

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.**

FAX

**American Hospital Association
325 - Seventh Street, N.W.
Suite 700
Washington, D. C. 20004-2802
202-638-1100**

TO: Marilyn Geager
FROM: Herb Kuba
DATE: 5-11-95
FAX #: 456-6218
PAGES: 4

NOTES: _____

American Hospital Association



Liberty Place
Washington Office
325 Seventh Street, N.W.
Suite 700
Washington, DC 20004-2802
202-638-1100

Contacts: William Erwin -- 202/626-2284
Carol Schadelbauer -- 202/626-2342
Alicia Mitchell -- 202/626-2339

AHA TO UNVEIL NEW DATA ON IMPACT OF MEDICARE REDUCTIONS

Medicare is on the chopping block this week in the Senate and House Budget committees. These enormous spending reductions could devastate hospitals, health systems and the communities they serve. On May 11, American Hospital Association President Dick Davidson will be releasing new data prepared by Lewin-VHI illustrating the impact on hospitals of the Medicare budget numbers. The effect on different types of hospitals, along with impact by state, will also be available. Hospital representatives from key states will present perspectives of the impact on their hospitals.

WHAT: Press Conference on impact of proposed Medicare reductions

WHEN: Thursday, May 11
9:00 - 9:30 a.m.

WHERE: Reserve Officers Association of the United States
The Congressional Hall of Honor -- 5th Floor
One Constitution Avenue, NE
(directly across the street from the Senate Dirksen Building)

The American Hospital Association, a not-for-profit organization, serves as a national advocate for about 5,000 hospitals and health networks and the patients they serve; provides education and information for its members; and informs the public about hospitals, health systems and health care issues.

American Hospital Association



Liberty Place
325 Seventh Street, N.W.
Washington, D C 20004-2802

Office of the President

One North Franklin
Chicago, Illinois 60606

May 10, 1995

The Honorable Bob Dole
Majority Leader
United States Senate
S - 230 The Capitol
Washington, DC 20510

(Identical letter sent to
Speaker Newt Gingrich)

Dear Majority Leader Dole:

We fear that rhetoric and reality appear to be on a collision course on one of the most important issues ever to face Congress: the future of Medicare and Medicaid. In the past week, for example, the American people were told that Congress was about to "save the Medicare trust fund" from bankruptcy. Then, the Senate and House budget committees proposed the deepest spending reductions in the 30-year history of health insurance for the elderly. Do these spending reductions avert the trust fund's insolvency? No, -- only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question. On the Medicaid side, the senior citizens and children who make up most of the population that program serves could lose access to some kinds of care altogether, joining the growing ranks of the uninsured.

It is disappointing to discover that what last week sounded like a refreshing departure from the "business as usual" Medicare hammering of the past has this week become a gutting of the health care portion of the Social Security contract with America. Thirty years after its inception, Medicare must change and the decisions about that change will require sacrifice from all, including hospitals. It will also require the strong support of the public.

But that's not what's happening today. As long as Medicare is still part of the federal operating budget, and as long as trust fund balances and spending reductions are all part of the deficit equation, then it is impossible to give our citizens the assurances that Medicare is on the road to recovery. The American people must not be led to believe that the trust fund is secure when it is not. The enormous spending reductions contained in both the House and Senate budget committee proposals must not be portrayed as merely "rate of growth" reductions. They will lead inevitably to real cuts in services and resources available to take care of people.

Medicare cannot be strengthened just by cutting the growth in spending for hospital and physician care. The Medicare rolls will continue to grow, people will live longer and need more help. New medical technology will cost more. Inflation in the general economy -- always unpredictable -- will play a significant role.

The Honorable Bob Dole
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There is no "silver bullet" fix for the serious problems confronting Medicare.

A wide range of options must be on the table and crafted into a long-term solution that is equitable to all. That means, considering not only reductions in the spending growth rate, but strong incentives for seniors to choose coordinated care, prudent increases in co-payments and deductibles, and fair means testing and eligibility criteria.

But the longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all.

Majority Leader Dole, we urge you to put Medicare back on the course outlined last week -- treating it as a real trust fund, not as a federal budget line item, and ensuring that "every penny saved" from the program is used to strengthen it for the future.

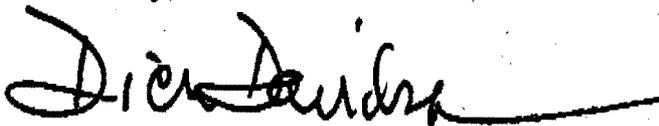
Months ago, hospitals introduced the concept of a truly independent commission to sort out the choices about Medicare funding; benefits and recipient payments; eligibility; payments to hospitals, doctors, and others; and oversee a process to allow the Congress to make those choices in an open and accountable way.

The Senate Budget Committee and others have embraced the concept, but only as a short-term alternative in the current budget environment. In our view, that is too limited and too narrow to ensure the long-term viability of a program that clearly, in some form, is a permanent commitment to our citizens.

We stand ready to work with the leadership of the Congress to thoughtfully control the growth of Medicare, but only in a way that strengthens, not weakens, the program. We believe a permanent, independent commission can help provide that strength.

Let's get on with that important work now, but let it be driven by the goal of making Medicare affordable for the nation and accessible to those who rely on it. Those were among the founding principles of the program 30 years ago, and they should remain its bedrock today and in the future.

Sincerely,



Richard J. Davidson
President

Courtesy Copy:
The Honorable Newt Gingrich



Liberty Place
Washington Office
325 Seventh Street, N.W.
Suite 700
Washington, DC 20004-2802
202-638-1100

Press Conference on the Impact of Medicare Reductions

Participants

Dick Davidson

President

American Hospital Association, Washington, D.C.

Frances M. Hoffman

Continuous Quality Improvement Coordinator

North Iowa Mercy Health System, Mason City, Iowa

Carmela Dyer

Vice President for Policy Development

American Hospital Association, Washington, D.C.



Liberty Place
Washington Office
325 Seventh Street, N.W.
Suite 700
Washington, DC 20004-2802
202-638-1100

NEWS RELEASE

FOR IMMEDIATE RELEASE
CONTACT: William Erwin - (202) 626-2284
Carol Schadelbauer - (202) 626-2342
Alicia Mitchell - (202) 626-2339

UNPRECEDENTED SPENDING REDUCTIONS COULD JEOPARDIZE HEALTH CARE

WASHINGTON, D.C. (May 11, 1995) -- Unprecedented reductions in Medicare spending proposed by Congressional budget committees could damage access to health care for the nation's senior citizens and the quality of care they receive, American Hospital Association President Dick Davidson said today in a letter to House Speaker Newt Gingrich (R-Ga.) and Senate Majority Leader Robert Dole (R-Kan.)

Davidson released the letter to reporters at a news conference on Capitol Hill. At the same time, he expressed disappointment about proposed massive Medicaid spending reductions and the effect these reductions would have on the older Americans and children who make up the bulk of Medicaid recipients.

"In the past week, the American people were told that Congress was about to 'save the Medicare trust fund' from bankruptcy," the AHA president said in the letter. "Do these spending reductions avert the trust fund's insolvency? No, only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question."

At the news conference, Davidson unveiled new estimates from the health consulting firm Lewin-VHI that illustrate the potential impact on hospitals of possible Medicare spending reductions. The estimates assume that Medicare spending will be reduced by \$250 billion over the next seven years. Senate and House budget committees have proposed even larger reductions.

(MORE)

MEDICARE REDUCTIONS/2

The Lewin-VHI analysis assumes that a \$250 billion reduction could translate into an estimated \$94 billion less for hospitals over seven years in Medicare payments for hospitalized acute care patients than they would receive under present Medicare law. In addition, the analysis assumes that a series of specific policies would be enacted to achieve these reductions (see Exhibit 4 attached).

The study found that:

- By the year 2002, Medicare could pay hospitals only 89 cents on the dollar for the operating costs of delivering inpatient care to a Medicare patient. Today, hospitals barely break even under the Medicare Prospective Payment System.
- Every type of hospital would suffer under the reductions. Urban and rural hospitals would be almost equally hard hit. Likewise, large hospitals would be affected as seriously as small hospitals.
- The average hospital in 2002 could lose \$889 per Medicare inpatient.

In his letter to Gingrich and Dole, Davidson said: "The longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all."

As part of the long-range solution for Medicare, Davidson urged Dole and Gingrich to support the creation of an independent citizens' commission to balance Medicare spending with the benefits covered by the Medicare program. The commission would make recommendations to Congress on changes in the Medicare program to bring spending within a target budget set by Congress.

(MORE)

MEDICARE REDUCTIONS/3

The recommendations would be considered under a "fast track" process, with Congress voting yes or no on the entire package of recommendations. Senate Republicans have proposed a somewhat similar commission, but with a life span of only a few months.

The commission proposed by the American Hospital Association, in contrast, would have an unlimited life, would be truly independent from day-to-day political battles in Congress and would have wide latitude to recommend changes in Medicare spending and benefits.

The AHA, a not-for-profit organization, is a national advocate for almost 5,000 hospitals and health networks, and the patients they serve; provides education and information for its members; and informs the public about hospitals, health systems and health care issues.

Exhibit 4: Assumptions for Modeling \$250 Billion in Medicare Spending Reductions: 1996 - 2002

	1996-2000	2001-2002	7-Year Total
Medicare reductions 1996 - 2000 (billions)	\$150	\$100	\$250
Assumed reductions in PPS hospital payments a/	\$57	\$37	\$94
Assumed method of reduction			
IME add-on cut by: b/	27.3%	27.3%	NA
DSH payments reduced by: c/	20.0%	20.0%	NA
Update Factor set at:	MB-4.5%	MB+2.8%	NA

- a/ Figures based on inpatient operating revenues only and do not include share of reductions applicable to capital or DME.
- b/ The indirect medical education (IME) add-on factor is reduced from 7.7 percent for every 0.1 residents per bed under current law to 5.6 percent for 1996-2002.
- c/ Disproportionate share hospital (DSH) payments are now directed at hospitals which serve a high proportion of medically indigent patients.



FACT SHEET

The following analysis modeled the impact of Medicare spending reductions of \$150 billion over 5 years and \$250 billion over 7 years on hospitals and health systems. This is similar to the level of spending reductions proposed by Sen. Pete Domenici (R-NM), chairman of the Senate Budget Committee. Spending reductions proposed by the House Budget Committee are even greater. No specific details have been released about how the Senate spending reductions would be achieved. We have assumed, based on the pattern of reductions in previous proposals, that these overall Medicare reductions could translate into hospital Prospective Payment System (PPS) reductions of \$94 billion over 7 years.

Using this assumption and others detailed in Exhibit 4, Lewin-VHI estimated the potential impact on Medicare inpatient PPS operating margins. These estimates are not intended to predict future hospital financial status with certainty, but rather to illustrate financial pressures hospitals would face if reductions of this magnitude were enacted.

Reductions of this order are bigger than anything ever proposed. This could be devastating to the nation's hospitals, health systems and the communities they serve.

The Lewin-VHI findings show:

- Under this scenario, every hospital loses -- rural, urban, large, small, teaching, non-teaching.
- By the year 2000, Medicare PPS inpatient operating margins could fall to negative 20.6 percent. Because most of the reductions are made in the first five years, margins rise for the last two years, but still remain negative -- a negative 12.2 in the year 2002.
- By the year 2000, hospitals could lose \$1,300 in PPS payments for every Medicare patient. Hospitals could lose \$900 per Medicare patient in the year 2002.
- Hospitals' PPS costs last year grew at 2.1 percent -- the lowest rate ever. Lewin-VHI estimates use a very conservative number for hospital cost growth (slightly less than 4 percent annually), based on recent experience.

Prospective Payment System (PPS) - A payment system, implemented in 1983, in which the amount a hospital receives for treating a patient is fixed in advance by Medicare or an insurer.

Medicare PPS Operating Margins - Medicare inpatient operating revenue minus Medicare inpatient operating costs divided by Medicare inpatient operating revenue. These margins relate only to Medicare operating revenues and costs.

PROJECTED MEDICARE PPS INPATIENT OPERATING MARGINS:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY HOSPITAL GROUP (IN PERCENT)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	0.3	3.6	5.4	-20.6	-12.2
TEACHING STATUS						
ALL TEACHING	1,020	3.7	6.9	8.7	-18.6	-10.1
MAJOR TEACHING	224	11.4	15.3	17.2	-11.9	-3.7
MINOR TEACHING	796	-0.1	2.6	4.5	-21.8	-13.2
NON TEACHING	4,027	-3.3	0.0	1.8	-22.7	-14.3
GEORAPHIC LOCATION						
URBAN HOSPITALS	2,810	0.3	3.9	5.7	-20.6	-12.1
LARGE URBAN	1,530	1.8	5.8	7.7	-18.7	-10.3
OTHER URBAN	1,280	-2.0	0.9	2.8	-23.4	-14.8
RURAL HOSPITALS	2,237	0.5	1.5	3.0	-20.7	-12.7
SOLE COMMUNITY	603	-2.3	0.8	2.3	-21.5	-13.4
SOLE COMMUNITY/RRC	53	6.4	6.3	7.8	-14.7	-7.0
RURAL REFERRAL CENTER	157	2.2	0.9	2.5	-22.1	-13.9
OTHER RURAL	1,424	-0.6	1.2	2.7	-20.7	-12.8
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	7.9	11.3	13.2	-14.8	-6.5
IME ONLY	494	-1.2	1.6	3.5	-23.0	-14.3
DSH ONLY	907	0.4	3.6	5.4	-19.8	-11.5
NO ADJUSTMENTS	3,120	-5.1	-1.7	0.1	-24.1	-15.6
MEDICARE UTILIZATION						
60% AND OVER	1,519	-2.0	0.8	2.6	-21.9	-13.4
UNDER 60%	3,528	0.9	4.2	6.0	-20.3	-11.9
BED SIZE						
1-49 BEDS	1,278	0.6	3.2	4.6	-18.2	-10.5
50-99 BEDS	1,139	-1.2	4.4	5.9	-16.9	-9.0
100-199 BEDS	1,198	-1.6	1.0	2.7	-22.2	-13.8
200-299 BEDS	682	-1.4	1.3	3.2	-22.4	-13.8
300 OR MORE BEDS	750	2.0	5.4	7.3	-19.8	-11.3
OWNERSHIP						
CHURCH	915	-0.0	3.2	5.0	-20.6	-12.1
VOLUNTARY	2,277	0.2	3.2	5.0	-21.4	-12.9
PROPRIETARY	701	0.9	5.8	7.7	-16.2	-8.0
GOVERNMENT	1,154	1.3	4.1	5.8	-21.3	-13.0

PROJECTED MEDICARE PPS INPATIENT NET INCOME PER CASE:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY HOSPITAL GROUP (IN DOLLARS)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	19	280	467	-1294	-889
TEACHING STATUS						
ALL TEACHING	1,020	271	666	936	-1415	-899
MAJOR TEACHING	224	1116	2022	2507	-1189	-434
MINOR TEACHING	796	-5	222	423	-1489	-1051
NON TEACHING	4,027	-163	1	128	-1207	-882
GEOGRAPHIC LOCATION						
URBAN HOSPITALS	2,810	18	329	540	-1400	-957
LARGE URBAN	1,530	124	531	776	-1362	-872
OTHER URBAN	1,280	-117	71	236	-1449	-1066
RURAL HOSPITALS	2,237	20	78	171	-866	-615
SOLE COMMUNITY	603	-83	37	121	-843	-609
SOLE COMMUNITY/RRC	53	304	383	522	-737	-407
RURAL REFERRAL CENTER	157	104	55	169	-1082	-788
OTHER RURAL	1,424	-20	58	139	-800	-571
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	636	1211	1557	-1223	-628
IME ONLY	494	-80	142	340	-1600	-1159
DSH ONLY	907	22	258	420	-1126	-761
NO ADJUSTMENTS	3,120	-241	-106	6	-1241	-932
MEDICARE UTILIZATION						
60% AND OVER	1,519	-97	49	183	-1143	-813
UNDER 60%	3,528	53	348	551	-1340	-912
BED SIZE						
1-49 BEDS	1,278	21	144	224	-659	-441
50-99 BEDS	1,139	-47	234	345	-730	-453
100-199 BEDS	1,198	-81	67	199	-1195	-864
200-299 BEDS	682	-82	102	273	-1383	-992
300 OR MORE BEDS	750	142	514	767	-1489	-989
OWNERSHIP						
CHURCH	915	-1	248	436	-1298	-886
VOLUNTARY	2,277	9	257	447	-1379	-967
PROPRIETARY	701	51	433	631	-974	-557
GOVERNMENT	1,154	67	296	457	-1209	-858

PROJECTED MEDICARE PPS INPATIENT REVENUE AS A PERCENT OF COST:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY HOSPITAL GROUP (IN PERCENT)

HOSPITAL TYPE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALL HOSPITALS	5,047	100.3	103.7	105.7	82.9	89.1
TEACHING STATUS						
ALL TEACHING	1,020	103.9	107.4	109.6	84.3	90.8
MAJOR TEACHING	224	112.8	118.1	120.7	89.4	96.4
MINOR TEACHING	796	99.9	102.7	104.7	82.1	88.3
NON TEACHING	4,027	96.8	100.0	101.8	81.5	87.5
GEOGRAPHIC LOCATION						
URBAN HOSPITALS	2,810	100.3	104.0	106.1	82.9	89.2
LARGE URBAN	1,530	101.9	106.1	108.3	84.2	90.7
OTHER URBAN	1,280	98.0	100.9	102.9	81.0	87.1
RURAL HOSPITALS	2,237	100.5	101.5	103.1	82.8	88.8
SOLE COMMUNITY	603	97.8	100.8	102.4	82.3	88.2
SOLE COMMUNITY/RRC	53	106.8	106.7	108.4	87.1	93.4
RURAL REFERRAL CENTER	157	102.3	100.9	102.6	81.9	87.8
OTHER RURAL	1,424	99.4	101.3	102.8	82.8	88.7
PAYMENT ADJUSTMENT						
IME & DISP SHARE	526	108.6	112.7	115.1	87.1	93.9
IME ONLY	494	98.8	101.7	103.7	81.3	87.5
DSH ONLY	907	100.4	103.8	105.7	83.5	89.7
NO ADJUSTMENTS	3,120	95.1	98.3	100.1	80.6	86.5
MEDICARE UTILIZATION						
60% AND OVER	1,519	98.0	100.8	102.7	82.1	88.2
UNDER 60%	3,528	100.9	104.4	106.4	83.1	89.4
BED SIZE						
1-49 BEDS	1,278	100.6	103.3	104.8	84.6	90.5
50-99 BEDS	1,139	98.8	104.6	106.3	85.6	91.7
100-199 BEDS	1,198	98.4	101.0	102.8	81.8	87.9
200-299 BEDS	682	98.6	101.4	103.3	81.7	87.9
300 OR MORE BEDS	750	102.0	105.7	107.9	83.5	89.8
OWNERSHIP						
CHURCH	915	100.0	103.3	105.3	82.9	89.2
VOLUNTARY	2,277	100.2	103.3	105.3	82.4	88.6
PROPRIETARY	701	100.9	106.2	108.3	86.1	92.6
GOVERNMENT	1,154	101.3	104.3	106.1	82.4	88.5

PROJECTED MEDICARE PPS INPATIENT OPERATING MARGINS:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY STATE (IN PERCENT)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	-1.4	2.8	4.6	-20.9	-12.4
ALASKA	16	-8.1	-8.0	-5.8	-32.9	-23.4
ARIZONA	56	6.4	10.5	12.7	-11.2	-2.8
ARKANSAS	80	5.2	6.3	7.9	-15.4	-7.5
CALIFORNIA	424	3.7	10.4	12.3	-12.0	-4.0
COLORADO	65	-2.2	1.6	3.3	-21.8	-13.5
CONNECTICUT	34	-8.7	-8.0	-6.5	-36.2	-27.4
DELAWARE	7	-8.7	-2.9	-0.8	-28.8	-19.5
WASHINGTON DC	9	-6.5	0.1	2.1	-29.7	-20.4
FLORIDA	208	-3.7	0.9	2.9	-22.5	-13.7
GEORGIA	156	-0.9	4.2	5.8	-19.5	-11.4
HAWAII	18	-19.4	-17.3	-15.7	-46.6	-37.1
IDAHO	35	1.3	1.5	3.1	-20.4	-12.3
ILLINOIS	203	-4.5	0.7	2.8	-24.6	-15.7
INDIANA	115	-12.3	-9.2	-7.4	-35.1	-25.8
IOWA	121	-2.4	-2.0	-0.2	-25.8	-17.2
KANSAS	129	-3.3	1.2	3.0	-22.2	-13.7
KENTUCKY	103	-0.4	2.6	4.4	-20.9	-12.4
LOUISIANA	132	-7.9	-0.2	1.6	-25.0	-16.3
MAINE	39	-7.3	-3.1	-1.4	-28.0	-19.4
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	8.3	11.5	13.4	-12.1	-4.0
MICHIGAN	159	5.1	9.0	11.0	-14.9	-6.5
MINNESOTA	145	10.6	11.7	13.1	-10.8	-3.4
MISSISSIPPI	99	2.1	3.2	4.9	-20.4	-12.1
MISSOURI	131	-4.1	0.7	2.7	-23.6	-14.8
MONTANA	54	2.7	2.4	4.1	-19.3	-11.1
NEBRASKA	87	-7.5	1.1	2.9	-23.0	-14.5
NEVADA	22	3.4	7.0	9.0	-14.3	-6.0
NEW HAMPSHIRE	26	-13.9	-4.8	-3.1	-29.5	-20.8
NEW JERSEY	88	-8.4	-4.6	-3.0	-30.5	-21.8
NEW MEXICO	35	7.4	11.6	13.5	-9.4	-1.5
NEW YORK	208	13.4	11.4	13.3	-13.2	-5.0
NORTH CAROLINA	124	-1.3	-1.8	-0.4	-28.3	-19.9
NORTH DAKOTA	46	1.0	6.7	8.8	-14.2	-5.9
OHIO	183	-2.8	-1.0	1.1	-26.5	-17.5
OKLAHOMA	111	4.8	5.0	6.9	-17.5	-9.2
OREGON	61	10.5	11.2	12.8	-10.0	-2.4
PENNSYLVANIA	212	2.0	5.4	7.3	-19.1	-10.6
RHODE ISLAND	12	11.4	11.1	13.0	-11.5	-3.6
SOUTH CAROLINA	68	-8.2	-4.3	-2.7	-31.3	-22.5
SOUTH DAKOTA	52	-3.1	0.3	2.2	-22.3	-13.7
TENNESSEE	129	-10.4	-5.8	-4.0	-30.8	-21.8
TEXAS	386	-3.6	2.4	4.1	-21.8	-13.4
UTAH	39	5.2	4.6	6.0	-18.7	-10.7
VERMONT	15	-9.2	-8.6	-7.0	-36.1	-27.1
VIRGINIA	97	-2.5	1.3	3.1	-23.0	-14.5
WASHINGTON	89	5.5	7.6	9.0	-14.8	-7.2
WEST VIRGINIA	57	-1.3	-3.0	-1.4	-28.0	-19.4
WISCONSIN	127	2.4	3.0	4.8	-20.6	-12.2
WYOMING	26	-5.4	2.2	4.0	-19.4	-11.0

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association.

PROJECTED MEDICARE PPS INPATIENT NET INCOME PER CASE:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY STATE (IN DOLLARS)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	-70	183	338	-1109	-765
ALASKA	16	-528	-668	-536	-2225	-1840
ARIZONA	56	388	838	1121	-723	-212
ARKANSAS	80	232	372	515	-741	-422
CALIFORNIA	424	269	1038	1346	-955	-371
COLORADO	65	-129	122	277	-1363	-981
CONNECTICUT	34	-637	-765	-689	-2753	-2417
DELAWARE	7	-518	-236	-70	-1877	-1489
WASHINGTON DC	9	-564	8	278	-2721	-2175
FLORIDA	208	-212	68	256	-1430	-1014
GEORGIA	156	-48	302	455	-1122	-766
HAWAII	18	-1432	-1721	-1726	-3705	-3432
IDAHO	35	62	91	207	-1023	-716
ILLINOIS	203	-255	57	238	-1508	-1117
INDIANA	115	-643	-649	-571	-1993	-1708
IOWA	121	-115	-119	-14	-1276	-988
KANSAS	129	-155	78	210	-1141	-820
KENTUCKY	103	-20	166	315	-1089	-754
LOUISIANA	132	-401	-15	128	-1410	-1069
MAINE	39	-358	-203	-103	-1478	-1184
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	547	1001	1282	-830	-316
MICHIGAN	159	331	773	1045	-1011	-513
MINNESOTA	145	617	898	1100	-659	-242
MISSISSIPPI	99	84	171	286	-874	-605
MISSOURI	131	-222	52	219	-1395	-1019
MONTANA	54	123	139	266	-930	-618
NEBRASKA	87	-383	80	232	-1339	-983
NEVADA	22	232	637	900	-1051	-518
NEW HAMPSHIRE	26	-781	-385	-276	-1904	-1561
NEW JERSEY	88	-518	-382	-276	-2021	-1678
NEW MEXICO	35	368	768	984	-503	-92
NEW YORK	208	1047	1117	1438	-1011	-448
NORTH CAROLINA	124	-74	-134	-31	-1715	-1405
NORTH DAKOTA	46	50	463	670	-795	-386
OHIO	183	-165	-77	89	-1608	-1233
OKLAHOMA	111	234	312	473	-883	-538
OREGON	61	614	852	1072	-615	-171
PENNSYLVANIA	212	121	431	639	-1199	-778
RHODE ISLAND	12	748	936	1201	-772	-277
SOUTH CAROLINA	68	-449	-322	-220	-1853	-1553
SOUTH DAKOTA	52	-139	18	146	-1106	-794
TENNESSEE	129	-520	-394	-296	-1687	-1391
TEXAS	386	-201	183	350	-1347	-965
UTAH	39	322	370	541	-1219	-816
VERMONT	15	-499	-607	-542	-2034	-1772
VIRGINIA	97	-130	88	234	-1282	-938
WASHINGTON	89	332	611	793	-958	-542
WEST VIRGINIA	57	-64	-184	-94	-1372	-1104
WISCONSIN	127	130	207	366	-1157	-795
WYOMING	26	-237	131	270	-969	-640

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association.

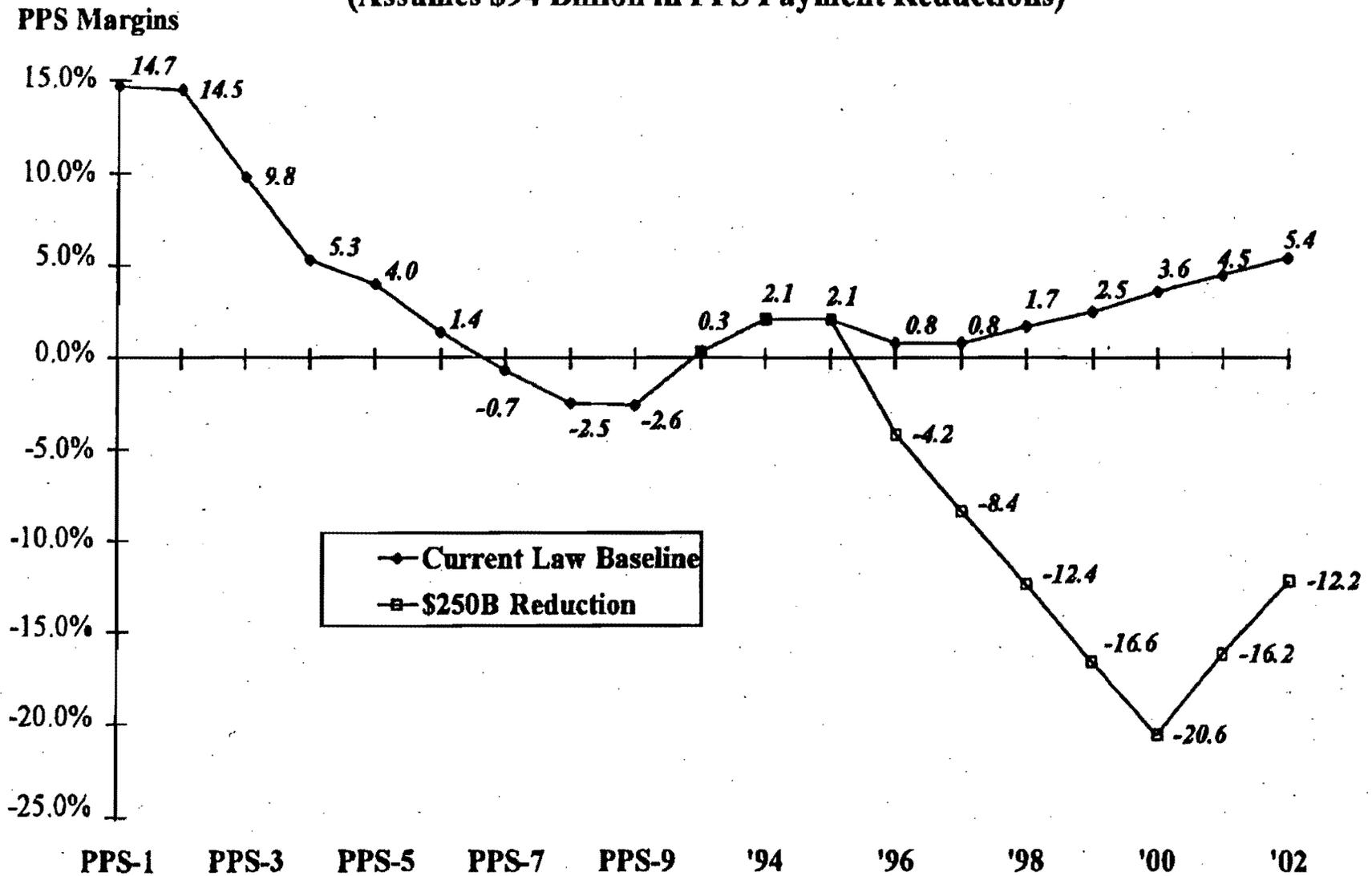
PROJECTED MEDICARE PPS INPATIENT REVENUE AS A PERCENT OF COST:
 CURRENT LAW BASELINE AND ILLUSTRATIVE 7-YEAR \$250 BILLION
 MEDICARE BUDGET REDUCTION SCENARIO
 BY STATE (IN PERCENT)

STATE	NUMBER OF HOSPITALS	BASE LINE FY-1993	BASE LINE FY-2000	BASE LINE FY-2002	ILLUSTRATIVE SCENARIO FY-2000	ILLUSTRATIVE SCENARIO FY-2002
ALABAMA	115	98.6	102.8	104.9	82.7	89.0
ALASKA	16	92.5	92.6	94.5	75.3	81.0
ARIZONA	56	106.9	111.7	114.5	89.9	97.3
ARKANSAS	80	105.4	106.7	108.5	86.7	93.0
CALIFORNIA	424	103.9	111.6	114.0	89.3	96.2
COLORADO	65	97.8	101.6	103.4	82.1	88.1
CONNECTICUT	34	92.0	92.6	93.9	73.4	78.5
DELAWARE	7	92.0	97.2	99.2	77.7	83.7
WASHINGTON DC	9	93.9	100.1	102.2	77.1	83.1
FLORIDA	208	96.5	100.9	103.0	81.6	88.0
GEORGIA	156	99.1	104.4	106.1	83.7	89.7
HAWAII	18	83.8	85.2	86.4	68.2	73.0
IDAHO	35	101.3	101.5	103.2	83.0	89.1
ILLINOIS	203	95.7	100.7	102.9	80.2	86.4
INDIANA	115	89.1	91.6	93.1	74.0	79.5
IOWA	121	97.6	98.1	99.8	79.5	85.3
KANSAS	129	96.8	101.2	103.1	81.8	87.9
KENTUCKY	103	99.6	102.6	104.6	82.7	89.0
LOUISIANA	132	92.6	99.8	101.7	80.0	86.0
MAINE	39	93.2	97.0	98.6	78.1	83.8
MARYLAND	N/A	N/A	N/A	N/A	N/A	N/A
MASSACHUSETTS	94	109.1	113.0	115.5	89.2	96.2
MICHIGAN	159	105.4	109.9	112.4	87.0	93.9
MINNESOTA	145	111.8	113.3	115.1	90.2	96.7
MISSISSIPPI	99	102.1	103.3	105.1	83.1	89.2
MISSOURI	131	96.1	100.7	102.8	80.9	87.1
MONTANA	54	102.7	102.4	104.3	83.8	90.0
NEBRASKA	87	93.0	101.1	103.0	81.3	87.4
NEVADA	22	103.6	107.6	109.9	87.5	94.3
NEW HAMPSHIRE	26	87.8	95.4	96.9	77.2	82.8
NEW JERSEY	88	92.2	95.6	97.1	76.6	82.1
NEW MEXICO	35	108.0	113.1	115.6	91.4	98.5
NEW YORK	208	115.5	112.9	115.3	88.3	95.2
NORTH CAROLINA	124	98.8	98.3	99.6	78.0	83.4
NORTH DAKOTA	46	101.0	107.2	109.7	87.6	94.4
OHIO	183	97.2	99.0	101.1	79.0	85.1
OKLAHOMA	111	105.1	105.3	107.4	85.1	91.6
OREGON	61	111.7	112.6	114.6	90.9	97.7
PENNSYLVANIA	212	102.1	105.8	107.9	84.0	90.4
RHODE ISLAND	12	112.9	112.5	114.9	89.7	96.6
SOUTH CAROLINA	68	92.4	95.9	97.4	76.2	81.6
SOUTH DAKOTA	52	97.0	100.3	102.2	81.8	87.9
TENNESSEE	129	90.5	94.5	96.2	76.5	82.1
TEXAS	386	96.5	102.4	104.3	82.1	88.2
UTAH	39	105.4	104.8	106.4	84.3	90.3
VERMONT	15	91.5	92.1	93.5	73.5	78.7
VIRGINIA	97	97.6	101.3	103.2	81.3	87.4
WASHINGTON	89	105.8	108.2	109.9	87.1	93.3
WEST VIRGINIA	57	98.7	97.1	98.6	78.1	83.7
WISCONSIN	127	102.5	103.1	105.0	82.9	89.1
WYOMING	26	94.9	102.2	104.2	83.7	90.1

N/A: Medicare operating margins were not calculated for Maryland which operates under a Medicare waiver. For Maryland's impact contact the Maryland Hospital Association.

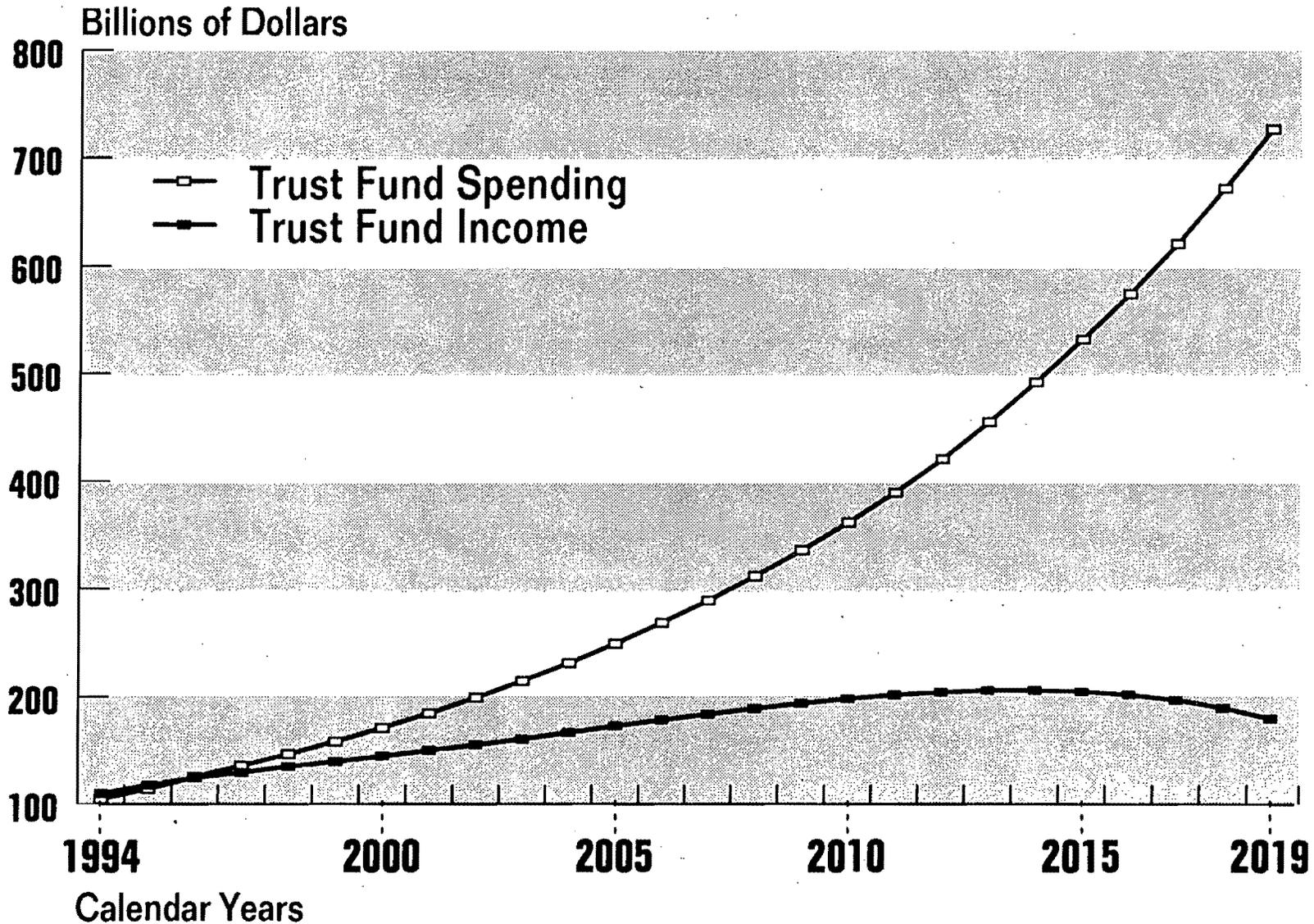
Exhibit 7: Projected Medicare PPS Inpatient Operating Margins Under Current Law and Illustrative \$250 Billion 7-Year Budget Reduction Scenario

(Assumes \$94 Billion in PPS Payment Reductions)



Spending Cuts Alone Won't Make Hospital Insurance Trust Fund Solvent

Hospital Insurance Trust Fund Income and Spending 1994-2019



SOURCE: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund



Liberty Place
325 Seventh Street, N.W.
Washington, D C 20004-2802

Office of the President

One North Franklin
Chicago, Illinois 60606

May 10, 1995

The Honorable Bob Dole
Majority Leader
United States Senate
S - 230 The Capitol
Washington, DC 20510

(Identical letter sent to
Speaker Newt Gingrich)

Dear Majority Leader Dole:

We fear that rhetoric and reality appear to be on a collision course on one of the most important issues ever to face Congress: the future of Medicare and Medicaid. In the past week, for example, the American people were told that Congress was about to "save the Medicare trust fund" from bankruptcy. Then, the Senate and House budget committees proposed the deepest spending reductions in the 30-year history of health insurance for the elderly. Do these spending reductions avert the trust fund's insolvency? No, -- only postpone it. Meanwhile, will access to and quality of medical care for seniors deteriorate? Without question. On the Medicaid side, the senior citizens and children who make up most of the population that program serves could lose access to some kinds of care altogether, joining the growing ranks of the uninsured.

It is disappointing to discover that what last week sounded like a refreshing departure from the "business as usual" Medicare hammering of the past has this week become a gutting of the health care portion of the Social Security contract with America. Thirty years after its inception, Medicare must change and the decisions about that change will require sacrifice from all, including hospitals. It will also require the strong support of the public.

But that's not what's happening today. As long as Medicare is still part of the federal operating budget, and as long as trust fund balances and spending reductions are all part of the deficit equation, then it is impossible to give our citizens the assurances that Medicare is on the road to recovery. The American people must not be led to believe that the trust fund is secure when it is not. The enormous spending reductions contained in both the House and Senate budget committee proposals must not be portrayed as merely "rate of growth" reductions. They will lead inevitably to real cuts in services and resources available to take care of people.

Medicare cannot be strengthened just by cutting the growth in spending for hospital and physician care. The Medicare rolls will continue to grow, people will live longer and need more help. New medical technology will cost more. Inflation in the general economy -- always unpredictable -- will play a significant role.

The Honorable Bob Dole
Page two

There is no "silver bullet" fix for the serious problems confronting Medicare.

A wide range of options must be on the table and crafted into a long-term solution that is equitable to all. That means, considering not only reductions in the spending growth rate, but strong incentives for seniors to choose coordinated care, prudent increases in co-payments and deductibles, and fair means testing and eligibility criteria.

But the longer we wait to craft a long-range plan for Medicare, the more doubt and confusion we will leave in the minds of the public. We are convinced the public will support tough choices if they feel they have been made openly and fairly and the consequences borne by all.

Majority Leader Dole, we urge you to put Medicare back on the course outlined last week -- treating it as a real trust fund, not as a federal budget line item, and ensuring that "every penny saved" from the program is used to strengthen it for the future.

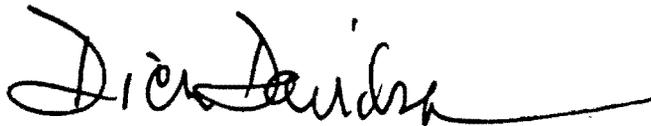
Months ago, hospitals introduced the concept of a truly independent commission to sort out the choices about Medicare funding; benefits and recipient payments; eligibility; payments to hospitals, doctors, and others; and oversee a process to allow the Congress to make those choices in an open and accountable way.

The Senate Budget Committee and others have embraced the concept, but only as a short-term alternative in the current budget environment. In our view, that is too limited and too narrow to ensure the long-term viability of a program that clearly, in some form, is a permanent commitment to our citizens.

We stand ready to work with the leadership of the Congress to thoughtfully control the growth of Medicare, but only in a way that strengthens, not weakens, the program. We believe a permanent, independent commission can help provide that strength.

Let's get on with that important work now, but let it be driven by the goal of making Medicare affordable for the nation and accessible to those who rely on it. Those were among the founding principles of the program 30 years ago, and they should remain its bedrock today and in the future.

Sincerely,



Richard J. Davidson
President

Courtesy Copy:
The Honorable Newt Gingrich

OVERVIEW

AFFILIATION

North Iowa Mercy Health Center is a Divisional Member of Mercy Health Services. Headquartered in Farmington Hills, Michigan, Mercy Health Services is the sixth largest employer in Iowa, owning five Iowa Hospitals. Because of our affiliation with Mercy Health Services, North Iowa Mercy and its staff are committed to carrying on the values and mission bestowed upon us by the founding Sisters of Mercy. Their example and inspiration translate to present and future needs. In a rapidly shifting health care environment, a compassionate, direct response to human need remains essential. North Iowa Mercy accepts that responsibility and has dedicated its human, technological and spiritual resources to meet that need.

Our affiliation with Mercy Health Services enables us to take advantage of other support services to enhance the delivery of quality health care in northern Iowa. Amicare Home Healthcare offers health-related services and equipment in the home to help individuals live as independently as possible. Amicare provides affordable options to lengthy hospital stays or nursing home placement. Nursing care, personal care, homemaking and live-in services are offered. A certified Medicare provider, Amicare also offers intermittent services in the home to speed recovery and rehabilitation. Such services include physical, occupational and speech therapies, and home health aide and social work services.

GNA is a rehabilitation service company which provides physical, occupational and speech therapy services to health care providers and employers. GNA works with North Iowa Mercy to provide comprehensive rehabilitation and occupational medicine services.

Mercy Health Plans provides leadership and consultative services for the development of insurance products, related services and negotiations with third party payers. Through its health plans, Mercy Health Plans provides responsible management of health care resources and contains costs while providing the highest quality of care.

OVERVIEW

North Iowa Mercy operates two campuses in Mason City, is licensed for 350 beds, serves a 15-county region, and employs over 2000 people from northern Iowa and southern Minnesota. North Iowa Mercy has approximately 200,000 patient visits each year. It is designated by the State of Iowa as a Rural Referral Center and offers comprehensive medical and related services to the 340,000 residents in north central Iowa and southern Minnesota.

North Iowa Mercy Health Center's goal is to create the healthiest community and region in the United States through the development of a comprehensive community health care system.

REGIONAL NETWORK

As the system of health care changes, North Iowa Mercy's mission has extended far beyond the patients who enter its doors. Our commitment to the future availability of quality health care throughout northern Iowa and southern Minnesota has resulted in the development of the North Iowa Mercy Regional Network. The Network includes the following programs and services:

- Contract affiliation with eight public rural hospitals, one community health center, and one Mercy Health Services hospital.
- Comprised of 32 physician clinics in Mason City and 21 rural communities
- Clinical/support services contracts
- Support of rural emergency medicine services
- Mercy Regional Laboratory

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



PHONE: (202) 690-6870 FAX: (202) 401-7321

From: Garry

Date:

To: Chris Jennings

Phone: (202) 690-
(202) 690-6870
FAX: (202) 401-7321

Phone: _____
Fax: _____

Number of Pages (Including Cover): _____

Comments:

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals.
 - For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. According to the 1994 Special Report of the National Association of Public Hospitals, while Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.
- Large reductions in Medicare payments could also endanger rural hospitals.
 - Nearly 10 million Medicare beneficiaries (25 percent 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 to serve primarily Medicare patients.
 - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

At least \$3200 ~~over~~

-- ~~between \$2,500 and \$3,300~~ more in out-of-pocket costs over 7 years. (Kasick would be higher)

• Republican Medicare cuts, in effect, amount to cuts in Social Security:

-- By 2002, the typical Medicare beneficiary would see 40-50 percent of his or her Social Security COLA eaten up by Medicare cost sharing and premiums.

-- About 2 million beneficiaries would have 100 percent or more of the COLAs eaten up by cost sharing and premiums.

Medicaid Cuts:

• Cuts in Medicaid are especially outrageous:

-- Medicaid provides health insurance for the most vulnerable Americans.

- 2/3 of Medicaid costs go to the indigent elderly and disabled, who have no other available resources.

-- Medicaid is also a vital protection for middle-income Americans.

- Working families with a parent who needs long-term care would face nursing home bills of an average of \$38,000 a year without Medicaid.

- Working couples who may need long-term care after retirement rely on Medicaid to get such care.

really weak

-- If distributed evenly between eliminating eligibility for the elderly and disabled, eliminating eligibility for children, cutting services, and cutting provider payments, Republican cuts in 2002 alone would mean:

- ~~7~~ million children would lose eligibility;
- ~~200,000~~ million elderly and disabled would lose coverage; and
- Tens of millions of Americans would lose important benefits of many forms,

Managed Care, Vouchers, and Savings (Donna Shalala):

Managed Care:

- Giving Medicare/Medicaid beneficiaries a "choice" of moving into managed care will do nothing to control costs.
- The "choice" option will play out in the following way:
 - The Medicare population includes people with some of the most serious health care problems and, thus, with the highest annual health care costs (notably, those "very old" -- 85 and up).
 - But many people on Medicare, including those close to age 65, are often quite healthy.
 - If managed care is voluntary, private HMOs will do everything they can to enroll those who are young and healthy -- and exclude those who are old and sick. Moreover, those who are already sick and undergoing intensive health care are the least likely to want to change health care providers.
 - To the extent that HMOs succeed in enrolling only the healthy, with below-average health care costs, they will make a profit -- and Medicare will "lose" money.
 - They will leave to Medicare the expense of treating those with the highest health care costs.
 - Thus, contrary to Speaker Gingrich's assertions, a managed care strategy will increase Medicare spending if the old and sick elderly keep the choice to remain in the current system.

Vouchers:

- Consider what happens to two typical elderly persons who get a \$5,000 voucher, as Speaker Gingrich has talked about:
 - One person, age 85 and frail, has annual medical expenses of \$9,000.
 - A second person, 65 and healthy, has annual medical expenses of \$1,000.
 - A \$5,000 voucher would, on average, cover their health care costs.
 - But giving a \$5,000 voucher to the healthy 65-year-old would increase Medicare's costs by \$4,000.
 - In contrast, the \$5,000 voucher would not cover the costs of the 85-year-old.

-- Thus, handing out \$5,000 vouchers would either cost the Government money, or leave the most vulnerable elderly without complete medical care.

- For the very old and frail who tend to have low incomes, medical costs not covered by the voucher will ultimately fall to the Government's Medicaid program.

The Earned Income Tax Credit (EITC) and the Economic Implications of Republican Budget Plans (Laura Tyson):

- While Republicans cut Medicare and Medicaid to finance their tax cut for the wealthy, they also plan a tax increase on low-income, working families.

- Republican tax proposals reveal the sharpest possible distinction between the President's vision for America and that of Republicans.

-- The President wants to provide targeted tax relief for middle-income Americans who may not have shared in the economic recovery.

- He wants to help them raise their children, educate and train themselves and their children, and save for the future.

- Republicans want to cut taxes for the wealthy, and actually increase taxes on the very people who need and deserve it most.

- Republicans plan to raise \$13 billion over five years by rolling back part of the President's 1993 expansion of the EITC, which would ensure that working Americans do not have to raise their families in poverty.

-- Most EITC recipients are doing the hardest job in America -- playing by the rules, working at modest wages to support their children.

-- The 1993 law was designed to help those who are not benefiting from the current economic expansion.

-- The cut eliminates the EITC entirely to families without children.

-- Freezing the proposed EITC expansions could cost millions of moderate-income families with children up to \$350 a year in added taxes.

HOUSE BUDGET COMMITTEE
Fiscal Year 1996 Budget Resolution
\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 050														
National Defense														
FY 1995 Discretionary Level	262,389	269,949	262,389	269,949	262,389	269,949	262,389	269,949	262,389	269,949	262,389	269,949	262,389	269,949
Policy Changes	5,611	-3,949	7,611	-3,949	15,611	-3,949	19,611	2,051	25,611	10,051	25,611	10,051	25,611	10,051
Proposed Discretionary Level	268,000	266,000	270,000	266,000	278,000	266,000	282,000	272,000	288,000	280,000	288,000	280,000	288,000	280,000
FY 1995 Mandatory Level	-971	-323	-971	-323	-971	-323	-971	-323	-971	-323	-971	-323	-971	-323
Policy Changes	265	-620	309	-411	240	-408	291	-360	307	-348	239	-417	205	-451
Proposed Mandatory Level	-706	-943	-662	-734	-731	-731	-680	-683	-664	-671	-732	-740	-766	-774
Chairman's Mark Function Total	267,294	265,057	269,338	265,266	277,269	265,269	281,320	271,317	287,336	279,329	287,268	279,260	287,234	279,226

Fiscal Year 1996 Budget Resolution

\$ in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT
Function 150														
International Affairs														
FY 1995 Discretionary Level	20,441	21,213	20,441	21,213	20,441	21,213	20,441	21,213	20,441	21,213	20,441	21,213	20,441	21,213
Policy Changes	-2,148	-495	-3,680	-2,025	-5,720	-4,087	-6,826	-5,779	-7,912	-7,508	-6,498	-6,624	-6,498	-7,012
Proposed Discretionary Level	18,293	20,718	16,761	19,188	14,721	17,126	13,615	15,434	12,529	13,705	13,943	14,589	13,943	14,201
FY 1995 Mandatory Level	-1,583	-2,332	-1,583	-2,332	-1,583	-2,332	-1,583	-2,332	-1,583	-2,332	-1,583	-2,332	-1,583	-2,332
Policy Changes	-910	-1,341	-1,518	-1,802	-1,830	-1,491	-2,364	-1,557	-457	-1,408	-316	-1,149	-336	-1,186
Proposed Mandatory Level	-2,493	-3,673	-3,101	-4,134	-3,413	-3,823	-3,947	-3,889	-2,040	-3,740	-1,899	-3,481	-1,919	-3,518
Chairman's Mark Function Total	15,800	17,045	13,660	15,054	11,308	13,303	9,668	11,545	10,489	9,965	12,044	11,108	12,024	10,683

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Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 250														
General Science, Space and Technology														
FY 1995 Discretionary Level	17,483	17,346	17,483	17,346	17,483	17,346	17,483	17,346	17,483	17,346	17,483	17,346	17,483	17,346
Policy Changes	-821	-533	-1,248	-816	-1,827	-1,421	-2,264	-1,963	-2,641	-2,358	-2,641	-2,491	-2,641	-2,508
Proposed Discretionary Level	16,662	16,813	16,235	16,530	15,656	15,925	15,219	15,383	14,842	14,988	14,842	14,855	14,842	14,838
FY 1995 Mandatory Level	-332	183	-332	183	-332	183	-332	183	-332	183	-332	183	-332	183
Policy Changes	371	-144	372	-143	372	-143	372	-143	372	-143	368	-147	368	-147
Proposed Mandatory Level	39	39	40	40	40	40	40	40	40	40	36	36	36	36
Chairman's Mark Function Total	16,701	16,852	16,275	16,570	15,696	15,965	15,259	15,423	14,882	15,028	14,878	14,891	14,878	14,874

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 270														
Energy														
FY 1995 Discretionary Level	6,293	6,564	6,293	6,564	6,293	6,564	6,293	6,564	6,293	6,564	6,293	6,564	6,293	6,564
Policy Changes	-1,112	-387	-1,515	-1,311	-1,973	-1,835	-2,025	-1,891	-2,124	-2,092	-2,124	-2,271	-2,124	-2,405
Proposed Discretionary Level	5,181	6,177	4,778	5,253	4,320	4,729	4,268	4,673	4,169	4,472	4,169	4,293	4,169	4,159
FY 1995 Mandatory Level	49	-1,615	49	-1,615	49	-1,615	49	-1,615	49	-1,615	49	-1,615	49	-1,615
Policy Changes	-874	-262	-922	-481	-793	-240	-423	25	-624	-166	-635	-164	-698	-256
Proposed Mandatory Level	-825	-1,877	-873	-2,096	-744	-1,855	-374	-1,590	-575	-1,781	-586	-1,779	-649	-1,871
Chairman's Mark Function Total	4,356	4,300	3,905	3,157	3,576	2,874	3,894	3,083	3,594	2,691	3,583	2,514	3,520	2,288

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Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 300														
Natural Resources and Environment														
FY 1995 Discretionary Level	21,932	21,495	21,932	21,495	21,932	21,495	21,932	21,495	21,932	21,495	21,932	21,495	21,932	21,495
Policy Changes	-3,065	-1,452	-3,246	-1,968	-3,103	-2,017	-3,200	-2,142	-3,295	-2,341	-3,294	-2,365	-3,294	-2,373
Proposed Discretionary Level	18,867	20,043	18,686	19,527	18,829	19,478	18,732	19,353	18,637	19,154	18,638	19,130	18,638	19,122
FY 1995 Mandatory Level	364	248	364	248	364	248	364	248	364	248	364	248	364	248
Policy Changes	48	-101	52	111	-1,953	-1,894	-525	-496	-1,628	-1,612	-1,086	-1,171	-1,183	-1,295
Proposed Mandatory Level	412	147	416	359	-1,589	-1,646	-161	-248	-1,264	-1,364	-722	-923	-819	-1,047
Chairman's Mark Function Total	19,279	20,190	19,102	19,886	17,240	17,832	18,571	19,105	17,373	17,790	17,916	18,207	17,819	18,075

Fiscal Year 1996 Budget Resolution

\$ in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT	BA	OT
Function 350														
Agriculture														
FY 1995 Discretionary Level	4,003	4,171	4,003	4,171	4,003	4,171	4,003	4,171	4,003	4,171	4,003	4,171	4,003	4,171
Policy Changes	-435	-385	-461	-518	-464	-559	-466	-580	-468	-595	-468	-597	-468	-598
Proposed Discretionary Level	3,568	3,786	3,542	3,653	3,539	3,612	3,537	3,591	3,535	3,576	3,535	3,574	3,535	3,573
FY 1995 Mandatory Level	9,961	8,539	9,961	8,539	9,961	8,539	9,961	8,539	9,961	8,539	9,961	8,539	9,961	8,539
Policy Changes	-488	-508	-713	-737	-1,918	-1,734	-2,100	-1,983	-3,304	-3,116	-5,389	-5,062	-5,394	-5,066
Proposed Mandatory Level	9,473	8,031	9,248	7,802	8,043	6,805	7,861	6,556	6,657	5,423	4,572	3,477	4,567	3,473
Chairman's Mark Function Total	13,041	11,817	12,790	11,455	11,582	10,417	11,398	10,147	10,192	8,999	8,107	7,051	8,102	7,046

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Fiscal Year 1996 Budget Resolution

\$ in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 370														
Commerce and Housing Credit														
<i>On-Budget</i>														
FY 1995 Discretionary Level	3,301	2,999	3,301	2,999	3,301	2,999	3,301	2,999	3,301	2,999	3,301	2,999	3,301	2,999
Policy Changes	-1,321	-519	-1,378	-775	-1,389	-983	-1,461	-1,099	-1,451	-1,124	-1,441	-1,209	-1,495	-1,199
Proposed Discretionary Level	1,980	2,480	1,923	2,224	1,912	2,016	1,840	1,900	1,850	1,875	1,860	1,790	1,806	1,800
FY 1995 Mandatory Level	1,365	-1,057	1,365	-1,057	1,365	-1,057	1,365	-1,057	1,365	-1,057	1,365	-1,057	1,365	-1,057
Policy Changes	-1,033	-8,355	852	-3,797	-439	-5,689	-1,046	-3,824	-1,323	-3,060	-1,930	-3,230	-2,206	-3,385
Proposed Mandatory Level	332	-9,412	2,217	-4,854	926	-6,746	319	-4,881	42	-4,117	-565	-4,287	-841	-4,442
On-Budget Total	2,312	-6,932	4,140	-2,630	2,838	-4,730	2,159	-2,981	1,892	-2,242	1,295	-2,497	965	-2,642
<i>Off-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level			0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	4,110	-30	6,800	-830	1,190	-1,390	2,860	-100	-190	-1,360	0	0	0	0
Proposed Mandatory Level	4,110	-30	6,800	-830	1,190	-1,390	2,860	-100	-190	-1,360	0	0	0	0
Off Budget Total	4,110	-30	6,800	-830	1,190	-1,390	2,860	-100	-190	-1,360	0	0	0	0
Chairman's Mark Function Total	6,422	-6,962	10,940	-3,460	4,028	-6,120	5,019	-3,081	1,702	-3,602	1,295	-2,497	965	-2,642

Fiscal Year 1996 Budget Resolution

\$ in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 400														
Transportation														
FY 1995 Discretionary Level	15,047	38,450	15,047	38,450	15,047	38,450	15,047	38,450	15,047	38,450	15,047	38,450	15,047	38,450
Policy Changes	-1,561	-76	-1,418	-1,447	-1,638	-2,327	-2,329	-3,336	-2,762	-4,059	-2,918	332	-3,072	-5,256
Proposed Discretionary Level	13,486	38,374	13,629	37,003	13,409	36,123	12,718	35,114	12,285	34,391	12,129	38,782	11,975	33,194
FY 1995 Mandatory Level	27,472	888	27,472	888	27,472	888	27,472	888	27,472	888	27,472	888	27,472	888
Policy Changes	-502	-430	1,635	-432	2,574	-402	3,537	-400	4,534	-359	4,174	-368	3,813	-377
Proposed Mandatory Level	26,970	458	29,107	456	30,046	486	31,009	488	32,006	529	31,646	520	31,285	511
Chairman's Mark Function Total	40,456	38,832	42,736	37,459	43,455	36,609	43,727	35,602	44,291	34,920	43,775	39,302	43,260	33,705

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Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 500														
Education, Training, Employment and Social Services														
FY 1995 Discretionary Level	42,021	39,326	42,021	39,326	42,021	39,326	42,021	39,326	42,021	39,326	42,021	39,326	42,021	39,326
Policy Changes	-6,892	754	-6,966	-3,075	-7,288	-4,619	-7,276	-4,825	-7,275	-4,815	-7,276	-4,826	-7,276	-4,834
Proposed Discretionary Level	35,129	40,080	35,055	36,251	34,733	34,707	34,745	34,501	34,746	34,511	34,745	34,500	34,745	34,492
FY 1995 Mandatory Level	16,279	15,404	16,279	15,404	16,279	15,404	16,279	15,404	16,279	15,404	16,279	15,404	16,279	15,404
Policy Changes	-5,671	-3,218	-6,318	-5,217	-6,138	-5,484	-5,623	-5,194	-5,127	-4,747	-6,065	-5,697	-6,462	-6,225
Proposed Mandatory Level	10,608	12,186	9,961	10,187	10,141	9,920	10,656	10,210	11,152	10,657	10,214	9,707	9,817	9,179
Chairman's Mark Function Total	45,737	52,266	45,016	46,438	44,874	44,627	45,401	44,711	45,898	45,168	44,959	44,207	44,562	43,671

Fiscal Year 1996 Budget Resolution
\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 550														
Health														
FY 1995 Discretionary Level	22,830	22,317	22,830	22,317	22,830	22,317	22,830	22,317	22,830	22,317	22,830	22,317	22,830	22,317
Policy Changes	-1,694	-727	-1,746	-1,146	-1,796	-1,197	-1,846	-1,260	-1,846	-1,291	-2,042	-1,440	-2,042	-1,496
Proposed Discretionary Level	21,136	21,590	21,084	21,171	21,034	21,120	20,984	21,057	20,984	21,026	20,788	20,877	20,788	20,821
FY 1995 Mandatory Level	93,789	93,438	93,789	93,438	93,789	93,438	93,789	93,438	93,789	93,438	93,789	93,438	93,789	93,438
Policy Changes	7,017	7,293	12,841	13,145	17,260	17,647	21,910	22,208	26,748	26,922	31,710	31,867	34,493	34,632
Proposed Mandatory Level	100,806	100,731	106,630	106,583	111,049	111,085	115,699	115,646	120,537	120,360	125,499	125,305	128,282	128,070
Chairman's Mark Function Total	121,942	122,321	127,714	127,754	132,083	132,205	136,683	136,703	141,521	141,386	146,287	146,182	149,070	148,891

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 570														
Medicare														
FY 1995 Discretionary Level	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992	2,992
FY 1995 Mandatory Level	159,647	158,068	159,647	158,068	159,647	158,068	159,647	158,068	159,647	158,068	159,647	158,068	159,647	158,068
Policy Changes	16,436	15,697	26,020	26,048	33,880	33,794	46,360	45,375	51,234	50,965	61,382	60,929	71,396	70,739
Proposed Mandatory Level	176,083	173,765	185,667	184,116	193,527	191,862	206,007	203,443	210,881	209,033	221,029	218,997	231,043	228,807
Chairman's Mark Function Total	179,075	176,757	188,659	187,108	196,519	194,854	208,999	206,435	213,873	212,025	224,021	221,989	234,035	231,799

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 600														
Income Security														
FY 1995 Discretionary Level	34,050	38,890	34,050	38,890	34,050	38,890	34,050	38,890	34,050	38,890	34,050	38,890	34,050	38,890
Policy Changes	1,373	636	1,584	2,956	9,077	2,292	6,136	2,736	4,869	3,895	4,913	3,645	4,965	3,957
Proposed Discretionary Level	35,423	39,526	35,634	41,846	43,127	41,182	40,186	41,626	38,919	42,785	38,963	42,535	39,015	42,847
FY 1995 Mandatory Level	185,889	183,331	185,889	183,331	185,889	183,331	185,889	183,331	185,889	183,331	185,889	183,331	185,889	183,331
Policy Changes	1,343	2,095	10,254	10,096	19,382	19,370	29,343	29,347	41,127	41,515	42,772	43,112	52,671	52,874
Proposed Mandatory Level	187,232	185,426	196,143	193,427	205,271	202,701	215,232	212,678	227,016	224,846	228,661	226,443	238,560	236,205
Chairman's Mark Function Total	222,655	224,952	231,777	235,273	248,398	243,883	255,418	254,304	265,935	267,631	267,624	268,978	277,575	279,052

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 650														
Social Security														
<i>On-Budget</i>														
FY 1995 Discretionary Level	0	2,533	0	2,533	0	2,533	0	2,533	0	2,533	0	2,533	0	2,533
Policy Changes	0	41	0	-67	0	-77	0	-77	0	-77	0	-77	0	-77
Proposed Discretionary Level	0	2,574	0	2,466	0	2,456	0	2,456	0	2,456	0	2,456	0	2,456
FY 1995 Mandatory Level			0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	5,880	5,880	8,060	8,060	8,800	8,800	9,598	9,598	10,482	10,482	11,051	11,051	11,650	11,650
Proposed Mandatory Level	5,880	5,880	8,060	8,060	8,800	8,800	9,598	9,598	10,482	10,482	11,051	11,051	11,650	11,650
On-Budget Total	5,880	8,454	8,060	10,526	8,800	11,256	9,598	12,054	10,482	12,938	11,051	13,507	11,650	14,106
<i>Off-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level	330,094	329,447	330,094	329,447	330,094	329,447	330,094	329,447	330,094	329,447	330,094	329,447	330,094	329,447
Policy Changes	18,314	16,260	35,876	33,090	55,411	52,441	74,163	71,050	93,292	90,364	113,804	110,703	135,424	132,140
Proposed Mandatory Level	348,408	345,707	365,970	362,537	385,505	381,888	404,257	400,497	423,386	419,811	443,898	440,150	465,518	461,587
Off-Budget Total	348,408	345,707	365,970	362,537	385,505	381,888	404,257	400,497	423,386	419,811	443,898	440,150	465,518	461,587
Chairman's Mark Function Total	354,288	354,161	374,030	373,063	394,305	393,144	413,855	412,551	433,868	432,749	454,949	453,657	477,168	475,693

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 700														
Veterans Benefits and Services														
FY 1995 Discretionary Level	18,341	18,308	18,341	18,308	18,341	18,308	18,341	18,308	18,341	18,308	18,341	18,308	18,341	18,308
Policy Changes	-278	646	-154	37	-154	4	-154	-121	-154	-171	-154	-208	-154	-231
Proposed Discretionary Level	18,063	18,954	18,187	18,345	18,187	18,312	18,187	18,187	18,187	18,137	18,187	18,100	18,187	18,077
FY 1995 Mandatory Level	19,313	19,084	19,313	19,084	19,313	19,084	19,313	19,084	19,313	19,084	19,313	19,084	19,313	19,084
Policy Changes	212	-1,103	581	650	953	1,130	1,550	1,766	1,749	3,403	2,236	4,034	2,649	4,427
Proposed Mandatory Level	19,525	17,981	19,894	19,734	20,266	20,214	20,863	20,850	21,062	22,487	21,549	23,118	21,962	23,511
Chairman's Mark Function Total	37,588	36,935	38,081	38,079	38,453	38,526	39,050	39,037	39,249	40,624	39,736	41,218	40,149	41,588

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Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 750														
Administration of Justice														
FY 1995 Discretionary Level	18,118	16,735	18,118	16,735	18,118	16,735	18,118	16,735	18,118	16,735	18,118	16,735	18,118	16,735
Policy Changes	-725	777	-1,535	49	-1,994	-315	-2,211	-499	-2,211	-626	-2,211	-626	-2,211	-626
Proposed Discretionary Level	17,393	17,512	16,583	16,784	16,124	16,420	15,907	16,236	15,907	16,109	15,907	16,109	15,907	16,109
FY 1995 Mandatory Level	404	389	404	389	404	389	404	389	404	389	404	389	404	389
Policy Changes	-44	-78	-67	-101	107	70	102	63	92	53	-325	-319	-414	-398
Proposed Mandatory Level	360	311	337	288	511	459	506	452	496	442	79	70	-10	-9
Chairman's Mark Function Total	17,753	17,823	16,920	17,072	16,635	16,879	16,413	16,688	16,403	16,551	15,986	16,179	15,897	16,100

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 800														
General Government														
FY 1995 Discretionary Level	12,093	12,125	12,093	12,125	12,093	12,125	12,093	12,125	12,093	12,125	12,093	12,125	12,093	12,125
Policy Changes	-1,376	-718	-1,389	-1,168	-1,424	-1,239	-1,446	-1,588	-1,469	-1,772	-1,470	-1,834	-1,470	-1,834
Proposed Discretionary Level	10,717	11,407	10,704	10,957	10,669	10,886	10,647	10,537	10,624	10,353	10,623	10,291	10,623	10,291
FY 1995 Mandatory Level	1,172	1,270	1,172	1,270	1,172	1,270	1,172	1,270	1,172	1,270	1,172	1,270	1,172	1,270
Policy Changes	-265	-297	-243	-428	616	438	-135	-293	313	347	-476	-486	-532	-549
Proposed Mandatory Level	907	973	929	842	1,788	1,708	1,037	977	1,485	1,617	696	784	640	721
Chairman's Mark Function Total	11,624	12,380	11,633	11,799	12,457	12,594	11,684	11,514	12,109	11,970	11,319	11,075	11,263	11,012

03-10-99 09:11AM FROM LUNG PETER DEUTSCH TO 93953729 P018/020

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 900														
Interest														
<i>On-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891	269,891
Policy Changes	25,937	25,937	34,398	34,398	38,805	38,805	44,764	44,764	49,971	49,971	50,755	50,755	53,440	53,440
Proposed Mandatory Level	295,828	295,828	304,289	304,289	308,696	308,696	314,655	314,655	319,862	319,862	320,646	320,646	323,331	323,331
On-Budget Total	295,828	295,828	304,289	304,289	308,696	308,696	314,655	314,655	319,862	319,862	320,646	320,646	323,331	323,331
<i>Off-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549	-34,549
Policy Changes	-4,917	-4,917	-9,975	-9,975	-15,124	-15,124	-20,578	-20,578	-26,389	-26,389	-32,653	-32,653	-39,409	-39,409
Proposed Mandatory Level	-39,466	-39,466	-44,524	-44,524	-49,673	-49,673	-55,127	-55,127	-60,938	-60,938	-67,202	-67,202	-73,958	-73,958
Off-Budget Total	-39,466	-39,466	-44,524	-44,524	-49,673	-49,673	-55,127	-55,127	-60,938	-60,938	-67,202	-67,202	-73,958	-73,958
Chairman's Mark Function Total	256,362	256,362	259,765	259,765	259,023	259,023	259,528	259,528	258,924	258,924	253,444	253,444	249,373	249,373

Fiscal Year 1996 Budget Resolution

\$'s in millions

	1996		1997		1998		1999		2000		2001		2002	
	BA	OT												
Function 920														
Allowances														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	-2,324	-1,948	-2,384	-2,312	-2,449	-2,543	-2,523	-2,712	-2,564	-2,823	-2,599	-2,868	-2,635	-2,912
Proposed Discretionary Level	-2,324	-1,948	-2,384	-2,312	-2,449	-2,543	-2,523	-2,712	-2,564	-2,823	-2,599	-2,868	-2,635	-2,912
FY 1995 Mandatory Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Mandatory Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chairman's Mark Function Total	-2,324	-1,948	-2,384	-2,312	-2,449	-2,543	-2,523	-2,712	-2,564	-2,823	-2,599	-2,868	-2,635	-2,912

03-10-95 09:55AM FROM CONG. PETER DEUTSCH TO 93953729 P019/020

Fiscal Year 1996 Budget Resolution
\$'s in millions

	1986		1987		1988		1989		2000		2001		2002	
	BA	OT												
Function 950														
Other Undistributed Offsetting Receipts														
<i>On-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783	-39,783
Policy Changes	5,366	5,366	5,586	5,586	2,150	2,150	3,389	3,389	1,641	1,641	1,887	1,887	779	779
Proposed Mandatory Level	-34,417	-34,417	-34,197	-34,197	-37,633	-37,633	-36,394	-36,394	-38,142	-38,142	-37,896	-37,896	-39,004	-39,004
On-Budget Total	-34,417	-34,417	-34,197	-34,197	-37,633	-37,633	-36,394	-36,394	-38,142	-38,142	-37,896	-37,896	-39,004	-39,004
<i>Off-Budget</i>														
FY 1995 Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Policy Changes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed Discretionary Level	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FY 1995 Mandatory Level	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432	-6,432
Policy Changes	-375	-375	-707	-707	-1,120	-1,120	-1,641	-1,641	-2,292	-2,292	-3,034	-3,034	-3,831	-3,831
Proposed Mandatory Level	-6,807	-6,807	-7,139	-7,139	-7,552	-7,552	-8,073	-8,073	-8,724	-8,724	-9,466	-9,466	-10,263	-10,263
Off-Budget Total	-6,807	-6,807	-7,139	-7,139	-7,552	-7,552	-8,073	-8,073	-8,724	-8,724	-9,466	-9,466	-10,263	-10,263
Chairman's Mark Total	-41,224	-41,224	-41,336	-41,336	-45,185	-45,185	-44,467	-44,467	-46,866	-46,866	-47,362	-47,362	-49,267	-49,267

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
 ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
 OFFICE OF HEALTH POLICY**



PHONE: (202) 690-6870 FAX: (202) 401-7321

From: Seanne **Date:** _____ **To:** CHRIS, Jennifer

Phone: (202) 690- _____ **Phone:** _____
 (202) 690-6870
FAX: (202) 401-7321 **Fax:** _____

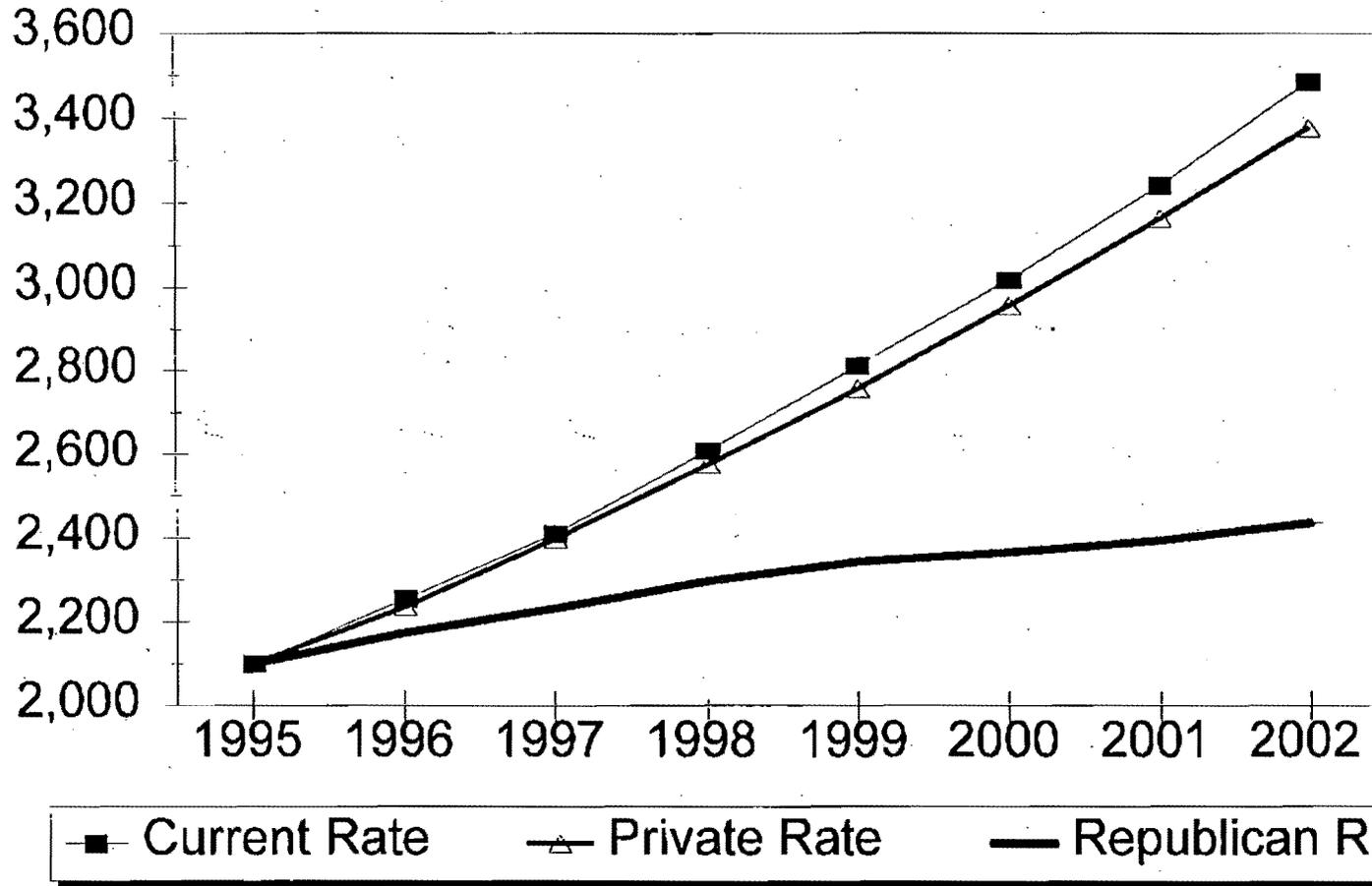
Number of Pages (Including Cover): _____

Comments: Two Things:
 (1) I'm working on fixing #s

(2) some additional Medicaid
 CHART OPTIONS

DRAFT

Medicaid Costs Per Recipient Rates at Private, Current & Proposed



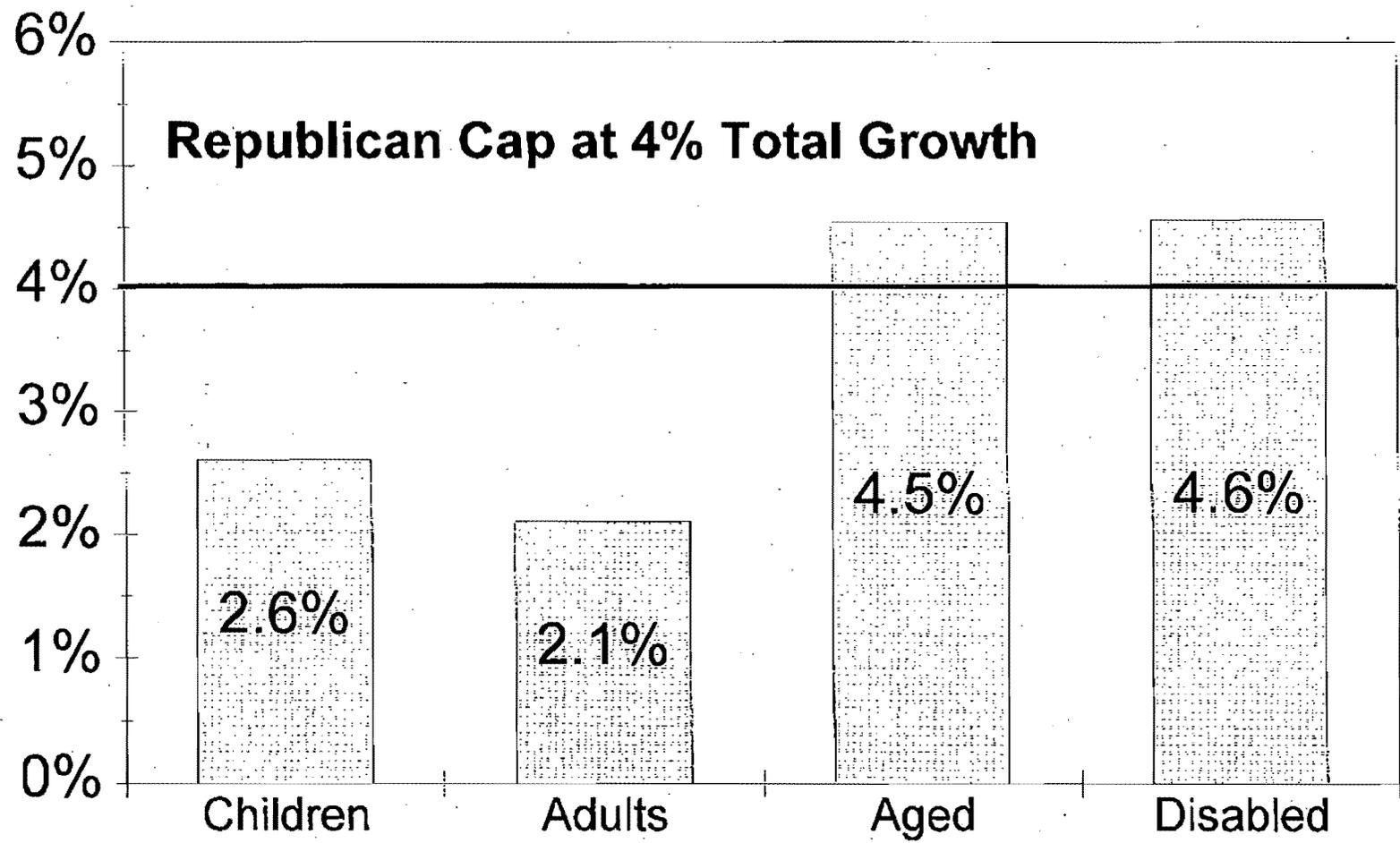
CBO Baseline, Excluding DSH

All line start with 1995 Costs per Recipient, and then apply different per-capita rates

DRAFT

Growth of Medicaid Coverage

Avg. Annual Growth Rates, 1996-2002



CBO Baseline Projections

DRAFT

Talking Points
on Republican Budget Proposals

May 10, 1995

"Republican
budget
bill on Medicaid
/cuts for S."

Overall message: Republicans are cutting Medicare and Medicaid, resulting in deep reductions in services and increases in out-of-pocket costs, to fund a tax cut for the wealthiest Americans.

I. Medicare and the Budget

- House Speaker Newt Gingrich wants to treat Medicare apart from the budget, but that statement is meaningless and the promise is a lie.
- Medicare is a federal program just like any other.
 - Its spending is part of the government's overall budget; if Medicare spending goes up, the deficit goes up.
 - Its payroll taxes are deducted from the paychecks of today's workers, and flow into the Treasury just like all other revenues.
- Republicans have to cut Medicare to reach their budget targets -- especially because they want to cut taxes for the wealthiest Americans.
- Republicans, themselves, admit that Medicare is an integral part of their budget.
 - See p. 5 of the Domenici plan, which lays it out in graphic detail.
 - It shows that without the Medicare cuts, Domenici would be \$62 billion short of his balanced budget goal in the year 2002.
- In fact, the Republican's Medicare cut is the largest single cut directed at any one program.
 - nearly \$1 in every \$3 in savings comes from Medicare, according to their own documents.

II. Medicare/Medicaid and the Republican Tax Cut

- Republicans are cutting Medicare to finance a tax cut that goes largely to the wealthiest Americans.

-- House Republicans have adopted a huge tax cut as part of their budget program.

-- House Speaker Newt Gingrich has called the tax cut "the crown jewel of the Republican contract."

-- Senate Republican leaders -- Bob Dole, Trent Lott, and others -- and Sen. Phil Gramm are committed to a tax cut and say they will push for one on the Senate floor.

- If they drop their tax cut for the wealthy, the Republican program could achieve the deficit target without Medicare cuts.

III. Medicare/Medicaid Cuts Hurt Real People

- Republicans say they want merely to limit the rate of growth in Medicare and Medicaid -- but these are real cuts, with real consequences.

-- "Limits" are actually cuts in services and increases in costs for the elderly, disabled, and low-income families with children.

- Medicare and Medicaid spending are rising 9-10 percent a year because of increases in the numbers of beneficiaries and the costs of medical services, including improvements in technology and care.

-- While that may seem high, on a per-person basis, Medicare spending is projected to grow at about the same rate as private health insurance costs.

- Thus, limiting the rate of growth of total (not per-person) Medicare spending to 7.1 percent, as Sen. Domenici proposes, will have real impacts on services and benefits for elderly and low-income Americans.

-- It could mean limits on the numbers of elderly or low-income individuals served.

-- It could mean limits on the quality and quantity of services that the programs provide.

-- It could mean that the elderly and low-income have to pay more, themselves, for some of the services that they now receive.

-- These "savings" could be passed on to businesses and individuals who buy health insurance and health care services.

- In short, reducing Medicare's rate of growth would hold it below the growth in the private sector -- creating a growing "quality gap" between care for seniors and health services for others.

Medicare Cuts:

- If distributed evenly between providers and beneficiaries, the Republican Medicare cuts could force beneficiaries to pay:

- between \$815 and \$980 more in out-of-pocket costs in 2002; and

- between \$3,100 and \$3,700 more in out-of-pocket costs over 7 years.

- Republican Medicare cuts, in effect, amount to cuts in Social Security:

- By 2002, the typical Medicare beneficiary would see 40-50 percent of his or her Social Security COLA eaten up by Medicare cost sharing and premiums.

- About 2 million beneficiaries would have 100 percent or more of the COLAs eaten up by cost sharing and premiums.

Medicaid Cuts:

- Cuts in Medicaid are especially outrageous:

- Medicaid provides health insurance for the most vulnerable Americans.

- 2/3 of Medicaid costs go to the indigent elderly and disabled, who have no other available resources.

- Medicaid is also a vital protection for middle-income Americans.

- Working families with a parent who needs long-term care would face nursing home bills of an average of \$38,000 a year without Medicaid.

- Working couples who may need long-term care after retirement rely on Medicaid to get such care.

- If distributed evenly between eliminating eligibility for the elderly and disabled, eliminating eligibility for children, cutting services, and cutting

provider payments, Republican cuts in 2002 alone would mean:

- 5-7 million children would lose eligibility;
- 800,000 to 1 million elderly and disabled would lose coverage; and
- Tens of millions of Americans would lose benefits of many forms.

IV. Managed Care, Vouchers, and Medicare/Medicaid Savings

Managed Care:

- Giving Medicare/Medicaid beneficiaries a "choice" of moving into managed care will do nothing to control costs.

- The "choice" option will play out in the following way:

- The Medicare population includes people with some of the most serious health care problems and, thus, with the highest annual health care costs (notably, those "very old" -- 85 and up).

- But many people on Medicare, including those close to age 65, are often quite healthy.

- If managed care is voluntary, private HMOs will do everything they can to enroll those who are young and healthy -- and exclude those who are old and sick. Moreover, those who are already sick and undergoing intensive health care are the least likely to want to change health care providers.

- To the extent that HMOs succeed in enrolling only the healthy, with below-average health care costs, they will make a profit -- and Medicare will "lose" money.

- They will leave to Medicare the expense of treating those with the highest health care costs.

- Thus, contrary to Speaker Gingrich's assertions, a managed care strategy will increase Medicare spending if the old and sick elderly keep the choice to remain in the current system.

Vouchers:

- Consider what happens to two typical elderly persons who get a \$5,000 voucher, as Speaker Gingrich has talked about:

-- One person, age 85 and frail, has annual medical expenses of \$9,000.

-- A second person, 65 and healthy, has annual medical expenses of \$1,000.

-- A \$5,000 voucher would, on average, cover their health care costs.

-- But giving a \$5,000 voucher to the healthy 65-year-old would increase Medicare's costs by \$4,000.

-- In contrast, the \$5,000 voucher would not cover the costs of the 85-year-old.

-- Thus, handing out \$5,000 vouchers would either cost the Government money, or leave the most vulnerable elderly without complete medical care.

- For the very old and frail who tend to have low incomes, medical costs not covered by the voucher will ultimately fall to the Government's Medicaid program.

V. Republican Plans for the Earned Income Tax Credit (EITC)

- While Republicans cut Medicare and Medicaid to finance their tax cut for the wealthy, they also plan a tax increase on low-income, working families.

- Republican tax proposals reveal the sharpest possible distinction between the President's vision for America and that of Republicans.

-- The President wants to provide targeted tax relief for middle-income Americans who may not have shared in the economic recovery.

- He wants to help them raise their children, educate and train themselves and their children, and save for the future.

- Republicans want to cut taxes for the wealthy, and actually increase taxes on the very people who need and deserve it most.

- Republicans plan to raise \$13 billion over five years by rolling back part of the President's 1993 expansion of the EITC, which would ensure that working Americans do not have to raise their families in poverty.

-- Most EITC recipients are doing the hardest job in America -- playing by the rules, working at modest wages to support their children.

-- The 1993 law was designed to help those who are not benefiting from the current economic expansion.

-- The cut eliminates the EITC entirely to families without children.

-- Freezing the proposed EITC expansions could cost millions of moderate-income families with children up to \$350 a year in added taxes.

DRAFT

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