Clinton Presidential Records
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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: **Tab 8: County/ County**

TAB 8: County by County Medicare Impact Analysis

THE WHITE HOUSE
Office of Media Affairs

FOR IMMEDIATE RELEASE **Contact: 202/456-7150**
August 7, 1995

The Republican Budget Resolution Conference Agreement:
County-by-County Analysis of Medicare Cuts

Republicans are proposing to cut more than $270 billion from Medicare between 1996 and 2002. Most of the $270 billion in Medicare cuts would not be necessary without the Republicans' $245 billion tax cut for well-off Americans. **A new study by the Department of Health and Human Services illustrates how these cuts would affect every county in the nation and the Medicare beneficiaries living in each county. The Republican Medicare cuts will specifically harm beneficiaries, hospitals and health care professionals in every county.**

County-by-County Analysis

If the Republican proposal is enacted, every county in the nation would face a dramatic loss of Medicare dollars. The new analysis provides the following detailed information:

- **Column 1:** **Name of county, listed alphabetically;**
- **Column 2:** **Number of beneficiaries in each county in 1994;**
- **Column 3:** **Reduction of Medicare dollars in 2002;**
- **Column 4:** **Reduction of Medicare dollars over 7 years (1996-2002); and**
- **Columns 5 & 6:** **Increased out-of-pocket costs over 7 years for single beneficiaries and couples.**

For example, Mobile County, Alabama would lose $555 million in Medicare funding over seven years, and $156 million in 2002 alone. Each of the 53,600 Medicare beneficiaries in Mobile County who wants to stay in their current fee-for-service Medicare would face, over seven years, an average of $3,850 in additional out-of-pocket costs and $7,700 more per couple.

*
NOTE: ALABAMA IS INCLUDED IN THIS PACKET AS AN EXAMPLE. ADDITIONAL COUNTY ANALYSES ARE AVAILABLE AS NEEDED THROUGH CABINET AFFAIRS AT (202) 465-2572.

County-by-County Estimates of the Effects of the Medicare Cuts

This analysis assesses the effects of the Medicare savings in the Congressional majority's Budget Resolution Conference Agreement on counties and their Medicare beneficiaries. In the Conference Agreement, Medicare spending would be reduced by approximately $270 billion between 1996 and 2002, $71 billion in 2002 alone.

Number of Beneficiaries '94:
The number of Medicare beneficiaries in each state is from the Health Care Financing Administration data. The number of Medicare beneficiaries in each county is estimated by multiplying the 1994 state number of beneficiaries by the proportion of the state's beneficiaries in each county in 1992 (the actual number of beneficiaries in each county was not available).

Reduction in 2002:
The reduction in Medicare spending per state and county is based on the total reduction of $71 billion in 2002. It is assumed that the cuts will be distributed across states and counties in proportion to the Medicare spending in states and counties. In other words, the more a county's health care providers receive from Medicare, the more the county will be affected by the cuts.

Reduction between 1996 - 2002:
The reduction in the Medicare spending per state and county for the seven year period is based on the total reduction of $270 billion. Similarly, it is assumed that the cuts will be distributed across states and counties in proportion to the Medicare spending in states and counties.

Increased Out-of-Pocket Costs, 1996-2002:
The county-level analysis of the increase in average out-of-pocket costs for beneficiaries is related to two previous analysis: the aggregate effect of the Congressional majority's cuts on beneficiaries ($625 in 2002, $2,825 over the period), and the state-by-state estimates released on July 28. Both analyses assumes that half of the total cuts could affect beneficiaries.

To reflect local conditions that affect health care costs, an adjustment was made to the state estimates. Half of the state estimate is assumed to remain constant across counties, since policies like premium increases affect all beneficiaries equally. However, half is adjusted to reflect local Medicare cost variation, as reflected in HCFA's Adjusted Average Per Capita Costs (AAPCC), which are county-based rates used to pay Medicare HMOs.

Impact of the Medicare Reductions in the Republicans' Budget Conference Agreement on ALABAMA

County	Number of Beneficiaries 1994	Loss in 2002 (millions)	Loss 1996-2002 (millions)	Increase in Out-of-Pocket Costs 1996-2002 Single	Couple
Alabama	**630,000**	**1,661**	**5,890**	**$3,775**	**$7,550**
AUTAUGA	4,100	10	37	$3,700	$7,400
BALDWIN	17,900	44	156	$3,650	$7,300
BARBOUR	4,200	12	43	$3,975	$7,950
BIBB	2,700	8	30	$3,825	$7,650
BLOUNT	5,100	15	52	$3,800	$7,600
BULLOCK	1,900	5	18	$3,525	$7,050
BUTLER	4,200	11	39	$3,550	$7,100
CALHOUN	18,400	43	152	$3,775	$7,550
CHAMBERS	7,100	16	56	$3,625	$7,250
CHEROKEE	3,200	8	29	$3,675	$7,350
CHILTON	5,200	16	58	$3,850	$7,700
CHOCTAW	2,700	7	24	$3,450	$6,900
CLARKE	4,500	12	42	$3,500	$7,000
CLAY	2,600	6	20	$3,425	$6,850
CLEBURNE	2,100	5	16	$3,550	$7,100
COFFEE	6,200	17	61	$3,850	$7,700
COLBERT	9,400	25	87	$3,825	$7,650
CONECUH	2,700	7	24	$3,575	$7,150
COOSA	1,700	4	15	$3,700	$7,400
COVINGTON	7,700	20	72	$3,875	$7,750
CRENSHAW	2,800	7	26	$3,600	$7,200
CULLMAN	12,100	31	111	$3,600	$7,200

Impact of the Medicare Reductions in the Republicans' Budget Conference Agreement on ALABAMA, continued

County	Number of Beneficiaries 1994	Loss in 2002 (millions)	Loss 1996-2002 (millions)	Increase in Out-of-Pocket Costs 1996-2002 Single	Couple
Alabama	**630,000**	**1,661**	**5,890**	**$3,775**	**$7,550**
DALE	6,400	17	59	$3,800	$7,600
DALLAS	8,500	21	73	$3,425	$6,850
DE KALB	9,400	21	74	$3,525	$7,050
ELMORE	7,400	18	65	$3,850	$7,700
ESCAMBIA	5,900	15	54	$3,750	$7,500
ETOWAH	18,900	51	181	$3,750	$7,500
FAYETTE	3,200	7	24	$3,375	$6,750
FRANKLIN	5,700	16	56	$3,850	$7,700
GENEVA	4,800	12	43	$3,775	$7,550
GREENE	1,700	4	14	$3,350	$6,700
HALE	2,900	7	26	$3,450	$6,900
HENRY	2,900	8	29	$3,850	$7,700
HOUSTON	11,500	31	108	$3,900	$7,800
JACKSON	8,100	19	66	$3,475	$6,950
JEFFERSON	110,800	320	1,134	$4,025	$8,050
LAMAR	3,000	7	26	$3,375	$6,750
LAUDERDALE	14,100	34	120	$3,650	$7,300
LAWRENCE	4,000	10	36	$3,775	$7,550
LEE	8,800	19	68	$3,375	$6,750
LIMESTONE	6,900	17	59	$3,475	$6,950
LOWNDES	1,600	4	15	$3,850	$7,700
MACON	3,500	8	27	$3,300	$6,600

Impact of the Medicare Reductions in the Republicans' Budget Conference Agreement on ALABAMA, continued

County	Number of Beneficiaries 1994	Loss in 2002 (millions)	Loss 1996-2002 (millions)	Increase in Out-of-Pocket Costs 1996-2002	
				Single	Couple
Alabama	**630,000**	**1,661**	**5,890**	**$3,775**	**$7,550**
MADISON	25,700	60	214	$3,700	$7,400
MARENGO	3,600	9	31	$3,425	$6,850
MARION	5,400	14	48	$3,700	$7,400
MARSHALL	13,600	35	125	$3,525	$7,050
MOBILE	53,600	156	555	$3,850	$7,700
MONROE	3,600	9	31	$3,400	$6,800
MONTGOMERY	28,600	70	248	$3,775	$7,550
MORGAN	15,100	37	131	$3,750	$7,500
PERRY	2,100	6	21	$3,400	$6,800
PICKENS	3,900	11	39	$3,500	$7,000
PIKE	4,900	13	46	$3,775	$7,550
RANDOLPH	4,000	8	30	$3,325	$6,650
RUSSELL	7,600	17	60	$3,575	$7,150
SHELBY	8,300	29	104	$4,350	$8,700
ST CLAIR	6,400	18	65	$3,900	$7,800
SUMTER	2,500	6	21	$3,275	$6,550
TALLADEGA	12,600	32	114	$3,825	$7,650
TALLAPOOSA	7,200	17	59	$3,575	$7,150
TUSCALOOSA	20,300	54	193	$3,775	$7,550
WALKER	13,300	41	147	$4,325	$8,650
WASHINGTON	2,400	6	23	$3,550	$7,100

Impact of the Medicare Reductions in the Republicans' Budget Conference Agreement on ALABAMA, continued

County	Number of Beneficiaries 1994	Loss in 2002 (millions)	Loss 1996-2002 (millions)	Increase in Out-of-Pocket Costs 1996-2002 Single	Couple
Alabama	**630,000**	**1,661**	**5,890**	**$3,775**	**$7,550**
WILCOX	2,400	5	19	$3,150	$6,300
WINSTON	4,100	12	41	$3,975	$7,950

NOTES: Number of beneficiaries: 1994 state beneficiaries; county number of beneficiaries estimated using 1992 distribution of beneficiaries by county. Reduction in 2002 & 1996-2002: based on total savings in the Conference Agreement, allocated to the state and county by the historical distribution of expenditures. Increase in out-of-pocket costs: assumes that 50% of total cuts affect beneficiaries. Based on historical state share of Medicare outlays & enrollment trended forward with growth in the states' share of outlays & enrollment. Based on Medicare outlays by location of service delivery. The county estimates are based on the states' estimates partially adjusted for local variation using the AAPCC. Variation in the costs per beneficiary reflects factors such as: (1) practice pattern differences, (2) cost differences, (3) differences in health status and the number of very old persons in a state, and (4) differences in the supply of health care providers. Source: US DHHS

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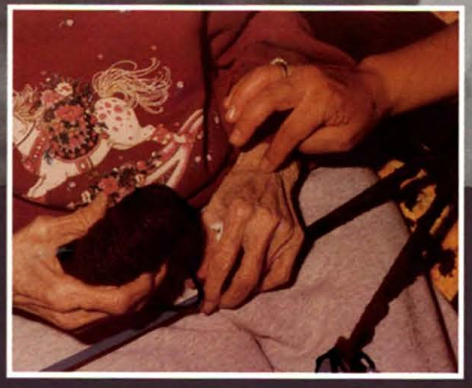
Timely Opportunities

What Works in Community Care for the Elderly



Lessons Learned from W.K. Kellogg Foundation Programming

W.K. KELLOGG FOUNDATION

HEALTH CARE QUESTIONS

- How/Do we define what "in the context of reform" means?

- Assuming we have a broad definition, should we have a proposal ready to go?

- Should a goal of significant deficit reduction be included in our definition and, if so, what number should we be shooting for?

- We have said that we think the Medicare Trust Fund insolvency issue should be dealt with in the context of reform. Should we come to an internal agreement about what is our goal vis a vis strengthening trust fund (e.g., is it extending insolvency date several years or long-term)? NOTE: Not even the most significant Medicare cuts currently under consideration by some Republicans ($300 billion plus over 7 years with a 5% cap on growth) extend the insolvency date beyond 2010.

- What position should the President stake out on Medicare in his May 3rd White House Conference on Aging speech? Should he have an agenda beyond simply opposing deep and arbitrary cuts outside context of reform? How should he talk about the Trust Fund issue? NOTE: It will coincide with two major Congressional hearings on the Trust Fund issue: Finance/April 26th; Ways and Means/May 3rd.

- Should the President respond to desires by AARP, GHAA, the business community and others and announce his own Medicare managed care proposal? Note: We have a proposal almost ready, which provides for broadened managed care choices, but does not produce short-term savings. (This would illustrate that we want to expand in this area and show we think there is potential for long-term savings, but would smoke out Republicans on how they achieve savings in their managed care proposal.)

- How do we position ourselves on the Medicaid issue? There are many options:

  -- Develop a proposal that provides for state flexibility, but for little/no savings and uses Medicaid as program for possible expansions.
  -- Develop a proposal that provides for state flexiblility, but produces some savings -- perhaps through DSH savings or per capita cap.
  -- Oppose changes that reduce coverage.
  -- Oppose changes that eliminate the entitlement nature of program.
  -- Oppose block grant approaches.
  -- Oppose cuts on basis of magnitude.

DRAFT

EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans have proposed to cut Medicare funding by $300 billion between now and 2002 -- a 24% cut in 2002 alone.

- Medicare managed care cannot produce the magnitude of savings being proposed by the Republicans. For example, Senator Gregg predicts that managed care could save $35 - $45 billion between 1996 and 2000, although there is no evidence that managed care can produce Medicare savings of this magnitude. But even this overly optimistic projection produces less than one-third of the cuts being proposed by Republicans.

  - Claims that substantial savings can be achieved through Medicare managed actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.

  - CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the necessary changes to the existing payment system would be "difficult to specify."

  - Even with an improved payment methodology, the savings to Medicare would be only small percentage of cuts being proposed by Republicans.

- Even if the level of savings suggested by Senator Gregg (extended through 2002) for Medicare managed care could be realized, the proposed cuts would have serious impacts on beneficiaries and providers. If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:

  - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about $2,980 more for Medicare. In 2002 alone, they would be required to pay about $775 more.

  - In 2002 alone, a $32 billion cut in Medicare payments to hospitals, physicians and other health care providers would be needed.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.

  - There are now 40 million uninsured Americans, and this number will continue to grow.

- These unprecedented Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

  - Republicans are talking about combined Medicare and Medicaid cuts of almost $500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts by raising their rates for private patients. Even if only one-quarter of these cuts are passed on to private payers, businesses and families will be forced to pay $125 billion more for health care between now and 2002.

- 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 to primarily serve 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.

  - 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.

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

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

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

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

DRAFT

EFFECTS OF CAPPING MEDICAID

IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
  - About 60% of Medicaid spending is for elderly and disabled people. (This includes both long-term care and acute care spending .)
- Republicans have proposed (through the use of a block grant with a 5% cap on growth) to cut federal Medicaid funding by more than $190 billion between now and 2002 a 30% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting $190 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. Even under optimistic assumptions, managed care could produce only about $10 billion in savings between now and 2002. The remaining $180 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.
- Finding the remaining $180 billion in Medicaid cuts without cutting provider fees which are already much lower than in the private sector would require massive reductions in health coverage and services. The number of uninsured Americans, currently about 40 million, would increase substantially.

To illustrate the types of cuts that states would have to make, cutting $180 billion through a combination of benefit and coverage reductions would require:

- Elimination of coverage for prescription drugs, dental care, and personal care services by 2002, and
- Elimination of Medicaid coverage for more than 13 million kids or for more than 2 million elderly or disabled people.

- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, the states could save money only if they cut more than $190 billion out of Medicaid.

VARIATION ACROSS STATES

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

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

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

- States already are aggressively pursuing managed care, but the populations for whom care can readily be managed children and AFDC adults account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

- Applying managed care techniques to the services typically used by the elderly and disabled (such as long-term care) is largely untried, making the potential for savings hard to predict.

- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care is not a real option.

- Some may point to low Medicaid growth rates in certain states as evidence that a 5% cap on growth is achievable.

  - While a few states may be able to hold growth down to 5% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.

  - Since 1992, 19 states have applied for state-wide health reform demonstration waivers from the Department of Health and Human Services. Under these waivers, states are able to change their Medicaid programs to increase efficiency and expand coverage. No state has projected an annual growth rate over the period at or below 5%.

- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.

o **Simpson and Kerrey to approach health care issue through Medicare and Medicaid reform.** During work on the budget reconciliation bill -- scheduled to begin when Congress returns from the Easter recess -- Republican Sen. Al Simpson and Democratic Sen. Bob Kerrey intend to work together on four separate bills aimed at reforming Medicare and Medicaid. Simpson and Kerrey plan to collaborate with Sen. Pete Domenici on one of the proposals, which would create block grants for state governments to administer their own Medicare and Medicaid systems, according to an aide close to the issue. "Basically, you would have a capitated grant going to each of the states based on their Medicaid-eligible population and the Medicare-eligible population that elect for it. And then people would get a voucher they would use to buy that amount of health insurance," the source said, adding, "The belief is that if you transform the dynamics of the health care market, you slow some of the excess health care cost inflation. And the grants would be capitated, so they wouldn't grow as quickly as Medicare and Medicaid have grown in recent years under their automatic pilot systems." Pointing out that health care costs rise faster than most other costs, the source said, "We would take that excess health care cost inflation and give the growth of the voucher credit for about two-thirds of that. In other words, what you're saying is the value of the vouchers will grow over time in such a way that if these reforms eliminated, say, one-third of the extra cost inflation in health care, the vouchers would be equally valuable in the year 2030 as they are today." Added the source: "In the worst case scenario, if you did nothing to slow down health care inflation by moving to a voucher system, then they'd still be worth about 88% what they are today, in terms of how far the health care dollar would go in the year 2030. But of course, we expect the voucher would even become more valuable over time because we expect the dynamics would be changed in such a way that a significant portion of health care hyperinflation would be eliminated."

Before the voucher legislation is introduced, however, Simpson and Kerrey plan to put forward three other reform proposals. "One would be hiking up Medicare's eligibility age to comport with that of Social Security. We'll gradually shift it up to 70 over the course of 20 years in the next century," a Simpson aide said, adding: "Another one would index the premiums so they stay at a constant percentage of program costs, which they don't now. The new costs are always thrust on the taxpayer and never on the recipient. This would just keep it constant."

Simpson and Kerrey will propose the change in eligibility age first, and then follow that legislation with a bill to "means-test" Medicare recipients. Under Part B, the Federal Government currently pays for 75% of the premium for Medicare. Simpson and Kerrey would require individuals with incomes of $30,000 and couples making $40,000 to pay for 30% of their premiums, while individuals making $60,000 and couples bringing in $100,000 would be required to pay 80%.

The indexing measure will likely be introduced along with the means-testing bill. According to a staffer working on the legislation: "The voucher is the most complicated and it's furthest down the line, but we plan to move all of this in budget reconciliation."

RNC TALKING POINTS
SAVING MEDICARE: BILL CLINTON TAKES A HIKE

April 7, 1995

Medicare provides an important source of health security for 32 million of our nation's senior citizens and four million disabled persons. But Medicare spending has been rising 10-11% a year, and if costs continue to soar, everyone will have to pay more: beneficiaries, taxpayers and businesses. If we don't act by the year 2002, the Medicare portion of FICA taxes for everyone will have to be raised 125% from their current level--that's $725 more on a $40,000 salary, and senior citizens will face a 300% increase in annual premiums (Source: 1994 Social Security Trustees Report).

Last year, in their annual report, the Social Security and Medicare Board of Trustees projected that the Part A Trust Fund will be broke by the year 2001. The Trustees, who included Secretary Reich, Secretary Shalala and then-Secretary Bentsen, concluded:

> "The Federal Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about seven years and is severely out of financial balance in the long range."

Today, the trustees told Congress that the Medicare trust fund will go bankrupt by the year 2002. Despite the fact they added another year to the forecast, the trustees called the long-term outlook for Medicare "extremely unfavorable" and recommended "prompt, effective and decisive action" to save the fund from insolvency. A similar call to action was issued last year by the Bipartisan Commission on Entitlement and Tax Reform headed up by Sen. Bob Kerrey (D-Neb.) and former Sen. John Danforth (R-Mo.).

Unfortunately, despite the recommendation of this presidential commission and his own cabinet officials, Bill Clinton has failed to act on Medicare. His FY 96 budget proposed no

solution to the problem, saying it would have to wait for health care reform. But short of admitting in his State of the Union Address that his government-run health care proposal had been a mistake ("I know that last year, as the evidence indicates, we bit off more than we could chew"), Clinton has not advanced a health care proposal this year.

Bill Clinton has basically decided to take a hike on Medicare and the whole issue of balancing the federal budget. Clinton's FY 96 budget contains $200 billion deficits every year as far as the eye can see, adding $1 trillion of new debt to the trillions we already owe. Apparently he's content to stick his head in the sand and leave these problems up to our children, who will be forced to pay enormous taxes as a result of his procrastination.

Republicans believe we owe it to our senior citizens to save Medicare from bankruptcy, and we owe it to our children not to saddle their futures with our debt. In the coming months we will address the problems of Medicare and present our plan to give the country a balanced budget by the year 2002. If Bill Clinton is not going to lead, Republicans will.

MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris J. and Jen K.
RE: Upadate on Health Policy Developments
cc: Melanne

April 7, 1995

We thought you might like an update memo on recent developments related to health care. As yesterday's enclosed Washinton Post editorial illlustrated, we are going to be under increasing pressure to at least appear to be more proactive on the health care front.

The issues that merit particular attention are: (1) Medicare Trust Fund developments, (2) health care developments on the Congressional front, and (3) the current status of our internal health policy development discussions.

Medicare Trust Fund

The Republicans have consistently attempted to draw us into the debate with their repeated "sky is falling" references to the Medicare Trust Fund and attacks on our "lack of leadership." They desperately want us to engage with them on this issue and will be turning up the heat during the recess and immediately after they return. Already, the Finance and Ways and Means Committees have announced Medicare Trust Fund hearings to take place in late April and early May. They have invited all of the trustees (Shalala, Rubin, Reich and Vladeck) to testify and to take a bashing from the Republicans. (As you know, the timing of these hearings happen to coincide with--or just before--the White House Conference on Aging.)

Interestingly enough, because we were well prepared for this past Monday's release of the Social Security Trustees report (and probably because there was more sensationalistic news to report), the media did not give the release all that much attention. To the extent it did receive coverage, we think (as the enclosed articles help illustrate) we came off looking all right -- at least for the moment. For your information, we are enclosing a set of talking points, Q's and A's, and a background summary on the Medicare Trust Fund issue. Also enclosed is some interesting testimony about the current state of the Medicare Trust Fund that was presented by one of our favorites -- Guy King. (He now works for Ernst and Young.)

Congressional Health Care Update

The Republicans are growing increasingly nervous about how their cuts in the Medicare and Medicaid programs are going to fare with the public. (This helps explain how much time Speaker Gingrich allocated tonight to outlining his "devotion" to Medicare and health care.)

The Speaker and the rest of the Republicans understand all too well, however, that they have gone too far with their tax and deficit reduction promises to back-track now. The Committee Chairs are currently reviewing unprecedented Medicare and Medicaid cuts. Although they will be gone most of the month, the Republicans will be working hard to make their case that they are merely reducing the rate of growth in order to strengthen the Medicare Trust Fund. They of course will also attempt to suggest that their "managed care" reforms will not only make the system more efficient, but will also provide more choices to beneficiaries. (As you will recall from our managed care memo, it is virtually impossible to achieve ANY substantive Medicare savings without limiting affordable health plan choices and/or increasing beneficiaries' cost sharing requirements.)

On April 26th, the Senate Budget Committee is planning to start their mark-up of the budget resolution. As of this writing, they are reportedly considering at least $250 billion and $130 billion in Medicare and Medicaid cuts respectively over seven years. In recent days, however, there have been rumors that increasing pressures to throw in some tax goodies for some of the more conservative Members may make the combination Medicare/Medicaid Senate number top the $400 billion mark. The House Budget Committee, which will start later, is likely to get closer to a $500 billion Medicare/Medicaid figure.

In addition to using Medicare and Medicaid as the "cash cows" for their agenda, the Republicans are obviously looking to paste on the term "insurance reform" on any health bill they unveil. They of course want to label their initiatives as "health reform," so they can say they are meeting the President's requirement that any such cuts are done in a broader context.

Questions relating to likely Republican actions are already arising. For example, do we oppose any major health policy change that does not expand coverage? Do we or should we have a ratio of spending to deficit reduction allocation when it comes to Medicare/Medicaid cuts? Earlier today, the President gave some answers to these questions when he publicly reiterated today his desire to expand coverage to at least the temporarily unemployed, while allowing that some savings would be used for deficit reduction. I believe he deftly handled the danger of appearing in a responsive mode by referencing the vision he outlined in the State of the Union and in his December Congressional Leadership letter.

The Medicaid program frequently gets lost in the political shuffle, but I think it's worth noting a couple of points. Every success there is in reducing the Medicare cut number may be at the expense of increases in Medicaid cuts. Whether this occurs or not, the lowest Medicaid cut now being discussed by the Republican Leadership is $130 billion over 7 years; it is just as likely to be closer to $190 billion. This, as you know is particularly significant since the size and scope of Medicaid cuts will almost inevitably lead to actual coverage reductions only a year after we were talking about universal coverage.

As far as the House is concerned, it is difficult to imagine anything other than a Medicaid block grant (with a 5-6% growth cap) emerging from the floor. The Republicans are absolutely sold on the block grant approach because (1) it is easy to understand and explain, (2) they are desperate for the money, and (3) most of the Governors are giving explicit or implicit cover OR they just are not paying attention yet.

The Senate may be a different ballgame. Senator Chafee is opposed to eliminating the entitlement and block granting the Medicaid program. As Chairman of the Finance Subcommittee on Medicaid and, more importantly, as the 11th Republican vote on the 20 Member Financing Committee, he may have a good deal of clout -- if all of his Democratic Finance brothers (and sister) join him. (It certainly is not clear that this is the case, though.)

Chafee is now in the process of developing alternatives to the block grant approach. He is currently playing around with an idea that eliminates Medicaid DSH payments in order to get significant savings. The primary problem with his approach is that it remains unclear whether there is sufficient political support from the provider groups, from Republicans, and even from the Democrats. Because of the retention of the entitlement, the lesser amount of flexibility, and the DSH payment reductions, there is little question that the Governors would oppose it. (Having said this, it is worth following this bill closely; I talked with Chafee's staff today and will keep you apprised of developments.)

As usual, the Democrats on the Hill are in disarray around the health care issue. The only thing they seem to agree on is a strategy to hold back, evaluate and hopefully expose the Republicans "mean-spirited" health care cuts. They, like the "pols" in the Administration, want us to prepare our ammunition but hold back UNTIL the Republicans get more specific. Attached, for your review, is a copy of the current set of talking points the Senate Democrats are using on the Medicare/Medicaid cuts.

Ever since Daschle introduced his health reform bill, he has been fairly silent on the issue. However, if there is any chance whatsoever for any bridges to be built from the Republicans to the Democrats (or vice versa) on health reform, it will be in the Senate. This is primarily the case because the Senate Republicans think they need a positive health care reform spin and many of the Democrats have deficit reduction fever.

Gephardt does not feel the need to develop any specific alternative and seems comfortable attacking (and preparing to attack) the Republicans cuts and lack of progress on health care. (This is of course largely due to the fact that he simply cannot achieve a broad-based consensus on any health reform package.) Leader Gephardt has announced, however, his intention to produce a bill sometime later this year. Andie King informs me, however, that this will be at most a "theme" and "political cover" bill -- nothing that is at all detailed or has any chance of passing. Andie (and Daschle's staff) are very interested in receiving our assistance in preparing back-up, substantive, and brief background on the Medicare and Medicaid cuts. (A copy of our latest -- but not final -- draft of these talking points is included behind this memo.)

Current Status of White House Health Policy Development

No senior level Administration official is arguing that the President should rush out any health reform initiative prior to the time the Republicans release their budget resolution. However, there continues to be somewhat of a split internally about how to proceed in health care.

Leon, Pat and George (among other politicals) do not see any great value and, in fact, see potential danger in the White House policy operation holding high level policy discussions to develop and review health reform options. (The "leak" fear is particularly prevalent if financing options are being considered.) Alice, Laura, Carol, Donna, and most recently Bob think we need to be reviewing our options because they feel we will be pulled in sooner or later into the deficit/trust fund debate. Moreover, they believe we have to be ready to go almost immediately if the President decides he wishes to move rapidly.

Laura, Carol, Alice, Donna and Bob have a growing desire to hold a meeting with Leon in the very near future to open up a discussion about whether or not any of our health care "vision" recommendations to the President are or should be changing. Primarily, I think they desire such a meeting to make certain everyone is still reading off the same page on this issue. Needless to say, NO such meeting will take place in your absence.

Relative to changing policy views, not much that I have to report will shock you. Having said this, the desire to capture some significant savings to go to deficit reduction seems to be intensifying. In other words, although the December policy options the President chose could achieve roughly $60–80 billion in deficit reduction over 10 years, Laura, Bob and Alice constantly point out how miniscule that amount is relative to the numbers the Republicans are talking about -- over $1 trillion in 7 years. They obviously would like to see much more.

Laura has recently suggested thinking about raising tobacco taxes even higher than the President suggested in December. She advocates an "in for a dime, in for a dollar" strategy and would like to dedicate all savings for coverage expansions through the tax code -- perhaps through the use of a tax credit. (This may be Laura's way of getting some money for coverage, while enabling all -- or virtually all -- of Medicare and Medicaid savings to go for deficit reduction.) Laura, Alice and Donna have asked how much coverage we can buy for an increased tobacco tax; as you will recall, we used about a .45 cent tax increase to pay for our kids benefit. Although this analysis is not done, I am certain it would at least pay for the kids and the temporarily unemployed benefits we have discussed.

Laura's tax credit idea has some political appeal since the media and the Republicans are less likely to call it a big, brand new public spending program. (The downside is we have a good deal of policy work to do if we want to pursue this option and Treasury's tax policy division hates this idea -- like the hate every tax credit idea.) The other downside, of course, is that there are probably few to no people in the political wing of the White House who would seriously contemplate a $1 or so increase -- let alone a one cent increase -- in the tobacco tax.

On the Medicare front, there is growing interest among us policy folks in developing a Medicare managed care proposal for the Administration. Such a proposal could show that the Republicans either "have no clothes" when it comes to their savings claims for Medicare managed care OR that they are going to significantly increase seniors' out-of-pocket costs. In recent meetings with the Group Health Association of America (Karen Ignagni's HMO organization) and AARP, it has become clear that the internal managed care proposal we are working on, which would expand managed care choices and is consistent with GHAA's short-term policy priorities, would receive widespread support. Moreover, Members like Chafee, Graham, Rockefeller and others would be likely want to introduce it.

The advantage of doing this is it illustrates that we want to move forward on expanding Medicare beneficiaries participation in managed care. The difference is that we want to do it the "right" way -- through broadened, not economically forced, choices.

The potential downside is that we might not be very good an defining our message. In other words, the "right" managed care approach might well not be enough of a clear contrast with the Republicans' version of managed care.

I think we need to closely evaluate this option. It might be something we might want to consider having the President offer when he addresses the White House Conference on Aging. If he did it, the contrasting message of "their proposal makes you pay more for choice, mine does not" would likely sell very well. It is also something that could be offered independent of broader reforms since it is neither a budget saver or coster.

On the Medicaid front, if alternative approaches to block grants are not found soon, we will witness a quickly passed Medicaid policy that will eliminate the entitlement and significantly reduce tens of billions of dollars to the program. We are reviewing some ideas that would provide unprecedented flexibility to the states, with the only major limitation being they cannot reduce the total number of covered people; however we continue to have trouble producing a politically viable policy that will preserve the best of the program while still achieving significant savings. We will keep you informed. There is a long OMB Medicaid background document floating around here. If you are interested, we will get you the complete set early next week.

Housekeeping

Jen and I would like to meet with you and Melanne about all of the above at your earliest convenience. We would also like to bring you up-to-date on the White House Conference on Aging, including -- Jen tells me -- the mammography event.

Lastly, in your absence, the President asked for the enclosed memo on a recent Families USA report on prescription drug prices. Speaking of drugs, the manufacturers seem to be relatively pleased with the regulatory reforms that were included in the White House/FDA report that we released yesterday. I mention this because I think the next time you sit next to a drug company CEO, they should be happier with the Agency and the Administration.

THE WASHINGTON POST
THURSDAY, APRIL 6, 1995

'Zippo' on Health Care

HOW TIMES and roles do change. There was Bob Dole the other day, attacking Bill Clinton for "a complete abdication of responsibility" for not proposing health care reform as part of this year's budget. Bob Packwood was, as ever, right at his patron's elbow; Mr. Clinton has proposed "zippo," the chairman of the Finance Committee said. These, of course, are the same Republicans who in the last Congress helped to derail the president by blocking health care reform when he did propose it. Their complaint then—and not just theirs; a lot of others, including us, felt the same way—was that his proposal was not a sound one and went too far.

They're right that this year he has gone to ground on the subject. The Republicans have promised to balance the budget. As the president kept pointing out and just about everyone agreed last year, there's no way to do that without imposing tight constraints on the giant health insurance programs, Medicare and Medicaid, that are now a sixth of all spending and the main budget engines. The health care problem and the budget problem are in a sense the same. Mr. Clinton's idea is that this year the Republicans should be the ones to take the heat for proposing a solution. As Mr. Dole put it, "The president wants to have it both ways and not do anything. He's out there bashing us. I think it's time for the president to become relevant in this process and join us."

The Republicans deserve praise if in fact they move to curtail the cost of the health care programs. But deciding somehow to cap the cost and thereby reduce the deficit and keep the Medicare trust fund from running dry and all those other good things—that's the relatively easy part. The hard part is then figuring out how to live within the caps without doing damage to the health care of the elderly or poor or merely shifting the cost of that care from the federal government to others—the states, for example—who may be even less capable of paying it.

The two great problems of health care remain what they were a year ago. The health care system doesn't cover everyone and even so costs too much. At any given moment a seventh of the population is now without health insurance even as the system consumes $1 of every $7 Americans spend. Except as a forcing device, a cut in federal health care spending won't solve either of these problems. Rather, it could make care even costlier and less accessible to the elderly, disabled and poor.

Congress shouldn't just cut and run. It and the president have to work through what they expect to happen next. If they want to cut the budget, as they should, they will also have to do what they failed to do last year and restructure the health care system. Right now the two sides are mostly exchanging taunts. They should begin exchanging practical ideas as well.

BACKGROUND ON MEDICARE TRUSTEES REPORT

On Monday, April 3, 1995, the Trustees reports for the Medicare Trust Funds will be released. The reports will conclude that the Medicare HI Trust Fund will be exhausted in 2002. This date represents an improvement over last year's report which predicted that the Trust Fund would be exhausted in 2001. (The conclusion is based on the Trustees' intermediate set of assumptions -- not too optimistic nor too pessimistic).

Problematic findings

- From 1996 on, the Medicare HI Trust Fund is predicted to pay out more in benefits each year than it receives in revenues.

- The financial problems faced by the Medicare HI Trust Fund are not new. In the 1982-84 period, the Trust Fund would have similarly failed the actuarial short-term solvency test (ten years solvency). Those problems were addressed with temporary solutions. The Trust Fund's short-range financial problems re-emerged in the early 1990s.

- While the short term (up to 10 years) solvency of the Trust Fund is the immediate focus of the Trustees Report, longer term projections (contained in this and previous years' reports) show the Trust Fund in serious long-term deficit. Right now, about 4 workers support every Medicare beneficiary. By the middle of the next century, this ratio will drop to about 2 workers for each beneficiary.

Moderating influences

- Actions proposed by the Administration and enacted in OBRA 1993 extended the life of the Medicare HI Trust Fund. These include:

  - Depositing tax revenues from the increased income taxation of Social Security benefits into the Medicare HI Trust Fund.
  - Repealing the wage cap for the Medicare HI payroll tax.
  - Imposing constraints on the growth of Medicare payments to providers.

Together, these actions postponed the date when the Trust Fund would be exhausted by about 3 years.

- Hospital cost inflation in recent years has been lower than expected. This has improved the financial situation of the Medicare HI Trust Fund. In 1994, stronger-than-expected economic growth also contributed to the health of the Trust Fund.

- The Trustees are proposing that the Quadrennial Advisory Council for the Medicare Program be re-established in order to recommend effective solutions to the Medicare problems.

MEDICARE TRUST FUND TALKING POINTS

- The Medicare HI Trust Fund shows modest improvement due to the actions taken in OBRA 1993 and a stronger-than-expected economy in 1994. Just 2 years ago, Trust Fund depletion was projected for 1999, now it has been delayed to 2002. Even with these improvements, however, the Trustees foresee financial problems for the Medicare HI Trust Fund.

- The financial problems faced by the Medicare HI Trust Fund reflect the problems affecting the entire health care system. The Administration looks forward to working with the Congress on developing lasting solutions to the Medicare fiscal problems in the context of broad-based health care reform.

- We need to do broad-based health reform because:

  -- Severe and arbitrary cuts focused solely on Medicare will create major market distortions that will produce additional problems for the rest of our health care delivery system.

  -- For example, (in the absence of reform) as the number of uninsured continues to grow, significant cuts in Medicare would severely strain, if not decimate, many of our fragile health care delivery systems in rural and inner-city communities.

  -- In addition, large Medicare cuts are likely to result in cost-shifting to many small businesses and individuals -- to those Americans who are already paying the highest health insurance premiums in the nation.

POSSIBLE Q&As

Q: Why isn't the President proposing a specific health care reform initiative and/or when will he submit one?

A: The President remains committed to national health care reform. What we've learned is that any broad-based health care reform solution must be done on a bipartisan basis. The President has invited the Republicans to work with him on developing such a plan. We stand willing and ready to work with them.

Q: Congressional Republicans state that they are going to solve the problems of the Medicare HI Trust Fund through legislative initiatives. Is this believable?

A: It certainly is ironic that while Congressional Republicans talk about placing the Medicare HI Trust Fund on sound financial footing, both their "Contract" and tax bill now on the House floor calls for tax cuts for the wealthy that would further weaken the Medicare HI Trust Fund.

* (Avoid going into more detail, but if you must, do so on background):

The Republicans propose to roll back the limited taxation of Social Security benefits for the 13 percent of beneficiaries with the highest incomes. Since these revenues from higher income beneficiaries are deposited directly into the HI Trust Fund, this further undermines the Trust Fund.

Q: Would passage of the Health Security Act have solved the long-term financial problems of the Medicare HI Trust Fund?

A: The Health Security Act would have strengthened the Medicare HI Trust Fund (as would any responsible broad-based health care reform).

SOCIAL SECURITY TALKING POINTS

- The 1995 Report indicates the financial status of the combined Old-Age and Survivors and Disability Trust Fund (OASDI) is virtually the same reported last year. The fund continues to be in surplus, collecting more in taxes than needed to pay today's benefits.

- The cash-flow surpluses are projected to continue through 2013, and the trust fund will be depleted in 2030, one year later than projected last year. Thus, social security is currently in good financial shape and benefits can be paid well into the next century without any changes in the program.

- The program is in deficit when looked at over 75 years (estimated to be 2.17 percent of payroll this year -- virtually the same as last year's estimate of 2.13 percent).

- The Quadrennial Social Security Advisory Council is scheduled to report this summer with specific recommendations to deal with the program's long-term deficit.

TESTIMONY BY

Guy King

Former Chief Actuary for HCFA

before the

Subcommittee on Health and Environment

House Committee on Commerce

March 28, 1995

Mr. Chairman, my name is Guy King. I am a Consulting Actuary with the firm of Ernst & Young. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994. During my time as Chief Actuary, the expenditures for both the HI and SMI programs grew at rates that are unsustainable in the long run, and they continue to grow at those unsustainable rates today and into the foreseeable future.

Hospital Insurance (HI) Trust Fund

The expenditures of the Hospital Insurance Trust Fund (Part A of Medicare) increased from $17.7 billion in 1978 to $107.2 billion in 1994. This is an average rate of increase of about 12 percent per year. In 1978, the Annual Report of the Board of Trustees projected that the HI trust fund would be bankrupt by 1990. Because of some minor price reduction changes in the program which have been legislated over the years, the date of bankruptcy has been pushed back by a few years, so that the 1994 Trustees Report projects that the HI fund will be bankrupt by 2001. Thus, during

my 15 years as Chief Actuary, virtually nothing was done as the problem grew and the HI program moved closer to the bankruptcy. The impending bankruptcy of the fund is just the tip of the iceberg, though. The hole is just going to continue to continue to get deeper for many years, and the pace of decline is going to accelerate. The tax rate necessary to support the current program will have tripled by the middle of the next century. Even by the year 2020 the tax rate necessary to support the cost of the program will have more than doubled.

I know that some people view these projections as a red herring. I have often heard it suggested that we should just wait awhile to see if these problems really begin to materialize. That is apparently what lawmakers were thinking when they heard the same projections back in the mid-1970's. The financial problems of the HI program aren't just the result of some extremely pessimistic assumptions about the growth of health care costs. The assumptions regarding the rate of growth in health care costs and the growth in income to support the program are really very optimistic. These projections are being driven now by the coming demographic shift. The Baby Boomers who will retire and begin drawing benefits starting in 2010 are all alive today. As the Post World War II Baby Boom begins to reach age 65, the growth in the number of workers paying taxes is going to decline, and at the same time the growth in the number of people eligible for Medicare benefits is going to increase. Currently, about four taxpayers support each HI beneficiary. By the middle of the next century, when all of the

baby boom will have retired, there will only be two covered workers supporting each HI beneficiary, so this problem is very real and very predictable.

The problem is so large that there isn't any painless way at this point to solve the problem. To place income and expenditures in balance even over the next 25 years, which is the easy part, is going to require either an immediate 34 percent reduction in expenditures or an immediate 52 percent increase in the HI tax rate, or some combination of both. And even then, the financial problems beyond 25 years would still remain unsolved.

Some have suggested that the apparent recent slowdown in the rate of growth in health care costs and the recent favorable experience in the Medicare program may be enough to save the government from having to make these decisions. That isn't going to happen. During my twenty years as a government actuary I observed that, when there was a threat of government action, health care costs always behaved very well. This occurred with the wage-price controls of the early 1970's, the threat of hospital cost containment legislation during the late 1970's, and during the discussions of health care reform in 1993 and 1994. Once the perceived threat is past, the rate of increase in expenditures once again accelerates.

In deciding how and when to take action to make the HI Program solvent, one of the difficult questions that needs to be addressed

is the issue of generational equity. Generational equity can be measured by comparing each generations' contributions to the program with the benefits they receive from the program. We measured generational equity under four combinations of the following policy options: 1) act immediately or delay action and 2) increase taxes or reduce benefits. Our studies show that the solutions resulting in the greatest generational equity involve taking immediate action rather than delaying action and reducing the growth in benefits rather than increasing taxes. The table below shows the impact of various policy options on generational equity for persons retiring in 1994, 2014, and 2034.

Ratio of Benefits to Contributions

Proposed Change in Financing	Person Retiring in: 1994	2014	2034
1. Do nothing until trust fund depleted, then increase taxes.	5.19	2.93	2.17
2. Do nothing until trust fund depleted, then reduce benefits.	3.25	1.31	1.14
3. Reduce benefits immediately.	2.10	1.36	1.54

4.	Increase taxes immediately.	5.19	2.20	1.68
5.	Reduce benefits immediately, then index tax rates.	2.10	1.61	1.94
6.	No changes (hypothetical)	5.19	3.45	3.90

Supplementary Medical Insurance (SMI) Trust Fund

Because of the way it is financed, through a combination of premium payments by individuals and debt financing by the Federal Government, the SMI program is not in immediate danger of insolvency. However, the growth rate in the cost of the program is so rapid that it is not sustainable in the long run. During my time as Chief Actuary the outlays for the Supplementary Medical Insurance Trust Fund (Part B of Medicare) increase from $7.8 billion in 1978 to $61.8 billion in 1994. This is an average rate of increase of about 14 percent per year. During that same 16 year period, benefits paid by the SMI Trust Fund increased from .32 percent of the U.S. Gross Domestic Product (GDP) to .89 percent of GDP. This occurred despite the fact that some of the costs of the program (such as for most home health benefits) were shifted to the HI program. Even during the last five years, which have been relatively favorable, expenditures by the program have increased 59 percent in the aggregate and 45 percent per enrollee. According to

the 1994 SMI Trustees report, SMI expenditures will be 3.27 percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be 4.05 percent of GDP by the middle of the next century when the Baby Boom will have been fully retired. As with the HI Program, these projections are being driven now by the coming demographic shift and the Baby Boom rather than pessimistic health care cost projections.

If some adjustments had been made to the SMI program years ago, this problem would never have developed to the size it is today. For example, if the SMI deductible had been indexed to increases in per capita program costs, and steps had been taken to ensure that Medicare supplemental plans did not neutralize the cost-saving features of the SMI deductible, then the outlays of the SMI program would be more than 25 percent lower than they are today. This would have allowed maintaining the SMI premium at $4.00 instead of the $42.80 it is today. At the same time, the government contribution to the program could have been nearly $5 billion less than it is today.

The outlays of the SMI program are excessive today due to two design features of the program which interact with each other to result in significant waste and abuse. These are the same two factors that are driving up health care costs for private sector health care plans.

The first factor is third party payment. When patients and

providers are spending other peoples money, they don't concern themselves with either the price or the quantity of services provided. Today, even the very modest cost sharing provisions of the original SMI Program have been eroded because they were not indexed to keep up with costs and because health care is, in effect, free for the 80 percent of SMI enrollees who buy Medicare supplemental policies or are eligible for Medicaid. Research conducted by HCFA's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who thus were subjected just to the (severely eroded) cost sharing provisions which exist in the Medicare program today, have significantly lower overall health expenditures. Moreover, an important research paper which will be published in Health Affairs, coauthored by Mark Freeland, Ph.D. and Al Pedon, Ph.D., shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third party payments. Their research shows roughly that every ten percentage point shift from out-of-pocket payments to third party payments results in an increase in the rate of growth of health care costs of about two percent, and this accelerated rate of growth persists for about ten years. In my opinion, this is the most important research conducted yet on health care costs because it explains the reason for the rapid growth in health care costs in the United States.

The second factor contributing to rapid growth in health care costs

is fee-for-service medicine. This factor interacts with third party payments to allow for unlimited increases in the volume and intensity of services provided to patients, without regard for the efficacy or cost effectiveness of those services. During the entire history of the SMI Program, most of the increase in per-capita costs have arisen from increases in the volume and intensity of services rather than price increases. During the ten year period ending in 1992, over three fourths of the increases in payments to physicians arose from volume and intensity increases.

The cost of health care can theoretically be controlled by removing either of the two offending factors---third party payments or fee-for-service medicine. Increasing coinsurance and deductibles is an example of dealing with the third party payment factor; introducing capitated services, as in the TEFRA Medicare Risk Program, is an example of dealing with the fee-for-service factor.

The problem that I have observed with the second approach is that the TEFRA risk sharing program is structured in such a way that, even if there were no risk segmentation, and with a 10 percent capitated penetration rate the most that could have been saved would have been 1/2 of one percent. However, because of risk segmentation, the TEFRA risk program has increased expenditures of the Medicare Program rather than reducing them.

If the costs of the Medicare Program were going to be controlled by

using managed care, then the structure of the program would have to be changed so that savings accrue to Medicare. This would have to be done in a way that didn't discourage managed care plans from participation in the program. Because of the extreme difficulty of balancing these conflicting goals, I'm not optimistic that managed care alone is a viable short term option for controlling costs in the Medicare program.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

SUMMARY OF TESTIMONY

The expenditures for both the HI and SMI programs have grown at rates that are unsustainable in the long run, and they continue to grow at those unsustainable rates.

The HI fund will be bankrupt by 2001. The tax rate necessary to support the current program will have more than double by 2020 and will have tripled by the middle of the next century. To place income and expenditures of the HI fund in balance even over the next 25 years would require either an immediate 34 percent reduction in expenditures or an immediate 52 percent increase in the HI tax rate, or some combination of both. Studies show that the solutions resulting in the greatest generational equity involve taking immediate action rather than delaying action and reducing the growth in benefits rather than increasing taxes.

According to the 1994 SMI Trustees report, SMI expenditures will increase from .89 percent of GDP in 1994 to 3.27 percent of GDP by 2020 and will be 4.05 percent of GDP by the middle of the next century.

The outlays of the Medicare program are excessive today due to two factors which interact with each other to result in significant waste and abuse. These are the same two factors that are driving up health care costs for private sector health care plans. The first factor is third party payment. The second factor is fee-for-service medicine. These factors interact to allow for unlimited increases in the volume and intensity of services provided to patients.

Senate Democrats Talking Points

REPUBLICAN BUDGET: MEDICARE AND MEDICAID

Issue: Though precise numbers are not yet available, Dole and Packwood have discussed cutting Medicare and Medicaid by $400 billion over seven years -- three times more than any budget proposal in history. Republicans will claim they are "restructuring" the programs to shore up the Medicare trust fund and to give states more flexibility with their Medicaid dollars.

Democratic Message: Under the guise of "restructuring" Medicare and Medicaid, Republicans are proposing to dismantle these programs to balance the budget and provide tax cuts for the wealthy. This shifts a disproportionate burden of deficit reduction to children, working families and seniors living on fixed incomes. If they are truly concerned about ensuring Medicare's solvency and slowing the rate of health care inflation, Republicans would accept Democrats' invitation to sit down at the table and work on a serious effort to reform our health care system.

TALKING POINTS: REPUBLICAN BUDGET

- Republicans have proposed slashing Medicare and Medicaid to balance the budget and finance tax cuts for the wealthy. These types of draconian cuts are an assault on the seniors and working families that depend on these programs.

- Republicans may hide behind the convenient cloak of Medicare Trust Fund solvency, but make no mistake about it, this effort will dismantle Medicare and Medicaid, not strengthen these programs. They are looking for short-term deficit reduction, not long-term solutions.

- If Republicans are so sincere about saving the trust fund, why does the Contract propose raiding it to pay for tax cuts for the wealthiest Social Security recipients? [The Contract proposes repealing the tax increase on a small percentage of upper-income seniors, proceeds of which go directly into the Trust Fund.]

- The only ways to produce the level of Medicare savings Republicans propose are to limit seniors choice of doctors by putting all Medicare beneficiaries into HMOs, shift more costs onto the elderly, or cut reimbursement to providers, destroying the hospitals and clinics upon which we all depend.

- Older Americans already pay almost one-quarter of their income for medical care. Cuts of this magnitude will mean that seniors over the next 5 years would pay at least $2,000 more out-of-pocket than they are already paying.

- Seniors will also be hit hard by the Medicaid cuts -- two-thirds of the Medicaid dollars support disabled Americans and elderly in nursing homes.

- The remaining Medicaid expenditures are largely for children and pregnant women. Medicaid now covers one fifth of all children, the majority of whom live in working families. Cuts of this magnitude will simply force states to push children off of the rolls, raising the number of kids without insurance.

- Democrats believe we must tackle problems with Medicare and Medicaid in the context of health reform. If we don't, the costs and problems in these programs will simply be shifted from the federal government to businesses, working families, providers and states.

- We have our health reform proposal and are ready to roll up our sleeves and get to work on a bipartisan plan that will strengthen Medicare and Medicaid and improve health care quality and access. When are Republicans going to get serious about health reform?

DRAFT

EFFECTS OF CAPPING MEDICAID

IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
  - ▸ About 60% of Medicaid spending services are for the elderly and disabled. (This includes acute care services, such as hospitals, physicians, and prescription drug coverage.)
  - ▸ About 35% of Medicaid spending is for long-term care.
- Republicans have proposed (through the use of a block grant with a 5% cap on growth) to cut federal Medicaid funding by more than $190 billion between now and 2002 -- a 30% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting $190 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. Even under optimistic assumptions, managed care could produce only about $10 billion in savings between now and 2002. The remaining $180 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.
- *Finding $180 billion in Medicaid cuts without cutting provider fees -- which are already much lower than in the private sector -- would require massive reductions in health coverage or services.*
  - ▸ *To protect coverage for the elderly and disabled, Medicaid coverage for over 20 million kids would need to be eliminated in 2002.*
  - ▸ *To protect coverage for kids, Medicaid coverage for over 3.5 million elderly and disabled people would have to eliminate coverage for in 2002.*
  - ▸ *To avoid dramatically increasing the number of uninsured and protect coverage for all Medicaid recipients, states could eliminate a long list of services by 2002. Even eliminating coverage for prescription drugs, home health care and other home and community-based services, hospice care, dental care, and EPSDT screening services for children would still not offset the Republican cuts in 2002.*
- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, states could save money only if they cut more than $190 billion out of Medicaid.

VARIATION ACROSS STATES

- An across-the-board 5% cap on Medicaid spending does not recognize significant differences across states, leaving some states even harder hit than these numbers suggest.

- Growth rates vary significantly across states and over time in a given state. Across states, variation results from differences in population, regional medical costs, enrollment patterns, and service mix. Over time, a state's growth rate can change because of recession or other economic factors.

- When a recession occurs in a state, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. With a cap on Medicaid, states would bear this burden.

- Ironically, states with the most efficient programs are most penalized by a 5% cap -- because it is hardest for them to find additional savings.

- Retirement states with large numbers of elderly residents would bear a disproportionate burden as the population ages.

- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission of the Future of Medicaid finds that a 5% cap on the growth of federal Medicaid payments would cost states over $167 billion between 1996 and 2002. [Note: This estimate is less than the CBO baseline estimate].

  - New York, California, Texas, Florida and Ohio would lose the largest amounts. New York would lose $18.5 billion, California over $14 billion, Texas almost $11 billion, Florida $9.5 billion, and Ohio over $7 billion.

  - States in the South and Mountain regions would have the biggest percentage reductions in federal payments. Reductions during the period would average over 20% in states such as Florida, Georgia, Arkansas, Colorado, Montana, West Virginia and North Carolina.

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

- Republicans claim that managed care can generate enormous savings.

  - But, there is no evidence that managed care alone can achieve the level of cuts they are proposing.

  - States already are aggressively pursuing managed care, but the populations for whom care can readily be managed -- children and AFDC adults -- account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

  - Applying managed care techniques to the services typically used by the elderly and disabled (such as long-term care) is largely untried, making the potential for savings hard to predict.

- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care also is not a real option.

- Some may point to low Medicaid growth rates in certain states as evidence that a 5% cap on growth is achievable.

- While a few states may be able to hold growth down to 5% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.

- Since 1992, 19 states have applied for state-wide health reform demonstration waivers from the Department of Health and Human Services. Under these waivers, states are able to change their Medicaid programs to increase efficiency and expand coverage. No state has projected an annual growth rate over the period at or below 5%.

- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.

EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans have proposed to cut Medicare funding by $300 billion between now and 2002 -- a 24% cut in 2002 alone.

- Medicare managed care cannot produce the magnitude of savings being proposed by the Republicans. For example, Senator Gregg predicts that managed care could save $35-45 billion between 1996 and 2000, although there is no evidence that managed care can produce Medicare savings of this magnitude. But even this overly optimistic projection produces less than one-third of the cuts being proposed by Republicans.

  - Claims that substantial savings can be achieved through Medicare managed care actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.

  - CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the necessary changes to the existing payment system would be "difficult to specify."

  - Even with an improved payment methodology, the savings to Medicare would be only a small percentage of cuts being proposed by Republicans.

- Even if the level of savings suggested by Senator Gregg (extended through 2002) for Medicare managed care could be realized, the proposed cuts would have serious impacts on beneficiaries and providers. If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:

  - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about $2,980 more for Medicare. In 2002 alone, they would be required to pay about $775 more.

  - In 2002 alone, a 9.3% cut in Medicare payments to hospitals, physicians and other health care providers would be needed.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.

  - There are now 40 million uninsured Americans, and this number will continue to grow.

- Huge Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

- ▸ *Republicans are talking about combined Medicare and Medicaid cuts of almost $500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts are passed on to private payers, businesses and families will be forced to pay $125 billion more for health care between now and 2002.*

- Reducing Medicare payments would disproportionately harm rural hospitals.

- Small rural hospitals -- often the only hospital in their county -- depend heavily on Medicare as a source of revenue. Many of these hospitals already are in financial difficulty and cannot absorb large Medicare payment reductions.

  - ▸ *Nearly 10 million Medicare beneficiaries (25% of the total live in rural America where there is often only 1 hospital in their county. These rural hospitals tend to be small and to primarily serve Medicare patients.*

  - ▸ *Significant reductions in their Medicare revenues will cause many of these hospitals, which are already in financial distress, to close or turn to local taxpayers to increase what are often substantial local subsidies.*

  - ▸ *Rural residents are more likely than urban residents to be uninsured, so offsetting Medicare cuts by shifting cost 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.*

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

- Despite the current rhetoric, Medicare 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 growing only about 1% faster than private health insurance.

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

THE WHITE HOUSE

WASHINGTON

March 28, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: CAROL RASCO CHR

SUBJECT: Families USA Prescription Drug Price Increase Report Analysis and Update

CC: Laura Tyson

You asked for an analysis of the recently released Families USA report on manufacturers' prescription drug price inflation and a more general update on this issue. The following attempts to be responsive to your request and concludes with a brief summary of potential policy options.

Background

As you know, inadequate prescription drug coverage represents one of our most difficult, expensive, and unsolved health policy challenges, particularly as it relates to older Americans. Facts that illustrate this point include:

- **Prescription drug costs remain the highest out-of-pocket health expenditure for three out of four seniors.**

- **Although they represent only 12 percent of the population, older Americans consume 34 percent of all retail prescriptions.**

- **A 1993 Urban Institute study found that 13 percent of seniors are forced to choose between purchasing food or needed medications.**

- **An AARP 1994 study found that fully 46 percent of older Americans (13.8 million) had no prescription drug coverage whatsoever** (no Medicaid, no Medigap, or no private retiree health coverage that covered medications.) Having said this, most of the "influential" elderly, i.e., those that contributed to the repeal of the Medicare Catastrophic Coverage Act, have some type of drug coverage and may not be interested in helping pay for something they already have.

Although not a required benefit, every state covers prescription drugs in their Medicaid programs. It is an expensive benefit, however, and there is little doubt that these **drug coverage programs will be vulnerable to major cuts or total elimination if Medicaid cuts of the magnitude that some Republicans in the Congress are now considering are enacted**. (The problem with this budget-driven strategy is that the short-term savings would be much more than offset by subsequent cost increases in hospitalization and mental health care.)

Families USA Report

The Families USA report, "Worthless Promises: Drug Companies Keep Boosting Prices," alleges that drug manufacturers have not been living up to their "voluntary" price constraint pledges. It accurately charges that the manufacturers continue to increase prices faster than the rate of general inflation for drugs that are sold to retail community pharmacies; as a result, out-of-pocket drug costs continue to grow even more burdensome, particularly for low income seniors.

The study reports that prices of the top 20 drugs used by all Americans increased in price 4.3 percent in 1993, or 1.6 times the 2.7 percent increase in general inflation (CPI). It also reports that the prices of the top 20 drugs used by older Americans increased by 4.0 percent in 1993, or 1.5 times the increase in general inflation.

The Families USA report also examines the profitability of the drug industry. It reports that from, 1989 through 1993, the median profitability of all industries was 2.9 percent, while drug industry profitability was 15 percent -- 5 times higher.

Analysis of Families USA Report

1. Inflation

The Families USA report chose to focus on inflation increases solely to retail pharmacists because they fill about 85 percent of all out-patient prescriptions. **However, had the Families USA analysis surveyed all purchasers, including HMOs, hospitals, mail order pharmacy, as well as retail pharmacists, it would have reflected price increases roughly equal to that of the general inflation rate.** (In 1994, e.g., the drug manufacturer's inflation rate was 2.6 percent compared with the 2.7 percent general inflation rate.)

The manufacturer's inflation rate drops when one incorporates the non-retail purchasers because the industry gives these purchasers deep discounts and restrains price increases. The manufacturers say they give these deals because the non-retailer purchasers -- unlike the retailers -- move drug product market share, primarily through the use of formularies. The retailers strongly believe they are being victimized by class of trade discrimination and have filed a class action suit alleging Robinson-Patman Act anti-competitive violations.

Regardless of which analytical model is used, there is no question that drug price inflation has significantly moderated since the days in the late 1980s and early 1990s when it frequently tripled the general inflation rate. However, since the vast majority of Americans purchase their prescriptions at retail pharmacies, they rightly perceive that the prices of their medication purchases are continuing to rise above the inflation rate. (This may help explain why the Families USA report has received such a receptive response.)

2. Profitability

The report's findings on drug profitability appear to be generally accurate. As you know, the drug manufacturers have always claimed that their high profits are necessary to attract investment in risky and expensive research. In the face of market pressures (through managed care, which now represents about 35–40 percent of the total outpatient drug market) and political pressures (through the White House, David Pryor, Bill Cohen, the media, etc.) to constrain price increases, the industry has been able to maintain its high profitability for several reasons. They include:

- **Significant mergers,** which have increased efficiency and eliminated duplication;

- **The growth of managed care and the accompanying centralization of drug purchasing,** which has enabled drug manufacturers to reduce the numbers of personnel utilized to sell (or "detail") new drug products; and

- **Aggressive movement into the generic drug marketplace** by the name brand manufacturers, which has enabled them to benefit from recent generic drug sales growth and to compensate for fact that many drugs are coming off patent.

Outstanding Questions

1. Inflation Moderation: Short or Long-Term Trend?

The obvious outstanding question relating to drug inflation is whether the recent positive trends represent a short or long-term phenomenon. Largely because the managed care market is expanding at unprecedented levels, it seems reasonable to assume that a recurrence of the price escalation the nation experienced in the late 1980s and early 1990s is unlikely -- at least for the immediately foreseeable future.

One threat to an inflation moderated era might be an attempt by some in the drug industry to take uncompetitive actions to confront the current competitive pressures. Some allege that the seeds of this problem are already being layed with the recent purchases of Pharmacy Benefit Management (PBM) companies (drug cost/management firms under contract with insurers and HMOs) by drug manufacturers. The purchase of three of the largest of these PBMs by Merck, Eli Lilly and Smith Kline means that manufacturers control 63 percent of the PBM market. The FTC has indicated that it is monitoring this trend very closely.

2. Retail Pharmacy as a Purchaser: What is their Status and Administration Position?

In the last Congress, in response to concerns raised by the retail pharmacy community, we incorporated a provision into the Health Security Act that explicitly prohibited class of trade pricing distinctions. Under HSA, as long as the retailers could prove they were providing the same economic benefit to the manufacturers that other purchasers were, the manufacturers would have to provide equal access to discounts. The enforcement stick was that the industry could not participate in our proposed new Medicare program if a violation was found.

The retail pharmacists strongly supported HSA largely because of the "equal access" provision; to their credit, though, they stuck with us (and the employer mandate) even in the worst of times. Predictably, the manufacturers hated this provision and lobbied extremely hard against it. (As a result, even in the last Congress, there was not a great likelihood that the provision would have survived even had some version of health reform passed last year.)

In the environment of a more drug manufacturer-friendly Congress and in a session that is highly unlikely to produce a traditional Medicare prescription drug benefit, the potential for passing an enforceable "equal access" provision appears to be dubious at best. In fact, the retail pharmacists may well decide they prefer their fate to be decided at the State level, in the courts, and through the development of their own competitive alternatives. (They may prefer this track rather than risk a lopsided defeat in the Congress.) On the competitive front, the chain drug stores just recently established their own Pharmacy Benefit Management company. This week we will be meeting with the retail pharmacy representatives (including Charlie West of NARD) to get a sense of their current position on this issue.

3. Lack of Adequate Prescription Drug Coverage: What are the Options?

The problem that will not go away is that the millions of low to middle income class Americans who have little or no prescription drug insurance coverage simply cannot afford their medications. The HSA provided for a prescription drug benefit in its basic insurance benefit for all Americans. It also included a Medicare drug benefit for all the elderly and disabled. However, a required standard benefit package and a $50-75 billion 5-year Medicare drug benefit is obviously not a politically or economically viable option at this time.

In response to your interest in this area, we have been working on three alternative drug coverage options. The first would require all Medicare managed care plans to offer a drug benefit. The second would create a Federally-funded drug benefit through the Medicaid program for those who are eligible for the Qualified Medicare Beneficiary (QMB) program. **The third option would provide for a new Federal Matching grant program to encourage States to set up pharmaceutical assistance programs** for low-income beneficiaries. Attached are some selected pros and cons of each. If you have any preferences, please let us know.

Option 1: Require Medicare Managed Care Plans to Offer Drug Benefit

Pros:

- No cost to Federal Government.
- Would increase from 35 percent to 100 percent the number of managed care plans that offer prescription drug benefits.
- Provides additional incentive for enrollment into managed care.

Cons:

- A required offering could be perceived as overly regulatory.
- Could lead to adverse selection of sick people into managed care plans and discourage managed care plans from entering market.
- Could be viewed by some advocates as presenting a Hobson's choice to the elderly: Choosing between keeping access to all doctors and need to have prescription drug coverage.

Option 2: Create a Federally Funded Prescription Drug Benefit through the Medicaid Program for Qualified Medicare Beneficiaries (QMBs).

Pros:

- Would cost substantially less than a full blown Medicare out-patient program (this option would cost about $9 billion over 5 years) and would better target the benefit to those who are most in need.
- Would use the established Medicaid program to expand coverage rather than set up a new funding/administrative mechanism.

Cons:

- Although States would not pay for the new drug coverage, they would likely face increased costs associated with greater use of the rest of the QMB benefit (because the drug coverage would attract more people.)
- Frequent changes in the eligibility status will make it difficult to distinguish between those who get the drug benefit because of their dual eligibility status or their QMB status. (In other words, it could well create administrative hassles and financing disputes with States.)

Option 3: Develop a New Federal Matching Grant Program for State-Run Pharmaceutical Assistance Programs for the Low Income

Pros:

- States would have discretion to determine eligibility and coverage.

Cons:

- Questionable that many States would opt to participate in an optional and potentially expensive new health program.