

MEMORANDUM

TO: Carol Rasco
FR: Chris and Jen
RE: Attached Contrasting Medicare Cut Charts

June 26, 1995

Attached is a set of charts that help graphically illustrate the differences between the President and the Republicans on the Medicare issue. Although all of us inside the White House are well aware that there are no new Medicare beneficiary cuts in the President's balanced budget proposal, this message has not filtered through to the general public. The media is basically saying it is less than the Republicans and are clinging to the "Republican light" label that some of our Dems have given the President's proposal.

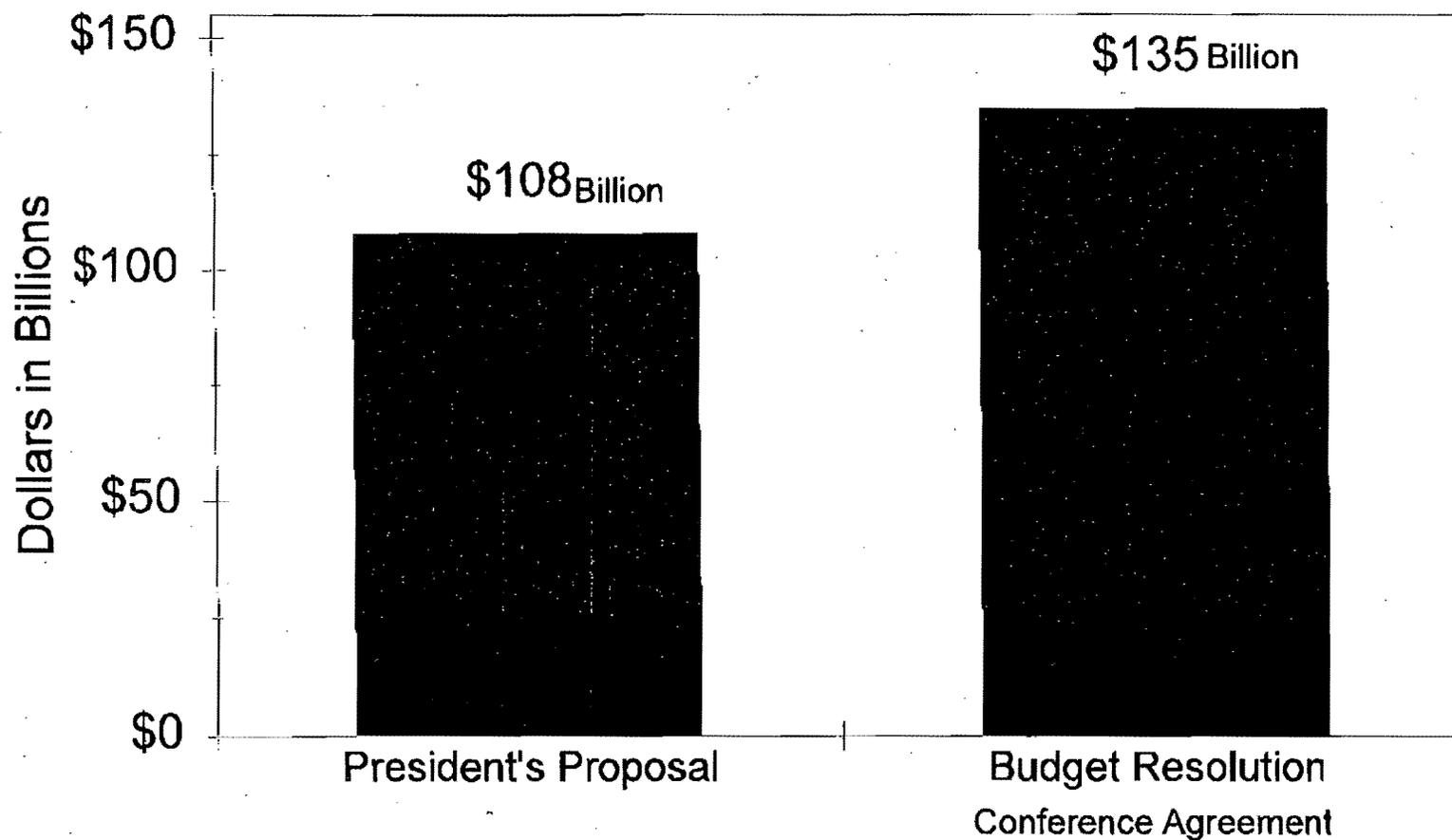
The analysis of the Republican budget conference agreement is consistent with what we and most other major analysts have assumed in the absence of specific proposals. That is to say, we have assumed a 50/50 split of beneficiary cuts to provider cuts. From our preliminary analysis of the Republican conference agreement and the fact that the providers are not complaining any more about their cuts than our cuts -- we believe this to be a fair assumption.

Assuming the 50/50 split obviously produces stark differences in the amounts of out-pocket-increases Medicare beneficiaries would pay. However, as you will see in the provider comparison, there is not such a wide gap -- although the Republicans still would cut more even if you assume such a small percentage provider hit. (Historically, providers have taken at least two-thirds of the cuts.) If you run into any providers, you could say that our 50/50 split analysis would be the absolutely least they would get hit under the Republican plan.

Two warnings Carol: First, these comparisons are accurate at this point in time. They should be used to clearly illustrate the differences between their proposal and the President's current proposal. We, of course, cannot preclude that we might support some new beneficiary savings proposals at some point in the future. Therefore, language used with these charts should be chosen carefully. Second, these charts assume in their baseline the President's February budget proposal to extend the requirement that the Part B premium make up 25 percent of program costs. (This is essentially an extension of current law and, because it was already proposed before, we do not count it as a new beneficiary proposal in our charts -- on either our side or the Republican side.)

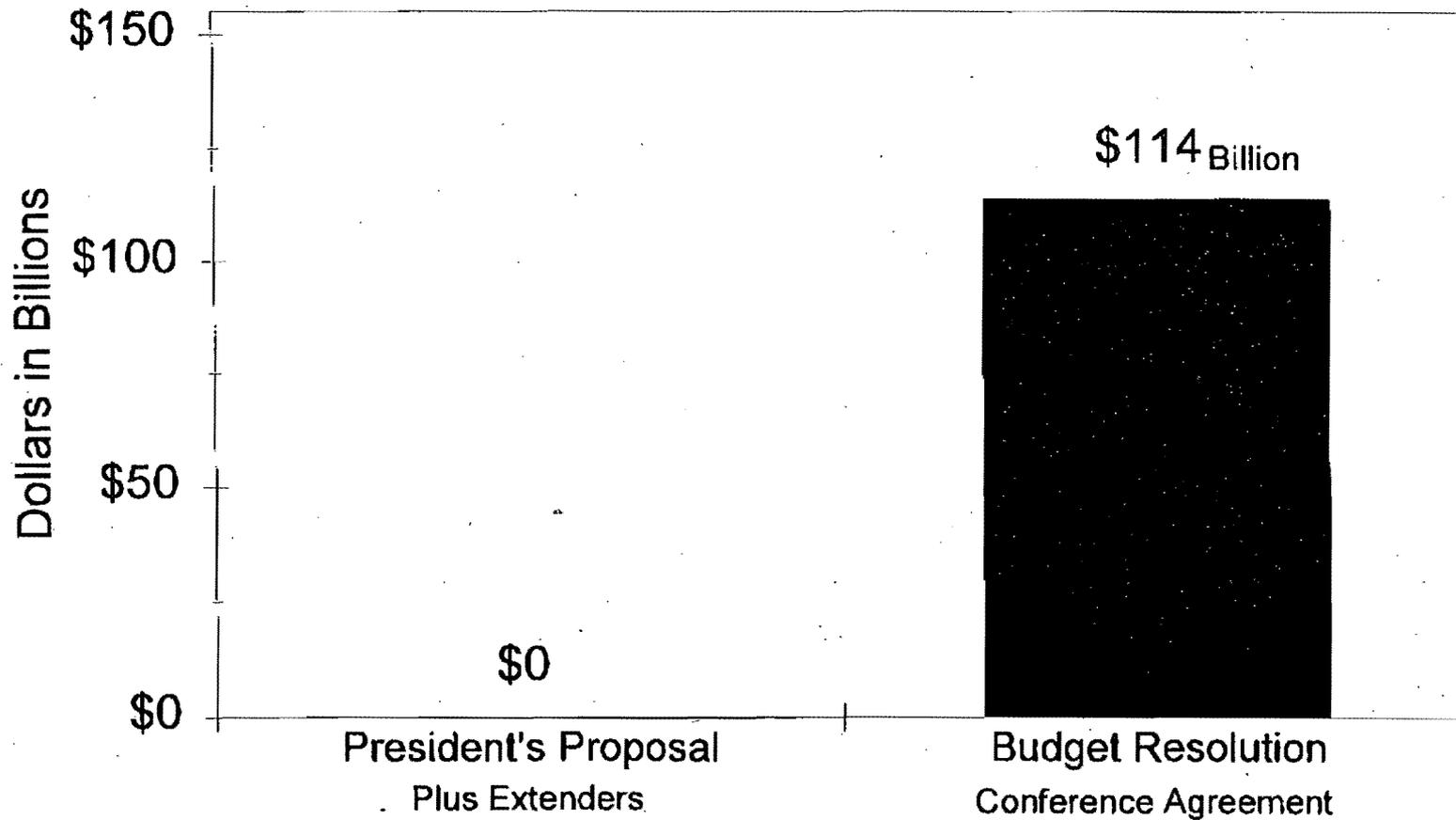
We need to do a much better job contrasting ourselves against the Republicans. We hope the attached can help you and other senior officials in the Administration in this regard.

Savings from Medicare Health Care Providers, 1996 - 2002



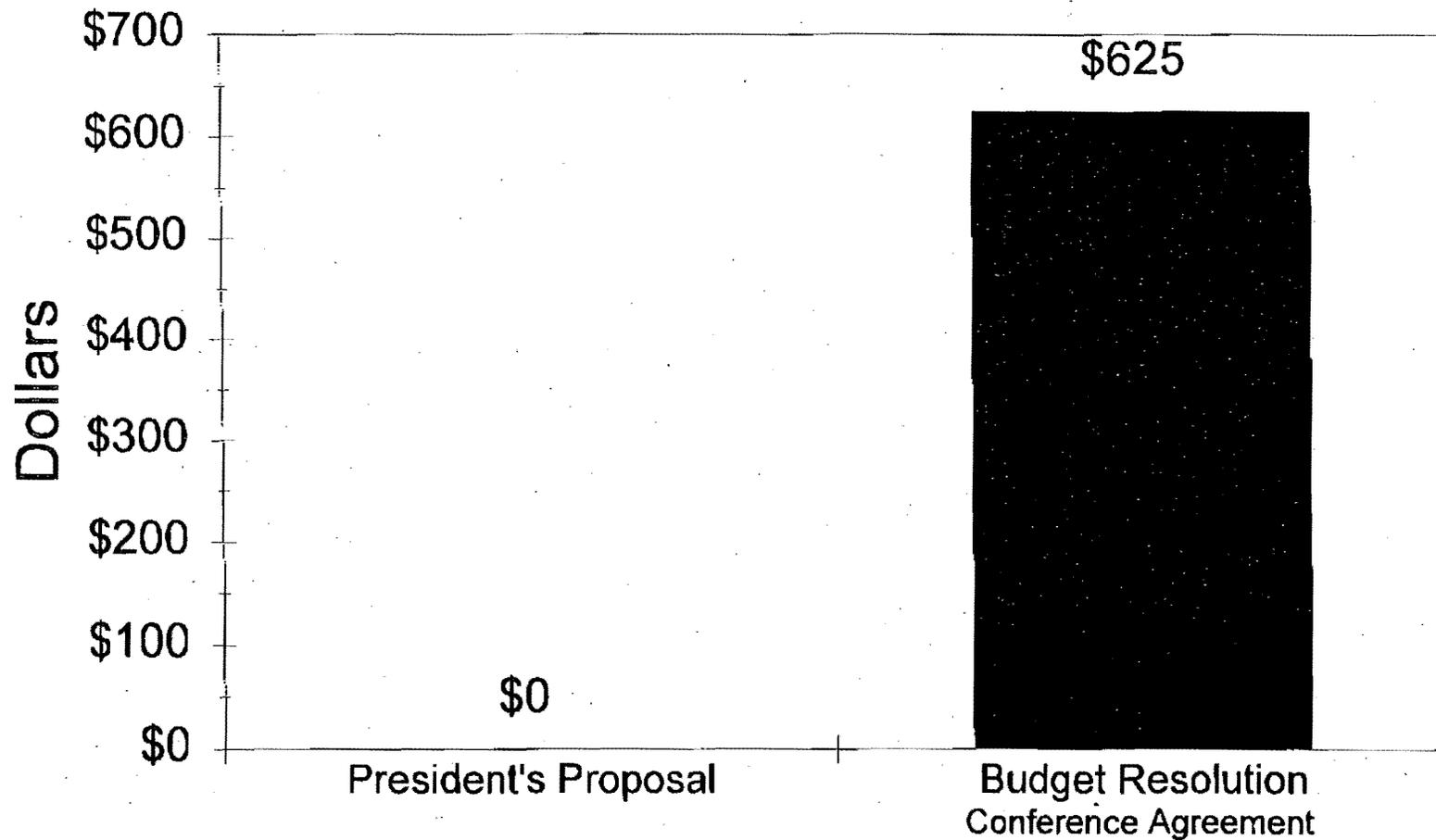
The President's Proposal includes the extenders that were previously incorporated in the President's FY 1996 Budget. This chart assumes 50% of Republican cuts affect providers. US DHHS Estimates

Increased Medicare Beneficiary Out-of-Pocket Costs, 1996 - 2002



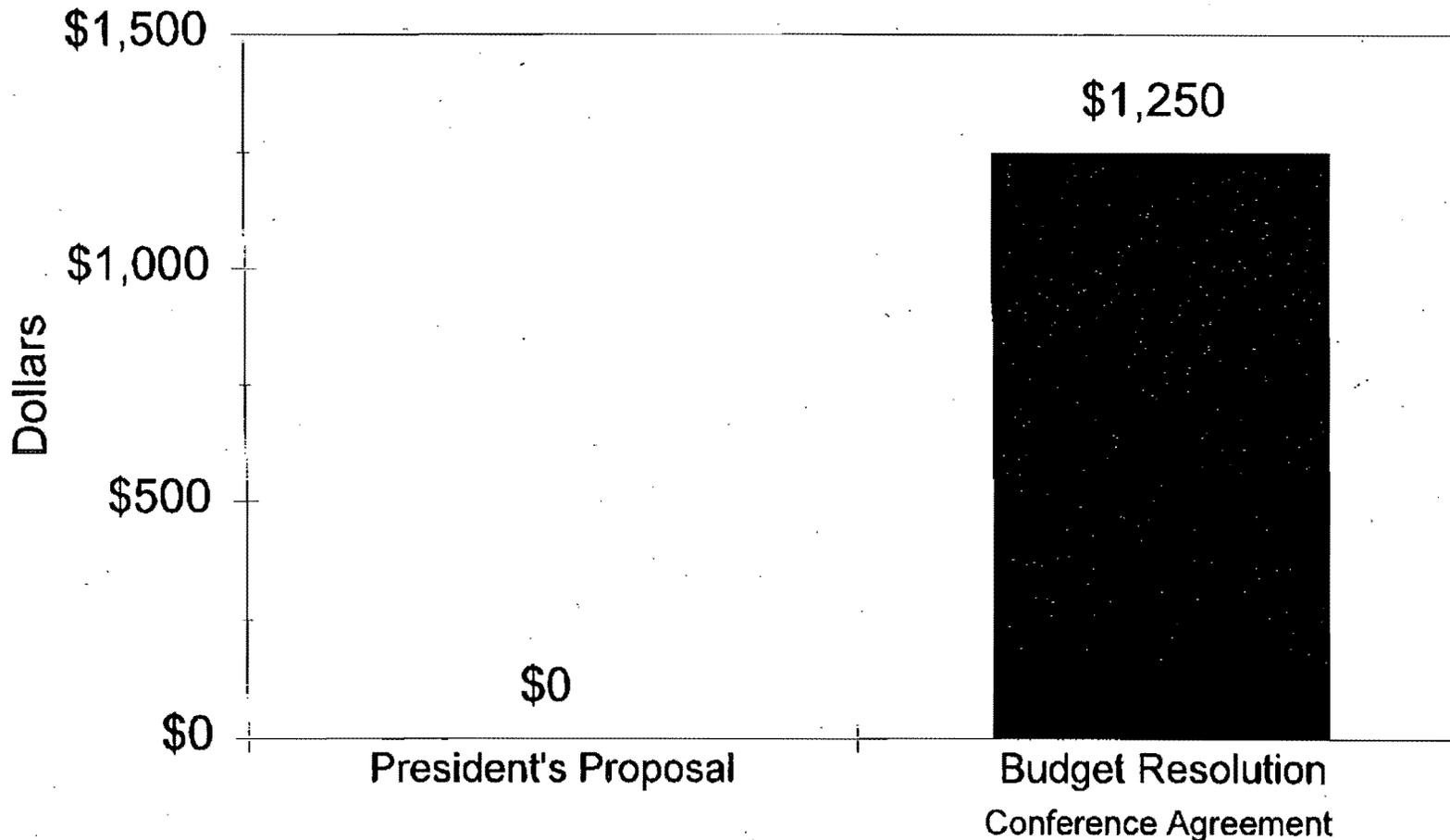
The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposal adjusted to reflect the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimates

Increased Medicare Out-of-Pocket Costs Per Beneficiary, 2002



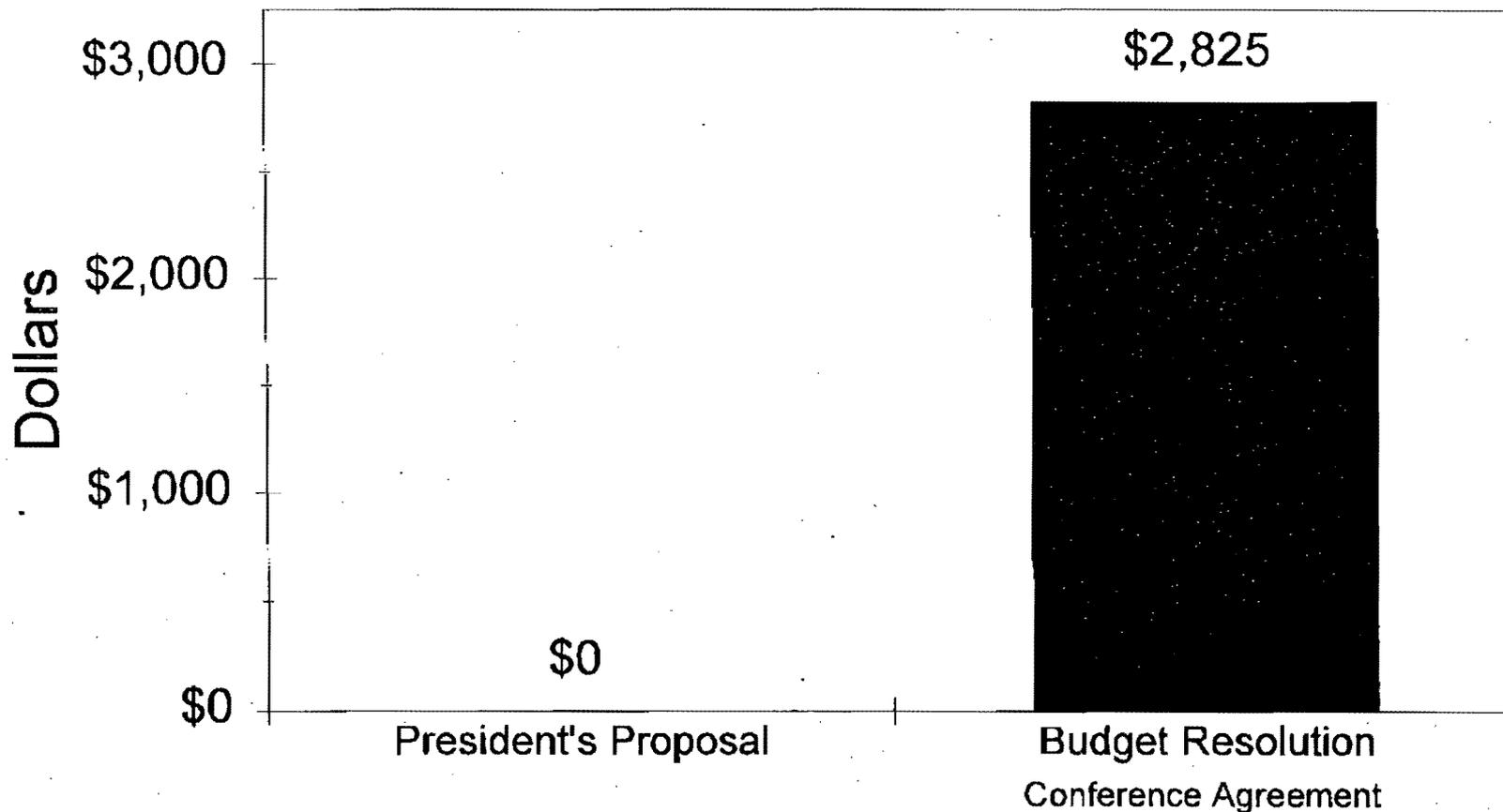
The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposal adjusted to reflect the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimates

Increased Medicare Out-of-Pocket Costs Per Couple, 2002



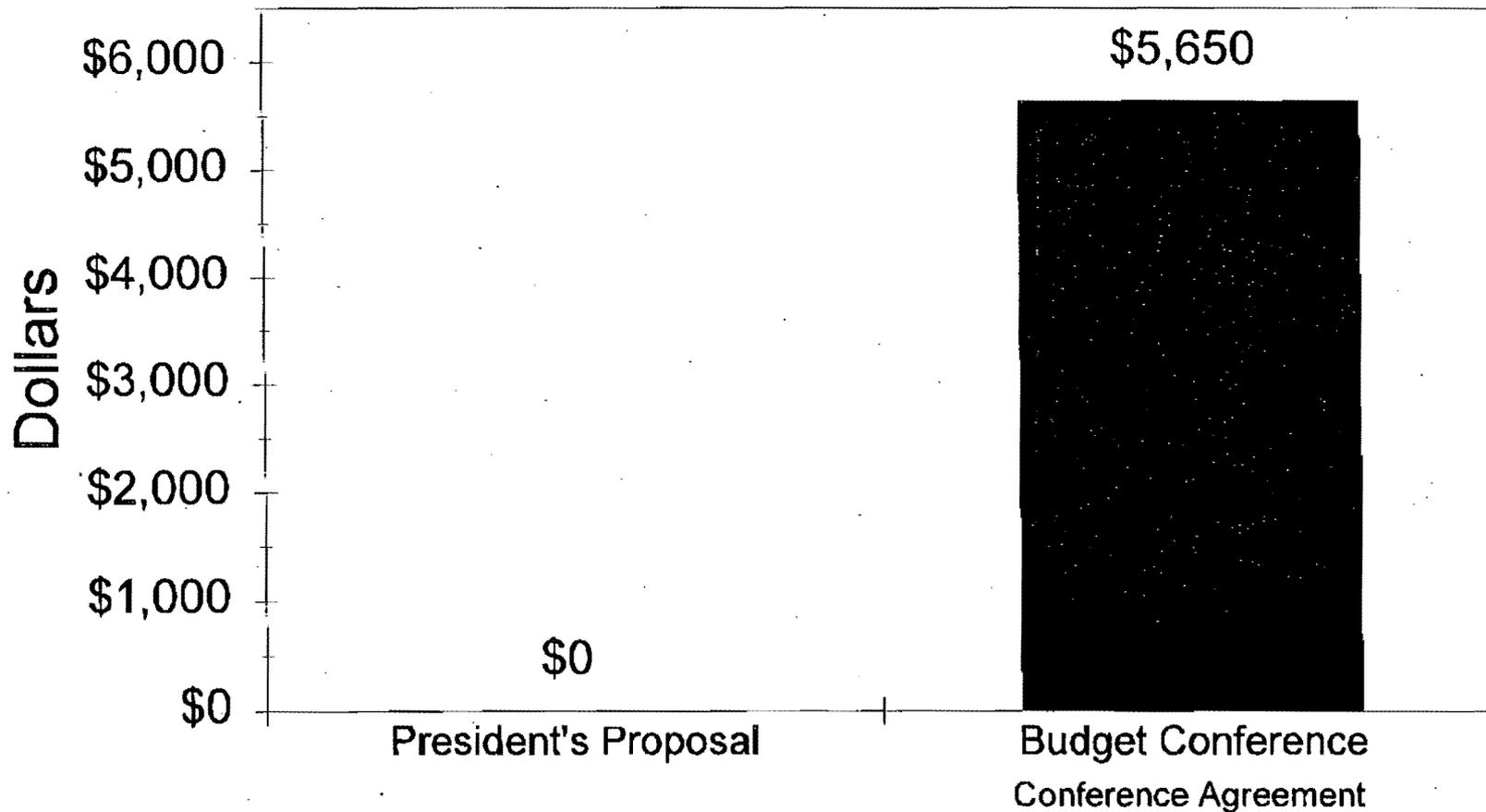
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Increased Medicare Out-of-Pocket Costs Per Beneficiary, 1996 - 2002



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Increased Medicare Out-of-Pocket Costs Per Couple, 1996 - 2002



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**Testimony of
Bruce C. Vladeck
Administrator
Health Care Financing Administration
Before the
Subcommittee on Health and the Environment
Committee on Commerce
U.S. House of Representatives
June 21, 1995**

Mr. Chairman and Members of the Committee:

I welcome the opportunity to be here this morning to discuss the history, accomplishments and future direction of the Medicaid program. This Administration has been working to strengthen Medicaid's inherent partnership between the Federal government and the States. We know we need to continue building on this partnership to make necessary improvements to the Medicaid program.

Introduction

Medicaid provides health coverage for 36.1 million Americans -- children, senior citizens, individuals with disabilities and others -- through a partnership between the Federal government and the States which provides States with substantial flexibility over eligibility, benefits and delivery systems.

Recently, States have also been seeking additional flexibility in the Medicaid program. We have responded by using our demonstration authority to enable States to pursue a number of innovative approaches to covering additional populations and redesigning Medicaid delivery systems. Just last week, the President also proposed important new reforms that will control Medicaid cost increases and provide States with additional programmatic flexibility.

Except for the period between 1989 and 1992, the Medicaid program has grown less rapidly than the private sector on a per capita basis (Chart 1). The unsustainable growth rates during this time were caused by several factors, including a national recession, States' use of statutory loopholes to leverage Federal dollars, and increased provider payments. In response, the Executive Branch worked with Congress and the States to bring program costs under control while maintaining the Medicaid program as an important source -- often the only source -- of coverage for low-income Americans. Our new cost containment proposals continue this commitment.

Medicaid is a Critical Safety Net

Medicaid is the primary source of coverage for a wide variety of Americans with diverse health care needs. It covers preventive care for low and moderate-income pregnant women and children and long term care for low-income senior citizens. It also provides a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

Generally, Medicaid acute-care coverage mirrors the employer-based coverage available to most Americans, but Medicaid also provides long term care benefits for senior citizens and individuals with disabilities that are rarely available or

affordable through other sources. Because Medicaid covers these services, the program ultimately helps a large number of working American families care for their chronically ill family members. For example, 61 percent of all nursing home residents rely on Medicaid to help pay for their care. Many beneficiaries have complex health needs or need long term care and therefore are very expensive to care for. In 1993, spending on all services for elderly and disabled individuals constituted approximately 70 percent of all Medicaid spending, excluding payments to disproportionate share hospitals (DSH). Approximately half of these dollars were spent on long term care in nursing homes. Without Federal Medicaid funding, many of these individuals -- the elderly, chronically ill, disabled and mentally ill -- would be the sole responsibility of States, local communities and their families. The remaining thirty percent of Medicaid spending is dedicated to care for low-income adults and children who use primarily hospital and physician services (Chart 2).

Americans who qualify for Medicaid are assured of financing for their essential health services. While eligibility varies from State to State, certain national standards apply to all States -- notably coverage for low-income pregnant women and children, and the low-income elderly and disabled. States provide the full range of services to beneficiaries, from childhood immunizations to nursing home care. Within these parameters, Medicaid has had substantial success serving diverse low-income populations. For

example, Medicaid coverage improves continuity of prenatal care for low-income pregnant women and increases disabled children's access to physicians.

Over the past few years, employer-based coverage has declined while Medicaid coverage has expanded. For example, while employer coverage fell from 66 to 59 percent of individuals under age 65 between 1989 and 1994, Medicaid coverage grew from 9 to 14 percent for the same population (Chart 3). Medicaid provides a safety net for some individuals and families who would otherwise be uninsured and picks up costs that do not disappear from the health system just because an individual loses private health insurance.

Medicaid's Management Successes

HCFA and the States have worked together to develop an efficient program. Our low Federal and State administrative costs -- 3.7 percent of total program spending in 1993 -- are an example of our success in minimizing administrative burden. As a result, we can target program dollars towards beneficiaries and their health needs. In addition, the Medicaid program has pioneered a number of innovations that enhance program efficiency, expand access to services, improve quality of care, and create new delivery mechanisms that better serve beneficiaries.

Using the flexibility inherent in the Medicaid program, States have developed programs that target their unique needs and have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

- Replacing institutionalized, nursing home care with home and community-based services for disabled and elderly beneficiaries, thus reducing nursing home costs while improving quality of life for these patients;
- Introducing magnetic-stripe cards to provide immediate access to eligibility information, third party liability and electronic claims filing;
- Experimenting with new, gatekeeper-oriented forms of managed care to maximize enrollee choice while also controlling costs; and
- Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

The Federal government continues working to provide substantial assistance to the States and forge new paths for the Medicaid program. Some notable examples include:

- Developing innovative Federal quality assurance guidelines for Medicaid managed care organizations;
- Spearheading the effort to define outcomes measures for Medicaid enrollees to provide greater assurance that

managed care enrollees receive high quality health services;

- Developing "best practices guidelines" for the States on significant program innovations, such as: primary care case management programs; Early, Periodic Screening, Diagnosis and Treatment (EPSDT) implementation; and quality-assurance in community-based programs;
- Implementing a national drug rebate program -- thus holding per person drug expenditures to 1988 levels -- and providing States with day-to-day technical assistance to simplify rebate requests;
- Strengthening our waiver approval process and developing streamlined waiver applications -- these improvements have eased State efforts to expand managed care enrollment, which now includes over 23 percent of all Medicaid beneficiaries; and
- Developing quality standards to protect seniors and others in nursing homes.

Many of these Federal efforts focus on ensuring Medicaid's fiscal integrity, protecting beneficiaries and ensuring that public dollars are well spent on high quality services, all within the broader context of providing substantial support to State programs.

Since 1993, this Administration has taken remarkable steps to build upon HCFA's history of partnership with the States. We are working with a number of States to test new, broad-based approaches to health financing and delivery through Statewide health reform demonstrations under Section 1115 of the Social Security Act. This authority gives the Secretary broad latitude to permit demonstrations that further the goals of the Medicaid program. Through these programs, States may test the effectiveness and efficiency of their own ideas. Historically, States had sought demonstration authority to test relatively narrow changes, such as changes to the Medicaid benefit package, payment methodologies or eligibility requirements for a defined group of beneficiaries or services. Since 1993, States have begun to develop broad, Statewide reform programs under this demonstration authority.

To date, this Administration has approved ten Statewide health reform demonstrations, and we are considering several additional proposals. These States will experiment with innovative financing and delivery systems on a broad scale. For example, Florida intends to develop a revolutionary health alliance system that will broker private health coverage for low-income and uninsured Floridians through a community purchasing network, while Hawaii has achieved insurance coverage for more than 95 percent of its population through a combination of Medicaid expansions and an employer mandate.

We continue our efforts to control growth in program spending. The substantial program growth of the late 1980s and early 1990s was largely driven by States' use of provider taxes, voluntary donations and disproportionate share hospital (DSH) payments to leverage Federal matching dollars. Fortunately, because of our work and Congress's efforts -- through this Committee and others -- the worst abuses have been tempered.

Today, we project that year-to-year expenditure growth in the Medicaid program will average 9.3 percent through 2000. Because enrollment growth has driven much of the spending increases in Medicaid, our per capita growth rates are much lower. We estimate that Medicaid's annual per capita growth will average 5.4 percent through 2000.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. We believe that this can best be achieved within the current Federal-State partnership. The

Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities and children are Medicaid-eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise, buying-power and technical assistance to achieve program goals.

The President's proposal seeks \$34 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care models a program option.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be enhanced further. Finally, we are evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment and other provider payment requirements.

Beyond increasing State flexibility, we know that Medicaid cost-containment must be continued. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the House budget proposal would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the House spending cut -- \$187 billion over seven years -- is too big to absorb through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither whole-scale use of

managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the House proposal. As the attached chart (Chart 4) demonstrates, Medicaid enrollment growth projections edge very close to the proposed spending limits on block grants. As you know, medical inflation influences public health care spending as well as private spending. Inflation, added to anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the House proposal. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the block grant proposal.

To maintain current coverage levels, the House budget proposal would force States to either absorb a large cost-shift from the Federal government, causing the proportion of State to Federal dollars invested in a State's Medicaid program to increase as States are forced to adjust to lost Federal matching payments. The Urban Institute concludes that if States chose to fill the gap, States would, on average, have to increase their spending by 39 percent to make up for the loss of Federal funds. However, in the current fiscal climate, few States may be able to devote new State dollars to their Medicaid program.

There are fundamental differences between the President's plan and the House budget resolution. We rely on per capita limits to allow for changes in enrollment, while the House proposal is based on an aggregate cap and therefore does not provide room for enrollment growth. In addition, we believe that the States and Congress can realize meaningful savings and additional flexibility without resorting to a block grant.

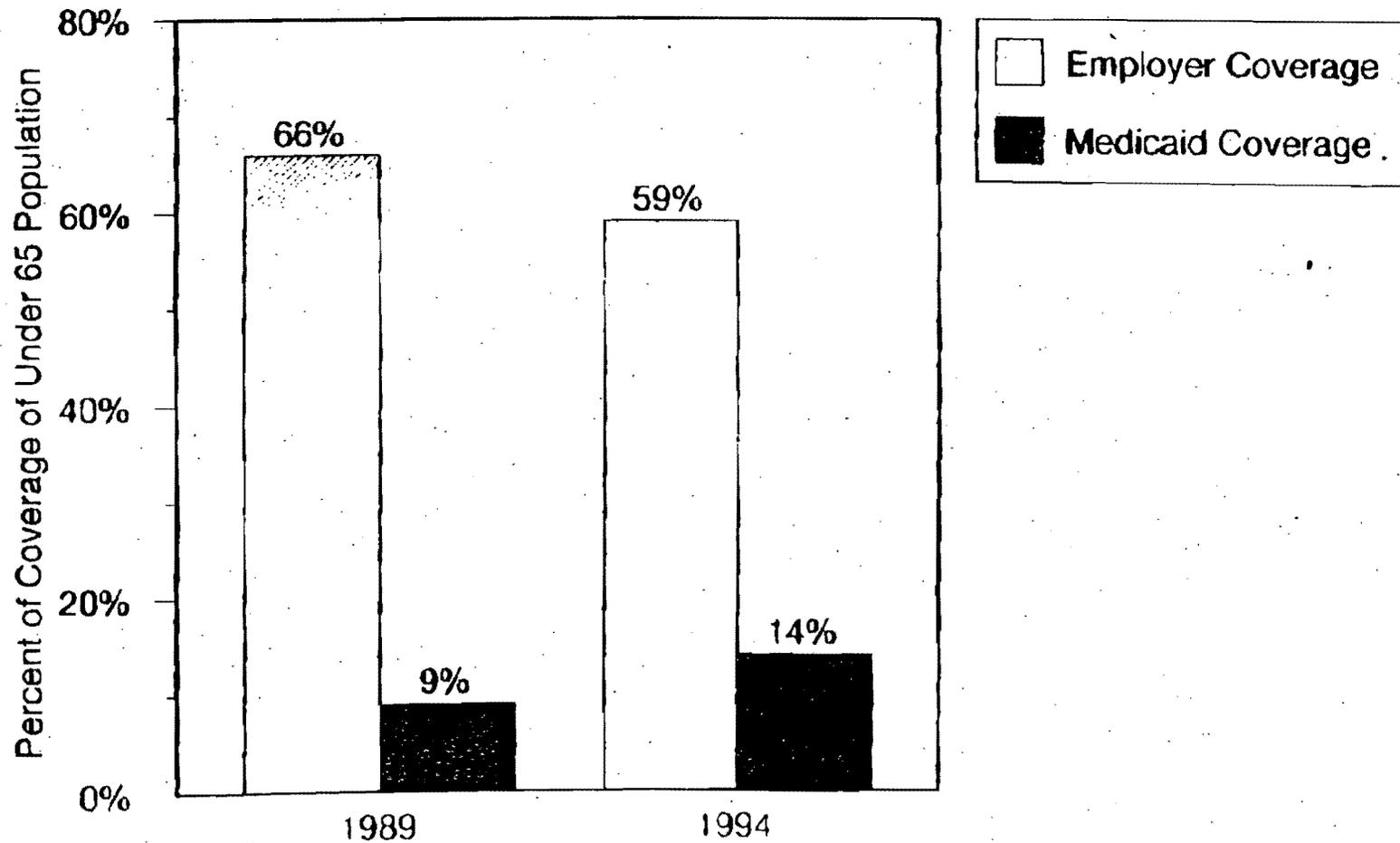
Conclusion

The Medicaid program has a substantial history of success -- together, the Federal government and the States have provided an essential safety net for children, seniors, nursing home residents, the disabled, and other vulnerable Americans.

We are committed to maintaining and building upon Medicaid's successes in order to better serve our beneficiaries. We believe this can best be achieved by making the changes that we know will help both the Federal government and the States control costs and maintain coverage for the Americans we serve today.

Medicaid is a Critical Safety Net

Employer Coverage Reduced, Medicaid Coverage Increased



Source: HCF A, Office of the Actuary at 1000 G Street, N.W.

104 AS5198

- **Eliminating the CoPayment for Mammograms:** Although coverage by Medicare began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance tap this potentially lifesaving benefit. One factor is the required 20 percent copayment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare copayment.

- **Expanding Managed Care Choices:** The President's plan expands the managed care options available to beneficiaries to include preferred provider organizations ("PPOs") and point-of-service ("POS") plans. The plan also implements initiatives to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal. Also included in his plan are important initiatives to streamline regulation.

- **Combatting Fraud and Abuse:** "Operation Restore Trust" is a five-state demonstration project that targets fraud and abuse in home health care, nursing home, and durable medical equipment industries. The President's budget increases funding for these critical fraud and abuse activities.

5. Long-Term Care

- **Expanding Home and Community-Based Care:** The President's plan provides grants to states for home-and community-based services for disabled elderly Americans. Each state, will receive funds for home-and community-based care based on the number of severely disabled people in the state, the size of its low-income population, and the cost of services in the state.

- **Providing for a New Alzheimer's Respite Benefit within Medicare:** The President's plan helps Medicare beneficiaries who suffer from Alzheimer's disease by providing respite services for their families for one week each year.

6. Reforming Medicaid

The President maintains Medicaid, expanding state flexibility, cutting costs, and assuring Medicaid's ability to provide coverage to the vulnerable populations it now serves.

- **Eliminating Unnecessary Federal Strings on States:** To let states manage their Medicaid programs more efficiently, the President's plan substantially reduces Federal requirements.

- States will be allowed to pursue managed care strategies and other service delivery innovations without seeking Federal waivers; and

- The "Boren Amendment" and other Federal requirements that set minimum payments to health care providers will be repealed.

- **Reducing Medicaid Costs:** The President proposes a combination of policies to reduce the growth of federal Medicaid spending, including expanding managed care, reducing and better targeting Federal payments to states for hospitals that serve a high proportion of low-income people, and limiting the growth in federal Medicaid payments to states for each beneficiary. Per-person limits, as opposed to a block grant on total spending, promote efficiency while protecting coverage.

Desperate Republicans Continue Medicare Misinformation Campaign

Republicans Cannot Defend Their Medicare Cuts Without Resorting to Distortions:

- (1) **Republicans claim that the same analysis that shows that their plan would increase Medicare beneficiaries out-of-pocket costs by at least \$600 more in 2002 (\$2,800 over 7 years) would translate into \$443 more under the President's balanced budget plan.**

This claim is simply untrue. The President's balanced budget proposal has NO new Medicare cost increases. The comparison is \$600 in the Republican plan vs. ZERO under the President's balanced budget.

The Republican \$600 out-of-pocket increase that has been documented is based on an analysis by the Department of Health and Human Services that simply assumes 50% of the \$270 billion in Republican Medicare cuts come from beneficiaries. This is actually a conservative assumption as the split between beneficiary to health care provider cuts in the July Republican Ways and Means Committee Medicare working document is 65% to 35%.

- (2) **Republicans are now claiming that the President's \$124 billion in Medicare savings really amounts to \$192 billion off of the Congressional Budget Office (CBO) baseline.**

Wrong again. The CBO has never stated or suggested that the President's \$124 billion in savings proposals equates to a \$192 billion cut. In fact, the only analysis of the President's balanced budget proposal by CBO (see June 16, 1995 letter to Sen. Domenici) assumed that the Administration's Medicare savings amounted to "\$128 billion" over seven years.

It is true that the CBO and the Office of Management and Budget (OMB) *baselines* are different -- about \$70 billion over 7 years. But because there are different assumptions behind the baselines and the policies that affect them, one cannot simply subtract the Administration's Medicare baseline from the CBO baseline and add that number to the President's Medicare savings number.

The \$124 billion in savings included in the President's balanced budget represents assumed policy changes that produce specific savings amounts. Historically, despite significant variations in the CBO and OMB baselines, scoring of specific policies have been very close. For example, the Medicare savings in the Health Security Act was scored by OMB to save \$118.3 billion; CBO scored them to be \$117.6 billion. Most recently, OMB scored the Medicare "extenders" to produce \$28 billion in savings; CBO scored them at \$30 billion. **Therefore, there is no reason to believe that CBO would score the President's Medicare savings at anywhere near the \$192 billion suggested by the Republicans.**

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Facts On The Republican Medicare Premium Increase

October 5, 1995

Republicans Can't Hide Their Premium Increases. No matter what the Republicans say, the bottom line always remains the same:

- The President's proposal maintains premiums at 25 percent of Medicare program costs.
- The Republicans' proposal increases premiums to 31.5 percent of Medicare program costs.

Medicare premiums are based on a percentage of the total Medicare Part B costs. No matter how much you shrink the Part B program, the above percentages always remain the same. If you apply a 25 percent premium (our plan) and a 31.5 percent premium (their plan) to the same Medicare Part B program, the 25 percent premium will always be smaller.

The Republican Plan Raises Premiums by \$18. When the Republicans claim that their 31.5 percent premium amounts to only \$4 more than the President's proposal, they are being deceptive -- they are comparing apples to oranges. They are not applying the 25 percent premium and the 31.5 percent premium to the same size Medicare program. If they compared apples to apples and applied the President's 25 percent policy to the Medicare program they are calling for, the difference would be \$18.

The Reality is That Under The Republican Plan: Older Americans Pay More and Get Less -- In Order To Finance Tax Cuts For The Wealthy. Any way you slice it, the Republican \$270 billion Medicare cuts -- three times larger than any cuts in history -- will force you to pay more to get less -- just to fund a tax cut for the wealthy.

- Increased Out-of-Pocket Costs. The GOP plan will increase out-of-pocket costs for all seniors -- regardless of their income or health.
- Increased Premiums and Deductibles. Both the House and Senate plans increase premiums, and the Senate plan also cuts benefits and doubles deductibles from \$100 a year today to \$210 a year in 2002.
- Reduced Spending. Medicare benefits per beneficiary will be cut \$1,700 in 2002, forcing spending to grow about 30 percent slower than in the private sector.
- Taking Money From Seniors To Pay For Tax Cuts. Not one penny of the increased premiums will go to the Medicare trust fund. Instead, seniors will pay more out-of-their-pockets to fund a huge tax cut for the wealthy.
- Raising the Eligibility Age. The Senate plan would gradually delay the Medicare eligibility age from 65 to 67 beginning in 2003. Tens of millions of Americans would have to work longer and pay more taxes to get fewer years of Medicare.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

September 21, 1995

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

The Honorable Robert Dole
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Speaker and Mr. Majority Leader:

I understand the House Majority is releasing its plan to restructure Medicare today. I am writing to discuss the condition of the Medicare Hospital Trust Fund in the context of these reform plans.

As Managing Trustee of the Medicare Hospital Insurance (HI) Trust Fund, I am concerned by a growing number of statements by Members of Congress which appear to be based on a misunderstanding of what our annual report said. Because votes for significant changes in Medicare should not be cast without Members knowing the facts, I want to recount briefly what the Trustees reported about the funding status of Medicare.

Simply said, no Member of Congress should vote for \$270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare Trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In the annual report to Congress on the financial condition of Medicare, the Trustees concluded that the HI Trust Fund will not be depleted until 2002, seven years from now. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then in the context of health care reform to make long-term changes in the system that would accommodate the influx of "baby-boomer" beneficiaries. At no time did the Trustees call the funding crisis "imminent." Without adequate time for reflection, a responsible, bipartisan, long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed.

Nonetheless, the Majority is asking for \$270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance (Part A) Trust Fund for the next ten years. Moreover, I understand that the \$270 billion of cuts proposed by the Majority includes increases in costs to beneficiaries under Part B of the Medicare program, even though increases in Part B do not contribute to the solvency of the Part A Trust Fund. In this context it is clear that more than \$100 billion in Medicare funding reductions are being used to pay for other purposes -- not to shore up the Medicare HI Trust Fund.

By contrast, the President's proposal, by providing ten years of trust fund security, is consistent with actions by prior Congresses and would afford us far more than sufficient time to propose a bipartisan solution to the long-term fiscal needs of Medicare. Such a bipartisan solution will be needed regardless of whether the President's plan or Congress's plan is finally adopted.

To emphasize, the Trustees did not recommend \$270 billion of Medicare cuts at this time nor state that the funding problems facing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I hope this information can be provided to Members of Congress on both sides of the aisle as they review the significant changes in Medicare that are being considered so that Members can have a clear understanding of the facts.

Sincerely,



Robert E. Rubin

4/26
5pm
MCR. 250

EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans are considering proposals that would cut Medicare funding by \$250 billion between now and 2002 -- a 20% cut in 2002 alone.
- Medicare managed care cannot produce the magnitude of savings being suggested by the Republicans. Claims that substantial savings can be achieved through Medicare managed care actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.
- Although Senator Gregg predicts that managed care could save \$35 - \$45 billion between 1996 and 2000, there is no evidence that managed care can produce Medicare savings of this magnitude. Even if one assumes the type of overly optimistic savings Senator Gregg suggests (extended for seven years), the savings would represent less than one-fourth of that targeted by Republicans.
- If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:
 - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about \$2,630 more for Medicare. In 2002 alone, they would be required to pay about \$680 more.
 - In 2002 alone, a \$28 billion cut in Medicare payments to hospitals, physicians and other health care providers would be needed.
- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.
 - There are now 40 million uninsured Americans, and this number will continue to grow, particularly when the Medicaid cuts being advocated by the Republicans are considered.
- These unprecedented Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.
 - Republicans are talking about combined Medicare and Medicaid cuts between \$400 billion and \$500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts by raising their rates for private patients. Even if only one-quarter of these cuts are passed on to private payers, businesses and families will be forced to pay between \$100 billion and \$125 billion more for health care between now and 2002.

- In the last Congress, bills sponsored by both Republicans and Democrats contained large Medicare cuts. However, unlike current Republican proposals, the bills last year reinvested their savings into the health care system through subsidies to expand insurance coverage. Reinvesting the savings would have reduced the uncompensated care burden on providers and businesses and mitigated many of the adverse effects of Medicare cuts.

- Reducing Medicare payments would disproportionately harm rural hospitals.

- ▶ Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.

- ▶ Significant reductions in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often already substantial local subsidies.

- ▶ Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.

- ▶ Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.

- ▶ Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about 1% faster than private health insurance.

- ▶ So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

(short)

4/26 5PM
mcd. 760

EFFECTS OF CAPPING MEDICAID

MAGNITUDE OF THE PROPOSED CUTS

- Republicans are considering cutting (through the use of a block grant with a 6% cap on growth) federal Medicaid funding by more than \$160 billion between now and 2002 -- a 25% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really suggesting is cutting \$160 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. It is unlikely that managed care can produce more than \$5 billion in "scorable" savings between now and 2002.
- The remaining \$155 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.

EFFECT ON PROVIDERS, BENEFITS, AND COVERAGE

- **Providers:** Cutting provider payments by \$155 billion would mean an 10% reduction in revenues providers receive from Medicaid between now and 2002. In 2002 alone, the cut in provider payments would amount to 16%.
- **Benefits:** Cutting \$155 billion out of Medicaid by reducing benefits would require the outright elimination of a long list of critical services by 2002. Even eliminating coverage for prescription drugs, home health care and other home and community-based services, and preventive and diagnostic screening services for children would not offset the cuts.
- **Coverage:** Cutting \$155 billion by limiting eligibility would require, for example, eliminating coverage for almost all children covered by Medicaid (over 20 million in 2002) or for over 3 million elderly or disabled people.
- **Combination of Benefits and Coverage:** Cutting \$155 billion through a combination of benefit and coverage reductions would require:
 - ▶ Elimination of coverage for prescription drugs, dental care, and preventive and diagnostic screening services for children, and hospice in 2002, and
 - ▶ Elimination of Medicaid coverage for more than 5.8 million kids and for more than 800,000 elderly or disabled people.

- **Combination of Benefits and Coverage: Cutting \$155 billion through a combination of cuts in provider payments, benefits and coverage reductions would require:**

- ▶ Reducing payments to hospitals, physicians and other health care providers by over \$50 billion between now and 2002. The cut in 2002 alone would be about \$14 billion.
- ▶ Elimination of outpatient prescription drugs for the tens of millions of Medicaid beneficiaries in 2002, and
- ▶ Eliminating coverage for roughly 3.5 million children and over half a million elderly and disabled together would offset the remainder of the cuts in 2002.

Long

4/26
5pm
Mcd. 1602

EFFECTS OF CAPPING MEDICAID

IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
 - ▶ About 60% of Medicaid spending is for elderly and disabled people. (This includes both long-term care and acute care spending.)
- Republicans are considering cutting (through the use of a block grant with a 6% cap on growth) federal Medicaid funding by more than \$160 billion between now and 2002 a 25% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting \$160 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. It is unlikely that managed care can produce any more than \$5 billion in "scorable" savings between now and 2002. The remaining \$155 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.
- Finding the remaining \$155 billion in Medicaid cuts without cutting provider fees -- which are already much lower than in the private sector -- would require massive reductions in health coverage and services. The number of uninsured Americans, currently about 40 million, would increase substantially.

To illustrate the types of cuts that states would have to make, cutting \$155 billion through a combination of benefit and coverage reductions would require:

- ▶ Elimination of coverage for prescription drugs, dental care, and preventive and diagnostic screening services for children, and hospice in 2002, and
- ▶ Elimination of Medicaid coverage for more than 5.8 million kids and for more than 800,000 elderly or disabled people.
- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, the states, on an aggregate basis, could save money only after they cut more than \$160 billion out of Medicaid.

VARIATION ACROSS STATES

- An across-the-board 6% cap on Medicaid spending does not recognize significant differences across states, leaving some states even harder hit than these numbers suggest.
 - ▶ Growth rates vary significantly across states and over time in a given state. Across states, variation results from differences in population, regional medical costs, enrollment patterns, and service mix. Over time, a state's growth rate can change because of recession or other economic factors.
 - ▶ When a recession occurs in a state, the number of people without work who qualify for Medicaid can rise dramatically, increasing program costs. With a cap on federal Medicaid payments, states would bear this burden.
 - ▶ Ironically, states with the most efficient programs are most penalized by a 6% cap -- because it is hardest for them to find additional savings.
 - ▶ Retirement states with large numbers of elderly residents would bear a disproportionate burden as the population ages.
- An analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission on the Future of Medicaid finds that a 5% cap on the growth of federal Medicaid payments would cost states over \$167 billion between 1996 and 2002. [Note: This estimate is about \$25 billion less than the CBO baseline estimate].
 - ▶ New York, California, Texas, Florida and Ohio would lose the largest amounts. New York would lose \$18.5 billion, California over \$14 billion, Texas almost \$11 billion, Florida \$9.5 billion, and Ohio over \$7 billion.
 - ▶ States in the South and Mountain regions would have the biggest percentage reductions in federal payments. Reductions during the period would average over 20% in states such as Florida, Georgia, Arkansas, Colorado, Montana, West Virginia and North Carolina.

NO EVIDENCE THAT THIS LEVEL OF GROWTH IS ACHIEVABLE WITHOUT SEVERE CUTS

- Republicans claim that managed care can generate enormous savings.
 - ▶ But, there is no evidence that managed care alone can achieve the level of cuts they are proposing.

- ▶ States already are aggressively pursuing managed care, but the populations for whom care can readily be managed -- children and AFDC adults -- account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.
- ▶ Applying managed care techniques to the services typically used by the elderly and disabled is largely untried, making the potential for savings hard to predict.
- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care is not a real option.
- Some may point to low Medicaid growth rates in certain states as evidence that a 6% cap on growth is achievable.
 - ▶ While a few states may be able to hold growth down to 6% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.
- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.

Newt Gingrich
Sixth District
Georgia



(202) 225-0600

Office of the Speaker
United States House of Representatives
Washington, DC 20515

April 28, 1995

The Honorable Bill Clinton
The White House
Washington, D.C.

8

Dear Mr. President:

I write to you out of deep concern for the future of Medicare. The most recent reports of the Medicare Hospital Insurance and Supplementary Medical Insurance Trustees paint a grim picture of the future of Medicare and make clear that immediate action is needed to ensure Medicare's survival.

The Trustees' reports predict dire results from a failure to address the growth rate in both parts of the Medicare program. Four of the Trustees are your own Secretaries of the Treasury, Labor, and Health and Human Services Departments and the Commissioner of Social Security. The Trustees indicated, in both their 1994 and 1995 reports that urgent action is necessary.

"...the HI program is severely out of balance and the Trustees believe that Congress must take timely action to fundamentally reform the HI program and control related program expenditures."

-- 1994 Board of Trustees Annual Report, Hospital Insurance Trust Fund

Last year, you agreed that program expenditures should be slowed, and you proposed to reduce the rate of growth by \$118 billion. Congress did not enact these reforms due to their entanglement in your health reform proposal.

This year, the Trustees warning is even more dire:

"To bring the HI program into actuarial balance even for the first 25 years...either outlays would have to be reduced by 30 percent or income increased by 44 percent (or some combination thereof)...the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program."

-- 1995 Supplemental Medical Insurance Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David

M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

"...growth rates have been so rapid that outlays of the program have increased 53% in aggregate and 40% per enrollee in the last five years...The Trustees believe that prompt, effective, and decisive action is necessary."

- 1995 Hospital Insurance Trust Fund Annual Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

Part B costs per beneficiary were \$2,046.00 in 1994. In the year 2002, the year in which the Trustees predict bankruptcy for the Part A program, costs per beneficiary are estimated to be \$4,430.47. This is obviously an unsustainable rate of growth, yet your most recent budget, however, contained *no new proposals* other than minor extensions of current law to limit the growth of the Part B program.

In the submission of your Health Security Act last year, you noted that Medicare reform should only be accomplished in the context of comprehensive health care reform legislation. The public Trustees clearly believe such action unwise, indicating in the 1995 report that Medicare savings should not be considered for any other purpose:

"...it is now clear that Medicare reform needs to be addressed as a distinct legislative initiative...The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken."

- Public Trustees David Walker and Stan Ross, 1995 Hospital Insurance Trustees Report

Given the urgency with which the Trustees have spoken, the Congress intends to address the Medicare crisis this year. We believe the American people expect us to work together on issues as important as the Medicare program. We ask that you direct Secretaries Reich, Rubin and Shalala, Commissioner Chater, and Administrator Vladek to make recommendations to the Congress no later than May 15, 1995. Specifically, we believe these recommendations should address these concerns and questions:

- Medicare bankruptcy has often been postponed by tax increase. The most recent tax increase merely postponed bankruptcy by one or two years; the underlying growth rate remains unaddressed and the program is no closer to long term solvency. The Trustees recommend two 25 year solvency tests for the HI Trust Fund. Please present proposals that would make Medicare meet both tests. It is obviously inappropriate that the recommendations concerning Parts A merely shifts its costs to Part B, particularly given

the Trustees concerns about cost increases in the Supplemental Medical Insurance program. Does the Administration recommend tax increases? *not at this time*

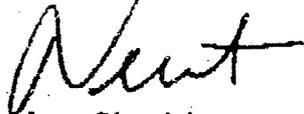
- The Public Trustees of the Medicare Hospital Insurance Trust Fund have stated unambiguously that Congress should undertake Medicare reform *independent* of any other health care reform activities. Do you believe that the Public Trustees are wrong in this assessment? *Yes*
- The Trustees recommend controlling the rate of growth for the Supplemental Medical Insurance program. Please recommend proposals to reduce the program's costs.
- The Administration's latest guidance on Medicare reform remains their 1994 proposals, which would result in Medicare savings of about \$118 billion. The Administration has indicated its support for incremental reform. Do you continue to support these proposals? *Not outside the realm*

We will provide a more detailed set of questions in a later communication.

We believe there is no excuse to ignore the problem of Medicare, a program that will spend more than it takes in next year, and will be completely unable to pay benefits in seven years.

Next week, you are convening the Fourth White House Conference on Aging, a nonpartisan event that occurs only once every decade. The final agenda for the Conference indicates that health is the primary concern of the delegates. Surely, this is the time to begin building a national consensus on how to make Medicare solvent.

Sincerely,



Newt Gingrich

THE WHITE HOUSE

WASHINGTON

May 1, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The President has asked me to respond to your letter of April 28, 1995. As the Administration has shown over the last two and a half years, we are committed to reducing the deficit and achieving meaningful health care reform. We continue to seek progress on both of these fronts, while also making our tax system fairer and our system of investing in education and children even stronger.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by \$27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over \$300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year \$345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconciliations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

The President has long stated that making significant cuts in Medicare and Medicaid outside the context of health care reform will not work. Such dramatic cuts could lead to

less coverage and lower quality, much higher costs to poor and middle income Medicare recipients who cannot afford them, a coercive Medicare program, and cost-shifting that could lead to a hidden tax on the health premiums of average Americans. That is why it is essential to deal with the Medicare Trust Fund in the context of health care reform that protects the integrity of the program, expands not reduces coverage, and protects choice as well as quality and affordability.

The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

A handwritten signature in black ink, appearing to read "Leon E. Panetta", written over a horizontal line. The signature is stylized and somewhat cursive.

Leon E. Panetta
Chief of Staff

REPUBLICAN MEDICARE CUTS

Republicans are considering proposals that would cut Medicare funding by between \$250 billion and \$305 billion between now and 2002. Slashing Medicare at this level translates into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

COERCION INSTEAD OF CHOICE: Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

ADDING TO ALREADY HIGH COSTS FOR SENIORS: Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or \$2,500) of their incomes to pay for out-of-pocket health care expenditures.

\$3,100-\$3,700 Out-of-Pocket Payments: If the Republican cuts (\$250 billion to \$305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional \$815 to \$980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between \$3,100 to \$3,700 more.

Reduce Half of Social Security COLA: The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

\$40-\$50 Billion in Cost-Shifting: Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a \$125 billion to \$150 billion cut over seven years. In 2002 alone, a \$33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion to \$50 billion in increased premiums and health care costs between now and 2002.

Rural and Inner City Hospitals At Risk: Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
 - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
 - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
 - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
 - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
 - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
 - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. **On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.**

MEDICARE TRUST FUND SOLVENCY PROBLEM

Unlike the Republicans, This is Not a Problem Democrats Just Discovered. The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed. Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

In Contrast to the Democrats, the Republicans Have Just Discovered this Issue. In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

The Republicans are Using the Trust Fund as a Smoke Screen for Cuts. Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution: Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by \$160 to more than \$190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if \$160 to \$190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut \$160 to \$190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE; and**
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE; and**
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the \$190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by \$10.7 to \$12.8 billion.

**MEDICARE/MEDICAID CUTS:
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES**

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or 'close its doors.'" (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least \$2000 more out of pocket than they would pay under current law. And over the next seven years they would pay \$3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

The National Council of Senior Citizens says:

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button."

"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to choose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Children's Defense Fund says:

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)

THE WHITE HOUSE

WASHINGTON

May 1, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The President has asked me to respond to your letter of April 28, 1995. As the Administration has shown over the last two and a half years, we are committed to reducing the deficit and achieving meaningful health care reform. We continue to seek progress on both of these fronts, while also making our tax system fairer and our system of investing in education and children even stronger.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by \$27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over \$300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year \$345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconcillations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

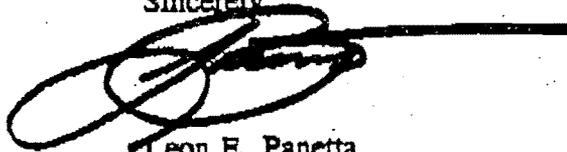
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The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

A handwritten signature in black ink, appearing to read 'Leon E. Panetta', with a long horizontal line extending to the right.

Leon E. Panetta
Chief of Staff

Newt Gingrich
Sixth District
Georgia

(202) 225-0600



Office of the Speaker
United States House of Representatives
Washington, DC 20515

April 28, 1995

The Honorable Bill Clinton
The White House
Washington, D.C.

8

Dear Mr. President:

I write to you out of deep concern for the future of Medicare. The most recent reports of the Medicare Hospital Insurance and Supplementary Medical Insurance Trustees paint a grim picture of the future of Medicare and make clear that immediate action is needed to ensure Medicare's survival.

The Trustees' reports predict dire results from a failure to address the growth rate in both parts of the Medicare program. Four of the Trustees are your own Secretaries of the Treasury, Labor, and Health and Human Services Departments and the Commissioner of Social Security. The Trustees indicated, in both their 1994 and 1995 reports that urgent action is necessary.

"...the HI program is severely out of balance and the Trustees believe that Congress must take timely action to fundamentally reform the HI program and control related program expenditures."

-- 1994 Board of Trustees Annual Report, Hospital Insurance Trust Fund

Last year, you agreed that program expenditures should be slowed, and you proposed to reduce the rate of growth by \$118 billion. Congress did not enact these reforms due to their entanglement in your health reform proposal.

This year, the Trustees warning is even more dire:

"To bring the HI program into actuarial balance even for the first 25 years...either outlays would have to be reduced by 30 percent or income increased by 44 percent (or some combination thereof)...the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program."

-- 1995 Supplemental Medical Insurance Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David

M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

"...growth rates have been so rapid that outlays of the program have increased 53% in aggregate and 40% per enrollee in the last five years...The Trustees believe that prompt, effective, and decisive action is necessary."

1995 Hospital Insurance Trust Fund Annual Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

Part B costs per beneficiary were \$2,046.00 in 1994. In the year 2002, the year in which the Trustees predict bankruptcy for the Part A program, costs per beneficiary are estimated to be \$4,430.47. This is obviously an unsustainable rate of growth yet your most recent budget, however, contained *no new proposals* other than minor extensions of current law to limit the growth of the Part B program.

In the submission of your Health Security Act last year, you noted that Medicare reform should only be accomplished in the context of comprehensive health care reform legislation. The public Trustees clearly believe such action unwise, indicating in the 1995 report that Medicare savings should not be considered for any other purpose:

"...it is now clear that Medicare reform needs to be addressed as a distinct legislative initiative...The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken."

Public Trustees David Walker and Stan Ross, 1995 Hospital Insurance Trustees Report

Given the urgency with which the Trustees have spoken, the Congress intends to address the Medicare crisis this year. We believe the American people expect us to work together on issues as important as the Medicare program. We ask that you direct Secretaries Reich, Rubin and Shalala, Commissioner Chater, and Administrator Vladek to make recommendations to the Congress no later than May 15, 1995. Specifically, we believe these recommendations should address these concerns and questions:

Medicare bankruptcy has often been postponed by tax increase. The most recent tax increase merely postponed bankruptcy by one or two years; the underlying growth rate remains unaddressed and the program is no closer to long term solvency. The Trustees recommend two 25 year solvency tests for the HI Trust Fund. Please present proposals that would make Medicare meet both tests. It is obviously inappropriate that the recommendations concerning Parts A merely shifts its costs to Part B, particularly given

the Trustees concerns about cost increases in the Supplemental Medical Insurance program. Does the Administration recommend tax increases? *Yes*

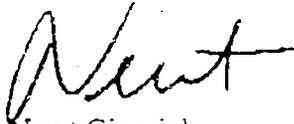
- The Public Trustees of the Medicare Hospital Insurance Trust Fund have stated unambiguously that Congress should undertake Medicare reform *independent* of any other health care reform activities. Do you believe that the Public Trustees are wrong in this assessment? *Yes*
- The Trustees recommend controlling the rate of growth for the Supplemental Medical Insurance program. Please recommend proposals to reduce the program's costs.
- The Administration's latest guidance on Medicare reform remains their 1994 proposals, which would result in Medicare savings of about \$118 billion. The Administration has indicated its support for incremental reform. Do you continue to support these proposals? *Yes*

We will provide a more detailed set of questions in a later communication.

We believe there is no excuse to ignore the problem of Medicare, a program that will spend more than it takes in next year, and will be completely unable to pay benefits in seven years.

Next week, you are convening the Fourth White House Conference on Aging, a nonpartisan event that occurs only once every decade. The final agenda for the Conference indicates that health is the primary concern of the delegates. Surely, this is the time to begin building a national consensus on how to make Medicare solvent.

Sincerely,



Newt Gingrich

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Republican Policy Committee

Don Nickles, Chairman Doug Badger, Staff Director 347 Russell Senate Office Building (202)224-2946

July 28, 1995

De-bunking Clinton's Medi-scare Tactics

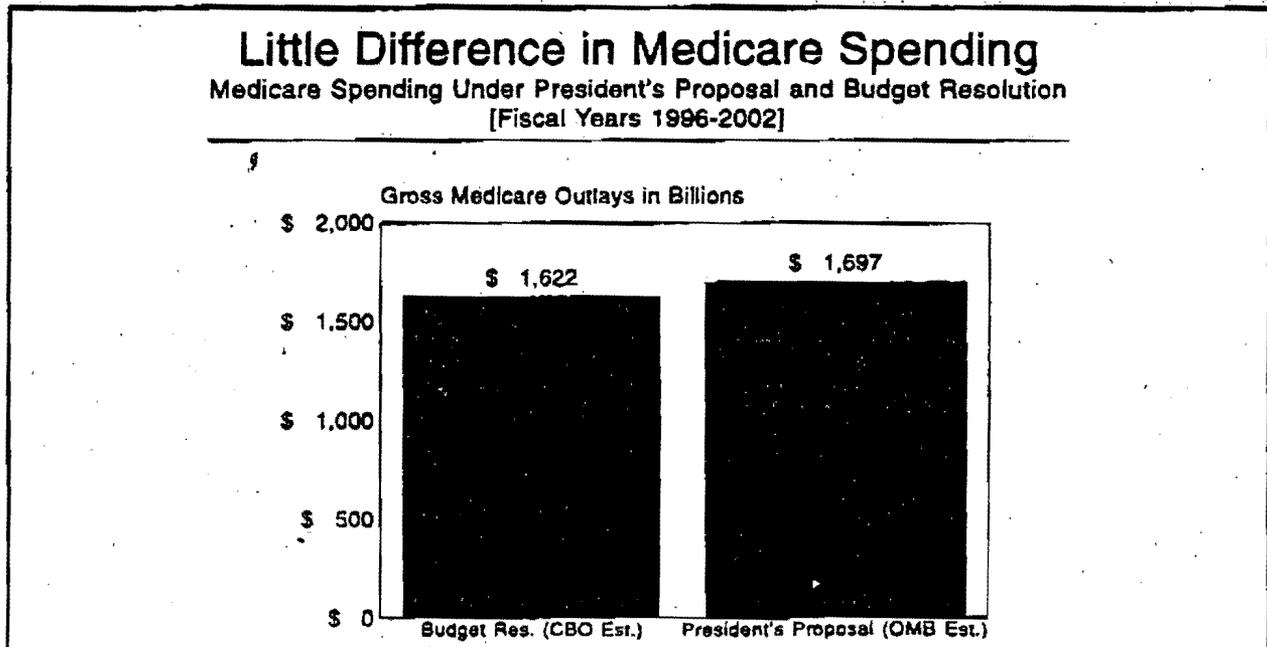
The President's Medicare Rhetoric

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[NOTE: This paper includes estimates of Medicare spending prepared by the Office of Management and Budget (OMB). OMB estimates of Medicare spending are used only to underscore the fact that the White House's own estimates of the President's proposed Medicare spending are strikingly similar to CBO's estimates of proposed Medicare spending under the budget resolution adopted by Congress last month.]

President Clinton has repeatedly attacked Congress for adopting a budget resolution that spends too little on Medicare. What the President has failed to point out, and would evidently like to ignore, is that, according to his own Office of Management and Budget (OMB), he wishes to spend little more on Medicare over the next seven years than Congress will.

According to OMB, President Clinton proposes to spend \$1.697 trillion on Medicare over the next seven years. That figure is amazingly close to the \$1.622 trillion that the Congressional Budget Office (CBO) says will be spent on the program under the budget resolution, a difference of less than a nickel on the dollar.



Reality versus Rhetoric: The Numbers Tell the Tale

The President's confidence in OMB's estimates is not shared by Congress, which relies on figures supplied by CBO. But if we take the President at his word, then there is very little difference between the President's proposal and the plan set forth in the budget resolution. Both proposals plan:

- to spend in excess of \$1.6 trillion and less than \$1.7 trillion over seven years.
- to increase spending in every one of those seven years.
- to spend at a rate less than the currently projected rate of growth.

The President's partisan attacks on proposed Medicare spending under the budget resolution are hardly justified, if he in fact believes the estimates prepared by his own budget analysts. When the comparison is done, the difference between Clinton and Congress is a scant \$75 billion (or, taking out the effects of inflation, it's \$60 billion) spread over seven years and over a total spending figure of more than \$1.6 trillion, a difference of just over 4 percent. That's less than a nickel's difference on the dollar — a small price to pay for saving a system that won't be worth a red cent in seven years if we don't act now.

From the Clinton Kitchen: Overheated Rhetoric and Half-baked Proposals

On the subject of Medicare savings, the President starts \$56 billion in the hole. That's the amount he took out of Medicare when he used it purely as a vehicle for deficit reduction as part of his 1993 budget — a partisan budget that also taxed Social Security and that no one outside his own party in Congress supported.

Nor has the President been consistent on Medicare. He has spun around like a weather vane in a whirlwind. Starting with his plan last year to put the entire American health care system under government control — essentially putting everyone's health care under the oversight of a White House that only now recognizes the Medicare system is facing imminent bankruptcy — he has had three widely divergent Medicare proposals in just over a year.

In his first budget this year, released in February (Clinton I), he claimed \$1.181 trillion in gross Medicare outlays for the FY 1996 to FY 2000 period. Just four months later in June, the President submitted his second budget (Clinton II) — and his third proposal for Medicare in just over a year. This time President Clinton claimed Medicare spending over the original five-year period of his first budget of \$1.131 trillion [see attached table]. The White House's own estimating agency, the OMB, in its July 14 supplementary summary of his current budget, concluded that the White House would spend \$1.697 trillion on Medicare over the same seven-year (FY 1996 to FY 2002) period that encompasses Congress' balanced budget [see attached table].

And what would that balanced congressional budget spend? According to estimates by the CBO — the same estimating body that the President promised to use when he began his presidency but has since abandoned — the budget agreed to by Congress would spend \$1.622 trillion over the same seven years. That's a \$75 billion difference with OMB's estimate of the Clinton plan. Despite all the White House's Medi-scare tactics, that amounts to less than a nickel's difference on the dollar between the two budgets on Medicare spending. If you take out the effect of inflation using CBO's most conservative estimate over the next seven years of 3.2 percent, that comes out to a \$60 billion difference in 1995 dollars spread out over seven years.

In fact, if one compares the Medicare spending over the five-year period in all three budgets (Clinton I, Clinton II, and the congressional budget), it is evident that Clinton II's Medicare spending is closer to that of the congressional budget (a \$45 billion difference over five years) than it is to Clinton I's (a \$50 billion difference). In other words, according to the White House's own numbers, there is a greater difference between Clinton and Clinton than between Clinton and Congress over Medicare spending.

By the numbers, Congress' proposal will:

- increase Medicare spending in each of the next seven years [source: CBO];
- increase total Medicare spending at an average rate of 6.3 percent [source: CBO]. By comparison, under OMB's estimates Clinton II spending only grows at an average rate of about one percent more;
- increase Medicare spending per beneficiary by \$1,900 — from \$4,800 in FY 1995 to \$6,700 in FY 2002 [source: CBO]; and
- allow seniors to receive a larger portion (42.3 percent) of a realistic, balanced budget than under Clinton's budget-that-never-balances (39 percent) [Source: Committee for a Responsible Federal Budget].

Medicare's Looming Bankruptcy: Even the President Acknowledges It

Despite what the White House would like to claim, Congress' budget is being balanced neither on the back of the Medicare program nor on those of the seniors who rely on it. **The congressional budget will not cut but increase Medicare spending annually.** In fact, the federal budget deficit has only an indirect effect on the need to reform Medicare. The facts are, according to the Medicare Trustees' report on April 3, 1995, the Hospital Insurance trust fund (commonly known as Medicare Part A, which covers the inpatient hospital and related care for 36 million elderly and disabled Americans) will be bankrupt within seven years under the most likely economic scenario. Thus, in contrast to White House fiction, the facts are:

- If the federal budget were balanced today, Medicare would still be bankrupt tomorrow.

- The April 3, 1995, report of Medicare's Board of Trustees — three of whom are members of the Clinton cabinet — examined the system's financial security under a variety of different economic scenarios. Their conclusion was:

"These projections clearly demonstrate that under a range of plausible economic and demographic assumptions the program is severely out of financial balance in the short range . . . "

- According to the Trustees' report, Medicare will begin running a deficit as early as next year.
- By law, once the system goes bankrupt it will be unable to issue any benefits for anyone for any reason.
- The problem is the system itself:
 - ▶ Quoting from the Medicare Trustees' 1995 report, Medicare "is financed primarily by payroll taxes, with the taxes paid by current workers and their employers used mainly to pay benefits for current beneficiaries."
 - ▶ Again quoting from the Medicare Trustees' 1995 report. "Currently about four covered workers support each enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the program inadequate to offset this demographic change, but under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur."
 - ▶ The average two-income couple retiring in 1995 will receive \$117,000 more in Medicare benefits than they paid in.
 - ▶ Rather than being a victim of the federal budget, Medicare has been and will continue to be a beneficiary.

This system cannot be sustained; after 2002, according to the Trustees, it won't be.

The Responses: Nero vs. Hero

Even President Clinton recognizes the Medicare problem. On June 11 he stated:

"We cannot leave the system the way it is. . . . When you think about what the baby boomers require . . . that's going to require significant long term structural adjustment. We'll have to look at what we can do there. But the main thing we can't do — we can't have this thing go broke in the meanwhile."

[Remarks at the senior citizen picnic by President Clinton and Speaker Gingrich at Claremont, New Hampshire on June 11, 1995.]

Yet, to date the President has not responded to the crisis. The absence of a realistic proposal to save Medicare or even a willingness to work with Congress to develop one casts President Clinton in the role of the Roman emperor Nero who, according to legend, was content to fiddle while Rome burned. The President's only concerted effort on Medicare has been rhetorical: to try and portray Congress as cutting Medicare.

Congress in contrast, with its balanced budget passed, has begun to work to solve the crisis. Just as the White House had not issued one word about Medicare's problems until three months ago, they have ignored repeated calls to join with Congress to work to save Medicare. Without changes, we are not only consigning Medicare to bankruptcy in seven years but confining seniors in a second-class health care system that offers little choice and is rife with fraud and inefficiency. It is safe to say that the most important savings in Congress' balanced budget resolution will be the Medicare system.

Reform is the Difference

According to the President's own numbers, there is little real — 4% — difference between what Congress and the White House plan to spend on Medicare over the next seven years. The only real difference between Congress and the White House is reform. Congress is pursuing it; President Clinton is not.

The President has produced a budget that on one hand doesn't balance in any of its ten years, and on the other does not reform Medicare. In effect it's all pain and no gain. Under the President's budget, in 2002 America will still strain under a \$210 billion deficit when it could have a balanced one under Congress' plan. Under any of the President's proposals (take your pick), America's seniors will still be facing impending bankruptcy of their health system, when they should be looking forward to the prospects of one that will deliver more choice, more quality, and on which they can depend.

In contrast to the President, Congress believes that we must not only preserve Medicare but strengthen it. Congress believes saving Medicare is worth a nickel on the dollar, because if we it we don't, Medicare's promise to seniors won't be worth a nickel.

Staff Contact: J.T. Young, 224-2946