

Gramm Medicare File**REVISED DRAFT: Phil Gramm's Comments on Medicare****MEDICARE'S LONG-TERM PROBLEM**

Medicare does face some serious challenges, especially the demographic changes as the baby boom generation retires. The President is interested in looking at every single option to address them. However, before taking on these challenges, we must recognize Medicare's accomplishments and its existing limitations:

- Medicare only pays for half of the elderly's health care costs and
- Medicare is less generous than 4 out of 5 private group health plans.

In addition, the Balanced Budget Act will save over \$400 billion in Medicare over the next 10 years. Working with Senator Gramm, we made important changes, including adding health plan choices and increasing HCFA's ability to purchase services competitively. This year's budget seeks to add new tools to improve Medicare's efficiency. We look forward to working with you to pass these improvements.

**Gramm: Per capita costs are exploding**

**Response: Thanks to the Balanced Budget, cost growth is under control.** According to both the Administration and CBO, Medicare cost growth per beneficiary will be less than private health insurance spending growth in the next 5 years.

**1997-2002**

Medicare: 4%

Private: 5%

If we can build upon the BBA, we can make significant strides toward solving Medicare's long-term problems.

**Gramm: Payroll tax will have to increase from 2.9 to 14.9%**

**Response:** Last year, the Medicare Actuaries reported that, with no change in spending at all, the payroll tax would have to increase from 1.45 percent (for employees and employers each) to 2.46 percent to keep the Trust Fund solvent for 25 years. Not only does this NOT take into account the over \$400 billion in savings over ten years resulting from the Balanced Budget Act -- it assumes absolutely no savings from any type of policy change.

**Gramm: We need to budget Medicare like we do the VA health system**

**Response:** This is the same flawed approach that the Republicans proposed -- and the President vetoed -- in 1995. Placing an arbitrary cap on Medicare spending could erode Medicare's ability to provide health care to the people who depend on it. Medicare costs could be higher than expected for a number of good reasons, such as a new cure for cancer or dramatic increases in life expectancy.

## MEDICARE BUY-IN

**Gramm: Most dramatic expansion of Medicare ever**

**Response: Senator Gramm himself proposed a more costly and risky proposal: Medicare Medical Savings Accounts (MSAs).**

**Covers more, costs less than the MSA demonstration**

	<b>MSA Demo</b>	<b>Medicare Buy-In</b>
Cost (CBO)	\$1.5 billion / 5 yrs	\$1.4 billion / 5 yrs
Participants (CBO)	390,000	410,000

**Unlike MSA demonstration, pays for itself over time**

Participants in the MSA demonstration never pay back their costs, causing the Trust Fund to lose money

Participants in the buy-in pay back the Medicare costs of their coverage.

The short-term, up-front costs of the buy-in are offset by Medicare anti-fraud savings.

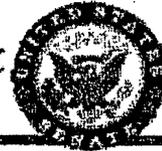
**Targets people without affordable health options, not the healthy and wealthy.** The Medicare buy-in provides an important option to people with poor access to affordable policies. In contrast, the Medicare MSA demonstration benefits beneficiaries in good health and with enough income to risk paying substantial amounts out of pocket if they get sick.

**Less than a day's worth of Medicare spending:** CBO independently assessed this proposal and determined that its net cost is \$300 million over 5 years — half of what Medicare spends in a single day and only 0.003 percent of Medicare spending over 5 years.

**Less than half of the cost of the preventive benefits added to Medicare in last year's budget.** These benefits cost \$4 billion according to CBO.

# United States Senator Phil Gramm

## Health Care and Medicare Policy



Clinton's Medicare Expansion Plan May Be Popular, But It's A 'Cynical' Deception, Says Health Care Chairman Gramm

By U.S. Senator Phil Gramm

Roll Call: The Newspaper of Capitol Hill

February 23, 1998

The nation hasn't caught on yet, but it's no secret in Washington that Medicare is on a collision course with bankruptcy despite the political quick-fix in last year's budget bill.

The Baby Boom generation is still headed for retirement; per-capita costs are still spiraling upward; the financing mechanism is still broken. And instead of passing the Senate's long-term Medicare reforms, the House and the White House decided last year that the best course would be to create a National Bipartisan Commission on the Future of Medicare and let it do the dirty work.

I'm proud to serve on this commission, even though we haven't had a meeting yet. And it is worth noting that President Clinton isn't waiting for any commission meetings, anyway. He's pre-empting us by pushing a new expansion of Medicare without waiting to see what might be recommended and regardless of the fact that Medicare will only go broke faster if we add more people to the rolls.

The President announced a sweeping expansion of Medicare benefits by offering coverage to anyone age 62 to 64 and to certain people as young as 55 years old. No one should be deluded into believing that the President's proposal to expand Medicare to the "near-elderly" will be anything less than very popular among some groups, but let me pose a reality check.

The facts are simple. Under the best of circumstances, Medicare will be a \$1 trillion net drain on the federal Treasury over the next 10 years. There is not an estimate that has been made by the Congressional Budget Office or the Office of Management and Budget or anybody else that does not project a deficit in self-funding for Medicare that is at least that high.

Secondly, and alarmingly, thirteen years from today, our Baby Boom generation will begin to move into retirement and we will transition from 3.9 workers supporting each retiree to just two workers per retiree. According to the Bipartisan Entitlement Commission and the trustees of the Medicare system, to fund existing benefits, the Medicare payroll tax will have to grow from 2.9 percent of wages today to 13 percent in 30 years.

If this sounds alarmist, consider that the payroll tax rate for Social Security and Medicare has already doubled in the last 30 years while the wage base subject to taxation has increased eight-fold, even without having a large demographic shift like the baby boom retirement will bring. In Germany, which invented debt-based benefits like Social Security and Medicare and which has staunchly resisted true reform, payroll tax rates are already 26 percent (compared to 15.3 percent in the United States) and increasing every year.

A doubling of the payroll tax to fund the current Social Security and Medicare programs would mean that the average working American family with a joint income of \$40,000 a year would face a 31 percent payroll tax rate and a 28 percent marginal income tax rate, not to mention state and local taxes. For the first time in American history, working people would be handing most of the money they earned to tax

collectors.

Another flaw in the President's proposal is that it cynically deludes these new Medicare beneficiaries into believing that they are paying for what they will get (and conversely, that they will get what they were told they paid for). That's false.

Last year Medicare spent an average of \$5,652 per beneficiary. Does anybody believe that an expansion which invites corporations to cut the cost of their health insurance benefits by moving their oldest, sickest early retirees into Medicare won't rapidly exceed \$5,652 a year, much less the \$3,600 a year that the President wants to charge? When the President uses the example of the ill retiree whose premiums are \$1,000 a month, is it possible that he does not understand that rates are that high because expected claims are that high? If you pay \$3,600 and your medical costs are \$12,000, Medicare is out \$6,400 per year.

Private health insurance companies can provide coverage comparable to Medicare for standard risk, non-smokers in the 55 to 64 age group for about \$2,400 a year, one-third less than the President's proposal. So it is likely that Medicare would be taking on only the most expensive individuals in this age group.

The President estimates that 300,000 people will take advantage of his Medicare expansion, but he can't say how many of these will simply drop private health coverage in order to get cheaper government health coverage. I believe it is a reasonable estimate that when the final numbers are revealed, more than half of the new Medicare recipients under the President's program will have dropped their private health insurance.

In the 55 to 64 age group, 86.2 percent of American families have health insurance. That is a higher percentage of insured than the population as a whole, and one of my fears is that if we adopt the President's proposal, we are going to induce people to drop their private health insurance, much like the Medicaid expansions of the past 10 years shifted children from private coverage to Medicaid while failing to reduce the percentage of uninsured children.

The answer for people age 55 to 64 who lack health insurance is to help them get private coverage, in part by giving tax equity to people who buy their own health insurance. The biggest problem that people who are retired have in buying health care is that they have to pay with after-tax dollars, where people who buy it through their employer get it tax-free. That makes a very big difference in the cost. So in the Health Care Bill of Rights which I proposed in December, the No. 1 issue on the list was a proposal to eliminate the tax code's discrimination against people who buy their own health insurance. That would cut the cost of health insurance for early retirees by about 25 percent.

What's the real answer to the overall Medicare problem? Well, starting with the tobacco settlement, we need to commit every penny we can get our hands on to maintaining the existing program. If tobacco caused the health problems that Medicare will have to pay for, then it would be foolish to start spending the federal share of the tobacco settlement on anything else.

Finally, it is clear that we need to begin shifting Medicare from the bankrupt debt-based system to an investment-based system in which workers have a direct stake in building for their own retirement. We need to save the current program for people like my mother and the millions of others who are retired or near retirement, but we need to create a new financing base for people like my children and the millions of others who are just entering the workforce.

As chairman of the Health Subcommittee in the Senate, my first obligation is to the 39 million current beneficiaries who have paid Medicare taxes, some since 1965, and who have retired based on a contract that they believe they have with Medicare. We must see to it that the system is there to pay their benefits. And as I said recently, if your mother is on the Titanic and the ship is sinking, the last thing on earth you want to be preoccupied with is getting more passengers on board.

I am preoccupied with trying to stop the ship from sinking. The President? He's still trying to sell discount tickets on the Titanic.

**DRAFT: Phil Gramm's Comments on Medicare****MEDICARE'S LONG-TERM PROBLEM**

**Gramm:** Per capita costs are exploding

**Response:** Gramm is trying to scare seniors. By exaggerating cost growth of Medicare, Gramm is attempting to paint the picture that Medicare will surely fail in the near future. This is the same strategies that Republicans used in 1995 to push for their radical overhaul of Medicare.

**Thanks to the Balanced Budget, cost growth is under control.** According to both the Administration and CBO, Medicare cost growth per beneficiary will be less than private health insurance spending growth in the next 5 years.

**1997-2002**

Medicare: 4%

Private: 5%

Medicare per capita cost growth does rise after the policies put in place by the BBA expire, but according to the Medicare Actuaries, real per capita cost growth is not "double" general inflation, even then:

	97-02	98-07	08-12	13-17	18-22
Real Per Capita Cost Growth	1.3%	3.5%	3.3%	2.0%	1.0%

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**Response:** Last year, the Medicare Actuaries reported that, with no change in spending at all, the payroll tax would have to increase from 1.45 percent (for employees and employers each) to 2.46 percent to keep the Trust Fund solvent for 25 years. Not only does this NOT take into account the over \$400 billion in savings over ten years resulting from the Balanced Budget Act -- it assumes absolutely no savings from any type of policy change.

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**Less than a day's worth of Medicare spending:** CBO independently assessed this proposal and determined that its net cost is \$300 million over 5 years — half of what Medicare spends in a single day and only 0.003 percent of Medicare spending over 5 years. The Administration will work with Congress to close this small gap.

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Roll Call

February 23, 1998

LENGTH: 1245 words

HEADLINE: Clinton's Medicare Expansion Plan May Be Popular, But It's A 'Cynical' Deception, Says Health Care Chairman Gramm

BYLINE: By Sen. Phil Gramm

BODY:

The nation hasn't caught on yet, but it's no secret in Washington that Medicare is on a collision course with bankruptcy - despite the political quick-fix in last year's budget bill.

Seventy-six million baby boomers are still headed for retirement; per capita costs for Medicare benefits are still spiraling upward; and the financing mechanism is still broken. And instead of passing the Senate's long-term Medicare reforms, the House and the White House decided last year that the best course would be to create the National Bipartisan Commission on the Future of Medicare and let the commission do the dirty work.

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*would have not done anything much*

I'm proud to serve on this commission, even though we haven't had a meeting yet. And it's worth noting that President Clinton isn't waiting for any commission meetings anyway. He's preempting us by pushing a new expansion of Medicare without waiting to see what might be recommended. And he's disregarding the fact that Medicare will only go broke faster if we add more people to the rolls.

*wrny*

Back in January, the President announced a sweeping expansion of Medicare benefits by offering coverage to anyone age 62 to 64 and to certain people as young as 55 years old. There's no question that the President's proposal will be very popular among some groups, but let me pose a reality check.

Under the best of circumstances, Medicare will be a \$1 trillion net drain on the federal Treasury over the next ten years. There is not an estimate that has been made by the Congressional Budget Office or the Office of Management and Budget - or anybody else for that matter - that does not project a deficit in self-funding for Medicare that is at least that high.

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If this sounds alarmist, consider that the payroll tax rate for Social Security and Medicare has already doubled in the last 30 years while the wage base subject to taxation has increased eightfold, even without having a large demographic shift like the one that the baby boom retirement will bring. In Germany, which invented debt-based benefits like Social Security and Medicare and which has staunchly resisted true reform, payroll tax rates have already reached 26 percent (compared with 15.3 percent in the United States) - and the rates there are increasing every year.

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A doubling of the payroll tax to fund the current Social Security and Medicare programs would mean that 30 years from now the average working American family with a joint income of \$40,000 a year would face a 31 percent payroll tax rate - and a 28 percent marginal income tax rate - not to mention state and local taxes. For the first time in American history, working people would be handing most of the money they earned to tax collectors.

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com

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Sen. Phil Gramm (R-Texas) is chairman of the Finance health care subcommittee.

LANGUAGE: ENGLISH

LOAD-DATE: February 23, 1998

# **President's FY 1998 Budget:**

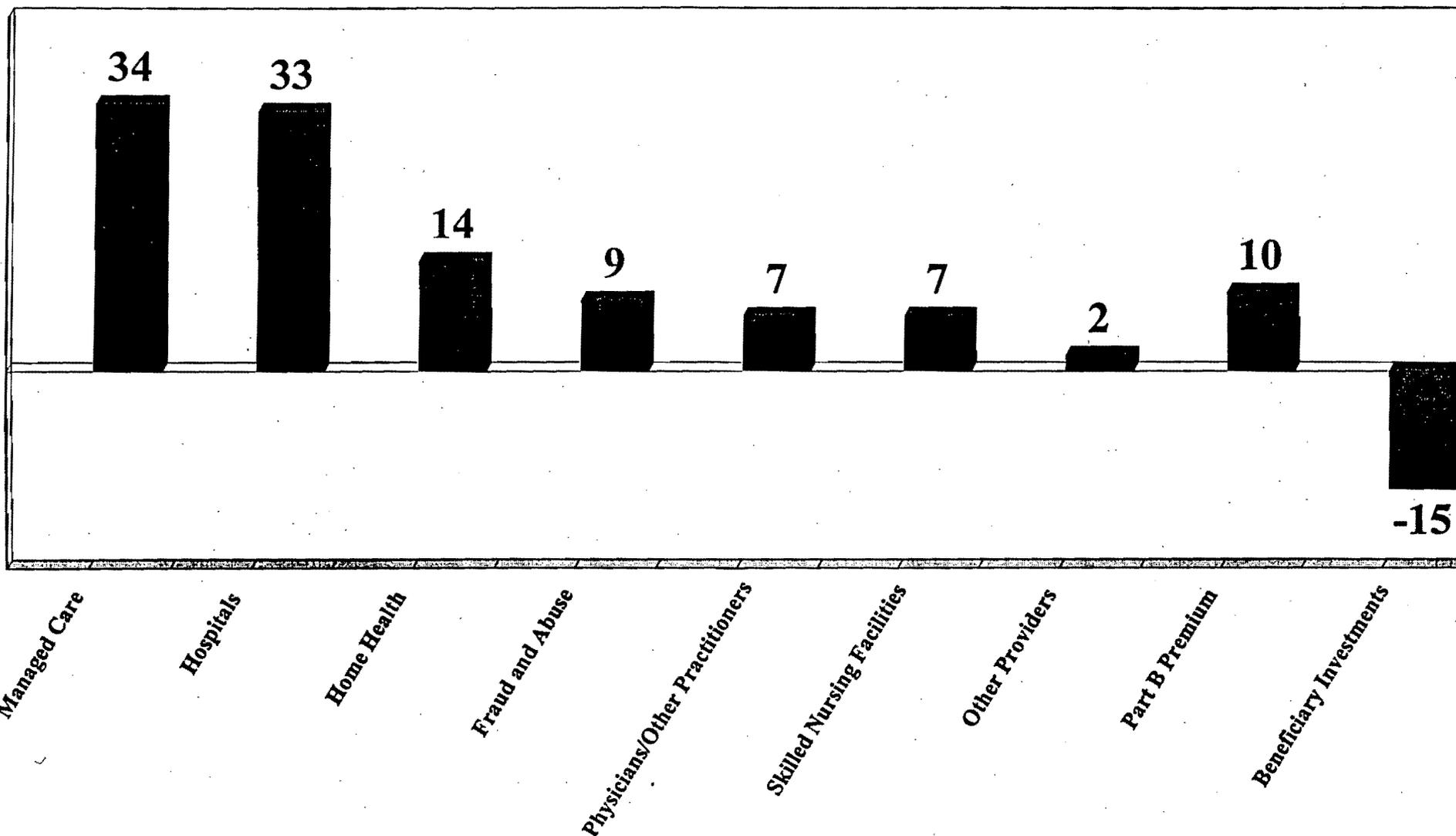
## **Medicare Savings and Investment Proposals**

### **Background Materials**

**February, 1997**

# The President's FY 1998 Budget Medicare Savings and Investment Proposals FY 1998 - FY 2002, Total Savings = \$100 billion

Billions of Dollars



# The President's FY 1998 Budget: Medicare Savings and Investment Proposals

(FY, \$'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding)

	1998	1999	2000	2001	2002	98-02
<b>PART A PROPOSALS</b>						
<b>Managed Care</b>	1.2	3.2	6.5	8.3	9.9	29.2
<b>Hospitals</b>	2.7	3.3	4.6	5.9	8.0	24.5
Reduce Hospital PPS Update	0.7	1.4	2.2	3.1	4.0	11.4
Extend PPS Capital Reduction	1.2	1.2	1.3	1.3	1.4	6.4
Reduce PPS-Exempt Update w/ Rebasing	0.3	0.4	0.6	0.8	1.0	3.2
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.8
Reform Base Puerto Rico Payment	0.0	0.0	0.0	0.0	0.0	-0.1
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.4
Expand Centers of Excellence	0.0	0.1	0.1	0.1	0.1	0.2
Lower IME	0.2	0.4	0.7	0.9	2.0	4.2
GME Reform	0.2	0.4	0.7	0.9	1.2	3.4
Eliminate Add-Ons for Outliers	0.5	0.5	0.5	0.6	0.6	2.6
PPS Redefined Discharges	0.7	0.8	0.8	0.9	1.0	4.1
SCH Rebasing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6
RPCH expansion	0.0	0.0	0.0	0.0	0.0	-0.1
Medicare dependent hospitals	0.0	0.0	-0.1	0.0	0.0	-0.1
Remove GME, IME, and DSH from AAPCC	-1.1	-1.9	-2.1	-2.6	-3.0	-10.7
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.7
<b>Home Health</b>	1.1	1.6	3.3	3.7	4.2	13.7
HH Freeze Extension	0.1	0.3	0.3	0.3	0.3	1.3
HH Interim System	0.9	1.3	1.5	1.8	2.1	7.7
HH PPS	0.0	0.0	1.5	1.6	1.7	4.7
<b>Fraud and Abuse</b>	0.1	0.9	2.0	1.5	1.7	6.2
Clarify and Enhance MSP Authority	0.1	0.2	0.2	0.3	0.3	1.0
Extend Expiring MSP Provisions	0.0	0.7	0.9	1.1	1.3	4.0
Repeal Objectionable Provisions	0.0	0.0	0.1	0.1	0.1	0.2
Pay Home Health on Location of Service	0.1	0.1	0.1	0.1	0.1	0.4
Require SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3
Eliminate Home Health PIP	0.0	0.0	0.8	0.1	0.1	1.0
<b>Skilled Nursing Facilities</b>	0.0	1.0	1.8	2.1	2.1	7.1
Extend Savings from OBRA 93 Freeze	0.0	0.2	0.3	0.4	0.4	1.3
Establish SNF PPS	0.0	0.9	1.5	1.7	1.7	5.8
<b>Beneficiary Investments</b>	-0.3	-0.4	-0.6	-0.7	-0.8	-2.7
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.3	-1.1
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	-0.1
Part A Premium Offset	-0.2	-0.2	-0.3	-0.4	-0.4	-1.5
<b>TOTAL PART A</b>	<b>4.8</b>	<b>9.6</b>	<b>17.7</b>	<b>20.8</b>	<b>25.0</b>	<b>77.9</b>

## The President's FY 1998 Budget: Medicare Savings and Investment Proposals

(FY, \$'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding)

	1998	1999	2000	2001	2002	98-02
<b>PART B PROPOSALS</b>						
<b>Managed Care</b>	-0.1	0.2	1.1	1.5	1.8	4.5
<b>Hospitals</b>	0.0	1.8	1.8	2.1	2.5	8.2
Outpatient PPS	0.0	1.8	1.8	2.1	2.5	8.1
Outpatient GME Reform	0.0	0.0	0.0	0.0	0.0	0.0
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.1
<b>Physicians and Other Practitioners</b>	0.2	0.8	1.6	2.1	2.6	7.2
Single Conversion Factor, Reform Update	0.1	0.7	1.2	1.5	1.8	5.3
Single Fee For Surgery	0.0	0.1	0.1	0.1	0.1	0.4
Incentives for In-hospital MD Services	0.0	0.0	0.3	0.5	0.7	1.5
Direct Payment to PA, NP, CNS	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Pay Acquisition Cost for Drugs	0.1	0.2	0.2	0.2	0.2	0.8
Increase Access to Chiropractors	0.0	0.0	0.0	-0.1	-0.1	-0.2
Interaction among Physician Proposals	0.0	0.0	0.0	0.0	0.0	-0.1
<b>Fraud and Abuse</b>	0.1	0.5	0.6	0.7	0.9	2.9
Clarify and Enhance MSP Authority	0.1	0.1	0.1	0.2	0.2	0.6
Expiring MSP Provisions	0.0	0.3	0.4	0.5	0.6	1.9
Require SNF Consolidated Billing	0.1	0.1	0.1	0.1	0.1	0.3
Repeal Objectionable Provisions	0.0	0.0	0.0	0.0	0.0	0.1
<b>Other Providers</b>	0.0	0.0	0.1	0.6	1.0	1.8
Competitive Bidding	0.0	0.0	0.0	0.5	0.8	1.4
Reduce ASC update	0.0	0.0	0.1	0.1	0.1	0.3
Reform Lab Payments	0.0	0.0	0.0	0.0	0.0	0.1
<b>Part B Premium</b>	0.0	0.7	1.8	3.0	4.7	10.2
Extend 25% Premium Beyond 1998	0.0	1.0	2.5	4.1	5.9	13.6
Prmium Offset	0.0	-0.3	-0.7	-1.1	-1.2	-3.4
<b>Beneficiary Investments</b>	-0.8	-2.2	-2.4	-3.1	-3.9	-12.4
Waive Mammography Costsharing	0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Annual Mammogram	0.0	-0.1	-0.1	-0.1	-0.1	-0.4
Respite Care	-0.4	-0.4	-0.4	-0.4	-0.4	-1.8
Colorectal Screening	0.0	-0.1	-0.1	-0.2	-0.2	-0.7
Diabetic Screening	-0.2	-0.3	-0.3	-0.3	-0.3	-1.5
Blood Glucose Monitor Strips	0.0	0.0	0.0	0.0	0.0	0.1
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0
Preventive Injections	0.0	-0.1	-0.1	-0.1	-0.1	-0.4
Actuarially Determined Premium Surcharge	-0.1	-0.2	-0.2	-0.2	-0.2	-0.8
Appropriate Outpatient Coinsurance	0.0	-1.1	-1.3	-1.8	-2.6	-6.8
<b>TOTAL PART B</b>	<b>-0.5</b>	<b>1.8</b>	<b>4.5</b>	<b>7.0</b>	<b>9.5</b>	<b>22.3</b>
<b>NET SAVINGS FROM TOTAL PACKAGE</b>	<b>4.3</b>	<b>11.4</b>	<b>22.2</b>	<b>27.8</b>	<b>34.6</b>	<b>100.2</b>

## THE PRESIDENT'S FY 1998 BUDGET MEDICARE SAVINGS AND INVESTMENT PROPOSALS

The President's plan achieves \$100 billion in net Medicare savings over five years by making a variety of reforms to the program and extends the life of the Part A Trust Fund to 2007.

### MANAGED CARE

The President's plan includes \$34 billion in managed care savings over five years. In addition to the savings components of the policy, there are several other proposals that address inequities in the current payment methodology and introduce important structural changes in the administration of the program.

- Address the Wide Geographic Disparity in Managed Care Payment Rates. Certain areas of the country receive much higher managed care payment rates than others. This proposal would raise payment levels for current low-payment counties, potentially encouraging managed care plans to enter new markets and thus providing more beneficiaries with a choice of plans. It also would limit payments for counties whose rates have been inflated by high service utilization in the fee-for-service sector. **This proposal is budget neutral; i.e., by limiting payments for certain higher-payment areas, funds can be redirected to lower-payment areas.**
- Indirect Savings from Fee-For-Service Reductions. The majority of managed care savings, about \$18 billion over five years, are an indirect effect of reductions in fee-for-service spending. Because increases in managed care payments are based upon the growth in fee-for-service payments, reductions in fee-for-service payments also produce managed care savings. In the last two years Medicare managed care payments have increased by about 13 percent, while private sector managed care payments have remained relatively flat.
- Carve Out GME, IME and DSH Payments From Managed Care Rates. These payments would be distributed directly to teaching and disproportionate share hospitals for managed care enrollees and to academic medical centers and managed care plans that run their own residency programs. **This proposal reduces payments by about \$10 billion over five years.**
- Reduce Medicare Reimbursement to Managed Care Plans From Its Current Rate of 95 Percent of Fee-For-Service Rates to 90 Percent Beginning in 2000. This proposal responds to substantial evidence that Medicare overpays managed care plans as a result of "favorable selection." The delay in the effective date of this provision is intended to

provide health plans the opportunity to prepare for the new methodology. This proposal achieves about \$6 billion in savings over five years.

- Consumer Information, Medigap Reforms and Increased Choice. Because many beneficiaries are unaware of their current options and would like greater choice among plans, the Administration proposes to increase managed care options, improve beneficiary awareness of the options, and improve access to Medigap coverage. First, the budget proposes to allow provider-sponsored organizations and preferred provider organizations that meet certain standards to participate as Medicare managed care plans. Second, the budget proposes to distribute comparative information on plan options to beneficiaries, ensuring that all are aware of the advantages and additional benefits that many managed care plans offer. Third, the budget guarantees that beneficiaries have the opportunity to enroll in community-rated Medigap plans annually without being subject to pre-existing condition exclusions. This provision would ensure that beneficiaries who try managed care, and are dissatisfied, can return to the Medigap plan of their choice. These policies are expected to increase enrollment in Medicare managed care plans.

## HOSPITALS

**The President's plan achieves \$33 billion in hospital savings over five years.**

- Reduce Annual Updates to Hospitals. This policy would reduce the annual update by 1.0 percent for PPS hospitals for each year from 1998-2002 (achieving about \$11 billion in savings over five years). Similarly, the market basket for hospitals that are exempt from Medicare's hospital prospective payment system (i.e., psychiatric, rehabilitation, long-term care, cancer, and children's hospitals) would be reduced by 1.5 percentage points for each year from 1998-2002 (achieving about \$3 billion in savings over five years). The larger reduction in the PPS-exempt update is needed to bring the projected double-digit growth in payments to PPS-exempt facilities under control.

Under current law, inpatient hospital prospective payment rates are updated annually by a "market basket index" that reflects inflation in the prices of operating an inpatient facility. An update of less than the full market basket is given to reflect anticipated productivity gains and provide an incentive for hospitals to increase efficiency. For 1998, a hospital paid under the prospective payment system would receive about a 1.8 percent increase rather than the projected increase in the market basket of 2.8 percent.

- Reduce Hospital Capital Payments. Hospitals receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. This proposal would reduce the 1998 hospital capital payment rate by 15.7 percent. In effect, this proposal permanently captures the savings from the OBRA 1990 capital provision, which limited payments for capital under PPS to 90 percent of what they

would have been under a reasonable cost system. **This proposal achieves about \$6 billion in savings over five years.**

In addition, this proposal would pay 85 percent of capital costs for PPS-exempt hospitals and units for FY 1998-2002, resulting in about \$0.8 billion in savings over five years.

- **Redefine Hospital "Transfer."** Currently, hospitals that move patients to PPS-exempt facilities and SNFs "discharge" the patient and receive a full DRG payment. This policy overpays hospitals and contributes to higher post-acute expenditure growth rates because these sites end up caring for more acutely ill patients. Under this proposal, moving a patient would be considered a hospital "transfer" rather than a discharge and payment would be on a per diem basis, not the DRG. **This proposal achieves about \$4 billion in savings over five years.**
- **Rural Health Provisions.** The President's plan invests about \$0.8 billion over five years to safeguard access to health care for rural beneficiaries. It: (1) extends the Rural Referral Center program; (2) improves the Sole Community Hospital program; (3) expands the Rural Primary Care Hospital program; and (4) extends the Medicare Dependent Hospitals program.
- **Give Hospitals Equal Subsidies for Teaching and "Disproportionate Share Hospital" (DSH) Costs for Medicare Fee-for-Service (FFS) and Managed Care Beneficiaries.** This proposal would give teaching and DSH hospitals additional payments, outside of their negotiated rates, when they treat Medicare beneficiaries in managed care plans. Currently, Medicare gives special payment adjustments to hospitals that run graduate medical education programs and/or serve a disproportionate share of low-income persons. These subsidies are only available when a hospital treats a Medicare FFS beneficiary. The President's plan would redirect the money for teaching and DSH that is being removed from managed care payments and pay it directly to eligible hospitals that provide services to Medicare managed care enrollees. Moreover, Medicare managed care plans that run their own teaching programs would also be eligible for payments to cover teaching costs. **This proposal returns about \$11 billion over five years to hospitals and eligible Medicare managed care plans.**
- **Graduate Medical Education Payments.** Medicare pays teaching hospitals for a share of the direct and indirect costs they incur in providing graduate medical education. Direct graduate medical education (GME) payments are based on a hospital's per resident costs (i.e., resident salaries and fringe benefits, overhead costs) and the number of full-time equivalent residents the hospital employs. The indirect costs are reimbursed through the indirect medical education (IME) adjustment to Medicare's hospital payments. **The graduate medical education proposals save about \$8 billion over five years.** These proposals would make the following changes in Medicare's graduate medical education payments:

- Graduate Medical Education Reform. This proposal actually contains three individual proposals, including two program expansions. The three proposals would: (1) cap the total number and the number of non-primary care residency positions reimbursed under Medicare at the current level; (2) count work in non-hospital settings for IME; and (3) allow GME payments to non-hospitals (e.g., Federally Qualified Health Centers) for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting. Most experts agree that the current GME and IME payment methodologies are flawed because they provide incentives to hospitals to increase their numbers of residents and to focus on specialty training at the expense of primary care training. This proposal is designed to slow the growth in Medicare spending on graduate medical education while encouraging more primary care training.
- Reduce IME Adjustment to 5.5 Percent. Through the IME adjustment, Medicare recognizes the higher indirect costs that teaching hospitals incur in running a teaching program (e.g., additional tests and procedures that residents may order as part of their training). Currently, the IME adjustment is based on a teaching hospital's ratio of interns and residents to beds (IRB), with payments increasing by about 7.7 percent for each 10 percent increase in a hospital's IRB. ProPAC recommends initially reducing the adjustment to 7 percent. However, ProPAC's research indicates that an IME adjustment of 4.1 percent corresponds more closely to the actual relationship between teaching intensity and costs. This proposal would reduce the IME adjustment to 7.4 percent in FY 1998, 7.1 percent in FY 1999, 6.8 percent in FY 2000, 6.6 percent in FY 2001, and 5.5 percent in FY 2002 and thereafter.
- Hospital Outpatient Departments (OPDs). Spending for OPD services is projected to nearly double between FY 1997 and FY 2002, from \$18 billion to \$31 billion. These services are still paid in part on the basis of a hospital's reported costs. The President's plan would move to a prospective payment system for these services effective January 1, 1999. Rates would initially be established so that total payments to hospitals for OPD services would be equal to projected FY 1999 hospital revenue (made up of Medicare's payments and beneficiary coinsurance payments), less savings from eliminating a flaw in the current payment methodology and assuming extension of certain policies set to expire at the end of 1998. **These proposals achieve about \$8 billion in savings over five years.**
- Expand "Centers of Excellence" Demonstration. Currently, HCFA is conducting a demonstration that pays 10 facilities, considered "centers of excellence," a flat fee to provide cataract or coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. This proposal would expand centers of excellence demonstrations to all urban areas by allowing Medicare to pay select facilities a single

rate for all services associated with CABG surgery or other heart procedures, knee surgery, hip replacement surgery, and other procedures that the HHS Secretary determines appropriate. This approach gives facilities incentives to provide high quality care more efficiently. Beneficiaries would not be required to receive services at these centers. **This proposal achieves about \$0.3 billion in savings over five years.**

- **Other Proposals that Achieve Net Savings of about \$3 billion over five years.**
  - Make new long-term care hospitals subject to the prospective payment system.
  - Eliminate increased IME and DSH payments that are attributable to so-called “outlier payments,” but allow hospitals to count IME and DSH as part of costs that trigger outlier payments, effective FY 1998.
  - Adjust the Puerto Rico payment rate to more appropriately reflect the costs of providing hospital care.

## **HOME HEALTH AGENCIES**

**The President’s plan achieves about \$14 billion in home health savings over five years.**

Home health care is one of the fastest growing areas of Medicare expenditures, with a projected average annual growth rate of 10.6 percent over the period FY 1997-2002. This high growth is driven primarily by increased volume. The average number of home health visits per user increased by over 40 percent between FY 1992 and FY 1997, rising from 52 visits per user to 74 visits per user. The average payment per visit has also increased, rising from \$57 per visit in FY 1992 to an estimated \$68 per visit by FY 1997. There is widespread consensus that the high rate of growth in home health expenditures needs to be addressed. These proposals would reform the home health payment methodology by making the following changes:

- **Reform Home Health Payment.** Medicare reimburses home health agencies on a cost basis, subject to limits. However, Medicare’s retrospective reimbursement rates often contribute to increased expenditures by failing to control volume. This proposal would constrain growth in expenditures through lower cost limits over the short run and implement a prospective payment system (PPS) for an appropriate unit of service for home health in 1999. Budget-neutral rates under the PPS would be calculated after reducing expenditures that exist on the last day prior to implementation by 15 percent.

Prior to PPS, this proposal would implement an interim payment system to help reduce home health costs and control volume. Beginning in FY 1998, home health agencies would be paid the lesser of: (1) the actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) the per visit cost limits (which would be based on 105 percent of national median costs); or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs.

- Reallocate Financing of Part of the Home Health Benefit to Part B. This proposal divides the financing of the Medicare home health benefit between Part A and Part B -- without imposing any additional beneficiary cost sharing. Under this proposal, effective in FY 1998, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. (Part B visits would not be subject to the Part B coinsurance or deductible; this shift also would not affect the Part B premium.) By re-creating a post-hospital home health benefit under Part A, this proposal recognizes that Part A covers services associated with inpatient hospitalization and that Part B finances the remaining home health services. Re-allocating the home health benefit in this way also extends the solvency of the Part A Trust Fund.
- Extend Savings from OBRA 1993 Home Health Cost Limits Freeze. Medicare pays for covered home health services on a cost basis, subject to limits that are updated annually. OBRA 1993 eliminated the update for the home health cost limits from July 1, 1994 to July 1, 1996. Although this proposal would not extend the freeze, future home health payments would be decreased by an amount necessary to recapture these savings as though the freeze had been extended.

## **FRAUD AND ABUSE**

**The President's plan achieves about \$9 billion in fraud and abuse savings over five years.**

- Medicare as Secondary Payer (MSP). Some Medicare beneficiaries have health coverage through an employer group health plan, workers' compensation, or automobile and liability insurance. In these cases, Medicare pays after a beneficiary's primary insurer, subject to certain restrictions and conditions. The MSP provisions in the President's plan permanently extends three expiring MSP provisions, requires a beneficiary's other insurance plan to tell Medicare when that beneficiary is covered and clarifies Medicare's authority to recover certain overpayments. **These provisions save about \$8 billion over five years.**
- Close Payment Loopholes. The President's plan proposes to close a number of "payment loopholes" that lead to wasteful and abusive spending.
  - Require Consolidated Billing for SNFs, Beginning in FY 1998. The HHS Office of Inspector General and others have reported that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. This proposal would require SNFs to bill Medicare for almost all services their residents receive, prohibiting payment to any entity other than SNFs for services or supplies furnished to Medicare-covered beneficiaries. This proposal will reduce double billing for some supplies and services and reduce beneficiary Part

B copayments for services covered under Part A. These two proposals would cost about \$0.04 billion over five years.

- Base Home Health Payments on Location of Service Delivery. Home health agencies (HHAs) are often established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, payment is based on the higher wage rate for the urban area, even though the service delivery occurred in a rural area. Under this proposal, payments would be based on the location where the services are *rendered*, not where the services are *billed*, beginning January 1, 1998. This proposal achieves about \$0.4 billion in savings over five years.
- Eliminate Periodic Interim Payments (PIP) for Home Health. PIP was established to help simplify cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, PIP is reconciled with actual expenditures. But, with about 100 new HHAs joining Medicare each month, access to home health care is no longer a problem, and new providers no longer need PIP to encourage them to participate in Medicare. Further, the HHS Office of Inspector General has found that Medicare tends to overpay providers who receive PIP and has a hard time recovering the money. This proposal would eliminate PIP for home health agencies simultaneous with PPS implementation in 1999 and achieves about \$1 billion in savings over five years.
- Repeal Objectionable Fraud and Abuse Laws. The President's plan proposes to repeal current law provisions enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that weaken fraud and abuse enforcement efforts. Repealing these objectionable provisions achieves about \$0.3 billion in savings over five years.
  - Repeal the Managed Care Exception to the Medicare and Medicaid Anti-kickback Statute. HIPAA included an exception to the Medicare and Medicaid anti-kickback statute for risk sharing arrangements (i.e., managed care plans). The HHS IG believes that this exception threatens the integrity of the Medicare program because it could allow "sham" risk sharing arrangements to meet the exception and thereby offer kickbacks for referrals.
  - Eliminate Advisory Opinions. HIPAA requires HHS and the Department of Justice (DoJ) to issue advisory opinions to providers on whether a proposed business venture violates the Medicare and Medicaid anti-kickback statute. We believe this process hinders the ability of the HHS IG and DoJ to prosecute providers who have obtained advisory opinions and who actually end up violating the anti-kickback statute (e.g., providers might obtain an advisory opinion under false pretext and then hide behind it to defraud the Medicare program).

- Reinstate Provider Requirement for Reasonable Diligence. HIPAA changed the standard that prosecutors must meet to enforce a Medicare or Medicaid civil monetary penalty (CMP). This provision makes it more difficult to impose a CMP in the Medicare program by increasing the government's burden of proof in CMP cases. The provision leads to costs because anticipated CMP recoveries assumed in the baseline will not be achieved in certain cases where the government cannot meet the new burden of proof.

## **PHYSICIANS AND OTHER PRACTITIONERS**

**The President's plan achieves about \$7 billion in net savings over five years from physicians and other practitioners.**

- Establish Single Conversion Factor and Reform Method for Updating Physician Fees. When Medicare implemented physician payment reform in 1992, there was one category of physicians and one annual fee update. Congress has since created three categories of services, and each category has its own standard payment amount and annual fee update. In 1997, the standard payment amount is \$35.77 for primary care services, \$40.96 for surgical services, and \$33.85 for all other services. The Physician Payment Review Commission (PPRC) has recommended that three different standard payment amounts -- and the statutory spending target and update formulas that created them -- are inconsistent with the basic principles of the 1992 physician payment reforms.

This proposal would implement several changes consistent with the PPRC's recommendations to improve the physician payment system. First, a single standard payment amount (or "conversion factor") would go into effect on January 1, 1998. Second, the 1998 single conversion factor will be equal to the 1997 conversion factor for primary care services, updated for 1998 by a single, average fee update. Third, the formula that is used to set spending growth targets would be changed to a "sustainable growth rate" based on real GDP per capita growth plus one percentage point. The sustainable growth rate would begin affecting updates to the single conversion factor beginning in 1999. Fourth, a ceiling of 3 percentage points above medical inflation would be put on annual fee increases, and the floor on annual fee decreases would be increased from 5 percentage points to 8.25 percentage points. **This proposal achieves about \$5 billion in savings over five years.**

- Make Single Payment for Surgery. Under certain conditions, Medicare will make an extra payment for each physician or other practitioner who assists the primary surgeon during an operation. These "assistants-at-surgery" are paid a percentage of the total fee paid to the primary surgeon. In view of evidence that this practice may lead to higher costs without better outcomes, this policy will make the same payment for a surgery

regardless of whether the primary surgeon elects to use an assistant-at-surgery. **This proposal achieves about \$0.4 billion in savings over five years.**

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient. Effective January 1, 2000, this proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 125 percent of the national median for urban hospitals (125 percent in 2002 and thereafter) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. **This proposal achieves about \$2 billion in savings over five years.**
- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). Effective January 1, 1998, this proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged. **The five-year investment for this proposal is about \$0.6 billion.**
- Pay Based on Acquisition Costs Subject to a Limit for Outpatient Drugs Prescribed in Physicians' Offices. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., certain specific drugs that are used with home infusion or inhalation equipment and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. The HHS IG estimates that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug. Effective January 1, 1998, this proposal would eliminate that mark-up by basing Medicare's payment on the provider's acquisition cost of the drug. As a back-stop, payments for a particular drug would not be allowed to exceed the national median cost of that drug. **This policy achieves about \$0.8 billion in savings over five years.**
- Improve Access to Chiropractic Services. If a beneficiary chooses to see a chiropractor for Medicare-covered services, Medicare currently requires that the beneficiary get an x-ray demonstrating spinal subluxation (i.e., misalignment) before beginning chiropractic spinal manipulation services. In some cases, this x-ray requirement may hinder a beneficiary's access to chiropractic services. Effective January 1, 1998, this proposal

would eliminate the pre-treatment x-ray requirement. The five-year investment for this proposal is about \$0.2 billion.

## **SKILLED NURSING FACILITIES**

The President's plan achieves about \$7 billion in skilled nursing facility savings over five years. The SNF program is one of the fastest growing benefits, with a projected average annual growth rate of 10.5 percent over the period FY 1997-FY 2002. This high growth is driven primarily by increases in intensity of service. While the average number of days per user is fairly stable, SNF patients are receiving an increasing amount of therapy services; SNF patients incurring at least \$2,000 in therapy charges per stay increased from 12 percent in 1989 to 26 percent in 1992. Overall, reimbursement per SNF day is projected to more than double between FY 1992 and FY 1997, rising from \$151 per day to \$314 per day. Medicare SNFs are reimbursed on a cost basis, subject to certain limits. For SNFs, limits are applied only to the routine services (i.e., room and board, nursing, administration, and other overhead); ancillary (e.g., drugs, physical therapy, speech therapy) and capital-related costs are not subject to any limits. Medicare's current retrospective reimbursement rates contribute to rising expenditures by providing incentives to increase costs. The SNF proposals make the following changes in reimbursement:

- Extend Savings from OBRA 1993 SNF Cost Limits Freeze. OBRA 1993 eliminated the annual update to the SNF routine cost limits for FY 1994 and FY 1995. Although this proposal would not extend the freeze, future SNF payments would be decreased by an amount necessary to recapture these savings as though the freeze had been extended.
- Establish Per-Diem SNF PPS, Beginning in FY 1998. The prospective rate would be designed to cover all three (i.e., routine, ancillary, and capital-related) SNF costs and would be case-mix adjusted. The PPS rates would also be set in a manner that reflects the permanent capture of the savings from the OBRA 1993 freeze on SNF cost limits.

## **OTHER PROVIDERS**

The President's plan achieves about \$2 billion in savings over five years by making a number of changes in reimbursement for a variety of other Medicare providers.

- Establish Competitive Bidding for Laboratories, Durable Medical Equipment and Other Items. The General Accounting Office and the HHS Inspector General have recommended that Medicare use more competitive strategies in managing payment for durable medical equipment and other items and supplies. Numerous reports over the past five years have indicated that private payers using competitive acquisition strategies paid 17 to 48 percent less than Medicare for certain nutritional supplements, that Medicare pays \$2.32 for surgical dressings that wholesale at 19 cents and for which VA pays 4

cents, and that Medicare pays 176 percent more than physicians for certain panels of laboratory tests. This proposal allows the Secretary to competitively bid for these and other items. This proposal saves about \$1 billion over five years.

- Reduce Updates for Ambulatory Surgical Center Fees Through 2002. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY 1994 and FY 1995. Utilization of ASC services has escalated rapidly since the mid-1980s. In addition, the number of ASC facilities has increased dramatically over the same period, suggesting that Medicare's payment rates are more than adequate to cover facility costs. This proposal would reduce the annual CPI update for ASC fees by 2 percentage points for each year between FY 1998 and 2002. This proposal achieves about \$0.3 billion in savings over five years.
- Reform Payment for Certain Automated Laboratory Tests. Medicare currently pays individually for several common laboratory tests that are typically performed as a group (or "panel" of tests) on automated equipment. This means that Medicare pays more for common tests than most private insurers pay. This proposal would add several chemistry tests to the existing list of tests that are classified and paid as automated tests. This proposal achieves about \$0.1 billion in savings over five years.

## **BENEFICIARY PREMIUMS**

- Extend Part B Premium at 25% of Program Costs. Premiums for Part B of Medicare are specified in the Medicare law for years 1991-1995. OBRA 1993 set the Part B premium at 25 percent of SMI program costs for 1996-1998. This provision would extend the OBRA 1993 provision and permanently set Part B premiums at 25 percent of Part B program costs. Five-year net savings from this proposal are about \$10 billion.

## **BENEFICIARY INVESTMENTS**

The President's plan makes a \$15 billion investment over five years to protect beneficiaries from unusually high coinsurance payment for certain services and to increase preventive health care to improve senior's health status.

- Set an Appropriate Level of Beneficiary Coinsurance for Hospital Outpatient Department Services. Another flaw in the reimbursement methodology for outpatient department services involves how beneficiary coinsurance payments are calculated. Because many outpatient services -- such as clinic visits, surgery, and physical therapy -- are reimbursed by Medicare based on cost, and cost is not known at the time of service delivery, copayments are calculated as 20 percent of *charges*. Because charges are significantly higher than the outpatient costs that Medicare recognizes, beneficiary coinsurance for

these services amounts to significantly more than 20 percent of the hospital's costs. In fact, beneficiaries currently make copayments of 46 percent on these outpatient services, and the percentage is rising as charges increase faster than costs. As part of the proposal to implement an OPD PPS, the President's plan proposes to "buy-down" beneficiary coinsurance to 20 percent by 2007. The five-year investment for this proposal is about \$7 billion.

- **Expand Preventive Benefits.** The President's plan strengthens the Medicare benefit package by expanding coverage for important preventive care, and it takes steps to encourage families to keep beneficiaries in the community and simultaneously avoid institutional costs for Medicare and Medicaid.
  - **Waive Cost-Sharing for Mammography Services.** Although Medicare's coverage of screening mammography services began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the benefit. One factor is the required 20 percent coinsurance. To remove financial barriers to women seeking preventive mammograms, this proposal waives the Medicare coinsurance and the deductible, effective January 1, 1998. The five-year investment for this proposal is about \$0.3 billion.
  - **Expand Screening Mammography Coverage for Beneficiaries Age 65 and Over.** OBRA 1990 mandated coverage of annual screening mammography for Medicare beneficiaries age 50-64, but only biennial mammograms for those 65 and over. This proposal would cover annual screening mammograms for beneficiaries age 65 and over, effective January 1, 1998. The five-year investment for this proposal is about \$0.4 billion.
  - **Cover Colorectal Screening.** Effective January 1, 1998, this proposal would cover four common preventive screening procedures -- barium enemas, colonoscopy, sigmoidoscopy, and fecal-occult blood tests -- for detection of colorectal cancers. Current law provides for these procedures only as diagnostic services. Normal coinsurance and deductibles would apply. The five-year investment for this proposal is about \$2 billion.
  - **Increase Payments to Providers for Preventive Injections.** Effective January 1, 1998, this proposal would increase the payment for administration of Medicare-covered preventive injections, which include pneumonia, influenza, and hepatitis B vaccines. It is expected that enhanced payment will increase utilization of these vital preventive services. In addition, the Part B deductible and coinsurance would be waived for hepatitis B injections, just as it is waived currently for other injections. The five-year investment for this proposal is about \$0.4 billion.

- Establish Diabetes Self-Management Benefit. Effective January 1, 1998, this proposal would provide Medicare coverage of diabetes outpatient self-management training services rendered by a certified provider in an outpatient setting. The proposal would also allow Medicare to cover blood-glucose monitors and associated testing strips as durable medical equipment for both Type II and Type I diabetics. Normal coinsurance and deductibles would apply. This proposal would also reduce payment for testing strips by 10 percent based on evidence of current overpayment for these items. **The five-year investment for this proposal is about \$1 billion.**
- Establish Respite Benefit. This proposal would establish a Medicare respite benefit for families of beneficiaries with Alzheimer's disease or other irreversible dementia, beginning in FY 1998. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. **The five-year investment for this proposal is about \$2 billion.**
- Restructure Enrollment and Premium Surcharges. Under current law, the Part B enrollment surcharge -- the penalty that beneficiaries pay for enrolling late -- is purely punitive and not at all linked to the costs borne by the program due to late enrollment. This proposal replaces the current punitive Part B premium surcharge with a surcharge based on the actuarially determined cost of late enrollment. This proposal would also replace the general enrollment period for Part B and premium Part A with a continuous open enrollment period. **The five-year investment for this proposal is about \$0.8 billion.**
- Assistance for the Working Disabled. The President's plan proposes a Medicare demonstration project to encourage Social Security Disability Insurance (SSDI) beneficiaries to work. Under the four-year demonstration project, SSDI beneficiaries who return to work would receive free Part A coverage. **The five-year investment for this proposal is about \$0.1 billion.**
- In addition, the President is proposing significant structural reforms that will bring Medicare into the 21st century. The President's plan also includes market-oriented reforms to assure quality and make the program more efficient.

File Chris Medicare  
options  
82-108

**MEDICARE SAVINGS OPTIONS**

\$100 BILLION

**CBO Baseline**

(Fiscal years, Dollars in billions)

	1998-2002
<b>BASE PACKAGE SAVINGS</b>	<b>-81.6</b>
<b>ADDITIONAL SAVINGS</b>	<b>-18.7</b>
<b>CBO SCORING FIXES</b>	<b>-1.0</b>
<b>HOSPITALS</b>	
Freeze PPS Update in FY 1998 (MB - 1)	-4.1
Freeze non-PPS Update in FY 1998 (MB - 1.5)	-0.8
Reduce PPS capital payments by 5%	-2.0
Value of capital when ownership changes	-0.3
Reduce IME: 6.6% in FY 1998, 5.5% in FY 1999	-2.0
<b>SUBTOTAL</b>	<b>-9.2</b>
<b>PHYSICIANS</b>	
Begin incentives for high-volume in CY 1999	-0.4
<b>SKILLED NURSING FACILITIES</b>	
Require Secretary to eliminate case mix creep	-0.5
Eliminate new provider exemptions	-0.4
Remove new providers from FY 1995 base rates	-1.1
<b>SUBTOTAL</b>	<b>-2.0</b>
<b>OTHER</b>	
Legislation for 40% cut in oxygen (net of premium)	-1.3
Therapy guidelines	-1.8
<b>SUBTOTAL</b>	<b>-3.1</b>
<b>BENEFICIARIES</b>	
Eliminate premium surcharge	-3.0
<b>TOTAL MEDICARE SAVINGS</b>	<b>-100.3</b>

**MEDICARE SAVINGS OPTIONS****\$115 BILLION****CBO Baseline****(Fiscal years, Dollars in billions)**

	<b>1998-2002</b>
<b>BASE PACKAGE SAVINGS</b>	<b>-81.6</b>
<b>ADDITIONAL SAVINGS</b>	<b>-33.9</b>
<b>CBO SCORING FIXES</b>	<b>-1.0</b>
<b>HOSPITALS</b>	
Freeze PPS Update in FY 1998 (MB - 1)	-4.1
Freeze non-PPS Update in FY 1998 (MB - 1.5)	-0.8
Reduce PPS capital payments by 5%	-2.0
Value of capital when ownership changes	-0.3
Reduce IME: 6.6% in FY 1998, 5.5% in FY 1999	-2.0
<b>PPS redefined discharges: extend to HH</b>	<b>-2.5</b>
<b>SUBTOTAL</b>	<b>-11.7</b>
<b>PHYSICIANS</b>	
Begin incentives for high-volume in CY 1999	<b>-0.4</b>
<b>SKILLED NURSING FACILITIES</b>	
Require Secretary to eliminate case mix creep	-0.5
Eliminate new provider exemptions	-0.4
Remove new providers from FY 1995 base rates	-1.1
<b>Update SNF PPS by MB - 1 for FY 1998-2002</b>	<b>-0.7</b>
<b>SUBTOTAL</b>	<b>-2.7</b>
<b>OTHER</b>	
Legislation for 40% cut in oxygen (net of premium)	-1.3
Therapy guidelines	-1.8
<b>SUBTOTAL</b>	<b>-3.1</b>
<b>BENEFICIARIES</b>	
Eliminate premium surcharge	-3.0
<b>Income-related premium, HSA level **</b>	<b>-3.0</b>
<b>Income-related premium, \$50/75</b>	<b>-6.0</b>
<b>Home health premium (Blue Dog approach)</b>	<b>-6.0</b>
<b>Eliminate OPD **</b>	<b>-7.0</b>
<b>SUBTOTAL</b>	<b>-15.0</b>
** Note included in subtotal	
<b>TOTAL MEDICARE SAVINGS</b>	<b>-115.5</b>

File Chris

"Medicare Options  
-- 82 - 100

## MEDICARE OPTIONS

### 1. MOVE TO \$100 BILLION IN CBO-SCORED SAVINGS

- CBO scored the Administration's \$100 billion package as achieving only \$82 billion in savings over 5 years. Because of differences in baselines and assumptions, CBO said that our savings policies would save less than the HCFA actuaries project, and our new benefits and program improvements would cost more.
- To close the gap with CBO, we would need to consider adding additional savings policies, and modifying some new benefits. We could achieve most of the additional savings through policy changes that would not be particularly controversial.

For example, we could raise our CBO-scored savings by:

- **Convincing CBO to modify its scoring--\$1 billion.** We believe we should be able to recapture as much as \$1 billion in savings that CBO failed to credit because of misunderstandings about the Administration's proposals.
- **Dropping premium surcharge policy--\$3 billion.** Our budget included a policy to replace the premium surcharge assessed against Part B beneficiaries who enroll in the program after the deadline with a surcharge that reflects the actual cost to the Medicare program of late enrollment at a cost of \$1 billion. CBO scored this new policy as costing \$3 billion; HHS agrees that if we need more savings, this policy should be dropped.
- **Adopting PROPAC's recommendation for no hospital increase in 1998--\$4 billion.** PROPAC's recommendation, which was based on data showing high hospital profits from Medicare payments, would give PPS hospitals no increase in 1998. Our policy, which was determined before PROPAC made its recommendation, gives hospitals a 1.8% increase in 1998. If we were to adopt the PROPAC recommendation for 1998 and then return to our policy for 1999-2002, we could save about \$3 billion more, including an additional \$1 billion from its indirect effect on managed care.
- **Additional hospital reductions --\$4 to 5 billion.** This could include policies such as freezing the non-PPS hospital update (\$0.8 billion); reducing the PPS capital payments by 5% (\$2.0 billion); value of capital when ownership changes (\$0.3 billion); and reducing IME to 5.5% in FY 1999 (\$2.0 billion).
- **Other provisions -- \$5.5 billion.** Savings could be increased by speeding up the implementation of the incentives for high volume physicians (\$400 million); further reductions in skilled nursing facility payments (\$2 billion); and putting regulations reducing oxygen payments (\$1.3 billion) and therapy guidelines (\$1.8 billion) into legislation.

- Achieving more than \$100 billion in CBO-scored policies would require us to make more significant, and more controversial, changes in our original package, such as dropping some of the new benefits; increasing savings from hospitals by further reductions in hospital reimbursements; and adopting other beneficiary savings proposals.

## 2. MOVE TO PLAN X-- \$113 BILLION IN CBO-SCORED SAVINGS

- Plan X achieves \$113 billion in savings over 5 years. Savings from managed care are lower than our plan (\$20 billion rather than \$30 billion); hospital savings are higher (\$33 billion rather than \$25 billion); savings from other providers are comparable, and Plan X includes the home health transfer from Part A to Part B to extend the solvency of the Trust Fund.
- Relative to the Administration's plan, the major issues with Plan X are that it:
  - **does not include any new preventive benefits**, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;
  - **has a higher Part B premium** because it includes the home health spending transferred from Part A in the calculation of the premium;
  - **proposes to income-relate the Part B premium**;
  - **includes a Medicare MSA**; and
  - **cuts medical education funding more deeply** than the Administration and does not include the IME/GME/DSH carve-out policy.
- If the Administration attempts to achieve around \$113 billion in savings, possible options to achieve this number are:
  - **home health reallocation in the Part B premium--\$6 billion** (with low-income beneficiary protections). Approximately \$11 per month increase in 2002 but only for individuals over \$30,000 (less than one-third of beneficiaries) -- same proposal as Blue Dogs -- or other approaches to assure that low-income beneficiaries are not disproportionately affected.
  - **income-relate the Part B premium --\$3 to 6 billion**. This phases in payment of 75 percent of the Part B costs (triple the current premium) for high-income beneficiaries. This means that high-income beneficiaries will pay about \$184 a month, over \$2,000 more a year. The low-range estimate reflects the policy included in the Health Security Act (\$90,000 for singles, \$110,000 for couples) while the high-range estimate reflects a policy that begins the phase out at \$50,000 for singles, \$75,000 for couples.
  - **other provisions--\$3.2 billion**. Includes policies like lower SNF updates (MB-1) (\$0.7 billion); and redefine PPS discharges for home health (\$2.5 billion).

Note: One could substitute elimination of the coinsurance protections -- which ensure that beneficiaries are paying the 20 percent coinsurance that current law intended-- (\$7 billion over five years) for one of the two beneficiary provisions outlined above.

Relative to Plan X, we achieve the \$113 billion in savings in this option without dropping the preventive benefits and the Alzheimer's respite provision, and without including MSAs.

### 3. MOVE TO PLAN Y--\$143 BILLION IN CBO-SCORED POLICIES OVER 5 YEARS

- Plan Y achieves \$143 billion in savings over 5 years. Savings from managed care are lower than in the Administration's plan (\$18 billion as opposed to \$30 billion); savings from hospitals are substantially higher (\$54 billion as opposed to \$25 billion); savings from other providers are comparable; and Plan Y does include the transfer of home health spending from Part A to Part B to extend the solvency of the Trust Fund.
- Relative to the Administration's plan, the major issues with Plan Y are that it:
  - **does not include any new preventive benefits**, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;
  - **has a higher Part B premium** because it includes the home health spending transferred to Part B in the calculation of the premium;
  - **increases the Part B deductible** from \$100 to \$150 and indexes it to inflation;
  - **includes a Medicare MSA and private fee-for-service options** that appear to be similar to those in the vetoed balanced budget bill;
  - **includes much higher hospital cuts**; and
  - **cuts medical education funding more deeply** than the Administration and does not include the IME/GME/DSH carve-out policy.
- If the Administration attempts to achieve \$143 billion in savings, we would be forced to adopt some of the policies in Plan Y. For example, we would probably have to drop all new benefits, include significantly higher hospital reductions, and possibly adopt additional beneficiary reductions. **Achieving \$143 billion in savings is substantially more difficult than achieving \$100 billion or \$113 billion in savings. This would be the equivalent of having more than \$270 billion in savings over 7 years -- the same number that we criticized so strongly in the last Congress.**

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THE WHITE HOUSE

Office of the Press Secretary  
(Miami Beach, Florida)

For Immediate Release

July 13, 1999

REMARKS BY THE PRESIDENT  
AT ANNUAL CONVENTION OF THE  
COMMUNICATION WORKERS OF AMERICA

Miami Beach Convention Center  
Miami Beach, Florida

1:35 P.M. EDT

**THE PRESIDENT:** Thank you for that wonderful welcome. (Laughter.) You, in particular. (Laughter and applause.) Thank you, President Bahr, Mrs. Bahr, members of the Executive Committee. President Sweeney, it's great to see you here. To see all of you out here and all of those behind. I always knew the CWA was behind me, but when I saw so many people up here I thought it was a literal proof today. (Laughter.)

I want to say I also believe that two gentlemen who came with me are still here -- Florida representatives, our Democratic Congressman, Representative Alcee Hastings, and Attorney General Bob Butterworth. I welcome them here. (Applause.)

I came here, first and foremost, to say a simple thank you -- thank you for what you do to make America great. Thank you for what you have done for me and the Vice President. Thank you for the help you have given us to move this country forward.

Harry Truman once said, when ever labor does well, the whole country does well. (Applause.) As usual, he was right. You prove it. The CWA is stronger than it's ever been and America is more prosperous than it has ever been. The bounty we enjoy today is in no small measure the result of your hard work -- every day programming computers, manning customer service

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centers, electronically filing news stories, running MRI machines, laying the very cable of the Information Superhighway. The CWA is building the new economy of the 21st century.

In that endeavor, the Clinton-Gore administration and

our allies in Congress have been your partners. Remember what it was like when I became President six and a half years ago? Unemployment was high, the deficit was huge and rising, poverty and inequality were increasing, our social problems were getting worse. We promised to make a new covenant with the American people: opportunity in return for responsibility; a community of all Americans and a government committed to giving the American people the tools and conditions they needed to solve their problems and make the most of their own lives.

That strategy was set in motion with our economic plan in 1993. In the years since, we have turned the red ink of deficits into the black ink of surpluses; lowered interest rates and fueled an economic expansion of truly historic proportions. Meanwhile, we've nearly doubled investment in education and training; put more police on the street and taken more guns out of the hands of criminals; invested more in technology, medical research, in cleaning up the environment; passed family leave and other family-friendly measures --(applause) -- including substantial tax cuts to help families pay for college and to help families raise their children.

We showed, in other words, that our Democratic administration could balance the budget while honoring our values. Now, because we believe it is wrong for any child to be without access to the Internet, one of the greatest vehicles of opportunity the world has ever seen, we created our e-rate program to make sure every classroom -- thanks to the leadership of Vice President Gore -- every classroom in America can be hooked up to the Internet by the year 2000. We're well over half way there now, and I thank you for your role in that.  
(Applause.)

I also want to thank Morty Bahr for serving on the Advisory Council on the National Information Infrastructure, which laid the groundwork for the e-rate program, which has brought discount after discount after discount to poor schools and libraries throughout America to make sure everybody can afford to be part of the Information Superhighway.

Now, because we believe all Americans should have the means to upgrade their skills, we unveiled in January a new

initiative to offer literacy and job training to every single working American who needs it now and who will need it in the future. (Applause.) And again, Morty Bahr was there with me at the unveiling, having served on our 21st Century Work Force Commission.

And now, because we believe that to be secure means

meeting the challenge of the aging of America by reforming Social Security and Medicare, providing more health care security, more retirement security and strengthening our economy, we have put forward a sweeping proposal to use most of our surplus for these purposes.

Today I want to talk to you in detail about the challenge of strengthening and modernizing Medicare for the 21st century. (Applause.) The simple problem is that more Americans are living longer. That's a high-class problem. But with the baby boom retirement just ahead of us and more Americans living longer, the number of Medicare beneficiaries is simply growing faster than the number of workers paying into the system.

By the year 2015, the Medicare trust fund will be insolvent, just as the baby boom generation begins to retire and enter the system, eventually doubling the number of Americans over 65 by the year 2030. Over the last six and a half years, we've taken some important steps to strengthen Medicare. When I first became President, Medicare was scheduled to go broke this year. We've helped to extend the life of the trust fund to 2015 by fighting waste, fraud, and abuse, and taking tough action to contain costs, in 1993 and in 1997.

But we must do more, not only to extend the solvency of Medicare, but to ensure that its benefits keep up with the advances of modern science. No one, for example, no one would devise a Medicare program if we were starting from scratch today without including a prescription drug benefit. (Applause.) It wasn't as important back in 1965. Many of the drugs we now use to treat heart disease, arthritis and other conditions didn't even exist back then when Medicare was first created.

When it comes to securing health care and its benefits, nobody -- nobody -- has done more than the CWA. When it comes to controlling health care costs and maintaining quality of care, no union has worked harder or more cooperatively with employers and

insurers than the CWA. What you have done for your retired members we as a nation must now do for all our senior citizens. (Applause.)

Last month I set out a plan to secure and modernize Medicare. Here are its elements. First and foremost, my plan would provide what every single objective expert has said Medicare must have if it is to survive -- more resources to shore up its solvency. The plan would devote 15 percent of the federal budget surplus over the next 15 years to Medicare to extend the life of the trust fund to 2027.

Second, the plan will use the force of competition and the best practices now in the private sector to keep costs down without sacrificing quality.

Third, the plan will allow Americans between the ages of 55 and 65 who don't have health insurance on the job or in their retirement to buy into Medicare in a way that does not compromise the solvency of the trust fund. This is a huge issue today, with more and more early retirees and others who don't have health insurance and simply cannot afford it in the private marketplace in the years when they may be most vulnerable. (Applause.)

Fourth, the plan will modernize Medicare's benefits to match the advances of medical science. For example, almost every week researchers seem to develop a new preventive screening to catch diseases in their early stages. Unfortunately, the copayments Medicare charges for these tests leaves many seniors struggling to pay rent and utility bills to put off getting those tests done until it's too late. It makes no sense for Medicare to put up roadblocks to screenings and then turn around and pick up the much more expensive hospital bills the screenings might have avoided. (Applause.)

That's why our plan will eliminate the deductible and all copayments for all preventive services. (Applause.) We pay for it by requiring modest copays for lab tests that are often overused, and indexing the very modest Part B premium. But we must help. If we're going to do this right, we must help seniors to meet their greatest growing need -- the need for affordable prescription drug coverage. (Applause.)

Now, many of our friends in the other party say, well, a lot of seniors have drug coverage today. Well, that's right, a lot do. But 15 million don't, and more are losing it every single day. And a lot of them are paying an arm and a leg for very modest coverage. For those who have good plans, they're not having any problems because our plan on this is entirely voluntary. It provides voluntary prescription drug coverage, paid for largely with resources we will save from making Medicare more competitive and innovative, plus a small fraction of the surplus that is dedicated to Medicare.

This benefit will cover half of all prescription drug costs, up to \$5,000, when fully phased in, with no deductible at all, and all for a modest premium that will be less than half the price the average Medigap policy costs, and will not apply -- will not apply -- to seniors up to 130 percent of the poverty line. This is a good deal for America, and we ought to do it.

(Applause.)

It is a program our seniors can afford, provided in a way the rest of America can afford. Nobody knows better the value of prescription drug coverage than union men and women that have fought hard for drug benefits more generous than those I'm proposing. But retired unionists are among the fortunate few. I say again: Nearly 15 million Medicare beneficiaries lack prescription drug benefits altogether. Nearly half of them are not poor; they're middle-class Americans. With prescription drug prices rising, the pressure is on employers to cut back or eliminate prescription drug coverage; and it's becoming more intense. Much of that pressure is coming from competing employers who don't offer these benefits. You and your employers should not have to fight this battle by yourselves. (Applause.)

Of course, America works best when we work together to meet our common challenges. Yesterday, at the White House, I met with leaders of both parties to discuss the budget and my plan for Medicare. I was pleased that Republican leaders expressed a willingness to work together with us. But they are putting together a tax plan today that leaves no resources available from the surplus for strengthening Medicare. That is why I am asking Republican leaders, in the interest of saving Medicare, to reconsider the size of their tax cut plan. First things first. (Applause.)

We worked very hard in putting this plan together to squeeze every penny of savings we could out of Medicare without harming the quality of care. But to extend the life of the trust fund for a quarter century without devoting a portion of the surplus to Medicare would mean -- listen to this -- would mean holding spending increases in Medicare to a rate that is more than 60 percent below what private insurance is expected to grow. It can't be done. That would severely cut both the quality and the quantity of health care available to seniors on Medicare and that will not happen on my watch. I won't let it happen. (Applause.) Thank you.

I am pleased that there does seem to be an agreement between the Republican leaders and our Democratic leaders and myself to devote that portion of the surplus attributable to Social Security taxes just to Social Security. But it is critical that we have a so-called lock box that actually locks in the debt reduction that we get from not spending that money and gives the benefit of that debt reduction to Social Security, so that we can extend the life of the trust fund, as my plan does, the Social Security trust fund, to 2053 -- adding 53 years from here to there. That's important. (Applause.)

I'll be talking more about this later. But the Social Security trust fund is expected to last until 2035 now. It's even more important that we devote some of these funds to Medicare right now because Medicare is expected to be insolvent almost 20 years earlier, in 2015.

We as a nation have got some big choices to make in the next few months. We've got to decide what to do with this surplus. Did you ever think a few years ago we'd even be having this conversation? We had a \$290-billion deficit when I took office; it was supposed to be up to \$380 billion this year. We quadrupled the debt four times, quadrupled the debt in 12 years. So I realize that it's tempting for a Congress to say, well, 16 months before election, let's do what is most immediately pleasing, whether it's right for America over the long run or not. This is a big test for us -- for our wisdom, for our judgment, for our concern for our people and their future.

I think the right choice is to devote most of the surplus to saving Social Security and Medicare. (Applause.) Let me tell you -- and let me walk through this with you again, because under our plan, besides reforming and saving Social

Security and Medicare, this plan will allow us to pay off publicly-held debt to make America debt-free in 15 years for the first time since 1835. (Applause.)

Now, what does that mean to the government? It means when you pay your tax money, we're not spending 13 cents, 14 cents or 15 cents on every dollar of your taxes just to pay interest on the debt. It means that future tax burdens can be lower.

What does it mean to ordinary citizens right now, and every year from now on? It means if America is on a path to becoming debt-free, interest rates will be lower. That means businesses can borrow at less cost. That means more new investment, more jobs and more money for higher wages. It means average families can borrow at less cost. That means lower home mortgages, lower credit card payments, lower car payments, lower college loan payments. I'm telling you, the average family will save a whole lot more under this plan looking after our future than they will under the tax cut plan offered by the other party. (Applause.)

Now, because their plan spends almost all the non-Social Security related surplus on a tax cut, it would not only do nothing to restore Medicare, it would require deep cuts in those things we need to be investing the most in -- in education, in hiring those 100,000 teachers, in medical research, in technology, in preserving the environment, in modernizing our national defense. We won't have the money to do that.

And again I say, this is a mistake because our plan has a sizeable tax cut -- nearly a quarter trillion dollars for middle-income families to meet their crucial needs -- for child care, for long-term care, for saving for retirement. It provides tax cuts for building world-class schools, for developing and installing new environmental technologies, for funding the New Markets Initiative -- which I highlighted on my tour to the poorest parts of America last week, simply to say we will give you the same tax breaks to invest in poor areas in America we give you to invest in poor areas overseas. It is the right thing to do. (Applause.)

So here's the choice: We can save Social Security and Medicare and make Medicare better. We can make America debt-free, giving our children a stronger economy and all of you lower interest rates. We can still have a good-size tax cut, but

not as large as the one the Republican leaders propose.

Again I say, their plan would spend almost the entire non-Social Security portion of the surplus on tax cuts. It wouldn't extend the solvency of Medicare by a single day. Depending on how they do it, it might not extend the solvency of Social Security by a single day. It would force drastic cuts in education, research and technology, defense and the environment. It would mean not paying off the debt and leaving us and our children more vulnerable to higher interest rates, a higher level of government spending for interest payments alone, higher taxes in years to come, a weaker economy, itself more vulnerable to the kind of global financial turmoil we've all seen the last couple of years.

So that's the choice. An America debt-free, with Social Security intact and Medicare even better, and a substantial tax cut -- or a return to the "spend now, pay later" approach that will not save and strengthen Medicare, may or may not lengthen the life of Social Security, will certainly cut education and other vital programs, and again I say, over the long run will be far more costly to every person in this room and every working family in the entire United States.

I believe we all want -- Republicans and Democrats and independents -- the strongest possible America for our children. I'm encouraged by the tone and the substance of the meeting I had yesterday with the leaders of Congress in both parties. So I ask, again the Republican leaders in Congress, for the sake of saving Medicare and strengthening our future, to reduce the size of your tax cut and join us in putting first things first. (Applause.)

If we would sit down at the table like responsible family members and figure out how much it would cost us to meet our current obligations to education, defense and other things, what we have to do to save Social Security and Medicare not just for the baby boom generation, but for their children and grandchildren who otherwise will be spending money they need to get along, to pay for education, to pay for the future on their parents, then we could figure out how much is left over for the tax cut. That's what I've tried to do, because I think it's the right thing for America. First things first, putting people first. It's the American way. (Applause.)

And to my fellow Americans who may think that this is just one of those Washington debates, and one side makes their

side sound good and the other side makes their side sound so good, and it's all just a bunch of politics, all I can offer is the record of the last six and a half years. (Applause.)

I ask -- think about it. With your help, we have nearly 19 million new jobs, the longest peacetime expansion in history, the lowest crime rate in 26 years, the lowest welfare rolls in 30 years, the highest home ownership in history, the lowest minority unemployment rates ever recorded. We have declining rates of teen pregnancy, smoking and drug abuse. We have cleaner air, cleaner water and safer food. We've got 90 percent of our children immunized against serious childhood illnesses for the first time. We've got 100,000 young people working in our communities in AmeriCorps, making America better and earning their way to college. The record indicates that when we say something is good for America's future, it probably is good for America's future. (Applause.)

That's why we're trying to pass this patients' bill of rights they're debating up there today. Think how you would feel -- that's what I asked the senators to do today -- think how you would feel if it was your child, your wife, your husband, and the question was, your doctor says you need to see a specialist and your HMO accountant says you don't. Should you have to hassle it out for three months, and then, if the damage is irrevocable, shouldn't you be able to hold somebody accountable? Think how you would feel. (Applause.)

Think how you would feel if, God forbid, you got hurt in an accident outside this convention hall and the ambulance had to drive you past two or three hospitals until they finally got to one covered by your HMO. Depending on what kind of injury you had, it could just be much more painful or terribly devastating.

Think how you would feel if your small employer changed health care providers in the middle of your wife's pregnancy or in the middle of the husband's chemotherapy treatment; and they said, I'm sorry, I know this is traumatic, I know you're six months pregnant and you've had a terrible pregnancy, but here's a new doctor for you. I know your life is on the line and you've got great confidence in this doctor supervising your chemotherapy treatment, but here's a new doctor for you.

I just try to think about what's right for the American people. Oh, they'll tell you how much it costs up there. But we put in the patients' bill of rights for the federal employees --

it costs less than a buck a month a policy to comply with. (Applause.) The Congressional Budget Office says that at the most, it would cost \$2 a month a policy. Don't you think it's worth \$24 a year to know that when you need to see a specialist, you can see one? (Applause.)

So that's what we're trying to do -- with our proposal to modernize schools, to finish hiring 100,000 teachers, to put even more police on the street and take even more guns out of the hands of more criminals. And that's what we're trying to do by shining the light of enterprise and opportunity at America's poorest communities. And most of all, that's what we're trying to do with our plan to save Social Security and Medicare, provide that prescription drug benefit and make America debt-free.

You know, in a year and a half, I'll retire with a pretty nice pension. I'll be all right, regardless. Thanks to the CWA, most of you will be all right, regardless. (Applause.) But, you know, if we haven't learned anything in the last six years, it ought to be that the policies that help the least of us help all of us; (applause) -- that when we strengthen America's families and workplaces and communities, we're all better off. (Applause.)

A lot of people that have made a lot of money out of the stock market in the last six and a half years, when it's more than tripled, they'd have been all right if the stock market hadn't gone up. But they're a lot better off because the lives of average Americans have gone up. That's why the stock market's done better. (Applause.)

And so, again, I'll say to all of you, we've got this phenomenal opportunity -- the opportunity of a lifetime, of a whole generation, to use the last 16 months of this century to get the 21st century off to a rousing start for America. We just have to be faithful to the covenant we made with the people in 1992. We have to put first things first. We have to put people first. And if we do it, watch out, you ain't seen nothin' yet.

God bless you and thank you. (Applause.)

END

2:10 P.M. EDT