

DUP

TO: Acting Assistant Secretary for Planning and Evaluation
THROUGH: Chris Bladen
FROM: George Greenberg, Ellie Dehoney
SUBJECT: MEDICARE HOSPITAL CAPITAL-RELATED TAX ADJUSTMENT

Background

The decision meeting on the PPS regulation is this Friday. HCFA needs to resolve all major issues if the final regulation is to be published by September 1. The one outstanding issue concerns whether to recognize hospital specific property taxes in capital payments (recommended by HCFA) or not (ASPE's staff recommendation). Under the current capital PPS methodology, all hospitals receive reimbursement for capital-related taxes. HCFA is proposing a new methodology in which Medicare tax payments are applied as an add-on based on hospital-specific tax liability as of 1992.

ASPE agreed to publication of the notice of proposed rulemaking in order to obtain public comments on this issue. These have now been received. Summarized below are arguments against the HCFA-proposed change. Staff indicate that ASL, ASMB, and DUSIGA (Monahan) are all likely to oppose this change, although John Callahan has not yet stated a position. Note that there is a political cost associated with retracting this proposal. The proprietaries cooperated in the analysis necessary to assess and implement the policy by providing documentation on their tax liability, and they are primed for the change to occur.

A number of industry stakeholders, including the Voluntary Hospital Association of America (VHA, Inc.), the National Association of Public Hospitals (NAPH), the New Jersey Hospital Association (NJHA), and the Catholic Health Association (CHA) submitted written comments to HCFA voicing concerns about this proposal. The Federation of American Health Systems (FAHS) and the American Hospital Association (AHA) submitted comments indicating strong support for the change, as have several individual hospitals that stand to benefit from the redistribution of tax payments.

Following is a summary of the issues surrounding the proposed change. It is ASPE staff's view that, in light of these important concerns, HCFA should not implement the proposed tax change.

Key Issues and Concerns

1. **Redistributing Payments to the For-profit Sector** The proposed tax adjustment would result in increased reimbursement for the for-profit hospital sector. Given that this sector already achieves higher Medicare margins than the not-for-profit sector, ASPE does not feel that it is necessary or appropriate to redistribute tax payments in a way that favors for-profit hospitals, particularly when all hospitals are facing dramatic overall cuts.
2. **Targeting Payments to a Sub-set of PPS Hospitals** In order to retain their tax-exempt status, non-profit hospitals must satisfy a "community benefit standard" by providing various free services to community residents. Both the CHA and NJHA argue that it is not fair to reimburse the tax expenses disproportionately borne by for-profit hospitals while excluding from payment the service-related expenses disproportionately borne by tax-exempt hospitals.

This raises a fundamental policy concern. To prevent gaming and encourage efficiency, the Prospective Payment System was explicitly designed to sever the link between spending decisions made by individual hospitals and Medicare payment levels. Reimbursing taxes that are tied to hospital capital moves the program back toward hospital specific reimbursement with its attendant inflationary incentives.

3. **Update Methodology** HCFA has not yet developed a methodology for updating the hospital-specific tax adjustment. Any implementation of HCFA's proposal should be postponed until sufficient research and analysis have been conducted to develop an equitable and accurate updating methodology.
4. **Preventing Gaming** HCFA has proposed making tax-based payments only to those hospitals subject to property taxes as of 1992 (unless the hospital became operational after 1992 or experienced a change in ownership status which made them newly subject to taxation). This provision is intended to prevent gaming; however, its implementation would raise equity issues and may not survive legal challenge. It would be difficult to justify denying payments to hospitals subject to property taxes simply because these taxes were levied after 1992.

If the tax adjustment proposal is adopted and the 1992 cut-off is removed in the future, taxes could be levied for the express purpose of increasing Medicare's contribution to hospital revenues. To help prevent this type of gaming, ASPE recommends specifying that in order to be reimbursable under Medicare, taxes must be "general" (i.e. imposed equally on industry sectors other than health care). This would create political barriers that should help stem tax-based gaming. (see NOTE below)

5. **Impact on Not-for-Profit Hospitals** HCFA has emphasized that this change in policy will not solely benefit for-profit hospitals, since there are also not-for-profit hospitals that pay property taxes. However, according to an analysis completed by Jim Hart at the request of OMB, the few non-profit hospitals that are subject to property tax would actually lose more from the reduction in payments necessary to maintain budget neutrality than they would gain from the redistribution of tax-based reimbursement.

Quick Outline of Arguments Against the Proposed Change

- 1) Redistributes money from non-profits and public hospitals to proprietary hospitals (although some non-profits and public pay taxes and would be reimbursed).
- 2) This could open Pandora's box, impelling other hospitals to argue that they too pay expenses that are beyond their control and which should be specially recognized.
- 3) Although not paying for taxes after 1992 prevents gaming by local jurisdictions seeking to pass taxes on to Medicare, it raises equity issues if a tax is passed after 1992. For this reason we may not be able to politically hold the line.
- 4) Proprietaries support the public good by paying taxes; non-profits and public support it by providing charity care-- Why should one be recognized and not the other? (Note that we do make DSH payments in recognition of not-for-profit's community service role; however, not all not-for-profits receive DSH.)
- 5) The policy inappropriately subsidizes a decision to convert to proprietary status. The payment system should be neutral on this issue. (This argument is valid only if we accept the premise that the service requirements borne by not-for-profits are equivalent to the tax liability borne by for-profits. If both types of hospital bear a cost, but only the for-profits receive reimbursement, then the tax change is an incentive to become proprietary.)
- 6) When we eliminated return on equity payments for proprietaries in 1985, we set a precedent of not recognizing costs that derive directly from the decision to be a for-profit entity. The proposed tax change runs counter to this policy.
- 7) Access to the capital market is restricted for public hospitals; it is open to proprietaries. Why are we then taking funds from public and non-profits by reducing the Federal Rate?
- 8) It is a return to cost-based reimbursement principles.

- 9) The proposal is incomplete. We can't adequately assess the implications of this change without knowing how payments would be updated.

NOTE--if this policy goes forward despite the above arguments, we have urged HCFA to clearly state that any tax recognized for this purpose be a tax of general applicability and not a hospital-specific tax. If the 1992 cut-off provision is at some point removed, this will help prevent gaming because it is much harder for local politicians to enact general taxes.

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Number of pages in addition to cover sheet: 1

* * * * *

Notes:

I spoke with Mary Ella who suggested I send you a couple of options to help work out a solution on the capital property tax adjustment.

Sorry, we have not connected. I will keep trying. Thanks!

MEDICARE INPATIENT CAPITAL ADJUSTMENT FOR PROPERTY TAXES AND PAYMENTS IN LIEU OF TAXES

POSSIBLE COMPROMISES TO PROPOSED REGULATIONS

- 1) Limit adjustment for property taxes and payments in lieu of taxes to hospitals making those payments prior to the end of fiscal 1992 and study whether to extend the adjustment to post 1992 facilities.
- 2) Cap the adjustment at 10 percent of the total capital payment per institution (approximate national average) and hold harmless all other hospitals at 99 or 98 percent of their total capital otherwise payable. Secretary could adjust these limits and hold harmless amounts to assure budget neutrality. *
- 3) Sunset the proposed regulation after 10 years. This would treat taxes like grandfathered old capital is treated under current regulations and take all the property tax dollars out of the base after 10 years.

* BACKGROUND: Under current payments, hospitals that pay taxes or non-profit hospitals that make payments in lieu of taxes receive only about 90 percent of their capital allocation because tax payments are not reallocated to them. Non taxpaying hospitals receive about 10% percent of their appropriate capital allocation because they receive an artificially high payment that includes taxes in the base.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



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REMARKS: *OMB Premium Staff,*
per your request

Medicare Part B Premium: Current Law and Alternatives
Preliminary and draft estimates of CBO scoring (calendar years)

DRAFT

Monthly Part B Premium

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current Law	\$29.90	\$31.80	\$36.60	\$41.10	\$46.10	\$43.70	\$48.20	\$53.20	\$55.00	\$56.90	\$58.80	\$60.80
25% Premium						\$43.70	\$48.20	\$53.20	\$59.10	\$67.20	\$74.30	\$82.80
30% Premium						\$52.40	\$57.80	\$63.80	\$70.90	\$80.60	\$89.10	\$99.30
31.5% Premium						\$55.00	\$60.70	\$67.00	\$74.40	\$84.60	\$93.60	\$104.30
33% Premium						\$57.60	\$63.60	\$70.20	\$78.00	\$88.70	\$98.00	\$109.30
35% Premium						\$61.10	\$67.40	\$74.40	\$82.70	\$94.00	\$104.00	\$115.90

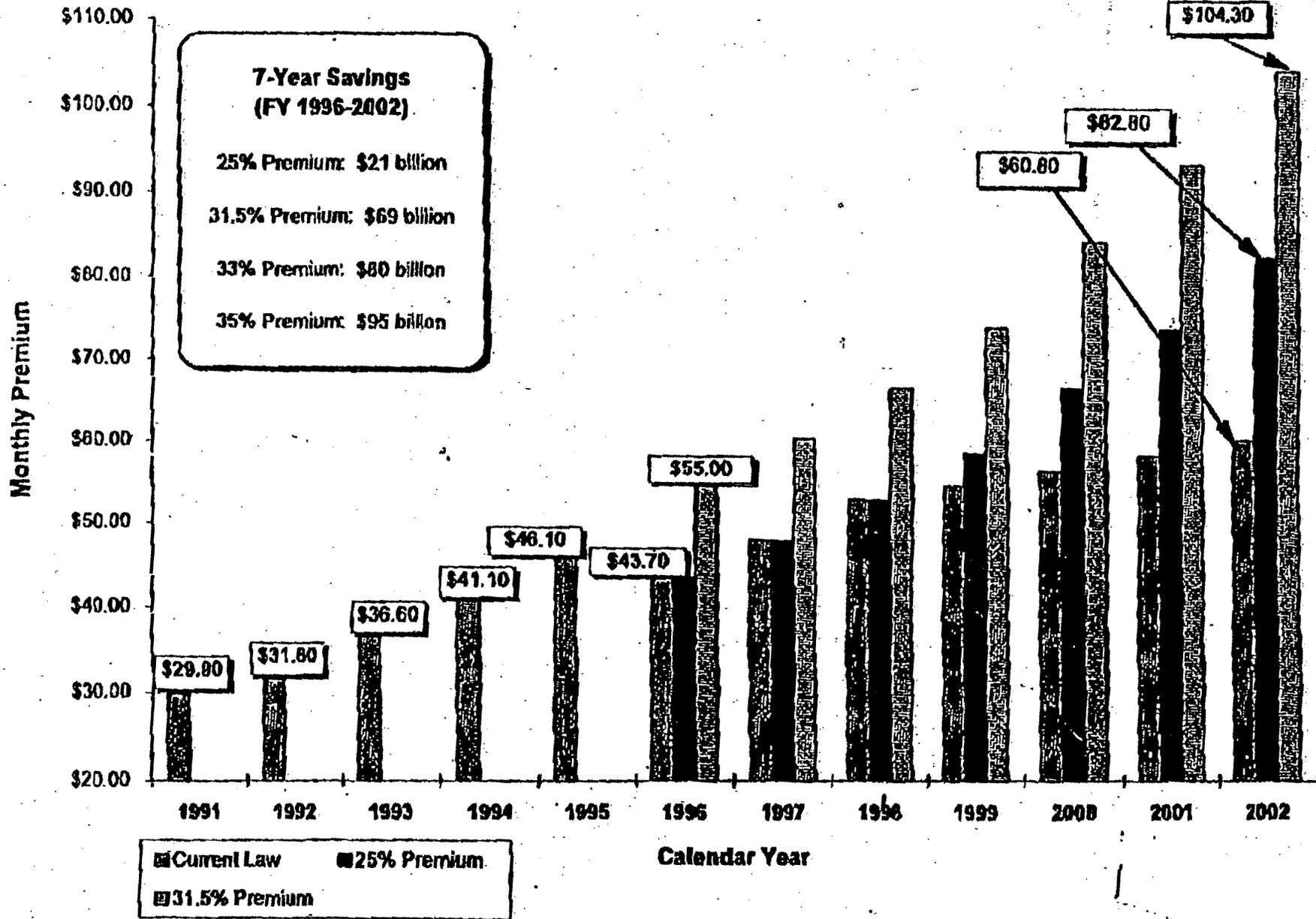
Premium as Percent of Program Cost Under Current Law

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
	23.9%	26.2%	26.0%	33.3%	31.5%	25.0%	25.0%	25.0%	23.3%	21.2%	19.8%	18.4%

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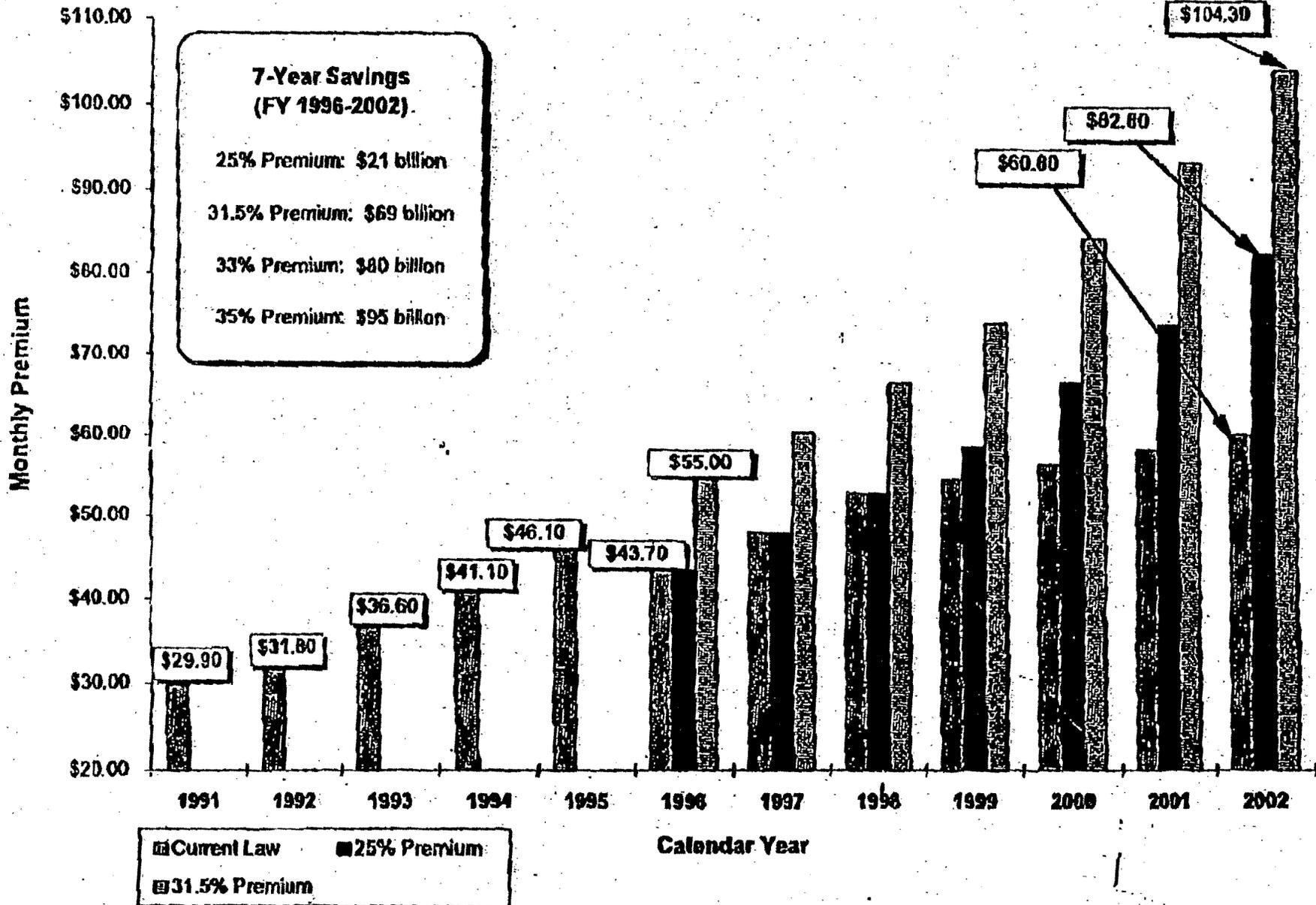
Medicare Part B Premium: Current Law and Alternatives



Preliminary and draft estimates of CBO scoring. Assumes no other Part B savings proposals.

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202 690 6518

Medicare Part B Premium: Current Law and Alternatives



Preliminary and draft estimates of CBO scoring. Assumes no other Part B savings proposals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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REMARKS: GROWTH RATE
TURKEY

MEDICARE SPENDING UNDER THE BALANCED BUDGET PROPOSALS

Medicare spending, savings and growth rates have become an important point of comparison between the President's and the Republicans' balanced budget plans. However, confusion over the right way to compare the Medicare proposals has surfaced. Specifically, the use of the Administration's Medicare baseline rather than the Congressional Budget Office's (CBO's) baseline has been used to create the misperception that the President's plan for Medicare would look more like the Republicans' plan if a common baseline were used. However, differences in estimating the baseline do not change the fact that the level of cuts called for by the Republicans are more than double those of the President's plan.

- **The baseline differences between the Congressional Budget Office (CBO) and the Administration are not large.**

Between 1996 and 2002, the dollar-amount difference between the two baselines is \$71 billion -- only 4 percent of the total CBO baseline. The baselines for inpatient hospital services, which represent nearly half of Medicare spending, are virtually identical.

- Eventually, comparisons of the plans will be made by pricing or "scoring" specific policies on the same baseline. Until such policies are specified, comparisons of the spending and savings under the plans can be made using simplifying assumptions.
- **One way to compare the President's plan to the Republican plan using the CBO baseline is to assume that the President's proportionate reduction in spending is the same under both baselines.**

The President's plan would reduce Medicare spending by 7% over the seven-year period, relative to the Republican plan, which reduces spending by 14%. Since this comparison describes the magnitude of the cut in relationship to the respective baseline, it takes the baseline issue out of the equation. This percent reduction could also be converted into a dollar amount: if the CBO baseline were reduced by 7%, then the President's plan would save \$130 billion.

- **Another approach was taken by the CBO who, in a letter to Senator Domenici, assessed the President's Medicare savings under the CBO baseline by assuming the President's savings are the same under both baselines.**

This means that the \$124 billion in savings projected off of the Administration baseline would be \$124 billion off of the CBO baseline as well. However, the CBO spending levels for the President's plan would be higher, since \$124 billion is subtracted from a higher baseline, yielding higher proposed spending.

Given the fact that CBO and Administration have frequently scored Medicare policies similarly in the past, this approach offers an approximation of the President's plan under

the CBO baseline. Recently, for example, the CBO scored the Medicare "extenders" in the President's 1996 budget at \$30 billion, whereas the Administration estimated their savings at \$28 billion. Similarly, the CBO and Administration estimates of the savings under the President's health reform bill were less than \$1 billion different over a five-year period.

However, the similarity in scoring depends on the specific set of policies. While hospital and premium policies have been scored similarly in the past, there have been differences in areas where baseline projections differ.

- **An incorrect way of comparing the President's plan to the Republican plan is to assume that the President's spending is the same under both baselines.**

It has been asserted that the President's plan has set down what he believes is an acceptable spending level, and that this represents a commitment to this spending level regardless of baselines. For instance, the total Medicare spending under the President's plan of \$1,675 billion over seven years -- estimated from the Administration's baseline -- would still be \$1,675 billion under the CBO baseline.

This is flawed logic, however. Projections of the spending that results from a set of policy changes are made by modifying baseline spending projections. Thus, if there are different baseline spending projections, the spending under the proposed law will be different. Assuming that the Medicare spending under the proposed law is fixed and does not change when different baseline assumptions are used is incorrect.

The President's commitment is not to a specific spending number, but a set of policies that result in that spending number.

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The President's commitment is not to a specific spending number, but a set of policies that result in that spending number.

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Budget Working Group

Routing Slip

DATE: 8/4/95

SUBJECT: August 4 Version of Medicare Briefing for Reporters

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ALL

White House Medicare Briefing Document

August 4, 1995

White House Medicare Briefing Document

Outline

- I. The Two Parts of Medicare and the History of the Part A Trust Fund
- II. Clinton Administration Response to Trust Fund Problems (1993, 1994)
- III. The Current Financial Status of the Part A Trust Fund (1995)
- IV. The New Republican Congress and the Trust Fund (1995)
- V. Clinton Administration Response to Trust Fund Problems (1995)
- VI. The Republican Budget Resolution
- VII. Current Clinton Efforts Compared to the Republican Efforts
- VIII. Why Increase In Per Beneficiary Spending is a Cut
- IX. Republican Vouchers and Overly Tight Growth Rates
- X.. Republican Vouchers vs. The President's Plan

The Two Parts of Medicare:

Hospital and Physician Services

The Medicare program has two distinct parts:

- **1. Hospital insurance [HI] or Part A**
 - Part A pays for mostly inpatient hospital care.

- **2. Supplemental Medical Insurance [SMI] or Part B**
 - Part B covers physician services, along with outpatient hospital services, laboratory services and durable medical equipment.

The Two Parts of Medicare:

The HI program -- Part A

- **The HI program** is funded through the HI trust fund. The Fund receives most of its income from the HI payroll tax (2.9% of payroll, split between employers and employees).
 - The HI or Part A Trust Fund is the fund that is characterized as "going broke" by the Congressional Majority.

The Two Parts of Medicare:

The SMI program -- Part B

- **Part B** is funded through the SMI Trust Fund. The Fund receives income from two primary sources: a general revenue transfer and premiums paid by enrollees.
 - ▶ While SMI or Part B Trust Fund growth effects deficit spending, it does not threaten SMI solvency and the SMI trust fund could never become insolvent (unlike the HI trust fund).

The History of the Part A Trust Fund Financial Status

- As the table on the following page demonstrates, the Medicare Part A trust fund solvency challenges are not new.
- On nine separate occasions, the trust fund has been projected to be insolvent in 7 years or less.

HISTORICAL PROJECTIONS OF HI TRUST FUND INSOLVENCY

Report Year	Projected Year of Insolvency	Years Until Insolvency
1970	1972	2 Years
1971	1973	2 Years
1972	1976	4 Years
1973	None Indicated	N/A
1974	None Indicated	N/A
1975	Late 1990s	N/A
1976	Early 1990s	N/A
1977	Late 1980s	N/A
1978	1990	12 Years
1979	1992	13 Years
1980	1994	14 Years
1981	1991	10 Years
1982	1987	5 Years
1983	1990	7 Years
1984	1991	7 Years
1985	1998	13 Years
1986	1996	10 Years
1987	2002	15 Years
1988	2005	17 Years
1989	No Report	No Report
1990	2003	13 Years
1991	2005	14 Years
1992	2002	10 Years
1993	1999	6 Years
1994	2001	7 Years
1995	2002	7 Years

Clinton Administration Response to Trust Fund Problems (1993)

- At the beginning of the Clinton Administration, the Trust Fund was projected to go insolvent by 1999.
- The President's 1993 five-year deficit reduction package (OBRA '93) extended the life of the trust fund by an additional three years -- to 2002.

No members of the current Congressional Majority supported the 1993 deficit reduction bill.

Clinton Administration Response to Trust Fund Problems (1993)

The extra three years were derived from:

1. Constraining the growth of Medicare, primarily through specific provider cuts.
2. Repealing the maximum earnings cap for the Medicare HI payroll tax.
3. Increasing the percentage of Social Security benefits of well-off seniors subject to taxation and dedicating that revenue to the HI trust fund.
4. Economic growth partly spurred from the deficit reduction bill

Clinton Administration Response to Trust Fund Problems (1994)

- The Clinton health reform plan would have delayed insolvency an additional five years past the current date of 2002.
- In addition, the Clinton health reform package would have addressed the Trust Fund problem in the context of the entire health care system.

The Current Financial Status of the Part A Trust Fund (1995)

- The Medicare Trustees, using intermediate assumptions, concluded that the HI Trust Fund will be depleted in 2002.
 - The projected year of trust fund exhaustion measures how long financial resources exist to pay bills. In other words, as long as the trust has sufficient resources, bills are paid. **The trust fund has never reached exhaustion.**
- **The program faces a long term insolvency crisis** because of the demographic shift that will occur with the aging of the baby boom population. The first baby-boomers will reach 65 in the year 2010.
- Neither Democrats or Republicans resolve this issue in their balanced budget proposals, but both agree that a bipartisan approach is essential for addressing this challenge.

The New Republican Congress and the Trust Fund (1995)

- The only thing that changed between the 1994 Trustee Report and the 1995 Trustee Report is that the 1995 report showed a one year improvement from 2001 and 2002.

- The only specific component of the Contract with America that addressed the Trust Fund made it worse.
 - The Contract called for repeal of the increase in the Social Security benefits tax for high income seniors -- a provision that helped improve the financial status of the trust fund. The repeal passed the House on April 5, 1995.

 - If this provision is enacted, the trust fund will become insolvent 8 months sooner.

Clinton Administration Response to Trust Fund Problems (1995)

- **The Clinton balanced budget** would extend the life of the Trust Fund through 2006. This proposal reduces HI Trust Fund spending on providers. [See attached letter from the HCFA Chief Actuary confirming 2006 Trust Fund status.]
- With the trust fund secure for better than 10 years from today, we are in the same situation we have been in before, many times, since 1970. This provides significant time for a bipartisan approach to address the long term Trust Fund issue.



The Administrator
Washington, D.C. 20201

August 3, 1995.

The Honorable Richard A. Gephardt
United States Senate
Washington, D.C. 20510

Dear Congressman Gephardt:

This is in response to your request for information about the effect of the Medicare savings in the President's balanced budget initiative on the exhaustion date of the Hospital Insurance (HI) Trust Fund.

Attached is a memorandum that I have received from the Chief Actuary of the Health Care Financing Administration (HCFA). The memo indicates that the year-by-year savings in the President's plan would extend the life of the HI Trust Fund from 2002 to the fourth quarter of calendar year 2006 (the first quarter of fiscal year 2007). This estimate is based on the 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Fund intermediate assumption baseline.

Please let me know if I can provide any further information.

Sincerely,

Bruce C. Vladeck

Attachment



Memorandum

Date August 2, 1995

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for HI Trust Fund under Administration's
Balanced Budget Proposal

To Administrator, HCFA

The purpose of this memorandum is to respond to the requests from Senator Daschle and Representative Gephardt for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare provisions in the Administration's balanced budget proposal. Based on the intermediate set of assumptions in the 1995 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in the fourth quarter of calendar year 2006 under the Administration's proposal (or, equivalently, in the first quarter of fiscal year 2007).

In the absence of corrective legislation, trust fund depletion would occur in the fourth quarter of calendar year 2002 (first quarter of fiscal year 2003) under the intermediate assumptions. Thus, the Administration's proposal would postpone the year of exhaustion by about 4 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees for their "high cost" projections, asset depletion could occur roughly 2 to 3 years earlier than the intermediate estimate. Conversely, favorable trends could delay the year of exhaustion significantly. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If Senator Daschle or Representative Gephardt would like additional information on the estimated impact of the Administration's Medicare proposals, we would be happy to provide it.

Richard S. Foster, F.S.A.

Clinton Administration Response to Trust Fund Problems (1995)

- The Clinton Balanced Budget calls for \$124 billion in savings -- less than 1/2 of the Republican Balanced Budget.
- Twenty percent of these savings are simply from extension of current laws -- which both the President and the Congressional Majority support.
- All new savings are from providers, and \$89 billion goes to Part A Fund, pushing the insolvency date back to 2006.

The Republican Budget Resolution

- The Republican budget resolution would cut the Medicare program by \$270 billion.
- The Republican budget resolution would also extend the life of the Trust Fund through at least 2006, and likely somewhat longer.
 - However, it is impossible to project for much longer without more detail about the allocation of cuts between Part A and Part B.
- **The size of the Republican cuts are excessive**, and drafts of their plan confirm that they are considering substantial out-of-pocket increases through higher premiums, co-payments, and deductibles.

The Republican Budget Resolution -- Beneficiary Impact

The Republican Medicare working document provides a preview of what is in store for beneficiaries who want to keep their fee-for-service plans. Specifically, preliminary estimates indicate that:

- The average Medicare recipient of skilled nursing home services will pay at least \$1,400 more.
- The average beneficiary receiving home health care services will pay at least \$1,700 more in 2002.
- The average beneficiary choosing to stay in the fee-for-service plan would pay at least \$2,825 more in premiums and copayments over 7 years; couples would pay at least \$5,650.

The Republican Budget Resolution -- Harming Vulnerable Elderly

- The cuts shift costs to seniors who on average, are already spending 21 percent of their income out-of-pocket on health care.
- Since 75 percent of these beneficiaries have incomes below \$25,000, it is hard to see how they can afford to pay more.
- The Republican cuts exceed the extenders on which we all agree by \$240 billion -- just about the amount they need to finance their tax cut.

The Republican Budget Resolution -- Part B Cuts Don't Help the Trust Fund

- A substantial portion (most likely more than \$100 billion) of their Medicare cuts come from Part B of the program. Savings from Part B savings do nothing to strengthen the Part A trust Fund.
- More specifically, the Republican Working Document calls for significant increases in Part B premiums, deductibles, and co-payments.

Current Clinton Efforts Compared to the Republican Efforts

The real issue is how much more is needed to shore up the trust fund and responsibly manage the program.

The President's proposal is a responsible approach to achieving these objectives:

- ✓ First, better than ten years of trust fund security is consistent with many periods in our history and adequate to allow Medicare's adaptation to the future.
- ✓ Second, more than this level of cuts might buy a few more years for the trust fund but would endanger the protection Medicare provides and the institutions and caregivers that serve Medicare's beneficiaries.
- While greater reductions might help for a few years, they are not real solutions and will cause long-term damage to the structure of the Medicare program.

Why Increase In Per Beneficiary Spending is a Cut

The Republicans say they will increase Medicare spending by \$1,900, from \$4,800 per beneficiary now being spent to \$6,700 in 2002. Yet, this amounts to a cut.

- This is a cut because you cannot buy today's Medicare benefits with this amount of money in 2002. Beneficiaries will pay substantially more or get less benefits.
- \$6,700 is about \$1,000 less per person than what it would be EVEN IF Medicare spending were constrained to 7.1 percent private sector per person growth rate.
- And remember, the Congressional Majority wishes to constrain the growth rate well below the private sector even though Medicare beneficiaries are, by any definition, a much more difficult to manage and expensive population than those with private insurance.

The Republican Budget Resolution -- Vouchers and Overly Tight Growth Rates

- The Republicans claim they want to emulate the health care cost containment successes of the private sector. They suggest that vouchers be used to increase current Medicare beneficiary participation in Managed Care plans.
 - The expectation is that this will result in reduced Medicare expenditures and growth rates.
- Emulating the private sector and permitting Medicare to grow at a 7.1 percent pace -- CBO's projection of the per person growth rate in the private sector -- would save significant federal dollars.
- However, the Republican \$270 billion in cuts would constrain Medicare to a much tighter and unrealistic 4.9% per beneficiary growth rate.

The Republican Budget Resolution -- Vouchers and Overly Tight Growth Rates

- Under the Republican Medicare restructuring plan, beneficiaries who wish to keep their fee-for-service plan and a guarantee of their choice of doctor, will have to pay significantly more.
- In order for a voucher system to achieve savings, beneficiaries who go into managed care plans will either have their current benefits reduced or will be forced to pay more for the same benefits. This is because the Republicans' overly tight growth rates will over time diminish the value of the voucher and the type of coverage it can purchase.
- In this environment, there would be overwhelming pressure on plans to avoid the elderly and sick, and "cherry pick" young, healthy beneficiaries.

The Republican Budget Resolution -- Vouchers and Overly Tight Growth Rates

- Addressing these problems would take significant regulatory interventions such as risk adjustment to pay for elderly, sick individuals. It would also require a more realistic growth rate. Both needed changes would increase costs and decrease managed care savings.
- Respected health care economists such as Robert Reischauer and Henry Aaron, as well as the Congressional Budget Office, have consistently stated that managed care that adequately protects beneficiaries are not likely to produce significant federal savings over the short term.

Republican Vouchers vs. The President's Plan

- The President's approach shows that you can strengthen the Medicare Trust Fund, offer more choice of plans, and provide new benefits without imposing new Medicare beneficiary cuts.
- The President's balanced budget also expands choice for beneficiaries by providing for a new Preferred Provider Organization option and authorizing HMOs to offer choice of doctor options through Point of Service plans.
 - ▶ However, it does this without financially coercing beneficiaries into plans.

FACT SHEET ON LIKELY REPUBLICAN MEDICARE CUTS

Wednesday, May 3, 1995

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

Choice or Coercion? Republicans claim their proposals would increase choice by giving vouchers to Medicare beneficiaries to buy insurance in the private market. In reality, the only way that this approach can achieve the magnitude of savings being contemplated is to significantly raise costs for traditional fee-for-service coverage, effectively forcing many beneficiaries to use vouchers to buy managed care. That would put Medicare's 37 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. That is simply a form of financial coercion.

Current Health Care Spending by Older Americans. Today, despite Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, typical Medicare beneficiaries already dedicate a staggering 21% (or \$2,500) of their incomes to pay for out-of-pocket health care expenditures.

More Out-of-Pocket Payments: If these cuts are distributed evenly between providers and beneficiaries, Medicare beneficiaries would pay:

- o \$815 to \$980 more in out-of-pocket expenses in 2002.
- o Between \$3,100 to \$3,700 more in out-of-pocket over the 7 year period.

Social Security COLAs: The Republicans claim they aren't cutting Social Security, but these Medicare cuts would effectively do that. By 2002, the typical Medicare beneficiary would see 40 to 50% 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 would have 100% or more of their COLAs consumed by the cost increases.

Rural and Inner City Hospitals. Cuts of this magnitude, combined with the growing uncompensated care burden (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. These cuts would threaten both the quality and access to needed health care in rural America.

FACT SHEET ON LIKELY REPUBLICAN MEDICAID CUTS

Wednesday, May 3, 1995

Congressional Republicans are currently considering cuts in federal Medicaid funding of \$160 to more than \$190 billion between 1996 and 2002. Republicans claim they are not cutting the program, but reducing its rate of growth. Yet, these technical number disputes avoid the real issue: how their proposals will affect real Americans; who will be hurt; who will lose coverage; and who will lose benefits if their cuts are made. It also ignores the fact that 3 to 4% of growth in Medicaid is due not to inflation but to additional children, elderly, disabled and others being insured under the program.

Impact on Working Families. Most people think Medicaid helps only low-income mothers and children. In fact, 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.

Insufficient Managed Care Savings. Savings from managed care cannot produce the magnitude of cuts Republicans have proposed. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. 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.

State Finances. Republicans say these cuts merely give states additional flexibility through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous cuts -- forcing them to choose between cuts in education, law enforcement, health care or other priorities.

Cuts in Eligibility, Benefits and Provider Payments. What do 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 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 children would lose coverage; and
- 800,000 to 1 million elderly and disabled beneficiaries would lose coverage; and
- Tens of millions of Americans would lose benefits, because all preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the cuts reach \$190 billion; and
- Already low payments to health care providers would be reduced by \$10.7 to \$12.8 billion.

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.**

White House Medicare Briefing Document

August 8, 1995

White House Medicare Briefing Document

Outline

- I. The Two Parts of Medicare and the History of the Part A Trust Fund
- II. Clinton Administration Response to Trust Fund Problems (1993, 1994)
- III. The Current Financial Status of the Part A Trust Fund (1995)
- IV. The New Republican Congress and the Trust Fund (1995)
- V. Clinton Administration Response to Trust Fund Problems (1995)
- VI. The Republican Budget Resolution
- VII. Current Clinton Efforts Compared to the Republican Efforts
- VIII. The Republican Budget Resolution -- Overly Tight Growth Rates
- IX. Why Increase In Per Beneficiary Spending is a Cut
- X. Republican Vouchers and Overly Tight Growth Rates
- XI. Republican Vouchers vs. The President's Plan

The Two Parts of Medicare:

Hospital and Physician Services

The Medicare program has two distinct parts:

- **1. Hospital insurance [HI] or Part A**

- Part A pays for mostly inpatient hospital care.

- **2. Supplemental Medical Insurance [SMI] or Part B**

- Part B covers physician services, along with outpatient hospital services, laboratory services and durable medical equipment.

The Two Parts of Medicare:

The HI program -- Part A

- **The HI program** is funded through the HI trust fund. The Fund receives most of its income from the HI payroll tax (2.9% of payroll, split between employers and employees).
 - The HI or Part A Trust Fund is the fund that is characterized as "going broke" by the Congressional Majority.

The Two Parts of Medicare:

The SMI program -- Part B

- **Part B** is funded through the SMI Trust Fund. The Fund receives income from two primary sources: a general revenue transfer and premiums paid by enrollees.
 - ▶ Part B premiums are directly deducted out of the monthly checks of Social Security beneficiaries. Therefore, increases in premiums decrease total dollar amount of the Social Security check.
 - ▶ While SMI or Part B Trust Fund growth effects deficit spending, it does not threaten SMI solvency and the SMI trust fund could never become insolvent (unlike the HI trust fund).

The History of the Part A Trust Fund Financial Status

- As the table on the following page demonstrates, the Medicare Part A trust fund solvency challenges are not new.
- On nine separate occasions, the trust fund has been projected to be insolvent in 7 years or less.

FUND INSOLVENCY

Report Year	Projected Year of Insolvency	Years Until Insolvency
1970	1972	2 Years
1971	1973	2 Years
1972	1976	4 Years
1973	None Indicated	N/A
1974	None Indicated	N/A
1975	Late 1990s	N/A
1976	Early 1990s	N/A
1977	Late 1980s	N/A
1978	1990	12 Years
1979	1992	13 Years
1980	1994	14 Years
1981	1991	10 Years
1982	1987	5 Years
1983	1990	7 Years
1984	1991	7 Years
1985	1998	13 Years
1986	1996	10 Years
1987	2002	15 Years
1988	2005	17 Years
1989	No Report	No Report
1990	2003	13 Years
1991	2005	14 Years
1992	2002	10 Years
1993	1999	6 Years
1994	2001	7 Years
1995	2002	7 Years

Clinton Administration Response to Trust Fund Problems (1993)

- At the beginning of the Clinton Administration, the Trust Fund was projected to go insolvent by 1999.
- The President's 1993 five-year deficit reduction package (OBRA '93) extended the life of the trust fund by an additional three years -- to 2002.

No members of the current Congressional Majority supported the 1993 deficit reduction bill.

Clinton Administration Response to Trust Fund Problems (1993)

The extra three years were derived from:

1. Constraining the growth of Medicare, primarily through specific provider cuts.
2. Repealing the maximum earnings cap for the Medicare HI payroll tax.
3. Increasing the percentage of Social Security benefits of well-off seniors subject to taxation and dedicating that revenue to the HI trust fund.
4. Economic growth partly spurred from the deficit reduction bill

Clinton Administration Response to Trust Fund Problems (1994)

- The Clinton health reform plan would have delayed insolvency an additional five years past the current date of 2002.
- In addition, the Clinton health reform package would have addressed the Trust Fund problem in the context of the entire health care system.

The Current Financial Status of the Part A Trust Fund (1995)

- The Medicare Trustees, using intermediate assumptions, concluded that the HI Trust Fund will be depleted in 2002.
 - The projected year of trust fund exhaustion measures how long financial resources exist to pay bills. In other words, as long as the trust has sufficient resources, bills are paid. **The trust fund has never reached exhaustion.**

- **The program faces a long term insolvency crisis** because of the demographic shift that will occur with the aging of the baby boom population. The first baby-boomers will reach 65 in the year 2010.

- Neither Democrats or Republicans resolve this issue in their balanced budget proposals, but both agree that a bipartisan approach is essential for addressing this challenge.

The New Republican Congress and the Trust Fund (1995)

- The only thing that changed between the 1994 Trustee Report and the 1995 Trustee Report is that the 1995 report showed a one year improvement from 2001 and 2002.

- The only specific component of the Contract with America that addressed the Trust Fund made it worse.
 - The Contract called for repeal of the increase in the Social Security benefits tax for high income seniors -- a provision that helped improve the financial status of the trust fund. The repeal passed the House on April 5, 1995.

 - If this provision is enacted, the trust fund will become insolvent 8 months sooner.

Clinton Administration Response to Trust Fund Problems (1995)

- **The Clinton balanced budget** would extend the life of the Trust Fund through 2006. This proposal reduces HI Trust Fund spending on providers. [See attached letter from the HCFA Chief Actuary confirming 2006 Trust Fund status.]
- With the trust fund secure for better than 10 years from today, we are in the same situation we have been in before, many times, since 1970. This provides significant time for a bipartisan approach to address the long term Trust Fund issue.



The Administrator
Washington, D.C. 20201

August 3, 1995

The Honorable Richard A. Gephardt
United States Senate
Washington, D.C. 20510

Dear Congressman Gephardt:

This is in response to your request for information about the effect of the Medicare savings in the President's balanced budget initiative on the exhaustion date of the Hospital Insurance (HI) Trust Fund.

Attached is a memorandum that I have received from the Chief Actuary of the Health Care Financing Administration (HCFA). The memo indicates that the year-by-year savings in the President's plan would extend the life of the HI Trust Fund from 2002 to the fourth quarter of calendar year 2006 (the first quarter of fiscal year 2007). This estimate is based on the 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Fund intermediate assumption baseline.

Please let me know if I can provide any further information.

Sincerely,


Bruce C. Vladeck

Attachment

**Memorandum**

Date August 2, 1995

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for HI Trust Fund under Administration's
Balanced Budget Proposal

To Administrator, HCFA

The purpose of this memorandum is to respond to the requests from Senator Daschle and Representative Gephardt for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare provisions in the Administration's balanced budget proposal. Based on the intermediate set of assumptions in the 1995 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in the fourth quarter of calendar year 2006 under the Administration's proposal (or, equivalently, in the first quarter of fiscal year 2007).

In the absence of corrective legislation, trust fund depletion would occur in the fourth quarter of calendar year 2002 (first quarter of fiscal year 2003) under the intermediate assumptions. Thus, the Administration's proposal would postpone the year of exhaustion by about 4 years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees for their "high cost" projections, asset depletion could occur roughly 2 to 3 years earlier than the intermediate estimate. Conversely, favorable trends could delay the year of exhaustion significantly. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If Senator Daschle or Representative Gephardt would like additional information on the estimated impact of the Administration's Medicare proposals, we would be happy to provide it.

Richard S. Foster

Richard S. Foster, F.S.A.

Clinton Administration Response to Trust Fund Problems (1995)

- The Clinton Balanced Budget calls for \$124 billion in savings -- less than 1/2 of the Republican Balanced Budget.
- Twenty percent of these savings are simply from extension of current laws -- which both the President and the Congressional Majority support.
- All new savings are from providers, and \$89 billion goes to Part A Fund, pushing the insolvency date back to 2006.

The Republican Budget Resolution

- The Republican budget resolution would cut the Medicare program by \$270 billion.
- The Republican budget resolution would also extend the life of the Trust Fund through at least 2006, and likely somewhat longer.
 - However, it is impossible to project for much longer without more detail about the allocation of cuts between Part A and Part B.
- **The size of the Republican cuts are excessive**, and drafts of their plan confirm that they are considering substantial out-of-pocket increases through higher premiums, co-payments, and deductibles.

The Republican Budget Resolution -- Beneficiary Impact

The Republican Medicare working document provides a preview of what is in store for beneficiaries who want to keep their fee-for-service plans. Specifically, preliminary estimates indicate that:

- The average Medicare recipient of skilled nursing home services will pay at least \$1,400 more in 2002.
- The average beneficiary receiving home health care services will pay at least \$1,700 more in 2002.
- The average beneficiary choosing to stay in the fee-for-service plan would pay at least \$2,825 more in premiums and copayments over 7 years; couples would pay at least \$5,650.

The Republican Budget Resolution -- Harming Vulnerable Elderly

- The cuts shift costs to seniors who on average, are already spending 21 percent of their income out-of-pocket on health care.
- Since 75 percent of these beneficiaries have incomes below \$25,000, it is hard to see how they can afford to pay more.
- The Republican cuts exceed the extenders on which we all agree by \$240 billion -- just about the amount they need to finance their tax cut.

The Republican Budget Resolution -- Part B Cuts Don't Help the Trust Fund

- A substantial portion (most likely more than \$100 billion) of their Medicare cuts come from Part B of the program. Savings from Part B savings do nothing to strengthen the Part A trust Fund.
- More specifically, the Republican Working Document calls for significant increases in Part B premiums, deductibles, and co-payments.
- So, for example, not one penny of the Part B Premium increase alone of \$1650 (\$3300 for couples) would contribute to strengthening the Medicare Trust Fund.

Current Clinton Efforts Compared to the Republican Efforts

The real issue is how much more is needed to shore up the trust fund and responsibly manage the program.

The President's proposal is a responsible approach to achieving these objectives:

- ✓ First, better than ten years of trust fund security is consistent with many periods in our history and adequate to allow Medicare's adaptation to the future.
- ✓ Second, more than this level of cuts might buy a few more years for the trust fund but would endanger the protection Medicare provides and the institutions and caregivers that serve Medicare's beneficiaries.
- While greater reductions might help for a few years, they are not real solutions and will cause long-term damage to the structure of the Medicare program.

The Republican Budget Resolution -- Overly Tight Growth Rates

- The Republicans claim they want to emulate the health care cost containment successes of the private sector. They suggest that vouchers be used to increase current Medicare beneficiary participation in Managed Care plans.
 - The expectation is that this will result in reduced Medicare expenditures and growth rates.
- Emulating the private sector and permitting Medicare to grow at a 7.1 percent pace -- the projection of the per person growth rate in the private sector of the CBO baseline -- would save significant federal dollars.
- However, the Republican \$270 billion in cuts would constrain Medicare to a much tighter and unrealistic 4.9% per beneficiary growth rate.

Why Increase In Per Beneficiary Spending is a Cut

The Republicans say they will increase Medicare spending by \$1,900, from \$4,800 per beneficiary now being spent to \$6,700 in 2002. Yet, this amounts to a cut.

- This is a cut because you cannot buy today's Medicare benefits with this amount of money in 2002. Beneficiaries will pay substantially more or get less benefits.
- \$6,700 is about \$1,000 less per person than what it would be EVEN IF Medicare spending were constrained to 7.1 percent private sector per person growth rate.
- And remember, the Congressional Majority wishes to constrain the growth rate well below the private sector even though Medicare beneficiaries are, by any definition, a much more difficult to manage and expensive population than those with private insurance.

The Republican Budget Resolution -- Vouchers and Overly Tight Growth Rates

- Under the Republican Medicare restructuring plan, beneficiaries who wish to keep their fee-for-service plan and a guarantee of their choice of doctor, will have to pay significantly more.
- In order for a voucher system to achieve savings, beneficiaries who go into managed care plans will either have their current benefits reduced or will be forced to pay more for the same benefits. This is because the Republicans' overly tight growth rates will over time diminish the value of the voucher and the type of coverage it can purchase.
- In this environment, there would be overwhelming pressure on plans to avoid the elderly and sick, and "cherry pick" young, healthy beneficiaries.

The Republican Budget Resolution -- Vouchers and Overly Tight Growth Rates

- Addressing these problems would take significant regulatory interventions such as risk adjustment to pay for elderly, sick individuals. It would also require a more realistic growth rate. Both needed changes would increase costs and decrease managed care savings.
- Respected health care economists such as Robert Reischauer and Henry Aaron, as well as the Congressional Budget Office, have consistently stated that managed care that adequately protects beneficiaries are not likely to produce significant federal savings over the short term.

Republican Vouchers vs. The President's Plan

- The President's approach shows that you can strengthen the Medicare Trust Fund, offer more choice of plans, and provide new benefits without imposing new Medicare beneficiary cuts.
- The President's balanced budget also expands choice for beneficiaries by providing for a new Preferred Provider Organization option and authorizing HMOs to offer choice of doctor options through Point of Service plans.
 - ▶ However, it does this without financially coercing beneficiaries into plans.