority member of the Subcommittee on Social Security, House Ways and Means Committee.

Robert M. Ball, was Commissioner of Social Security in 1962-73. He is senior scholar, Institute of Medicine, National Academy of Sciences.

Barber Conable, United States House of Representatives (R-N.Y.), ranking minority member, House Ways and Means Committee.

Martha E. Keys, former Assistant Secretary of Health and Human Services. She served in the 94th and 95th Congresses.

Claude D. Pepper, United States House of Representatives (D-Fla.), chairman, House Select Committee on Aging.

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the wing's first Air Force inspection in July, 1996, the first ever for a composite wing and the largest in Air Force history; and

"Whereas, the opening of a training range near Mountain Home Air Force Base is essential to maintain the readiness and strike force capabilities of this unique military asset;

Now, therefore, be it "Resolved, by the members of the Second Regular Session of the Fifty-third Idaho Legislature, the House of Representatives and the Senate concurring therein. That we urge the Congress of the United States to pass necessary legislation to establish and fund the training range at the Mountain Home Air Force Base, Idaho.

"Be it further resolved, That the Chief Clerk of the House of Representatives be, and she is hereby authorized and directed to forward a copy of this Memorial to the President of the Senate and the Speaker of the House of Representatives of Congress, and the congressional delegation representing the State of Idaho in the Congress of the United States."

POM-579. A joint resolution adopted by the Legislature of the State of Alaska; to the Committee on Commerce, Science, and Transportation.

"RESOLVE NO. 39

"Whereas more fish were discarded in the federally managed fisheries of the North Pacific Ocean than were landed by American fishermen in the North Atlantic Ocean in 1992; and

"Whereas, in 1994, 25,881,596 kilograms of halibut and 1,866,372 kilograms of herring were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 15,469,253 crab were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 195,609 salmon were harvested in groundfish fisheries of the North Pacific Ocean and the Bering Sea; and

"Whereas these discarded herring, crab, and salmon are resources managed by the State of Alaska that were intercepted in offshore federal waters; and

"Whereas these resources are the economic and cultural lifeblood for many Alaskans who depend on the sea for their livelihoods and subsistence; and

"Whereas marine wildlife species in Alaska marine waters that depend on fish for food are faced with declining populations and a potential loss of endangered species; and

"Whereas the continued wanton waste undermines and long-term management strategy for sustainable commercial, subsistence, and recreational fisheries, and places the rural communities of Alaska at risk; and

"Whereas it is necessary to implement severe penalties against vessels responsible for high bycatch and discard rates have failed; and

"Whereas minimizing the catch of undersized fish and reducing wanton waste will conserve fisheries resources for present and future generations of subsistence users, commercial and recreational fishermen, seafood industries, coastal communities, consumers, and the nation; and

"Whereas fisheries can technically or operationally reduce waste and the incidental taking of nontarget species if given economic incentives or if appropriate regulatory measures are applied; be it

"Resolved, by the Alaska State Legislature That the wanton waste now occurring in federal fisheries of the North Pacific Ocean and the Bering Sea is of utmost ecological, social, and economical importance; and be it

"Further resolved, That the Alaska State Legislature respectfully urges the Congress to amend the Magnuson Fishery Conserva-

tion and Management Act, or to enact other legislation, encompassing a broad range of measures to reduce wanton waste in North Pacific Ocean and Bering Sea fisheries, including harvest priority incentives for clean fishing practices and other management tools."

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. SPECTER, from the Select Committee on Intelligence, with amendments:

S. 1745. An original bill to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes (Rept. No. 104-278).

By Mr. STEVENS, from the Committee on Governmental Affairs, without amendment:

S. 1488. A bill to convert certain excepted service positions in the United States Fire Administration to competitive service positions, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

By Mr. GRAHAM (for himself, Mr. BAUCUS, and Mr. FRYOR):

S. 1858. A bill to provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse; to the Committee on Finance.

By Mr. GRAHAM (for himself and Mr. BAUCUS):

S. 1859. A bill to create a point of order against legislation which diverts savings achieved through medicare waste, fraud, and abuse enforcement activities for purposes other than improving the solvency of the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act, to ensure the integrity of such trust fund, and for other purposes; to the Committee on Rules and Administration.

By Mr. McCONNELL (for himself, Mr. DOLE, Mr. MOYNIHAN, and Mr. LIEBERMAN):

S. 1860. A bill to provide for legal reform and consumer compensation relating to motor vehicle tort systems; and for other purposes; to the Committee on Commerce, Science, and Transportation.

S. 1861. A bill to provide for legal reform and consumer compensation; and for other purposes; to the Committee on the Judiciary.

By Mr. PRESSLER (for himself and Mr. HATCH):

S. 1862. A bill to permit the interstate distribution of state-inspected meat under ap-

propriate circumstances; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DASCHLE:

S. 1863. A bill to require the Secretary of the Army to acquire permanent flowage and saturation easements over land that is located within the 10-year floodplain of the James River, South Dakota, and for other purposes; to the Committee on Environment and Public Works.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. NICKLES (for himself, Mr. DASCHLE, Mr. LOTT, Mr. FORD, Mr. TEURMOND, Mrs. KASSEBAUM, Mr. ABRAHAM, Mr. AKAKA, Mr. ASHCROFT, Mr. BAUCUS, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BRADLEY, Mr. BREAUX, Mr. BROWN, Mr. BRYAN, Mr. BUMPERS, Mr. BURNS, Mr. BYRD, Mr. CAMPBELL, Mr. CHAFFEE, Mr. COATS, Mr. COCHRAN, Mr. COHEN, Mr. CONRAD, Mr. COVERDELL, Mr. CRAIG, Mr. D'AMATO, Mr. DEWINE, Mr. DODD, Mr. DOMENICI, Mr. DORGAN, Mr. EXON, Mr. FAIRCLOTH, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRIST, Mr. GLENN, Mr. GORTON, Mr. GRAHAM, Mr. GRAMM, Mr. GRAMS, Mr. GRASSLEY, Mr. GREGG, Mr. HARKIN, Mr. HATCH, Mr. HATFIELD, Mr. HEFLIN, Mr. HELMS, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUE, Mr. JEFFORDS, Mr. JOHNSTON, Mr. KEMPTHORNE, Mr. KENNEDY, Mr. KERREY, Mr. KERRY, Mr. KOEL, Mr. KYL, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mr. LUGAR, Mr. MACK, Mr. MCCAIN, Mr. McCONNELL, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mr. MOYNIHAN, Mr. MURKOWSKI, Mrs. MURRAY, Mr. NUNN, Mr. PELL, Mr. PRESSLER, Mr. PRYOR, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. ROTH, Mr. SANTORUM, Mr. SARBANES, Mr. SHELBY, Mr. SMON, Mr. SIMPSON, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Mr. STEVENS, Mr. THOMAS, Mr. THOMPSON, Mr. WARNER, Mr. WELLSTONE, and Mr. WYDEN):

S. Res. 258. A resolution to designate the balcony adjacent to rooms S-230 and S-231 of the United States Capitol Building as the "Robert J. Dole Balcony"; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

THE MEDICARE RESTORATION ACT

Mr. DOLE, Mr. President, last Wednesday the Medicare trustees released their report on the state of the Medicare trust fund, and the report was grim. Instead of going bankrupt in 2002, as they previously forecasted, the

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trustees conclude that Medicare will go bankrupt in 2001—just 5 years from now.

For the past year and a half, this Republican Congress has attempted to deal honestly and forthrightly with the impending Medicare meltdown.

We put forward a budget that would protect, preserve, and strengthen Medicare by reducing its unsustainable rate of growth, while still allowing for a healthy growth rate.

We did not claim that our plan was perfect or that it solved the long-term problem. But it was a real attempt to alleviate a crisis that will immediately impact 37 million seniors and disabled Americans, and will have repercussions on tens of millions more.

In May 1995, I called for a bipartisan Commission to be set up to save Medicare similar to the one that saved Social Security. Unfortunately the White House dismissed the idea and decided to attack Republican plans to save the Medicare system.

That is why I rise today to introduce the Medicare Restoration Act to establish a blue-ribbon bipartisan advisory commission to help deal with this crisis.

In my view, leadership means more than just talking about problems. It also means doing something to solve them.

This Commission will be responsible for reviewing the current, short-term and long-term condition of the Medicare Trust funds. The Commission will be composed of 15 members appointed by the President, Senate, and House of Representatives. The members of this commission will be from both political parties, because it is clear to me that if we are to be successful we must put politics aside and work on a bipartisan basis.

Unfortunately, President Clinton has been unwilling to do that.

In February 1995, President Clinton submitted a budget that contained no provisions for saving Medicare.

In April 1995, the Medicare trustees—three of whom are members of his administration—issued their original report and urged "prompt, effective and decisive action." The administration instead chose to attack Republican plans to save the system.

Last March, the President submitted a budget which, according to the Congressional Budget Office, would only delay off Medicare's bankruptcy for one more year.

It is an undeniable fact that the Republican proposal allowed Medicare spending per beneficiary to increase from \$4,800 per person to \$7,200 per person over 7 years.

It is also an undeniable fact that in their ill-fated health care reform proposal the Clinton administration advocated allowing Medicare's rate of growth.

Despite these facts, however, the President vetoed our Medicare program, and we have heard nothing but attacks on Republicans for slashing and cutting Medicare.

And when the President was asked, not long ago at a news conference, why he continued to use these terms even though they are not true, his response was essentially that the media made him do it.

With the release of the trustee's report, the inescapable conclusion is that while the rhetoric flew, Medicare was put at further risk.

And those who say that talk is cheap should know that 18 months of misleading rhetoric may have gained one side points in the opinion polls, it also put Medicare another \$90-billion-plus in the red.

The bottom line is that the 37 million Americans who depend on Medicare deserve better. Future generations of Americans who will need Medicare deserve better.

I call on the President to come forward and support this bipartisan commission so we can preserve the Medicare Program and to join with Republicans on a bipartisan basis, as I have proposed before, to address this very serious problem.

I send the bill to the desk and ask it be appropriately referred. It is cosponsored by Senators ROTH, SIMPSON, PRESSLER, HATCH, CHAFFE, and MURKOWSKI, who are on the Senate Finance Committee. I certainly welcome additional cosponsors on either side of the aisle. This will be a bipartisan commission.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1856

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Restoration Act of 1996."

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the National Commission on Medicare Reform (referred to in this Act as the "Commission").

SEC. 3. FINDINGS.

The Congress finds that—

(1) the Medicare program under title XVIII of the Social Security Act provides essential health care insurance to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund will be bankrupt in the year 2001, and faces even greater solvency problems in the long-run with the aging of the baby boom generation;

(3) the trustees of the trust funds of the Medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund is unsustainable; and

(4) expeditious action is needed in order to restore the fiscal health of the Medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

SEC. 4. DUTIES OF THE COMMISSION.

The Commission shall—

(1) review relevant analyses of the current, short-term, and long-term financial condition of the Federal Hospital Insurance Trust

Fund and the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act;

(2) identify problems that threaten the solvency of such trust funds;

(3) analyze potential solutions to such problems that will both assure the financial integrity of the Medicare program under such title and the provision of appropriate benefits under such program;

(4) make recommendations to restore the short-range and long-range solvency of the Federal Hospital Insurance Trust Fund, to provide for sustainable growth of the Supplementary Medical Insurance Trust Fund, and on related matters as the Commission deems appropriate; and

(5) review and analyze such other matters as the Commission deems appropriate.

SEC. 5. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(1) five shall be appointed by the President, of whom not more than 3 shall be of the same political party;

(2) five shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 3 shall be of the same political party; and

(3) five shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 3 shall be of the same political party.

(b) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with section 4.

(c) TERM OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(d) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(e) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(f) CHAIRPERSON AND VICE CHAIRPERSON.—Not later than 15 days after all the members of the Commission are appointed, such members shall designate a Chairperson and Vice Chairperson from among the members of the Commission.

(g) VACANCIES.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(h) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(i) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 6. STAFF AND SUPPORT SERVICES.

(a) DIRECTOR.—

(1) APPOINTMENT.—Upon consultation with the members of the Commission, the Chairperson shall appoint a Director of the Commission.

(2) COMPENSATION.—The Director shall be paid the rate of basic pay for level V of the Executive Schedule.

(b) STAFF.—With the approval of the Commission, the Director may appoint such personnel as the Director considers appropriate.

(c) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of

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title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) **EXPERTS AND CONSULTANTS.**—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) **STAFF OF FEDERAL AGENCIES.**—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(f) **OTHER RESOURCES.**—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(g) **PHYSICAL FACILITIES.**—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

SEC. 7. POWERS OF COMMISSION.

(a) **HEARINGS.**—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(b) **DELEGATION OF AUTHORITY.**—Any member or agent of the Commission may, if authorized by the Commission, take any action the Commission is authorized to take by this section.

(c) **GIFTS, REQUESTS, AND DEVICES.**—The Commission may accept, use, and dispose of gifts, bequests, or devices of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devices of money and proceeds from sales of other property received as gifts, bequests, or devices shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission.

(d) **MAILS.**—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

SEC. 8. REPORTS.

Not later than June 30, 1997, the Commission shall submit a report to the President and to the Congress on the findings and conclusions of the Commission.

SEC. 9. TERMINATION.

The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to the Congress under section 8.

SEC. 10. FUNDING.

The Secretary of Health and Human Services shall provide to the Commission, out of funds otherwise available to such Secretary, such sums as are necessary to carry out the purposes of the Commission.

Mr. ROTH. Mr. President, I rise as a cosponsor of legislation introduced by the majority leader to establish a National Commission on Medicare Reform.

According to the Medicare trustees' report released last Wednesday, June 5, the Medicare hospital insurance trust

fund will be bankrupt earlier than expected. In fact, the trustees, of which three of the six trustees are members of President Clinton's Cabinet, indicate that the trust fund may run out of money as early as calendar year 2000.

Senator DOLE's proposal is consistent with the recommendations of the Medicare trustees. The trustees recommend:

*** the establishment of a national advisory group to examine the Medicare Program. The advisory group would collect and disseminate information and help develop recommendations for effective solutions to the long-term financing problem. This work will be of critical importance to the administration, the Congress and the American public in the extensive national discussion that any changes would require.

We are now 2 years closer to insolvency of the Medicare trust fund than we were at this time last year. We lost a year trying to address the problem, and the program is 1 more year closer to bankruptcy than we expected. Yet, I regret, we are miles away from reaching an agreement on a solution.

Given the very short time that Medicare will remain solvent, and given the large number of baby boomers who will be joining the Medicare Program in just a few years, we cannot afford more delay. It is time to put politics aside and find a solution.

What is happening to the Medicare trust fund is pretty basic. The program is paying out more than it is taking in. This simple dynamic, if left unchecked, will lead Medicare to bankruptcy in less than 5 years. And, simply put, bankruptcy of the trust fund means there will not be money to pay the hospital bills of our senior citizens and disabled individuals reliant on Medicare.

Again, I believe it is time to put politics aside. A Medicare Reform Commission is an important step in the right direction to bringing together a bipartisan, lasting agreement on resolving Medicare's fiscal crisis.

The 1983 National Commission on Social Security Reform was an essential catalyst to resolving the then-looming bankruptcy of Social Security. The 1983 Commission brought together people in a cooperative bipartisan spirit. Ultimately, the work of the Commission laid the ground for a solution to the solvency crisis. I believe a Medicare Reform Commission might be able to do the same today.

We are facing a crisis. A crisis requires action. We cannot be a government of empty promises. We must restore Medicare to robust health for our children and our grandchildren.

By Mr. DOLE:

S. 1657. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration, to the Committee on Rules and Administration.

THE BIPARTISAN CAMPAIGN PRACTICES COMMISSION ACT OF 1996

Mr. DOLE. Mr. President, as I prepare to leave an institution in which I

have served for over 35 years, I am mindful that in many ways the public has lost confidence in the ability of legislators to represent their interests, not special interests.

We should not allow this to continue. Representative Democracy, founded on fair and competitive elections, is at the core of what makes America great. Yet, concern over how we finance elections threatens to erode the trust the American people have in our elected officials.

As my colleagues know, Congress has tried repeatedly to grapple with this issue and largely failed. However, I continue to believe that the very nature of the problem makes it difficult to resolve in the normal give and take of the legislative process.

In 1990, for example, Senator Mitchell and I appointed a six-member commission of outside experts to look at this issue and report back to us, but the report was unfortunately ignored by Congress.

I suggested in 1994 and repeatedly since then that a similar commission be constituted to report back to Congress, but with an important difference. This time, the report should be in the form of recommended legislative language which provides a solution and Congress should have an opportunity for an up and down vote.

As my colleagues know, both President Clinton and Speaker Gingrich endorsed a similar concept last year when they met in New Hampshire.

I therefore send to the desk a bill that establishes an eight-member commission of outside experts. They would have the broadest possible mandate to think through this problem, come up with solutions and report back to Congress not more than 30 days after the convening of the 105th Congress.

The commission will send Congress legislative language for those recommendations on which seven members agree. Congress will consider those recommendations under expedited procedures that mirror the fast-track authorities in our trade laws.

I know my colleagues will be grappling with this issue soon. However, I believe that it would be better to take this issue out of what is already a super-heated partisan atmosphere, and allow a bipartisan approach to be developed that Congress cannot ignore.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1657

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Bipartisan Campaign Practices Commission Act of 1996".

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the "Bipartisan Commission on



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 6

Date: 11/4/96

To:	From:
<u>Chris</u>	<u>Debbie</u>
Fax: <u>456-5542</u>	Fax: <u>202 690-8168</u>
Phone: _____	Phone: _____

REMARKS: Medicare Trust Fund Commission File

HEALTH CARE FINANCING ADMINISTRATION
 200 Independence Ave., SW
 Room 341-H, Humphrey Building
 Washington, DC 20201

Dec. 16 / Administration of Ronald Reagan, 1981

National Commission on Social Security Reform

*Executive Order 12335.
December 16, 1981*

By the authority vested in me as President by the Constitution of the United States of America, and to establish, in accordance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. App. I), the National Commission on Social Security Reform, it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the National Commission on Social Security Reform. The Commission shall be composed of fifteen members appointed or designated by the President and selected as follows:

(1) Five members selected by the President from among officers or employees of the Executive Branch, private citizens of the United States, or both. Not more than three of the members selected by the President shall be members of the same political party;

(2) Five members selected by the Majority Leader of the Senate from among members of the Senate, private citizens of the United States, or both. Not more than three of the members selected by the Majority Leader shall be members of the same political party;

(3) Five members selected by the Speaker of the House of Representatives from among members of the House, private citizens of the United States, or both. Not more than three of the members selected by the Speaker shall be members of the same political party.

(b) The President shall designate a Chairman from among the members of the Commission.

Sec. 2. Functions. (a) The Commission shall review relevant analyses of the current and long-term financial condition of the Social Security trust funds; identify problems that may threaten the long-term solvency of such funds; analyze potential solutions to such problems that will both assure the financial integrity of the Social Security System and the provision of appropriate benefits; and provide appropriate recommendations to the Secretary of Health and

Human Services, the President, and the Congress.

(b) The Commission shall make its report to the President by December 31, 1982.

Sec. 3. Administration. (a) The heads of Executive agencies shall, to the extent permitted by law, provide the Commission such information as it may require for the purpose of carrying out its functions.

(b) Members of the Commission shall serve without any additional compensation for their work on the Commission. However, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the government service (5 U.S.C. 5701-5707), to the extent funds are available therefor.

(c) The Commission shall have a staff headed by an Executive Director. Any expenses of the Commission shall be paid from such funds as may be available to the Secretary of Health and Human Services.

Sec. 4. General. (a) Notwithstanding any other Executive Order, the responsibilities of the President under the Federal Advisory Committee Act, as amended, except that of reporting annually to the Congress, which are applicable to the Commission, shall be performed by the Secretary of Health and Human Services in accordance with the guidelines and procedures established by the Administrator of General Services.

(b) The Commission shall terminate thirty days after submitting its report.

Ronald Reagan

The White House,
December 16, 1981.

[Filed with the Office of the Federal Register, 2:22 p.m., December 16, 1981]

National Commission on Social Security Reform

*Appointment of the Membership.
December 16, 1981*

The President today announced his intention to appoint/designate the following indi-

viduals to serve on a 15-member bipartisan National Commission on Social Security Reform. Alan Greenspan will serve as Chairman.

Establishment of the Commission fulfills a pledge made by the President in September to create a bipartisan task force to work with the President and Congress to reach two specific goals:

- To propose realistic, long-term reforms to put social security back on a sound financial footing, and
- To forge a working, bipartisan consensus so that the necessary reforms can be passed into law.

Robert A. Beck, chairman of the board and chief executive officer, Prudential Insurance Co. of America, Newark, N.J. He is a member of the President's Export Council.

Mary Falcey Fuller, vice president, finance, Shaklee Corp., San Francisco, Calif. Previously she was senior vice president and director, Blyth Eastman Dillon & Co., Inc., New York, N.Y.

Alan Greenspan, chairman and president, Townsend-Greenspan and Co., Inc., New York, N.Y. He is a member of the President's Economic Policy Advisory Board.

Alexander B. Troubridge, president, National Association of Manufacturers, Washington, D.C. He is a member of the President's Task Force on Private Sector Initiatives.

Joe D. Waggoner, Jr., consultant, Bossier Bank & Trust Co., Plain Dealing, La. He represented the Fourth Congressional District of Louisiana during the 87th to 95th Congresses.

Senate Majority Leader Howard Baker, in consultation with Senate Minority Leader Robert Byrd, selected the following individuals to serve on the Commission:

William Armstrong, United States Senate (R-Colo.), chairman of the Subcommittee on Social Security of the Senate Finance Committee.

Robert Dole, United States Senate (R-Kans.), chairman of the Senate Finance Committee.

John Heinz, United States Senate (R-Pa.), chairman of the Senate Special Committee on Aging.

Lane Kirkland, president of the American Federation of Labor-Congress of Industrial Organizations.

Daniel Patrick Moynihan, United States Senate (D-N.Y.), ranking minority member of the Subcommittee on Social Security of the Senate Finance Committee.

House Speaker Thomas P. O'Neill, in consultation with House Minority Leader Robert Michel, selected the following individuals to serve on the Commission:

William Archer, United States House of Representatives (R-Tex.), ranking minority member of the Subcommittee on Social Security, House Ways and Means Committee.

Robert M. Ball, was Commissioner of Social Security in 1962-73. He is senior scholar, Institute of Medicine, National Academy of Sciences.

Barber Conable, United States House of Representatives (R-N.Y.), ranking minority member, House Ways and Means Committee.

Martha E. Keys, former Assistant Secretary of Health and Human Services. She served in the 94th and 95th Congresses.

Claude D. Pepper, United States House of Representatives (D-Fla.), chairman, House Select Committee on Aging.

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the wing's first Air Force inspection in July, 1995, the first ever for a composite wing and the largest in Air Force history; and

"Whereas, the opening of a training range near Mountain Home Air Force Base is essential to maintain the readiness and strike force capabilities of this unique military asset:

Now, therefore, be it "Resolved, by the members of the Second Regular Session of the Fifty-third Idaho Legislature, the House of Representatives and the Senate concurring therein. That we urge the Congress of the United States to pass necessary legislation to establish and fund the training range at the Mountain Home Air Force Base, Idaho.

"Be it further resolved, That the Chief Clerk of the House of Representatives be, and she is hereby authorized and directed to forward a copy of this Memorial to the President of the Senate and the Speaker of the House of Representatives of Congress, and the congressional delegation representing the State of Idaho in the Congress of the United States."

POM-579. A joint resolution adopted by the Legislature of the State of Alaska; to the Committee on Commerce, Science, and Transportation.

"RESOLVE No. 39

"Whereas more fish were discarded in the federally managed fisheries of the North Pacific Ocean than were landed by American fishermen in the North Atlantic Ocean in 1992; and

"Whereas, in 1994, 25,891,596 kilograms of halibut and 1,866,272 kilograms of herring were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 15,459,253 crab were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 195,609 salmon were harvested in groundfish fisheries of the North Pacific Ocean and the Bering Sea; and

"Whereas these discarded herring, crab, and salmon are resources managed by the State of Alaska that were intercepted in offshore federal waters; and

"Whereas these resources are the economic and cultural lifeblood for many Alaskans who depend on the sea for their livelihoods and subsistence; and

"Whereas marine wildlife species in Alaska marine waters that depend on fish for food are faced with declining populations and a potential for becoming endangered species; and

"Whereas continued wanton waste undermines and hampers management strategy for sustaining commercial, subsistence, and recreational fisheries, and places the rural communities of Alaska at risk; and

"Whereas efforts to implement severe penalties against vessels responsible for high bycatch and discard rates have failed; and

"Whereas maximizing the catch of undersized fish and reducing wanton waste will conserve fisheries resources for present and future generations of subsistence users, commercial and recreational fishermen, seafood industries, coastal communities, consumers, and the nation; and

"Whereas fisheries can technically or operationally reduce waste and the incidental taking of nontarget species if given economic incentives or if appropriate regulatory measures are applied; be it

"Resolved, by the Alaska State Legislature That the wanton waste now occurring in federal fisheries of the North Pacific Ocean and the Bering Sea is of utmost ecological, social, and economical importance; and be it

"Further resolved, That the Alaska State Legislature respectfully urges the Congress to amend the Magnuson Fishery Conserva-

tion and Management Act, or to enact other legislation, encompassing a broad range of measures to reduce wanton waste in North Pacific Ocean and Bering Sea fisheries, including harvest priority incentives for clean fishing practices and other management tools."

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. SPECTER, from the Select Committee on Intelligence, with amendments:

S. 1745. An original bill to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes (Rept. No. 104-278).

By Mr. STEVENS, from the Committee on Governmental Affairs, without amendment:

S. 1488. A bill to convert certain excepted service positions in the United States Fire Administration to competitive service positions, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred, as indicated:

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

By Mr. GRAHAM (for himself, Mr. BAUCUS, and Mr. PRYOR):

S. 1858. A bill to provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse; to the Committee on Finance.

By Mr. GRAHAM (for himself and Mr. BAUCUS):

S. 1859. A bill to create a point of order against legislation which diverts savings achieved through medicare waste, fraud, and abuse enforcement activities for purposes other than improving the solvency of the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act, to ensure the integrity of such trust fund, and for other purposes; to the Committee on Rules and Administration.

By Mr. MCCONNELL (for himself, Mr. DOLE, Mr. MOYNIHAN, and Mr. LIEBERMAN):

S. 1860. A bill to provide for legal reform and consumer compensation relating to motor vehicle tort systems; and for other purposes; to the Committee on Commerce, Science, and Transportation.

S. 1861. A bill to provide for legal reform and consumer compensation; and for other purposes; to the Committee on the Judiciary.

By Mr. PRESSLER (for himself and Mr. HATCH):

S. 1862. A bill to permit the interstate distribution of state-inspected meat under ap-

propriate circumstances; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DASCHLE:

S. 1863. A bill to require the Secretary of the Army to acquire permanent flowage and saturation easements over land that is located within the 10-year floodplain of the James River, South Dakota, and for other purposes; to the Committee on Environment and Public Works.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. NICKLES (for himself, Mr. DASCHLE, Mr. LOTT, Mr. FORD, Mr. THURMOND, Mrs. KASSEBAUM, Mr. ABRAHAM, Mr. ARAKA, Mr. ASHCROFT, Mr. BAUCUS, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BRADLEY, Mr. BREAUX, Mr. BROWN, Mr. BRYAN, Mr. BUMPERS, Mr. BURNS, Mr. BYRD, Mr. CAMPBELL, Mr. CHAFFE, Mr. COATS, Mr. COCHRAN, Mr. COHEN, Mr. CONRAD, Mr. COVERDELL, Mr. CRAIG, Mr. D'AMATO, Mr. DEWINE, Mr. DODD, Mr. DOMENICI, Mr. DORGAN, Mr. EXON, Mr. FAIRCLOTH, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRIST, Mr. GLENN, Mr. GORTON, Mr. GRAHAM, Mr. GRAMM, Mr. GRAMS, Mr. GRASSLEY, Mr. GREGG, Mr. HARKIN, Mr. HATCH, Mr. HATFIELD, Mr. HEFLIN, Mr. HELMS, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUE, Mr. JEFFORDS, Mr. JOHNSTON, Mr. KEMPTHORNE, Mr. KENNEDY, Mr. KERREY, Mr. KERRY, Mr. KOHL, Mr. KYJE, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mr. LUGAR, Mr. MACK, Mr. MCCAIN, Mr. MCCONNELL, Ms. MIKULSKI, Mr. MOSELEY-BRAUN, Mr. MOYNIHAN, Mr. MURKOWSKI, Mrs. MURRAY, Mr. NUNN, Mr. PELL, Mr. PRESSLER, Mr. PRYOR, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. ROTH, Mr. SANTORUM, Mr. SARBANES, Mr. SHELBY, Mr. SIMON, Mr. SIMPSON, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Mr. STEVENS, Mr. THOMAS, Mr. THOMPSON, Mr. WARNER, Mr. WELLSTONE, and Mr. WYDEN):

S. Res. 258. A resolution to designate the balcony adjacent to rooms S-230 and S-231 of the United States Capitol Building as the "Robert J. Dole Balcony"; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

THE MEDICARE RESTORATION ACT

Mr. DOLE, Mr. President, last Wednesday the Medicare trustees released their report on the state of the Medicare trust fund, and the report was grim. Instead of going bankrupt in 2002, as they previously forecasted, the

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Trustees conclude that Medicare will go bankrupt in 2001—just 5 years from now.

For the past year and a half, this Republican Congress has attempted to deal honestly and forthrightly with the impending Medicare meltdown.

We put forward a budget that would protect, preserve, and strengthen Medicare by reducing its unsustainable rate of growth, while still allowing for a healthy growth rate.

We did not claim that our plan was perfect or that it solved the long-term problem. But it was a real attempt to alleviate a crisis that will immediately impact 37 million seniors and disabled Americans, and will have repercussions on tens of millions more.

In May 1995, I called for a bipartisan Commission to be set up to save Medicare similar to the one that saved Social Security. Unfortunately the White House dismissed the idea and decided to attack Republican plans to save the Medicare system.

That is why I rise today to introduce the Medicare Restoration Act to establish a blue-ribbon bipartisan advisory commission to help deal with this crisis.

In my view, leadership means more than just talking about problems. It also means doing something to solve them.

This Commission will be responsible for reviewing the current, short-term and long-term condition of the Medicare Trust funds. The Commission will be composed of 15 members appointed by the President, Senate, and House of Representatives. The members of this Commission will be from both political parties, because it is clear to me that if we are to be successful we must put politics aside and work on a bipartisan basis.

Unfortunately, President Clinton has been unwilling to do that.

In February 1995, President Clinton submitted a budget that contained no provisions for saving Medicare.

In April 1995, the Medicare trustees—three of whom are members of his administration—issued their original report and urged "prompt, effective and decisive action." The administration instead chose to attack Republican plans to save the system.

Last March, the President submitted a budget which, according to the Congressional Budget Office, would only delay off Medicare's bankruptcy for one more year.

It is an undeniable fact that the Republican proposal allowed Medicare spending per beneficiary to increase from \$4,800 per person to \$7,200 per person over 7 years.

It is also an undeniable fact that in all related health care reform proposals, the Clinton administration advocated allowing Medicare's rate of growth.

Despite these facts, however, the President vetoed our Medicare program, and we have heard nothing but attacks on Republicans for slashing and cutting Medicare.

And when the President was asked, not long ago at a news conference, why he continued to use these terms even though they are not true, his response was essentially that the media made him do it.

With the release of the trustee's report, the inescapable conclusion is that while the rhetoric flew, Medicare was put at further risk.

And those who say that talk is cheap should know that 18 months of misleading rhetoric may have gained one side points in the opinion polls, it also put Medicare another \$90 billion-plus in the red.

The bottom line is that the 37 million Americans who depend on Medicare deserve better. Future generations of Americans who will need Medicare deserve better.

I call on the President to come forward and support this bipartisan commission so we can preserve the Medicare Program and to join with Republicans on a bipartisan basis, as I have proposed before, to address this very serious problem.

I send the bill to the desk and ask it be appropriately referred. It is cosponsored by Senators ROTH, SIMPSON, PRESSLER, HATCH, CHAFFEE, and MURKOWSKI, who are on the Senate Finance Committee. I certainly welcome additional cosponsors on either side of the aisle. This will be a bipartisan commission.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1856

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Restoration Act of 1996".

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the National Commission on Medicare Reform (referred to in this Act as the "Commission").

SEC. 3. FINDINGS.

The Congress finds that—

(1) the Medicare program under title XVIII of the Social Security Act provides essential health care insurance to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund will be bankrupt in the year 2001, and faces even greater solvency problems in the long-run with the aging of the baby boom generation;

(3) the trustees of the trust funds of the Medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund is unsustainable; and

(4) expeditious action is needed in order to restore the fiscal health of the Medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

SEC. 4. DUTIES OF THE COMMISSION.

The Commission shall—

(1) review relevant analyses of the current, short-term, and long-term financial condition of the Federal Hospital Insurance Trust

Fund and the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act;

(2) identify problems that threaten the solvency of such trust funds;

(3) analyze potential solutions to such problems that will both assure the financial integrity of the Medicare program under such title and the provision of appropriate benefits under such program;

(4) make recommendations to restore the short-range and long-range solvency of the Federal Hospital Insurance Trust Fund, to provide for sustainable growth of the Supplementary Medical Insurance Trust Fund, and on related matters as the Commission deems appropriate; and

(5) review and analyze such other matters as the Commission deems appropriate.

SEC. 5. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(1) five shall be appointed by the President, of whom not more than 3 shall be of the same political party;

(2) five shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 3 shall be of the same political party; and

(3) five shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 3 shall be of the same political party.

(b) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with section 4.

(c) TERM OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(d) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(e) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(f) CHAIRPERSON AND VICE CHAIRPERSON.—Not later than 15 days after all the members of the Commission are appointed, such members shall designate a Chairperson and Vice Chairperson from among the members of the Commission.

(g) VACANCY.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(h) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(i) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 6. STAFF AND SUPPORT SERVICES.

(a) DIRECTOR.—

(1) APPOINTMENT.—Upon consultation with the members of the Commission, the Chairperson shall appoint a Director of the Commission.

(2) COMPENSATION.—The Director shall be paid the rate of basic pay for level V of the Executive Schedule.

(b) STAFF.—With the approval of the Commission, the Director may appoint such personnel as the Director considers appropriate.

(c) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of

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title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III, of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(f) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(g) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

SEC. 7. POWERS OF COMMISSION.

(a) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(b) DELEGATION OF AUTHORITY.—Any member or agent of the Commission may, if authorized by the Commission, take any action the Commission is authorized to take by this section.

(c) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission.

(d) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

SEC. 8. REPORTS.

Not later than June 30, 1997, the Commission shall submit a report to the President and to the Congress on the findings and conclusions of the Commission.

SEC. 9. TERMINATION.

The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to the Congress under section 8.

SEC. 10. FUNDING.

The Secretary of Health and Human Services shall provide to the Commission, out of funds otherwise available to such Secretary, such sums as are necessary to carry out the purposes of the Commission.

Mr. ROTH. Mr. President, I rise as a cosponsor of legislation introduced by the majority leader to establish a National Commission on Medicare Reform.

According to the Medicare trustees' report released last Wednesday, June 5, the Medicare hospital insurance trust

fund will be bankrupt earlier than expected. In fact, the trustees, of which three of the six trustees are members of President Clinton's Cabinet, indicate that the trust fund may run out of money as early as calendar year 2000.

Senator DOLE's proposal is consistent with the recommendations of the Medicare trustees. The trustees recommend:

*** the establishment of a national advisory group to examine the Medicare Program. The advisory group would collect and disseminate information and help develop recommendations for effective solutions to the long-term financing problem. This work will be of critical importance to the administration, the Congress and the American public in the extensive national discussion that any changes would require.

We are now 2 years closer to insolvency of the Medicare trust fund than we were at this time last year. We lost a year trying to address the problem, and the program is 1 more year closer to bankruptcy than we expected. Yet, I regret, we are miles away from reaching an agreement on a solution.

Given the very short time that Medicare will remain solvent, and given the large number of baby boomers who will be joining the Medicare Program in just a few years, we cannot afford more delay. It is time to put politics aside and find a solution.

What is happening to the Medicare trust fund is pretty basic. The program is paying out more than it is taking in. This simple dynamic, if left unchecked, will lead Medicare to bankruptcy in less than 5 years. And, simply put, bankruptcy of the trust fund means there will not be money to pay the hospital bills of our senior citizens and disabled individuals reliant on Medicare.

Again, I believe it is time to put politics aside. A Medicare Reform Commission is an important step in the right direction to bringing together a bipartisan, lasting agreement on resolving Medicare's fiscal crisis.

The 1993 National Commission on Social Security Reform was an essential catalyst to resolving the then-looming bankruptcy of Social Security. The 1983 Commission brought together people in a cooperative bipartisan spirit. Ultimately, the work of the Commission laid the ground for a solution to the solvency crisis. I believe a Medicare Reform Commission might be able to do the same today.

We are facing a crisis. A crisis requires action. We cannot be a government of empty promises. We must restore Medicare to robust health for our children and our grandchildren.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

THE BIPARTISAN CAMPAIGN PRACTICES COMMISSION ACT OF 1996

Mr. DOLE. Mr. President, as I prepare to leave an institution in which I

have served for over 35 years, I am mindful that in many ways the public has lost confidence in the ability of legislators to represent their interests, not special interests.

We should not allow this to continue. Representative Democracy, founded on fair and competitive elections, is at the core of what makes America great. Yet, concern over how we finance elections threatens to erode the trust the American people have in our elected officials.

As my colleagues know, Congress has tried repeatedly to grapple with this issue and largely failed. However, I continue to believe that the very nature of the problem makes it difficult to resolve in the normal give and take of the legislative process.

In 1990, for example, Senator Mitchell and I appointed a six-member commission of outside experts to look at this issue and report back to us, but the report was unfortunately ignored by Congress.

I suggested in 1994 and repeatedly since then that a similar commission be constituted to report back to Congress, but with an important difference. This time, the report should be in the form of recommended legislative language which provides a solution and Congress should have an opportunity for an up and down vote.

As my colleagues know, both President Clinton and Speaker Gingrich endorsed a similar concept last year when they met in New Hampshire.

I therefore send to the desk a bill that establishes an eight-member commission of outside experts. They would have the broadest possible mandate to think through this problem, come up with solutions and report back to Congress not more than 30 days after the convening of the 105th Congress.

The commission will send Congress legislative language for those recommendations on which seven members agree. Congress will consider those recommendations under expedited procedures that mirror the fast-track authorities in our trade laws.

I know my colleagues will be grappling with this issue soon. However, I believe that it would be better to take this issue out of what is already a super-heated partisan atmosphere and allow a bipartisan approach to be developed that Congress cannot ignore.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1857

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Bipartisan Campaign Practices Commission Act of 1996".

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the "Bipartisan Commission on

Medicaid Trust Fund Bill

FROM THE OFFICE OF

Senator Daniel Patrick Moynihan

New York

FOR IMMEDIATE RELEASE
Thursday, October 31, 1996

CONTACT: Mike Waterman
(202) 224-4451

STATEMENT OF SENATOR DANIEL PATRICK MOYNIHAN

ON THE FUTURE OF MEDICARE

I would be honored to serve on a bipartisan commission on Medicare in any Administration. Senator Rockefeller and I proposed such a commission in the Senate Finance Committee in September, 1995, but lost on a party line vote. More recently, in the second Presidential debate, President Clinton called for a "bipartisan group" to look at what we have to do to save Medicare "when the baby boomers retire." Now Senator Dole has proposed a bipartisan commission to go directly to work.

And so a certain consensus emerges as to how we might proceed. All to the good.

In the meantime, the President has proposed measures that would extend Medicare solvency by 10 years. This is a pressing matter to be addressed directly in the next Congress.

MEMORANDUM

TO: Interested Parties October 28, 1996

FROM: Chris Jennings
Jen Klein

SUBJ: Treasury Department's Monthly Report Shows Improvement in the Status of the Medicare HI Trust Fund

Earlier today (Monday), the Treasury Department released their monthly report on the financial status of the Medicare HI Trust Fund. In short, the Department concluded that the status of the Trust Fund for the month of September is about \$4 billion better than what was previously projected for this time period by the Medicare Trustees in June, and \$3.2 billion better than what we projected it would be in the mid-session review in August.

It remains unclear exactly why the Trust Fund projections have declined so much and we are still reviewing the reasons behind it. It is likely to be related to a late provider payment in August that reduced the September liability, decreases in health care inflation and increases in employment -- and thus increases in Medicare payroll contributions. **Having said this, there is still an operating deficit of \$4.2 billion -- greater than any deficit in recent years.**

The Republicans on the Hill are trying to use this report to bolster their position that the Trust Fund is getting worse every day and we have done nothing to "save" it. Although the press will inevitably use this as another excuse to hit us a bit, the print media (*NY Times*, *USA Today*, and *Washington Post*) seem to be mostly reporting that the real news the Republicans are ignoring is that the Trust Fund seems to be improving.

Our position on the release of this and every monthly Trust Fund report is that no one should read too much into these reports. And no one should use them in an attempt to needlessly scare the elderly into believing that bankruptcy is imminent. With over \$125 billion in surplus, it is simply not the case. Monthly reports represent little more than a picture in time and frequently do not reflect overall trends. [More to the point, in the absence of Medicare reforms, the Trust Fund will always -- over time -- get worse; as such, we have chosen to downplay even good news reports].

Attached is a one page set of talking points for your use. Please don't hesitate to call us at 456-5560 with any questions.

STATUS OF THE HOSPITAL INSURANCE TRUST FUND

In September 1996, the Medicare Hospital Insurance (HI) Trust Fund fared better than projected.

- The September Monthly Treasury Statement shows that the HI trust fund is about \$4 billion better off than projections by the Medicare Trustees (June) and \$3.2 billion better off than estimates by OMB in its Mid-Session Review (August).

In no way should this information be used to scare Medicare's 38 million elderly and disabled into thinking that Medicare will not pay their claims.

- Over \$125 billion remains in the Trust Fund. There is no imminent danger that claims will not be paid.

Although the report is encouraging, it does not reduce the need to work together on a bipartisan basis to strengthen the Medicare Trust Fund.

From the start, President Clinton has taken action to strengthen the Medicare trust fund.

- The President's 1993 Economic Plan extended the life of the Trust fund by 3 years -- without a single Republican vote.
- The President's balanced budget guarantees the life of the Medicare trust fund for at least a decade from today.
- The President's proposed Medicare reforms give beneficiaries more choices among private health plans, provide more preventive health care benefits, attack fraud and abuse, and cut the growth of provider payments without raising the Part B premium to 25 percent of program costs.

Q. What are the reasons behind this decline? [USE ONLY IF PRESSED]

A. The reasons for the Trust Fund's improved status are unclear but the improvement is likely related to the improved economy and the overall reductions in medical inflation. However, we are still reviewing all of the reasons.



OFFICE OF ECONOMIC POLICY

Fax Cover Page

September 24, 1996

Pages Including Cover: 2

TO: Chris Jennings

Phone: 456-5560

Fax: 456-5542

FROM: Glen Rosselli
Deputy Assistant Secretary for Policy Analysis
U.S. Treasury Department

Phone: 622-0090

Fax: 622-2633

Message:

9/23/96

Status of Hospital Insurance Trust Fund

As anticipated, the Hospital Insurance (HI) trust fund experienced a cash-flow deficit in August 1996.

- The August Monthly Treasury Statement (released today) shows that the HI trust fund had total income of \$8.1 billion and total expenditures of \$11.4 billion, for a deficit of \$3.3 billion.

The status of the HI trust fund balance is in line with the estimates released in this year's Trustees Report and the Mid-Session Review.

- For the 1996 fiscal year to date the trust fund has a cumulative deficit of nearly \$6 billion (\$5.88 billion).
- In this year's Mid-Session Review, the deficit for fiscal year 1996 was estimated to be \$6.9 billion, lower than the corresponding \$8.2 billion estimate shown in the 1996 Trustees Report.

In no way should this information be used to scare seniors and the disabled into thinking that Medicare will not pay their claims.

- Over \$123 billion remains in the Trust Fund. There is no imminent danger that claims will not be paid.

From the start, President Clinton has taken action to strengthen the Medicare Trust Fund.

- The President's 1993 Economic Plan extended the life of the Trust Fund by 3 years - *without a single Republican vote.*
- The President's Health Care Reform Plan would have extended the life of the Trust Fund by *another 5 years.*
- The President's balanced budget guarantees the life of the Medicare trust fund for at least a decade.

October 22, 1996



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Nancy-Ann Min

Through: Barry Clendenin
Mark Miller

BC

MM

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Subject: HI Trust Fund Report for September/
FY 1996 End-of-Year Report

With informational copies for:
HD Chron, HFB Chron, HFB
Medicare, Barry Anderson, Ellen
Balis, Jill Blickstein, Keith
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The attached charts (Tab A) display data from the Monthly Treasury Statement on outlays, revenue, and change in the balance of the Hospital Insurance (HI) Trust Fund, including September and end-of-year data that will be released on Monday, October 28th in the Monthly Treasury Statement for September.

The HI Trust Fund posted a \$1.804 billion surplus for September, resulting in a total loss of \$4.182 billion for FY 1996. This shortfall is less than predicted under any of the alternative assumptions presented in the Trustees' Report in June, the President's FY 1997 Budget and MSR, or CBO's March baseline.

Note that, although the HI Trust Fund's FY 1996 losses were less than expected, the losses were still the largest in the Trust Fund's history. Discussions with HCFA's Office of the Actuary indicate that this new information will not move the Trust Fund's expected insolvency date from FY 2001.

Monthly Performance in September

Surprisingly, September was a good month for the HI Trust Fund. Outlays were consistent with previous years' experience at \$9,713 million, while revenues were higher than expected at \$11,517 million (probably caused by high employment-tax revenue). The combination of these outlays and revenues yielded a surplus in September of \$1,804 million. The fiscal year-to-date HI Trust Fund deficit at the end of September was \$4,182 million (down from a deficit of \$5,986 million at the end of August).

As of the end of September, the Trust Fund's balance was \$125,805 million.

Performance for FY 1996 Compared to Trustees' Report, President's Budget, MSR, and CBO

The following table compares the actual FY 1996 HI Trust Fund Deficit to the predictions in the 1996 Trustees' Report, the FY 1997 President's Budget, the Mid-Session Review of the FY 1997 Budget, and CBO's March baseline.

	<u>FY 1996 HI Trust Fund Deficit</u> (\$ in millions)
Actual	\$4,182
FY 1997 President's Budget	\$6,100
FY 1997 MSR	\$6,900
CBO March Baseline	\$7,200
Trustees' Low Cost Assumptions	\$8,000
Trustees' Intermediate Assumptions	\$8,200
Trustees' High Cost Assumptions	\$8,600

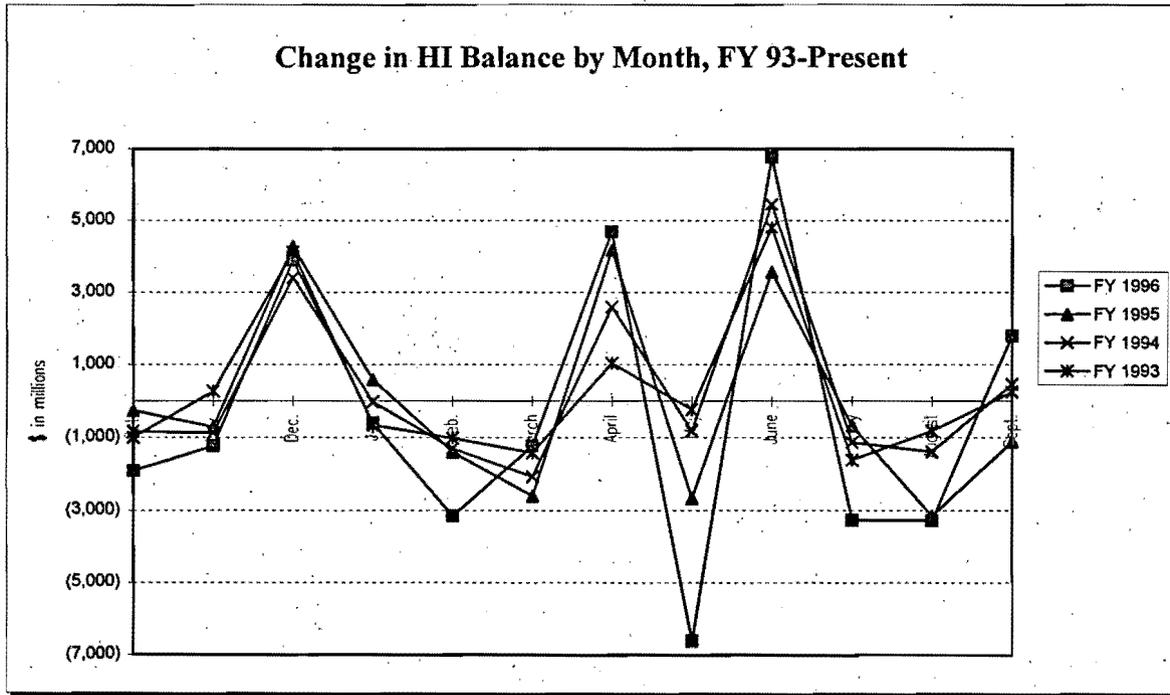
As this table shows, the HI Trust Fund's actual performance in FY 1996 was better than anyone predicted, although the Trust Fund still lost more money than in any previous year.

Please note that the above table compares actual performance to forecasts. You may recall that last year the Trustees predicted a surplus of \$4.7 billion, but the actual experience was a \$36 million loss.

Although lower than expected, a \$4 billion loss is still a substantial, and losses will continue to accumulate over the coming years. Furthermore, discussions with HCFA's Office of the Actuary indicate that this new information is unlikely to extend the projected insolvency date of the Trust Fund beyond FY 2001 (as forecast in the Trustees' Report under their intermediate assumptions).

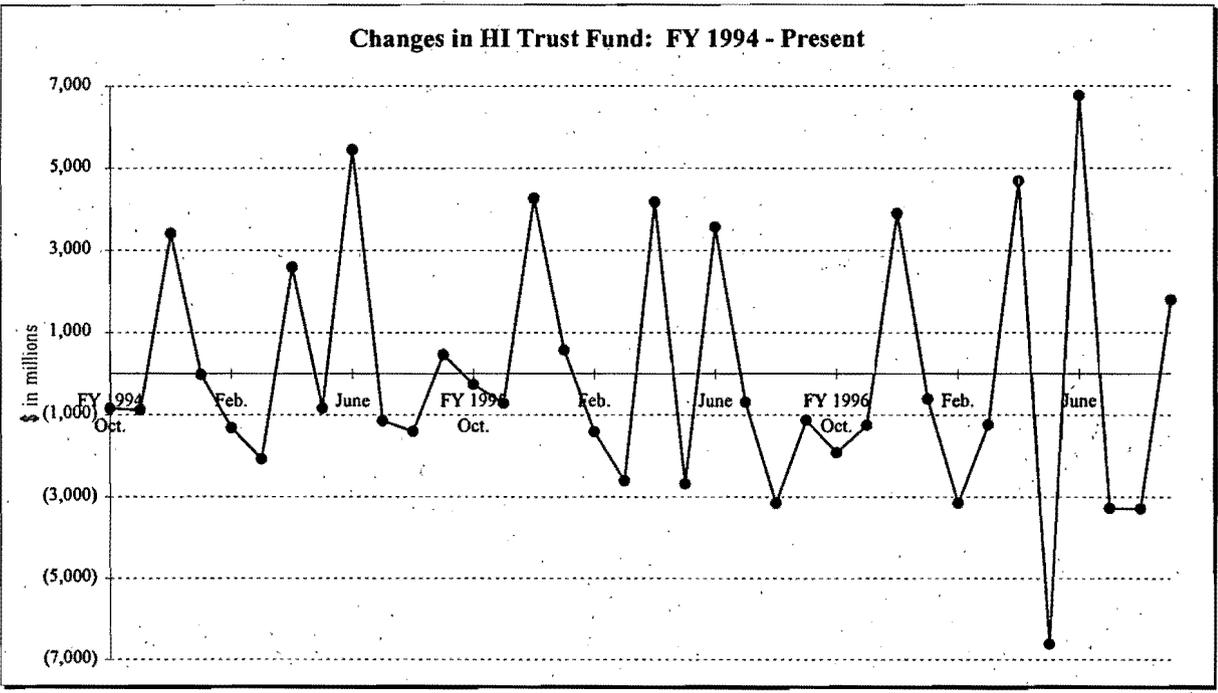
Change in HI Trust Fund: September 1996 Report
Comparison of 1996 Monthly Performance to Previous Years
(\$ in millions – FY totals may not add due to rounding)

<u>Actual Change</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 1995	(260)	(718)	4,266	577	(1,400)	(2,601)	4,167	(2,670)	3,559	(683)	(3,153)	(1,121)	(37)
FY 1994	(838)	(879)	3,406	(27)	(1,308)	(2,076)	2,595	(831)	5,455	(1,138)	(1,393)	459	3,425
FY 1993	(1,000)	261	4,128	(671)	(1,018)	(1,416)	1,035	(243)	4,807	(1,610)	(826)	246	3,693
FY 1996 - FY 1995	(1,657)	(518)	(366)	(1,191)	(1,751)	1,371	518	(3,942)	3,207	(2,588)	(136)	2,925	
% Difference	637%	72%	-9%	-206%	125%	-53%	12%	148%	90%	379%	4%	-261%	



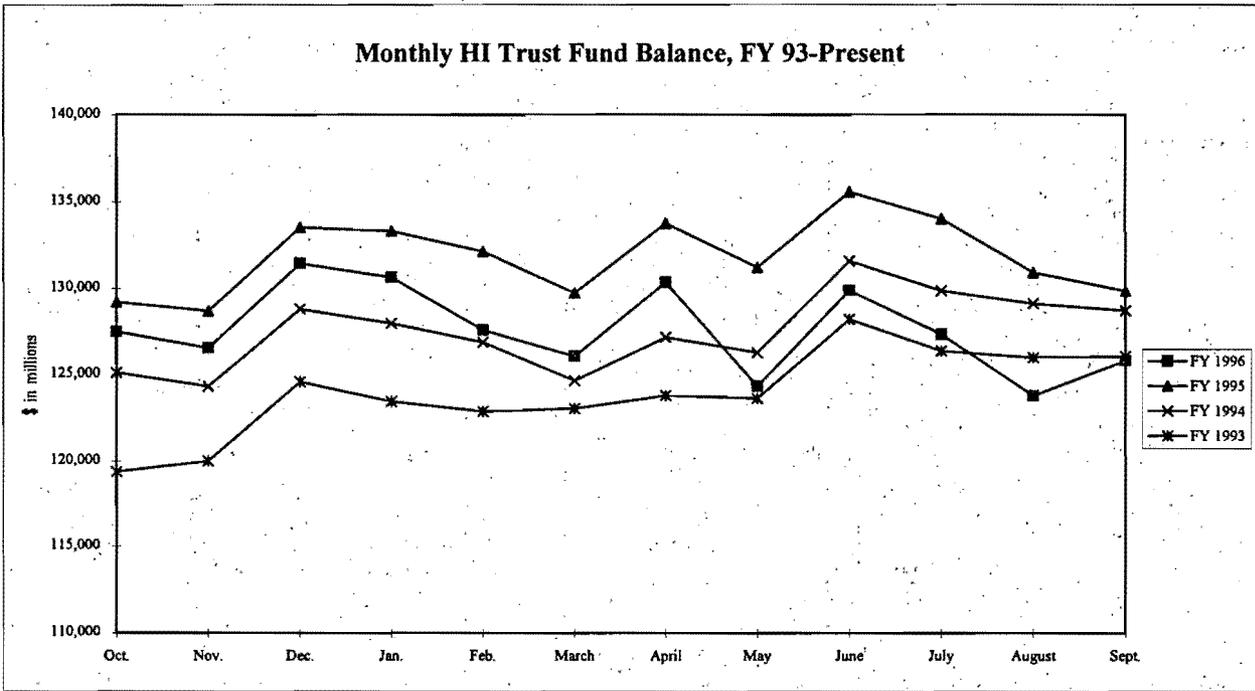
Change in HI Trust Fund: September 1996 Report
Cumulative Comparison of 1996 Performance to Previous Years
(\$ in millions – FY totals may not add due to rounding)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
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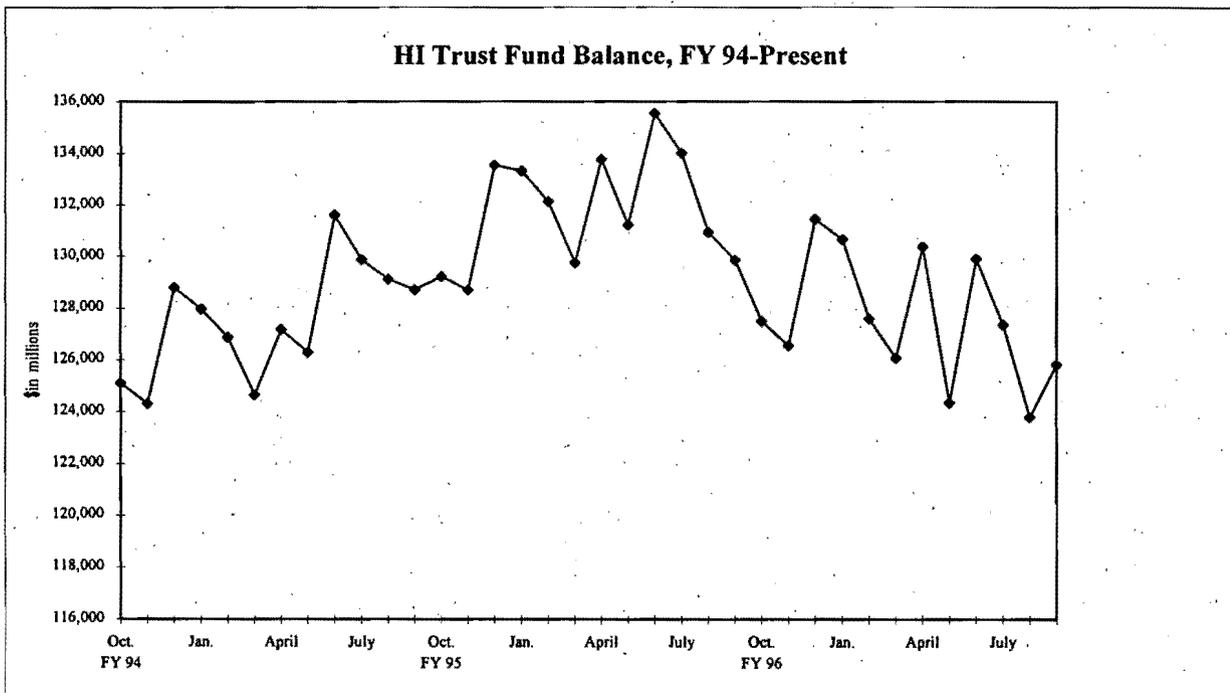
HI Trust Fund Balance: September 1996 Report
Comparison of 1996 Monthly Balance to Previous Years
(\$ in millions)

<u>Actual Change</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Average</u>
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610
FY 1995	129,218	128,695	133,541	133,316	132,132	129,750	133,765	131,222	135,559	134,013	130,931	129,864	131,834
FY 1994	125,104	124,309	128,804	127,969	126,876	124,645	127,177	126,289	131,599	129,876	129,114	128,716	127,540
FY 1993	119,371	119,993	124,584	123,443	122,883	123,040	123,805	123,626	128,222	126,381	125,995	126,078	123,952
FY 1996 - FY 1995	(1,723)	(2,141)	(2,098)	(2,667)	(4,549)	(3,678)	(3,408)	(6,883)	(5,669)	(6,658)	(7,151)	(4,059)	
% Difference	-1%	-2%	-2%	-2%	-3%	-3%	-3%	-5%	-4%	-5%	-5%	-3%	



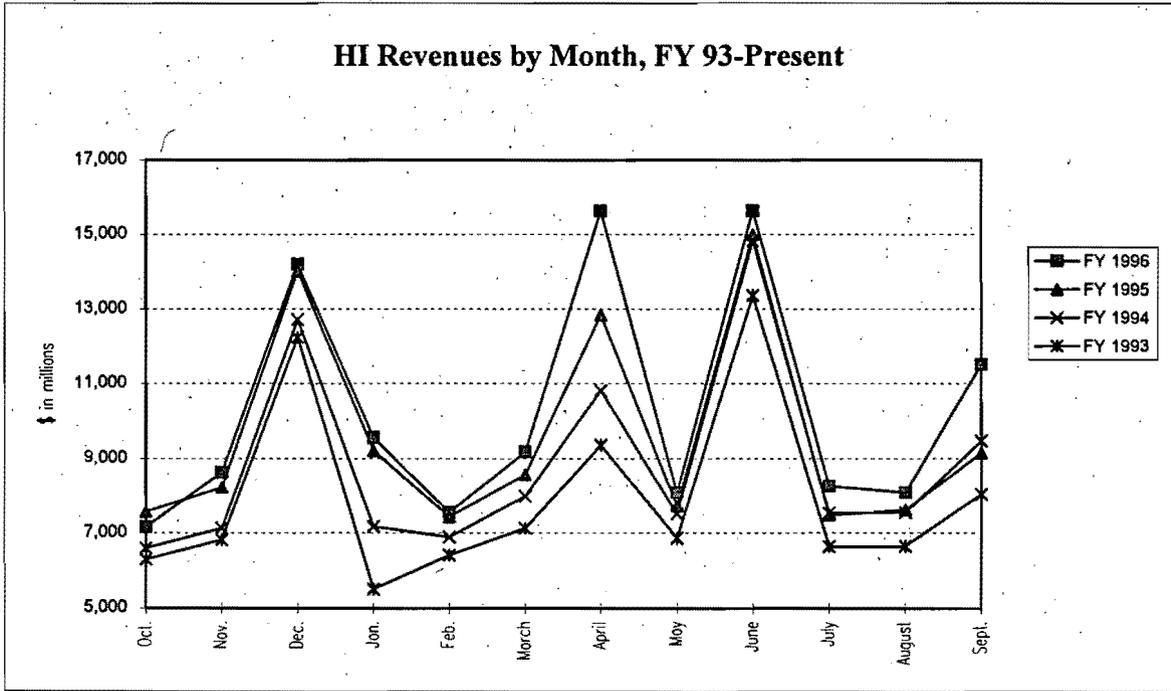
HI Trust Fund Balance: September 1996 Report
Long-Term Comparison of 1996 Balance to Previous Years
 (\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Average</u>
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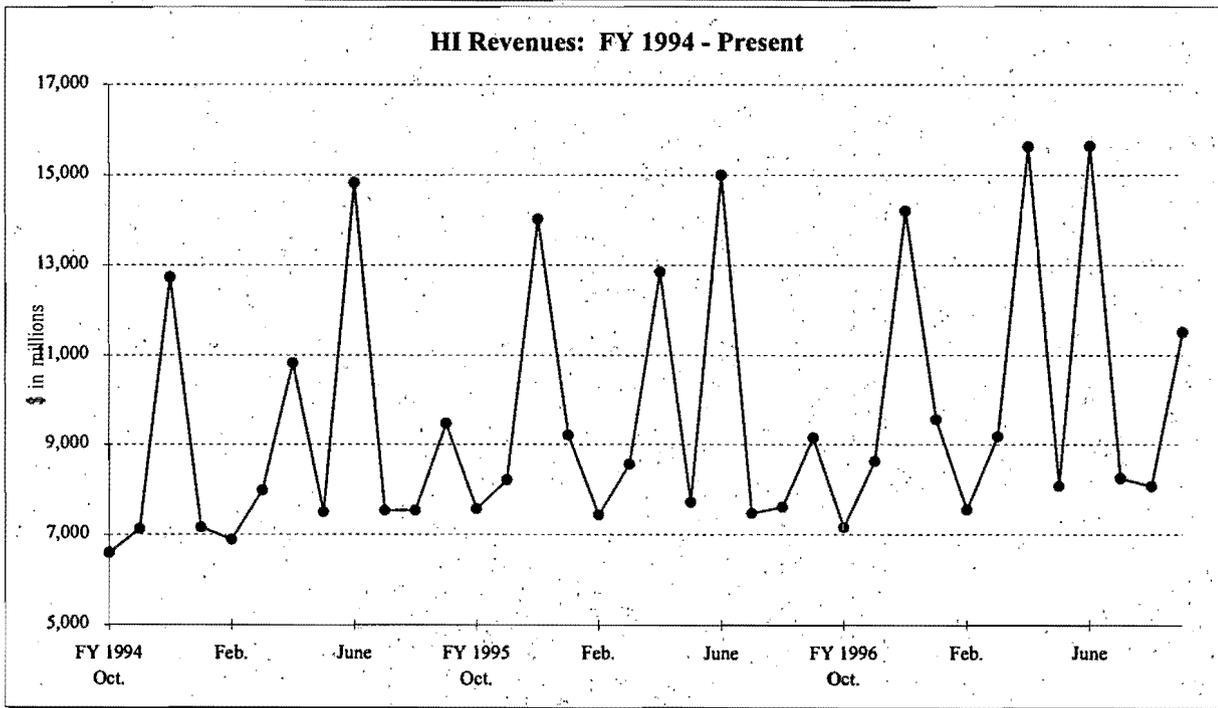
HI Revenues: September 1996 Report
Comparison of 1996 Monthly Performance to Previous Years
(\$ in millions)

<u>Actual Revenues</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 1995	7,574	8,224	14,023	9,207	7,438	8,570	12,847	7,724	14,999	7,474	7,617	9,150	114,847
FY 1994	6,594	7,127	12,725	7,166	6,888	7,993	10,819	7,508	14,829	7,538	7,544	9,465	106,196
FY 1993	6,299	6,816	12,245	5,500	6,405	7,123	9,356	6,859	13,366	6,639	6,650	8,038	95,296
FY 1996 - FY 1995	(409)	409	179	348	120	610	2,785	363	647	785	466	2,367	
% Difference	-5%	5%	1%	4%	2%	7%	22%	5%	4%	11%	6%	26%	



HI Revenues: September 1996 Report
Cumulative Comparison of 1996 Performance to Previous Years
(\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
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FY 1994	6,594	7,127	12,725	7,166	6,888	7,993	10,819	7,508	14,829	7,538	7,544	9,465	106,196
FY 95 - 96 Cumulative Difference	(409)	0	179	527	647	1,257	4,042	4,405	5,052	5,837	6,303	8,670	
Cumulative % Difference	-5.4%	0.0%	0.6%	1.4%	1.4%	2.3%	6.0%	5.8%	5.6%	6.0%	6.0%	4.5%	

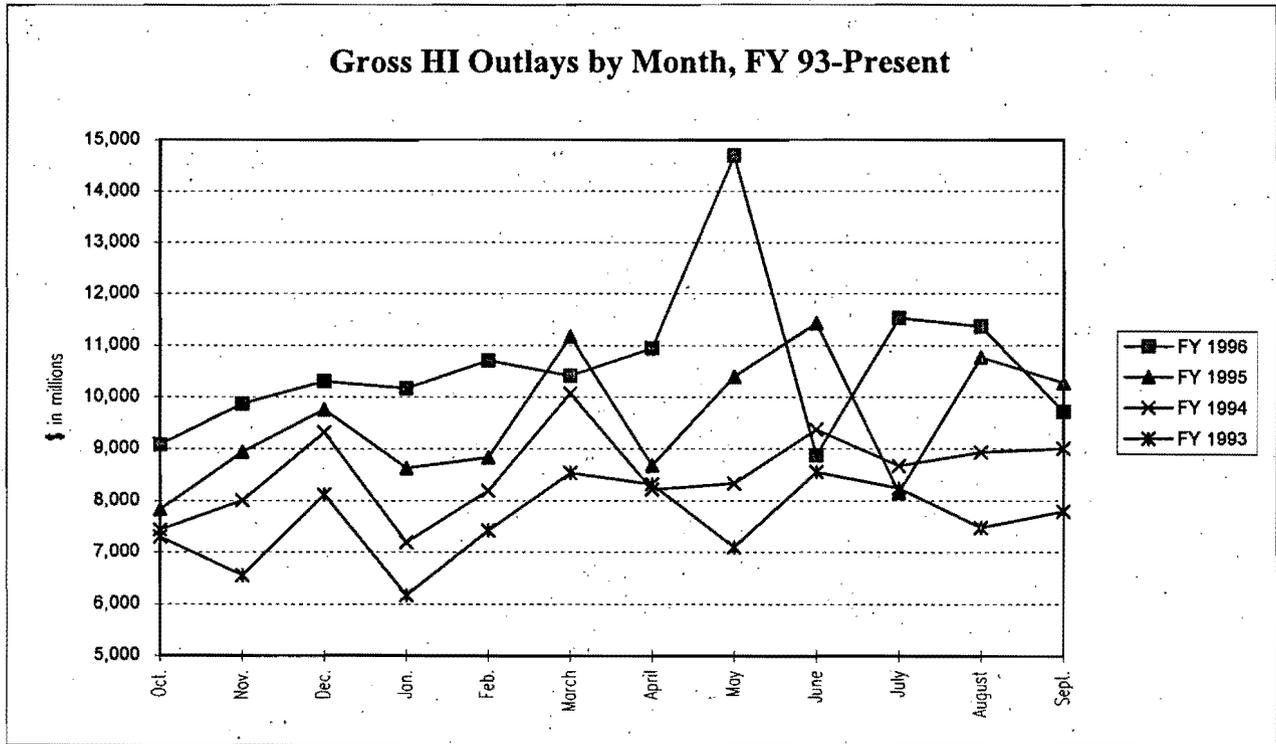


Gross HI Outlays: September 1996 Report

Comparison of 1996 Monthly Performance to Previous Years

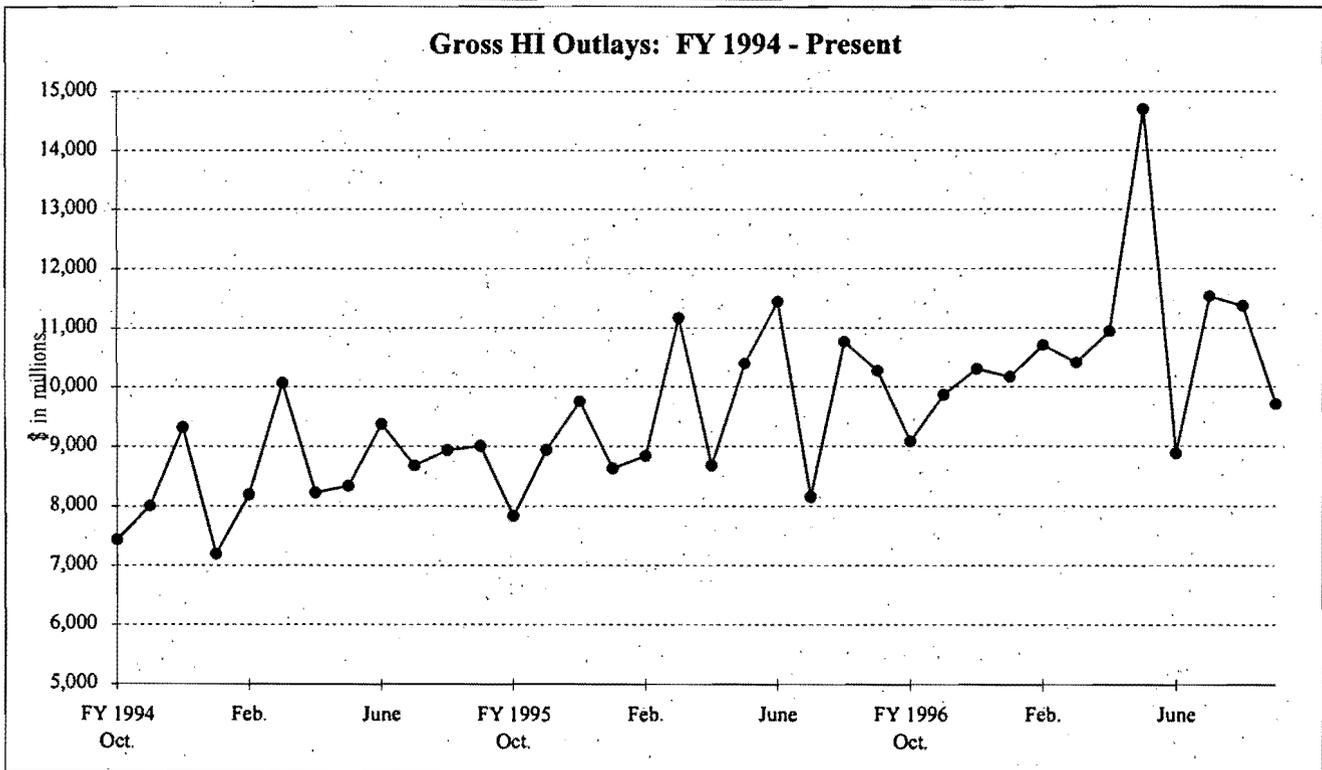
(\$ in millions)

<u>Actual Outlays</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 1995	7,834	8,942	9,757	8,630	8,838	11,171	8,680	10,394	11,440	8,157	10,770	10,271	114,884
FY 1994	7,432	8,006	9,319	7,193	8,196	10,069	8,224	8,339	9,374	8,676	8,937	9,006	102,771
FY 1993	7,299	6,555	8,117	6,171	7,423	8,539	8,321	7,102	8,559	8,249	7,476	7,792	91,603
FY 1996 - FY 1995	1,248	927	545	1,539	1,871	(761)	2,267	4,305	(2,560)	3,373	602	(558)	
% Difference	16%	10%	6%	18%	21%	-7%	26%	41%	-22%	41%	6%	-5%	



Gross HI Outlays: September 1996 Report
Cumulative Comparison of 1996 Performance to Previous Years
(\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
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FY 1994	7,432	8,006	9,319	7,193	8,196	10,069	8,224	8,339	9,374	8,676	8,937	9,006	102,771
FY 95 - 96 Cumulative Difference	1,248	2,175	2,720	4,259	6,130	5,369	7,636	11,941	9,381	12,754	13,356	12,798	
Cumulative % Difference	15.9%	13.0%	10.3%	12.1%	13.9%	9.7%	12.0%	16.1%	10.9%	13.6%	12.8%	11.1%	



C. JENNINGS

September 20, 1996



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

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Chris Jennings

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Through: Barry Clendenin /BC
Mark Miller

Subject: HI Trust Fund Report for August

With informational copies for:
HD Chron, HFB Chron, HFB
Medicare, Barry Anderson, Ellen
Balis, Jill Blickstein, Keith
Fontenot

From: Bob Donnelly SD

Phone: 202/395-4930
Fax: 202/395-7840

E-mail: donnelly_r@a1.eop.gov
Room: #7002

The attached charts (Tab A) display data from the Monthly Treasury Statement on outlays, revenue, and change in the balance of the Hospital Insurance (HI) Trust Fund, including August data that will be released on Monday, September 23rd in the Monthly Treasury Statement for August.

The data for August in the attached charts appear to be the basis for Rep. Thomas' assertion yesterday (Tab B) that the Trust Fund would become insolvent in 1999, instead of early in 2001 as estimated in the 1996 Trustees' Report published in June. You may want share this report with Jack Lew, Larry Haas, and Rebecca Culberson, who received copies of this news story from Jill this morning.

Based on previous years' outlay and revenue trends, HFB staff expect that the Trust Fund will post a shortfall of between \$1.5 and \$2 billion in September, resulting in a loss of between \$7.5 and \$8 billion for FY 1996. This is consistent with the \$8.2 billion shortfall predicted by the Trustees in their intermediate assumption scenario -- contrary to Rep. Thomas' assertion, there does not appear to be evidence that the Trust Fund is performing worse than the Trustees projected in June. (Note: this is based on preliminary HFB estimates of income and revenues; these are not official estimates).

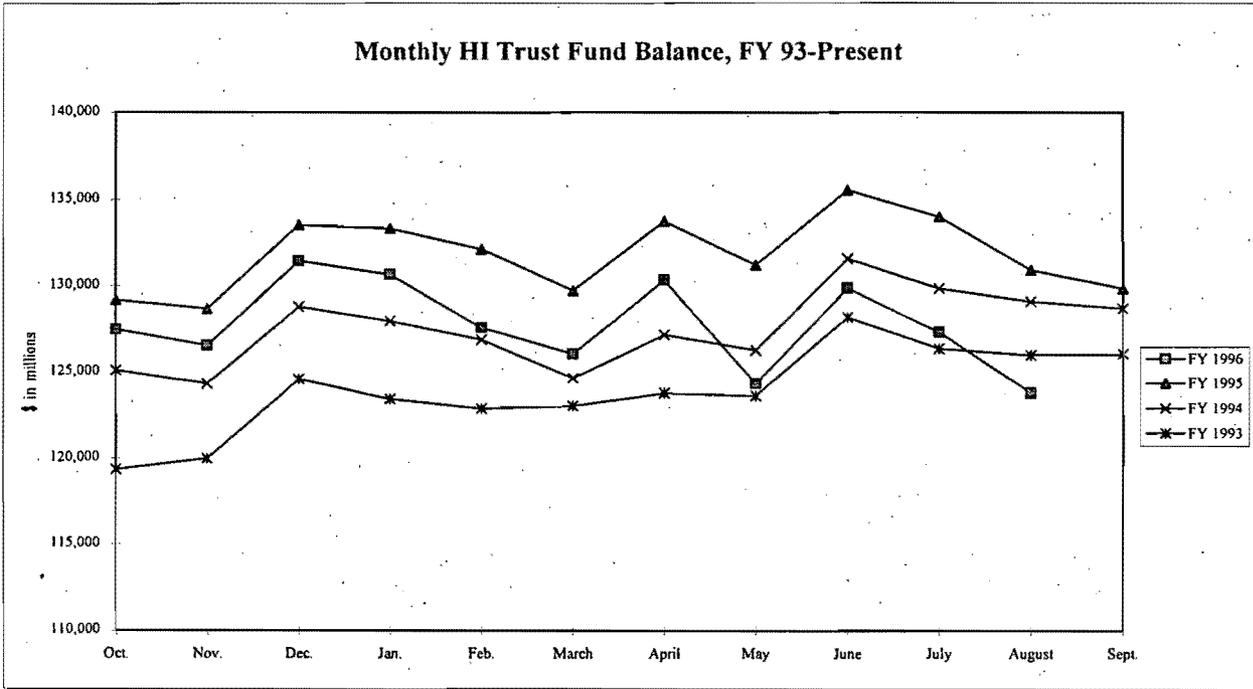
As expected, August was another **bad month** for the HI Trust Fund. At \$11,372 million, outlays were about what was expected from **previous** years' experience. HI revenues for August were \$8,083 million, which is well within the **range** of what would be expected from previous years' trends. The combination of these outlays **and** revenues yielded a shortfall in August of \$3,289 million. The fiscal year-to-date HI Trust Fund deficit at the end of August was \$5,986 million (down from a deficit of \$2,679 million **at the** end of July).

As of the end of August, the Trust Fund's balance was \$123,780 million.

Tab A

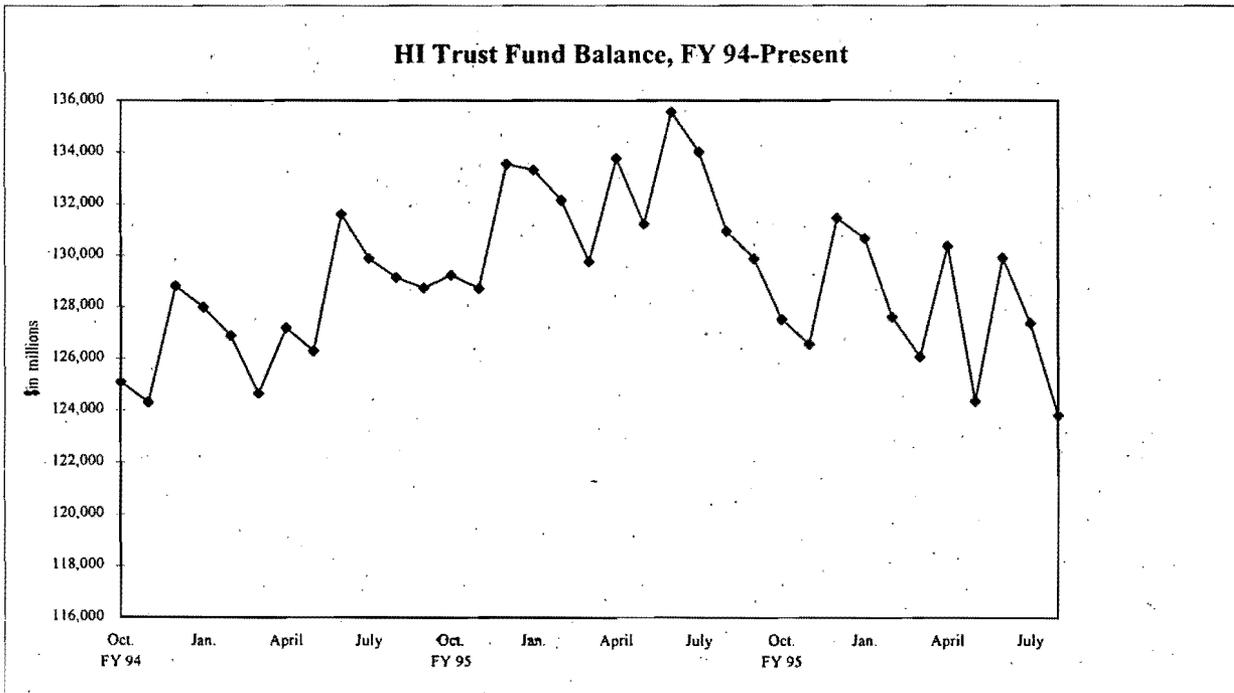
HI Trust Fund Balance: August 1996 Report
Comparison of 1996 Monthly Balance to Previous Years
(\$ in millions)

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FY 1996 - FY 1995	(1,723)	(2,141)	(2,098)	(2,667)	(4,549)	(3,678)	(3,408)	(6,883)	(5,669)	(6,658)	(7,151)		
% Difference	-1%	-2%	-2%	-2%	-3%	-3%	-3%	-5%	-4%	-5%	-5%		



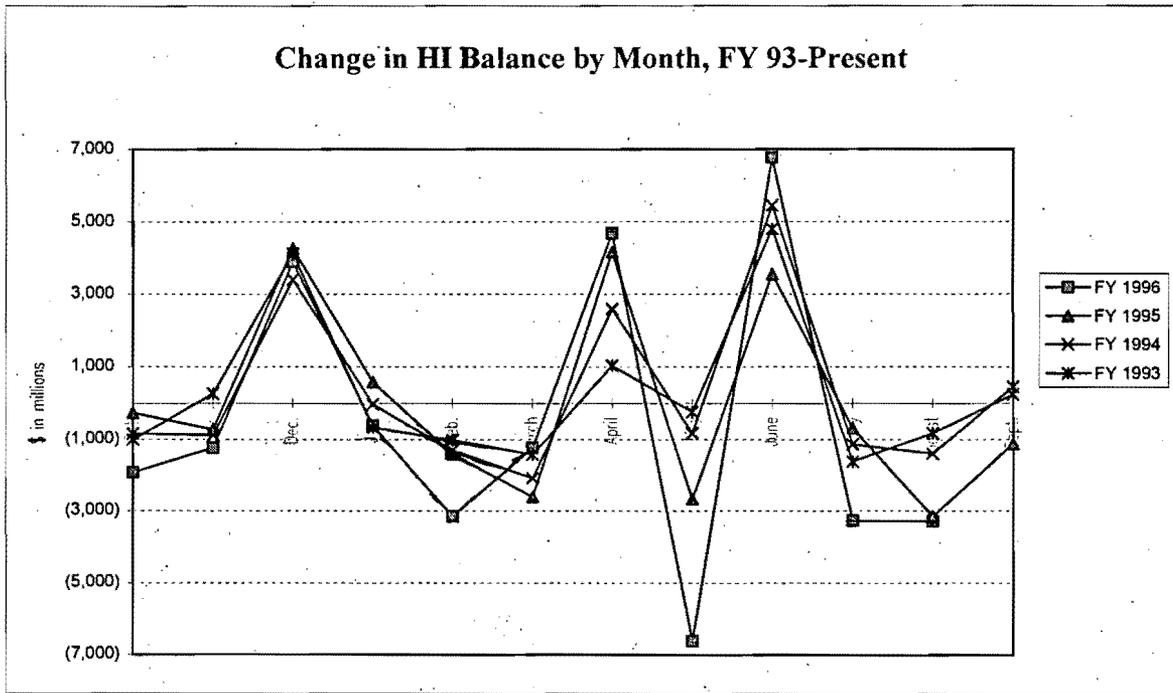
HI Trust Fund Balance: August 1996 Report
Long-Term Comparison of 1996 Balance to Previous Years
(\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Average</u>
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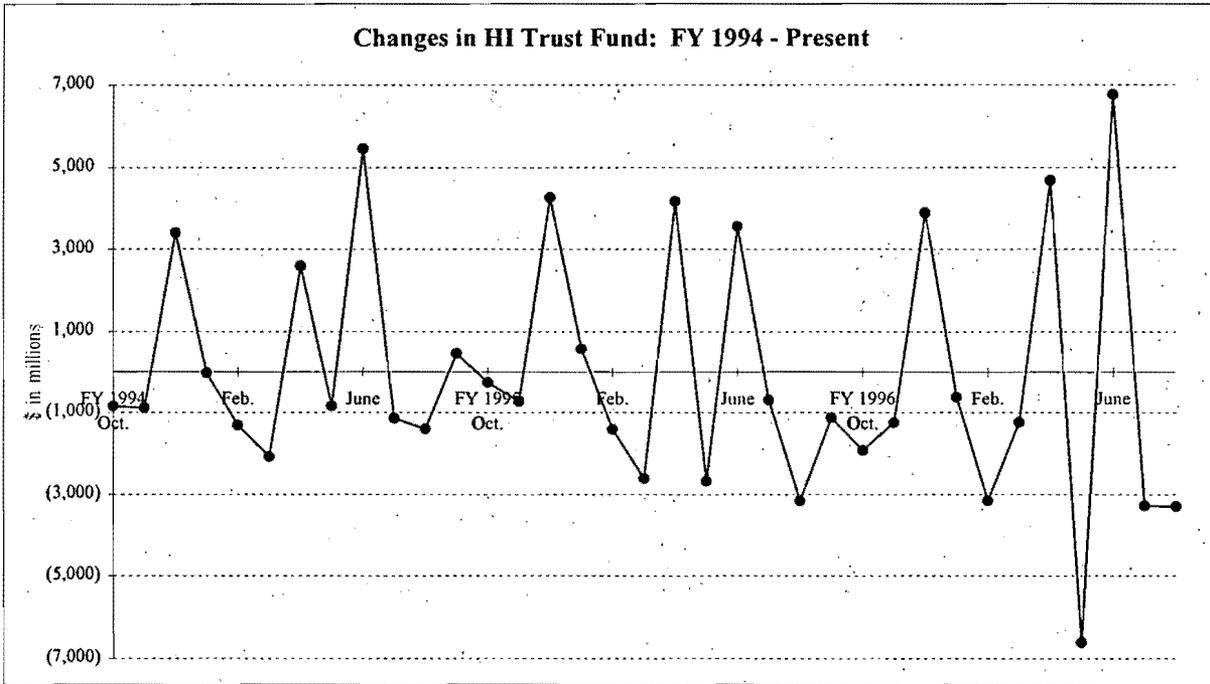
Change in HI Trust Fund: August 1996 Report
Comparison of 1996 Monthly Performance to Previous Years
(\$ in millions – FY totals may not add due to rounding)

<u>Actual Change</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
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FY 1993	(1,000)	261	4,128	(671)	(1,018)	(1,416)	1,035	(243)	4,807	(1,610)	(826)	246	3,693
FY 1996 - FY 1995	(1,657)	(518)	(366)	(1,191)	(1,751)	1,371	518	(3,942)	3,207	(2,588)	(136)		
% Difference	637%	72%	-9%	-206%	125%	-53%	12%	148%	90%	379%	4%		



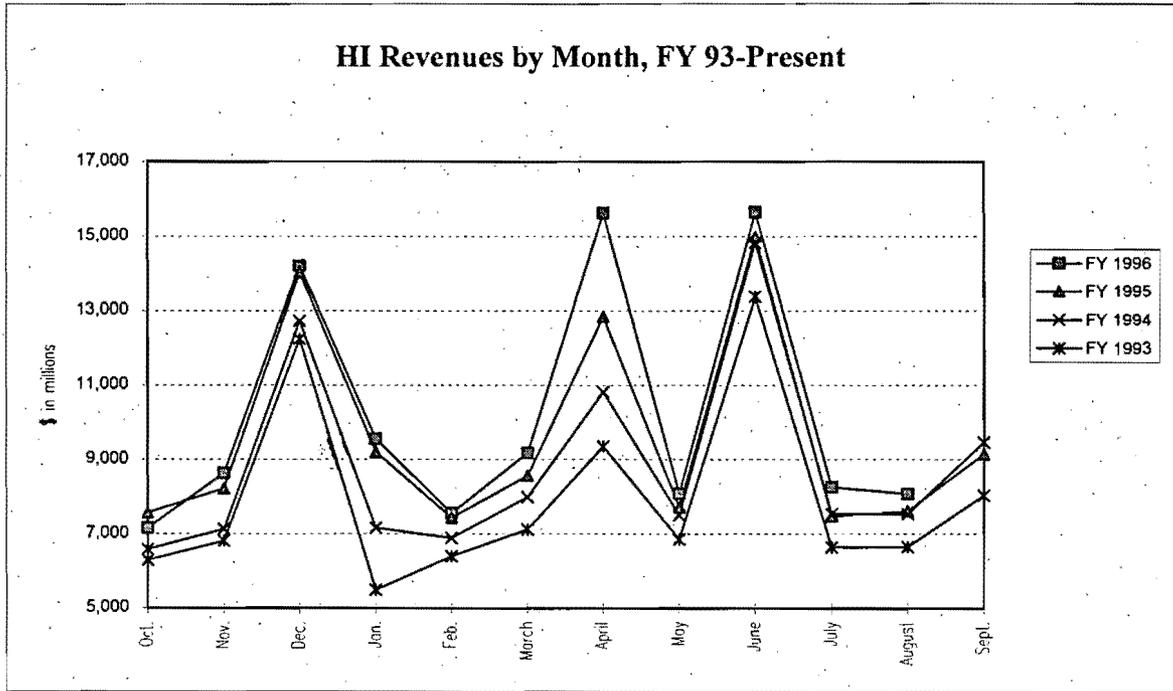
Change in HI Trust Fund: August 1996 Report
Cumulative Comparison of 1996 Performance to Previous Years
(\$ in millions – FY totals may not add due to rounding)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)		(5,986)
FY 1995	(260)	(718)	4,266	577	(1,400)	(2,601)	4,167	(2,670)	3,559	(683)	(3,153)	(1,121)	(37)
FY 1994	(838)	(879)	3,406	(27)	(1,308)	(2,076)	2,595	(831)	5,455	(1,138)	(1,393)	459	3,425



HI Revenues: August 1996 Report
Comparison of 1996 Monthly Performance to Previous Years
(\$ in millions)

<u>Actual Revenues</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083		112,000
FY 1995	7,574	8,224	14,023	9,207	7,438	8,570	12,847	7,724	14,999	7,474	7,617	9,150	114,847
FY 1994	6,594	7,127	12,725	7,166	6,888	7,993	10,819	7,508	14,829	7,538	7,544	9,465	106,196
FY 1993	6,299	6,816	12,245	5,500	6,405	7,123	9,356	6,859	13,366	6,639	6,650	8,038	95,296
FY 1996 - FY 1995	(409)	409	179	348	120	610	2,785	363	647	785	466		
% Difference	-5%	5%	1%	4%	2%	7%	22%	5%	4%	11%	6%		

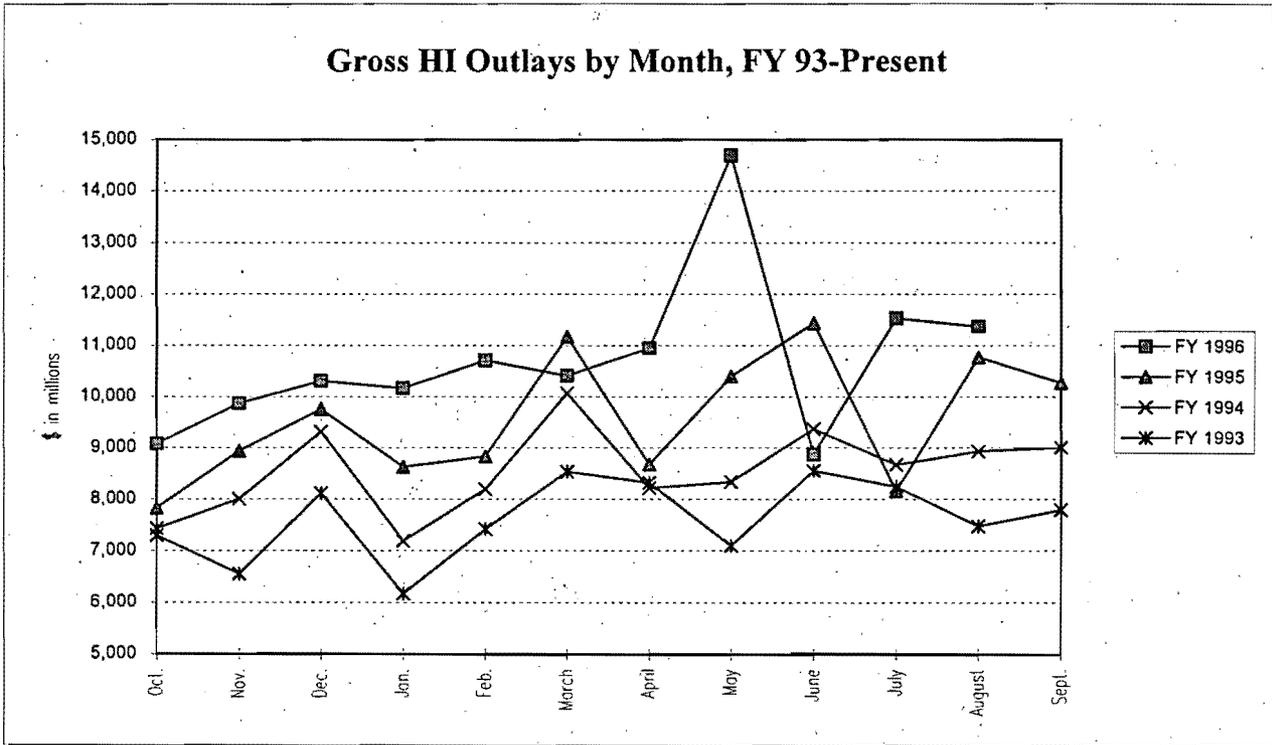


Gross HI Outlays: August 1996 Report

Comparison of 1996 Monthly Performance to Previous Years

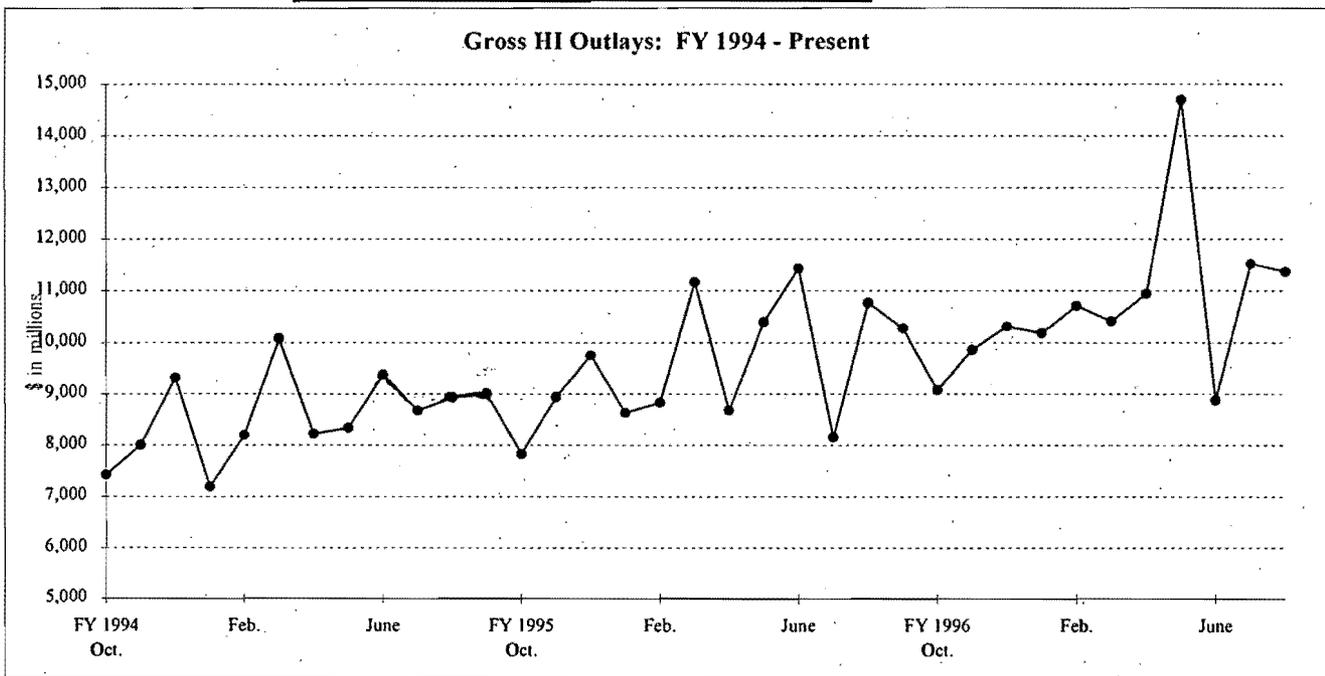
(\$ in millions)

<u>Actual Outlays</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372		117,969
FY 1995	7,834	8,942	9,757	8,630	8,838	11,171	8,680	10,394	11,440	8,157	10,770	10,271	114,884
FY 1994	7,432	8,006	9,319	7,193	8,196	10,069	8,224	8,339	9,374	8,676	8,937	9,006	102,771
FY 1993	7,299	6,555	8,117	6,171	7,423	8,539	8,321	7,102	8,559	8,249	7,476	7,792	91,603
FY 1996 - FY 1995	1,248	927	545	1,539	1,871	(761)	2,267	4,305	(2,560)	3,373	602		
% Difference	16%	10%	6%	18%	21%	-7%	26%	41%	-22%	41%	6%		



Gross HI Outlays: August 1996 Report
Cumulative Comparison of 1996 Performance to Previous Years
(\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Total Through August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	117,969		117,969
FY 1995	7,834	8,942	9,757	8,630	8,838	11,171	8,680	10,394	11,440	8,157	10,770	104,613	10,271	114,884
FY 1994	7,432	8,006	9,319	7,193	8,196	10,069	8,224	8,339	9,374	8,676	8,937	93,765	9,006	102,771
FY 95 - 96 Cumulative Difference	1,248	2,175	2,720	4,259	6,130	5,369	7,636	11,941	9,381	12,754		13,356		
Cumulative % Difference	15.9%	13.0%	10.3%	12.1%	13.9%	9.7%	12.0%	16.1%	10.9%	13.6%		12.8%		



Tab B

From: BLICKSTEIN_J@A1@CD@LNGTWY

*To: LEW_J@A1@CD@LNGTWY

*To: HAAS_L@A1@CD@LNGTWY

*To: CULBERSON_R@A1@CD@LNGTWY

*To: MIN_N@A1@CD@LNGTWY

*To: CLENDENIN_B@A1@CD@LNGTWY

*To: MILLER_ME@A1@CD@LNGTWY

Date: 9/20/96 9:08am

Subject: Trust Fund To Run Out Of Money By 1999, Thomas Says

Trust Fund To Run Out Of Money By 1999, Thomas Says

New information to be released next week indicates that the Medicare Trust Fund will run out of money by 1999, two years earlier than predicted by program trustees just several months ago, Rep. Bill Thomas (R-Calif) said Sept. 19.

Speaking at a legislative conference sponsored by the National Association of Medical Equipment Services, Thomas said information on trust fund activity for August, to be released Sept. 23, indicates that the trust fund will be bankrupt by 1999 "or at best 2000," necessitating even larger spending reductions in program spending than the \$270 billion over seven years proposed by congressional Republicans in the 104th Congress.

The new report will indicate the state of the trust fund "will be even worse than we ever imagined," Thomas told conference participants. The Treasury Department has been releasing monthly reports on the trust fund's status.

"We need more money than we thought in a shorter time than we thought," he said, referring to the amount of savings reductions needed to save the program from bankruptcy. "Not \$100 (billion), not \$116 (billion), or \$160 (billion), or \$270 (billion), but far, far more than that."

More Extreme Changes Possible

The choices to be made by Congress to reform the program "will have to be more extreme than they would have had we begun [to reform Medicare] two or three years ago," he added.

The trustees of the Medicare Trust Fund in June reported that the Part A trust fund would be out of money in 2001 or 2000, and recommended establishing a long-term advisory group to develop long-term options for the program. Four of the trustees are Clinton administration officials.

Given the state of the trust fund, Thomas said Congress "should be in the business of determining the larger structure" of Medicare and leave smaller issues of how to achieve them to be worked out in consultation with industry representatives. Thomas said he fears that President Clinton, if reelected, will attempt to merely "ratchet down" Medicare provider payments in lieu of genuine reform.

Speaking before Thomas, Chris Jennings, special assistant to Clinton for health policy development, said no matter who retains control of Congress, the debate over how much to cut from the program will start with the figure of \$124 billion over seven years contained in the administration's fiscal 1997 budget proposal.

Jennings said he expected the administration to first focus on protecting the trust fund in the short term, and then turn its attention to reforming the program so that it will remain viable past 2010, when vast numbers of retiring baby boomers will begin to draw on program benefits.

The latter debate "will be the most significant process since 1983 when we passed the Social Security Act amendments," Jennings said.

The administration will use two criteria in the coming debate to decide how to change Medicare, Jennings said. Any proposals will be evaluated on whether they strengthen the trust fund and in the "context of a legitimate policy approach," he added. Jennings said the administration would not support what he said was the method taken by Republicans in the 104th Congress of starting with a spending reduction target for the program and then finding policy to support it.

The administration would try to reduce the annual increase in Medicare spending to a figure more closely resembling the private sector, however, Jennings said.
Medicare

MEMORANDUM

September 25, 1996

TO: Distribution

FROM: Chris Jennings and Jen Klein

SUBJ: Monthly Report on State of Medicare Trust Fund

The Department of the Treasury released a monthly report on the state of the Medicare Trust Fund. As expected, outlays exceeded revenues by about \$3.3 billion. Republicans, particularly Ways & Means Subcommittee Chairman Thomas, may try to use these numbers to allege our mismanagement of the Trust Fund. Although we have not received any specific criticisms since the release of the report, this issue may be raised during the Presidential debates.

Suggested talking points are attached. Please note that the talking points mirror our response to similar criticisms in the past.

We hope that you find this information helpful. If you have any questions, please call us.

9/24/96

FOR INTERNAL USE ONLY

STATUS OF HOSPITAL INSURANCE TRUST FUND

As anticipated, the Medicare Hospital Insurance (HI) trust fund experienced a cash-flow deficit in August 1996.

- The August Monthly Treasury Statement shows that the HI trust fund had total income of \$8.1 billion and total expenditures of \$11.4 billion, for a deficit of \$3.3 billion.

The status of the HI trust fund balance is in line with the estimates released in this year's Trustees Report and the Mid-Session Review.

In no way should this information be used to scare seniors and the disabled into thinking that Medicare will not pay their claims.

- Over \$123 billion remains in the Trust Fund. There is no imminent danger that claims will not be paid.

From the start, President Clinton has taken action to strengthen the Medicare trust fund.

- The President's 1993 Economic Plan extended the life of the Trust Fund by 3 years -- *without a single Republican vote.*
- The President's balanced budget guarantees the life of the Medicare trust fund for at least a decade.
- The President's proposed Medicare reforms give seniors more choices among private health plans, attack fraud and abuse, cut the growth of provider payments while holding the Part B premium to 25 percent of program costs.

FOR INTERNAL USE ONLY

Monthly Status of Hospital Insurance Trust Fund, FYs 95 and 96

FY 95	Surplus/Deficit	HI Fund	FY 96	Surplus/Deficit	HI Fund
October	-0.260	129.3	October	-1.917	127.6
November	-0.718	128.6	November	-1.236	126.4
December	4.266	132.8	December	3.900	130.3
January	0.577	133.4	January	-0.614	129.7
February	-1.399	132.0	February	-3.151	126.5
March	-2.601	129.4	March	-1.230	125.3
April	4.167	133.6	April	4.685	130.0
May	-2.670	130.9	May	-6.612	123.3
June	3.559	134.5	June	6.766	130.1
July	-0.683	133.8	July	-3.290	126.8
August	-3.153	130.6	August	-3.289	123.5
September	-1.121	129.5	September		
Cumulative Total	-0.036		Cumulative Total	-5.988	

Lynn M. Etheredge
4805 DeRussey Pkwy.
Chevy Chase, MD 20815

F41

November 8, 1995

(301)-654-4185

file: Etheredge

Ms. Carol Rasco
Senior Domestic Policy Adviser
Mr. Chris Jennings
Health Policy Coordinator
The White House
Washington, DC 20500

Dear Carol & Chris:

How about a consumer-focused health policy for the re-election year?

Best wishes,

Sincerely,


Lynn Etheredge

Chris make sure
he wrote Thankyou
note to Lynn

Called Roz. Waiting for reply.

**The Evolution Of A New Paradigm:
Competitive Purchasing of Health Care**

by

Lynn Etheredge

**The New Competition:
Dynamics Shaping the Health Care Market**

November, 1995

11/5/95

The U.S. health system is in a period of rapid, multi-dimensional change. Major employers have led the way away from the traditional health insurance model that fostered decades of hyper-inflation toward a new paradigm of competitive purchasing of health care from managed systems of care. As this market-oriented strategy has started to show success, federal and state governments are now considering ways to modernize the Medicare and Medicaid programs, with over 65 million enrollees, by adopting similar purchasing strategies and techniques.

Within just the past five years, traditional fee-for-service health insurance -- which had dominated US healthcare financing for a half-century -- has gone the way of the dinosaurs. Just as billions of years of single-cell life was followed by an unprecedented explosion of new, multi-cellular life forms (some quite strange-looking) in the Cambrian Age, so too has this new period seen a burgeoning of new flora and fauna in many local health eco-systems, and many new competitive, cooperative, and synergistic relations, in a changing world where survival (as well as prosperity) is often at stake. Based on experience in advanced markets, e.g. California, there are estimates that 30-40% of the nation's hospitals beds may close, and that 160,000 physicians may be surplus. ¹

What factors best explain these evolutionary trends - and the new selection processes for survival of the fittest? There is so much interesting, varied and rapid change within the hospital and physician arenas - an established focus of attention for health policy analysts - that most attention has been paid to these actors and their

strategies. We need far more reliable and timely information about such developments and how well they are working. The view expressed in this paper, however, is that many of these changes should be seen, in broader perspective, as similar to the wild gyrations (and gradual settling in to new orientations) of a collection of compass needles set off by the presence of a new magnetic force.

We should note that, on a nationwide basis, most of these chaotic and rapid changes all tend toward the same end: organization of health care providers (and insurers) into competing systems of care that are designed to provide comprehensive health services for a defined population at a capitated payment rate.

Why is this happening? The suggestion offered in this paper is that the health system is responding to a new purchasing paradigm in which most employers want to purchase health care from organized systems of care that compete for their premium dollars on the basis of competitive performance in terms of costs, quality/outcomes and service. * Health care providers and insurers are changing because, in this new environment, they need to do so to attract patients and revenues, or they will lose out to competitors.

A view that health care services should be purchased on a competitive basis may seem a non-controversial idea to a newer generation of health care experts. Indeed, with some audiences, one risks incredulity when describing a time when hospitals were

* Competitive purchasing is now widespread in the health sector. This paper focuses on employers (and consumers) as purchasers and their influence.

literally paid whatever they spent and doctors whatever they billed, a period when employers and government programs wrote open-ended checks, decade after decade, for double-digit annual premium increases. Yet this traditional health insurance paradigm has only recently ceased to be the U.S. norm. In international context, the U.S. transition to a market-oriented health economy is a unique (and often perplexing) experiment.

Optimism for the future of new purchasing strategies is now ascendent. Given the substantial oversupply of hospitals, hospital overuse, and excess supply of physician specialists, health care may be even more of a “buyers market” in the foreseeable future. Yet there are grounds for uncertainty and concern. Health care market development is still at an early stage; buyers are often not yet very well-organized, well-informed, and effective in their purchasing efforts. Today’s healthcare markets do not conform to designs that leading theorists have suggested are optimal for a well-functioning consumer-choice market.

In the traditional health insurance paradigm, payers of health care received little attention. Their role was simply to pay bills. The focus of attention for health policy analysts was (and still usually is) mostly on health care providers and inside-the-Beltway and state capital developments. Given the view expressed in this paper - that purchasers of health care are now coming into their own as forces to be reckoned with in shaping the future health system - this paper aims to make a start at describing the history of these developments and the factors that could favorably shape their future. It is concerned with two basic questions:

- How did this new purchasing paradigm emerge over the past twenty-five years?
- How can the consumers of health care, and those who purchase on their behalf, best use their collective \$1 trillion of annual healthcare purchasing power to foster new levels of excellence in health care quality/outcomes, efficiency and service?

The Development of the Healthcare Market

With the clarity of hindsight, the shift from traditional health insurance to a competitive purchasing paradigm can be seen as a process that has been going on for several decades. The following is a brief sketch of developments.

At the start of the 1970s, President Nixon declared that the health system was in a state of crisis and proposed a number of measures to address runaway inflation and the numbers of uninsured. The Nixon plan for national health insurance, based on employer mandates, included a national system of hospital and physician price controls, to be run by state governments. At the time, the Nixon administration's health policy analysts did not believe that market-based strategies could achieve short-term control of national health care costs. Nevertheless, the Nixon administration also proposed an ambitious effort to expand the small HMO industry, 30 HMOs in 1971, to 1,700 by 1976, enrolling 40 million people. ** This effort was to try to develop a self-regulating healthcare market and lessen the longer-term need for government regulation of the health system.

** The initial option for Medicare HMO enrollment was enacted in 1972:

The proposal for nationwide development of a healthcare market, based on competition between HMOs and fee-for-service insurance, was an avante garde proposal, particularly unexpected from a Republican administration. Today, there is a tendency to view HMOs as a conservatives' idea, fostered by Wall Street investors, the insurance industry, and large corporations. But, for most of the history of HMO-like reforms (the Committee on the Costs of Medical Care, for example, advanced favorable views on "prepaid group practice" in the 1930's), progressive reformers were the major champions. The AMA and conservatives attacked the concept as a socialist or communistic challenge to fee-for-service medicine and the solo physician. The Nixon administration was influenced by the California-based leadership at DHEW, who were familiar with practical success of the Kaiser HMO, as well as by Paul Ellwood, who coined the phrase "Health Maintenance Organization". What the HMO Act of 1973 actually accomplished is still controversial - many believe it actually slowed the development of HMOs in the 1970s by imposing benefit package and rating requirements that made them uncompetitive in the marketplace - but it did mark initial political interest in an HMO development strategy. In 1980, Alain Enthoven's Health Plan presented a case for structuring the health system around competition among HMOs -- "managed competition" in today's parlance. ²

Other health proposals debated in the 1970s also had impact on future developments, although not necessarily as anticipated. National health insurance proposals (including government price controls), supported by Presidents Nixon, Ford and Carter, were not enacted; the national health planning law enacted in 1974 that created a continent-wide system of state and local level health planning agencies backed

by “certificate of need” laws, was widely considered ineffective and repealed by the end of the decade; the Carter administration’s hospital cost regulation bill passed the Senate but failed in the House of Representatives. From these experiences, the nation’s large employers undoubtedly drew the lesson that government regulation could not be relied upon to deal with their rising health insurance premiums.

The 1970s legislation that has most profoundly affected subsequent healthcare developments - especially employer-based purchasing - was the Employee Retirement Income Security Act (1974). Indeed, ERISA has arguably been the most important health legislation enacted in the 30 years since the passage of Medicare and Medicaid in 1965.

ERISA was not of much interest to health policy specialists when it was being debated, nor until a number of years later. In 1974, national health sector regulation proposals - national health insurance and health planning legislation - were at center stage. Most health policy specialists, if they heard about ERISA, thought it was just about pension reform. The ERISA legislation did grow out of many years of work by pension reformers, e.g. to deal with looting of union pension funds, and the interest of national employers in having a single national regulatory standard for their benefit plans. ERISA provided a federal regulatory framework for employer self-funded benefit plans and exempted such self-funded plans from state regulation. Its state preemption language was, however, quite broad and emphatic.

Section 514:

"The provisions of this (law) shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan"

This language carved out self-insured health benefit plans from state regulation, but (unlike the pension area) provided little federal health plan regulation. Nevertheless, ERISA had little immediately apparent consequence for the health system. In 1974, fewer than 5% of employer-financed health insurance benefits were self-funded. Almost all employers still purchased private health insurance policies, and states had federally-recognized authority to regulate the health insurance industry.

Nevertheless, ERISA altered the calculus of large employers about "self-insurance" vs simply paying insurance premiums. If an employer self-insures, it can (under ERISA) be exempt from state benefit mandates, as well as from state premium taxes, and also could use the cash "float" on the money it had been paying to insurers. ***

Following Ronald Reagan's election, the 1980s saw each of the major payers, including employers and government programs, deciding to go their own way to deal with health care costs. Medicare adopted its DRG and RBRVS price controls, and states were allowed to de-link Medicaid payment rates from Medicare's payment rates.

***ERISA also limits the ability of health sector interests to frustrate purchasing efforts by self-insured employers through state legislation.

In this environment, the movement toward business self-insurance progressed rapidly. By 1980, over 30% of the employer-provided health benefits were self-insured; by 1984, business self-insurance had replaced about 55% of the group health insurance business, and had been adopted by nearly all of leading Fortune 100 companies. Using these new arrangements - in which self-insured employers typically hired a "third party administrator" (TPA) to pay claims - business managers gained greater insight into their health care costs and could begin to do something about them. "First generation" managed care elements were rapidly adopted by leadership companies. In the two-year period 1982-1984, the percentage of employer plans requiring a hospital deductible more than doubled, from 30% to 63%, requirements for pre-admission hospital approval rose more than ten-fold, from 2% to 25%, and the requirements for hospital length-of-stay review more than quadrupled from 8% to 34%. The business coalition movement helped to educate businesses about health care and to create a new, supportive culture for employer efforts; by 1985, there were 140 such coalitions.³ As the decade progressed, business purchasers came to view health care as an industry, and to consider new ways to use their purchasing power. An exemplary publication from this period is the Midwest Business Group on Health's *Model Competitive Health Care Purchasing System* (1984).

With employer sponsorship, HMO enrollments, which had risen only from 6 million to 10.8 million in the 1976-1982 period, more than doubled in the subsequent 1982-1986 period, to 23.7 million enrollees. New models of "managed care" evolved along with traditional closed-panel HMOs. By the end of the 1980s, health policy analysts needed a lexicon that also included IPAs, PPOs, and POS plans. Employers

began to experiment with arrangements such as the "triple option": offering workers a choice of competing HMOs, PPOs and fee-for-service plans.

The new employer strategies had traumatic effects on the health insurance industry. For nearly half a century, the health insurance industry sold essentially the same product - traditional fee-for-service insurance - on a group basis. Aided by generous tax subsidies (the exclusion of employer paid premiums from employee taxable incomes), the growth of private health insurance was one of the great success stories in the annals of American business. The population covered by private health insurance rose from 12 million in 1940 to 122 million in 1960 and 189 million in 1980. But, by the mid-1980s, the health insurance market was changing radically: (1) employer coverage was falling; (2) most of the employer market had switched to self-insurance; (3) employees were often able to choose individually from among multiple competing plans, including managed care plans, even within a large employer group; and (4) employers often broke up the insurance "package" into different pieces, and subcontracted for firms that would do the best job, e.g. TPAs, a separate utilization review company, bill-audit firms, carve-outs for mental health and substance abuse benefits, "centers of excellence" contracting. Insurers were slow to respond. They had little expertise in managing health benefits and dire shortcomings in most of the competencies needed to respond to their customers' new demands.

The 1980s also saw pathbreaking work in studies of clinical practice variations, in clinical effectiveness and outcomes research, and in quality assurance. These efforts laid a foundation for the development of protocols, practice guidelines, clinical

pathways and TQM/CQI techniques, “report cards” and other similar efforts in the 1990s.⁴

Despite all of the activity, the purchasing of care did not go well in the 1980s. The changes did not translate into slowing of national health care costs. In 1990, when Paul Ellwood convened a meeting of health care and health insurance leaders - later to be called the Jackson Hole Group (JHG) - it was from a sense, not of success, but of despair. The nation seemed inevitably on the course to a government-regulated health system. From the ensuing series of meetings, a Jackson Hole Group proposal emerged, *The 21st Century American Health System* (1991), that combined universal health insurance coverage with the best ideas of theorists and practitioners for how to structure a “managed competition” future for the health system. In this proposal, accountable health plans (organized systems of care accountable for the health of enrolled population) would compete on the basis of cost, quality/health care outcomes, and service.

The JHG’s ideas for “managed competition” attracted broad, bi-partisan support among those searching for a centrist alternative between a laissez-faire market and a government-regulated health system, including President Bush and his eventual successor, President Clinton.⁵ Ultimately, neither elements of the JHG proposals nor the Clinton Plan were enacted into law. Nevertheless, the apparent political consensus for “managed competition”, and expectations for legislative action, had a galvanizing effect on health care market development. Energy and funds poured into developing “managed care” plans, of many varieties, and employers dramatically increased

enrollment in managed care plans, from about 30% in 1988 to a 70% share in 1995. About a dozen states also enacted legislation for some version of “health insurance purchasing cooperatives”, e.g. Florida, Washington, California. The National Committee for Quality Assurance (NCQA) launched a national HMO accreditation initiative and a “report card” system for quantifiable HMO performance comparisons (HEDIS).

Each of these factors, in turn, fostered other competitive dynamics. Insurers and providers now need to take part in managed care as a matter of their own survival, to protect their own patient or business base, simply because their competitors are doing so. New plans need to offer very competitive prices to get enrollees, and can take advantage of the oversupply of hospitals and physicians to do so; in turn, existing plans must find comparable economies. In a health system over-inflated by years of fee-for-service, open-ended reimbursements, such new market dynamics - from purchasers, intermediaries, and competitors - are now producing large adjustments in a compressed time period.

In sum, the evolution of a purchasing paradigm was influenced by at least five major factors over the last twenty-five years: (1) ideas about how to develop an effective health care market; (2) national and state political processes on health reform - including their successes, failures, and unintended results; (3) economic imperatives for employers to manage their benefit plans; (4) market conditions (oversupply and overspending) that created opportunities for effective purchasing; and (5) successful entrepreneurs and implementers, the “doers”, who created a better-functioning market. ⁶

Perhaps these developments will one day be said to have been predictable: both that employers would inevitably move to use their purchasing power, if government did not restrain healthcare costs; and that their efforts would be successful, in a health system characterized by much excess supply. On the other hand, there were also those who predicted that markets could never work in health care, or that business and providers would opt for different, political solutions, e.g. all-payer rate setting and government budgeting, as they have in other nations.

Over the last twenty-five years, this evolution of the healthcare market has followed general patterns seen in other sectors of the economy since the start of the industrial revolution. These changes include:

Demand side

- Greater use of market-based purchasing, including competitive comparison of suppliers on the basis of cost, quality and service;
- Development of both “wholesale” (group) purchasing and “retail” (consumer) purchasing, with professionalized large group purchasers (employers, managed care companies) leading the way in pushing suppliers for better cost, quality and service;
- Expansion from local markets to regional (and even national) procurement for specialized services, e.g. transplants, heart by-pass surgery, cancer care.

Market information

- Increasing availability and sophistication of comparative quality, costs and service information;
- Cooperative work by leading purchasers and suppliers on standardization of such measures;
- New enterprises specializing in market-oriented information.

Supply side

- A move from independent “cottage industry” organization (solo practice physicians, individual community hospitals) toward larger organizations, with economies of scale, and toward more vertically and horizontally integrated systems;
- Greater emphasis on managing cost, quality and service, including: use of professional managers, e.g. physician office managers, HMO medical directors; application of management techniques, e.g. TQM/CQI, statistical performance measures, benchmarking, clinical protocols/pathways; and performance incentives (including risk-sharing);
- Market-orientation, including active marketing for customers, new products, strategic alliances and strategic positioning;
- A greater use of capital market financing.

As the nation’s healthcare markets have evolved, so too have views about competitive purchasing of healthcare services. Today, serious research and discussions about healthcare markets seem to be gaining acceptance as valid ways to understand the world, as leading to interesting insights, and as useful for devising effective action.

If one reflects on the current scene, compared to a fee-for-service insurance mindset of ten years ago, one can sense some of the new paradigm’s possibilities as it has gained its current acceptance and use by health sector actors.

In a traditional fee-for-service environment, the role of payers was simply to be a financing source, to pay bills. Health care providers held sway without serious questioning or challenge. Hospital boards passed hospital budgets; physicians’ decisions were seldom questioned, and physicians were usually paid whatever they decided to charge. Quality activities addressed mostly essential requirements for licensure, or aimed at outliers. Nearly any willing provider was assumed to be

qualified for reimbursement, and the burden of proof fell on the payer if it questioned a bill.

In contrast, a purchasing mindset automatically brings a quite different set of working assumptions to health care issues, such as:

- Quality, price, and service vary;
- Competitive purchasing is the best way to get higher quality, price and service;
- Value to the consumer is the best metric for quality, price, and service;
- Suppliers should be accountable to consumers and purchasers for their performance.

Among the kinds of questions that have become more frequently asked, with greater urgency, throughout the health system as the paradigm of competitive purchasing from organized care systems has become dominant in the health care system are:

- Building health systems: What are the relative merits of HMOs, POSs, IPAs, PPOs, etc.? What number of primary care physicians, specialists, hospitals, and other services are needed for serving a given population? What are the contractual terms, financial incentives, and management practices needed for a successful health system?
- Comparative performance: Which are the best-performing health plans and health care providers in terms of quality, costs and service? What should be in the NCQA's "report cards"?
- Effectiveness/outcomes/value: What are the best protocols and guidelines for treatment of different conditions? What is the solid scientific evidence for effectiveness of different therapies? What are the best measures for assessing patient outcomes?
- Consumer satisfaction: What makes for satisfied or dissatisfied customers? What information do consumers want to know concerning health plans and health care providers? How can consumers make better-informed choices among alternative therapies?

- Prevention and disease management: Where are there failures to provide proven preventive measures, e.g. immunizations, or failures to provide good care management, e.g. asthma hospitalizations? How can prescription drug use, compliance, and self-care be improved for individuals with chronic diseases?
- Managing health care systems: What are the most effective techniques for improving health care providers' performance, e.g. TQM/CQI, clinical pathways? What are best respective roles of primary care physicians and specialists in the treatment of different conditions? What are the best practices in all areas, the benchmarks for competitive performance?

Which of these questions did health care providers ever feel an urgent need to answer - and to rapidly implement answers better than their competitors' - in the world of traditional health insurance? In what other country, with government price-setting and budgeting, is there such concern and activity around such fundamentally important questions? Today's pervasiveness, focus, and pace of change in coming to grips with such issues are indicative of how far our thinking has moved, from the mindsets of past decades as well as from the mindsets that prevail in other countries.

The market development today may be not nearly where payers, consumers and theorists think it should be - but one hears no calls by payers to return to the era of open-ended insurance and double-digit rate increases. Similarly, a purchasing paradigm may turn out to have some of the shortcomings suggested by its skeptics, but would we want to give up the benefits of the new ways of thinking?

The Future of Healthcare Purchasing

We are at the early stages of the purchasing revolution. The nation's largest employers, as well as large group purchasing arrangements (CalPers, FEHBP) have little

question that the market is working for them. Conversely, small businesses with little individual purchasing clout, particularly in areas in which there is still sparse competition among organized systems of care, appear to have seen less favorable results. The potential consumer role is even less well developed. We know far less than what we should want to know about how well purchasing strategies can work, for whom, and their pitfalls.

Recent developments have already produced some surprises. For many years, market theorists thought Kaiser-type, fully-integrated HMOs were the best product; now, even Kaiser is reconsidering that model and thinking about divesting itself of owning hospitals. POS and PPO type arrangements, with greater consumer choice of provider, are providing much of the growth in the marketplace. So it is hard to say just how purchaser and provider strategies will play out.

How can we foster the most effective use by payers and consumers of their \$1 trillion of annual purchasing power to better meet their own needs?

The following three priority areas are suggested for discussion at the conference:

1. Rapidly strengthen the ability to purchase healthcare based on quality Whereas fee-for-service medicine has incentives for overuse of services, capitated payment arrangements create incentives for underservice. Thus tough accreditation standards - and competitive performance measures on quality and service - are particularly important.

The healthcare purchasing revolution is now at risk of outrunning its ability to purchase healthcare on the basis of quality. Only a minority of HMOs now have accreditation by the National Committee for Quality Assurance (NCQA), and state regulatory authorities with regard to the managed care industry focus mostly on financial solvency issues and offer little assurance of quality.

There is now an initiative underway to supplement the NCQA efforts via establishment of the FAcct (Foundation for Accountability) to establish national health plan reporting requirements that meet the needs of payers, including private sector employers as well as the Medicare and Medicaid programs. In addition, the focus on health plan-level data, which is the major concern for employer purchasing, can usefully be supplemented in two areas:

- Consumer-oriented information Employer health benefit managers are concerned primarily with deciding which health plans to offer for their employees, and are thus interested most in plan-level performance data. But consumers have different sets of questions, many of which relate to selection of specific providers. Consumer questions also vary depending on whether individuals are looking for a primary care provider or whether they have particular chronic conditions that require specialist treatment.
- Service-specific contracting information The employer community has already used various forms of “carve-outs” from health plans, particularly where it can be demonstrated that specialized providers can do a better job. Examples of selective contracting include: pharmacy benefit management, transplants, heart surgery, cancer care, mental health and substance abuse, and others. In many fields, specialization has been a proven means to greater efficiency, higher quality, and better service. If specialized providers, with various service packages, can compete with comprehensive managed care plans, using standardized performance measures, this will facilitate comparison shopping, help everyone concerned to identify best practices and

set performance standards, help to reward first-rate providers, and create even stronger competitive markets.

2. Promote vigorous competition for excellence in serving the chronically ill, disabled and high-expense populations Even individuals friendly to the ideas of managed competition among competing health plans worry about how well managed care plans will do in serving the chronically ill, disabled and high-expense populations. It is sensible to expect that the managed care industry will compete well for enrolling and serving the great majority of the population, on which they expect to make money. But given that a fairly small percentage of the population accounts for much of healthcare spending, e.g. 5% of enrollees consume 50% of care, the incentives of health plans are to “demarket” (at least) such populations, on which they will predictably lose money.

As pointed out in a forthcoming article by Stan Jones, the competitive health system that purchasers, patients and providers should want is one in which health plans compete to excel in taking care of all patients - particularly those who most need good medical care. Much of the potential benefit of managed care probably lies in improving services for these populations. But today even the best plans are forced to be “in the pack” (at least) so as not to be more favorable to higher-expense populations than other plans. ⁷

The Medicare and Medicaid programs, as well as many employers, have large potential roles in developing more effective competition for these patients. There are several approaches which experts studying these issues believe are worth exploring.

- Different blends of capitation and fee-for-service payments. A well-calibrated premium payment may not be achievable at the level of the individual patient. But providers, patients, and employers could be satisfied with various combinations of fee-for-service, some capitation, and performance incentives.
- Service-specific “carve-out” contracts, PPO or POS features (without additional cost-sharing) for designated centers of excellence and specialty providers. Expenditures for those providers would be subtracted from the full capitation amount payable to a health plan in which the individual were enrolled. This approach creates an incentive for a health plan to match the standards of excellence of the best providers of care for chronically ill and high expense populations since it receives less money if the patient goes out of network. Employer and consumer are also assured of patient access to the best care.
- Purchasing standards and “benchmarks” for care of the chronically ill, disabled and high expense populations that can be incorporated into the purchasing RFPs by large employers for deciding which of the many managed care plans they will make available to their employees. If the Bay Area business coalition and CalPers (as well as Medicare and Medicaid), for example, required top-rate performance for these populations as the entry price for being offered to their membership, health plans that aimed to have a large market share would need to meet these standards.

3. Greatly expand use of multiple employer purchasing arrangements, e.g. HPCS Small employer groups (and their employees) need organizations like Healthcare Purchasing Cooperatives (HPCs) to assist their purchasing efforts. These arrangements make possible buying in large volume, with expert advice, to obtain the best cost, quality, and service. Market-friendly legislation is essential for the full benefits of a purchasing approach to be realized by the one-half of the population working for smaller firms. For the longer term, even larger employers may also find that - if healthcare markets begin to work really well - they can move toward defined-contribution arrangements, step back from trying to manage healthplan competition individually, and let their workers choose their health plans from HPC-like organizations.

In this new evolutionary stage, we also need to think clearly about the key issues of: (1) the "selection" process for the "survival of the fittest" in the healthcare system, and (2) the competitive criteria it employs. Today, purchasers have an important new role in these matters. Public policy thus needs to pay greater attention to the question: How can we assist consumers of healthcare, and those who purchase on their behalf, to make the best use of their \$1 trillion of annual purchasing power to foster new levels of excellence in health care quality/outcomes, efficiency and service?

Conclusion

The evolution of competitive purchasing of healthcare, as a national paradigm, now extends for at least 25 years. Will tough purchasing lead to a better health system? One basis for considering that question is suggested by Michael Porter's *The Competitive Advantage Of Nations* in which he reviews dozens of international industries to determine what factors make for world-class leadership. He identifies four factors that are essential - in a nation's home market - for global leadership: excellent infrastructure and productive resources; internationally competitive suppliers; first-rate competitors -- and the world's most sophisticated and demanding purchasers. None of the world-class industries he studied received their revenues from an open-ended, undemanding insurance system. Competitive purchasing of healthcare, if it is well done, thus may prove to be a key to continuously-improving excellence in quality/outcomes, efficiency, and service in the U.S. health system.

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1 The introduction of evolutionary concepts into economic theory is a particularly fruitful way to discuss economic change. For recent overviews, see Richard Nelson "Recent Evolutionary Theorizing About Economic Change" in *Journal of Economic Literature* (March 1995) and Geoffrey Hodgson Economics and Evolution: Bringing Life Back Into Economics University of Michigan (1993). Ecological concepts are also apt, but have seen less integration into economic thinking. See E. J. Kormondy Concepts of Ecology Prentice-Hall (1984).

2 Martin Feldstein's idea to create a consumer-based health care market by raising health plan deductibles is also still influential in proposals for medical IRAs coupled with catastrophic health insurance coverage. RAND's health insurance experiment, led by Joe Newhouse, established the importance of consumer market price for medical care decisions.

3 Statistics cited here and elsewhere about health sector changes come from a variety of sources, including Hewitt Associates, Interstudy, GHAA, HIAA, Foster-Higgins, KPMG.

4 Among the contributors were Jack Wennberg, David Eddy, researchers working with RAND and Interstudy, Don Berwick, and others.

5 Legislation sponsored by Representative Jim Cooper and colleagues was the leading bill based on the JHG's managed competition design (the Cooper/Breaux bill, H.R. 3222/S 1579)

6 Through the efforts of Dick Sharpe, the John A. Hartford foundation supported a number of the leading initiatives to improve the healthcare market.

7 Stanley Jones "Why Not The Best?" (in process)