

File (5)  
AARP

To: Sarah - 456-5557

For Chris Jennings

• Strike Kyl

• Establish an unrestricted fee-for-service demonstration project with the following provisions:

- = require minimum payment floor for plans and prohibit unrestricted fee-for-service plans from offering "extra benefits" until the minimum payment floor is met
- = require that premiums, deductibles and coinsurance not exceed the actuarial value of cost-sharing in traditional Medicare
- = require non-contract providers to accept as payment from the beneficiary no more than the amount they could collect if a beneficiary were enrolled in traditional Medicare
- = require minimum Medicare Choice/Plus plan enrollment
- = prohibit beneficiary calendar year maximums
- = limit beneficiary disenrollment from unrestricted fee-for-service to the annual enrollment period
- = require internal quality review programs and contracts with external quality review entities
- = require medical records to be accurate, confidential and accessible to beneficiaries in a timely way
- = require marketing materials to carry specifically worded disclosure -- prominently displayed -- about out-of-pocket costs, limits on provider payments and any other restrictions
- = require HHS to issue regulations precluding the use of specific types of plan names and descriptions that are likely to mislead beneficiaries into thinking they are enrolling in traditional Medicare
- = Establish a separate Medigap product for beneficiaries enrolled in unrestricted fee-for-service and prohibit enrollment in the current standardized Medigap policies

(companies would not be required to offer such a plan, but would have the option)

Chris: Call for background

7/22/97

## Draft Ideas for VP AARP Speech

### I. Medicare Accomplishments

**Preserved and Protected Medicare.** Proud that we were able to work together to protect Medicare from flawed structural reforms that undermine the program. Medicare has been an essential program for millions of older Americans. Since the program began, the rate of uninsured elderly has dropped from 46 percent to 1 percent.

**Improved and Modernized Medicare in the BBA.** Also proud of what we were able to accomplish together last year in the Balanced Budget Act. Together we put in place historic Medicare reforms that improved the program for beneficiaries and extended the life of the Trust Fund for a decade.

- **New benefits improvements and unprecedented plan choices.** The BBA included new preventive benefits -- such as mammography, colorectal screening, diabetes education and testing, and bone mass measurement for osteoporosis to help beneficiaries get the preventive care they need. It also included new health plan options for beneficiaries, such as PPOs and PSOs to allow beneficiaries to choose the care that best meets their needs.
- **Ensuring beneficiaries understand these new improvements.** While these benefits gave new choices and improvements to Medicare, these important reforms also have the potential to cause confusion. We should work together to ensure that beneficiaries and their families fully understand these new options.
  - Insurance Counseling Programs/other education campaigns that AARP runs will be critical in this process and we want to work with you to make sure older Americans understand all of their new options.
  - Customer Satisfaction/Quality. Medicare recently launched a new CAPHS survey that measures patient satisfaction about their health plans. This information will come out this fall so that for the first time beneficiaries can compare plans on the basis of quality.

### II. Fighting Fraud and Abuse.

The other thing we must do to preserve and strengthen Medicare is to root out fraud and abuse. We all know there are still too many bad apple providers that are bilking the system.

- **Administration Accomplishments.** This Administration has an unprecedented record in cracking down on fraud and abuse. Since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240 percent and we have saved some \$20

billion in health care claims. The Kassebaum-Kennedy legislation created -- for the first time ever -- a stable funding source to fight fraud and abuse. This year's historic Balanced Budget Act also gave us an array of new weapons before in our fight to keep scam artists and fly-by-night health care out of Medicare and Medicaid. Etc. etc.

- **Beneficiaries Reporting Fraud.** But we must do more. No one knows how important this is for Medicare than you. That is why today, I am announcing that we are releasing a new regulation that gives beneficiaries rewards for reporting fraud. (Examples of when this has been successful). We must all work together if we are going to root out fraud and abuse and make this program is strong for the millions of Americans who depend on it.

**III. Medicare Commission.** Now that we have worked together to preserve the program for the short-term, we need to ensure that this program is prepared as it is strong as the baby boomers retire.

- **Important process.** As we continue discussion of Social Security should also focus on the important process underway to discuss how to prepare Medicare for the baby boom generation. We hope we can work together as we did in the Balanced Budget process.
- **Should not just be an exercise in financing.** Should examine ways to improve Medicare for the future -- looking at ways in can better serve older Americans and people with disabilities.

**IV. Medicare Buy-in -- why this proposal is so important**

- **Helps a vulnerable group of Americans who the insurance market has failed.** This proposal gives vulnerable Americans ages 55 to 65 new options for health care without hurting the Medicare Trust Fund or undermining the Balanced Budget. Highlight AARP's report on this problem that validates the Administration's proposal.

**V. Quality/Customer Satisfaction.** Transition to other things we are doing to ensure high quality care and improve medical outcomes.

- **Quality Forum.** Later this month, I am launching quality forum which brings together the public and private sectors in an unprecedented efforts to coordinate our efforts to improve the quality of care. This process is designed to give consumers more information about the quality of care they are receiving, and will help ensure that health plans compete on the quality of care delivered rather than cost.

- **Patients' Bill of Rights.** If we are really going to improve the quality of care, then we must work to ensure important that patients have the protections they need in a rapidly changing health care system. One of our highest priorities is passing a patients' bill of rights, and we look forward to working with you to ensure that Congress passes these protections before they adjourn.

## **VI. Investments in Biomedical Research/Health Improvements**

- **Importance of Research.** Scientists are making strides in biomedical research -- breakthroughs in cancer, genetics, and better understanding aging process and aging diseases, such as osteoporosis and Alzheimers. How important this is for the treatments and care available to older Americans.
- **Passing the Administration's historic, multi-year investment in biomedical research.** We must work together to urge Congress to pass the President's historic investment in biomedical research this year.

## **VII. Social Security**

- Thank them for participating in this educational process. This an important program and look forward to working with them throughout this process. (Add stuff per conversation with AARP.

FYI - TO  
Read TONIGHT -

I think we're  
pretty smart + (or at  
least very consistent)

July 4, 1997

**MEMORANDUM TO THE PRESIDENT**

**FROM:** Chris Jennings

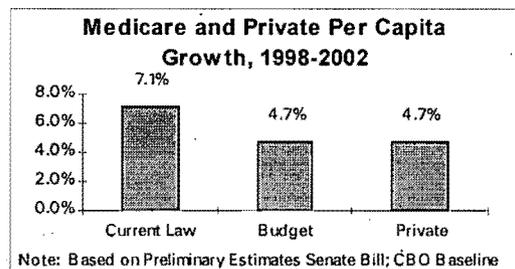
**cc:** Gene Sperling, Bruce Reed, John Hilley

**SUBJECT:** The Challenge of Long-Term Medicare Reform

Both the House and the Senate reconciliation bills include a Medicare Commission to address long-term reform. Your policy advisors from NEC, DPC, CEA, OMB, HHS, and Treasury have uniformly concluded that it is highly unlikely that a politically and policy-viable Medicare reform initiative, which comprehensively addresses the program's long-term financing challenges, can emerge from a Commission within the next one or two years. This memo focuses on the underpinnings of this conclusion and supplements the decision memo Gene sent to you yesterday.

**BACKGROUND**

The Medicare reforms in the budget agreement represent a major restructuring of the program and produce savings that are larger than any enacted in the history of the program. In fact, the Congressional Budget Office (CBO) projects that Medicare spending under the budget would slow from 7.1 percent per capita to 4.7 percent on average between 1998 and 2002 — almost exactly mirroring the projected private premium growth of 4.7 percent. Medicare's Actuaries estimate that the policies we are supporting in the upcoming House/Senate conference would extend the life of the Hospital Insurance (Part A) Trust Fund through 2010.

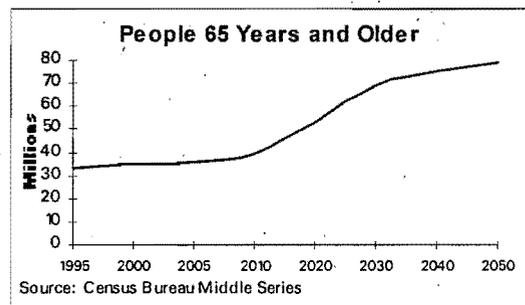


Even more important than the unprecedented level of savings credited to us by CBO are the structural changes to the program that have extraordinary potential to constrain Medicare growth for a much greater time than a traditional 5-year budget would produce. Specifically, your reforms provide for: (1) more managed care plan choices (PPOs and Provider Sponsored Organizations); (2) the authority to develop and implement "risk adjusted" managed care

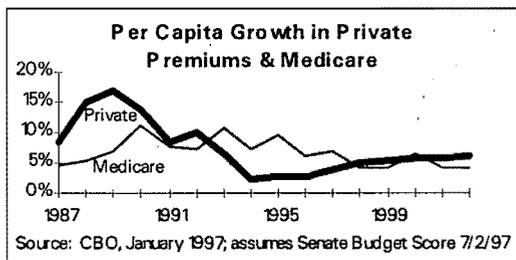
reimbursement reforms; (3) the establishment of prospective payment for nursing homes, home health care, and outpatient departments; (4) the authority to use new “prudent purchasing” techniques (like competitive bidding for the myriad devices and services that Medicare buys); (5) a major set of anti-fraud and abuse initiatives; and (6) the coverage of services and tests that detect diseases before they become severe and expensive to treat. These important provisions could produce savings that would have a significantly positive impact on the state of the Medicare Trust Fund during the next decade and beyond.

Although CBO does not give full credit to the above-mentioned structural reforms as producing significant “scorable” savings, health policy experts agree that they are more important to the program’s long-term viability than traditional fee-for-service cuts. The elite media, however, does not define these major changes as “structural reform” because their definition cannot be met unless beneficiaries are directly hit and are complaining about it.

Regardless of all the positive changes to Medicare we hope to make this year, the long-term financing crisis remains constant. Medicare’s spending growth, while constrained in the next 10 years due to the budget, will increase thereafter. This growth will be primarily driven by demographics. Beginning in 2010, the baby boom generation begins to turn 65 years old. The number of people age 65 and older is projected to increase from 39 million in 2010 to 69 million in 2030. People aged 85 and older will double by 2025 and increase fivefold by 2050. In 2030, one in five Americans will be elderly compared to 13 percent today. This will have an enormous impact on Medicare although its impact might be mitigated by other trends. For instance, seniors in the 21st century might be wealthier or healthier and have less of a need for health care. Or, if given the opportunity or need, they might choose to extend their working careers and maintain their employer coverage.



Additionally, Medicare’s spending growth is inextricably linked to general health inflation. In fact, with the exception of the last several years, Medicare spending growth per beneficiary has paralleled that of the private spending per person over the last 30 years. This is good news as long as the private sector continues to be successful at constraining costs to the levels they have in recent years; unfortunately, the most recent forecasts predict a possible return to higher private



sector health care inflation. The unanswerable question in health care these days is can private and public successes in constraining cost growth be repeated for long periods of time OR are we about to witness a new cycle of inflation that will not easily be broke because the excess in the system was squeezed out in the 1990s.

This uncertainty is increased by the nature of health care. The factors that affects its growth — different disease patterns, scientific break-throughs, changes in technology and health care delivery systems — will have profound but as-yet unknown effects on Medicare spending's rate of increase. If, for example, the new age of biology starts producing remarkably successful treatments for extraordinarily expensive diseases, a brand new and positive Medicare Trust Fund cost projection could ensue.

### **Range of Options**

Unfortunately, in the proposed Commission's one to two-year time frame, we will not know the real benefit of the new structural reforms. We also will not have any better understanding of possible dramatic positive or negative health spending trends, described earlier, that could change the size and nature of Medicare's long-term problem. As a result, any Medicare Commission would work off assumptions that are fairly close to our current projections — however flawed and temporal they may be. So, for instance, working off of this baseline, even if we could maintain a relatively low per capita cost growth over an extended period of time, the Actuaries suggest it would still be necessary to find hundreds of billions to make the Trust Fund solvent in the long-term. This would require the Commission to consider all or a combination of the following range of options:

***Provider cuts.*** Reducing payment rates to providers is typically the first place that policy makers go to achieve Medicare savings. Both in the recent past and near future, there has been enough excess in the system to generate significant savings from this approach. While there are still ways to improve provider payments, the size of the financing problem will dwarf savings from these changes. Provider cuts that reduce Medicare growth well below private premium growth could potentially cause problems with access, quality, hospital closure, and the general criticism of turning the program into a "second class" system.

***Benefits reduction.*** Another way to reduce costs is to reduce what is covered. Although strong arguments can be made for re-designing certain benefits to have a greater and more traditional copayment structure, such an approach would do little other than to cost-shift to private Medigap plans or the Medicaid program which, taken together, cover 85 percent of the elderly. In so doing, we would not be addressing the over-utilization problem unless we prohibited Medigap plans from offering the first-dollar copayment coverage. While arguably good policy, such an approach does not seem likely to emerge from the current Congress. Finally, and perhaps most importantly, the Medicare benefits package — contrary to its image — is not excessively generous to start with. In fact, because it does not cover prescription drugs or cover catastrophic costs, it ranks in the 20th percentile of plans offered by large businesses. As such, reducing the benefits package is not easy to do when it already has a value well below that of the standard Federal employee package.

**Beneficiary contribution increases.** Last week, the Senate affirmed a growing sentiment that Medicare beneficiaries should shoulder more of the costs of Medicare through both premium and cost sharing increases. While there is undoubtedly some room to do this, particularly for premiums for high-income beneficiaries, it is important to keep in mind that Medicare's benefits pay for less than half of the health care costs of seniors; the average community-based elderly person pays about \$2,600 per year for premiums and out-of-pocket health care costs. In addition, increased cost sharing — as mentioned above — has its effect blunted by Medicaid and Medigap. And, lastly, even if we assume the enactment of all of the new beneficiary contributions passed by the Senate, the life of the Trust Fund would be extended by less than 2 years. A separate memo on the three primary issues, , is being submitted

**Defined contribution / voucher / private plan approach.** During the 1995 budget debate, Republicans proposed to cut \$270 billion primarily by putting a cap on Federal Medicare spending. In other words, beneficiaries would be entitled to a fixed dollar amount or “defined contribution” rather than a defined benefit. This approach is similar to increased beneficiary contributions in that its effect (if not its goal) is to limit Federal liabilities. And, like beneficiary contributions, it may not slow overall Medicare cost growth. Plans and providers may react to the fixed contribution by reducing their own costs to compete within this cap. Alternatively, they could erode the benefits, quality of care, or bill beneficiaries to make up for losses. If not done extremely carefully, this policy could undermine Medicare's basic promise of health care for the elderly and disabled. Moreover, since the program is already growing at a relatively modest 5 percent per person clip, a defined contribution's growth would have to set well below this amount to achieve the savings needed under today's definition of the Trust Fund problem. In fact, the Medicare Actuaries estimate that this growth would have to be below general inflation (about 1 to 2 percent per capita) to achieve long-term solvency without tax increases. Over time, this could produce access problems as managed care plans avoid the sickest beneficiaries.

**Taxes.** If there is not a significant downward adjustment in the current long-term financing projections, a bipartisan Commission would likely be forced to suggest a significant increase in the current Medicare payroll tax. For example, even if we assumed success in maintaining per capita growth rates at or below 5 percent through provider payment reductions and structural reform, the Medicare Actuaries project the need for a 2.4 percentage point increase in the Medicare HI payroll tax; it would rise from 2.9 to 5.3 percent, or 1.45 to 2.65 percent per employee. Such an increase would raise \$540 billion over 5 years.

### **Conclusion**

Medicare's long-term financing is one of the most important public policy issues of our generation. However, as outlined above, the exact size of the problem depends on health inflation trends, the nature of the demographic changes, and the long-term impact of the structural reforms passed in this year's budget. We are concerned about the potential negative consequences of a Commission that has the almost impossible burden of reviewing a rapidly changing program in a compressed amount of time and, in so doing, developing ill-informed and rushed recommendations.

Unlike Social Security, there has been no comprehensive attempt to define problems and new trends facing the program, and to develop thoughtful analysis and options. If we assume current trends and push forward with recommendations on Medicare, we will face a choice of extremely difficult and unpopular options — options that appear unlikely to gain much consensus, particularly in the absence of a perceived crisis. Moreover, attempts to move quickly may well lead to ill conceived and inadequately considered proposals that could undermine rather than strengthen Medicare. Finally, groups such as AARP have quietly indicated to us a great preference for Social Security over Medicare reforms, and are willing to work with us to help educate their Members and younger generations of Americans on this matter.

As a result of our concerns with the Medicare Commission provisions pending in the budget conference, we are recommending that we focus our efforts on redesigning any Commission that emerges from the budget reconciliation bill to be a study-oriented, non-binding body that is not “stacked” against the Administration. Its findings would be used to inform and advance the debate on how to address the long-term financing challenge, but the Commission itself would not be expected to come up with the final resolution(s) to the problem.

Finally, in suggesting a cautious approach with any Medicare Commission, we are not advocating allowing Medicare’s problems to go unaddressed. As we better understand the dimensions of the long-term problem, we can take the necessary actions that the problem requires. In the meantime, we should give serious consideration to addressing the policy shortcomings of the income-related premium proposal passed by the Senate to make it acceptable for inclusion in either the budget agreement or some other legislative vehicle that subsequently becomes available. (Clearly, opting for this type of reform in the context of the balanced budget will require a reading by John Hilley and others of how it would affect the votes from our rather shaky Democratic base in the House.) In addition, there are other reforms like postponing Medicare’s eligibility age to 67 (with protection to ensure access to coverage), making Medicare managed care more competitive, requiring Medicare managed care plans to offer standardized benefits (e.g., basic coverage and basic plus drugs), and Medigap reforms that could make significant contributions to the long-term financing problem.

We will keep you informed of both developments on the Hill with regard to the Commission and our internal discussions about long-term financing reform of the Medicare program.

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**EXPLANATION OF OMB AND CBO SCORING DIFFERENCES FOR BBA: MEDICARE**

**Medicare: Summary of OMB and CBO Scoring  
FY 1998 - FY 2002**

(OACT standalone estimates, OMB calculations of managed care interactions)

	<b>CBO Scoring</b>	<b>OMB Scoring</b>	<b>OMB over CBO</b>
<b>Managed Care</b>	\$21.7 billion	\$45.5 billion	\$23.8 billion
<b>Hospitals</b>	\$39.9 billion	\$56.3 billion	\$16.4 billion
<b>Medicaid Cost Sharing</b>	(\$4.4 billion)	(\$2.3 billion)	\$2.1 billion
<b>Part B Premiums</b>	\$14.8 billion	\$16.3 billion	\$1.5 billion
<b>SNF/Hospice</b>	\$9.7 billion	\$10.4 billion	\$0.7 billion
<b>Home Health</b>	\$16.2 billion	\$16.7 billion	\$0.5 billion
<b>Physicians</b>	\$4.9 billion	\$5.3 billion	\$0.4 billion
<b>Fraud and Abuse</b>	\$0.1 billion	\$0.3 billion	\$0.2 billion
<b>Other Policies</b>	(\$1.7 billion)	(\$1.8 billion)	(\$0.1 billion)
<b>MSP</b>	\$7.9 billion	\$6.8 billion	(\$1.1 billion)
<b>New Benefits</b>	(\$3.9 billion)	(\$6.5 billion)	(\$2.6 billion)
<b>Other Part B</b>	\$6.9 billion	\$3.0 billion	(\$3.9 billion)
<b>Total</b>	\$112.1 billion	\$149.8 billion	\$37.7 billion

- What is the difference between OMB and CBO scoring of the BBA Medicare provisions?

OMB (the HCFA Actuaries) scored \$149.8 billion in savings over five-years and \$513.0 billion in savings over ten-years to the BBA Medicare policies. CBO scored the same policies at \$112.1 billion (\$37.7 billion less than OMB) over five-years and \$386 billion (\$127 billion less than OMB) over ten-years.

- Compare OMB savings to the savings in the Vetoed 1995 Conference Agreement.

The initial seven year savings (FY96-FY02) attributable to the vetoed 1995 Conference Agreement, as scored by CBO, totaled \$226.8 billion. Adjusting those policies forward, OMB estimates that the Conference Agreement would have reduced CBO's Medicare baseline by 17 percent, or \$336.7 billion, over the seven-year period FY98-FY04. By contrast, the savings over the same seven-year period attributable to the BBA policies will reduce the OMB baseline by only 14 percent, or \$270.3 billion.

- Explain the difference between OMB and CBO scoring.

The bulk of the difference occurs in the estimates for Medicare+Choice and hospitals.

**Medicare+Choice.** OMB scores \$23.8 billion more savings to Medicare+Choice than does CBO (\$45.5 billion from OMB vs. \$21.7 billion from CBO). Disagreement about the effects of the BBA's mandated risk adjustment of Medicare+Choice payments accounts for \$10 billion of this difference: OMB scores \$10 billion in savings to this provision, while CBO scores no savings. Most of the remaining difference can be explained by larger OMB savings from fee-for-service providers. Due to the link between fee-for-service growth and Medicare+Choice payments every cut to a fee-for-service provider also results in a cut in managed care payments. Thus, OMB's higher level of fee-for-service savings automatically results in a higher level of managed care savings.

**Hospitals.** OMB scores \$16.4 billion higher savings from the hospital provisions than does CBO (\$56.3 billion from OMB vs. \$39.9 billion from CBO). CBO and OMB scoring differed significantly for 4 of the approximately 20 hospital policies in the BBA:

- *The PPS update* (+\$5.7 billion over CBO). OMB assumes a higher hospital market basket than CBO, thus achieves more savings from a freeze in hospital payments than CBO (savings from a freeze are equal to the hospital market basket).
- *PPS capital* (+\$1.9 billion over CBO). CBO appears to attribute a higher percentage of their hospital baseline to operating costs than OMB, thus a capital cut achieves lower savings off of their baseline.
- *Hospital Transfers* (+\$3.9 billion over CBO). The final BBA policy was limited to 10 DRGs for two years. OMB assumes that this policy will be expanded beyond 10 DRGs after two years, whereas CBO believes that the policy will remain limited for a longer period of time.
- *Graduate Medical Education* (+\$3.1 billion over CBO). The main focus of the GME policy is a cap on residents. OMB assumes that resident slots will grow by between 3-4 percent per year while CBO assumes a growth rate of approximately 2 percent. Thus, OMB achieves more savings.

**MEDICARE GROWTH RATES**  
**Comparison of OMB and CBO BBA Impacts on Net and Per Capita Spending**  
*Five and Ten Years, All Mandatory Outlay, \$s in billions*

**CBO January Baseline**

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	1,418.5	3,290.7
Spending Growth	8.8%	8.6%
Per Capita Growth	7.5%	7.2%
Post-BBA Spending	1,306.4	2,904.4
Spending Growth	5.6%	7.1%
Per Capita Growth	4.3%	5.6%
Spending Difference	(112.1)	(386.3)
Spending Growth (pct pt)	(3.3)	(1.6)
Per Capita Growth (pct pt)	(3.3)	(1.5)

**OMB FY 1998 MSR Baseline**

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	1,432.7	3,262.8
Spending Growth	8.9%	8.7%
Per Capita Growth	7.6%	7.2%
Post-BBA Spending	1,282.9	2,749.0
Spending Growth	4.9%	6.2%
Per Capita Growth	3.6%	4.8%
Spending Difference	(149.8)	(513.8)
Spending Growth (pct pt)	(4.0)	(2.5)
Per Capita Growth (pct pt)	(4.0)	(2.5)

**OMB/CBO Difference, Pct. Point**

	FY 1997 - FY 2002	FY 1997 - FY 2007
Baseline Spending	14.2	(27.9)
Spending Growth	0.1	0.1
Per Capita Growth	0.1	0.1
Post-BBA Spending	(23.5)	(155.4)
Spending Growth	(0.7)	(0.9)
Per Capita Growth	(0.7)	(0.9)
Spending Difference	(37.7)	-127.5
Spending Growth (pct pt)	(0.8)	(1.0)
Per Capita Growth (pct pt)	(0.7)	(0.9)

Why is  
 97-02  
 Baseline  
 Higher  
 (But 97-07  
 Lower)

1412.7?

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**MEDICARE: Comparison of 1995 Conference Agreement (CBO) and 1997 BBA (OACT) Seven Year Scoring**  
 (fiscal year, dollars in billions)

DRAFT

Fiscal Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total	
											FY96-FY02	FY98-FY04
<b>CBO -- SEVEN YEAR SAVINGS FROM 1995 VETOED CONFERENCE AGREEMENT</b>												
Net Mandatory Outlays, CBO 12/95 /1	157.0	176.6	194.9	213.1	233.3	254.7	278.3	303.7	328.3	356.5	1,654.6	1,967.9
Growth	-	12.5%	10.4%	9.3%	9.5%	9.2%	9.3%	9.1%	8.1%	8.6%	9.9%	9.0%
Per Capita	\$ 4,180	\$ 4,632	\$ 5,039	\$ 5,448	\$ 5,897	\$ 6,363	\$ 6,872	\$ 7,415	\$ 7,922	\$ 8,496		
Growth	-	10.8%	8.8%	8.1%	8.2%	7.9%	8.0%	7.9%	6.8%	7.2%	8.5%	7.7%
Net Medicare Cut /2	-	6.4	13.8	22.8	34.2	41.8	50.0	57.8	62.4	67.7	226.8	336.7
Percent of Baseline	-	3.6%	7.1%	10.7%	14.7%	16.4%	18.0%	19.0%	19.0%	19.0%	13.7%	17.1%
Revised Net Mandatory Outlays	157.0	170.2	181.1	190.3	199.1	212.9	228.3	245.9	265.9	288.8	1,427.8	1,631.2
Growth	-	8.4%	6.4%	5.1%	4.6%	6.9%	7.2%	7.7%	8.1%	8.6%	6.6%	6.9%
Per Capita	\$ 4,180	\$ 4,464	\$ 4,683	\$ 4,865	\$ 5,032	\$ 5,319	\$ 5,637	\$ 6,004	\$ 6,417	\$ 6,882		
Growth	0.0%	6.8%	4.9%	3.9%	3.4%	5.7%	6.0%	6.5%	6.9%	7.2%	5.3%	5.7%
Spending Growth Rate Change	-	(4.1)	(4.0)	(4.3)	(4.9)	(2.2)	(2.0)	(1.4)	0.0	0.0	(3.3)	(2.1)
Per Capita Growth Rate Change	-	(4.0)	(3.9)	(4.2)	(4.8)	(2.2)	(2.0)	(1.4)	0.0	(0.0)	(3.2)	(2.1)
<b>OACT -- SEVEN YEAR SAVINGS FROM 1997 BBA</b>												
Net Mandatory Outlays, OACT FY 98 MSR	159.8	174.2	187.8	204.7	224.0	243.6	264.9	287.8	312.4	339.0	1,586.9	1,876.4
Growth	-	9.0%	7.8%	9.0%	9.4%	8.8%	8.7%	8.7%	8.6%	8.5%	8.8%	8.8%
Per Capita	\$ 4,254	\$ 4,569	\$ 4,856	\$ 5,233	\$ 5,661	\$ 6,087	\$ 6,541	\$ 7,027	\$ 7,539	\$ 8,079		
Growth	-	7.4%	6.3%	7.8%	8.2%	7.5%	7.5%	7.4%	7.3%	7.2%	7.4%	7.5%
Net Medicare Cut	-	-	-	8.7	18.7	31.4	41.3	49.6	56.5	64.1	149.8	270.3
Percent of Baseline	-	-	-	4.2%	8.4%	12.9%	15.6%	17.2%	18.1%	18.9%	9.4%	14.4%
Revised Net Mandatory Outlays	159.8	174.2	187.8	196.0	205.2	212.2	223.5	238.2	256.0	274.9	1,437.2	1,606.1
Growth	0.0%	9.0%	7.8%	4.4%	4.7%	3.4%	5.4%	6.6%	7.5%	7.4%	5.9%	5.6%
Per Capita	4,254	4,569	4,856	5,012	5,188	5,301	5,520	5,816	6,176	6,552		
Growth	0.0%	7.4%	6.3%	3.2%	3.5%	2.2%	4.1%	5.4%	6.2%	6.1%	4.6%	4.4%
Spending Growth Rate Change	-	-	-	(4.6)	(4.7)	(5.4)	(3.4)	(2.1)	(1.1)	(1.1)	(2.9)	(3.2)
Per Capita Growth Rate Change	-	-	-	(4.6)	(4.7)	(5.3)	(3.3)	(2.1)	(1.1)	(1.1)	(2.9)	(3.2)
Enrollment	37.6	38.1	38.7	39.1	39.6	40.0	40.5	41.0	41.4	42.0		

**Notes:**

1/ FY 03 and FY 04 CBO 12/85 baseline grown by growth rates for those years in the 1/97 CBO baseline

2/ FY and FY 04 savings amounts are estimated as the same baseline reduction from FY 02 (19 percent).

All per capitas are calculated using OACT's unduplicated count of beneficiaries.

*thoughts are used part 4 Baseline*

5:29 PM

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## **Clinton Presidential Records Digital Records Marker**

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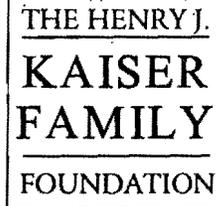
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## **OVERVIEW OF SELECTED MEDICARE PROVISIONS:**

**A Side-by-Side Comparison of Medicare Current Law with House and Senate Provisions to  
the Balanced Budget Act of 1997**

**Prepared by:  
Health Policy Alternatives, Inc.**

**Prepared for:  
The Henry J. Kaiser Family Foundation**

**July 1997**

Blue Dog 1997 File

## Medicare Priorities -- John Tanner (representing Blue Dog budget)

1. **AAPCC Payments for risk contractors in rural and underserved areas** is of great concern to us. The current payment methodologies discourage the formation of managed care and other private Medicare options in rural areas, and thereby severely restricting beneficiary choice in these areas. We support the establishment of a fair and equitable payment floor and the rapid implementation of a blended national area rate. The Coalition budget set a national floor on payments at 85% of the national average, and achieved a blend of 70% county and 30% national by 2000

2. **Provider Sponsored Networks** We strongly endorse the reforms allowing Provider Sponsored Organization, Preferred Provider Organizations and Point of Service plans to be offered as options for Medicare beneficiaries. In particular, we believe that it is extremely important that Medicare reform legislation facilitate the creation of Provider Sponsored Organizations. The Coalition budget contained very strong provisions allowing for the creation of PSOs in order to make it possible for hospitals and doctors to absorb the reimbursement reductions in the Coalition budget. We are very concerned that Medicare legislation that places greater restrictions on the ability of PSOs to participate in the Medicare program more than the Coalition budget will make it difficult for providers to absorb the reimbursement reductions of the magnitude being discussed.

Since Medicare is a federal program, we believe that any solvency standards, regulations and certification process should be established by the federal government and should be made as uniform as possible. This would not preclude state involvement. In fact, the Coalition budget would allow states to administer the federal standards after an interim period. States would continue to be free to set their own standards for PSOs participating in the private commercial market. The Coalition budget requires that PSOs be integrated, but provides flexibility in how providers can come together, and establishes solvency standards that take into account the broader means available to a health care delivery system for protection against insolvency.

3. **Graduate Medical Education** We support a permanent and reliable funding source for teaching hospitals. This can best be accomplished through the creation of a GME and teaching hospital trust fund within the Medicare program, divided between Part A and Part B. The trust fund would derive its funding by removing GME payments from the AAPCC. A discretionary program subject to annual appropriations or a mandatory fund authorized for a finite period of time would not give teaching hospitals a dependable funding source.

4. **Study of Medicare Reforms** We believe any Medicare reforms enacted this year be accompanied by the a process to monitor the impact of the reforms enacted on the Medicare program and the health care system, particularly in rural areas. The Coalition budget proposed a Medicare Commission that would be directed to make regular reports to Congress regarding the changes in the rate of growth of the Medicare program, the quality and access of care for Medicare recipients., the availability of choices in rural areas to private plans resulting from the Medicare reforms, whether payments to private plans are sufficient to provide adequate benefits. The Commission would be required to report to Congress on the impact that the reforms have on providers in rural settings and to make recommendations for changes in the Medicare program to address the special needs of rural areas.

**Medicare**  
(outlay savings in billions of dollars)

	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>5-Year Savings</u>	<u>10-Year Savings</u>
Medicare, net	---	-7.3	-15.1	-24.2	-28.9	-39.5	-41.7	-47.0	-54.7	-60.9	-67.6	-115.0	-386.9

→ repeat

**Description**

- Reduce projected Medicare spending by \$115 billion over five years
- Extend the solvency of the Part A Trust Fund to at least 2008 through a combination of savings and structural reforms (including the home health reallocation)
- Limit savings from increased beneficiary contributions to maintaining the Part B premium at 25 percent of program costs and phase in over seven years inclusion in the calculation of the Part B premium the portion of home health expenditures reallocated to Part B, including expanded mandatory benefits under Medicaid for SLMB-eligible Medicare beneficiaries to 150% of poverty, with 100 percent Federal reimbursement
- Reform managed care payment methodology to address current Medicare overpayment to HMOs and to address geographic disparity that has limited HMO access in rural areas
- Reform payment methodology by establishing prospective payment for home health providers, skilled nursing facilities, and outpatient departments
- Include policies for competitive pricing for durable medical equipment and laboratory services, and further expand the "Centers of Excellence" program
- Funding for new health benefits including: (1) expanded mammography coverage and lower cost-sharing for mammograms; (2) coverage for colorectal screenings; (3) coverage for diabetes self-management; and (4) higher payments to providers for

preventive vaccinations. Invest \$4 billion over five years (and \$20 billion over ten years) to limit beneficiary copayments for outpatient services.

- Increase the number of health plan options, by adding provider sponsored organizations and preferred provider organizations, and provide beneficiaries with comparative information about their options
- Exclude provisions for: (1) association plans; (2) budget "lookback mechanisms; (3) proposals that eliminate or weaken current law balance billing restrictions; or (4) medical savings accounts beyond the provisions in Kennedy-Kassebaum

May 8, 1997.

**Medicaid**  
(outlay savings in billions of dollars)

	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>5-Year Savings</u>	<u>10-Year Savings</u>
Medicaid	---	0.0	-1.4	-2.3	-3.5	-5.0	-5.7	-6.5	-7.7	-8.8	-10.5	-12.1	-51.3

*(Estimates subject to change)*

**Description**

- Include \$12.1 billion in Medicaid savings over five years (net additional Medicaid spending on a higher match for D.C., an inflation adjustment for programs in Puerto Rico and other territories, expanded SLMB protections, and Part B premium interactions)
- The \$12.1 billion in Medicaid savings do not reflect the health care investments for children's coverage, protections for legal immigrants under welfare reform, or the extension of veterans' Medicaid income protections
- Savings derived from reduced disproportionate share payments and administrative flexibility provisions
- Include provisions to allow States more flexibility in managing the Medicaid program, including repeal of the Boren amendment, converting current managed care and home/community-based care waiver process to State Plan Amendment (with appropriate quality standards), and elimination of unnecessary administrative requirements

May 8, 1997

**Medicare**  
(outlay savings in billions of dollars)

	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>5-Year Savings</u>	<u>10-Year Savings</u>
Medicare, net	--	-7.3	-15.6	-25.0	-29.9	-37.2	-41.7	-47.0	-54.7	-60.9	-67.6	-115.0	-386.9

*(Numbers may not add due to rounding)*

**Description**

- Reduce projected Medicare spending by \$115 billion over five years
- Extend the solvency of the Part A Trust Fund to at least 2007 through a combination of savings and structural reforms (including the home health reallocation)
- Limit savings from increased beneficiary contributions to maintaining the Part B premium at 25 percent of program costs and phase in over seven years inclusion in the calculation of the Part B premium the portion of home health expenditures reallocated to Part B, including protections for QMB and SLMB-eligible beneficiaries
- Reform managed care payment methodology to ensure that Medicare no longer overpays HMOs for healthier beneficiaries, and address geographic disparity that has limited HMO access in rural areas
- Reform payment methodology by establishing prospective payment for home health providers, skilled nursing facilities, and outpatient departments
- Include policies for competitive pricing for durable medical equipment and laboratory services, and further expand the "Centers of Excellence" program
- Include \$9 billion for: (1) new health benefits (expanded mammography coverage and lower cost-sharing for mammograms; coverage for colorectal screenings and diabetes self-management; higher payments to providers for preventive injections; and demo program to encourage SSDI beneficiaries to work); and (2) amended Administration proposal to limit beneficiary

copayments for outpatient services, phased in over a longer time period to reduce aggregate Medicare costs

- Exclude Administration proposals for respite benefit and Part B premium surcharge
- Increase the number of health plan options, including Provider Service Organizations and Preferred Provider Organizations; carve out from managed care rates payments to teaching and disproportionate share hospitals; reform Medigap so beneficiaries can enroll in community-rated Medigap plans annually without being subject to pre-existing condition exclusions; and provide beneficiaries with comparative information about managed care and Medigap plans
- Exclude proposals that: (1) expand medical savings accounts beyond current law; (2) diminish any of the current restrictions on balance billing; (3) allow managed care plans to charge higher premiums than allowed under current law; or (4) alter medical malpractice rules.

May 1, 1997

MEMORANDUM

April 24, 1997

TO: Distribution List  
FR: Chris Jennings  
RE: Updated Medicare Trust Fund Talking Points

Attached are the updated Medicare Trust Fund talking points that were revised after the report was released. I have also attached a letter from HCFA's Chief Actuary confirming that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

We hope you find this information useful. Please call me at x6-5560 if you have any questions.

## MEDICARE TRUST FUND TALKING POINTS

April 24, 1997

**THE MEDICARE TRUSTEES REPORT CONFIRMS WHAT THE PRESIDENT HAS CONSISTENTLY STATED -- THAT REPUBLICANS AND DEMOCRATS SHOULD COME TOGETHER AND ENACT MEDICARE REFORM THIS YEAR.**

- The 1997 Trustees Report estimates that the Medicare Trust Fund will remain solvent until 2001.

**WE WELCOME CONCERNS ABOUT THE TRUST FUND. PRESIDENT CLINTON HAS BEEN ACTING TO ADDRESS THE PROBLEM SINCE HE TOOK OFFICE.**

- The President's 1993 Economic Plan extended the life of the Trust Fund by three years.
- In 1994, the reforms included in the Health Security Act would have strengthened the Trust Fund by five years.
- In 1995 and 1996, the President proposed Medicare reforms in the context of his balanced budget that would have extended the life of the Trust Fund for at least a decade.

**THIS YEAR THE PRESIDENT'S BALANCED BUDGET GUARANTEES THE LIFE OF THE TRUST FUND AT LEAST A DECADE.**

- An April 24, 1997 letter from HCFA's Chief Actuary confirms that the life of the Trust Fund would be extended until "2008 under the [President's] Budget proposals."

**ACTION IS NEEDED -- REPUBLICANS AND DEMOCRATS SHOULD USE THIS OPPORTUNITY TO COME TOGETHER IN A BIPARTISAN MANNER TO ADDRESS THE NEED FOR REAL MEDICARE REFORM.**

- **The need for responsible intervention to improve the Trust Fund is real.** The President has a proposal that addresses this need in a responsible way, without imposing devastating provider cuts, increasing beneficiary costs, or enacting structural changes that devastate the program and the people it serves.
- **This report should not be used irresponsibly.** The upcoming Trust Fund report should not be used to recklessly frighten the 38 million Medicare beneficiaries and their families into thinking that their benefits are in imminent danger. They simply are not.
- **We have time to act this year. Over \$120 billion remains in the Trust Fund** (as of March 1997). While incoming revenues are somewhat less than outgoing payments, the current balance in the Trust Fund means that there is no danger that claims will not be paid.

**IT IS TIME TO PUT PARTISAN DIFFERENCES ASIDE AND AGREE ON MEDICARE REFORMS THAT WILL EXTEND THE LIFE OF THE TRUST FUND AND STRENGTHEN THE MEDICARE PROGRAM.**



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care  
Financing Administration**Memorandum**

Date April 24, 1997

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for the HI Trust Fund under the Medicare Legislative Proposals in the President's 1998 Budget, Based on 1997 Trustees Report Assumptions

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare legislative proposals developed for the President's 1998 Budget. Based on the intermediate set of assumptions in the 1997 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in calendar year 2008 under the Budget proposals.

In the absence of corrective legislation, trust fund depletion would occur in calendar year 2001 based on the intermediate assumptions. Thus, the Budget proposals would postpone the year of exhaustion by about 7 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Budget proposals is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Medicare proposals in the President's 1998 Budget, we would be happy to provide it.

  
Richard S. Foster, F.S.A.

AARP File

FOR CHRIS JENNINGS

## THE VICE PRESIDENT'S MEETING WITH AARP ON MEDICARE

DATE: June 6, 1997  
LOCATION: AARP Headquarters, 601 E St, Washington, DC  
TIME: 1:00 p.m. - 2:05 p.m.  
FROM: Maria Echaveste  
Christopher Jennings  
Bill White

### I. PURPOSE

To receive a letter of support from AARP on the Medicare budget agreement, to deliver a targeted message on Medicare to millions seniors through AARP media, and to lay the foundation for a longstanding relationship with the largest and most influential senior organization in the country.

### II. BACKGROUND

The American Association of Retired Persons (AARP) is a nonprofit, nonpartisan organization dedicated to helping older Americans achieve lives of independence, dignity, and purpose. AARP has a membership of 34 million people age 50 and older.

#### AARP and Health Care Reform Issues

Since the repeal of the Medicare Catastrophic Coverage Act (MCCA) in 1988, AARP has become much more cautious in "getting out in front" of its Members on any major health issue. (As you will recall, they were strong advocates of the MCCA until they -- like the rest of the Congress -- were angrily run over by many of their own Members.)

During the Health Security Act debate, it took late into 1994 for them to endorse the Mitchell alternative -- an approach that was actually less favorable to seniors than the President's initial proposal. Their delay in getting on board at that time was certainly frustrating to the President and the First Lady, and enabled the opposition to successfully mount strong, unambiguous attacks in the face of a quiet and unhelpful sleeping giant -- AARP.

During the Medicare debate in the last Congress, they were extremely slow to be overly critical of the Republican Medicare ill-conceived changes to the program. Speaker Gingrich spent a good deal of personal time attempting to coopt them, or at least buy silence and time. Impressively, despite provisions that were clearly against the interests of AARP and their membership, Speaker Gingrich was successful at getting AARP to hold their fire until the very, bitter end.

In fact, although the Medicare provisions in the President's balanced budget alternative almost exactly mirrored their stated priorities, AARP would not endorse or even generally support our plan. Their political read was that they had to position themselves in what

they perceived to be the middle of the debate to ensure that they could be "players" on the Hill at the critically important final deal-making sessions. (In the last 15 years or so, AARP has placed a much greater priority on inside, quiet lobbying, rather than outside-in advocacy -- frequently to the dismay of other aging advocates.) They also wanted to avoid getting too closely associated with any Presidential candidate.

Because AARP value their non-partisan image, it is sensitive when they believe their positions are being distorted. Last year, AARP complained bitterly about a Dole campaign commercial that implied AARP supported his Medicare record. And in October, 1996, when you said on "Meet The Press" that AARP supported our Medicare plan, AARP wanted to release a letter to you objecting to the mischaracterization. Leon Panetta called their Executive Director, Horace Deets, and resolved the issue without the need for a letter.

### **1997 Budget Agreement**

This year, we were successful at crafting a bipartisan budget deal that has, to date, met with their broad approval. During the final days of the budget agreement discussions, they were extensively consulted -- particularly by Gene Sperling and Chris Jennings. They made clear that they would support the agreement if we could deliver on four major priorities:

- (1) That we could come up with a way to moderate the premium impact of the home health transfer;
- (2) That we could retain at least some of the outpatient hospital copayment protections that were included in the President's original budget submission;
- (3) That we could successfully obtain a commitment to protect low income beneficiaries through an improvement of the Qualified Medicare Beneficiary (QMB) program; and
- (4) That we would reject ill conceived and flawed structural reforms (like fall-back caps, the repeal of balanced billing protections, and open-ended MSAs) that would hurt the program.

While we delivered on all of these priorities, these last second discussions were very tense times. Many within the White House were concerned about how a premium increase on virtually every Medicare beneficiary would play. However, we trusted that AARP would be generally supportive of the Medicare agreement and, in the end, they were. This played a critical role in the reception of the budget agreement on Capitol Hill and, without being excessively appreciative, you may want to acknowledge this fact.

It should be noted that AARP also opposed our Medicaid per capita cap. They were concerned that it would place great pressures on the states, over time, to cut back on important services to the elderly. As such, when we dropped that provision in the last day of the negotiations, AARP was particularly pleased. (They fancy themselves as great

protectors of the most vulnerable elderly on Medicaid.) Your involvement in getting this per capita cap dropped was no doubt noticed and appreciated.

While the AARP team you are meeting with will acknowledge and praise our budget agreement (with the exception of tax allocation issues and perhaps defense spending) they will also want to know how we feel the current budget process is going. They -- like many others of our base groups -- are nervous that the Republicans will start pushing back on commitments that were made in the budget agreement.

AARP is probably most concerned about the status of the low income premium protections. (We are still strongly supporting it and, in fact, Frank Raines wrote a letter on June 5th explicitly reiterating our position.) They may also raise some other issues, including their concern about MSAs -- although they understand and accept that a MSA demo is a necessary evil.

One other issue that they and the rest of the aging advocacy community have raised recently has been their opposition to a provision HCFA was advocating in the budget called the "homebound definition." This initiative was designed to help cut back on unnecessary and expensive home health visits by tightening up the definition of who could be eligible.

Unfortunately, in trying to tighten up the definition, the advocates believe that HCFA went too far in the opposite direction. As a result, AARP and others feared that people who truly needed such benefits would be ineligible to receive them.

Within the last week, we hosted AARP and a large group of other aging groups to hear their concerns out. As a result of the meeting, we decided to alter our position. In fact, last night, an amendment to strike the "homebound definition" was accepted in the Ways and Means Committee Subcommittee mark-up (with our explicit approval). AARP and the rest of the aging community is appreciative of our responsiveness of their concerns.

Beyond discussion how you believe the rest of the budget mark-up process may go, AARP may ask you to begin commenting on the financing challenges facing Medicare for the long-term.

### **Medicare Commission**

AARP will praise you and the Congress for working out a bipartisan agreement that institutes important structural reforms, including more choice of plans, improved Medigap protections, a greater emphasis on prevention, stronger consumer protections, and of course, another 10 plus years on the life of the Trust Fund. [And if they don't point this out, you may want to considering doing so yourself.] However, they will likely raise the question what you believe should take place in the next round to address the retirement of the baby boomers in 2010 and beyond.

While we are not yet ready to comment in any specific substantive way, we believe there are things you can say:

We have always supported a two-part strategy on Medicare reform. (1) We believe that we must enact short-term Medicare reform that will extend the life of the trust fund for at least a decade and strengthen the program. We should stress to the AARP that although we have an initial agreement, we still have lots of work to do, and that we still need to work to ensure that we get the provisions agreed to in the Budget Agreement.

(2) The Administration has always supported a bipartisan process to achieve that goal. The agreement itself will lay a solid foundation for the next steps; the new payment systems, the new plan options, and the new preventive benefits will help the next generation have a much more modern and responsive program.

The AARP is in complete agreement with us on this strategy. In their advertising prior to the budget agreement, AARP constantly pressed for a two-step process to address Medicare and Social Security. Step one called upon the Administration and the Congress "to hammer out a fair short-term agreement to ensure Medicare funding through 2006." Step two involved a call for a national dialogue aimed at "seeking solutions that will preserve and strengthen Medicare and Social Security for our children and grandchildren."

However, it is important to note that we will have to think carefully about this process. The Balanced Budget Agreement illustrates that Republicans and Democrats can place their partisan natures aside to help address the problems facing the nation. However, we have to be careful about just leaping into a Commission without thinking exactly what its charge is and who should serve on it. The road is littered with Commissions who did not have a clear vision of the desired outcomes and possible options and, as a result, very little was accomplished. You should stress to AARP that we very much need their input on what should be the priority with any appropriate bipartisan process.

There are some important issues to keep in mind as you think about how to discuss long-term reform with the AARP. The economy, new findings in health research, and continued success in constraining health care costs could significantly alter the projections of the financing burden. Although there are a great deal of factors we cannot control or know, we do know that the demographic trends will not significantly change. In 2010, the growth rate in the elderly population actually doubles. As this occurs, there will be greater financing pressures on the Trust Fund. Just as we should not rush to make reckless and premature decisions without sufficient information, we cannot let that be an excuse for doing nothing.

If we have learned anything, we have learned that hard decisions become harder as we delay them. But we must make sure that the hard decisions are the right decisions for the future of the program and the people it serves. We look forward to working with you in the future as constructively and productively as we have done in the past.

### III. Your Meeting

Your meeting with AARP is part of a larger strategy to solidify the framework of the Medicare agreement and to inoculate the agreement from attacks from the left and right. Your visit to AARP headquarters will begin with a meeting with Horace Deets, and his senior staff to discuss Medicare. At the meeting, Horace will present a letter addressed to the President and Congress that endorses the central elements of the Medicare agreement, including a fair level of Medicare savings, strengthening the Medicare Trust Fund, important new preventive benefits, protection against excessive hospital outpatient coinsurance, premium protection for low-income beneficiaries, and structural reforms to improve quality, control health care costs, and offer more choices for managed care. The letter will close by raising concerns on outstanding policy issues such as Medical Savings Accounts (MSAs), and protections for low-income seniors.

The letter will be widely distributed on the Hill and will serve the purpose of helping inoculate us from criticisms from the left that this budget agreement is unfair to vulnerable Americans. It will also help us fight against some of the potential provisions that Republicans will try and insert into the final Budget Agreement, such as a broad MSA demo.

Following your meeting with Horace Deets and senior staff, you will proceed to the AARP radio studio on the 3rd floor to tape a 15 minute interview with Mike Cuthbert, host of Prime Time, AARP's weekly radio show with a distribution to 50 public radio stations across the country. You will then proceed to the Green Room for a 20 minute interview with Susan Crowley, the senior editor of the AARP Bulletin (c. 22 million households).

Approximately 34 million Americans are 65 years or older. Although seniors (also referred to as older Americans) represent 13% of the population, they represent 20% of the vote.

The leadership of AARP last visited the White House in February to present the President with his AARP membership card. Mrs. Gore visited AARP Headquarters in May to raise awareness of Sudden Infant Death Syndrome (SIDS).

### IV. PARTICIPANTS

Gene Sperling

Christopher Jennings

Larry Haas

Horace Deets

John Rother

Kevin Donnellan

Cheryl Cooper

Joseph Perkins

Allan Tull

Jim Holland

AARP Executive Director

AARP Director of Legislation and Public Policy

AARP Director of Advocacy

AARP Chief of Staff

AARP President-Elect

AARP Vice Chairman of the Board of Directors

AARP Director of Communications

## V. PRESS PLAN

Closed press.

## VI. SEQUENCE OF EVENTS

- o You will be briefed in your West Wing Office by Chris Jennings and Larry Haas. (12:30 p.m. - 12:45 p.m)
- o Upon arrival, you will be greeted by John Rother and Kevin Donnellan and proceed to the Board Room on the 10th Floor.
- o You will greet Horace Deets, who will introduce his staff and make welcoming remarks. Horace will present to you a letter supporting the Medicare agreement.
- o **You will make brief remarks** (see attached talking points) and engage in a discussion with the participants. (1:00 p.m. - 1:30 p.m.)
- o You depart Board room, escorted by Kevin Donnellan and Jim Holland, and proceed to studio on 3rd floor. **You will tape an interview with Mike Cuthbert, host of Prime Time radio program.** (1:35 p.m. - 1:50 p.m.)
- o **You will then proceed to the Green Room across the hall for an interview with Susan Crowley, Senior Editor of the *AARP Bulletin*.** (1:50 p.m. - 2:05 p.m.)
- o You depart.

## VII. ATTACHMENTS

Your Talking Points.

Medicare Background Papers

Medicare Q & As

Social Security Q & As

Background on Older Americans Act and Senior Housing.

A draft of the endorsement letter will be provided to you prior to the event.

**TALKING POINTS FOR VICE PRESIDENT GORE  
MEETING WITH AARP LEADERSHIP  
FRIDAY, JUNE 6, 1997**

Thank you for inviting me to meet with you today and for the opportunity to address your broader membership through the *AARP Bulletin* and the AARP Radio show.

I would also like to thank you for the letter you have presented to me endorsing the Medicare framework in the budget agreement. On behalf of the President and myself, we very much appreciate this endorsement and the hard work you have done on this effort.

You have worked tirelessly to help secure what we believe are some of the most important priorities in this budget, including rejecting ill-conceived plans that allow for balanced billing charges, securing preventive benefits, and protecting low-income beneficiaries.

I am delighted that the budget reconciliation process is moving forward with our Medicare recommendations in place. However, you and I know that the fight is far from over.

We still have work to do to ensure that we protect the provisions that are in the Budget Agreement -- including the low-income protections and an excessively large MSA demo. We look forward to working with you on these issues in the coming weeks.

We also strongly believe that reforming our Medicare program will be a two step process: First, we must secure the provisions that were agreed on in the Budget Agreement which preserve and improve the Medicare program and extend the life of the trust fund for over a decade.

Only once we have secured that process should we look to the next step. That next step is to develop a bipartisan process that will ensure that Medicare is secure for the next generation. That next step is a big challenge.

We will have to think carefully about this process will need to engage the American public in a national exchange of ideas. We need AARP to be a part of that dialogue.

As we begin to consider this problem, we should remember that the economy, new findings in health research, and continued success in constraining health care costs could significantly alter the projections of the financing burden.

That being said, by 2010, the growth rate in the elderly population actually doubles. As this occurs, there will be greater financing pressures on the Trust Fund.

We also must remember that the structure, the make-up, and the charge of any bipartisan body is essential to a successful outcome. With that in mind, we must be sure that carefully consider our next steps.

I would also like to thank you for your strong support of the President's position against block granting the Medicaid program in the last Congress. The President's willingness to take on this issue has made the program stronger than ever. And I want to thank you for helping us protect this high priority program.

And I know that you and all of your Members care as much about our children as we value Americans who are in the twilight of their lives. That is why we have fought so hard to ensure that the Budget Agreement includes investments to cover millions of uninsured children, to improve our education system, and to balance the budget.

I am here today to thank you for your endorsement of the Medicare framework established in our balanced budget plan. I am also here to listen to your thoughts and concerns on Medicare reform. I look forward to a good discussion.

## THE PRESIDENT'S MEDICARE STRUCTURAL REFORMS

The President's budget contains important structural changes necessary to modernize Medicare for the 21st century. It adopts the best innovations in the private sector, which has developed new techniques to control health care costs and improve quality. It also restructures Medicare, offering more choices for managed care, shifting to competitive pricing, enhancing preventive coverage, and offering consumers more information. The following are just some of the more significant reforms in the President's plan.

### **Restructures the Payment System for Medicare's Fastest-Growing Services**

- **Problem:** Medicare costs are skyrocketing for home health care, skilled nursing facilities, and hospital out-patient services. These services account for most of the excessive growth in Medicare spending. They are rising so quickly because Medicare pays after the fact, creating incentives for overutilization.
- **The President's budget** builds on the success Medicare has had in controlling hospital costs, restructuring the entire payment system so that rates are set in advance. This prospective payment system will prevent health care providers from charging too much in these areas.

### **Offers Consumers More Choices for Managed Care**

- **Problem:** Current law only enables Medicare to contract with a narrow range of managed care plans. Also, under today's rules, many older Americans are reluctant to try managed care for fear that, if they don't like it, they will be unable to return fee-for-service with their previous Medigap plan.
- **The President's budget:** By allowing Medicare to work with Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs), the President's budget opens up new options that have proved popular and cost-effective in the private sector. By providing annual Medigap enrollment without fear of higher premiums or penalties for pre-existing conditions, it also provides older Americans with a meaningful choice.

### **Broadens Availability of Managed Care and Ensures that Medicare Trust Fund Shares in the Savings**

- **Problem:** Today, the Medicare Trust Fund actually loses money on the average beneficiary that enrolls in a managed care plan because Medicare pays too much money to insure the relatively healthier Medicare beneficiaries in managed care plans.
- **The President's budget** takes steps to remedy this well-documented overpayment through a one-time reduction of about 5 percent in HMO payments in the year 2000. It also addresses the flawed payment methodology that has led to great geographical disparity, which has limited most of rural America's access to managed care.

### **Introduces Successful Competitive-Bidding Strategies to Lower Costs**

- **Problem:** Although the Health Care Financing Administration is the largest purchaser of health care services in the United States, Medicare often pays more for services and equipment because it lacks the legal authority to negotiate lower prices. Too often, Medicare pays far more for medical supplies and durable medical equipment than other purchasers.
- **The President's budget** institutes competitive pricing to introduce market pressures and keeps Medicare costs down by leveraging the government's enormous buying power in the health care sector. It also builds on innovative cost-cutting pilot programs like "Centers of Excellence," which use new payment incentives for hospitals or health centers that provide outstanding service while keeping costs down. In a Medicare demonstration, these incentives have achieved real savings of 12 percent on coronary bypass graft procedures with a higher quality of service.

### **Encourages More Prevention and Prepares for the Retirement of the "Baby Boomers"**

- **Problem:** Medicare does not cover many of the preventive services that can cut costs and help people lead healthier lives.
- **The President's budget** expands coverage for mammograms and colorectal screening, improves self-management of diseases like diabetes, and extends respite benefits that are increasingly important to our older Americans. These benefits will be good for beneficiaries and, over time, will save Medicare dollars.

### **Gives Consumers the Information They Need**

- **Problem:** Many seniors today lack the basic information they need to make informed choices about which Medicare plan to choose.
- **The President's budget** empowers America's seniors to make educated choices about their health care by providing beneficiaries with comparative information on all managed care and Medigap plans in the area where they live. To help make those comparisons meaningful, the budget would create standardized packages for additional benefits.

## MEDICARE Q & A

**Q: REPORTS HAVE SUGGESTED THAT THE ORIGINAL MEDICARE PREMIUM ESTIMATES WERE TOO LOW AND THE ACTUAL INCREASE WILL BE TWICE AS HIGH AS PREVIOUSLY PROJECTED (ABOUT A DOLLAR A MONTH). IS THIS TRUE?**

**A: While original preliminary CBO projections may have been slightly off, we still estimate that the Part B premium will be only about \$1 more in 1998 than under current law. In subsequent years within the 5-year Budget Agreement, the annual increase should be no more than about \$2 more per month. As a result, by 2002, we project the premium being approximately \$8 more than it otherwise would have been without the home health reallocation.**

**Regardless of the final projection, the Part B premium will be almost \$20 per month less than it would have been if it was set at the same 31.5 percent level that the President vetoed. The monthly premium under the 1997 Budget Agreement will be about \$69 in 2002. If the policy were a 31.5 percent premium instead of 25 percent, the premium would be about \$87. In 2002 alone, this would equate to about \$215 a year more for a single beneficiary, \$430 for a couple.**

**Low-income beneficiary protections are expanded.** Unlike the 1995 Budget Agreement that the President vetoed, which eroded current-law low-income protections, the 1997 Balanced Budget Agreement invests \$1.5 billion to expand premium assistance to low-income beneficiaries. We believe this commitment will help many of the estimated 2.5 million Medicare beneficiaries who have incomes between 125 and 150 percent of poverty-- just above the current eligibility level for Medicare premium protection.

**Savings from the new premium are offset by investments in beneficiary improvements.** The \$9 billion in savings that comes from gradually including home health in the 25 percent premium is virtually identical to the amount of money dedicated to the investment in new benefits. Specifically, the 1997 Balanced Budget Agreement invests \$3-4 billion in new preventive benefits (which will, for example, detect breast and colon cancer, and cover the management of diabetes), \$4 billion to limit excessive hospital outpatient coinsurance to beneficiaries, and \$1.5 billion in premium protections for low-income Medicare beneficiaries. (This contrasts with the vetoed 1995 balanced budget agreement, which reinvested virtually none of its much greater beneficiary savings for benefit enhancements.)

**Q: THE REPUBLICANS ARE PROVIDING NUMBERS THAT SHOW THAT THE MEDICARE CUTS YOU SAID WOULD DEVASTATE THE PROGRAM IN THE LAST DEBATE ARE ESSENTIALLY THE SAME YOU NOW ENDORSE. DOESN'T THIS PROVE YOU WERE DEMAGOGING THE ISSUE?**

**A: While the total Medicare savings have moved closer together, they are still less than the \$270 billion in savings that the President vetoed.**

**This does not even take into account fundamental differences between the 1997 Balanced Budget Agreement and the Medicare proposal the President vetoed.**

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

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

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

## SOCIAL SECURITY Q & A

### **Q: WHAT ARE YOU DOING ABOUT SOCIAL SECURITY?**

First, we must remember that the Social Security system in the United States has been a resounding success. It has dramatically reduced poverty among the elderly -- from over 35 percent in 1959 to 10.5 percent in 1995 -- and provided real security for millions of elderly Americans.

Second, we all know that Social Security faces substantial challenges as the baby boom ages. The most recent Trustees report projected that the Trust Fund will be exhausted in 2029. I look forward to exploring possible reforms to address this challenge within a bipartisan process -- as in 1983. This process should study a wide range of options, including possibly privatization, but no decisions should be made without careful study and review.

Third, it is important to note that the budget agreement -- which will balance the budget for the first time since 1969 -- will help to raise national saving and productivity. It is thus a necessary and crucial first step in addressing our longer-term challenges. We had to address our immediate challenges before being able to turn to the longer-run ones.

### **Q: IN THE WAKE OF THE SOCIAL SECURITY ADVISORY REPORT LAST YEAR, THE PRESIDENT HAS NEITHER RULED IN NOR RULED OUT THE PRIVATIZATION RECOMMENDATIONS. WHERE DOES THE ADMINISTRATION STAND ON THE ISSUE OF ALLOWING WORKERS TO INVEST PRIVATELY IN THE MARKET A PORTION OF THEIR CONTRIBUTIONS?**

**A:** First and foremost, Social Security ought to be addressed within a bipartisan process -- as in 1983. This process should be allowed to study a range of options, but we will not support implementing ideas that change Social Security without careful study and review.

There are some concerns that would have to be addressed and fully analyzed -- particularly regarding the volatility of equities -- before one made any such decision, and the overriding concern is to make sure that we have a protected and safe Social Security system well into the future.

**Department of Housing and Urban Development  
Section 202 -- Housing for the Elderly**

**Criticism:** AARP may indicate their disappointment that the Administration's budget recommends a reduction in funding for the Section 202 elderly housing program by requesting only \$300 million -- less than half the funding of current levels. How can you justify this reduction?

**Response:** This reduction does not reduce the number of elderly households currently being assisted.

The 1997 Appropriations Act provided a total of \$839 million for the Section 202 elderly (\$645 million) and Section 811 disabled (\$194 million) programs. For 1998, the President's Budget proposes a total of \$474 million for elderly and disabled activities -- with \$300 million for Section 202 elderly and \$174 million for Section 811 disabled.

Although the 1998 request is significantly lower -- with the elderly being reduced by 53 percent-- than the level enacted in fiscal year 1997, this reduction does not reduce the number elderly of households currently being assisted.

The funding reduction will lower new grants available to build additional elderly housing, reducing new units by about half. Still, the \$300 million 1998 request will produce 3,865 units of elderly housing.

**Other HUD Programs that Assist the Elderly**

- The Department also insures mortgages for privately developed elderly housing; last year, the FHA multifamily insurance program supported development of approximately 4,000 elderly units.
- In addition to the Section 202 elderly program, elderly households are eligible for and extensively served by HUD's regular public and assisted housing programs, making up about 1/3 of HUD's total assisted population.
- HUD is also looking at ways to leverage the limited resources for its elderly and disabled programs with private capital to build more units and begin to link elderly developments with supportive service funding at the State level.

**Additional information:**

- HUD's worst-case housing needs report show worst-case housing needs (very low-income renters who are paying over 50 percent of income on rent or living in severely distressed housing) among the elderly have remained stable. A higher proportion of elderly households with worst-case needs receive HUD assistance than do families with children.
- Many of the new developments financed with the Low-Income Housing Tax Credit (\$3 billion in annual revenue losses; 50,000 new or rehabilitated units each year) are for the low-income elderly.

## **Administration on Aging**

The Older Americans Act serves as the basis of AoA's activities and is the source of authorization for most of the programs administered by AoA. AoA administers its programs through a network of 57 State units on aging, over 200 Indian tribal organizations, 661 Area Agencies on Aging, approximately 6,400 senior centers, and more than 27,000 service providers throughout the country.

The President's FY1998 Budget proposes an \$8 million increase in AoA funding over the FY1997 level -- about a 1% increase -- for a new Alzheimer's Initiative to assist victims of Alzheimer's disease and related dementias. Other programs within AoA are flat-funded.

### **Senior Community Service Employment Program (SCSEP)**

The Senior Community Service Employment Program (SCSEP) provides work opportunities in community service activities for unemployed low-income people over the age of age 55. Program participants generally work 20-25 hours per week in a wide variety of activities, such as day-care centers, schools, hospitals, senior citizen centers, and conservation projects. Service opportunities are made possible through federal formula project grants to public and private nonprofit national level organizations and to units of State government.

#### American Association of Retired Persons (AARP)

The AARP is one of ten current national sponsors that operates local SCSEP projects. Local projects operate through contracts with agencies on aging or community groups and through local affiliates of the sponsoring national organization. The AARP is the third largest national sponsor but ranks highest in unsubsidized job placements.

The Congress has been trying to eliminate funding for national sponsors. The Administration has strongly resisted this in the past and will continue to do so.

#### The President's FY 1998 Budget

The President's FY 1998 Budget proposed \$440 million for the SCSEP, which will support the same number of participants as in FY 1997.

#### Transfer of the SCSEP to HHS: Opposition and Administration Response

The proposal to transfer the SCSEP from the Department of Labor's Employment and Training Administration to HHS's Administration on Aging (AoA) originated with the NPR REGO II initiatives in March 1995. The proposal aimed to consolidate within AoA programs providing services to senior citizens.

This year the senior citizen interest groups, like AARP, have voiced strong opposition to the proposed transfer on the grounds that they believe it will jeopardize future funding for national sponsors.

Representative Martinez has recently introduced his Older Americans' reauthorization bill which does not propose the transfer of the SCSEP. While the FY 1998 budget proposes transferring the program, the Administration is giving this proposal a low profile given Rep. Martinez' bill and opposition from the elderly advocacy groups.