DON-FYI

MEMORANDUM

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

April 7, 1995

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

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

Medicare Trust Fund

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

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

Congressional Health Care Update

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

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

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

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

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

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

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

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

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

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

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

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

Current Status of White House Health Policy Development

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

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

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

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

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

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

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

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

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

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

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

Housekeeping

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

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

Newt Gingrich,

previous two centuries. People were buying gold, antiques, baseball cards—anything to get out of holding their own country's money. Savings were devalued, and plans for the future became totally unpredictable. Only when Ronald Reagan took the helm was inflation brought under control again.

Daniel Yankelovich describes this need for a secure relationship between people and their government as a "giving and getting contract." People want to know what they have to give during their lifetime and what they will get back for having done their duty. In a stable, healthy society, there is a strong sense that if you work hard, save your money, pay your taxes, and fulfill the duties of citizenship, then the government will keep things stable enough for you to collect your rewards. Inflation strikes at the very heart of this "giving and getting contract." It says that those who borrow, gamble, and spend today do better than those who work hard and live frugally. Hyperinflation absolutely destroys any sense of trust and stability between people and their government.

Baby boomers need to realize that the federal government must balance its operating budget if they are ever going to be able to collect their Social Security. Now is the time to put our house in order. Every time you see an insurance company or an investment company urging you to plan for your retirement, you ought to apply the same logic to the whole country. If individuals and families must plan years ahead for retirement, isn't the same thing true of generations and nations?

Those who think the situation is still too distant to worry about need look no further than Medicare to understand that America is on the precipice of substantial fiscal problems. Medicare is the foundation of health care for our senior citizens. It is a government monopoly and therefore inefficient, wasteful, and slow to adapt to innovations in technology and management. As a result, the system is rapidly growing out of control. Fraud, waste, and mismanagement divert resources that ought to go to the medical care of our senior citizens.

Executive Office

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Under the current projections of the Medicare board of trustees, Medicare will spend $2 billion more than it receives in 1996, $39 billion more in 2002, and $71 billion more in 2005. Outlays are projected to rise from $200 billion at the end of the century to $600 billion by 2014. Costs are currently doubling every seven years. Such a rate of increase is clearly unsustainable. It will either bankrupt Medicare or bankrupt America.

At this rate, maintaining the Medicare Trust Fund would require raising Medicare taxes 125 percent and senior citizens' annual premiums 300 percent by 2002. Even that will only buy time. If growth continues, taxes and premiums will have to be raised again and again. Sooner or later taxpayers or senior citizens or both will rebel.

If we are going to save our senior citizens' health system, our baby boomers' retirement, and our children's future we are going to have to remake the federal government and balance the budget. As I noted earlier, this is a moral necessity, a financial necessity, and a personal obligation for all Americans. Our personal future will be determined by whether or not we have the courage to undertake the task.

Means amt coming in
< amount owed → so
Trust Fund ↓
① #s on amt in $ out →
② But right 2nd sentence "outlays" wrong

Actually, balancing the budget is a pretty straightforward process. Once we set our minds to the task, it should not be all that difficult. In 1995 the federal government took in revenues of $1.4 trillion. By 2002 the government should have revenues of $1.8 trillion. *Slowing* the growth of government spending so that seven years from now we are spending only $1.8 trillion would produce a balanced budget.

One way to think about the scale of the challenge is to look at the last seven years. From 1989 through 1995 the federal government has spent $9.5 trillion. During the next seven years a balanced budget would allow us to spend $11.7 trillion. In other words, we could spend $2.2 trillion *more* over the next seven years and still balance the budget. It's just a matter of cutting out the extra increases.

I have argued consistently that Social Security must be off

DEPARTMENT OF THE TREASURY
WASHINGTON
August 10, 1995

ASSISTANT SECRETARY

MEMORANDUM FOR: Jennifer Klein

FROM: Alicia Munnell

SUBJECT: Newt Gingrich on Medicare

Summary

In his recent book, Newt Gingrich inappropriately characterizes the Medicare program as a government monopoly and therefore inefficient, wasteful, and slow to adapt to new technologies. He also presents data on the projected growth in Medicare costs which are not entirely consistent with recent official projections.

Discussion

The Medicare program makes the Federal Government the major *insurer* of health care services for the elderly. This in turn has the effect of making the government an oligopsonistic buyer of those services with respect to the elderly population. The government generally does not *provide* health care services. Decisions about whether to adapt to new technologies are made by private sector health care providers who supply services to both the elderly and nonelderly populations. Of course, the government's management of the payment system may influence those decisions.

Gingrich presents the following data on the Medicare program:

Year	Medicare Deficits (billions)	Medicare Outlays (billions)
1996	$2	
2000		$200
2002	$39	
2005	$71	
2014		$600

The data in the table ostensibly are official projections from the Board of Trustees. However, it is difficult to reconcile these data with data from the 1995 Trustees' Report shown in the table below (conclusions are the same for the 1994 Trustees' Report). The deficit figures for 2002 and 2005 are consistent with the difference between total income

Medicare Projections from the 1995 Trustees' Report
(fiscal years - billions of dollars)

	Part A		Part B		Total	
Year	Outlays	Balance	Outlays	Balance	Outlays	Balance
1996	122.3	0.1	76.0	6.2	198.3	6.3
2000	167.6	-24.1	114.5	1.4	282.1	-22.7
2002	195.3	-41.1	141.8	1.7	337.1	-39.4
2005	244.6	-72.6	198.8	2.4	443.4	-70.2
2014*	491.8		545.7		1,037.5	

*Data in this row are for calendar years.

and total outgo for Part A and Part B combined. However, the same calculation yields a $6 billion surplus for 1996 in contrast to the $2 billion deficit presented by Gingrich.

The outlay figures are more troublesome. The $200 billion for 2000 and $600 billion for 2014 (Gingrich says that costs are doubling every seven years which would imply outlays of $800 billion in 2014 rather than $600 billion.) do not correspond to official outlay projections for either Part A or combined Part A and Part B.

Finally, Gingrich says that in order to maintain the Medicare Trust Fund (the definition here is unclear) taxes will have to be raised 125 percent and premiums raised 300 percent by 2002. The latter figure is roughly consistent with official outlay projections for Part B. That is, if all future outlay growth in Part B were covered by enrollee premiums then, by 2002, the monthly premium would be about three times what it is for 1995 ($46.10). Of course, the Part B program does not work this way. Government contributions cover 25-30% of costs. Under current law, the Part B premium is projected to increase to about $59 per month in 2002, a 29 percent increase over the 1995 premium.

Gingrich's statement on taxes implies that by 2002 the payroll tax rate would be 6.52 percent (2.25x2.9) in that year. Though maintenance of the trust fund is not defined by Gingrich, one interpretation is that the Part A program would operate on a strict pay-as-you-go basis with payroll taxes increased each year to match increases in outlays. In that case, the payroll tax would increase from 2.9 percent to about 3.7 percent in 2002, a 28 increase. Perhaps Gingrich meant 25 percent rather than 125 percent.

Alan Cohen

Comments on Newt Gingrich piece on Medicare:

The numbers that the author presents on the difference between outgo and income are essentially correct. The difference between income and outgo for Part B alone is small in all years. Therefore, the figures for Part A plus Part B are very similar to the figures for Part A alone. In either case, the numbers in the 1995 Trustee's report are fairly close to the numbers presented by the author.

Essentially beginning in 1996, outgo for Part A exceeds income. The excess gets greater and greater each year. This runs down the balance in the Part A Trust Fund until it reaches zero in 2002.

The author's figures on outlays are inaccurate (see Munnell memo). There are also major problems with the payroll tax and premium calculations (see Munnell memo).

DRAFT; June 5, 1995; 11:27 pm

STATEMENT OF ROBERT B. REICH
SECRETARY OF LABOR
BEFORE THE SENATE FINANCE COMMITTEE
JUNE 6, 1995

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to discuss the future of the Medicare system. My fellow trustees and I recently submitted to Congress our annual report on the financial status of the two separate Medicare trust funds -- the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. As you know, this year's report shows that the Hospital Insurance Trust Fund will be insolvent by the year 2002, and that the costs of the SMI program will continue to soar.

These problems are not new. Indeed, for the past 15 years, the trustees have called for reform. And the Clinton Administration has already worked with Congress to address the problem, although there is still much more to be done. Prior to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the HI Trust Fund was expected to be depleted by 1999. But the reforms included in OBRA 93, along with the strong economy America has enjoyed since then, have delayed the Trust Fund's depletion until 2002. These short-term remedies, let me be clear, do not solve the deeper problems with the Medicare system, nor do they exhaust the Administration's commitment to reform. But they do buy us precious time in which to devise and implement a more comprehensive solution. It is now up to all of us to use this time well.

We all agree that the Medicare system is in need of change. The President has repeatedly said that he would like to sit down with Congress to produce a bipartisan blueprint for broad-based health care reform. The Clinton Administration believes that the financing problems that the Medicare system faces must be solved within the broader context of health care reform. As

a trustee of the Medicare trust funds, I am very concerned about the impending insolvency of the HI Trust Fund, and pleased that this Congress seems intent on addressing this issue. However, I am deeply troubled by some of the approaches that are being discussed.

Attempts to quickly shrink federal spending without reform by greatly reducing Medicare benefits will leave many Americans worse off while ignoring the fundamental structural flaws of our health care system. Large reductions in Medicare will increase health care costs to the elderly. They will also strain the finances of many health care providers, including some of America's most valuable and vulnerable health-care institutions. But the effects don't stop there. Providers may attempt to shift costs to private health insurance companies. If costs are shifted, many working Americans who are privately insured, and who may believe themselves to be insulated from the Medicare issue, will in fact feel the squeeze.

Speaker Gingrich and others claim that reducing Medicare expenditures will be "painless." This simply is not plausible. Dramatically cutting spending for a program like Medicare--at the level the Senate Budget resolution has proposed--without reforming the overall health care system requires either reducing services or shifting the costs of the services to somebody else. There are, however, enough data to trace out the effects of some of the more likely approaches.

THE ELDERLY:

While no specific bill has been put on the table, one prominent proposal would increase premiums, co-payments, and deductibles for elderly and disabled Medicare recipients. Under this plan, deductibles would be doubled from their current levels, premiums would be hiked every year until 2002, and there would be a dramatic increase in co-payments for home health care and other services. These changes, taken together, would raise annual Medicare costs by over $2,000 per couple in 2002 alone. For the typical Medicare beneficiary, increased premium costs will come right off the top of their Social Security checks--the simple equivalent of a Social Security benefit cut.

DRAFT; June 5, 1995; 11:27 pm

HEALTH CARE PROVIDERS:

Some vulnerable health care providers will also feel the pain of these deep Medicare cuts that will potentially be used to pay for tax cuts for the rich. When Medicare benefits are slashed outside the context of the overall health care reform, some hospitals may shift the pain of the spending cuts to the privately-insured. In the face of large Medicare cuts, hospitals whose patients are predominately Medicare beneficiaries and the uninsured will have few other options except to reduce the quality of care to all patients, or to close their doors. In particular, we are concerned that large reductions in Medicare payments could endanger rural and urban safety-net hospitals.

Hospitals in rural areas are often small. Some serve mostly Medicare recipients, and often are the only health care provider within 50 or more miles. Since many of these hospitals are already in financial distress, large Medicare cuts in isolation from broader efficiency improvements may cause rural hospitals to reduce the quality of care or to squeeze the wages of hospital workers. In extreme cases, these hospitals will be forced to go out of business, and workers will be laid off. Nearly 10 million Medicare beneficiaries live in rural areas. Such large cuts in Medicare outside the context of overall health care reform puts their health care in greater jeopardy. Some urban "safety net" hospitals, faced with a growing burden of uncompensated care, are equally limited in their ability to shift the burden of drastic reductions in Medicare benefits, and will face similar cost pressures.

PRIVATELY-INSURED WORKING AMERICANS:

~~Some hospitals that can shift costs to insured patients will usually do so.~~ Many of America's hospitals have used gains from some payers to cover losses from others. Health care providers frequently charge insured patients more to cover the expenses of the 40 million Americans who do not have health insurance and thus frequently receive uncompensated care. In this context, slashing the Medicare program without broader health care reform may lead

hospitals to increase costs to the privately-insured to make up for the enormous losses from Medicare patients.

For example, the 1995 Prospective Payment Assessment Commission (ProPac) report to Congress stated that as payments for Medicare and Medicaid were reduced over the last decade, hospitals responded by increasing revenue from private payers. Indeed, in 1992, hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they took in $29 billion in revenue above their costs of providing care to privately-insured patients. For example, just a few miles away at Georgetown University Hospital they charge paying patients 95 cents for an Advil tablet--8 times the retail price--in order to help offset the costs of uncompensated care.

For any action there is an equal and opposite reaction. This is an immutable law of physics, and applies in comparable ways to health-care policy. Those who prefer concrete models to abstract theorems can think of it as squeezing a balloon. If you push on one side, the air is forced to the other side. It stands to reason that deep Medicare cuts of the magnitude proposed by the Senate Budget resolution--without reforming the health care system itself and without denying medical care to Medicare beneficiaries--will likely force 150 million privately-insured Americans to pay more. The cost shifting that results from large Medicare cuts--outside the broader context of health care reform--would essentially impose a hidden tax on working Americans. As Henry Aaron, an expert on health care issues at the Brookings Institution, recently testified: "Large reductions in Medicare spending within the current program framework will impose...taxes on private businesses and individuals."

A Congressional Budget Office analysis concludes that some of the expenditure reductions to providers will simply be shifted--in the form of price increases--to private payers. Martin Feldstein, a Harvard professor and former chairman of the Council of Economic Advisers, agrees. He wrote last year that a "very large hidden tax would result from reducing government payments to hospitals and other providers of Medicare services without any reduction in the care that they are expected to give. As a result, the hospitals and other providers would just raise their prices

to patients and insurance companies. In the end, it would be the privately insured individuals who bear those costs in the form of higher insurance premiums and lower wages."

A hidden tax is serious enough. But even worse, we are concerned that cost-shifting--triggered by large Medicare cuts--will have the ultimate effect of reducing health-care coverage. If such dramatic cuts are taken, more costs may be shifted to the privately-insured and premiums will tend to rise to cover those costs. And as premiums increase, some workers and their families will be priced out of the market, and will end up without coverage. Mark Pauly, a health care economist at the University of Pennsylvania, wrote in a survey of the relevant literature that "there is fairly consistent evidence that insurance coverage is sensitive to proxies for its price." A recent CBO report confirms this assessment too.

Traditionally, membership in the American middle class included not only a job with a steadily increasing income, but a bundle of benefits that came with employment. Since 1979, we have seen a divergence in health benefits, related to education and skills. Employer-sponsored health coverage for workers with college degrees has declined only slightly, from 79 percent in 1979 to 76 percent in 1993. But rates for high school graduates have fallen from 68 percent to 60 percent over the same period, and for high school dropouts, the 1979 rate--already low at 52 percent--has plummeted to 36 percent. Nearly 100,000 Americans are already losing health insurance each and every month. Medicare cuts unaccompanied by broader reforms can only exacerbate this crisis.

According to a recent study by David and June O'Neill, less-educated workers are more likely to lose coverage when confronted with higher premiums. This suggests ample reason to believe that the hidden tax associated with cost shifting will disproportionately affect workers with less education--the very group that has suffered the sharpest drop in health-care coverage since 1979, and whose overall prospects have become bleaker and more unsettled in today's changing economy.

One drawback to cutting Medicare in isolation was recently summarized by *The*

Economist: "Although the federal budget would benefit [from reduced Medicare expenditures], these savings could be offset by higher costs in private health care... Thus the best way to cut Medicare... would be to subsume them within broader health-care reforms." For that reason, we need to sit down together--in a bipartisan manner--and produce a blueprint for broad-based health care reform. We must put the HI Trust Fund on a sound, sustainable footing. We have all known this for a long time now. But we have a responsibility to every American who works hard and plays by the rules to fix the problem of our health-care system, not simply shuffle from one group to another the excess costs that the current flawed system produces.

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DRAFT

DISCUSSION DRAFT -- NOT FOR DISTRIBUTION

POSSIBLE RESPONSES TO DEMAND THAT TRUSTEES SPECIFY MEDICARE REFORMS

Background: House Republicans are likely to pass a bill requiring that the Medicare Trustees issue a report to Congress by June 30, 1995, detailing specific actions to ensure the short-run solvency of the Medicare Trust Funds (both the HI and SMI Trust Funds). If the Senate considers a similar bill, the Administration needs to develop a strategy for a response.

Legal Analysis (incomplete): Congress generally has no legal recourse against the Trustees if they do not meet the June 30 deadline. Many Congressionally-set deadlines for studies are missed, with no legal consequences. However, there is a political risk if the deadline is missed. Congressional Committees can be expected to hold hearings where the Trustees are grilled harder and more personally than ever, since the Republicans are desperate for dollars. They will do anything to humiliate, cajole, or shame the Administration into providing needed cover for Medicare cuts. This process will no doubt severely strain relations with the Hill.

Financial analysis: The HI Trust Fund needs around $80-100 billion (7-year figure) in additional revenues or spending cuts to ensure solvency through 2005 (the exact figure depends on the time path of savings/revenues). Around $160 billion (7-year figure) in additional revenues or spending cuts is needed to ensure that the HI Trust Fund maintains a reserve fund equal to one year's expenditures through 2005. Once the Baby Boom generation starts to retire in droves (i.e., by 2020), the entire system will be under severe financial stress, requiring additional reform steps.

Options: Several alternatives are presented below. These alternatives are nowhere near exhaustive. Moreover, portions of the alternatives can be mixed and matched with others to create composite alternatives (perhaps an infinite number of them).

ALTERNATIVE 1: RELY ON SENATE DEMOCRATS TO DELAY OR SCUTTLE ALTOGETHER

• Administration works with Senate Democrats to ensure that bill is not passed. Potential strategies could involve filibusters, lengthy amendment strategies, etc.

Pros:

• Does not use up much political capital.

• Administration keeps low profile and is not perceived as defending status quo.

• Recognizes the political nature of this bill and draws battle lines on political grounds.

Cons:

• Very unclear if there is even a majority of Senate Democrats willing to do this.

• Public could perceive this effort as evidence that the Administration and Senate Democrats are not serious about addressing Medicare solvency issue.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

DRAFT

ALTERNATIVE 2: DIRECT BLOW-OFF STRATEGY

• Administration vetoes bill and states that the time frame permitted and the callousness of their approach illustrates all too well that the Republicans are using the Trust Fund as a political football and a bank for their tax cuts. We will simply say that we won't participate in such a sham.

Pros:

• Administration does not respond to what is essentially a political strategy with a policy response.

• Administration sends strong message that it will address Medicare only on its own terms or within the context of wider reforms in a serious manner.

•If we carry-off throughout the entire Administration (no off-the-record second guessing) the President could appear strong, particularly if it is combined with a restated, but more clear, commitment to produce, or work with Congress to produce, a plan once the President's previously outlined criteria have been met.

Cons:

• Elite press probably attacks Administration for missing opportunity to address Medicare Trust Fund solvency.

• Uses up political capital to sustain veto.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

ALTERNATIVE 3: INDIRECT BLOW-OFF STRATEGY

• Administration signs bill or allows it to become law, but issues report shortly thereafter which states that Medicare reform must be done in the context of overall health care reform.

> **Possible Variation:** Report states that solvency of Medicare Trust Funds could be improved if revenues that would be used for proposed tax cuts instead are directed to Trust Funds.

Pros:

• Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.

• Does not use much political capital.

• Administration does not respond to what is essentially a political strategy with a policy response.

• Repeats current message on health care.

• Does not provide political cover to Republican attempts to cut Medicare expenditures.

Cons:

• Public and media could perceive this report as non-responsive and evidence that the Administration is not serious about addressing Medicare insolvency.

• Elite press attacks Administration for missing opportunity to address Medicare Trust Fund solvency.

• Congressional Republicans become more antagonistic toward Trustees (and perhaps rest of Administration).

• Could be criticized for using funds that do not exist as a specific part of the budget proposal (this might only be an elite press problem).

• Transfer of general fund revenues to Medicare Trust Fund might be criticized as an undesirable precedent.

ALTERNATIVE 4: RESTRUCTURING BAND AID RESPONSE

• Administration signs bill or allows it to become law. Report focuses on the transfer of some items from Medicare Part A to Part B (e.g., home health care). Premiums charged for Part B could (but need not) increase to cover costs of this service.

Pros:

• Seems like a reasonable response to bill's requirements.

• Would substantially increase the solvency of HI Trust Fund by removing a large (e.g., $15-20 billion per year for home health care) and fast-growing cost component.

• If Part B premium is increased to cover part of increased cost of benefits, this would reduce Federal deficit (a premium equal to 25 percent of the actuarial cost of home health care would reduce deficit by about $5 billion per year).

• If Part B premium is increased to cover part of increased cost of total Part B benefits, beneficiaries would be paying part of the cost of a fast-growing component of Medicare benefits.

Cons:

• Beneficiaries may view this shift as breaking an implicit contract, to the extent they counted on receiving these benefits in return for HI taxes.

• Could be portrayed as increasing the burden of beneficiaries.

• Could be portrayed as an accounting fiction, especially if Part B premiums are not increased to cover the cost of benefits shifted to the SMI Trust Fund.

ALTERNATIVE 5: SERIOUS BUT PARTIAL RESPONSE THAT BEGINS TO ADDRESS THE TRUST FUND ISSUE

• Administration signs bill or allows it to become law. Report lists $X billion (perhaps $50 billion) in Medicare Part A cuts; suggests that proposed tax cuts be scaled down and the additional revenues dedicated to Trust Funds.

Pros:

• Appears to be responsive to law.

• Elite press may see this as responsible policy toward Medicare.

• Could be viewed as a "down payment" on a larger plan to address long-term Medicare solvency.

Cons:

• Provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).

• Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans). The rest of our base supporters may also conclude it is premature to throw any semblance of a lifeline to the Republicans.

• To the extent that general fund revenues are transferred to Medicare Trust Fund, this option might be criticized as setting undesirable precedent.

ALTERNATIVE 6: POTUS HEALTH REFORM PROPOSAL RESPONSE

• Administration signs bill or allows it to become law. Report presents a viable health care reform proposal. This could incorporate increased insurance coverage as well as reforms to Medicare, Medicaid, and other health programs.

Pros:

• Consistent with Administration message that reform of Medicare can only take place in the context of overall health care reform.

• Could be an opportunity for Administration to achieve a bipartisan breakthrough on a major policy issue.

Cons:

• Provides policy response to what is essentially a political demand.

• The "sources of funds" portion of the proposal provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).

• Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans).

ALTERNATIVE 7: SUGGEST THAT POLITICALLY "POPULAR" REVENUE OPTIONS (BOTH REAL AND UNLIKELY) BE UTILIZED TO STRENGTHEN TRUST FUND

• Administration signs bill or allows it to become law. Report suggests that certain revenue streams be earmarked for deposit into Medicare HI Trust Fund. Possible candidates include: increased excise taxes on tobacco or alcohol; increased HI payroll tax; reduction in tax expenditures claimed by special interests (e.g., tax subsidies provided to American living abroad, to oil and gas industries); and closing tax loopholes (e.g., expatriation proposal, limiting corporate dividend received deduction to pro rate dividends).

Pros:

• It is possible to raise enough revenue to make the HI Trust Fund solvent.

• Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.

• Senator Bradley is already pushing idea of dedicating a tobacco tax and/or "corporate welfare" tax breaks.

Cons:

• Administration likely to be characterized as promoting "tax and spend" policies.

• Transfer of general fund revenues to Medicare Trust Fund might be criticized as setting undesirable precedent.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration) because the bill focuses on Medicare spending restraints and the response focuses on revenues.

Draft

(June 5, 1995, 3:00pm)

MASTER

For Release Upon Delivery
Expected at 2:30 p.m.
June 6, 1995

STATEMENT OF TREASURY SECRETARY ROBERT E. RUBIN BEFORE THE SENATE FINANCE COMMITTEE

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Finance Committee today in my role as Managing Trustee and Chairman of the Medicare Boards of Trustees. The Boards are required to report annually to the Congress on the financial status of two separate Medicare trust funds -- the Hospital Insurance (or HI) Trust Fund and the Supplementary Medical Insurance (or SMI) Trust Fund.

As you know, this year's reports show that the HI Trust Fund will be exhausted by the year 2002 and that the costs of the SMI program continue to rise rapidly. This is the third consecutive year in which the Board has formally notified Congress about the HI Trust Fund's short-term insolvency~~, which the Board defines as a trust fund balance falling below 100 percent of annual outlays within ten years~~. Thus, this Administration clearly recognizes that the projected Medicare shortfall needs to be addressed.

The Medicare financing problem is a complex interaction of demographics and the rapidly rising costs that affect all parts of our health care system. ~~Addressing the Medicare problem by mandatory cuts to meet a deficit reduction target is the wrong approach.~~ We need to carefully reform Medicare, in the context of health care reform, in order to get the best possible solution for both the short term or long term. Or, to put the same matter differently, the Administration believes that the growth of federal health care expenditures, including Medicare, needs to be reduced in order to control the budget. But reducing this growth must be done by carefully weighing trade-offs and reforming these programs in the context of health care reform. Only such a process will lead to an outcome that best meets the multiplicity of objectives that need to be considered.

The alternative is arbitrary attempts to resolve the financing crisis that may restore solvency to the HI Trust Fund, but will create and intensify other problems. Specifically, we are concerned that deep reductions in Medicare may cause

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cost shifting, which could reduce private insurance coverage, raise health care costs in the private sector, and increase outlays for other government programs.

The Trustees have provided an early warning and it is time to develop effective Medicare reforms in the context of health-care reform, an objective this Administration has energetically pursued since it first took office in January of 1993. But we do have enough time to fix it right, even if we have to do it in stages, so that we avoid a hasty, unworkable solution that may have to be undone in the future.

The Medicare program merits this type of careful consideration because it is very crucial to a large number of our citizens. One of the most important things our country has done over the past 30 years has been to work to reduce poverty and deprivation among senior citizens and disabled persons, and thereby also reduce the burden on and the anxiety of their children. Medicare has effectively provided a reliable source of medical care coverage for aged and disabled Americans. There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly.

Changes to Medicare as part of health care reform can restore Medicare to financial soundness, while at the same time improving the health of elderly and disabled Americans. As I mentioned a few moments ago, the Clinton Administration has sought to work with Congress -- since the Administration first came to office -- to solve the current Medicare financing problem and the more general health care crisis.

Financial Status of the Medicare Trust Funds

As noted, the Trustees reported in April that the HI Trust Fund will be exhausted in 2002, one year later than projected last year. This slight improvement largely reflects the effects of the President's 1993 deficit reduction plan, the stronger-than-expected economy in 1994, and lower-than-expected program cost increases. Since this Administration took office, the exhaustion date has been extended by three years.

~~Since the latter part of the 1980s, the Board has projected that the HI Trust Fund would be exhausted around the turn of the century and has urged Congress to take action to control HI program costs. This year, in addition to urging Congressional action, the Trustees have called for the re-establishment of the Quadrennial Advisory Council on Medicare to bring outside expertise into the process of developing options to resolve Medicare financing problems.~~

Over the long term, the 75-year actuarial balance (interpreted as the amount of payroll tax increase or benefit reduction needed now to balance the trust fund over the next 75 years) was reduced from last year's estimate of 4.14 percent to 3.52 percent of payroll. The reduction is largely the result of lower expected future increases in HI costs, based on the recently observed slowdown in HI spending growth. Despite the decline, the HI program

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remains substantially out of long-run actuarial balance, and that problem is not addressed by either of the current Congressional budget resolutions.

The Trustees also continue to project rapid growth in Supplementary Medical Insurance program costs well into the future. Over the next five years, outlays are expected to increase 78 percent in the aggregate and 66 percent per enrollee. During the same period, the program is expected to grow about 38 percent faster than the overall economy.

Combined HI and SMI costs are expected to increase from 2.6 percent of GDP in 1995 to 8.8 percent in 2069 -- roughly tripling -- largely due to anticipated demographic changes. Because of this rise in long-term program costs and the expected exhaustion of the HI fund in 2002, the Board of Trustees recommends effective Medicare reform, but again, ~~that~~ must be done with a careful weighing and balancing of all impacts and all considerations and in the context of health care reform.

History of Medicare Costs

When the Hospital Insurance program faced financing problems in the past, Congress and the Executive Branch have been able to cooperate on making modest changes in the program that slowed the rate of cost increases.

The program has experienced financial difficulty since its inception in 1966 ~~due to~~ rapidly rising hospital costs, higher-than-expected utilization, and program expansion. The actuarial balance deteriorated between 1966 and 1972, leading to an increase in payroll taxes in 1972 and temporary control of hospital prices between 1972 and 1974. After 1974, annual hospital costs again increased rapidly until 1983 legislation changed the manner in which Medicare pays for hospital services (from a ~~reimbursement~~ to a prospective basis). Consequently, the annual growth of hospital costs was modest in the mid-1980s ~~although by the end of the decade it was again above 10 percent.~~

During the 1990s, program expenditure increases were below those of the previous decade, reflecting a comparatively moderate rise in overall health care inflation and utilization. The President's 1993 deficit reduction plan, which included Medicare spending cuts, removal of the earnings limit for HI contributions, and increased taxation of OASDI benefits (with the proceeds going to the HI Trust Fund), is partly responsible for the recent decline in growth rates and the increase in revenues which, together, extended the trust fund exhaustion date by three years.

Although technically the SMI Trust Fund is actuarially sound because the majority of its funding is from general revenue, spending for physician services has grown faster than spending for hospital services in recent years. This is due, in part, to the establishment, in 1983, of Medicare's prospective payment method for hospital services, which, among other things, shifted some services from an inpatient to a less expensive outpatient basis. In 1992, the SMI program began to phase in its own ~~version of a prospective payment~~ system based

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on the estimated cost of resources needed for various physician services. ~~Although this change should help restrain the future growth of SMI expenditures,~~ SMI ~~and HI face~~ face similar near-term financial pressures because of medical price inflation and rising utilization of services. Over the long term, demographic change will dominate, as an aging population compounds the financing problem for both programs.

Nevertheless, also (5)

Medicare Financing and Health Care Reform

in a vaccum

The fundamental reason for the rise in Medicare expenditures is the increase in health care costs affecting all parts of the nation's health care system. A dramatic attempt by government to contain Medicare spending -- large reductions in payments to hospitals, for example -- ~~will~~ could cause significant distortions and inefficiencies elsewhere in the health care system, unless such a reduction is undertaken in the context of health care reform.

at the magnitude proposed in the House and Senate budget resolutions

~~The proposed~~ Medicare cuts, if not accompanied by health care reform, will harm the most vulnerable in society -- the elderly and the disabled -- and ~~will~~ cause doctors, hospitals, and other health care providers to shift costs to everyone else. That means that working families will face higher private insurance premiums or will lose their insurance coverage. In addition, Medicare cuts of this magnitude, without any other reforms, ~~will~~ lead to the closing of already scarce rural hospitals; real pressures on big, urban public hospitals and academic health centers; and reduced services to many vulnerable people through cutbacks in ~~payments~~ for uncompensated care.

may

In contrast, much more can be done if we undertake health care reform. ~~Savings to Medicare would arise immediately as health~~ insurance coverage ~~is extended~~ to the uninsured population and a competitive health care market will yield long-term savings to the Medicare program as the growth in overall health care spending slows under a more efficient system.

Taking steps to extend

rising

In closing, the Administration believes it is possible to address the HI Trust Fund problem, the costs in the rest of the Medicare program, and health care reform, in a thoughtful manner and produce effective, acceptable solutions that will stand the test of time. We are ready, and we have been from the beginning of this Administration, to work with the Congress to achieve these goals.

objectives

I will be happy to answer any questions you may have.

could broaden

to strengthen the Medicare program

the development through insurance reforms, of

MASTER

DRAFT: June 6, 1995: 2:38 pm

STATEMENT OF ROBERT B. REICH
SECRETARY OF LABOR
BEFORE THE SENATE FINANCE COMMITTEE
JUNE 6, 1995

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to discuss the future of the Medicare system. My fellow trustees and I recently submitted to Congress our annual report on the financial status of the two separate Medicare trust funds -- the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. As you know, this year's report shows that the Hospital Insurance Trust Fund will be insolvent by the year 2002, and that the costs of the SMI program will continue to soar.

These problems are not new. Indeed, for the past 15 years, the trustees have called for reform. And the Clinton Administration has already worked with Congress to address the problem, although there is still much more to be done. Prior to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the HI Trust Fund was expected to be depleted by 1999. But the reforms included in OBRA 93, along with the strong economy America has enjoyed since then, have delayed the Trust Fund's depletion until 2002. These short-term remedies, let me be clear, do not solve the deeper problems with the Medicare system, nor do they exhaust the Administration's commitment to reform. But they do buy us precious time in which to devise and implement a more comprehensive solution. It is now up to all of us to use this time well.

We all agree that the Medicare system is in need of change. The President has repeatedly said that he would like to sit down with Congress to produce a bipartisan blueprint for broad-based health care reform. The Clinton Administration believes that the financing problems that the Medicare system faces must be solved within the broader context of health care reform. As

a trustee of the Medicare trust funds, I am very concerned about the impending insolvency of the HI Trust Fund, and pleased that this Congress seems intent on addressing this issue. However, I am deeply troubled by some of the approaches that are being discussed.

Attempts to quickly shrink federal spending by reducing Medicare benefits will leave many Americans worse off while ignoring the fundamental structural flaws of our health care system. It will increase health care costs to the elderly. It will also strain the finances of many health care providers, including some of America's most valuable and vulnerable health-care institutions. But the effects don't stop there. Many providers will unsuccessfully attempt to shift costs to private health insurance companies. As costs are shifted, millions of working Americans who are privately insured, and who may believe themselves to be insulated from the Medicare issue, will in fact feel the squeeze.

Speaker Gingrich and others claim that reducing Medicare expenditures will be "painless." This simply is not plausible. Cutting spending for a program like Medicare without reforming the overall health care system requires either reducing services or shifting the costs of the services to somebody else. ~~Unless broader reforms to boost efficiency are on the table, service-cutting or cost-shifting pretty much exhaust the options for cutting Medicare costs. We do not yet know what the balance will be between these two outcomes, because Congress has yet to detail its plans to cut spending. But there are enough data to trace out the effects of some of the more likely approaches.~~

THE ELDERLY:

While no specific bill has been put on the table, one prominent proposal would increase premiums, co-payments, and deductibles for elderly and disabled Medicare recipients. Under this plan, deductibles would be doubled from their current levels, premiums would be hiked every year until 2002, and there would be a dramatic increase in co-payments for home health care and other services. These changes, taken together, would raise annual Medicare costs by over $2,000

per couple by the year 2002. For the typical Medicare beneficiary, these increased costs will come right off the top of their Social Security checks--the simple equivalent of a Social Security benefit cut.

HEALTH CARE PROVIDERS:

Some health care providers will also feel the pain of these budget-driven cuts. ~~When Medicare costs are cut in this manner, providers are left with four choices: they can (1) increase costs for those with private insurance or for private payers, (2) provide reduced quality of care, (3) close their doors if they can't absorb the lost income, or (4) do some combination of the first two.~~ Many hospitals will have no trouble shifting the pain of the spending cuts to the privately-insured. However, hospitals whose patients are predominately Medicare beneficiaries and the uninsured will have few other options except to reduce the quality of care to all patients, or to close their doors. In particular, large reductions in Medicare payments could endanger rural and urban safety-net hospitals.

Hospitals in rural areas are often small. Some serve mostly Medicare recipients, and often are the only health care provider within 50 or more miles. Since many of these hospitals are already in financial distress, Medicare cuts in isolation from broader efficiency improvements will cause many rural hospitals to reduce the quality of care or to squeeze the wages of hospital workers. In extreme cases, these hospitals will be forced to go out of business, and workers will be laid off. Nearly 10 million Medicare beneficiaries live in rural areas. Cutting Medicare outside the context of overall health care reform puts their health care in greater jeopardy. Some urban "safety net" hospitals, faced with a growing burden of uncompensated care, are equally unable to shift to others the burden of reduced Medicare benefits, and will face similar cost pressures.

DRAFT; June 5, 1995; 2:38 pm

PRIVATELY-INSURED WORKING AMERICANS:

~~Hospitals that can shift costs to insured patients will usually do so. America's hospitals have always used gains from some payers to cover losses from others.~~ Health care providers frequently charge insured patients more to cover the expenses of the 40 million Americans who do not have health insurance and thus frequently receive uncompensated care. In this context, slashing the Medicare program without broader health care reform ~~must be expected to~~ may lead hospitals to increase costs to the privately-insured to make up for the losses from Medicare patients.

For example, the 1995 Prospective Payment Assessment Commission (ProPac) report to Congress stated that as payments for Medicare and Medicaid were reduced over the last decade, hospitals responded by increasing revenue from private payers. Indeed, in 1992, hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they took in $29 billion in revenue above their costs of providing care to privately-insured patients. ~~For example, hospitals charge $[illegible] for an aspirin, in large part to make up for the costs of uncompensated care.~~

deep Medicare cuts of the magnitude proposed by the House and Senate budget resolutions

~~For any action there is an equal and opposite reaction. This is an immutable law of~~ physics, and applies in comparable ways to health-care policy. ~~Those who prefer concrete models to abstract theorems can think of it as squeezing a balloon. If you push on one side, the air is forced to the other side.~~ ~~Cutting~~ Medicare ~~costs~~ without reforming the health care system itself, and without denying medical care to beneficiaries, ~~merely~~ will likely forces 150 million privately-insured Americans to pay more. The cost shifting that results from Medicare cuts—outside the broader context of health care reform--would essentially impose a hidden tax on working Americans. As Henry Aaron, an expert on health care issues at the Brookings Institution, recently testified: "Large reductions in Medicare spending within the current program framework will impose...taxes on private businesses and individuals."

IT depends to reason that

Medicare

large

~~ProPac's recent report considers the impact of a reduction in Medicare spending on private~~

In public pol. as well as physics, actions often have opposite reactions.

DRAFT; June 5, 1995; 2:38 pm

~~insurance premiums. Their conclusion is extreme: "Every percentage point of Medicare cost increase not reimbursed by the Medicare payment increase will, all else equal, translate into a percentage point of additional revenue needed from the private sector." Congressional Budget Office (CBO) estimates are smaller, but still significant. CBO's analysis concludes that about one-third of the expenditure reductions to providers will simply be shifted in the form of price increases to private payers. This would effectively amount to an increase in private insurance premiums of more than $40 billion cumulatively from now to 2002.~~

agrees. He

Martin Feldstein, a Harvard professor and former chairman of the Council of Economic Advisers, wrote last year that a "very large hidden tax would result from reducing government payments to hospitals and other providers of Medicare services without any reduction in the care that they are expected to give. As a result, the hospitals and other providers would just raise their prices to patients and insurance companies. In the end, it would be the privately insured individuals who bear those costs in the form of higher insurance premiums and lower wages."

-- triggered by these large Medicare cuts --

A hidden tax is serious enough. But even worse, cost-shifting will have the ultimate effect of reducing health-care coverage. As more costs are shifted to the privately-insured, premiums will tend to rise to cover those costs. And as premiums increase, some workers and their families will be priced out of the market, and will end up without coverage. Mark Pauly, a health care economist at the University of Pennsylvania, wrote in a survey of the relevant literature that "there is fairly consistent evidence that insurance coverage is sensitive to proxies for its price." A recent CBO report confirms this assessment.

we are concerned that may be. and

With such dramatic cuts in Medicare costs, If

Traditionally, membership in the American middle class included not only a job with a steadily increasing income, but a bundle of benefits that came with employment. Since 1979, we have seen a divergence in health benefits, related to education and skills. Employer-sponsored health coverage for workers with college degrees has declined only slightly, from 79 percent in 1979 to 76 percent in 1993. But rates for high school graduates have fallen from 68 percent to 60 percent over the same period, and for high school dropouts, the 1979 rate--already low at 52 percent--has plummeted to 36 percent. Nearly 100,000 Americans are already losing

health insurance each and every month. Medicare cuts unaccompanied by broader reforms can only exacerbate this crisis.

According to a recent study by David and June O'Neill, less-educated workers are more likely to lose coverage when confronted with higher premiums. This suggests ample reason to believe that the hidden tax associated with cost shifting will disproportionately affect workers with less education--the very group that has suffered the sharpest drop in health-care coverage since 1979, and whose overall prospects have become bleaker and more unsettled in today's changing economy.

One drawback to cutting Medicare in isolation was recently summarized by *The Economist*: "Although the federal budget would benefit [from reduced Medicare expenditures], these savings could be offset by higher costs in private health care." For that reason, we need to sit down together--in a bipartisan manner--and produce a blueprint for broad-based health care reform. We must put the HI Trust Fund on a sound, sustainable footing. We have all known this for a long time now. But we have a responsibility to every American who works hard and plays by the rules to fix the problem of our health-care system, not simply shuffle from one group to another the excess costs that the current flawed system produces.

###

Gene - Do you think this is OK, given that we don't want to get drawn into a commission? Ken

What about commission question?

PRIVATE HEALTH CARE COST INCREASES

Question: Doesn't the fact that the growth of private health costs has slowed dramatically, and was, in fact, negative in 1994 according to at least one study, suggest that Medicare could benefit from changes similar to those taking place in the private sector?

Answer:

- The private and government sectors should both exploit (real) efficiencies in the delivery of health care experienced by the other.

- However, the slowdown in private sector health costs relative to Medicare costs appears to be a temporary deviation from a long-term trend in which costs in both sectors have grown at about the same rate.

- The relative slowdown in private sector costs may be due, in part, to employers shifting to lower cost plans and reducing benefits. While direct evidence on this issue is not available, ~~however~~, . . .

- In fact, over the next ten years, costs in both sectors are projected by the Health Care Financing Administration to increase at about the same rate.

Background

- According to the Health Care Financing Administration (HCFA), cost increases per enrollee have risen at about the same rate for both Medicare and the private sector. Since 1967, the average annual growth rate in expenditures has been 11.4 percent for Medicare and 12.2 percent in the private sector. In 1994, private costs per enrollee rose 5.4 percent while Medicare costs per enrollee rose 9.1 percent. HCFA expects this to be a temporary phenomenon, however.

- A major survey of private employers conducted by Foster-Higgins reported a decline in private sector costs in 1994. However, the shift to managed care and decline in costs were experienced mainly by large employers in the northeast. Some of the cost saving occurred as employers "carved out" expensive prescription drug and mental health provisions from their primary benefit plans.

Use this

- The Bureau of Labor Statistics' Employment Cost Index showed a 4 percent increase in employer health costs between 1993 and 1994.

Office of Economic Policy
May 30, 1995

MEDICARE SOLUTIONS

Question: How would you solve the Medicare financing problem?

Answer:

- The growth in Medicare costs reflects the growth in general health care costs. This fact should form the premise for a solution to the Medicare financing problem.
- In the current system, costs are growing too fast. Creating a more competitive health care market would slow the growth of health care costs by reducing inefficiencies in the current system.
- The rate of overall health care spending would slow as would spending in the Medicare program. For example:
  - Medicare makes substantial payments to hospitals that serve a disproportionate share of low-income patients. As insurance coverage is extended, these payments could be reduced.
  - ~~Universal~~ Insurance coverage would also permit a reduction in the indirect medical education payments that are intended to help cover uncompensated care by hospitals.
- The House-passed tax cut bill (H.R. 1215) is a step in the wrong direction. By reducing the taxation of social security benefits it will worsen HI financing. If the bill were ~~to become~~ law, the HI Trust Fund would be depleted almost a year sooner.

Office of Economic Policy
May 26, 1995

SAVINGS UNDER HEALTH CARE REFORM

Question: What do you see as the goals of comprehensive health care reform and how would such reform yield savings to the Medicare program?

Answer:

- Health care reform should help move toward universal health insurance coverage. This will prevent the shifting of health care costs from uninsured to insured individuals that occurs in the current system and assist in further development of a competitive health care market.

- Savings to Medicare would arise immediately as health insurance coverage is extended to the uninsured population.

- For example, Medicare makes substantial payments to hospitals that serve a disproportionate share of low-income patients. As insurance coverage is extended, these payments could be reduced.

- Moving toward universal insurance coverage would also permit a reduction in the indirect medical education payments to hospitals that is intended to help cover uncompensated care.

- A competitive health care market will yield long-term savings to Medicare. The growth in overall health care spending will slow under a more efficient system, so that the price of health care directly reflects the cost of care.

Office of Economic Policy
May 26, 1995

HOSPITAL INSURANCE TRUST FUND SOLVENCY

Question: As Managing Trustee of the Medicare Trust funds are you concerned that the President's budget does nothing to address the impending insolvency of the Hospital Insurance (Part A) Trust Fund? What should be done about this problem?

Answer:

- The impending insolvency has been a problem since 1987. Since then, the projected exhaustion date for the HI Trust Fund has varied in a relatively narrow range, between 1999 and 2005. There is nothing new here.

- Nevertheless, as Managing Trustee, I am committed to getting the program back on an even keel.

- However, fixing Medicare should not be done on a rushed basis in a race to balance the budget.

- The solution for Medicare should be the same as for the health care system as a whole. Bringing overall health care expenditures under control through a major health care reform initiative will help solve the Medicare insolvency problem.

- The Trustees have asked for the help of a Quadrennial Advisory Council in order to give this complicated program the attention it needs.

- We are anxious to work with you on developing solutions.

Office of Economic Policy
May 26, 1995

HEALTH CARE REFORM

Question: Your position is that financial problems in the Medicare program should be solved within the context of overall health care reform. What exactly do you mean by overall health care reform?

Answer:

- The United States has nearly 40 million people without adequate health insurance coverage and health care expenditures are increasing faster than the economy is growing.

- These two problems must be resolved in order to get the kind of health care system the Nation wants.

- The President remains committed to the goal of assuring health insurance coverage for all Americans and moving toward containing the growth in health care costs.

- He has also outlined his vision for reform -- in his State of the Union, his letter to the Cong. Leadership and, most recently, in his speech to the White House Conference on Aging. He has said that we need to expand coverage for working families, reform the insurance market, and provide LTC for families, help states set up purchasing pools

He has also said that this year we can take the first steps.

Office of Economic Policy
May 26, 1995

PART A SOLVENCY THROUGH SPENDING CUTS

Question: What magnitude of cuts would achieve solvency in Medicare Part A? CBO has suggested that $165 billion in cuts over seven years would sustain a 100% Part A trust fund ratio. Do you agree that this is the right amount for Part A cuts?

Answer:

- I am aware of the CBO calculation but I do not agree that those cuts are *right* for the Part A program.

- Changes to Medicare should be in the context of a sensible approach to health care reform. Cutting expenditures in only one part of the health care system will lead to distortions in other parts of the system.

- The CBO calculation is based on continuation of the existing health care system. Under a reformed health care system, Medicare spending would look quite different.

Background:

Short-run

According to CBO, in order to prevent the Part A Trust Fund from falling below 100 percent of a year's outlays, $165 billion of cuts would be required over the period 1996-2002. According to the Health Care Financing Administration (HCFA), cuts of $147 billion dollars over the same period would be required. The difference between these two estimates is accounted for primarily by the difference in baselines (CBO is higher). Also, CBO estimates were done on a fiscal year basis while HCFA estimates are on a calendar basis and the path of cuts differ somewhat (HCFA is more backloaded). The cuts would require Part A spending to grow at an annual rate of roughly 4.7-4.8 percent during 1996-2002. Under current law projections, Part A spending will grow at an annual rate of about 8%.

Long-run

According to HCFA, a constant growth rate in spending of 5.3 percent would achieve actuarial balance over 75 years. This is a looser spending constraint than what is required for the short-run because Part A revenues are projected to grow relatively slowly during the next few years and Part A outlays are currently about $6 billion above non-interest (payroll tax) income.

Office of Economic Policy
May 26, 1995

CAUSES OF FINANCING PROBLEMS

Question: What are the primary causes of the deficit in the HI program?

Answer:

- The growth in Medicare costs reflects the growth in general health care costs and this fact should form the premise for a solution to the Medicare financing problem.
- In the short run, excess medical care inflation (price increases above economy-wide general inflation) is the main impediment to trust fund solvency.
- In the long run, demographic factors drive costs. As the baby boom generation ages into retirement years beginning around 2010, the percentage of the population eligible for Medicare will increase significantly.
- As the baby boom continues to age, health care utilization will rise and will be the dominant factor in health care cost increases.

This makes it seem as though nothing can be done
Make argument about overall reform.

Office of Economic Policy
May 26, 1995

MEDICARE SPENDING REDUCTIONS

Question: The Senate has proposed a reduction of $256 billion in Medicare spending over 7 years and the House has proposed a reduction of $288 billion. What is your reaction to these proposals? What reductions, if any, do you propose?

Answer:

- Changes to Medicare should be in the context of a reasoned approach to overall health care reform, not as a way of balancing the Federal budget or of financing a tax cut.

- In the absence of health care reform, drastic reductions like those in the Senate and House plans create distortions and lead to cost shifting. For example, in response to reduced payments from public programs, hospitals and insurers will raise their charges to private payers.

- Dramatic spending reductions will have especially severe effects on beneficiaries. The proposed cuts will force beneficiaries to pay higher premiums and other out-of-pocket costs.

Impact of cuts talking points?

Background:

Neither the Senate nor the House have specified how their proposed cuts would be achieved or how they would split the reductions between Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance).

The Senate plan would reduce the growth in Medicare outlays from 10.2% over seven years to 6.8%. The House plan would reduce the growth to 5.4%. Although these spending reductions are not "too big" from the point of view of trust fund solvency, they are Draconian from the point of view of beneficiaries.

The trustees have recommended reestablishment of the Quadrennial Advisory Council for the Medicare program. The Council would provide critical assistance to the Administration and Congress as they develop solutions to the Medicare financing problem.

Office of Economic Policy
May 26, 1995

MEANS-TESTING MEDICARE

Question: How do you feel about means-testing the Medicare program?

Anwer:

- The Hospital Insurance Program (Medicare, Part A) is financed by payroll contributions throughout individuals' worklives. A means test for receipt of benefits from this program seems inappropriate.

- The Supplementary Medical Insurance Program (Medicare, Part B) is financed partially (25 percent) by premiums paid by enrollees and primarily (75 percent) by general government revenues.

Check w/ Gene.

- Because of the large general revenue subsidy, there is more scope for consideration of relating premiums to income in Part B of Medicare, if it is done in the context of overall health care reform.

Background:

The President's Health Security Act proposed income-related premiums for Part B coverage. Enrollees with incomes exceeding $90,000 ($115,000 for couples) would pay higher premiums that would cover about 75 percent of the average benefits per enrollee, in contrast to the 25 percent now paid by all enrollees.

Office of Economic Policy
May 26, 1995

Need to discuss approach on vouchers -- can ignore edits.

MEDICARE VOUCHERS

Question: A number of proposals have recommended a voucher system for Medicare. What is your view of a Medicare voucher system?

Answer:

- Without health care reform, a voucher system for Medicare would lead health plans to select only healthy enrollees.
- A voucher system would not guarantee insurance coverage and, for those who obtain coverage, it would not assure adequate coverage. This would leave many elderly vulnerable to the risk of high health care costs.
- ~~A Medicare voucher system would need to be accompanied by a mechanism that~~ assures that all elderly would have coverage, regardless of their health care needs.

Background.

Under the current Medicare system, the Federal government is a dominant purchaser of health care services and attempts to contain its expenditures by controlling provider reimbursement rates. Individuals do not shop for insurance and have little incentive to seek efficient health care providers. Under a voucher system, the Federal government provides beneficiaries with vouchers with predetermined values to purchase qualified private health plans. This system has many buyers of insurance and the government contains its expenditures by controlling the value of the voucher. Insurers and individuals have an incentive to use efficient health care providers. A voucher system has no direct effect on the financing of Medicare but has the following important effect on expenditures:

- In the current Medicare system, the risk of higher-than-expected Medicare utilization is borne by the government. In a voucher system, this risk is shifted to the private sector.
- In the longer term under both systems, the risk of higher-than-expected Medicare cost per unit of service is shared by the government and beneficiaries.

A voucher system provides a predictable (and controllable) rate of growth in the federal part of the program. The government can set the rate of growth in voucher value (say, to GDP growth).

Office of Economic Policy
May 26, 1995

PUBLIC TRUSTEES

Question: Who has the President decided to nominate to fill the two public slots on the Board of Trustees?

Answer:

- On April 24, 1995, the President nominated Marilyn Moon and Steven J. Kellison to be the new public trustees.

- Marilyn Moon is a noted health care economist with the Urban Institute who published a very recent book on the Medicare program.

- Steven Kellison is a former Executive Director of the American Academy of Actuaries.

Office of Economic Policy
May 26, 1995

CASH FLOW BETWEEN THE TRUST FUNDS AND GENERAL FUND

Question: The current financing schedule for the Part A Trust Fund is sufficient to sustain the fund until 2002 (calendar year). When will the fund begin to incur a cash shortfall and thereby begin to draw from the general fund of the Treasury?

Answer:

- Payroll taxes and other noninterest income to the HI program have been lower than disbursements since 1992.

- Currently, benefits are being paid in part with interest income paid to the HI Trust Fund by the general fund.

- Beginning in 1996, total HI income (tax plus interest income) will fall below total disbursements and the HI fund will start cashing out the Treasury securities that it purchased during surplus years.

- The HI Trust Fund will be exhausted in 2002. In the absence of benefit or tax changes, Congress will have to establish provisions for the payment of benefit claims beyond that point.

Background:

Technically, when the trust fund is exhausted there is no provision that permits payment of benefit claims from the general fund. As a consequence, in the absence of changes that move the exhaustion date for the fund, benefits could not be paid beyond 2002.

When payroll contributions exceed benefit payments, the surplus is invested by the Managing Trustee (Secretary of the Treasury) in interest-bearing securities of the U. S. Government. This creates a cash flow from the trust fund to the general fund. If benefit payments exceed payroll contributions, benefit claims are paid from interest earnings or liquidation of securities. This creates a cash flow from the general fund to the trust fund.

Office of Economic Policy
May 26, 1995

MEDICARE AND THE LONG-RUN BUDGET DEFICIT

Question: Isn't it virtually impossible to control the federal deficit without significant Medicare cuts?

Answer:

- It is impossible to control the deficit in the long-run without addressing the issue of health care costs. The President has been making this point from the beginning of his administration. That was a major reason for our proposal to reform the nation's health care system.

- Medicare (and Medicaid) are the fastest growing major programs in the Federal budget. Controlling health care costs is fundamental to bringing these programs and the budget deficit under control.

- Given the complexity of the structure of the Medicare program and its interactions with the remainder of the health care system, the Trustees have recommended that the Quadrennial Advisory Council be reinstituted to begin analyzing reform options. A panel of technical experts, experienced with health care issues and the Medicare program, seems the best way to proceed.

3 part strategy.
- must do in context of reform.

Office of Economic Policy
May 26, 1995

HOUSE TAX PROVISION TO REPEAL OBRA93 TAXATION OF SOCIAL SECURITY BENEFIT CHANGES

Question: How much tax revenue is lost to the HI trust fund from the provision to reduce the taxation of Social Security benefits in the House tax cut bill? How many beneficiaries are affected by this provision?

Answer:

- From FY 1996-2000, $21.9 billion in income taxes on social security benefits will be lost to the HI trust fund. From FY 1996-2002, the loss to the trust fund will be $34.3 billion.

- In tax year 1996, approximately 5.6 million higher income Social Security recipients, roughly 13 percent of all beneficiaries, will benefit from this provision of the tax cut bill.

Background:

Note that while the House provision phases out the OBRA 93 tax increases on Social Security benefits from 1996 to 2000, there is a fully-phased in loss to the HI trust fund in 1996. This is because the provision is written so that all of the tax liability from the OBRA 93 changes is to be transferred to the OASI trust fund beginning in 1996. Thus, the fully-phased in loss to the HI trust fund is immediate, but the loss in tax revenue to the Treasury in 1996 is less than the loss to the HI trust fund.

Office of Tax Policy
May 25, 1995

MEDICARE AND CORPORATE WELFARE

Question: Mr. Secretary, Senator Conrad has proposed raising $228 billion from cutting "corporate welfare", rather than cutting Medicare outlays, in order to help balance the Federal budget. What do you think about cuts in corporate welfare?

Answer:

- The Federal governments provides assistance to businesses through several means, such as programs that provide water, energy, and other business inputs at lower-than-market cost; programs that support the price or demand for the goods produced, and tax incentives that encourage business investment in certain activities.

  -- Most of these programs were designed to achieve certain economic goals, such as the more rapid development of technology or the improvement of the nation's infrastructure.

  -- It is also misleading to characterize all Federal assistance to business as "corporate welfare"; the benefits received are often passed through to customers and workers, and contribute to a more rapid economic growth than would otherwise be possible.

- But at a time when all Federal spending is being critically reviewed, and the elderly and low-income individuals are being asked to make do with less, it is appropriate that Federal assistance to businesses, including that provided through the tax system, also be critically examined to see if such assistance continues to be needed.

Background:

Labor Secretary Reich supports plans to cut "corporate welfare". Tax Policy's review of corporate tax expenditures indicates that far less than the $228 billion suggested can, or should, be raised from reductions in these tax incentives. Budget Chairman Kasich has also suggested eliminating a more modest $25 billion in "corporate welfare" as part of the Ways and Means Committee's contribution to deficit reduction, but Chairman Archer declined to accept responsibility for any "tax increase."

Office of Tax Policy
May 26, 1995

What about commission question?

DRAFT; June 1, 1995; 5:39pm

THE ADMINISTRATION'S HEALTH CARE PLAN

Question: You have charged that the Congress is misguided in its attempt to reform the Medicare system. Where is the Administration's health care plan?

Answer:

- The President has always been committed to reforming the health care system and has always maintained that any significant changes in the Medicare system take place in the larger context of health care reform.

- The Administration put forth a health care plan last year. Our plan, like the Dole plan, the Chafee plan and other, ultimately did not pass this Congress. But all of the plans recognized that Medicare must be addressed within the context of broader health care reform.

- We all must maintain last year's commitment to reforming the Medicare system. Let's not abandon this bipartisan goal just because it is budget season.

Pres has outlined ~~plan~~ vision for reform - - ins. reform etc.
(see Treas. answer)

1. Pres has said he will sit down w/ them if they're willing to meet certain criteria.
2. If not, need to see and evaluate their specific proposals, as with the recession bill.

DRAFT; June 1, 1995; 3:41pm

HEALTH CARE REFORM

Question: Your position is that financial problems in the Medicare program should be solved within the context of overall health care reform. What exactly do you mean by overall health care reform?

Answer:

- The United States has nearly 40 million people without adequate health insurance coverage and health care expenditures are increasing faster than the economy is growing.

- These two problems must be resolved in order to get the kind of health care system the Nation wants.

- The President remains committed to assuring health insurance coverage for all Americans and to the goal of containing the growth of health care costs.

- PRESIDENT'S CRITERIA FOR HEALTH CARE REFORM

See other cards.

DRAFT; June 1, 1995; 4:48 pm

THE HEALTH SECURITY ACT'S IMPACT ON THE HI TRUST FUND

QUESTION:

We heard a lot about "broad-based" health care reform, but little about its affects on the HI Trust Fund. What would the Health Security Act have done for the HI Trust Fund? In particular, how many years would have the Health Security Act extended the Trust Fund's solvency?

ANSWER:

- According to the Department of Health and Human Services, the Health Security Act would have extended the solvency of the HI Trust Fund by five years.

- However, the Medicare savings themselves from the Health Security Act did not go toward reducing the budget deficit. They were reinvested in Medicare to provide new benefits--prescription drug coverage and a new long-term care program--which the elderly needs very badly.

- Furthermore, the Medicare savings would not have shifted costs to the privately-insured because the Health Security Act increased the efficiency of the entire health care system. With economies, the rate of increase in health care costs can decline without any reduction in services or cost shifting to the elderly, the privately-insured, or the providers.

DRAFT; June 1, 1995; 4:48 pm

PUBLIC TRUSTEES COMMENTS ON REFORM & GINGRICH LETTER

QUESTION:

According to the statement of the Public Trustees, David Walker and Stan Ross, in the 1995 HI Trustees Report:

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

How do you reconcile this statement with your insistence on tying Medicare reform to health care reform?

[Note this question was posed to President Clinton by Speaker Gingrich in his letter of April 28]

ANSWER:

- First, these statements were taken out of context. In their report, the public trustees said that they had hoped and still hope for broad-based health care reform that included Medicare reform.

- They conclude that Medicare reform should be addressed as a distinct legislative initiative only because they--like most Americans--are sick and tired of the partisan gridlock which killed health care reform during the last Congress. How would you do this? Can provide only short-term solutions?

- The health care system--including Medicare--needs to be reformed. We all have known this for a very long time now. But, we can not just slash the Medicare program to balance the federal budget. Health care reform needs to be addressed in a bipartisan--if not a nonpartisan--manner. This issue is far too important for one party to go at it alone.

QUESTION:

You said earlier that demographic shifts are the major cause of the long-range deficit in the HI Trust Fund. Should we, therefore, consider an increase in the eligibility age for Medicare benefits?

ANSWER:

- This is an issue that would have to be considered in the broader context of health care reform. Any proposal to increase the eligibility age for Medicare benefits would have consequences on the rest of the nation's health care system. At a time when 40 million Americans are uninsured, we are especially concerned with any proposal that would keep additional individuals out of a program that essentially guarantees them health care.

QUESTION:

If the real issue here is to assure short-term solvency for the Medicare Trust Fund, then why do we no just reprogram Social Security taxes to HI?

ANSWER:

- Rearranging revenues is a shell game. It simply takes the revenues out of one place and puts them in another, without ever responding to the original problem.

- Accounting gimmicks like this do nothing to solve the underlying problems with the health care and Medicare systems.

QUESTION:

Does it make sense combining the financing of Part A and Part B of Medicare?

ANSWER:

- It is premature to discuss the combination of the two parts of the Medicare Trust Funds. The possibility of combining these two parts requires consideration of a number of issues. For instance, (1) could such a combination serve our beneficiaries better? and (2) how would it effect their out-of-pocket spending?

DRAFT; June 1, 1995; 3:43pm

PART A SOLVENCY THROUGH SPENDING CUTS

Question: CBO says that $165 billion of cuts would achieve solvency in Medicare Part A Trust Fund over the period 1996-2002. The Health Care Financing Administration (HCFA) estimates that cuts of $147 billion over the same period would be required. Do you agree with them?

Answer

- (DO NOT SAY YES TO WHETHER OR NOT YOU AGREE WITH THEM)
  I understand how CBO and HCFA calculated their estimates. The difference between the two is accounted for primarily by the difference in baselines (CBO is higher). Also, CBO estimates were done on a fiscal year basis while HCFA estimates are on a calender basis. Further, the path of cuts differ somewhat (HCFA is more backloaded).

- The cuts would require Part A spending to grow at an annual rate of roughly 4.7-4.8 percent during 1996-2002. Under current law projections, Part A will grow at an annual rate of about 8 percent.

- However, ~~CBO and HCFA's estimates miss the point.~~ focusing on these estimates misses the point. As I have pointed out in my testimony, reducing Medicare benefits outside the context of broader health care reform will lead to increase health costs for the elderly, squeeze health care providers in rural areas, threaten teaching hospitals in urban areas, and shift costs to millions of privately insured Americans.

DRAFT; June 1, 1995; 4:48 pm

MEDICARE BENEFITS IN RELATION TO CONTRIBUTIONS

QUESTION:

Do new enrollees in the Medicare program receive benefits in excess of their prior contributions? Is this a problem that should be addressed?

ANSWER:

- Medicare enrollees receive more in benefits than they contribute in payroll taxes during their worklives.
- The primary reason is that health care costs have risen faster than wages.
- If we are committed to addressing this problem, then we need to reform the Medicare system within a broad-based health care reform. Unless we get some control over rising health care costs through overall health care reform, this problem will persist.

DRAFT; June 1, 1995; 4:48 pm

IS AN INCREASE A CUT OR IS ONLY A CUT A CUT?

QUESTION:

According to the Budget Resolution passed by the Senate, seven years from today we will spend nearly $100 billion more on Medicare than we do today. Even the President once said that only in Washington is an increase in spending called a cut. Why do you insist on calling our Medicare proposal a cut when it is actually a slowing of the rate of growth?

ANSWER:

- In order to determine whether or not spending is increased or decreased, one should analyze whether per capita spending, after adjusting for inflation, rises or falls. If it rises than it can be considered an increase. If it falls, it is a cut.

- The Budget Resolution passed by the Senate includes cuts in the Medicare program.

Here are two easy to explain analogies of why an increase can be a cut:

METHOD 1:

- Many Members of Congress talk about the deep cuts in defense spending over the past several years. However, actual defense spending was at the same level in FY 94 as in FY 87--$282 billion in both years. Yet during this seven year period, the number of Army divisions declined from 28 to 20, the number of Air Force fighter wings dropped from 36 to 22, the number of Navy fighting ships decreased from 568 to 387, and the number of troops fell from 2.2 million to 1.6 million.

- The defense program was cut, in so small part because the defense budget did not keep pace with inflation and therefore lost purchasing power.

METHOD 2:

- Let's suppose that I were to have a barbecue this weekend. I decided that I wanted to invite four of my closest friends, so I bought four hamburgers. That's one hamburger per friend.

- Since we had such a great time during the first barbecue, we decided that we would invite eight people the next weekend. So, I increased the number of hamburgers I bought to six. That leaves just three-quarters of a hamburger per friend. According to my friends, that's a cut.

DRAFT; June 1, 1995; 3:42pm

MEDICARE SOLUTIONS

Questions: How would you solve the Medicare financing problem?

Answer:

- The Medicare Part A Trust fund problems are not new. The Trust Fund faced fiscal insolvency when Mr. Reagan was President, when Mr. Bush was President and is still a problem. In fact, when the Medicare Trustees report was released in 1970, the Trust Fund was projected to go broke by 1972.

- The Clinton Administration has been successful in extending the short-term life of the Medicare Part A Trust Fund as a result of the President's 1993 deficit reduction plan, the stronger than expected economy in 1994 and lower-than-expected program cost increases.

- The growth in Medicare costs is inherently related to the growth in general health care costs. This fact should form the premise for a solution to the Medicare financing problem.

- Reforming the health care system in a way that results in a more competitive health care market would mean that health insurance premiums would more directly reflect the cost of providing care.

- If we can make the health care system more efficient, the rate of overall health care spending would slow as would spending in the Medicare program. This would alleviate the Trust Fund's solvency problem.

Need to discuss approach on vouchers -- ignore edits

DRAFT; June 1, 1995; 4:48 pm

MEDICARE VOUCHERS

QUESTION:

A number of proposals have recommended a voucher system for Medicare. Indeed, many economists including Henry Aaron and Stuart Butler have advocated converting Medicare into a voucher system. What is your view of a Medicare voucher system?

ANSWER:

- The emphasis must be on choice. At this time, a voucher system for Medicare is premature and would take considerable time to develop properly. This is a very complex issue that cannot be separated from the broader issues of health reform.
- A voucher system for Medicare is not feasible in the absence of accompanying changes, such as development of an effective risk adjustment framework that would prevent health plans from selecting only healthy enrollees. Risk adjustment procedures are not well-developed.
- In order for a voucher system to work, a market must be established such that seniors are not vulnerable to trickery and deception. Therefore, we would have to set up a system regulations to protect elderly consumers.

BACKGROUND:

Under the current Medicare system, the Federal government is the dominant purchaser of health care services and tries to contain its expenditures by controlling provider reimbursement rates. Individuals do not shop for insurance and have little incentive to seek efficient health care providers. In general, under a voucher system, the Federal government provides beneficiaries with vouchers with predetermined values to purchase qualified private health plans; the Gregg Plan allows beneficiaries to choose a fee-for-service option. This system has many buyers of insurance and the government contains its expenditures by controlling the value of the voucher. Insurers and individuals have an incentive to use efficient health care providers. A voucher system has no direct effect on the financing of Medicare, but has the following important effects on expenditures:

- In the current Medicare system, the risk of higher-than-expected Medicare utilization is borne by the government. In a voucher system, this risk is shifted to the private sector.
- In the longer term under both systems, the risk of higher-than-expected Medicare cost per unit of service is shared by the government and beneficiaries. Beneficiaries may bear these costs more immediately and directly in a voucher system if the price of coverage rises relative to the value of the voucher.

A voucher system provides a predictable (and controllable) rate of growth in the federal part of the program. The government can set the rate of growth in voucher value (say, to GDP growth).

Want to give capped voucher.
Ends entitlement to Medicare
Instead of fed commitment to get benefits, give them only money to buy what they can in the market.

DRAFT; June 1, 1995; 4:48 pm

MEANS-TESTING MEDICARE

QUESTION:

There are currently thousands of rich, elderly Americans who receive Medicare. How do you feel about means-testing the Medicare program?

ANSWER:

- Part A of Medicare--Hospital Insurance--is financed by payroll taxes throughout individuals' worklives. A means test for receipt of benefits from this program, therefore, seems inappropriate.

- On the other hand, Part B--Supplemental Medical Insurance--is financed primarily by general government revenues. This year, nearly 70 percent of SMI finances come from general revenues and this proportion will only increase in the future.

- Because of the large general revenue subsidy, there is more scope for consideration of means-testing in Part B of Medicare. In the context of broader health car reform, the President's Health Security Act proposed income-related premiums for Part B coverage. Enrollees with incomes exceeding $90,000 ($115,000 for couples) would pay higher premiums that would cover about 75 percent of the average benefits per enrollee, in contrast to the 31.5 percent now paid by all enrollees.

See edits.

LONG-RANGE FINANCING PROBLEMS

QUESTION:

What are the primary causes of the long-range deficit in the HI Trust Fund?

ANSWER:

- Driving the expected imbalance between expenditures and revenues in the long run is the demographic shift that will occur with the aging of the baby-boom generation. A larger percentage of our population will be eligible for Medicare, and a correspondingly smaller percentage will be paying the taxes that support the Trust Fund.

- As the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop. Currently about four covered workers support each HI enrollee. The trustees expect that only two covered workers will be available to support each enrollee in the middle of the 21st century.

- In the short run, economic factors play an important role. Excess medical care inflation (price increases above economy-wide general inflation) and slow wage growth work against trust fund solvency.

- Increasing utilization--due to such factors as technological advances and the rising age of the beneficiary population--and program enrollment growth also lead to rising costs in the short run.

- Problems in Medicare reflect problems in health care. We can not slow the rate of growth of Medicare expenditures without addressing the rate of growth of spending in the overall health care sector.

DRAFT; June 1, 1995; 4:48 pm

CASH FLOW BETWEEN THE GENERAL FUND AND THE TRUST FUND

QUESTION:

When will the HI Trust Fund begin to incur a cash shortfall and thereby begin to drain the Federal Treasury?

ANSWER:

- Payroll taxes and other non-interest income are currently not sufficient to cover Part A disbursements. Payroll taxes and other non-interest income to the HI program has been lower than disbursements since 1992.

- Presently, interest income from the general fund is being used to pay claims. In other words, there has been a net cash flow from the general fund to the HI Trust Fund in recent years.

- Beginning in 1997, total HI income (payroll tax plus non-interest income plus interest income) will fall below total disbursements and the HI Trust Fund will start cashing out Treasury securities purchased during surplus years.

- As the 1995 Trustee Report stated, the HI Trust Fund will be exhausted in 2002. In the absence of benefit or tax changes, Congress will have to establish provisions for the payment of benefit claims beyond that point.

BACKGROUND:

Technically, when the Trust Fund is exhausted there is no provision that permits payment of benefit claims from the general fund. As a consequence, in the absence of changes that move the insolvency data for the fund, benefits could not be paid beyond 2002.

When payroll contributions exceed benefit payments, the surplus is invested by the Secretary of Treasury--the Managing Trustee--in U.S. Government interest-bearing securities. This creates a cash flow from the Trust Fund to the general fund. Payment of interest and redemptions of securities cause an opposite cash flow. The direction of the overall net flow depends on whether a Trust Fund's tax income is sufficient to cover program expenditures.

DRAFT; June 1, 1995; 4:48 pm

SHORT GENERAL QUESTIONS

QUESTION:

Who has the President nominated for the two public trustee slots?

ANSWER:

- The President has nominated Marilyn Moon, a noted economist with the Urban Institute, and Steven Kellison, the past Executive Director of the Academy of Actuaries.

QUESTION:

How many years did OBRA 93 push back the depletion of the HI Trust Fund?

ANSWER:

- OBRA 93 and stronger-than-expected economic growth has extended the life of the Trust Fund by 3 years from 1999 to 2002. The provisions in OBRA 93 that helped delay the exhaustion of the HI Trust Fund were (1) imposing constraints on the growth of Medicare payments to providers; (2) depositing tax revenues from increased income taxation of Social Security benefits into the Trust Fund; and (3) repealing the maximum earnings cap for the HI payroll tax. Taken together the tax increases from OBRA 93 fell only on the richest 13 percent of beneficiaries.

QUESTION:

Could you give estimates of the effects on the Trust Fund of the tax provisions relating to Social Security benefits in the Contract with America?

ANSWER:

- The House tax cuts would lower the maximum proportion of Social Security benefits subject to Federal income taxes to 50 percent. This proposal phases-out the tax over 5 years but they no longer credit any of this money to the HI Trust Fund. From the Trust Fund's perspective, this is the equivalent to immediately eliminating the tax instead of phasing it out.

- This tax provision costs the HI Trust Fund more than $34 billion in lost revenue over the next 7 years and will cause the Trust Fund will be insolvent nearly one year earlier than currently projected.

QUESTION:

What does the 1995 Trustees Report say about what would be necessary to close the actuarial deficit for HI?

ANSWER:

- If we do not reform the health care system, revenues would have to be increased by 44 percent or outlays reduced by 30 percent or some combination of the two to bring the HI program into actuarial balance for the first 25 years.

- Without any efficiency gains in the health care system, to close the long-range, 75-year deficit, the HI payroll tax (currently 1.45 percent for both employees and employers) would have to be immediately more than doubled or benefits would have to be reduced by more than half.

DRAFT; June 1, 1995; 3:42pm

HOSPITAL INSURANCE TRUST FUND SOLVENCY

Question: As a Trustee of the Medicare trust funds are you concerned that the President's budget does nothing to address the impending solvency of the Hospital Insurance (Part A) Trust Fund? What should be done about this problem?

Answer:

- As a Trustee, I am very concerned about the expected insolvency of the Part A Trust Fund in 2002.

- The goals for the Federal budget should not be mingled with the goals for the Medicare program.

- The impending insolvency of the Medicare Trust Fund has been a problem for over 15 years and reflects the structural problem with the Medicare system. The President is committed to broad-based health care reform and strongly feels that any reforms to the Medicare system must be pursued within this context.

3 step solution

- The solution for Medicare should be the same as for the health care system as a whole. When overall health care expenditures are brought under control, through a major health care reform initiative, the Medicare insolvency problem will be solved.

DRAFT; June 1, 1995; 4:48 pm

MEDICAL SAVINGS ACCOUNTS

QUESTION:

Do you believe that restructuring Medicare to utilize Medical Savings Accounts would be an efficient mechanism to eliminate cost-shifting from Medicare beneficiaries to middle-class workers?

ANSWER:

- The Administration does not believe that a Medical Savings Account (MSA) would serve either Medicare beneficiaries or the Medicare program well.

- About 75 percent of beneficiaries have incomes of less than $25,000, and one-third rely on Social Security benefits for 80 percent of their income. Many of these individuals simply do not have the resources to put money into a MSA, even if the accounts were supplemented by the Federal government.

- Many of those who did choose the MSA would constantly face the choice of spending their money on medical care or other necessities such as food. Given such difficult choices, it is not surprising that some elderly Americans will be forced to underutilize health care.

- In addition, since 25 percent of Medicare beneficiaries account for over 90 percent of expenditures, there will be a strong incentive for insurance companies selling the catastrophic care package to avoid selling to that portion of seniors.

- Also, the fact that such a small percentage of beneficiaries account for most of the costs in the system casts serious doubt on the level of spending control that can be achieved by a policy that only deals with health care spending below a deductible.

- The MSA approach could create a two-tiered Medicare system with the wealthiest and healthiest choosing the MSA while the rest remain in the traditional program. In this two-tiered system, Medicare cost increases could accelerate leaving expenditures higher than they would be otherwise.

BACKGROUND:

- Under the MSA proposal, 95 percent of the annual expected Medicare expenditures would be used to purchase a beneficiary's catastrophic coverage ($3,000 deductible policy) from a private insurer. Remaining funds would be deposited in the beneficiary's MSA. The beneficiaries would probably have to make additional payments into the MSA as well.

- The beneficiary would be responsible for all medical costs up to the deductible. Moreover, the beneficiary could keep any money that was used during the year.

- As you know, last year the Clinton Administration fought hard for health care reform. While we could not reach agreement on legislation, there can be little disagreement that the problems remain. Nearly 40 million Americans have no health insurance and millions more are just one pink slip or illness away from losing it. Eighty-four percent of the uninsured in 1993 were in working families, and more that 55 percent lived in families headed by full-time workers. And while health care costs have begun to slow down, they are continuing to rise at three times the rate of inflation.

- As the President said in his State of the Union address and in his December letter to the Congressional Leadership, we remain firmly committed to guaranteeing health security to all Americans and to containing health care costs for families, businesses and Federal, state and local governments.

- The President believes that we should take a step-by-step approach. This year, we can take the first steps. The Congress can and should:

  - Reform the insurance market -- so that people can't be denied insurance because they have a so-called preexisting condition, so that they don't lose their insurance when they lose their job or change jobs or a family member falls ill, and so that small businesses can afford to buy insurance for their workers.

  - affordable
    Make coverage available for working families
  - ~~Make coverage affordable for and available to children.~~

  - Help workers who lose their jobs keep their health insurance.

  - Continue to
    Level the playing field for the self-employed by giving them the same tax treatment as other businesses.

  - Help families provide long-term care for a sick parent or a disabled child.

- Because their constituents are demanding action, some Republicans have begun to respond to the President's challenge by coming forward with proposals and bills. We look forward to working with them to take the first steps this year.

Some thoughts on Medicare Vouchers --

The President will evaluate any health care proposal against the following criteria: coverage, choice, affordability.

The voucher proposals being considered so far don't meet these criteria.

- They don't guarantee coverage, but instead provide a defined contribution that may or may not enable a beneficiary to but all services in the private market. Beneficiaries are no longer entitled to a set of health care services.

- They don't provide real choice, but instead would leave no other option for some beneficiaries than to go into the cheapest plan in an area.

- They don't ensure that Medicare beneficiaries will be able to afford the benefits that they have always received. If health care costs rise faster than the voucher, beneficiaries can buy less and less coverage.

[The President has also used "quality" as one of his criteria, but I'm not sure you can make the argument that you won't get quality in the private market.]

Jennifer K

MANAGED CARE, VOUCHERS, AND MEDICARE SAVINGS

Republican proposals to make Medicare a voucher program do not produce savings by expanding choice, they reduce spending by shifting costs to beneficiaries and effectively forcing many of them into managed care.

Even a document prepared by the House Budget Committee concedes that: "Most likely, the beneficiary would have to pay an amount in addition to the voucher" to remain in the traditional Medicare benefit plan. *(Draft House Republican Budget Committee Recommendations, May 3, 1995.)*

Republican voucher proposals would effectively force Medicare beneficiaries into HMOs, because many of them could not afford to do anything else. This is coercion, not choice.

According to the Urban Institute, the elderly now pay over $2,500 a year on average in out-of-pocket health care costs (about 21% of their income). Under the Republican voucher plan, beneficiaries would be required to pay an average of over $1,000 per year more between 1996 and 2002 to retain traditional, Medicare fee-for-service coverage.

Republican voucher proposals would take away from Medicare beneficiaries their entitlement to health coverage.

Republican voucher proposals would give beneficiaries a capped voucher growing at an arbitrary rate that is lower than the expected increase in health care costs. This means that, every year as heath care costs go up faster than the voucher, beneficiaries can buy less and less coverage.

Republicans call their voucher a defined contribution. This means that beneficiaries are no longer entitled to a set of health care services. Instead, they get an arbitrary amount as a voucher that may or may not be enough to buy health coverage.

In fact, a document prepared by the House Budget Committee concedes that a capped voucher might not be enough to obtain health coverage for all beneficiaries. To try to address this problem, they present an alternative -- tying the voucher to the cheapest plan in each area. However, they admit that this approach would not achieve the Medicare cuts they are counting on to provide tax cuts to the wealthy and balance the budget by 2002. *(Draft House Republican Budget Committee Recommendations, May 3, 1995.)*

Even this more "moderate" Republican plan says to our nation's seniors that we will only guarantee them the cheapest health coverage available, and that they can get better coverage only if they can afford it.

Republican voucher proposals rely on the private insurance market, yet they ignore many of its problems.

For example, private insurers discriminate against people based on their age, how sick they are, and where they live. Under the current Medicare program, everyone is treated the same.

Republican proposals would inevitably result in higher costs for people who are the sickest and need Medicare the most.

Under Republican proposals, younger and healthier beneficiaries would buy less expensive, catastrophic coverage and pocket the difference between the voucher amount and the catastrophic plan.

However, catastrophic coverage would not be cheaper for beneficiaries who have health problems because they have very large out-of-pocket expenses.

Thus, older and sicker beneficiaries would have little choice but to purchase more comprehensive coverage. However, because costs would be spread only over older and sicker beneficiaries, these health plans would be very expensive.

CONTRACT WITH AMERICA PROVISION TO REPEAL TAXATION OF SOCIAL SECURITY BENEFIT CHANGES IN OBRA 93

Q. What is the estimated loss in individual income tax revenue associated with the proposed phased-in repeal of the OBRA 93 increase in taxation of Social Security benefits contained in the Contract with America? Does the estimated loss in tax revenue differ from the estimated reduction in deposits to the HI trust fund?

A. From FY 1996-2000, the loss in individual income taxes is estimated to be $15.3 billion. From FY 1996-2002, the loss in individual income taxes is estimated to be $27.7 billion. From FY 1996-2005, the loss in individual income taxes is estimated to be $49.1 billion.

Transfers to the HI trust fund for the taxation of Social Security benefits from FY 1996-2000, from FY 1996-2002, and from FY 1996-2005 is estimated to decline by $21.9 billion, $34.3 billion, and $55.5 billion, respectively.

BACKGROUND

- OBRA 93 required that additional revenue attributable to the increase in the taxation of Social Security benefits be deposited in the HI trust fund.
- The Contract with America provision phases out the OBRA 93 tax increases on Social Security benefits from 1996 to 2000. The repeal of the OBRA 93 increases in the taxation of Social Security benefits is fully phased-in in 2000.
- The Contract with America provision also requires that all of the subsequent tax revenue from the OBRA 93 increases in taxation of Social Security benefits be deposited to the OASI trust fund beginning in Tax Year 1996.
- Thus, there is an immediate loss to the HI trust fund beginning in 1996 of all subsequent revenue attributable to the OBRA 93 increases in the taxation of Social Security benefits, but only a partially phased-in loss in tax revenue to the Treasury until the year 2000.

Office of Tax Policy
June 5, 1995

(June 1, 1995, 10:30pm)

For Release Upon Delivery
Expected at 2:30 p.m.
June 6, 1995

STATEMENT OF TREASURY SECRETARY ROBERT E. RUBIN BEFORE THE SENATE FINANCE COMMITTEE

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Finance Committee today in my role as Managing Trustee and Chairman of the Medicare Boards of Trustees. The Boards are required to report annually to the Congress on the financial status of two separate Medicare trust funds -- the Hospital Insurance (or HI) Trust Fund and the Supplementary Medical Insurance (or SMI) Trust Fund.

As you know, this year's reports show that the HI Trust Fund will be exhausted by the year 2002 and that the costs of the SMI program continue to rise rapidly. This is the third consecutive year in which the Board has formally notified Congress about the HI Trust Fund's short-term insolvency -- which the Board defines as a trust fund balance below 100 percent of annual outlays within ten years. Thus, this Administration clearly recognizes that the projected Medicare shortfall needs to be addressed.

The Medicare financing problem is a complex interaction of demographics and the rapidly rising costs that affect all parts of our health care system. Addressing the Medicare problem in the context of deficit reduction without recognizing these complex interactions is unlikely to produce a viable long-term solution. Therefore, the Administration believes the Medicare financing crisis will be handled best outside the current race to balance the budget and in the context of overall health care reform. Our judgment is that attempts to resolve it solely to help balance the budget and finance tax cuts will take us further away from sound health care policy. Even if such attempts to resolve the financing crisis succeed in restoring solvency to the HI Trust Fund, they will create and intensify other problems -- in public health, in reduced insurance coverage, in less affordable health care, and in the cost of other government programs.

Recognizing this complexity, the Board of Trustees recommended re-establishing the quadrennial advisory council on Medicare to allow the Administration to bring together program experts from around the nation to develop recommendations for consideration by the Administration and the Congress. This process could be completed within a year or two following establishment of the Council. Although an HI trust fund crisis is clearly coming, we do have several years to fix it right and avoid a hasty, unworkable solution that may have to be undone in the future. The Trustees have provided an early warning and the Administration agrees it is time to begin to develop effective Medicare reforms in the context of overall health care reform.

One of the most important things our country has done over the past 30 years has been to work to reduce poverty and deprivation among senior citizens and disabled persons, and thereby reduce the anxiety of their children. Medicare has effectively provided a reliable source of medical care coverage for aging and disabled Americans. There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly.

Changes to Medicare as part of overall health care reform can restore Medicare to solvency, while at the same time improving the health of elderly and disabled Americans. The Clinton Administration stands ready to work with Congress to solve the current financing problem.

Financial Status of the Medicare Trust Funds

As noted, the Trustees reported in April that the HI Trust Fund will be exhausted in 2002, one year later than projected last year. This slight improvement largely reflects the effects of the President's 1993 deficit reduction plan, the stronger-than-expected economy in 1994, and lower-than-expected program cost increases.

Since the latter part of the 1980s, the Board has projected that the HI Trust Fund would be exhausted around the turn of the century and has urged Congress to take action to control HI program costs. This year, in addition to urging congressional action, the Trustees have called for the re-establishment of the Quadrennial Advisory Council on Medicare in order to bring outside expertise into the process of developing options to resolve the Medicare financing problem.

Over the long term, the 75-year actuarial balance (interpreted as the amount of payroll tax increase or benefit reduction needed now to balance the trust fund over the next 75 years) was reduced from last year's estimate of 4.14 percent to 3.52 percent of payroll. The reduction in the deficit is largely the result of lower expected future increases in HI costs, based on the recently observed

slowdown in HI spending growth. Despite the decline in the deficit, the HI program remains substantially out of long-run actuarial balance.

The Trustees also continue to project rapid growth in Supplemental Medical Insurance program costs well into the future. Over the next five years, outlays are expected to increase 78 percent in the aggregate and 66 percent per enrollee. During the same period, the program is expected to grow about 38 percent faster than the overall economy.

Combined HI and SMI costs are expected to increase from 2.6 percent of GDP in 1995 to 8.8 percent in 2069 -- roughly tripling -- largely due to anticipated demographic changes. Because of this rise in long-term program costs and the expected exhaustion of the HI fund in 2002, the Board of Trustees recommends prompt, effective, and decisive Medicare reform.

History of Medicare Costs

When the Hospital Insurance program faced financing problems in the past, Congress and the Executive Branch have been able to cooperate on making modest changes in the program that slowed the rate of cost increases.

The program has experienced financial difficulty since its inception in 1966 due to rapidly rising hospital costs, higher-than-expected utilization, and program expansion. The actuarial balance deteriorated between 1966 and 1972, leading to an increase in payroll taxes in 1972 and temporary control of hospital prices between 1972 and 1974. After 1974, annual hospital costs again increased rapidly until 1983 legislation changed the manner in which Medicare pays for hospital services (from a reimbursement to a prospective basis). Consequently, the annual growth of hospital costs was modest in the mid-1980s, although by the end of the decade it was again above 10 percent.

During the 1990s, program expenditure increases were below those of the previous decade, reflecting a comparatively moderate rise in overall health care inflation and utilization. The President's 1993 deficit reduction plan, which included Medicare spending cuts, removal of the earnings limit for HI contributions, and increased taxation of OASDI benefits (with the proceeds going to the HI Trust Fund), is partly responsible for the recent decline in growth rates which extended the trust fund exhaustion date by three years.

Although technically the SMI Trust Fund is actuarially sound because the majority of its funding is from general revenue, spending for physician services has grown faster than spending for hospital services in recent years. This is due, in part, to the establishment, in 1983, of Medicare's prospective payment method for hospital services, which, among other things, shifted some services from an

inpatient to a less expensive outpatient basis. In 1992, the SMI program began to phase in its own version of a prospective payment system based on the estimated cost of resources needed for various physician services. Although this change should help restrain the future growth of SMI expenditures, SMI and HI face similar near-term financial pressures because of medical price inflation and rising utilization of services. Over the long term, demographic change will dominate, as an aging population compounds the financing problem for both programs.

Trustees' Recommendations

This year the Trustees specifically recommended re-establishing the Medicare Quadrennial Advisory Council, which was dropped when the Social Security Administration became an independent agency. The outside expertise of the Council can be of great assistance to the Board in developing options to solve the Medicare financing problem. The Board also has urged the Congress to take action through health care reform designed to reduce the growth of health care costs and address the Medicare financial imbalance in both the short run and long run. The sooner action is taken, the more likely we will be able to maintain and improve the health care for our elderly, and at the same time provide sufficient saving to restore financial balance.

Medicare Financing and Health Care Reform

The fundamental reason for the rise in Medicare expenditures is the increase in health care costs affecting all parts of the nation's health care system. A dramatic attempt by government to contain Medicare spending -- large reductions in payments to hospitals, for example -- will cause significant distortions and inefficiencies elsewhere in the health care system, unless such a reduction is undertaken in the context of overall health care reform.

The net effect of reducing Medicare payments by government fiat, unconnected with health care reform, will be to further undermine the private health insurance system. More of our non-elderly citizens will be uninsured and the quality of their care will be reduced as a result of price increases imposed to offset the reduction in Medicare payments. These unilateral changes in Medicare will also raise out-of-pocket costs for seniors, reduce the quality of their health care, and limit choice of physician, and they could lead to more rural hospitals closings.

In contrast, much more can be done if we undertake overall health care reform. A more competitive health care market -- in which consumers have a real choice among networks of doctors, hospitals, and insurers -- would move patients and insurance customers toward the most efficient, highest-quality health care plans.

Health insurance premiums would more directly reflect the cost of providing care and the rate of growth in overall health care spending would be slowed, leading to lower Medicare spending.

In closing, the Administration believes firmly that the Medicare financing problem would be best handled in the context of broad-based health care reform. Resolving this complex issue solely to help balance the budget by 2002 while cutting taxes could produce an unworkable solution that will have to be undone later. The Trustees and the Administration believe it is possible to address this question thoughtfully and produce an effective, acceptable solution that will stand the test of time. We are ready to work with the Congress to achieve that goal.

I will be happy to answer any questions you may have.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

5/11/95

LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 1293

FILE NO: 765

Total Page(s): 6

TO: Legislative Liaison Officer - See Distribution below:

FROM: Janet FORSGREN (for) Janet L. Forsgren
Assistant Director for Legislative Reference

SPECIAL

OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: TREASURY Proposed Testimony on financial status of the Medicare trust funds.

DEADLINE: Monday, May 22,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Hearing will be before the Senate Finance Committee. The date of the hearing has not yet been set, but is likely to occur during the first week in June. The attached is Secretary Rubin's oral statement.

NOTE: Secretary Rubin's statement will not be cleared until close to the date of the hearing. The deadline noted above is to solicit comments from the below listed agencies.

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RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 1293
FILE NO: 765

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter.

Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: TREASURY Proposed Testimony on financial status of the Medicare trust funds.

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

For Release Upon Delivery
Expected at 9:30 a.m.
June 1, 1995 ??????

STATEMENT OF ROBERT E. RUBIN
SECRETARY OF THE TREASURY
BEFORE THE SENATE FINANCE COMMITTEE

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Finance Committee today in my role as Managing Trustee and Chairman of the Medicare Boards of Trustees. The Boards are required to report annually to the Congress on the financial status of two separate Medicare trust funds -- the Hospital Insurance (or HI) Trust Fund and the Supplementary Medical Insurance (or SMI) Trust Fund.

As you know, this year's reports show that the HI trust fund will be exhausted by the year 2002 and that the costs of the SMI program continue to rise rapidly. This is the third consecutive year in which the Board has formally notified the Congress about the Hospital Insurance (HI) Trust Fund's short-term insolvency -- defined by the Board as a trust fund balance below 100 percent of annual outlays within ten years. Since at least the middle 1980s, the Board has regularly projected that the HI fund would be exhausted within ten to fifteen years and has urged Congress to take action to control HI program costs. This year, in addition to urging Congressional action, the Trustees have called for the re-establishment of the Quadrennial Advisory Council on Medicare in order to bring outside expertise into the process of developing options to resolve the Medicare financing problem.

The Administration believes the Medicare financing crisis would be handled best in the context of overall health care reform and largely within the structure of the current program. Our judgment is that attempts to resolve it in the absence of health care reform take us further away from a sound national health care system. Even if such attempts to resolve the financing crisis succeed in balancing Medicare's revenues and expenses, they will create and intensify other problems -- in public health, in reduced insurance coverage, and in the cost of other government programs -- resulting in no net improvement in overall social well-being, and could end up leaving us worse off.

One of the most important things our country has done has been to work to reduce poverty and deprivation among senior citizens and thereby reduce the anxiety of their children. Medicare has effectively provided a reliable source of medical care coverage for aging Americans. There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly.

Changes to Medicare in the context of overall health care reform can restore Medicare to solvency, while improving the services delivered to elderly Americans. The Clinton Administration desires a solvent Medicare system. Indeed, we stand ready to work with Congress to solve the current financing problem but cannot support reducing Medicare benefits to pay for tax cuts for the most well off.

Financial Status of the Medicare Trust Funds

As noted, the Trustees reported in April that the HI Trust Fund will be exhausted in 2002, one year later than projected last year. This slight improvement from last year reflects mainly the effects of the President's 1993 deficit reduction plan, the stronger-than-expected economy in 1994, and lower-than-expected program cost increases.

Over the long term, the 75-year actuarial balance (interpreted as the amount of payroll tax increase or benefit reduction needed now to balance the trust fund over the next 75 years) was reduced from last year's estimate to 3.52 percent of payroll. The reduction in the deficit is largely the result of lower expected future increases in HI costs, based on the recently observed slowdown in HI spending growth. Despite the decline in the deficit, the HI program remains substantially out of long-run actuarial balance.

The Trustees also continue to project rapid growth in SMI program costs well into the future. Over the past five years, outlays increased 53 percent in the aggregate and 40 percent per enrollee. During the same period, the program grew about 19 percent faster than the overall economy. Although these increases are a little below the comparable increases reported last year, they are still substantial.

Combined HI and SMI costs are expected to increase from 2.6 percent of GDP in 1995 to 8.8 percent in 2069. Because of this rise in long-term program costs and the expected exhaustion of the HI fund in 2002, the Board of Trustees recommends prompt, effective, and decisive action on Medicare financing.

History of Medicare Costs

When the HI program faced financing problems in the past, Congress responded by making changes within the context of the existing program structure. We see no reason to treat the current situation differently.

The program has experienced financial difficulty since its inception in 1966 due to rapidly rising hospital costs, higher-than-expected utilization, and program expansion. The actuarial balance deteriorated between 1966 and 1972 leading to an increase in payroll taxes in 1972 and temporary control of hospital prices between 1972 and 1974. After 1974, annual hospital costs again increased rapidly until 1983 legislation changed the manner in which Medicare pays for hospital services (from a reimbursement to a prospective basis). Consequently, the annual growth of hospital costs was modest in the mid-1980s, although by the end of the decade it was again above 10 percent.

During the 1990s, increases in program expenditures were below the increases of the previous decade, reflecting a comparatively moderate rise in overall health care inflation and utilization. The President's 1993 deficit reduction plan, which included Medicare spending cuts, removed the earnings limit for HI contributions, and increased the taxation of OASDI benefits (with the proceeds going to the HI trust fund) is partly responsible for the recent decline and extended the trust fund exhaustion date by three years.

Although technically the SMI trust fund is actuarially sound because the majority of its funding is from general revenue, spending for physician services has grown faster than spending for hospital services in recent years. This is due, in part, to the establishment, in 1983, of Medicare's prospective payment method for hospital services, which, among other things, shifted some services from an inpatient to a less expensive outpatient basis. In 1992, the SMI program began to phase in its own version of a prospective payment system based on the estimated cost of resources needed for various physician services. Although this should help restrain future growth in SMI expenditures, SMI and HI face similar near-term financial pressures because of medical price inflation and rising utilization of services. Over the long-term demographic change will dominate, as an aging population compounds the financing problem for both programs.

Trustees' Recommendations

This year the Trustees specifically recommended re-establishing the Medicare Quadrennial Advisory Council which was dropped when the Social Security Administration became an independent agency. The Board has also urged the Congress to take action through broad-based health care reform designed to control health care costs and address the Medicare financial imbalance in both the short run and long run. The sooner action is taken, the more modest program changes will have to be in order to provide sufficient saving to restore financial balance.

The House-passed tax cut bill (H.R. 1215) which would, among other things, reduce the taxation of social security benefits by returning to pre-1994 law, would worsen the HI deficit. If the House-passed bill becomes law, the HI trust fund would be exhausted about eight to nine months sooner. The Senate should not

agree to this change. As Senator Bradley noted recently in this Committee, it does not make sense for 85 percent of the elderly to finance a tax cut for the wealthiest 15 percent of the elderly, through cuts in their Medicare.

Medicare Financing and Health Care Reform

The fundamental reason for the rise in Medicare expenditures is the increase in health care costs affecting all parts of the nation's health care system. A dramatic attempt by government to contain Medicare spending -- large reductions in payments to hospitals, for example -- will cause significant distortions and inefficiencies elsewhere in the health care system, unless such a reduction is undertaken in the context of overall health care reform.

The net effect of reducing Medicare payments by government fiat, unconnected with health care reform, will be to further undermine the private health insurance system. More of our citizens will be uninsured and the quality of their care will be reduced as a result of price increases imposed to offset the reduction in Medicare payments.

By contrast, much can be done within the context of health care reform. A more competitive health care market -- in which consumers have a real choice among networks of doctors, hospitals, and insurers -- would move patients and insurance customers toward the most efficient, highest-quality health care plans. Health insurance premiums would more directly reflect the cost of providing care and the rate of growth in overall health care spending would be slowed, leading to lower Medicare spending.

The Administration believes firmly that the Medicare financing shortfall would be best handled in the context of broad-based health care reform, and further, that the needed changes should not affect the basic structure of the existing Medicare program. We stand ready to work with the Congress in a bipartisan manner to achieve that goal.

I will be happy to answer any questions you may have.

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

10-May-1995 02:02pm

TO: (See Below)

FROM: Robert J. Pellicci
Office of Mgmt and Budget, LRD

SUBJECT: Medicare Trust Fund Legislation

Yesterday (5/9) Sen. Packwood and Rep. Archer each introduced legislation that would require the Trustees of the Medicare trust funds to report recommendations on resolving the financial imbalance in the trust funds. Sen. Packwood's bill is S. 785 and Rep. Archer's bill is HR 1590. The bills were referred to Finance in the Senate and Ways and Means and Commerce in the House, respectively.

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