News From the

MEDICARE COMMUNICATIONS GROUP

A Project of the House Republican Conference

June 8, 1995

Dear Republican Colleague:

During the Memorial Day recess Frank Luntz attended several town hall meetings and focus groups on Medicare. The attached memo summarizes the key findings from these meetings.

The Frank Luntz memo underscores that we must continue to stress our four basic themes:

1. Medicare is going bankrupt
2. Republicans are committed to saving Medicare
3. We will spend more money – an additional $1600 per person
4. We are listening and want ideas from constituents.

We hope this information is helpful and please give any us a call if you have any questions.

Sincerely,

Dan Miller Jim McCrery Jim Greenwood

Republicans are committed to protecting, preserving and strengthening Medicare

THE
LUNTZ RESEARCH COMPANIES
Luntz Research & Strategic Services ■ The Public Opinion Company ■ Luntz Corporate ■ Luntz Worldwide

Memorandum

To: Interested Parties
From: Frank Luntz
Re: Everything You Ever Wanted to Know About Communicating Medicare
Date: June 7, 1995

"We have a problem with the national attitude. There is a feeling that, if I can get it, why not take it. You see it in Medicare every day."

"We are the patriots of America. We're the ones who hang our flags out on Memorial Day. Why should we be the ones who are asked to sacrifice yet again?"

With the help of the ***United Seniors Association***, we have conducted more than a half dozen focus groups and three town hall meetings with pre-retirees and current Medicare recipients during the Memorial Day recess and over the past few weeks. This memo summarizes our key findings. We hope it will assist you in future communication efforts.

AT THE BEGINNING

1. **You MUST communicate to your supporters as well as the overall senior community.** Keep in mind that seniors are very "pack-oriented" and are very susceptible to following one very dominant person's lead. You must ensure that balance exists at each town meeting, and be careful to keep individual anecdotes or isolated incidents from dominating (and driving) the process.

2. **Distribute the Summary of the Trustees' Report to everyone over age 50.** If you can't get a hold of enough copies of the actual summary, xerox the key passages and distribute them to your constituents ***as they arrive*** for your meetings, or place them on their seats before they arrive. Nothing is more credible and powerful than the report itself, and informing your constituents of the Trustees' findings ***(reading to them word-for-word the most egregious conclusions)*** must be at the core of your communication strategy.

3. You absolutely must tell people at the outset that the Trustees include high-level Clinton Administration officials -- list who they are by name. Your audience will recognize many of the names, and that will give credibility to your defense that your efforts to strengthen Medicare are non-partisan. Remind your constituents that these Trustees warned in last year's report that Medicare was headed for bankruptcy. We cannot wait any longer to begin the rescue of the system.

4. Personalize YOUR interest in Medicare. This must take place at the very beginning of your presentation. Reassure your seniors that this issue affects you personally, and not just in theory (otherwise you may come across as an accountant rather than a human being). Talk about your parents, relatives or life-long friends currently on Medicare. For those of you in your late 50s or early 60s, you can talk about your own countdown to the day you yourself will qualify.

5. Your Number One Priority is to save Medicare. "Saving, preserving and strengthening" Medicare needs to be repeated as the central theme at the beginning, during the session and at the close. Let your seniors know that you personally will not allow a program for 37 million people to go bankrupt by ignoring its current problems.

GENERAL COMMUNICATION TIPS

There are certain communication *rules* that apply to Medicare that don't apply to other issues. Words are especially important, and setting the right tone at the outset is critical.

1. You MUST appear bi-partisan. The responses in our recent Town Halls say it all:

   - *"We sent you all to Washington to work for us, not play sides! We want the best for all people, Democrats and Republicans. You need to work together for the good of all the country."*

   - *"The unity of both parties is essential. A new broom sweeps cleaner."*

   Partisanship also affects whether or not people trust the Medicare numbers you offer. Right now, the Trustees' Report is the most credible source because it lacks partisan identification (CBO credibility is questionable because of the word "Congressional" -- and no one knows what the initials mean by themselves). Be careful not to come across too harshly against the Dems, but it is acceptable to ask rhetorically for President Clinton's help.

2. Don't talk about "improving" Medicare -- you are strengthening it. We cannot afford to raise expectations, but that's exactly what you will do if you tell seniors you're going to "improve" Medicare. When seniors hear the words *improve* and *Medicare* in the same sentence, they immediately think of lower deductibles, free prescription drugs, subsidized hearing aids and eye glasses, cheaper in-home care, and reductions in everything else they now have to pay for. ***The quickest path to defeat is to overpromise seniors.***

3. The newspaper is still very important to seniors. Seniors diligently read the newspaper, and they often clip articles about fraud and abuse involving Medicare. This is one issue where print media is as important as television or radio – if not more so. Consequently, clip several local newspaper articles about Medicare waste and/or fraud and bring them to your town hall meetings to distribute to attendees. The word will spread rapidly.

4. Seniors read their mail and scrutinize their hospital and doctor bills. Everyone has a story to tell, though none as poignant as this one:

> *"I went in for eye surgery and they charged me for an autopsy. I complained and they came back and said 'I'm sorry Mrs. Colby but that should have been for an EKG.' I told them I didn't have one of those either."*

We were bombarded with anecdotes of over-billing, double-billing and false-billing. Ask your constituents to write your office with their accounts of abuse and also devote the first fifteen minutes of your meeting to "fraudtoids." Beginning this way helps pave the way for the following arguments about the need for change, while also letting you know at the outset who's with you and who's against you.

THE EDUCATIONAL PROCESS

The public in general, and the older population in particular, is moving in our direction, but it has been and will continue to be a slow, deliberate process. Seniors are distrustful of Washington, know their own strength as a political constituency, and simply do not believe their elected officials will turn their back on a such a strong voting block.

Knowledge

1. No one believes Medicare will actually go bankrupt. A growing number of seniors are familiar with the current Medicare debate, but they still enter the room skeptical. They have great difficulty trusting the government's numbers when they feel they've been lied to in the past (and proposed changes in how COLAs are calculated are making it worse).

2. Seniors will not even consider changes in Medicare until they're convinced the system's going broke. Before talking about new options the need for reform must be clarified. *Between now and the July 4th recess, you need to concentrate on educating the public on the problems with Medicare rather than talking about your solutions.* We will be hit hard in September if we have not laid the groundwork for our ultimate proposals. ✓

3. Explain what bankruptcy really means, and why dipping into general revenues to sustain Medicare is not an option.

4. The difference between Medicare and Medicaid is still not widely known. As a recent front page *Washington Times* headline can attest, few people distinguish between Medicare and Medicaid. It is therefore not surprising that even when quoting written articles, seniors also don't know the difference between the two. Make sure you explain the difference early in your presentation.
Seniors particularly hate the idea that legal and illegal aliens are receiving ✓ government benefits in general, and Medicare or Medicaid in particular.

5. Remind audiences about changes in retirement patterns over the past thirty years. Seniors know their life expectancy is significantly longer now than it was in the 1960s. They recognize they will be spending more years in retirement, and are therefore taking more out of the system. This begins to build the case for Medicare transformation.

Cost/Financing

> *"I know I live in a never-never land. I don't care about the medical charges because I'm not paying for them."*

> *"The hospital tells me 'Why are you worried about costs. You don't pay for it. Medicare does.' It's that attitude that causes prices to go up."*

This is at the crux of our argument. If we can't prove that Medicare is going bankrupt, we'll never be able to sell our solutions. Plan on spending no less than 30 minutes -- and up to an hour -- discussing the numbers alone. You cannot move on until your audience fully understands the financial ramifications.

1. **Seniors realize that they're getting a great deal. Understandably, they're reluctant to give it up.** It is therefore necessary to explain that while they may like what they have *now*, it won't be there *in the future* unless real changes are made. This is why so much effort must be devoted to the simple task of explaining that Medicare is going broke.

2. **Seniors use specific figures to make their points. So should we.** When discussing waste and over-billing, a surprising number of seniors point to $10 aspirins, $150 eye exams, and can remember the cost of their hospital bill to the penny. They have the ability to remember the cost of a single drug and a particular procedure because they *personalize* rather than *globalize* their medical care. We must do the same. **Informing Medicare recipients that the average couple will take out over $100,000 more from Medicare than they have contributed to the system personalizes Medicare's impending bankruptcy (use exact numbers) in the same manner as a $10 aspirin personalizes its abuses.**

3. **The potential need for increasing premiums by 300% is the "Killer Stat." No one knows this, but the information is believed.** After seniors are presented with the financial information on Medicare, they will inevitably ask for the consequences. Showing them the chart about what happens to Medicare if it goes bankrupt immediately disrupts the complacent atmosphere. The possibility that Medicare premiums will increase by 300% is simply not acceptable to seniors -- and they will do anything to prevent this from happening. (Note: The other options, such as increasing taxes on working class families, produce virtually no reaction.)

4. **Even if YOU keep Medicare and the budget separate, your constituents may not. Be prepared.** As more than one participant volunteered, *"Republicans say they're going to balance the budget in seven years, but they also tell us that Medicare is going broke in seven years. Is this just a coincidence?"* We are strengthening Medicare because we are committed to its survival. We are balancing the budget for our children and the next generation of Americans. We will succeed on both counts because we must succeed on both counts.

Waste, Fraud & Abuse

The same people who believe eliminating foreign aid will balance the budget also believe that eliminating waste, fraud, and abuse will solve the Medicare problem. For seniors, the government may be the enemy, but the real emotional venom is reserved for doctors and hospitals. What a paradox -- the very people who help keep them alive are the very people they hate the most. Everyone has a story or complaint:

- *"The doctors they all want a piece of the pie. Just yesterday, the doctor charged me $150 just to look at my nose."*

- *"The medical profession is milking Medicare the doctors, drug suppliers and others in the medical industry. They're making too much money. They all don't need to drive a Mercedes or BMW. Some should be driving Chevys."*

1. **Separate waste (defensive medicine) from fraud (deliberate defrauding) from abuse (double billing, mis-billing).** When seniors complain about "waste, fraud and abuse," they actually mean three very distinct problems with the current Medicare system. To seniors:

   Waste involves the unnecessary and costly tests and procedures that recipients have to undergo because the doctors and hospitals are practicing defensive medicine. Seniors have only limited sympathy for doctors and hospitals in this situation. *"Why don't we go after the medical community to decrease their fees, or at least stop recommending so many tests."*

   Fraud is the deliberate attempt by doctors and hospitals to milk Medicare for every dime. Seniors want these people prosecuted to the fullest extent of the law. *"Some of these doctors keep having their patients come back and come back and come back, and it's positively unnecessary."*

   Abuse is the non-deliberate billing mistakes that Medicare recipients believe take place all the time. Well over half of all seniors have personal experience with Medicare abuse -- and they all want to talk about it. *"Why can't the government train personnel to pull medical records like the income tax and check to see if doctors or hospitals overcharge? Maybe doctors and hospitals would be more careful if they thought they would be checked."*

   Understand that the combination of "waste, fraud and abuse" has produced a virulent anti-physician mentality in the eyes of seniors.

2. **Waste, fraud, and abuse cuts two ways.** We must be careful not to suggest to seniors that Medicare will be fine if we eliminate all the waste, fraud and abuse in the system. Seniors are willing to accept the need for reform because of the many problems they see with the system, but they will not understand why they have to pay more for what they have now even after all the waste, fraud and abuse is eliminated.

OTHER FINDINGS

1. **"Choice" is not a high priority with seniors.** Medicare recipients are less concerned with choice of plans than they are with stability and maintaining their current doctor-patient relationship. This is especially true with older seniors. They must be told again and again that they will be able to maintain their current Medicare situation if they so choose.

2. **Don't raise the Social Security issue.** Seniors with good memories recall when Congress told them Social Security was going broke. They remember that Congress made changes to the system, and they don't expect to have to revisit it anytime soon. Any mention of future problems with Social Security only angers seniors and makes them less willing to discuss changing the Medicare system.

AT THE END

1. **Let your constituents know that other seniors' groups exist.** Show your seniors that AARP is not the only seniors' representative on Capitol Hill or nationwide. Bring information about the *United Seniors Association* and other groups who are doing good work on behalf of the elderly, and encourage people to investigate alternative points of view. The more we educate seniors to AARP alternatives, the more successful we will be.

2. **Remind your audience that Republicans want to "*INCREASE* spending but at a slower rate."** This language works. Remind your constituents that only in Washington is an increase from $4,800 to $6,400 (a 33% increase) per recipient defined as a cut.

3. **Republicans must be seen as the party of hope; the party that took on the problems of Medicare head-on.** It is the Democrats who are using "scare tactics" by allowing a program to go broke, to be riddled with waste and fraud, to become overly bureaucratized without offering a solution or even acknowledging a problem -- all just to score political points. Republicans *will* find a solution. For our efforts to be successful, *we have to make the status quo a worse option than change.*

4. **You must solicit citizen input.** *"Government seems to be trying and is willing to listen to us old guys."* said one town hall participant. Public opinion and input must be a key component of the process. Allowing seniors – and not just Washington insiders – to work on creating a strengthened Medicare system will help these seniors accept changes to the system.

5. **You must have the last word in this debate.**

> *"I have gone from a negative opinion to a more positive one*
> *I think you will make progress on this matter."*

This is what we need to hear. For too many seniors, it will be the last word that ultimately sways them. We need it to be ours. Don't end your town meetings, interviews, or public communication efforts on a down note. Do not assume that just because AHA or AARP hasn't targeted your district, or that only two people came up and talked to you about Medicare last week, that you are out of the woods. This issue is *live* and will remain so right up until Election Day.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

25-Jul-1995 04:03pm

TO: Jennifer L. Klein

FROM: Seth E. Masket
Presidential Correspondence

SUBJECT: Proposed Rick Davidson letter

[Here's the draft. It's based on the information I got from you and the material you faxed to me. Please let me know if it will work. Thanks for your help. -Seth]

Dear Rick:

Thank you for your letter about Medicare and Medicaid. I appreciate your involvement in this important issue, and I understand the concerns that led you to write.

We all agree that Medicare and Medicaid need to be reformed if they are going to continue to provide their important services well into the future. However, there is a right way to reform and there is a wrong way. The Republicans have chosen the wrong way. Their Medicare "voucher" proposals will reduce services for beneficiaries while raising costs for many patients.

My health plan, however, seeks to reform Medicare in the right way. It will strengthen the Medicare Trust Fund, offer more choice of health plans, and provide new benefits without imposing new beneficiary ~~cuts~~. My plan calls for only the smallest cuts in Part A of Medicare that are needed to extend the solvency of the Trust Fund through the year 2005. Similarly, my plan will preserve Medicaid while reforming it to make it work more efficiently.

Additionally, my Administration shares your interest in improving and extending the managed care choices available to beneficiaries. While we must keep in mind the limits of a rapid expansion of managed care in Medicare, we should allow the beneficiaries themselves to determine the pace of their movement to managed care plans. Clearly, managed care will have an even more important role in Medicare's future than it does today, and I look forward to working with you to make these changes work for the American people.

Again, thank you for writing. As we move forward in our efforts,

I will certainly keep your concerns in mind.

Sincerely,

Bill Clinton

REPUBLICAN VOUCHER PROPOSALS OFFER FALSE CHOICES

- **Republicans Offer the Ultimate False Choice: You Can Choose to Pay More OR You Can Choose to Get Less.** Under the Republican "voucher" plan, beneficiaries who wish to keep their fee-for-service plan and a guarantee of their choice of doctor will have to pay significantly more. Even those beneficiaries who go into managed care will have their current benefits threatened. This is because the Republicans' overly tight growth rates will, over time, diminish the value of the voucher and the type of coverage it can purchase.

- **The Republican Medicare working document provides a preview of what is in store** for beneficiaries who want to keep their fee-for-service plans. Specifically, preliminary estimates by HCFA indicate that in 2002:

  -- **The average beneficiary receiving home health care services would pay about $1,020 more.**

  -- **The average Medicare recipient of skilled nursing home services would pay about $1,000 more.**

  -- **Every beneficiary choosing to stay in the fee-for-service plan would pay at least $400 more in Part B premiums.** Couples would pay $800 more and this does not include any other additional copayment and deductible increases that the Republicans have yet to specify.

- **Republicans Slash Medicare Growth Rate Levels Far Below Private Sector.** The Republicans claim they want to emulate the health care cost containment successes of the private sector. Permitting Medicare to grow at a 7.1 percent pace -- CBO's projection of the per person growth rate in the private sector -- would save significant Federal dollars. However, the Republican $270 billion in cuts would constrain Medicare to a much tighter and unrealistic 4.9 percent per beneficiary growth rate. That is not emulation; that is decimation.

- **Capped Vouchers Mean Cruel Medicare Birthday Present.** At best, on the eve of the 30th anniversary of Medicare's enactment, Republicans would force beneficiaries to pay much more to keep what they have today. Since 75% of these beneficiaries have incomes below $25,000, it's hard to imagine how they could afford to do so. At worst, beneficiaries would be forced to buy coverage that doesn't meet their needs. **That's not choice; that's financial coercion.**

- **The President's Plan Offers Real Choice and Has No New Cost Increases.** The President's approach shows that you can strengthen the Medicare Trust Fund, offer more choice of plans, and provide new benefits without imposing new Medicare beneficiary cuts. **In contrast, Republican House Majority Leader Armey says that Medicare is "a program I would have no part of in a free world."**

#

Revised July 18, 1995

July 20, 1995

MEMORANDUM FOR JENNIFER KLEIN AND JASON GOLDBERG

FROM: Zoë Neuberger

SUBJECT: Statements on Medicare

Speaker Newt Gingrich

May 7, 1995:

> *"Forget the budget pressure, let's find out what number saves Medicare. We'll plug that into the budget. We're not going to find out what number the budget needs and try to reshape Medicare to that effect."* (on "Meet the Press"; Source: Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*)

> *"We are going to propose to keep the current Medicare system for anyone who wants to stay in it. . . . and we're going to do everything we can to keep that system operating exactly as it does now."* (Source: *The New York Times*, May 8, 1995)

April 28, 1995:

> *"Every penny saved in Medicare should go to Medicare . . .It should not be entangled in the budget debate."* (Source: *The Wall Street Journal*, May 1, 1995)

Congress Member Clay Shaw (June 25, 1994):

> *"We have here in this bill the seeds of the destruction of Medicare . . . let's not destroy a health care program in this country that we know works and that our seniors are depending on."* (source: Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*, May 8, 1995)

Senator Bob Dole (July 30, 1985):

> *"Much of our significant gains and life expectancy, improvement in the quality of life, and decreases in infant mortality can be directly attributed to the passage of the Social Security Amendments of 1965. The Medicare and Medicaid programs have played a central role in improving both access to and quality of health care services for the country's elderly, poor, and disabled. Equally significant, it may be argued that Medicare and Medicaid have provided a foundation for the phenomenal growth and the dissemination of new medical technologies that now contribute to the well being of all the people of all nations."* (Source: Democratic Policy Committee, United States Senate, Special Report: *Medicare's 30th Anniversary*, July 14, 1995)

The Future Of MEDICARE

Moving Toward The 21st Century

May 25, 1995

Dear Colleague:

For almost 30 years, older and disabled Americans have depended upon Medicare to help cover their medical expenses. But as the program enters its fourth decade, its only certainty is that it is targeted for change.

To stimulate a free-flowing and wide-ranging exchange of ideas about the direction of Medicare in the next 10 years and beyond, the American Association of Retired Persons (AARP) Andrus Foundation and *Health Affairs*, the nation's leading health policy journal, will convene a conference, **The Future of Medicare: Moving Toward the 21st Century,** July 20 and 21, 1995, in Washington, DC, at the Omni Shoreham Hotel.

We invite you to join nationally recognized policy experts and researchers at this important conference for in-depth discussion and debate of the broad spectrum of issues facing Medicare.

Different points of view about what the future direction of Medicare should be – ranging from traditional fee-for-service and regulated marketplace FEHBP models to voucher/privatization proposals – will be captured in four "big picture" presentations by:

Henry J. Aaron and *Robert D. Reischauer* of The Brookings Institution;

Stuart M. Butler of The Heritage Foundation;

Karen Davis and *Marilyn Moon* of The Commonwealth Fund and The Urban Institute, respectively; and

Gail R. Wilensky of Project HOPE.

Reactor panels of experts chosen to represent a range of views will provide commentary on each presentation. The audience will be given time to ask questions and make observations.

Bruce C. Vladeck, HCFA Administrator, will deliver the keynote address, and an historical perspective of the Medicare program will be provided by *Robert M. Ball*, Commissioner of Social Security from 1962 to 1973.

Other sessions will include a panel discussion of consumer concerns such as the patient/provider relationship, ethical issues, and quality considerations; and a presentation by polling experts about public opinion issues.

This is your opportunity to be part of meaningful discussion of the long-term direction of Medicare; not marginal improvements, but real solutions. We hope you will be able to join us.

Sincerely,

Horace B. Deets
Executive Director
AARP

John K. Iglehart
Founding Editor
Health Affairs

The Future Of MEDICARE

Moving Toward The 21st Century

Agenda for Thursday, July 20

8:15 - 9:00 a.m.	**Registration**	Palladium Room
9:00 - 9:15 a.m.	**Welcome, Introductions, Acknowledgment of Sponsors**	Palladium Room
9:15 9:45 a.m.	**Medicare: An Historical Perspective** Presenter: Robert Ball	Palladium Room
9:45 - 10:30 a.m.	**Medicare: Current Trends and Future Directions** Presenter: Bruce Vladeck Audience Participation	Palladium Room
10:30 - 10:45 a.m.	**Break**	
10:45 a.m. - 12:15 p.m.	**The Future of Medicare: I** Authors: Henry Aaron and Robert Reischauer Moderator: Marina Weiss Reactor Panel: 1. To be determined 2. Shoshanna Sofaer 3. Karen Ignagni Audience Participation	Palladium Room
12:15 - 12:30 p.m.	**Break**	
12:30 - 2:15 p.m.	**Lunch**	Blue Room
	The Medicare Program: What the Polls Show Presenters: Robert Blendon and Bill McInturff Audience Participation	Blue Room
2:15 - 2:30 p.m.	**Break**	
2:30 - 4:00 p.m.	**The Future of Medicare: II** Authors: Stuart Butler and Robert Moffit Moderator: Stan Jones Reactor Panel: 1. Howard Cohen* 2. Judith Feder 3. Peter Fox Audience Participation	Palladium Room

*invited but not confirmed

[redacted]

4:00 - 4:15 p.m.	**Break**	
4:15 - 5:45 p.m.	**The Future of Medicare: III**	Palladium Room
	Authors: Karen Davis and Marilyn Moon	
	Moderator: John Iglehart	
	Reactor Panel: 1. Tom Scully	
	2. Andi King	
	3. Richard Kronick	
	Audience Participation	
6:00 - 7:00 p.m.	**Reception**	Empire Room

Friday, July 21

7:45 a.m.	**Continental Breakfast**	Palladium Room
8:15 - 9:00 a.m.	**Medicare: A Unique Provider/ Hill Perspective**	Palladium Room
	Presenters: Representative Jim McDermott and Senetor Bill Frist	
	Audience Participation	
9:00 10:30 a.m.	**The Future of Medicare: IV**	Palladium Room
	Author: Gail Wilensky	
	Moderator: Lynn Etheredge	
	Reactor Panel 1. David Abernethy	
	2. Mary McGrane*	
	3. To be determined	
10:30 - 10:45 a.m.	**Break**	
10:45 a.m. - Noon	**The Future of Medicare: The Consumer Perspective**	Palladium Room
	Moderator: Christine Cassel	
	Panelists: 1. Robert Brook	
	2. Joanne Lynn	
	3. Heather Palmer	
	Panel Discussion and Audience Participation	
Noon- 12:30 p.m.	**Summation/ Closing Observations**	Palladium Room
	Presenter: Uwe Reinhardt	
12:30 p.m.	**Adjournment**	Palladium Room

*invited but not confirmed

[redacted]

July 14, 1995
Publication: SR-4-Social Services

dpc special report

Medicare's 30th Anniversary

- ❑ A Democratic Vision
- ❑ An American Success

DPC Staff Contact: Dave Corbin (202-224-3232)
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Democratic Policy Committee
United States Senate
[illegible] D.C. 20510-7050

Thomas A. Daschle, Chairman
Harry Reid, Co-Chairman

Medicare's 30th Anniversary

❑ A Democratic Vision
❑ An American Success

On July 30, 1965, President Lyndon B. Johnson traveled to Independence, Missouri, and, in the presence of former President Harry Truman, signed Medicare into law. That simple ceremony marked the end of a long struggle for Democrats trying to enact the measure, and the beginning of a new era of health and economic security for America's seniors.

President Franklin D. Roosevelt envisioned an America with financial security for Americans who retire after years of hard work and a health care safety net for all Americans. He was able to achieve part of that dream, when he signed Social Security into law in 1935. But the struggle for health care protections would last for decades. The historical record is clear: If it had been up to the Republican Party, Medicare never would have been enacted.

President Harry Truman offered several proposals to Congress. President John F. Kennedy made health care for seniors an issue in his 1960 campaign and saw his plan defeated in the Congress. Only after Democrats called the 1964 election a "mandate" for Medicare, and Democrats triumphed at the polls, did the Democratic vision of Medicare become a reality. Even then, the majority of Congressional Republicans voted against it.

Today, Medicare provides health care security for more than 36 million Americans. It is the only way most seniors could ever acquire adequate health care in today's health care market. Medicare helps seniors both obtain the health care they need *and* remain financially secure and independent.

Medicare is an efficient program. Administrative costs are only two percent of its budget—a fraction of the administrative costs of private health care plans. It is a responsible program: Beneficiaries contribute to the medical expenses through premiums, co-payments, and deductibles.

Public support for Medicare is extremely high. Eighty-nine percent of Americans support Medicare, and that support is strong among all age groups.[1] Medicare can be improved; but it must be protected. It should not be assaulted under the guise of deficit reduction or to provide tax breaks for the wealthy—as Republicans now propose.

Thirty years ago, Medicare was part of the Democratic vision for a better America. Today, it still is. This report chronicles the struggle to enact Medicare, and shows how, three decades later, Medicare truly is an American success story.

A Democratic Vision from the Start

In his message to Congress on January 17, 1935, urging passage of Social Security, President Franklin Roosevelt explained that the goal of the program was to provide for:

> *"the security of the men, women, and children of the Nation against certain hazards and vicissitudes of life."*

An important part of that security, President Roosevelt explained, was health care. Social Security would become law and provide what President Roosevelt called "some measure of protection...against poverty-ridden old age."[2]

But a national health care plan in any form was repeatedly met with intense, well-financed opposition.

In Congress, Democratic Senators Robert Wagner (NY) and James Murray (MT) and Representative John Dingell (MI) introduced several national health care proposals. No action was taken on any of them.

With the administration of President Harry Truman, the idea of national health care gained strength and momentum. Shortly after taking office, President Truman proposed a comprehensive, prepaid medical insurance plan for persons of all ages. In his Special Message to Congress Recommending a Comprehensive Health Program (November 19, 1945), Truman declared:

> ***"Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection."***

Congressional Republicans opposed this effort by raising the specter of government controlled medicine—in a word, socialism.

Senator Robert Taft (OH), the leading Republican spokesperson in Congress at the time, called it:

> *"the most socialistic measure that this Congress has ever had before it."* [3]

Republican Representative Charles A. Plumley (VT) charged:

> *"Behind this alleged humanitarian program is to be found the basis and genesis for a planned and socialized America....It is a proposal to establish a form of socialism, a socialistic government as unadulterated as if it came from the sanctified pen of Karl Marx himself."* [4]

Hearings were held, but no further action was taken.[5]

President Truman's Second Effort

Two years later, President Truman was back with another proposal for national health insurance. In his "Special Message to the Congress on Health and Disability" (May 19, 1947), he declared:

> *"A great and free Nation should bring good health care within the reach of all its people....Healthy citizens constitute our greatest national resource."*

"With Republicans in control of both chambers of Congress in 1947-48," as *CQ Almanac* later noted, "there was no chance for enactment."[6] Again, hearings were held, but no further action was taken.[7]

President Truman Persisted

In a Special Message to the Congress on the Nation's Health Needs (April 22, 1949), President Truman, for the third time, called for national health insurance:

> *"The best hospitals, the finest research laboratories, and the most skillful physicians are of no value to those who cannot obtain their services."*

Republican opposition again appeared in full force. This time, Senate Republican Leader Senator Robert Taft (OH) exclaimed:

> *"This is not insurance. It is a plan for government administration of all medical services....Regardless of form, first a socialization of medicine, and second, a transfer of all control over health activities from the States and local government to a Washington Bureau."* [8]

Again, no action was taken.[9]

Democrats Focus on Seniors

In the face of staunch and well-financed Republican opposition to providing health care security for all Americans, Democrats decided to focus their efforts on America's elderly.[10]

According to the Truman Health Commission, the elderly were poorer and less insured than the general population. For one thing, health insurance firms would not insure such high-risk groups without exorbitantly high premium payments.[11] With their low income levels, America's aged often could not afford health insurance. As proponents of Medicare pointed out, "the cost of medical care is beyond the reach of many older citizens."[12] Sometimes the elderly found themselves uninsurable regardless of cost—largely because of their age or medical condition.

Congressional efforts. In 1957, Democratic Representative Amie Forand (RI) proposed a Social Security approach to health care for the elderly, the first "Medicare"-type proposal. Several versions of this proposal were offered in Congress, but all of them met similar fates—committee hearings were held, but no action taken.

In 1960, the "medicare" concept gained an important supporter. Democratic Senator John F. Kennedy (MA) sponsored a version of the Forand bill, pointing out:

> *"Unfortunately, voluntary health insurance has not and cannot do the job....The very competition between insurance companies tends to either exclude older people or limit their protection. If benefits are restricted, the very purpose of the insurance is defeated."* [13]

Senator Kennedy then quoted a letter from a constituent that read:

> *"It is impossible for a wage earner to put away enough in a lifetime to pay for six months in a hospital."* [14]

Later that year, JFK became the Democratic presidential nominee and announced that enactment of "medicare" legislation was one of his chief legislative goals for the August session.[15]

The Eisenhower Administration, which considered such national health care programs as "socialistic," opposed the Democratic proposal.[16]

Congressional Republicans also assailed the plan.[17] It was wrong, Senator Barry Goldwater (AZ) explained, because:

> *"social welfarism, in its most advance form, has always been an inseparable part of totalitarian systems, ancient and modern, Fascist and Communist, openly brutalitarian or heavily disguised as benevolent despotisms."* [18]

As a result of this Republican opposition, on August 23, 1960, the Senate defeated Kennedy's first attempt to provide health insurance for the Nation's elderly. Ninety-seven percent of Republican Senators voted no.

President Kennedy's Priorities

Presidential candidate John F. Kennedy made health insurance for the elderly a campaign issue in the 1960 presidential election. As president, he was determined to see Medicare enacted.

In a Special Message to the Congress on Health and Hospital Care on February 9, 1961, President Kennedy proposed a health care program for the aged to be financed by an increase in the Social Security tax. President Kennedy declared:

> *"Twenty-six years ago this Nation adopted the principle that every member of the labor force and his family should be insured against the haunting fear of loss of income caused by*

retirement, death, or unemployment....But there remains a significant gap that denies to all but those with the highest incomes a full measure of security—the high cost of ill health in old age."

A few days later, President Kennedy's Medicare plan was introduced in both Houses of the Congress. The *Hospital Insurance Benefits Act of 1961* (King-Anderson bill), was introduced in the Senate by Democratic Senator Clinton Anderson (NM) and in the House by Democratic Representative Cecil King (CA).[19]

Hearings were held, but there was no further action.

President Kennedy Persists

In the second year of his Administration, President Kennedy renewed his push for Medicare. The Kennedy administration promised a "great fight across this land" to secure the enactment of Medicare.[20]

On May 20, 1962, at a Sunday afternoon rally in Madison Square Garden in New York City sponsored by the National Council of Senior Citizens, President Kennedy launched a new campaign for what became his "Medicare" health care program. The speech was carried via closed circuit television to similar rallies in 32 major cities at which cabinet members and other public officials spoke to mass gatherings in support of the needed health benefits.[21]

Republicans again raised the specter of socialized medicine. Republican Senator Carl Curtis (NE) exclaimed:

"The enactment of the Kennedy proposal means government medicine."[22]

This time Medicare came to a vote in the Senate when Democratic Senator Clinton Anderson tried to add it to a Social Security measure. In a dramatic, down-to-the-wire roll call vote on July 17, 1962, however, the measure lost by two votes. Once again, Republicans were united in their opposition—86 percent of Republican Senators voted against it.

JFK's Third Effort

With the opening of the 88th Congress, President Kennedy, for the third time, requested passage of Medicare in his "Special Message on Aiding our Senior Citizens" (February 21, 1963). Democratic Representative King and Senator Anderson again introduced the Medicare bill.[23]

Again, Republicans quickly rose to denounce it.[24]

In the 88th Congress, there were hearings but no further action.[25]

President Johnson Takes Up the Cause

After President Kennedy's assassination, President Johnson took over JFK's efforts on behalf of Medicare. When second session of the 88th Congress opened, President Johnson urged enactment of a "medicare bill."[26]

During the Senate debate on a bill to increase Social Security benefits in July of 1964, (**H.R. 11865**), Senator Albert Gore, Sr. (TN) offered a medicare bill as an amendment.

Senator Gore proclaimed:

> *"We are dealing with the most pressing, unmet problem of our society....What happens when a serious illness strikes? Current income which is needed for groceries and rent must go for medical care. Savings must be depleted. The home may have to be sold. Then, hat-in-hand, this formerly self-sufficient, self-reliant, respected member of the community must go to the welfare people and beg for a handout. This is a disgrace in a country such as ours."* [27]

Opponents of Medicare were as determined to defeat the needed health care measure as President Johnson and Congressional Democrats were to enact it.

Congressional Republicans seemed to come up with every possible excuse to oppose and vote against health care for America's elderly.

They called it socialism.

- Republican Senator Gordon Allott (CO) called it a "foot in the door" for socialized medicine.[28]

They said it would destroy the best health care system in the world.

- *Republican Senator James Pearson (KS):* "American medicine has achieved an unprecedented level of development through its own efforts....It would appear foolish to endanger this high level of initiative and performance by imposing the heavy blanket of government supervision. A Federal health program, financed under Social Security, would represent such a danger."[29]

They said it would not work.

- *Republican Senator Carl Curtis:* "This amendment would be a great disappointment to older people."[30]

- *Republican Senator James B. Pearson:* "[I]t would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices."[31]

They said it was too bureaucratic.

- *Republican Senator Roman Hruska charged:* "With Federal funds come Federal control. In the area of medical care, Federal interference presents frightening prospects."[32]

They said it would wreck the Social Security System.

- *Republican Senator Jack Miller (IA):* "I believe that most people do not wish to have the social security program threatened by any unsound financial tinkering such as this amendment represents."[33]

- *Republican presidential nominee, Senator Barry Goldwater (AR) characterized* Medicare as the "most significant step" in making Social Security a relief and charity organization.[34]

This time, the Senate approved the Medicare amendment by a vote of 60-28 on September 3, 1964. Again, a majority of Republican Senators acted against Medicare. Eighty-five percent voted to kill it. The measure did not survive the joint House-Senate conference on **H.R. 11865**, the *Social Security bill.*[35]

The National Referendum

In an important, dramatic move, the sponsor of the 1964 Medicare amendment,[36] Democratic Senator Albert Gore (TN) called for the 1964 election to be a "mandate" on Medicare. Senator Gore proclaimed:

> *"This means that the President will go to the people and ask for a mandate on this issue."* [37]

President Johnson took up the challenge. Throughout the 1964 political campaign, he promised, if elected, to seek the passage of Medicare."[38] During a press conference, President Johnson explained:

> *"I think Senator Gore very properly presented the situation when he said that it is now a matter that the people of this country can pass judgment on. I hope that we can get a mandate in November."* [39]

The news media also began to consider the 1964 election a "mandate on Medicare."

> *New Republic:* "The current Medicare strategy is based on a major Johnson mandate on election day."[40]

> *Business Week:* "Tuesday's election will be a key to whether the [Medicare] issue will be resolved quickly in Congress next year....Medicare proponents say a Johnson landslide, bringing 20 additional Democrats into the House, would insure passage of the legislation."[41]

In the 1964 election, Democrats picked up 37 seats in the House along with two in the Senate. As a result:

- in the House of Representatives, Democrats outnumbered Republicans 295-140; and,

- in the Senate, Democrats outnumbered Republicans 68-32.

The Democratic Victory

The "sweeping Democratic victories," according to *CQ Almanac*, "made passage [of Medicare] almost a foregone conclusion."[42]

President Johnson went before Congress to proclaim:

> *"the specter of catastrophic hospital bills can [now] be lifted from the lives of our older citizens."* [43]

The first bill introduced in each House of the 89th Congress was the King-Anderson bill to establish "Medicare" as a permanent part of the social security program.[44]

In introducing the measure, Democratic Rep. Cecil King (CA) said:

> *"The results of the November election should leave no doubt in anyone's mind over how the American voters feel about these measures....We can no longer permit hospital costs—or the fear of hospital costs—to deprive our elderly citizens of the security and peace of mind that should be their due after a lifetime of work.*
>
> *"We will be able to take great pride in having had a hand in bringing financial security and peace of mind to millions of older Americans."* [45]

Democratic Senator Anderson explained:

> *"I feel certain that historians will mark this year as the turning point in our long struggle to solve the major part of what has become one of the most urgent issues of public policy—the problem of financing the costs of hospital care for the aged, costs which now represent the major remaining cause of personal financial disaster among our aged citizens.*
>
> *"Every month that we delay in providing the needed protection means that more and more elderly persons will be forced to look to public welfare programs for help in getting he health care they need."*[46]

Despite the Democratic victories and Democratic determination, Congressional Republicans were not ready to give up their fight against health care for America's elderly.

Once again, they came up with every possible excuse to vote against the needed measure and to try to defeat it.

Once again, they said it was socialism.

- *Republican Representative James Utt (CA):* "I do not happen to be one of those who is dazzled by the great majority President Johnson obtained last November....Let me tell you here and now it is socialized medicine."[47]

- *Republican Representative Delbert Latta (OH):* "Believing as I do that Medicare is the first step towards socialized medicine in America, I intend to vote 'no' on final passage."[48]

Once again, they said it was too bureaucratic.

- *Republican House Leader and future President Gerald Ford (MI):* "[W]e are going to find our aged bewildered by a multi-headed bureaucratic maze of confusion over what program covers what and who is on first base."[49]

Once again, they said it would destroy the best health care system in the world.

- *Republican Representative Utt:* "Let us not go on the assumption here that we are not destroying the quality and the quantity of medicine and that we are not socializing medicine, because that is exactly what we are doing."[50]

And they said it was a threat to Social Security.

- *Republican Representative Bob Dole (KS):* "[T]he real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax....[A]dequate medical protection should be made available to the aged but it should be voluntary and should reflect the ability to pay...This one provision poses an enormous threat to the cash benefit programs under the social security programs."[51]

In a last-ditch attempt to defeat Medicare, Republicans came up with an "alternative" plan—a voluntary system in which the elderly would pay their own premiums. The majority of Congressional Republicans supported this plan—but Democrats prevailed and brought Medicare to a vote.

Representative Dole and a majority of Congressional Republicans again voted against Medicare.

Congress finally passed (Senate, 70-24; House, 307-116) the Medicare bill which President Johnson promptly signed into law on July 30, 1965. President Johnson traveled to Independence, Missouri, to sign Medicare into law, so that former President Harry Truman could participate in this ceremony, and to underscore Democrats' long-standing commitment to our Nation's seniors.

Chronology of Passage of Medicare, 1965

1/4 —— President Johnson's State of the Union Address listed health care for the elderly as a high priority.

1/4 —— Representative King and Senator Anderson introduced identical Medicare bills in each House of Congress.

1/7 —— President Johnson's message on "Advancing the Nation's Health" assigned top priority to the President's recommendations for a health insurance program for the elderly.

4/8 —— House approved Medicare.

7/9 —— Senate approved Medicare.

7/14 —— Conference on Medicare began.

7/21 —— Conference committee reached agreement upon a compromise.

7/27 —— House ratified the conference agreement.

7/28 —— Senate ratified the conference agreement.

7/30 —— President Johnson signed the bill in Independence, making it Public Law 89-97.

Medicare—An American Success

"From the beginning," reports the Urban Institute, "[Medicare has] proved remarkably successful" as it has contributed to the well-being of America's oldest and most disabled citizens.

Medicare has achieved its goal of providing increased access to health care among the Nation's elderly.

- By 1970, nearly all the Nation's elderly were enrolled in the Medicare program.

- Today, more than 36 million Americans are protected by Medicare.

Medicare has improved the quality of life among the America's elderly.

- Medicare has dropped the poverty rate among America's elderly by 13.4 percent.[52]

Medicare is an efficient health program.

- Medicare's administrative costs average two percent of program outlays, compared with 25 percent in small group market plans and 5.5 in large group plans.[53]

Medicare benefits all Americans regardless of income status.

- Eighty-three percent of Medicare outlays go to beneficiaries with incomes of $25,000 or less.[54]

- Only three percent goes to elderly individuals or couples with incomes in excess of $50,000.[55]

Medicare is a popular health care program.

- Eighty-nine percent of Americans want Medicare to continue.[56]

- Ninety-two percent of Americans say Medicare is the only way many older Americans can possibly obtain adequate health care.[57]

- A Kaiser-Commonwealth Fund 1993 health insurance survey found that 52 percent of Medicare beneficiaries are very satisfied with their Medicare insurance compared to 44 percent of families covered by employer-provided private coverage, and 30 percent of those whose purchase private health insurance individually.[58]

- Seventy-five percent of Americans oppose cutting Medicare in order to balance the budget.[59]

- When asked what should be the most important goal for the budget, the number one answer was "protecting Medicare and Social Security."[60]

Medicare has become so successful that Senator Dole, who voted against enactment of Medicare, now praises it:

> *"Much of our significant gains and life expectancy, improvement in the quality of life, and decreases in infant mortality can be directly attributed to the passage of the Social Security Amendments of 1965. The Medicare and Medicaid programs have played a central role in improving both access to and quality of health care services for the country's elderly, poor, and disabled. Equally significant, it may be argued that Medicare and Medicaid have provided a foundation for the phenomenal growth and the dissemination of new medical technologies that now contribute to the well-being of all the people of all nations."*[61]

But today, Medicare is once again under Republican attack. House Majority Leader Richard Armey says he "deeply resents the fact that when I am 65, I must enroll in Medicare." He calls it part of government that "teaches dependence," and says it is a program I would have no part of in a free world."[62]

Once again, Republicans are proposing voluntary systems, such as medical savings accounts, or plans which would require seniors to shop for their own coverage or pay much higher premiums.[63] Republicans would use the savings to pay for tax breaks for the wealthy.

These proposals always have been and still are unacceptable to Democrats. Senate Democratic Leader Tom Daschle has declared:

> *"In three decades, Medicare has come to symbolize this Nation's commitment to the health and financial security of our elderly citizens and their families. It is the fulfillment of the dreams as well as the efforts of Presidents Truman, Kennedy and Johnson and hundreds of Congressional Democrats. On this, the 30th anniversary of Medicare, it is important to recall the long and difficult struggle to enact this much-needed program and applaud its success and recommit ourselves to keeping the program strong and viable."*[64]

End Notes

[1] AARP poll, July 11, 1995.

[2] Statement upon signing the *Social Security Act* into law on August 14, 1945.

[3] *Congress and the Nation, 1945-1964*, "A Review of Government and politics in the Postwar Years," 1965, p. 1152. The American Medical Association's (AMA's) efforts to defeat national health insurance also must be recognized. The AMA compared Truman's health care proposal to the "totalitarianism of [Nazi] Germany." "Fishbein Assails New Health Plan," *New York Times*, November 27, 1945. For AMA's official position, see "AMA Vote Assails Health Insurance," *New York Times*, December 5, 1945, and "Dentists Oppose U.S. Health Plan," *New York Times*, December 7, 1945.

[4] "The Proposal for a Federal Compulsory Insurance System, of Citizens Medical Care," *Congressional Digest*, August-September, 1946.

[5] *Congress and the Nation, 1945-1964*, p. 1152.

[6] *1965 CQ Almanac*, p. 244.

[7] *Congress and the Nation, 1945-1964*, p. 1152.

[8] "Medical Insurance for the U.S., Voluntary or Compulsory?" *Congressional Digest*, March 1949. Again, the AMA's role in the defeat should not be underestimated. In unprecedented lobbying efforts, the AMA spent $1,522,683 in 1949 and $1,326,078 in 1950 for lobbying purposes—the two highest lobby spending reports ever filed by any organization until that time. It sent each member of Congress a pamphlet, "A Simplified Blueprint of the Campaign Against Compulsory Health Insurance," and a booklet, *25 Questions You want Answered on Compulsory Health Insurance Versus Health the American Way*. State organizations worked to get important national and local organizations to come out against the measure, and each of 10,234 opposing endorsements was to be sent to the appropriate Member of Congress and the President. *1965 CQ Almanac*, pp. 246-247: *1949 Congressional Almanac*, p. 294.

[9] *Congress and the Nation, 1945-1964*, p. 1152.

[10] Theodore Marmor, *The Politics of Medicare*, London, Routledge and Kegan, p.19.

[11] *Congress and the Nation, 1945-1964*, "A Review of Government and Politics in the Postwar Years," 1965, p. 1152.

[12] Michael Alderman, "Why We Need Medicare," *New Republic*, October 26, 1964, pp. 17-20. Dr. Aldelman was an MD who broke ranks with the AMA's opposition to Medicare to point out that the elderly were not able to afford the medical treatment they needed.

[13] *Congressional Record*, January 26, 1960, 1241-2.

[14] *Congressional Record*, January 26, 1960, 1241-2.

[15] *1965 CQ Almanac*, p. 243.

[16] *Congress and the Nation, 1945-1964*, p. 1154.

[17] *1962 CQ Almanac*, pp. 192-930; *1965 CQ Almanac*, pp. 236-237: *Congress and the Nation, 1965-68*, p. 754.

[18] *Congressional Record*, August 25, 1960.

[19] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74. The AMA, Chamber of Commerce, and health insurance associations promptly opposed this new health care measure. They testified to the committees holding the hearings and lobbied individual offices, warning of dire consequences if Medicare became a reality. Dr. Edward R. Annis of the AMA warned that Kennedy's proposal "would have disastrous effects on the quality of medical care our patients would receive." "The Controversy Over the Administration's New Medicare Plan for the Aged." *Congressional Digest*, January, 1962.

[20] *Congress and the Nation, 1945-1964*, "A Review of Government and Politics in the Postwar Years," 1965, p. 1154.

[21] To counter President Kennedy's efforts, the AMA purchased time on national television to rebut his remarks. AMA President Dr. Leonard Arson said the Kennedy bill would deprive older people of a private system of medical care. AMA advertisements ran in 29 leading newspapers and on 40 FM radio stations across the country. And the AMA flooded the country with posters with the headline: "Socialized Medicine and You," and the warning: "your freedom is at stake." "Health-Plan Battle: The AMA or JFK," *Newsweek*, May 8, 1962.

[22] Address before National Retail Merchants Association, April 5, 1962, excerpted in *Congressional Digest* "The Question of Expanding Social Security to Provide More Medical Care for the Aged," August-September 1963.

[23] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[24] See, for example, Rep. Frank Row, Address to American Academy of General Practice, Chicago, April 1, 1963, excerpted in *Congressional Digest*, "The Question of Expanding Social Security to Provide More Medical Care for the Aged," August-September 1963.

[25] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[26] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[27] *Congressional Record*, August 31, 1964.

[28] *1962 CQ Almanac*, p. 196.

[29] *Congressional Record*, August 31, 1964.

[30] *Congressional Record*, September 1, 1964.

[31] Senate Speech, August 31, 1964 in, "The Medicare Controversy," *Congressional Digest*, March 1965.

[32] *Congressional Record*, September 2, 1964.

[33] Senate Speech, September 2, 1964 in, "The Medicare Controversy," *Congressional Digest*, March 1965.

[34] "President's Plan for Care of Aged Voted by the Senate," *New York Times*, September 3, 1964.

[35] Congressional Digest, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[36] Milton Viorst, "How Medicare Was Lost This Year," *New Republic*, October 17, 1964, pp. 6-7.

[37] "Aid to Appalachia, Medicare Die in Adjournment Push," *Washington Post*, October 3, 1964.

[38] "Medicare Set For Next Round," *Business Week*, October 31, 1964, p. 32.

[39] News Conference, October 3, 1964.

[40] "How Medicare was Lost this Year," *New Republic*, October 17, 1964, pp. 6-7.

[41] "Medicare Set for the Next Round," *Business Week*, October 31, 1964, p. 32.

[42] *1965 CQ Almanac*, p. 247.

[43] 1965 State of the Union Address.

[44] *Congressional Digest*, "The 'Medicare' Controversy in the Current Congress, Pro & Con," March 1965, p. 74.

[45] *Congressional Record*, January 4, 1965.

[46] *Congressional Record*, January 6, 1965.

[47] *Congressional Record*, April 8, 1965, pp. 7389-90.

[48] *Congressional Record*, April 8, 1965, p. 7420.

[49] *Congressional Record*, April 8, 1965, p. 7434.

[50] *Congressional Record*, April 8, 1965, pp. 7389-90.

[51] *Congressional Record*, April 3, 1965, p. 7375.

[52] Based on Census Bureau's "Valuation of Non-Cash Benefits," 1993.

[53] Bruce Vladeck, Administrator, Health Care Financing Administration (HCFA), May 15, 1995; Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[54] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995; HCFA, "Medicare Fact Sheet," January, 1995.

[55] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[56] DYG, Inc. poll for AARP, July 11, 1995.

[57] DYG, Inc. poll for AARP, July 11, 1995.

[58] Karen Davis, President of Commonwealth Fund, "Medicare Solvency and Financial Security for Beneficiaries," testimony before U.S. Senate Budget Committee, May 3, 1995.

[59] ICR Survey Research Group, for AARP, May 5-14, 1995.

[60] Gallup/*USA Today* Poll, June 5-6, 1995.

[61] *Congressional Record*, July 30, 1985, p. S10367.

[62] "GOP Leader Lashes Out at Medicare," *Chicago Tribune*, July 11, 995.

[63] "Private Solutions Eyed for Medicare," *Washington Times*, July 8, 1995.

[64] Remarks recognizing the forthcoming 30th Anniversary of Medicare, July 12, 1995.

MEMORANDUM

TO: Carol
FR: Chris J.
RE: Medicare/Medicaid Growth Rate Comparisons
cc: Jen and Jeremy

July 17, 1995

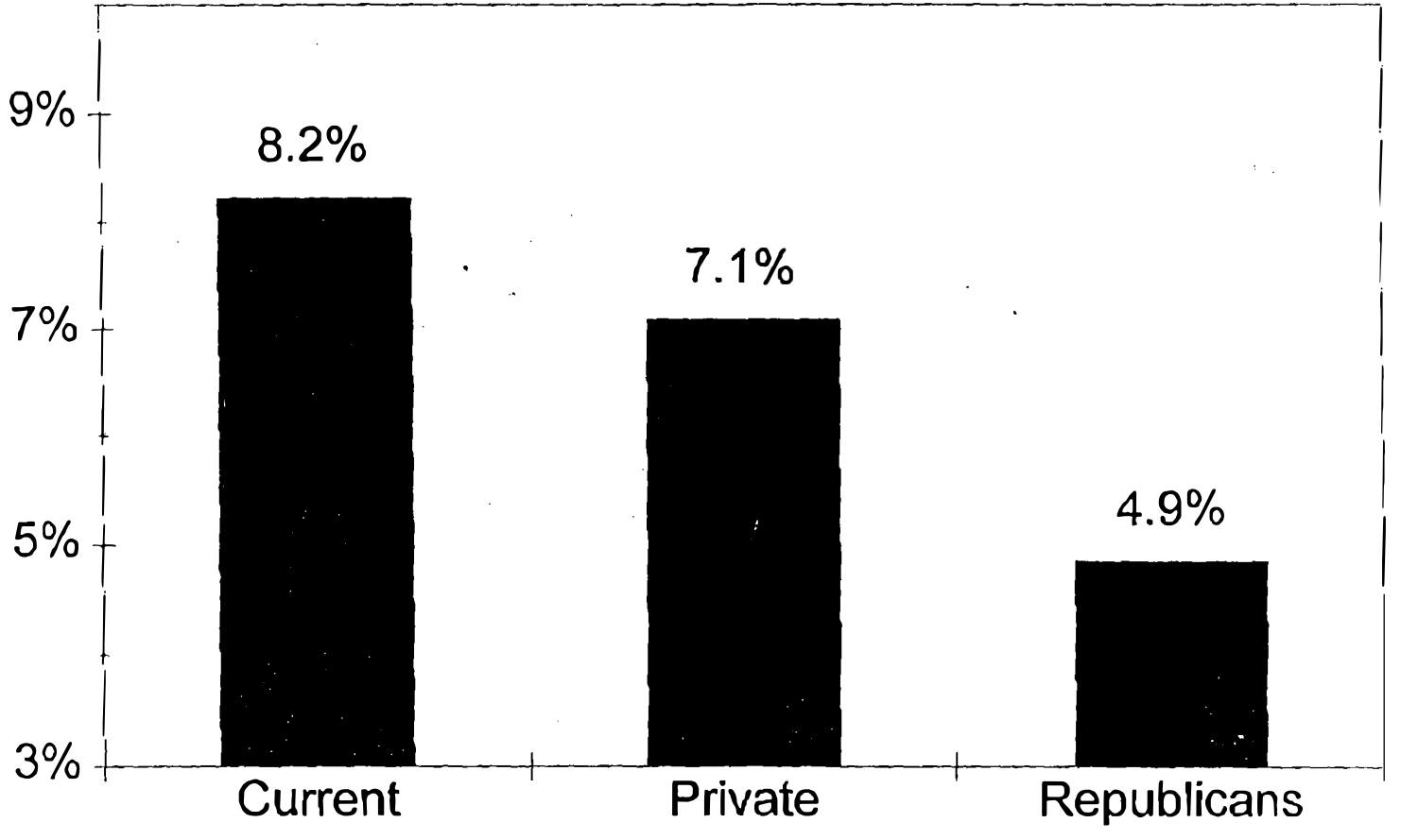
Attached you will find a set of charts and background information on Medicare/Medicare growth rate comparisons with the private sector. Since everyone is working off the CBO baseline, I had our HHS folks do our estimates working with the CBO model/numbers.

As you will note, CBO projected private sector per capita baseline over the next 7 years is running at 7.1 percent. If the Republican cuts were enacted, the Medicare/Medicaid per capita growth rates would be running at 4.9% and 1.4% respectively.

These numbers have been reviewed by OMB, but not yet finally cleared. I would say, however, that I am confident enough in them to give them to you for your use.

One last point, because the Medicaid baselines are so different, we recommend NOT attempting to try to project an Administration proposal growth rate onto the CBO baseline. However, it is important to note that our Medicare growth rate number (if you assume $124 billion off of the CBO baseline) is 6.4% -- also less than the 7.1% CBO projection for the private sector growth rate. At this point, I would recommend against talking about our growth rates -- either Medicare or Medicaid -- on an assumed CBO baseline.

Medicare Growth Per Beneficiary: Effects of the Republican Proposal 1996-2002

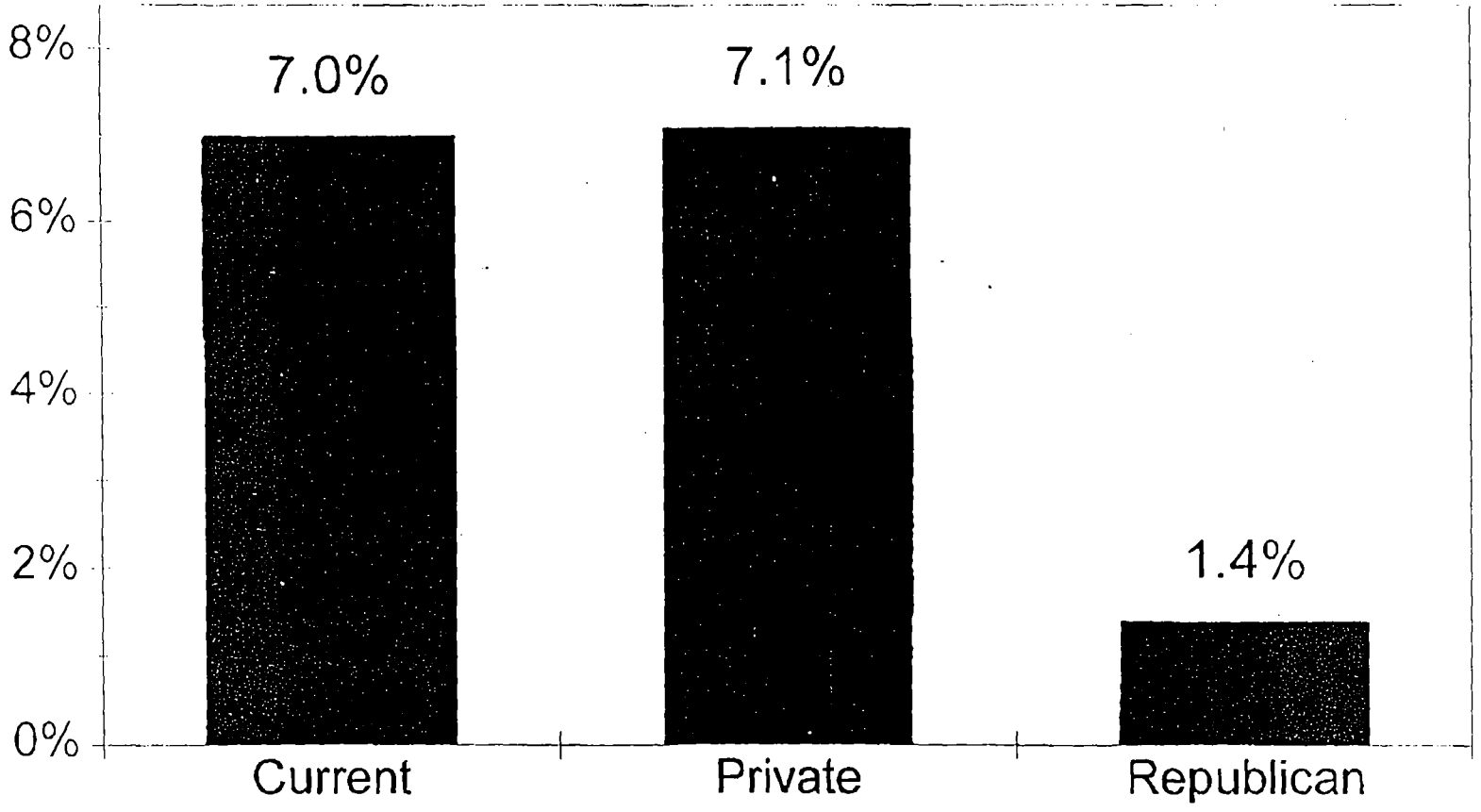


All estimates are calculated by the Administration using CBO data.

Medicaid Growth Per Recipient

Effect of the Republican Proposal

1996-2002



All estimates are calculated by the Administration using CBO data.

MEDICARE SPENDING AND GROWTH RATES UNDER THE REPUBLICANS' BALANCED BUDGET PROPOSAL

The Republicans have proposed that Medicare spending can be reduced by $270 billion between 1996 and 2002 in their Balanced Budget Proposal.

MAGNITUDE OF THE CUTS

- **Medicare cuts are 33% of all spending reductions under the Republicans' Proposal.**
  Although the Medicare beneficiaries represent about 13% of the U.S. population and Medicare is 11% of the Federal outlays, Republicans have proposed that over 33% of the savings from policy change leading to deficit reduction will come from Medicare.

- **Almost all Veterans's Benefits would have to be eliminated to equal the size of the Medicare cuts.**
  To get a sense of how large $270 billion is, the Congressional Budget Office projects that Veterans' Benefits will cost about $280 billion between 1996 and 2002. Ninety-five percent of government spending on Veterans would need to be eliminated to equal the size of the Medicare cuts.

- **Republicans would reduce Medicare spending by 14%.**
  The cuts proposed by the Republicans represent a 14% reduction in Medicare spending between 1996 and 2002. This is 20% in 2002 alone. If service reductions were the only way to achieve $270 billion dollars in savings, then Medicare could no longer cover home health and the skilled nursing facility services under the Republican proposal.

SPENDING PER BENEFICIARY

- **Medicare spending per beneficiary will fall by $1,700 by 2002 under the Republican Proposal.**
  Under current law, total Medicare spending will be $274 billion in 2002, or $8,350 per beneficiary. The projected Medicare spending per beneficiary after the Republican cuts would be $6,650, or $1,700 less.

- **Republicans cuts would add billions to older American's already high costs.**
  Currently, older Americans spend 21% of their income on out-of-pocket health care costs. Assuming that the Republican cuts are divided equally between beneficiaries and providers:

  - In the year 2002 alone, each beneficiary could pay $625 more in out-of-pocket costs than under the President's proposal; couples could pay $1,250 more.

- Over the seven-year period, beneficiaries could pay an additional $2,825 ($5,650 per couple) out-of-pocket relative to the President's proposal.

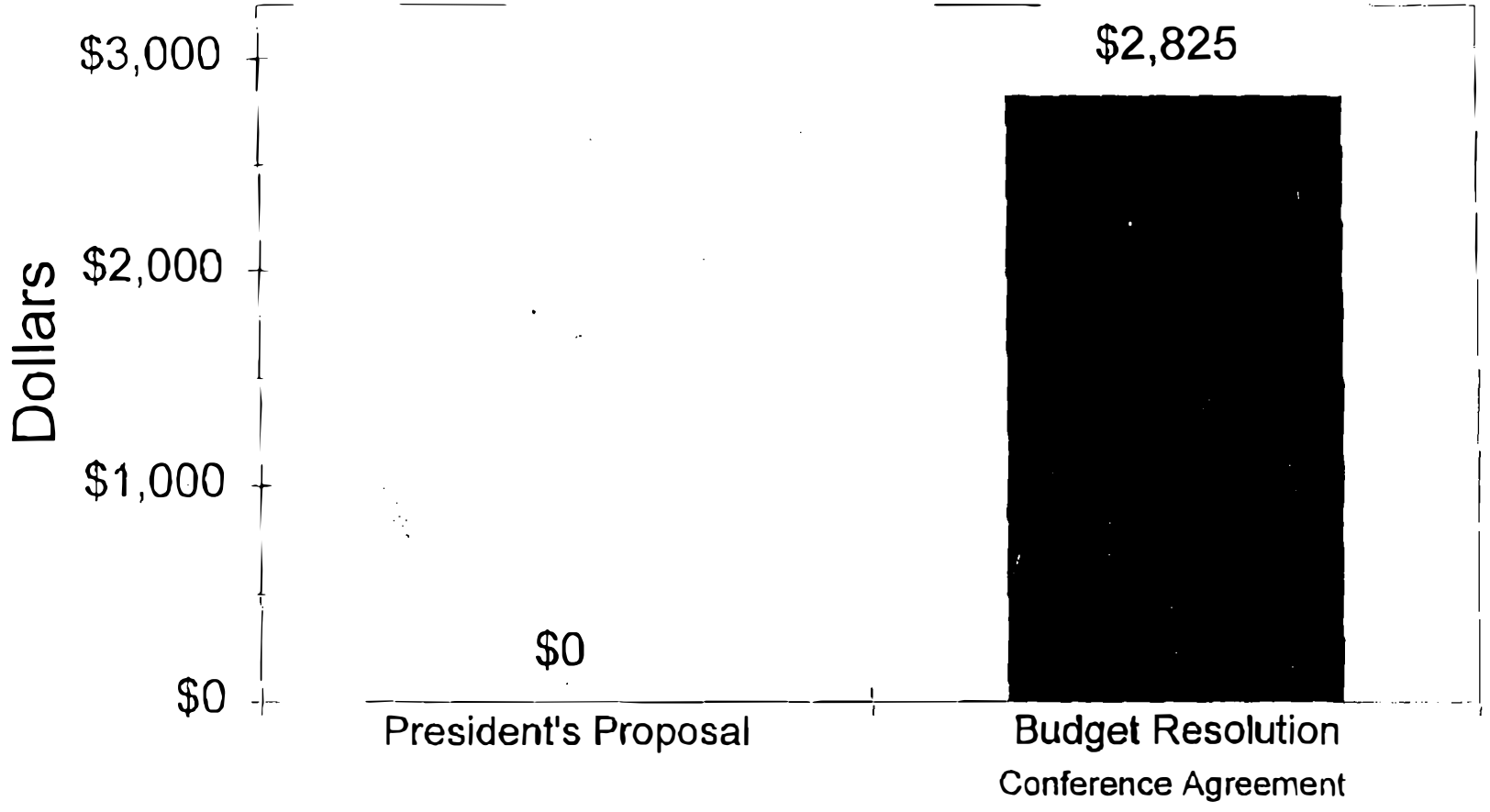
GROWTH RATES

- **Republicans would reduce growth in spending per beneficiary by more than one-third.**
  Growth in expenditures per recipient is expected to average 8.2% under the CBO baseline between 1996 and 2002. The Republican proposal would reduce this rate by over one-third to 4.9% over this same period.

- **Republicans' Medicare growth would be significantly slower than that of private spending per beneficiary.**
  The Republican growth rate per beneficiary of 4.9% would be significantly lower than the private per recipient growth rate of 7.1%.

- **Republicans' Medicare growth would also be lower than medical inflation.**
  Medical inflation (the medical component of the consumer price index (CPI)) is projected to be 5.3%, which is higher than the 4.9% projected under the Republicans' Proposal.

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



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

BACKUP

Comparison of President's Proposal and Republican Conference Agreement

	Baseline	President	Republicans
Medicare savings as a percent of spending changes		30%	33%
Percent Reduction from Baseline:			
1996-2002		11%	20%
2002		7%	14%
Spending per beneficiary*	$8,350	$7,425	$6,650
Growth Per beneficiary, 1996-2002	8.2%	6.4%	4.9%

*Adjusts to CBO baseline by subtracting Admin. estimated savings from CBO baseline spending

House
REPUBLICAN
Conference

John Boehner, Chairman
8th District, Ohio

Setting the Record Straight

A Response Plan to the American Hospital Association's Attack on House Republicans

May 22, 1995

Contains

1. **Introduction**: What this packet is about and why we need to take on special interest misinformation campaigns;

2. **Action Items**: Activities your office can undertake to get this action plan underway;

3. **Sample Delegation Letter**: This letter and accompanying charts and state-by-state Medicare facts will help engage these local officials in a dialogue about the future of Medicare;

4. **Sample letter to hospital administrator**: This letter's aim is to engage your local hospital administrators, before AHA is able infuse them with misinformation, about the current Medicare debate;

5. **Sample News Release on AHA ad**: This sample release is provided in case the AHA print ad is run in your district;

6. **Talking points**: Highlights of AHA's recent fear campaign;

7. **Boehner Dear Colleague letter on the AHA**;

8. **AHA's response**;

9. **Boehner's response to AHA**;

10. **Democrat Leadership's Press packet including AHA citations;**

11. **AHA's ad in Roll Call**;

12. **AHA's ad run against Rep. Lindsey Graham (R-SC).**

Introduction:

During our fight to preserve and protect Medicare, numerous special interest lobbyists will be waging war to protect the status quo that, although bankrupting the system and putting all of America's seniors at risk, has meant great personal financial gain for themselves and some of their clients.

This package contains all of the materials your office will need to beat back the latest "astro-turf" (i.e. phony grass roots) assault on our efforts to save Medicare from bankruptcy. This round of special interest scare tactics is being lead by the American Hospital Association (AHA).

The AHA is technically the Washington representative of America's hospitals, hospital administrators, and hospital boards of directors. They have recently decided to launch, apparently before they even knew what Medicare changes Republican's were proposing, a full-scale media campaign in coordination with the Democrat leadership in the House. This campaign has already included ***advertisements in Members' districts personally attacking our Republican colleagues – by name*** with claims that Republicans were going to "devastate Medicare." AHA has also been cited as a source in Democrat leadership's sample op-eds and press releases which accuse Republicans of forcing hospitals "to close or at least slash services and care" in order to pay for a "tax break to the wealthiest Americans." The AHA is listed along side the Clinton Department of Health and Human Services and the AARP, as an "Organization Contact" in the House Democrats' press secretary kit "Delivering the Medicare Message District Press Packet" dated May 11, 1995 – a plan of attack on the Republican budget and Medicare proposals.

Although they publicly claim a desire to work with Republicans to reform Medicare, their blatant *ad hominem* attacks on House Republicans, their scare tactic advertising campaign, and their alliance with House Democrats tell a different story.

In order to defeat this and future attacks on our proposals each member office needs to be both prepared and proactive. Too often people believe that their representatives in Washington are invoking their name acting in their interests. The ideas listed in this document are here to engage local hospitals in a dialogue and offer them, at the very least, the other side of the story. Our goals are simple: to educate local hospitals and media about our efforts to preserve and protect Medicare; invite local hospital officials to help us formulate a way to save Medicare (an invitation the AHA has thus far declined); and to prepare for this and other misinformation campaigns orchestrated from Washington by special interest groups.

COUNTER THE AHA MEDICARE MISINFORMATION CAMPAIGN

ACTION ITEM:
Gather names and addresses of hospital board members and administrators in your district, send them a letter re: Medicare.

Have a member of your district staff contact local hospitals to obtain a list of the names and business addresses of hospital board members. Send each a letter (see sample for administrators enclosed) informing them about our efforts to protect Medicare, AHA's campaign to misrepresent these efforts, and our invitation to these local officials to help solve Medicare's problems.

TIMING:
Immediately

ACTION ITEM:
Send a delegation letter to your state hospital association.

Using the enclosed delegation letter as a sample, gather the signatures of other Republican members of your state delegation for a letter to your state's hospital association. This letter will help diffuse the AHA onslaught and at the same time invite your state hospital officials to help become part of the solution.

TIMING:
Immediately

ACTION ITEM
Write a news release in response to an AHA ad in your district.

In order to diffuse and deflect the AHA paid advertising campaign, use the enclosed sample news release to prepare your own localized response to the AHA. Keep this release "in the can" for when and if the AHA ad runs in your local papers as it has elsewhere in the nation.

TIMING:
Prepare immediately, issue as events warrant

ACTION ITEM

Set up a data base code for all AHA driven letters into your office.

Prepare to respond to AHA-generated "astro-turf" mail by building a AHA code into your constituent letter data. Respond to each letter with a reply referencing the AHA current special interest campaign and what their defense of the status quo will bring.

TIMING:

Immediately

ACTION ITEM:

Use Medicare Earned Media Action Kit.

The Medicare Earned Media Action kit is designed to help you carry our Medicare message forward. The kit, which will arrive in you office this week under a separate cover, describes hospital tours, hotline numbers, and other actions your office can take to draw your constituents into a dialogue about the future of Medicare.

TIMING:

Begin to plan the week before the Memorial Day recess.

SAMPLE DELEGATION LETTER TO STATE HOSPITAL ASSOCIATION:

(Your state) Hospital Association

Dear X:

The U.S. House of Representatives recently passed a resolution which will result in a balanced budget by the year 2002. Integral to this debate over how to save America's future from financial disaster is a discussion about how we can preserve and protect Medicare from its impending bankruptcy.

As you already know, Medicare's own trustees concluded earlier this year that if nothing is done the Medicare Hospital Insurance Trust Fund will start running out of money next year and will be bankrupt in 2002, if not earlier. Next year, Medicare Part A will spend $1 billion more than it takes in, and the "baby boomers" haven't even begun to retire.

While these circumstances will effect all Americans, none will know it better than America's hospitals. That is why we are writing to you today. If we are to solve this Medicare crisis while preserving and protecting Medicare from bankruptcy, we must all act together. One of the things that makes this task so difficult is the special interest groups in Washington, D.C. who have refused to join us in this effort. Some would rather see the status quo preserved and ignore Medicare's impending disaster. Unfortunately, one of these groups is the American Hospital Association.

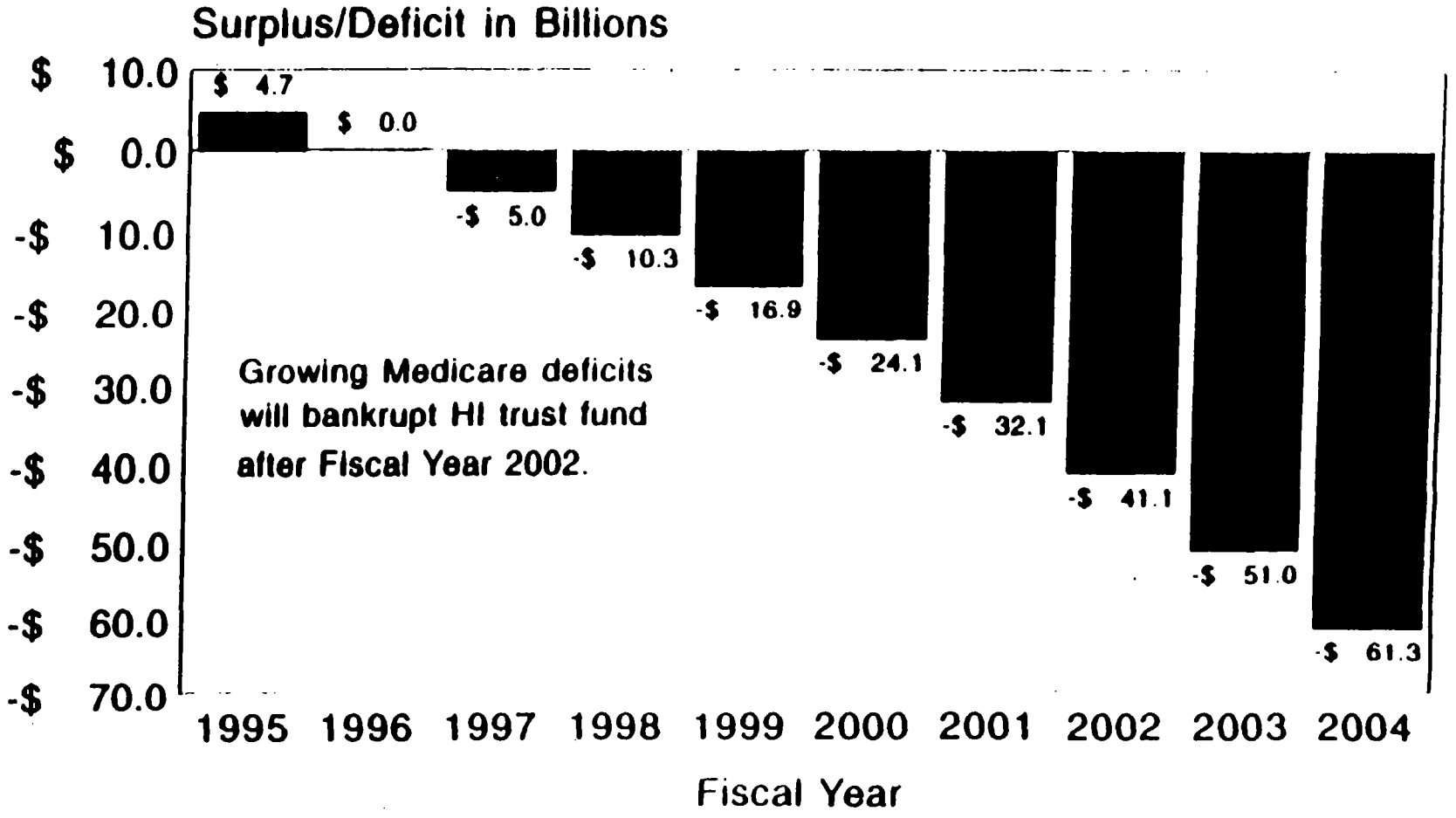
AHA has launched a vigorous, all-out campaign to defeat the balanced budget. Using your resources and invoking your name, AHA is attempting to derail our current campaign to seek solutions to our Medicare crisis with targeted advertising with its only aim is to scare people with misrepresentations of the facts. For instance, AHA is describing the $3.1 billion ***increase*** in Ohio's Medicare spending between 1995 and 2002 as a ***cut***. (Use your state's statistics from the attached pages)

We are asking you, as we have asked AHA, to become part of the solution. AHA has cast its lot with the rest of the status quo's defenders, but you can help bring about responsible, constructive change so Medicare will be saved for generations to come. Please write to us and let us know your ideas for preserving Medicare, and let AHA know that you would like them to be an agent for solutions, instead of being part of the problem.

Sincerely,

Mounting Medicare Deficits

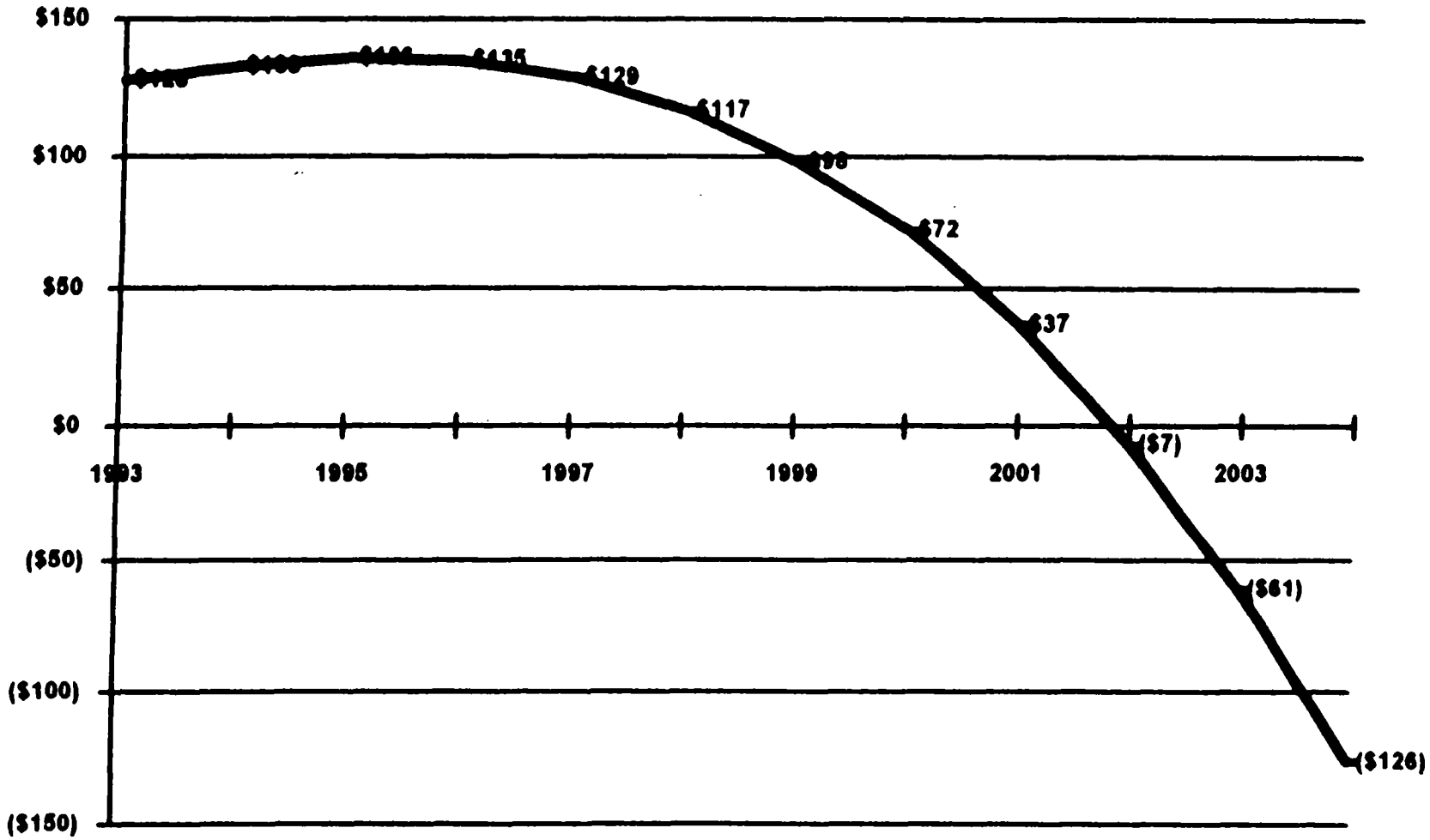
Annual Surpluses/Deficits of HI Fund (Fiscal Years 1995 - 2004)



Source: HI Trustees Report, p. 8

Medicare *Is Going Broke*

If nothing is done, Hospital-Insurance Trust Fund will be $7 billion in the red by 2002



Source: 1995 HI Trustees Report, signed by
Clinton Cabinet Secretaries Rubin, Shalala, and Reich

Under the House Budget Committee Proposals

	1995 Per Beneficiary Spending ($)	2002 Per Beneficiary Spending ($)	Increase in Per Beneficiary Spending from 1995 to 2002 ($) *	Aggregate Per Beneficiary Spending 1995 to 2002 ($)
US	4,816	6,361	1,545	40,298
Alabama	4,733	6,251	1,518	39,589
Alaska	3,683	4,865	1,182	30,817
Arizona	4,638	6,126	1,488	38,808
Arkansas	3,851	5,086	1,235	32,220
California	5,821	7,688	1,867	48,705
Colorado	4,317	5,703	1,385	36,125
Connecticut	5,135	6,782	1,647	42,985
Delaware	5,025	6,637	1,612	42,047
District of Columbia	NA	NA	NA	NA
Florida	5,871	7,755	1,884	49,127
Georgia	4,876	6,440	1,564	40,795
Hawaii	3,943	5,208	1,265	32,993
Idaho	2,996	3,957	961	25,065
Illinois	4,952	6,012	1,460	38,084
Indiana	4,263	5,631	1,368	35,671
Iowa	3,304	4,363	1,060	27,641
Kansas	4,473	5,908	1,435	37,427
Kentucky	4,158	5,492	1,334	34,793
Louisiana	5,669	7,487	1,819	47,431
Maine	3,457	4,566	1,109	28,924
Maryland	5,010	6,617	1,607	41,916
Massachusetts	5,916	7,814	1,898	49,500
Michigan	4,651	6,143	1,492	38,917
Minnesota	3,840	5,072	1,232	32,129
Mississippi	4,173	5,512	1,339	34,920
Missouri	4,493	5,935	1,441	37,595
Montana	3,426	4,525	1,099	28,667
Nebraska	3,398	4,488	1,090	28,433
Nevada	4,671	5,170	* 499	39,083
New Hampshire	3,796	5,014	1,218	31,763
New Jersey	4,938	6,523	1,584	41,320
New Mexico	3,140	4,147	1,007	26,269
New York	5,312	7,017	1,704	44,449
North Carolina	4,002	5,286	1,284	33,488
North Dakota	4,028	5,320	1,292	33,704
Ohio	4,351	5,747	1,396	36,407
Oklahoma	4,118	5,439	1,321	34,455
Oregon	3,779	4,991	1,212	31,620
Pennsylvania	5,404	7,138	1,734	45,216
Rhode Island	4,686	6,161	1,497	39,032
South Carolina	3,730	4,926	1,197	31,208
South Dakota	3,411	4,505	1,094	28,537
Tennessee	5,328	7,037	1,709	44,578
Texas	5,021	6,632	1,611	42,014
Utah	3,740	4,940	1,200	31,295
Vermont	3,369	4,449	1,081	28,186
Virginia	3,689	4,872	1,183	30,865
Washington	3,706	4,895	1,189	31,012
West Virginia	3,727	4,923	1,196	31,188
Wisconsin	3,570	4,715	1,145	29,867
Wyoming	2,940	3,883	943	24,601
Puerto Rico	1,880	2,483	603	15,730

* Per beneficiary Medicare spending increases 32.1% from 1995 to 2002

Representative Christopher Shays
May 17, 1995
Revision 2

	1995 Medicare Spending ($ millions)	2002 Medicare Spending ($ millions)	Increase in Medicare Spending from 1995 to 2002 ($ millions)	Percent Increase from 1995 to 2002	Aggregate Medicare Spending 1995 to 2002 ($millions)
US	178,200	258,900	80,700	45.3%	1,584,000
Alabama	3,038	4,395	1,357	44.7%	28,939
Alaska	124	242	118	94.6%	1,321
Arizona	2,777	4,555	1,778	64.0%	28,508
Arkansas	1,627	2,291	663	40.8%	14,207
California	21,179	31,022	9,844	46.5%	189,138
Colorado	1,828	2,932	1,103	60.3%	17,216
Connecticut	2,588	3,621	1,034	40.0%	22,517
Delaware	505	788	283	52.0%	4,810
District of Columbia	1,270	1,845	575	45.3%	11,287
Florida	15,357	22,892	7,535	49.1%	138,540
Georgia	4,059	6,138	2,079	51.2%	38,921
Hawaii	595	980	385	61.4%	5,622
Idaho	449	677	228	50.9%	4,078
Illinois	7,400	10,183	2,783	37.3%	63,719
Indiana	3,528	5,014	1,488	42.2%	30,984
Iowa	1,573	2,115	542	34.5%	13,387
Kansas	1,718	2,351	633	36.9%	14,781
Kentucky	2,436	3,498	1,063	43.6%	21,505
Louisiana	3,302	4,748	1,446	43.8%	29,178
Maine	699	1,012	313	44.8%	6,199
Maryland	3,027	4,483	1,456	48.1%	27,202
Massachusetts	5,545	7,785	2,240	40.4%	48,341
Michigan	6,300	9,103	2,803	44.5%	56,825
Minnesota	2,429	3,405	977	40.2%	21,156
Mississippi	1,652	2,324	673	40.7%	14,418
Missouri	3,748	5,204	1,456	38.8%	32,472
Montana	442	641	198	44.8%	3,925
Nebraska	848	1,151	303	35.7%	7,253
Nevada	906	1,823	916	101.1%	9,827
New Hampshire	593	896	303	51.0%	5,391
New Jersey	5,802	8,117	2,315	39.9%	50,477
New Mexico	666	1,068	401	60.3%	9,270
New York	14,352	19,072	5,020	35.7%	120,304
North Carolina	4,115	6,356	2,241	54.5%	37,896
North Dakota	417	565	149	35.7%	3,564
Ohio	7,284	10,347	3,063	42.1%	63,920
Oklahoma	2,008	2,828	820	40.9%	17,519
Oregon	1,777	2,616	838	47.2%	15,915
Pennsylvania	11,257	15,617	4,360	38.7%	97,478
Rhode Island	788	1,081	295	37.5%	6,772
South Carolina	1,898	2,924	1,026	54.1%	17,466
South Dakota	399	550	151	37.8%	3,446
Tennessee	4,097	6,009	1,912	46.7%	38,617
Texas	10,496	16,046	5,550	52.9%	98,088
Utah	704	1,126	422	59.9%	6,622
Vermont	280	408	129	46.0%	2,492
Virginia	3,019	4,565	1,545	51.2%	27,480
Washington	2,547	3,778	1,231	48.4%	22,911
West Virginia	1,230	1,715	486	39.4%	10,684
Wisconsin	2,724	3,792	1,067	39.2%	23,634
Wyoming	178	281	103	57.8%	1,661
Puerto Rico	896	1,311	415	46.3%	7,997

Representative Christopher Shays
May 17 1995
Revision 2

COMMITTEES
AGRICULTU
EDUCATION A
LABOR
HOUSE ADMINISTRATION

4. SAMPLE LETTER TO HOSPITAL ADMINISTRATOR

1020 LONGWORTH HOUSE OFFICE BLDG
WASHINGTON DC 20515-3508
(202) 225-6205

DISTRICT OFFICES
617 LIBERTY FAIRFIELD ROAD
HAMILTON, OH 45011
(513) 894-6003

12 SOUTH PLUM STREET
TROY OH 45373
(513) 339-1524

DISTRICT TOLL FREE NUMBER
1-800-582-1001

Congress of the United States

House of Representatives

May 19, 1995

Mr. David Meckstroth
President/CEO
Upper Valley Medical Centers
3130 N Dixie Highway
Troy, Ohio 45373

Dear Dave:

The U.S. House of Representatives recently passed a resolution which will result in a balanced budget in the year 2002. As this resolution was designed to preserve, protect and improve Medicare and thus may impact Upper Valley Medical Centers, I wanted to take this opportunity to explain why I supported this resolution, as well as to express my grave concerns with the related actions of the American Hospital Association.

America is at a crossroads. Either we continue to run enormous budget deficits every year, leaving the tab to our children, or we balance the budget and save their future. Either we continue to allow Medicare spending to grow out-of-control, going bankrupt in 2002, or we make the necessary reforms to save this vital program for our nation's seniors.

We only need to look at President Clinton's own advisors to see the magnitude of the problems with Medicare. The Medicare Board of Trustees, which includes three of President Clinton's Cabinet Secretaries -- Robert Reich, Robert Rubin, and Donna Shalala -- concluded that the Medicare Hospital Insurance Trust Fund will start running out of money next year and will be bankrupt in 2002, if not earlier. Next year, Medicare Part A will spend $1 billion more than it takes in, and the "baby boomers" haven't even begun to retire.

If we do nothing this year to reform Medicare, we will face several options in the near future -- all of which are far worse than what we are proposing as part of this year's budget process. We will have to triple Medicare payroll taxes from the 2.9% that workers and their employers already have to pay. We will have to raise premiums by an estimated 300 percent and offer fewer benefits. **We will also have to slash reimbursement to providers despite the already low rates.** As a member of Congress, I cannot accept any of these options. We will spend this summer working with all of you to design an improved Medicare system, which preserves the security of Medicare.

To keep Medicare solvent, we don't need to cut spending. In fact, Medicare spending will continue to increase over the course of the next seven years. Spending will continue to increase in excess of private-sector health care spending. We spent $844 billion on Medicare from 1989-1995. Under our plan, we will spend $1.586 trillion during 1996-2002 -- an increase of $742 billion. Without reforms, we will spend $1.869 trillion during that same period -- bankrupting the system.

We can create a Medicare system that offers the best care at the lowest cost with senior citizens having the greatest control over their own health care. We will implement new approaches, new management, and new technologies. Waste and fraud will be tackled head on and eliminated. In the end, Medicare will be protected and saved for generations to

come.

As you can guess, this level of change is dramatic. In fact, it is the most daunting task undertaken by Congress and the nation in the past fifty years. To make it harder, there are some groups in Washington, D.C. who do not want to join with us in working for this needed change. They want to stick with the status quo which will result in a failed and bankrupt Medicare system. **Unfortunately, the American Hospital Association is one of these groups.**

AHA has launched a vigorous, all-out campaign to defeat the balanced budget. Using your resources and invoking your name, it is working to ensure that the budget is not balanced and Medicare is not saved from bankruptcy. While I respect its right to do so, I also believe it is short-sighted and counterproductive to what we are trying to accomplish. If AHA is successful, we will not balance the budget, we will not save Medicare, and taxpayers, senior citizens, and **health care providers** will be stuck with an unpayable tab.

I don't believe the AHA is serving the best interests of you or your hospital. They cannot on one hand expect to take part in devising a solution to the Medicare problem while at the same time engaging in an expensive media campaign demagoging about our efforts. If you agree, I would appreciate it if would contact your representatives in Washington and let them know that you want them to work with us in balancing the budget and saving Medicare. They need to know that you will not stand for politics-as-usual. We need all of the help we can get. The AHA can be a valuable player in our efforts to save Medicare, especially considering the stake that hospitals have in the Medicare system. But they can't serve that role by resorting to fear tactics and false charges all paid for by your membership fees.

This process is about doing what is right for ourselves and our children. If we fail, the consequences will be enormous. We need everyone in this nation working together, including you and the American Hospital Association.

Thank you for your attention to this matter. I have enclosed some materials for your review. Please let me know if I can provide any further information.

Sincerely,

John A. Boehner

JAB/jhf

SAMPLE NEWS RELEASE TO USE IF AHA AD RUNS IN YOUR DISTRICT

WASHINGTON LOBBYISTS LIE TO (ANYTOWN)

Special interest group buys ad to scare seniors, line their own pockets

In today's edition of the *Anytown Daily Record* a Washington, D.C. special interest group bought advertising aimed at scaring the senior citizens of Anytown and lying to their children about the current efforts to protect and preserve Medicare.

The advertisement was purchased by the American Hospital Association, representing hospitals' boards of directors. Unfortunately, according to local Representative Pat Doe (R-USA), the ad is a misrepresentation of the facts.

"This special interest group is lying when it claims in their ads that Republicans are going to 'devastate Medicare'," Rep. Doe said. "The truth may not matter to lobbyists in Washington, but in Anytown, people aren't brought up to look kindly on this kind blatant and public abuse of the facts."

The ads run in today's paper are a part of a nationally orchestrated "fear" campaign, designed by Washington lobbyists to scare Americans into believing that Medicare shouldn't be improved or protected.

The debate in Washington has turned to Medicare ever since the Republicans in Congress have heeded the advice of that program's board of trustees. That board, responsible for monitoring Medicare's financial security, reported in April of this year that Medicare will begin to go broke next year and will be completely bankrupt by the year 2002 if nothing is done to protect the system.

"We must protect, preserve, and improve the current Medicare program," Rep. Doe said. "Unfortunately many lobbyists in Washington have made their fortunes off the current system -- a system they don't want to change -- even if that change is necessary to protect Medicare from bankruptcy."

-30-

House
REPUBLICAN
Conference

Talking Points

JOHN BOEHNER
Chairman
8th District, Ohio

May 22, 1995

THE AHA RECORD: SPECIAL INTEREST POLITICS AT ITS WORST

The American Hospital Association is currently running an all out campaign against House Republicans to discredit our attempts to protect and preserve Medicare. Instead of offering to become part of the solution, they have decided to defend the status quo and become part of the problem. Below are just a few of their current activities in this endeavor.

- THE AHA HAS PLACED ADVERTISEMENTS IN MEMBERS' DISTRICTS **PERSONALLY** ATTACKING OUR REPUBLICAN COLLEAGUES – **BY NAME** – AND CLAIMING THAT REPUBLICANS WERE GOING TO "***DEVASTATE MEDICARE***."

- AHA HAS BEEN USED AS A SOURCE IN THE DEMOCRAT LEADERSHIP'S SAMPLE OP-EDS AND PRESS RELEASES WHICH ACCUSE REPUBLICANS OF FORCING HOSPITALS "*TO CLOSE OR AT LEAST SLASH SERVICES AND CARE*" IN ORDER TO PAY FOR A "*TAX BREAK TO THE WEALTHIEST AMERICANS*."

- THE AHA HAS MADE ITSELF AVAILABLE TO HOUSE DEMOCRATS WISHING TO ATTACK REPUBLICAN ATTEMPTS TO PRESERVE AND PROTECT MEDICARE.

- THE AHA IS LISTED ALONG SIDE CLINTON'S DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE AARP AS AN "ORGANIZATION CONTACT" IN THE HOUSE DEMOCRATS' PRESS SECRETARY KIT "DELIVERING THE MEDICARE MESSAGE DISTRICT PRESS PACKET" DATED MAY 11, 1995 WHICH IS A PLAN OF ATTACK ON THE REPUBLICAN BUDGET AND MEDICARE PROPOSALS.

1010 LONGWORTH HOUSE OFFICE BUILDING, WASHINGTON, D.C. 20515 202/225-5107

JOHN A. BOEHNER
8TH DISTRICT, OHIO

ROOM 1018
LONGWORTH HOUSE OFFICE BUILDING
(202) 225-6167

House Republican Conference
U.S. House of Representatives
Washington, DC 20515

May 15, 1995

Dear Republican Colleague:

The American Hospital Association and the American Association of Retired Persons e beginning their campaigns against our budget resolution. What are they fighting -- a balanced budget that ensures our children will have a secure future? A preserved, protected and improved Medicare system that means current retirees can be assured their Medicare will be solvent? Or is it change they're fighting?

Let's remember who our opponents are. The AARP -- over the objections of its members -- supported the Clinton-Gephardt health care bill last year, a bill that would have resulted in a complete government takeover of our health care system, price controls on private health care spending, and devastating job-killing payroll taxes.

And AHA? Well last year, their political action committee supported Democrats by more than a 2-to-1 margin, giving Democrats $647,000 and Republicans $314,000. Incumbents received $800,000: challengers, only $24,000. Clearly AHA did not endorse our agenda of change.

When your office receives calls from these organizations -- and we should expect them to begin today -- ask the callers this question:

- Do you know that President Clinton's own cabinet says Medicare will be bankrupt in just 7 years? That the Republican plan to preserve, protect, and improve Medicare will increase spending per beneficiary, from $4,700 to $6,300? And that the Clinton administration and the Democrats in Congress have no plans to save the program?

Please don't argue with your constituents. Just tell them the facts, and tell them we want to know their ideas about protecting this critical program. AARP and AHA are launching fear campaigns among their own membership, and that's generating the calls. When we can tell callers the truth, we'll win and shut down these scare campaigns.

Sincerely,

John Boehner

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

May 18, 1995

The Honorable John A. Boehner
U.S. House of Represenatives
Washington, DC 20515

Dear Congressman Boehner:

I would like to respond to your May 15 Dear Colleague letter related to the position of the American Hospital Association (AHA) on the budget resolution. We are disappointed in and concerned about the content of your letter, and would like to clarify our position on the budget, particularly with respect to Medicare.

First, hospitals agree with Rep. Gingrich (R-GA) and other members of the Republican leadership. The Medicare program needs to be restructured. This has been our position for the last several years. The private market has already undergone major restructuring, and hospitals are on the cutting edge of this change. If Medicare better reflected the private market, greater savings would result through a better alignment of incentives in the program.

In addition, hospitals are willing to accept some Medicare reductions. We are not naive; clearly there will be program reductions. At a reasonable level and done primarily through restructuring, savings are achievable. For example, we are willing to work within the framework put forward by Senator Judd Gregg (R-NH) and the Senate Budget Task Force to achieve significant Medicare savings.

There is a serious willingness on the part of hospitals to work with Republicans on this issue. We clearly share many common interests in structural reform. No other group in the health care debate has both supported restructuring and publicly expressed a willingness to look for significant savings. Hospitals want to be a constructive partner in the debate if savings are sustainable on a policy basis.

Regrettably, the House budget resolution goes too far in its effort to achieve Medicare savings to balance the budget. Reductions of this magnitude will seriously jeopardize hospitals' ability to meet community obligations. Moreover, such large reductions will make it far more difficult for hospitals to restructure to meet future health care needs. This "starvation" strategy could easily result in reductions of services and hospital closures.

The budget resolution's potentially adverse impact on hospitals is not speculation. A summary of findings by Lewin VHI, a well-known consulting firm, of the impact nationally of approximately $250 billion in Medicare reductions over seven years is attached. As you can see, hospitals would only receive approximately 83 cents per dollar of care delivered by the year 2000 if they are required to sustain the proportion of cuts they absorbed in previous budget reconciliation legislation. We have also provided you with your congressional district specific impact.

We are disappointed that you are taking us to task for pointing out the potentially devastating impact the budget resolution could have on your hospitals. We believe it is our responsibility to articulate the effect that any legislation, including the budget resolution, could have on institutions that are vital to the communities you represent. To label such an effort a "fear campaign" seems to unfairly criticize us for legitimately expressing the concerns of our membership and the communities they serve. We would be remiss if we did not let the Congress know the consequences of proposed legislation with respect to such an important part of every community.

Lastly, we think it unwise for you to couple a criticism of our views on a substantive issue with a discussion of political action committee (PAC) giving. We are more than willing to engage in a discussion of our position on the budget resolution, and have had a number of straightforward and honest talks with Republican Members who disagree with our views on the issue. To dismiss and summarily reject the views of the hospital field based upon our political contributions, as your letter does, raises serious concerns in our mind.

We want to continue our dialogue with you on the important issue of Medicare and the budget, and we hope that you give serious consideration to the impact changes in Medicare policy will have on the hospitals in your district and across the country. If you have any questions or comments, please contact me.

Sincerely,

Rick Pollack
Executive Vice President
Federal Relations

IMPACT OF MEDICARE AND MEDICAID SPENDING REDUCTIONS ON HOSPITALS

MEDICARE SPENDING: Gross Medicare Revenue as a Percent of Total Gross Patient Revenue in District 8 = 41.6%

Ohio District 8 9 Hospitals	**Baseline** **1993**	**Baseline** **2000**	**Illustrative Scenario ($150 B) Over 5 Years 2000**	**Illustrative Scenario ($250 B) Over 7 Years 2002**
Medicare PPS Operating Margins	-15.3%	-15.9%	-47.7%	-32.2%
Payments as a Percentage of Costs	86.7%	86.3%	67.7%	75.7%
Medicare Dollars per case Gain\(Loss)	($670)	($897)	($2,111)	($1,722)

MEDICAID FEDERAL SPENDING*: Gross Medicaid Revenue as a Percent of Total Gross Patient Revenue in District 8 = 10.0%

Ohio	**Current Projected Spending**	**Proposed Spending**	**Reduction**	**% Change**
1996-2002	40,969	35,327	(5,643)	-13.8%

* WITH 8, 7, 6, 5, 4 % CAP ON TOTAL EXPENDITURES IN MILLIONS

VICE CHAIRMAN
SUSAN MOLINARI
13th DISTRICT, NEW YORK

SECRETARY
BARBARA VUCANOVICH
20 DISTRICT, NEVADA

House Republican Conference
U.S. House of Representatives
Washington, DC 20515

May 18, 1995

Mr. Rick Pollack
Executive Vice President
American Hospital Association
325 Seventh Street, NW, Suite 700
Washington, DC 20004

Dear Mr. Pollack:

I read the American Hospital Association's ad in Roll Call today attacking Republican attempts to preserve, protect and improve our nation's Medicare system. Therefore, I must say I was somewhat puzzled to also receive today your letter professing a willingness to work with House Republicans and to read in Congress Daily of your discussions regarding Medicare with Speaker Gingrich. All I can surmise is that your propaganda machine is disconnected from your policy machine.

The shrill partisan rhetoric used in your advertising and the Democrat "company line" regurgitated in your letter's enclosure causes me to doubt AHA's willingness to work with House Republicans.

Let me specifically address a few points made in your letter:

- Unless I am greatly mistaken, private sector health care costs grew by approximately 4% last year while Medicare's costs increased by 10.5%. It seems to me that allowing Medicare to continue to grow, but at a slower rate, say 6%, would help Medicare better reflect the private market. I don't believe, and I'm sure in all honesty, neither does your association, that this would make it harder for senior citizens to receive the level of care they need or that our rural and inner-city hospitals would be forced to close.

- Only in Washington would a person believe that spending $6300 per Medicare recipient in the year 2002 is a reduction of spending over the current level of $4700 per year. Your insistence on relying on pretend baseline numbers proffered by the Democrat Party demonstrates to me that AHA hasn't quite got the message yet that Congress is now

using honest numbers in its budget process. In the past, it may have been fun to budget on wishful thinking, but today, Republicans are serious about facing up to the challenge of saving Medicare and balancing the budget. Peddling a page of dishonest numbers for each Member's Congressional District adds nothing to the debate. If AHA would care to recalculate your "illustrative scenarios" based on fact, rather than fictional baselines, I'd be happy to review them with you.

- You may not be aware of this, but Lewin-VHI is a wholly owned subsidiary of Value Health, Inc., an Avon, Connecticut managed care health company. To trumpet the supposed independent findings of a company with an obvious financial self interest in the outcome of the Medicare debate as validation of your position strikes me as not the strongest argument on your part.

- If my criticisms of AHA funding of the Democrat Party and their candidates is of concern, all I can say is that sometimes the truth hurts. I would trust that AHA's involvement in the political campaign process is guided by your association's views and beliefs. By your actions in 1994, you clearly thought that the Democrat Party and their efforts to nationalize health care, increase the Federal debt, increase the regulatory burdens on the private sector and to raise taxes were of benefit to you.

As long as the American Hospital Association chooses to continue this dialogue by mimicking the Democrat line and running a paid fear campaign in the media, I feel is it is my responsibility as Chairman of the House Republican Conference to keep Conference members assessed of your public actions in opposition to our agenda. When you are ready to engage in a serious dialogue with House Republicans to preserve, protect and improve Medicare, based on fact and not hyperbole, I am confident we would welcome your participation.

Sincerely,

John Boehner
Chairman

From the Democratic Policy Committee Phone 5-6760 Fax 6-0938

District press packet

House Democratic Leadership

Communications

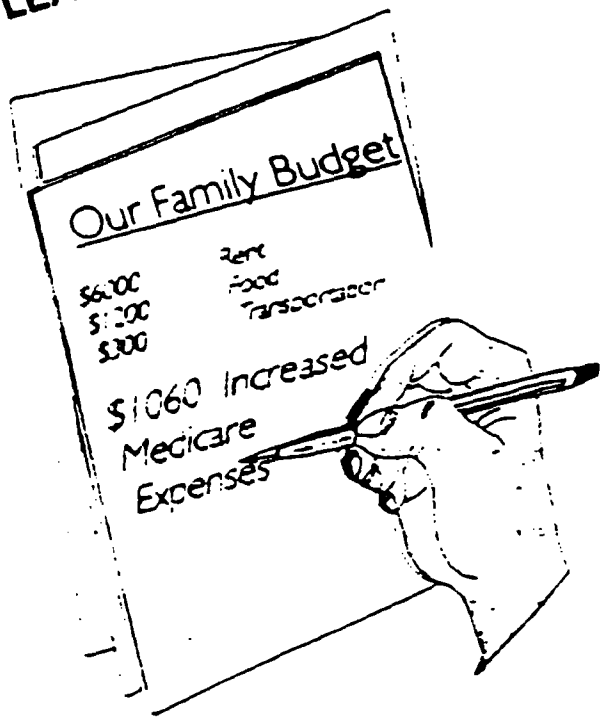
Richard [illegible], rnk. Chair
[illegible] 'ce Chair
[illegible] nce Chair

May 11, 1995

DEMOCRAT LEADERSHIP'S MATERIAL WITH AHA CITATIONS

Delivering the [illegible]edicare Message

10.



Organization Contacts:

National Association of Area Agencies on Aging
Janice Figner, 202/296-8130

American Association of Retired Persons
Marty Corry, 202/434-3750

National Council of Senior Citizens
Ed Braman, 202/624-9544

Older Women's League
Dianna Porter, 202/783-6686

National Council on Aging (senior center network)
Tori Wagman, 202/479-6613

National Association of Public Hospitals
Christine Capito Burch, 202/408-0223

American Hospital Association
Rick Wade, 202/ 638-1100

~~Catholic Health~~
Jack B--

DEMOCRAT LEADERSHIP'S MATERIAL WITH AHA CITATIONS

10.

Pr[illegible]ant Health Alliance
Sherry Hayes, 202/547-5574

American Nurses Association
Marjorie Vanderbilt, 202/651-7085
Joan Meehan, 202/651-7020

Department of Health and Human Services
Assistant Secretary Legislation, Jerry Klepner 202/690-7627

SAMPLE OP-ED

CLOSING HOSPITALS TO PAY FOR TAX CUTS FOR THE WEALTHY
THE DARKER SIDE OF THE CONTRACT WITH AMERICA

By _____

During the first hundred days of the 104th Congress, the new Republican majority followed a curious logic. On one hand, both Republicans and Democrats agreed that it was a time of great fiscal austerity, requiring government to tighten its belt, and rein in spending across the board. On the other hand, Republicans argued, we could afford to give a $340 billion tax break to the wealthiest Americans -- such as their capital gains tax cut, 80 percent of which goes to those earning more than $100,000 a year, and their loophole to allow billionaires to actually renounce their citizenship and pay no taxes at all.

Democrats opposed these unprecedented tax giveaways as a matter of simple fairness. The wealthiest Americans don't need tax relief. And we knew that the bill would soon co[illegible], and would most likely be paid by hard-working, middle class America. Now [illegible] presentation of the Republicans' budget plans in the House, that bill [illegible]. To pay for their trickle-down tax cut, the Republicans h[illegible] dangerous cuts in the Medicare portion of the Social Security [illegible] were in _____ and all across America, hospitals could h[illegible] cutbacks and even close their doors due to these Medicare [illegible]

10. [illegible]icare program -- and also the Medicaid program, also slated for deep cuts [illegible] Republican budget plan -- pays the bills and expenses of many who use our local hospitals, such as _____ and _____. Hospitals rely upon those funds, just as the patients do. The American Hospital Association estimates that one in four American hospitals is already in financial trouble, and that Medicare cuts alone could force them to close or at least slash services and care. Can we really afford to lose some of our most important medical centers so that the wealthiest 1.1 million Americans can have a $20,000 tax break? Can we truly risk longer emergency room lines, fewer hospital beds, and maybe no beds at all in some communities? Is that really what America voted for last November?

Closing hospitals to make up for an unrelated tax-cut is quite simply an outrage. Medicare is a crucial health care commitment -- not a fiscal candy jar. Of course, Republicans will deny any connection between Medicare cuts and their special interest tax breaks. But the Republican tax giveaway costs about $340 billion dollars over seven years, and the Republican Medicare cut is very close to that amount. So while the Republicans claim they have no choice but to cut Medicare, the fact is that they've painted themselves into a corner with their own special interest agenda.

Now they say they want Democratic help in the form of a bipartisan commission or its equivalent to address the growing costs of Medicare. But Democrats strongly oppose the G.O.P. tax giveaway -- and there is no way we will help close hospitals to pay for it.

Of course, Democrats know we must do much more to secure the long-term solvency of the Medicare trust fund -- and we are ready to work on a bipartisan basis to do it. But first, the Republicans must give up every dime of tax breaks to the wealthy. They must say to the wealthiest Americans: if giving you a tax break means that millions of Americans are shut out of decent health care, then we just won't do it. Then, when Republican leaders are ready to talk about the Medicare trust fund on its own terms -- in a manner that protects the integrity of the program instead of degrading it, and protects the network of hospitals that is one of our nation's greatest strengths -- we can begin a real bipartisan dialogue on this issue.

America deserves better than the Republican stealth agenda. It goes without saying that the Republicans' plan for a balanced budget -- requiring $1.2 trillion in cuts over seven years -- will demand sacrifice from every American. But we must remember that the availability of quality hospitals is not a luxury -- it is not a giveaway to some eager constituency, like the Republican tax cuts -- it is a necessity, and often a matter of life and death. That is why Democrats will fight to preserve Medicare and the support it provides to our hospitals -- and no special interest agenda will stand in our way.

# # #

SAMPLE PRESS RELEASE

REP. _____ DENOUNCES REPUBLICAN PLAN THAT WOULD CLOSE HOSPITALS TO FUND TAX CUTS FOR WEALTHY

Rep. _____ today denounced the Republican budget proposal, which could force many _____-area hospitals to close their doors or scale back services to pay for large tax cuts for the most affluent Americans.

As part of their Contract With America, the Republicans passed a tax cut package that overwhelmingly benefits the most affluent Americans. Its centerpiece is a capital gains tax cut, 80% of which benefits those earning more than $100,000 a year. The wealthiest 1.1 million Americans would get a $20,000 windfall every year. Overall, this tax cut created a hole in the federal budget.

The Republicans now hope to close that hole by almost the same amount, and also forcing deep cuts in Medicare and Medicaid payments. _____-area hospitals depend upon Medicare and Medicaid payments to keep their doors open, the consequences for _____-area residents could be staggering.

DEMOCRAT LEADERSHIP'S MATERIAL WITH AHA CITATIONS

10. _____ said, "We can't afford to lose some of our most important medical centers so the wealthiest can have a tax break. We can't afford to risk longer emergency room lines, fewer hospital beds, and maybe no beds at all in some parts of the ____th district. This isn't what the American people voted for last November -- closing hospitals to make up for an unrelated tax-cut for the wealthy. I think it's an outrage."

The American Hospital Association estimates that one in four American hospitals is already in financial trouble, and that Medicare cuts alone could force them to close or at least slash services and care. In a budget proposal presented this Wednesday, the House Republicans proposed to cut $283 billion from Medicare and another $184 billion from Medicaid.

# # #

AHA'S AD IN ROLL CALL 5/18/95

SOME IN CONGRESS WANT TO REDUCE MEDICARE BY MORE THAN $250 BILLION

This is more than 3 times the largest Medicare reduction in history.

Who will be hurt the most? Certainly seniors will be harmed, because their Medicare is being reduced — again. But not only seniors — *everyone* will feel the impact if community hospitals have to reduce their services or close their doors.

A new study by Lewin-VHI, one of the nation's top research firms, finds that with reductions of $250 billion, *every hospital* will lose money treating Medicare patients.

WHAT WILL HAPPEN TO HEALTH CARE?

These reductions will mean:

- Money-losing but crucial services like trauma care, burn units and ICU's may have to be closed.
- Senior citizens will find it harder to receive the level of care they need as they grow older.
- New life-saving technology that people need could be delayed.
- Innovative community outreach programs that help millions of Americans could get trimmed.
- Needed hospitals in rural or inner-city communities could be forced to shut their doors, period.

Hospitals are successfully controlling costs, but these reductions go beyond what is reasonable. They're going to hurt—not just folks on Medicare, but anyone who may need the high quality care that only a hospital can give. And that will leave some very important people—you the voter—looking for answers.

Hospitals and Congress should work together to reform, restructure and save money in Medicare—but let's not gut it.

Federation of American Health Systems

AHA American Hospital Association

WHAT WILL YOU TELL YOUR MEMBER OF CONGRESS IF HE TAKES $250 BILLION OUT OF YOUR MEDICARE?

Congress has been busy lately—so maybe your Member of Congress, Congressman Graham, hasn't focused attention on a particularly painful Congressional proposal that would devastate Medicare. Maybe *he* hasn't—but *you* should.

This proposal would squeeze hundreds of billions of dollars from Medicare at a time when more and more Americans are relying on it for their health care.

Medicare is a Contract with America. Senior citizens have kept their part of that contract and working Americans honor that contract with every paycheck deduction for Medicare. Now it's time for Congress to keep their part of the deal.

Dear Congressman Graham,

Drastic Medicare reductions will hurt senior citizens who have paid all their working lives and need to know the program will be there to provide health care when they need it most. Don't break the Medicare promise. Vote against irresponsible Medicare reductions. Please help to preserve affordable care for seniors and access for all Americans to essential, but costly hospital services such as burn units, trauma care and intensive care units.

Medicare matters to me. Medicare matters to every American.

Mail to: Congressman Lindsey Graham, Washington, DC 20051

Or call Congressman Graham at (202) 225-5301 and let him know you expect him to honor the Medicare contract by voting against Medicare reductions

The South Carolina Hospital Association The American Hospital Association

Ad in Index-Journal 5-17-95

12. AHA'S AD RUN AGAINST REP. LINDSEY GRAHAM (R-SC)

May 11, 1995

The Honorable William M. Thomas
Chairman
House Subcommittee on Health
1136 Longworth HOB
Washington, D.C. 20515

Dear Bill:

Recognizing the challenges your subcommittee faces in the coming months in passing legislation to save the Medicare system, we want to take this opportunity to share with you three separate plans we believe will help protect, preserve and improve the current system, which, as you know, will be bankrupt in seven years.

Congress and the Administration have a historic opportunity to improve the quality of care for seniors, increase choice, reduce waste and inefficiency, and, most importantly, save the program from bankruptcy.

There is no reason why Medicare should not be able to realize the same improvements in health care delivery and reductions in the rate of growth experienced by the private sector during the past few years. Unfortunately, as we discovered, part of the problem is that Medicare's current structure is designed to meet the market place of the 1960's, not the market place of the 1990's and beyond.

We have attached information about our three plans. We do not send them to you advocating one plan over another, but simply pass them on as different approaches you may want to consider in working to provide more choice, greater effectiveness and a lower rate of growth in the Medicare system, all of which is essential to avoiding bankruptcy. Each plan has been scored by CBO, and while we believe them to be viable, we also know they can be improved.

In short, the three plans are as follows:

A. Incentive Based Medicare Reform

This proposal would implement 35 specific proposals that reform the existing Medicare system to help create more choice and incentives for competition and cost effectiveness.

Congressman
Christopher Shays
Fourth District Connecticut

Offices

10 Middle Street, 11th Floor
Bridgeport, CT 06604-4223

Government Center
888 Washington Boulevard
Stamford, CT 06901-2927

1502 Longworth Building
Washington, DC 20515-0704

Telephones

Bridgeport 579-5870
Norwalk 866-6469
Stamford 357-8277
Washington, DC 202/225-5541

B. Defined Medicare Contribution

This proposal would provide a defined contribution -- adjusted for age, gender, geographic location, disability and ESRD status -- towards the plan of choice for each beneficiary.

C. Incentive Based Medicare Reform with Look Back Sequester

Under this approach, specific proposals would be implemented initially to achieve savings and encourage seniors to choose more cost-effective plans. It would also include a yearly savings target that if not met through private care would trigger additional cost saving measures to meet annual targets.

We hope this information will be helpful to your subcommittee and look forward to working with you in your efforts to protect, preserve and improve the Medicare system.

Sincerely,

Christopher Shays
Member of Congress

David Hobson
Member of Congress

Dan Miller
Member of Congress

Steve Largent
Member of Congress

cc: The Honorable Bill Archer

May 11, 1995

The Honorable Michael Bilirakis
Chairman
Subcommittee on Health and Environment
2125 Rayburn HOB
Washington, D.C. 20515-6118

Dear Mike:

Recognizing the challenges your subcommittee faces in the coming months in passing legislation to save the Medicare system, we want to take this opportunity to share with you three separate plans we believe will help protect, preserve and improve the current system, which, as you know, will be bankrupt in seven years.

Congress and the Administration have a historic opportunity to improve the quality of care for seniors, increase choice, reduce waste and inefficiency, and, most importantly, save the program from bankruptcy.

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Congressman
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Offices

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Stamford 357-8277
Washington, DC 202/225-5541

OPTIONS FOR PRESERVING MEDICARE

**Congressmen Christopher Shays, Dave Hobson,
Dan Miller, and Steve Largent**

May 11, 1995

NOTE ON SCORING: All three plans provide for Medicare growing from $178 billion in 1995 to $288 billion in 2002. This is an overall growth of 44.9 percent over the seven years and 5.4 percent compounded annually. The resulting slower growth rate achieved from implementation of any one of the plans would save $288 billion over seven years.

As an integrated plan overall scoring for Plan A will not equal the total of the individual proposals. This is due to the interactive behavior of the proposals when combined into one plan. If taken separately, the 35 proposals save $302 over seven years. But as an integrated plan the savings, as scored by the Congressional Budget Office (CBO) totals $288 over seven years. Therefore, the ultimate savings is $288 billion, not the total of the 35 proposals.

In addition, some of the proposals contained in Plan A are new and had not been previously scored by the CBO. As it has continued to analyze these new proposals, CBO has revised its assumptions, thereby altering savings figures. It is expected CBO will continue to make revisions.

PLAN A: INCENTIVE BASED MEDICARE REFORM

This plan consists of four sets of proposals aimed at accomplishing these goals:

I. Proposals to *expand choice for seniors*, to introduce incentives for the market to compete, and to convert Medicare to a system similar to the Federal Employees Health Benefits Program.

II. Proposals to eliminate waste and overpayments and motivate providers to practice more cost effectively by bringing market principles to Medicare.

III. Proposals to increase cost consciousness and reduce the Medicare subsidy.

B. Defined Medicare Contribution

This proposal would provide a defined contribution -- adjusted for age, gender, geographic location, disability and ESRD status -- towards the plan of choice for each beneficiary.

C. Incentive Based Medicare Reform with Look Back Sequester

Under this approach, specific proposals would be implemented initially to achieve savings and encourage seniors to choose more cost-effective plans. It would also include a yearly savings target that if not met through private care would trigger additional cost saving measures to meet annual targets.

We hope this information will be helpful to your subcommittee and look forward to working with you in your efforts to protect, preserve and improve the Medicare system.

Sincerely,

Christopher Shays
Member of Congress

David Hobson
Member of Congress

Dan Miller
Member of Congress

Steve Largent
Member of Congress

cc: The Honorable Thomas Bliley

IV. Proposals that will end Washington budget gaming by *permanently* extending current law that is set to expire.

Expand Choices for Medicare Beneficiaries

Twelve initiatives are proposed to transform Medicare. These proposals will promote more health care choices for the elderly and are designed to encourage Medicare beneficiaries to choose plans based on cost effectiveness and quality. They also contain incentives to motivate private plans to participate in the Medicare program. These proposals represent the largest reform of the Medicare program since its inception. Although several of the following proposals do not produce direct savings by themselves, they contribute indirectly by improving the overall Medicare program.

1. Inform Beneficiaries (no outlay savings)

Many Medicare beneficiaries are not even aware of the HMO option they have now. Under a system where there are many more options, it will be imperative that they be informed of the many advantages these plans have over their current system. This proposal would require that Medicare beneficiaries be supplied with comparable information on all their choices of health plans (including Medicare fee-for-service) similar to what Office of Personnel Management (OPM) now provides during the open enrollment season for federal employees. Included in this information should be report cards on quality of health care plans.

2. Allow Plans Price Flexibility and Rebates (no outlay savings)

Currently, Medicare allows HMOs the option to offer extra benefits to Medicare beneficiaries, such as prescription drugs and preventive care. Some HMOs are able to offer these extra benefits because their Medicare payment is far higher than the cost to treat the beneficiary.

This proposal would allow plans to give beneficiaries the option of extra benefits or a cash rebate (not allowed under current law) for the difference between the Medicare payment and the plan's cost to treat the beneficiary. Beneficiaries who choose a less expensive plan should be rewarded for that choice and be allowed to receive a rebate.

3. Establish a Preferred Provider Option for Both Part A and Part B of Medicare ($26.3 billion savings over seven years)

Medicare beneficiaries are uncertain about joining coordinated care plans because it limits their ability to choose a doctor. A Preferred Provider Organization has a combination of advantages over coordinated care plans and indemnity plans: it offers a very broad array of doctors with negotiated discounted rates. Beneficiaries can still choose a doctor outside the health plan if they pay a higher copayment. This proposal

would model a Medicare preferred provider system after those that have emerged as a major way to control the growth in costs in private sector insurance programs. Providers who choose to be on Medicare's preferred provider list would provide fee discounts to Medicare.

4. **Allow Beneficiaries to Remain in Their Employer Plans (no outlay savings)**

Currently, if an individual belongs to an employer sponsored plan that does not participate in Medicare, that individual must leave their plan when they become a Medicare beneficiary. This problem will become more prevalent as the private health care population turns in increasing numbers to coordinated care plans — because most of these plans do not have contracts with Medicare. This proposal would provide a seamless health care transition when employees retire and become Medicare beneficiaries by allowing Medicare payment to employer sponsored plans.

5. **Lift the "50/50" Legislation (no outlay savings)**

This Health Care Financing Administration rule requires HMOs with a Medicare contract to have at least as many commercial customers as it does Medicare customers. Almost all insurance plans cite HCFA's "50/50" rule as the major barrier for starting a Medicare HMO in many areas of the country.

6. **Allow Plans to Sell More Products (no outlay savings)**

Insurers believe they could recruit more beneficiaries, and be more profitable, if they could offer more Medicare products in addition to the very regulated HMO product that the Medicare laws now allow. These include point-of-service plans, preferred provider organizations, medical savings accounts, and partial capitation plans. Payment to these plans would be made through a contribution from Medicare that is based on a revised method of how Medicare currently pays HMOs (see proposal below). Beneficiaries would receive a rebate or pay an additional amount depending on the price of the plan they choose.

7. **Increase Incentive for HMOs to Contract with Medicare by Making Medicare Payments to HMOs More Equitable ($9.9 billion in savings over seven years)**

Currently, Medicare payment to HMOs vary greatly from county to county because the HMO payment is based on average fee-for-service Medicare costs. For example, Medicare pays HMOs in some counties in California around $650 per month per beneficiary because Medicare has very high fee-for-service costs in that area. But HMOs in the Minneapolis area are paid only around $350 per month per beneficiary because Medicare fee-for-service is less costly in this area. For this reason, HMOs with Medicare contracts are concentrated in a few areas around the country, leaving most areas with no Medicare HMOs at all because it would be unprofitable for them. Also, while the HMOs in the high paying areas are able to offer beneficiaries extra benefits, such as prescription drugs, with no monthly premium. HMOs in low paying areas must charge the beneficiary a monthly premium upwards of $60 and are still

unable to offer any extra benefits. This proposal would unlink HMO payment from Medicare fee-for-service costs by increasing current HMO payments by 5 percent each year (instead of increasing payments by the increase in fee-for-service costs) and would collapse the range of HMO payments by increasing by only 1.5 percent payments to HMOs that are now paid over 120 percent of the national median until those HMO payments fall within 120 percent of the national median.

8. **Make Payments and Population More Stable for Managed Care Organizations (no outlay savings)**

This proposal would discontinue the 30-day disenrollment policy for HMOs and require beneficiaries to remain in a plan for one year (as does FEHBP). An exception would be made, allowing beneficiaries who are first-time HMO enrollees a 90-day trial period before committing to the full-year enrollment. The proposal would allow plans a three-year payment contract option to eliminate uncertainty in payments that the current year to year contract involves.

9. **Eliminate Part B Premium for Coordinated Care (no outlay savings)**

Medicare beneficiaries would be encourage to join coordinated care plans by eliminating the beneficiary Part B premium of about $50 per month. This premium, which currently is included in the Federal Government payment to Medicare HMOs, would be excluded from the federal payment. HMOs could then, in the annual premium charge to HMO beneficiaries, raise their current premium rate to make up for some or all of this reduced federal payment. Because HMOs can presumably deliver services more efficiently than Medicare fee-for-service, competition will likely result in a premium of less than $50 per month. These savings will accrue directly to the beneficiary.

10. **Increase Premium for New Beneficiaries Who Choose Medicare Fee-For-Service ($3.8 billion in savings over seven years)**

The Medicare Part B program is highly subsidized out of general revenues (projected to receive transfers of $59 billion in 1996). Beginning in 1999, all new enrollees choosing Medicare fee-for-service would pay a Part B premium $20 higher than that of current Medicare beneficiaries. This would help reduce the subsidy while encouraging beneficiaries into more cost effective plans. Current enrollees would be exempt from this proposal.

11. **Move Medicare Deductible Toward Average Deductibles in Private Sector Health Care ($15.2 billion in savings over seven years)**

The Medicare Part B deductible has been increased only three times in the history of the program: the original $50 deductible of 1965 is now $100. This low deductible provides a major incentive to overuse medical services. This proposal would increase the deductible to $150 in 1996 then index it to program growth. Beneficiaries will have the option to avoid paying this deductible (or avoid paying an increased premium for

a Medigap policy that covers this deductible) by choosing a private plan, such as an HMO, that does not charge a deductible.

12. **Convert Medicare to an FEHBP-Like System. (savings are realized beyond seven-year period)**

After the above proposals have increased private market capacity for Medicare beneficiaries, and have helped to introduce beneficiaries to the advantages of the new expanded choice system, Medicare will be converted to a capitated voucher system in which the government will make a standard, defined contribution to the plan each beneficiary chooses, similar to the way the government contributes to the plan of each Federal employee's choice under the Federal Employee Health Benefits Plan (FEHBP).

II. Eliminate Waste and Overpayments and Motivate Providers to Practice More Cost Effectively by Bringing Market Principles to Medicare

13. **Allow Medicare Beneficiaries to Share in the Savings When they Detect Inappropriate Medicare Payments (savings undetermined)**

This proposal would allow Medicare beneficiaries to receive 10 percent of the savings if they detect that Medicare was charged for services they did not receive or for medical equipment they did not request or need.

It is almost impossible for HCFA to thoroughly monitor payments to the thousands of Medicare products and services providers. But 37 million beneficiaries ensuring that their bills are correct will help to reduce Medicare waste and abuse.

14. **Limit Payments to Hospital Physicians Whose Costs Far Exceed the National Median ($6.0 billion in savings over seven years)**

The volume and intensity of physician services per hospital admission varies widely from hospital to hospital even after adjusting for case-mix, geographic price differences, teaching status, and disproportionate share. This proposal would withhold 10 percent to 20 percent of the Medicare payment to physicians in hospitals which exceed 115 percent of the national median. If the physician staff reduces volume and intensity in the year of the withhold, Medicare will pay the physician staff some or all of the withhold at the end of the year. This is the first Medicare fee-for-service proposal ever that provides an organized group of physicians, the hospital medical staff, with the incentive to manage utilization.

15. **Transfer Post-Acute Care Decisions from the Government to the Private Sector by Bundling the Hospital Payment ($19.3 billion in savings over seven years)**

Home Health Care, Skilled Nursing Facilities (SNF), and rehabilitation care — together known as post-acute care — are some of the fastest growing components of Medicare spending. Since 1985, post-acute spending has grown by over 25 percent annually,

from about $2 billion in 1985 to $16 billion in 1994. In the last two years, post-acute spending for SNF and home health services grew at an annual growth rate of 40 percent. Beginning in 1997, this proposal would make a single prospectively determined payment to hospitals that combines (and hospitals would be responsible for) all post hospital SNF and rehabilitation services, along with 60 days of home health services, thereby shifting the responsibility for deciding the appropriateness of post-acute care services from the Federal Government to the private sector. Bundling post-acute care services into the hospital payment would also correct the incentive that hospitals now have to discharge patients more quickly into post acute care settings because payment rates have traditionally been higher in post-acute settings.

16. **Require Competitive Bidding on Clinical Labs and Durable Medical Equipment ($1.6 billion in savings over seven years)**

This proposal will require HCFA to run competitive bidding programs throughout the country in 1997 for certain durable medical equipment (oxygen, parenteral and enteral, MRI, and CAT scans) and clinical laboratory tests. Bids are expected to lower average prices by at least 10 percent nationally. If this average price reduction is not obtained, fees for certain durable medical equipment and clinical lab tests would be reduced to obtain an average price reduction of 10 percent nationally.

17. **Establish Payment Limits for Outpatient Department Services Not Covered Under Current Cost Limits ($3.1 billion in savings over seven years)**

Nearly 40 percent of outpatient costs are exempt from cost limits or prospective payment rates. These costs have greatly expanded in the past five years. This proposal requires HCFA to set payment limits similar to cost-reimbursed outpatient services.

18. **Readjust the Medicare Volume Performance Standard (MVPS) Formula ($3.4 billion in savings over seven years)**

The MVPS is the Medicare annual "growth target" for physician expenditures. If actual physician expenditures fall below this target, physicians are rewarded with an increase in the next year's fees — but then the next years target is raised — and vice versa. The problem with the current law is that there is an asymmetry in the adjustment formula. That is, the upward adjustment in the target is smaller than the downward adjustment because of the expected behavioral change of increased volume and intensity of services when physician fees are reduced.

The asymmetrical treatment of future MVPSs, therefore, effectively rewards physicians for exceeding the limit since future target limits are adjusted upwards for expected volume increases. This proposal, which is supported by the Physician Payment Review Commission, would determine future MVPSs symmetrically by eliminating the behavioral offset assumption from the calculation.

19. **Reduce Payments to Physicians for Overhead ($0.9 billion in savings over seven years)**

Medicare physician fees are calculated to include, among other things, physician office overhead costs. This component of the fee is based on historic charges instead of resource costs which are more reliable. This policy moves overhead expenses towards a resource-cost system.

20. **Eliminate Formula Error That Causes Outpatient Overpayment ($16.0 billion in savings over seven years)**

The current Medicare payment formula for certain outpatient department services (ambulatory surgery, radiology, and diagnostic tests) contains an anomaly in the payment formula that was not intended by Congress when it was first designed. Beginning in 1998, this proposal would correct the anomaly in the outpatient payment methodology by changing how beneficiary coinsurance is applied in the blended limit formula.

21. **Reduce Medicare Payments to Hospitals for Direct Costs of Medical Education ($6.1 billion in savings over seven years)**

Medicare makes a separate payment to hospitals for the direct costs they incur in providing graduate medical education, namely residents' salaries and benefits, teaching costs, and institutional overhead. This proposal would reduce teaching and overhead payments for residents, but continue to pay their salaries and fringe benefits. The overall reduction in the level of subsidy is warranted since market incentives appear to be sufficient to encourage a continuing flow of new physicians.

22. **Reduce Medicare Payments to Hospitals for Indirect Costs of Medical Education ($21.1 billion in savings over seven years)**

This proposal would lower Medicare indirect education (ICE) in 1996 from 7.7 percent to 3 percent for each 10 percent increase in the intern and resident-to-be ratio (IRA ratio). The GAO and Prospective Payment Assessment Commission (Prepuce) have both found that the 7.7 percent adjustment overcompensates teaching hospitals for these costs.

23. **Eliminate Medicare Payments to Hospitals for Medicare Patients' Bad Debts ($2.7 billion in savings over seven years)**

Hospitals are responsible for collecting certain deductibles and co-payments from Medicare beneficiaries for inpatient services. Medicare fully reimburses unpaid balances for hospitals that have collection efforts. There is little incentive for thorough collection activities and bad debt claims have more than doubled since program inception. Hospitals that serve financially needy are already compensated through other Medicare payments. The HHS Office of the Inspector General recommends legislation to modify bad debt payment policy. Eliminating bad debt is included in CBO's spending and revenue options book.

24. **Phase Out Medicare Payment to Hospitals for Disproportionate Share ($28.8**

billion in savings over seven years)

Under Medicare's prospective payment system (PPS), higher rates are paid to hospitals with a disproportionately large share of low income patients. In 1985, Congress added this adjustment to account for low income Medicare patients that may be sicker and more expensive to treat. In 1996, disproportionate share (DSH) payments are projected to total $3.7 billion, more than 5 percent of all PPS payments.

Data on hospital costs, however, provide only limited support for any disproportionate share adjustment. Although more than 1,900 hospitals receive DSH payments, only 8.4 percent of hospitals have high DSH values accounting for one fifth of DSH payments. This proposal would phase out Medicare DSH payments over a two-year period. In addition to Medicare DSH payments, hospitals also receive DSH payments from the Medicaid program.

25. **Bring Surgeon Conversion Factor in Line With Primary Care ($5.8 billion in savings over 7 years)**

Under the Medicare physician fee schedule, relative value units (RVUs) are allocated for each physician procedure. A physician's payment amount is determined by multiplying the number of units (assigned to the procedure) by a dollar amount called the conversion factor. Currently, this conversion factor is $35.15 for surgery, $33.72 for primary care, and $32.91 for all other physicians. (For example: an appendectomy may be assigned 100 units -- this is multiplied by $35.15 to determine a payment of $3515.00). Beginning in 1998, this proposal would reduce the surgery conversion factor to the same as the primary care conversion factor. Because surgical procedures are generally assigned more RVUs, this proposal would not necessarily reduce surgeon payments to the level of primary care.

III. Increase Cost Consciousness and Reduce the Medicare Subsidy

26. **Reduce the Medicare Subsidy to High-Income Beneficiaries ($18.0 billion in savings over seven years)**

The current Medicare Part B premium charged to seniors covers 30 percent of total program costs (in 1996 this will go down to just 25 percent because of an OBRA 1993 law). The remaining 70 percent of the cost of providing Medicare Part B services is paid from the Federal Government's general tax revenues (only Medicare Part A is financed by the Medicare payroll tax).

This proposal gradually reduces the Medicare Part B premium subsidy for high income beneficiaries. The subsidy decrease would phase in to adjusted gross income of $70,000 for individuals and $90,000 for couples and would by phased out to zero for individuals above $95,000 and couples above $115,000 in income. At the zero subsidy level, beneficiaries will pay the full monthly premium amount: $164 per month.

27. **Expand Medicare Coinsurance to Services Now Provided at No Cost to**

Beneficiaries: Clinical Laboratory and Home Health Services ($25.8 billion in savings over seven years)

These provider services are the only Medicare services which do not now include a beneficiary co-insurance. Requiring beneficiaries to share the cost of these services would help to discourage over utilization and reduce the Medicare subsidy. Beginning in 1996, beneficiaries would pay 10 percent of all home health visit costs. beginning in 1999, this amount would increase to 20 percent. Beneficiaries would pay 20 percent of all laboratory services beginning in 1997. Beneficiaries below 150 percent of the poverty level would be excluded from paying this coinsurance.

IV. End Washington Budget Gaming by Permanently Extending Current Laws that are Set to Expire

28. **Freeze 1996 Physician Payment at the 1995 Level and Reduce Future Updates by 3 Percent ($2.5 billion in savings over seven years)**

This proposal would adjust the annual update component of the Medicare physician fee schedule so that its statutory formula will not continue to award physicians with large updates. In 1994 and 1995, physicians received cumulative overall Medicare rate increases of 15.2 percent (7.0 percent in 1994 and 7.7 percent in 1995).

29. **Reduce the Excess Capacity Adjustment for Hospital Inpatient Capital Payments ($5.4 billion in savings over seven years)**

Current Medicare prospective and cost reimbursed payments to PPS hospitals for inpatient capital is based on the assumption that the hospital has a 100-percent occupancy rate. Hospital occupancy, however, has actually been about 60 percent over the last five years and, as a result, Medicare is paying hospitals for empty beds. This proposal would adjust Medicare hospital capital payments for excess capacity. In the late 1980s, these capital payments were reduced by 15 percent. In the 1990s, this reduction was scaled back to 10 percent.

This proposal recaptures the 5 percent in Medicare capital savings given back to hospitals in the 1990s. While this capital proposal addresses Medicare overpayments only for excess capacity.

The capital extender proposal (below), preserves the OBRA 1990 savings that reduced excessive Medicare capital payments resulting primarily from the previous Medicare capital cost reimbursement system that encouraged hospitals to buy the most expensive as opposed to the most efficient types of equipment and buildings.

30. **Extend 10-Percent Reduction for Inpatient Capital Related Costs ($7.0 billion in savings over seven years)**

OBRA 1990 included a 10-percent reduction in the amount of payments attributable

to capital related costs that would otherwise be made to hospitals. The Secretary determines the amount of the reduction from prior year data. The OBRA 1990 provision expires in 1995. As Medicare continues to grow at or above 10 percent per year, it is viewed that there is sufficient flexibility to adjust capital payments.

31. **Reduce Hospital Update to Market Basket Minus 2 Percentage Points through 1999 and Minus 1 Percentage Point in 1998 and 1999 ($25.9 billion in savings over seven years)**

Since the beginning of the hospital prospective payment system, the Medicare payments per hospital admission have been gradually higher than the hospital market basket inflation factor. OBRA 1993 reduced the hospital market basket update by 2.5 percentage points in 1994 and 1995, 2 percentage points in 1996, and 0.5 percentage points in 1997. This proposal reduces the update to market basket minus 2 percentage points through 1999 and market basket minus 1 percentage point thereafter. The market basket reductions are based in part on the Medicare overpayments to hospitals relative to inflation since the beginning of the hospital prospective payment system in 1983. The reduction incorporates the OBRA 1993 reduction of 0.5 percentage points from the market basket, as well as a 1-percentage-point productivity gain, and conforms the hospital update to that of other Medicare updates.

32. **Maintain Savings from Skilled Nursing Facilities Cost Limits ($2.0 billion in savings over seven years)**

This provision would maintain the savings from the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) that froze for two years the costs limits for Medicare payments to skilled nursing facilities (SNFs). Payments to SNFs are based on average costs subject to cost limits, which are updated each year. The cost limit freeze in OBRA 1993 would expire October 1, 1995. This provision would not continue the freeze, but simply would update the cost limit without including cost increases during the two years of the cost limit freeze. This extender was included in the President's 1996 budget.

33. **Maintain Savings from Home Health Cost Limits ($3.1 billion in savings over seven years)**

This provision, like the SNF provision, would maintain the savings from the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) that froze for two years the costs limits for Medicare payments to home health agencies (HHAs). Payments to HHAs are based on agency's costs subject to cost limits, which are updated each year. The cost limit freeze in OBRA 93 would expire July 1, 1996. This provision would not continue the freeze, but simply would update the cost limit without including cost increases during the two years of the cost limit freeze. This proposal was included in the President's 1996 budget.

34. **Increase Part B Premium $5 per Month for 1996-99 and $7 per Month beginning in 2000 ($36.3 billion in savings over seven years)**

OBRA 1993 set the Medicare Part B premium at 25 percent of program costs for 1996-98 (as a result of this, beneficiaries' will see their monthly premiums drop from $46.10 in 1995 to $43.00 in 1996 because currently the premiums are set to pay for about 30 percent of program costs). For the past three years, the monthly premium has risen about $5 per year. This proposal would replace the OBRA 1993 25-percent law with a flat increases in the monthly premium of $5 (i.e. $60 per year) in the early years and $7 (i.e. $84 per year) beginning in 2000.

35. **Permanently Extend OBRA 1993 Medicare Secondary Payer Provisions ($6.4 billion in savings over seven years)**

This provision would permanently extend certain Medicare Secondary Payer provisions from OBRA 93. In general, payment for services provided to a Medicare recipient is first required from a private payer, if the recipient has private health coverage. Under current law, MSP for the disabled, End Stage Renal Disease (ESRD) patients, and MSP data match would expire in 1998. These provisions make Medicare the secondary payer for disabled and ESRD beneficiaries, and would authorize data links to obtain information about primary payers for other beneficiaries. This proposal was included in the President's 1996 budget.

PLAN B: DEFINED MEDICARE CONTRIBUTION

Under this option, Medicare is transformed into a defined contribution program for *every* beneficiary. Medicare will make a contribution to the health plan of each beneficiary's choice. Choices will include a broad range of plans with varying levels of coverage. Beneficiaries will pay extra if the plan they choose is more costly than the amount of the contribution and will receive a rebate if the plan is less than the amount of the contribution.

Private plans can include indemnity plans, HMOs, preferred provider organizations, point-of-service plans, medical savings accounts as well as other innovative insurance products. Any plan available in the market to be purchased with a Medicare contribution *must include catastrophic coverage* for out-of-pocket costs over $10,000. Plans would be required to meet a minimal set of other eligibility requirements, including quality review, in order to prevent marketing abuses.

The value of the contribution would be determined by setting total Medicare expenditures at an overall 5.4 percent compounded annual growth rate. The contribution would be adjusted based on the beneficiaries' age, gender, geographic location, disability status and ESRD status. Average contribution amounts, along with current 1995 per beneficiary spending, are as follows:

1995	1996	1997	1998	1999	2000	2001	2002
$4,816	$5,122	$5,338	$5,574	$5,786	$5,955	$6,162	$6,361

Total spending for Medicare would be as follows:

	1995	1996	1997	1998	1999	2000	2001	2002
(billions)	$178.2	$192.6	$203.9	$215.7	$226.8	$237	$247.7	$258.9

Medicare could continue to offer the traditional Medicare benefit plan by determining the actuarial value of Medicare and allowing beneficiaries to purchase it with their contribution. Savings would be achieved by limiting total expenditures to a reduced rate of growth.

PLAN C: INCENTIVE BASED MEDICARE REFORM WITH LOOK BACK SEQUESTER

Under this option, reforms to preserve Medicare would be implemented in a two level plan. First, proposals would be adopted to ensure the financial solvency and reduce the irresponsible growth in general revenue payments in the near term. Second and concurrently, Medicare would be expanded to allow market based choices for beneficiaries, promoting cost efficient care and incentives through potential rebates or added benefits. As these reforms improve the Medicare system, the financial solvency will be strengthened.

While market based reforms will be structured to give clear incentives, beneficiaries will not be forced to join the private market plan. They may stay in the government-run fee for service Medicare option if they so choose. It is anticipated that the private plans will sufficiently reduce the rate of growth in Medicare to keep the program on sound footing. However, both the market plans and the government-run Medicare fee for service system will be structured to grow at financially viable rates. Medicare target spending will be established based on assumptions of how many beneficiaries will choose private plans. If an insufficient number of beneficiaries join the private plans and spending targets for the year are exceeded, Congress would implement additional cost saving measures for the government run non-market Medicare plan.

First Level: Immediate Financial Solvency Measures

Upon implementation of this plan, immediate measures would be taken to lower growth rates in the current Medicare system. Present growth rates of 11 percent per year would be reduced to an 5.4 percent compounded annual growth rate over a seven year period. Proposals to achieve this growth rate include:

- Establish home health, skilled nursing, clinical lab coinsurance
- Reduce hospital inflation update by 1.5 Percent
- Bundle Post-Acute Care Services
- Withhold payments to medical staffs above 115 percent of the national median
- Freeze physician update
- Extensions of OBRA 90 and 93
- Increase Part B deductible from $100 to $150 then index to program growth

In addition to reducing the spending growth of Medicare, these proposals would help reduce the over utilization of government run Medicare services, and introduce market incentives into the program.

Second Level: Savings from Private Market Plans

Medicare private plans would be expanded from the current limited offering to include Preferred Provider Organizations, Point of Service plans, Medical Savings Accounts, and other types of plans. Currently, nine percent of Medicare beneficiaries are enrolled in HMOs. As these market based reform improve the options available to seniors, it is anticipated that enrollment in private plans will grow steadily (projected enrollment rates are below).

Year	1995	1996	1997	1998	1999	2000	2001	2002
enrollment	9%	15%	25%	35%	45%	50%	55%	59%

Each year, Medicare will conduct an open enrollment period for beneficiaries to choose their coverage option. Enrollees in the private plans will receive a Medicare contribution toward the cost of the plan chosen. The contribution will be adjusted to account for age, gender, medical costs, and health status. Compounded annual growth of the amount contributed will be 5.4 percent. The beneficiary can choose the plan that meets his or her health insurance coverage needs, and select deductibles, benefits, rebates, and other parameters as desired.

The amount of spending in the Medicare market plans and government-run plan is projected to be as follows:

Year (billions)	1996	1997	1998	1999	2000	2001	2002
Private	$28.9	$50.9	$75.5	$102.0	$118.5	$132.2	$153.6
Government	$163.7	$153.0	$140.2	$124.8	$118.5	$115.5	$105.3
Total	$192.6	$203.9	$215.7	$226.8	$237.0	$247.7	$258.9

Third Level: Look Back Mechanism

To ensure that spending in both the Medicare market plans and the government-run program achieve financially viable rates of spending, the following procedure is implemented.

I. Determination of Projected Spending:

a. At the completion of the Medicare open enrollment season, the Health Care Financing Administration shall report on the number of enrollees in market based plans, and shall calculate the total Medicare contribution for the program.

b. HCFA shall then determine, for the fiscal year, the amount of spending in the government-run Medicare program --given the reduction policies initially implemented in level one and any additional legislation passed in the current fiscal year affecting Medicare.

II. Look Back Sequester:

a. If the total contributions to private plans are lower than the projected target; or if government-run Medicare spending is projected higher than the target,
   - HCFA shall submit to Congress a list of proposals for the government-run Medicare program to meet the total spending target.
   - Congress shall act on these proposals, or meet the target with other proposals before the beginning of the fiscal year.
   - If Congress does not meet the deadline, HCFA shall implement its recommendations to meet the targets.

b. Order of sequestered savings:
   - First order proposals shall be reductions in provider payment updates, such that updates are positive.
   - Second order proposals shall be reductions in add on payments not directly related to providing services, and cost limit changes.
   - Third order savings shall be cost sharing in high growth services.

c. The ratio of beneficiary savings proposals relative to providers shall not exceed fifty percent.
   - Prohibited savings proposals: Congress and HCFA shall not recommend increases to the Hospital Insurance payroll tax, or increase the percentage of Supplementary Medical Insurance program costs covered by government contributions in the base year.