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 02:51pm

TO: (See Below)

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

SUBJECT: HI Trust Fund Markup Tonight

According to Karen Pollitz, the House Ways and Means Committee will markup HR 1590 -- Archer's bill that was introduced yesterday. The bill requires the Trustees to recommend to Congress both short-term and long-term solutions to the Medicare trust fund financial situation. I am receiving from HHS a copy of the legislation which I will send to you. Under the bill, the Trustees are required to submit their recommendations no later than June 30, 1995.

Karen tells me that she will notify Ways and Means that no one from the Administration will attend the markup.

Distribution:

TO: Nancy-Ann E. Min
TO: Christopher C. Jennings
TO: Jennifer L. Klein
TO: Gene B. Sperling
TO: Kenneth S. Apfel

CC: Barry T. Clendenin
CC: Charles S. Konigsberg
CC: Mark E. Miller
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CC: Keith J. Fontenot
CC: Janet R. Forsgren
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OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

FROM: Bob Pellicci -- 395-4871

DATE: 5/10/95 **TIME:** 3:10 pm

Pages sent (including transmittal sheet): 5

COMMENTS:

TO:
Nancy-Ann Min
Chris Jennings
Gene Sperling
Jennifer Klein

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

H.L.C.

104TH CONGRESS
1ST SESSION

H. R. 1590

IN THE HOUSE OF REPRESENTATIVES

Mr. ARCHER and Mr. Thomas introduced the following bill; which was referred to the Committee on _____

A BILL

To require the Trustees of the medicare trust funds to report recommendations on resolving projected financial imbalance in medicare trust funds.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TRUSTEES' CONCLUSIONS REGARDING FINANCIAL STATUS OF MEDICARE TRUST FUNDS.

(a) HI TRUST FUND.—The 1995 annual report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, submitted on April 3, 1995, contains the following conclusions respecting the financial status of such Trust Fund:

(1) Under the Trustees' intermediate assumptions, the present financing schedule for the hospital insurance program is sufficient to ensure the payment of benefits only over the next 7 years.

(2) Under present law, hospital insurance program costs are expected to far exceed revenues over the 75-year long-range period under any reasonable set of assumptions.

(3) As a result, the hospital insurance program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program.

(b) SMI TRUST FUND.—The 1995 annual report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, submitted on April 3, 1995, contains the following conclusions respecting the financial status of such Trust Fund:

(1) Although the supplementary medical insurance program is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program.

(2) In spite of the evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth

rates are projected to increase above those of the recent past.

(3) Growth rates have been so rapid that outlays of the program have increased 53 percent in aggregate and 40 percent per enrollee in the last 5 years.

(4) For the same time period, the program grew 19 percent faster than the economy despite recent efforts to control the costs of the program.

SEC. 2. RECOMMENDATIONS ON RESOLVING PROJECTED FINANCIAL IMBALANCE IN MEDICARE TRUST FUNDS.

(a) REPORT.—Not later than June 30, 1995, the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund shall submit to the Congress recommendations for specific program legislation designed solely—

(1) to control medicare hospital insurance program costs and to address the projected financial imbalance in the Federal Hospital Insurance Trust Fund in both the short-range and long-range; and

(2) to more effectively control medicare supplementary medical insurance costs.

(b) USE OF INTERMEDIATE ASSUMPTIONS.—The Boards of Trustees shall use the intermediate assumptions described in the 1995 annual reports of such Boards in making recommendations under subsection (a).

MEDICARE TRUST FUND SOLVENCY PROBLEM

Unlike the Republicans, This is Not a Problem Democrats Just Discovered. The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed. Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

In Contrast to the Democrats, the Republicans Have Just Discovered this Issue. In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

The Republicans are Using the Trust Fund as a Smoke Screen for Cuts. Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution: Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

REPUBLICAN MEDICARE CUTS

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

COERCION INSTEAD OF CHOICE: Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

ADDING TO ALREADY HIGH COSTS FOR SENIORS: Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or $2,500) of their incomes to pay for out-of-pocket health care expenditures.

$3,100-$3,700 Out-of-Pocket Payments: If the Republican cuts ($250 billion to $305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional $815 to $980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between $3,100 to $3,700 more.

Reduce Half of Social Security COLA: The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

$40-$50 Billion in Cost-Shifting: Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a $125 billion to $150 billion cut over seven years. In 2002 alone, a $33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of $40 billion to $50 billion in increased premiums and health care costs between now and 2002.

Rural and Inner City Hospitals At Risk: Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
  - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
  - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
  - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
  - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. **On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.**

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by $160 to more than $190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if $160 to $190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut $160 to $190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE**; and
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE**; and
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the $190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by $10.7 to $12.8 billion.

MEDICARE/MEDICAID CUTS:
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least $2000 more out of pocket than they would pay under current law. And over the next seven years they would pay $3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

The National Council of Senior Citizens says:

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about go belly-up; a seven-year window does not merit a panic button."

"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to chose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Children's Defense Fund says:

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)

THE WHITE HOUSE

WASHINGTON

May 1, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The President has asked me to respond to your letter of April 28, 1995. As the Administration has shown over the last two and a half years, we are committed to reducing the deficit and achieving meaningful health care reform. We continue to seek progress on both of these fronts, while also making our tax system fairer and our system of investing in education and children even stronger.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by $27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over $300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year $345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconcillations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

The President has long stated that making significant cuts in Medicare and Medicaid outside the context of health care reform will not work. Such dramatic cuts could lead to

less coverage and lower quality, much higher costs to poor and middle income Medicare recipients who cannot afford them, a coercive Medicare program, and cost-shifting that could lead to a hidden tax on the health premiums of average Americans. That is why it is essential to deal with the Medicare Trust Fund in the context of health care reform that protects the integrity of the program, expands not reduces coverage, and protects choice as well as quality and affordability.

The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

Leon E. Panetta
Chief of Staff

Newt Gingrich
Sixth District
Georgia

(202) 225-0600

Office of the Speaker
United States House of Representatives
Washington, DC 20515

April 28, 1995

8

The Honorable Bill Clinton
The White House
Washington, D.C.

Dear Mr. President:

I write to you out of deep concern for the future of Medicare. The most recent reports of the Medicare Hospital Insurance and Supplementary Medical Insurance Trustees paint a grim picture of the future of Medicare and make clear that immediate action is needed to ensure Medicare's survival.

The Trustees' reports predict dire results from a failure to address the growth rate in both parts of the Medicare program. Four of the Trustees are your own Secretaries of the Treasury, Labor, and Health and Human Services Departments and the Commissioner of Social Security. The Trustees indicated, in both their 1994 and 1995 reports that urgent action is necessary.

> "...the HI program is severely out of balance and the Trustees believe that Congress must take timely action to fundamentally reform the HI program and control related program expenditures."
>
> -- 1994 Board of Trustees Annual Report, Hospital Insurance Trust Fund

Last year, you agreed that program expenditures should be slowed, and you proposed to reduce the rate of growth by $118 billion. Congress did not enact these reforms due to their entanglement in your health reform proposal.

This year, the Trustees warning is even more dire:

> "To bring the HI program into actuarial balance even for the first 25 years, either outlays would have to be reduced by 30 percent or income increased by 44 percent (or some combination thereof)...the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program."
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> 1995 Supplemental Medical Insurance Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David

M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

"...growth rates have been so rapid that outlays of the program have increased 53% in aggregate and 40% per enrollee in the last five years...The Trustees believe that prompt, effective, and decisive action is necessary."

- 1995 Hospital Insurance Trust Fund Annual Report from Secretaries Reich, Rubin and Shalala, Commissioner Chater, Public Trustees Stanford G. Ross, and David M. Walker, and Bruce C. Vladek, Administrator of HCFA and Secretary to the Board of Trustees.

Part B costs per beneficiary were $2,046.00 in 1994. In the year 2002, the year in which the Trustees predict bankruptcy for the Part A program, costs per beneficiary are estimated to be $4,430.47. This is obviously an unsustainable rate of growth, yet your most recent budget, however, contained *no new proposals* other than minor extensions of current law to limit the growth of the Part B program.

In the submission of your Health Security Act last year, you noted that Medicare reform should only be accomplished in the context of comprehensive health care reform legislation. The public Trustees clearly believe such action unwise, indicating in the 1995 report that Medicare savings should not be considered for any other purpose:

"...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."

- Public Trustees David Walker and Stan Ross, 1995 Hospital Insurance Trustees Report

Given the urgency with which the Trustees have spoken, the Congress intends to address the Medicare crisis this year. We believe the American people expect us to work together on issues as important as the Medicare program. We ask that you direct Secretaries Reich, Rubin and Shalala, Commissioner Chater, and Administrator Vladek to make recommendations to the Congress no later than May 15, 1995. Specifically, we believe these recommendations should address these concerns and questions:

- Medicare bankruptcy has often been postponed by tax increase. The most recent tax increase merely postponed bankruptcy by one or two years; the underlying growth rate remains unaddressed and the program is no closer to long term solvency. The Trustees recommend two 25 year solvency tests for the HI Trust Fund. Please present proposals that would make Medicare meet both tests. It is obviously inappropriate that the recommendations concerning Parts A merely shifts its costs to Part B, particularly given

the Trustees concerns about cost increases in the Supplemental Medical Insurance program. Does the Administration recommend tax increases?

- The Public Trustees of the Medicare Hospital Insurance Trust Fund have stated unambiguously that Congress should undertake Medicare reform ***independent*** of any other health care reform activities. Do you believe that the Public Trustees are wrong in this assessment?

- The Trustees recommend controlling the rate of growth for the Supplemental Medical Insurance program. Please recommend proposals to reduce the program's costs

- The Adminstration's latest guidance on Medicare reform remains their 1994 proposals, which would result in Medicare savings of about $118 billion. The Administration has indicated its support for incremental reform. Do you continue to support these proposals?

We will provide a more detailed set of questions in a later communication.

We believe there is no excuse to ignore the problem of Medicare, a program that will spend more than it takes in next year, and will be completely unable to pay benefits in seven years

Next week, you are convening the Fourth White House Conference on Aging, a nonpartisan event that occurs only once every decade. The final agenda for the Conference indicates that health is the primary concern of the delegates. Surely, this is the time to begin building a national consensus on how to make Medicare solvent.

Sincerely,

Newt Gingrich

FORTNEY PETE STARK
THIRTEENTH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

MEDICARE CUTS? LOOK WHAT REPUBLICANS SAID LAST YEAR!

Dear Democratic Colleague:

The Republicans are about to try to cut Medicare $250 to $310 billion over the next 7 years.

Last year all 14 Republican Members of the Ways and Means Committee signed the following minority views to HR 3600, the Health Reform bill:

> *"The reimbursement levels of medicare have reached potentially disastrous levels, as ProPAC's current report underscores.*
>
> *"Anyone who doubts this only has to look at the current Medicare program for the elderly and the Medicaid program for the poor. For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare and Medicaid patients--and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."*

As you remember, HR 3600 did cut Medicare spending $157 billion over 7 years but returned ALL the money to the health care system by insuring everyone (no more bad debt and uncompensated care for doctors and hospitals) and providing seniors with a prescription drug coverage and better Medicare benefits. The Republican cuts won't go for Medicare improvements or health care reform--they will just be cuts.

We should all remind the Republicans--often--of what they said last year.

Sincerely,

Pete Stark
Member of Congress

Newt Gingrich
Sixth District
Georgia

(202) 225-0600

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United States House of Representatives
Washington, DC 20515

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May 1, 1995

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Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by $27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over $300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year $345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconciliations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

The President has long stated that making significant cuts in Medicare and Medicaid outside the context of health care reform will not work. Such dramatic cuts could lead to

less coverage and lower quality, much higher costs to poor and middle income Medicare recipients who cannot afford them, a coercive Medicare program, and cost-shifting that could lead to a hidden tax on the health premiums of average Americans. That is why it is essential to deal with the Medicare Trust Fund in the context of health care reform that protects the integrity of the program, expands not reduces coverage, and protects choice as well as quality and affordability.

The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

Leon E. Panetta
Chief of Staff

May 2, 1995

MEMORANDUM TO THE SECRETARY OF TREASURY

Through: Ben Nye

From: Gene Sperling

Subject: Medicare Trust Fund Q&A

I just wrote these up now, so I haven't had a chance to vet them around here, but I think they are on point and could be helpful for your press briefings today. Let me know what you think as I may edit these and circulate them later.

1: QUESTION: REGARDLESS OF THE REPUBLICANS FAULTS, ISN'T THE PRESIDENT ABDICATING RESPONSIBILITY FOR COMING UP WITH A SOLUTION TO THE MEDICARE TRUST FUNDS ISSUE:

ANSWER:

- **President's Budget Strengthened Trust Fund:** Nothing could be further from the truth. When the President came into office the Trust Fund was running out of funds in 1999. Through tough actions that the President passed, and every Republican opposed, the Trust Fund was strengthened by three years.

- **Sought Greater Progress in Health Care:** The President then proposed a highly detailed health care proposal that would have significantly strengthened the Medicare Trust Fund, and again was opposed by most Republicans.

- **Still Reaching Out to Republicans to Strengthen Medicare in the Context of Health Care Reform:** Since the election, the President has made clear that he still wants to work on cost issues with the Republicans but that it has to be in the context of health care reform, and not a context in which Medicare is being used as a cover to pay for tax cuts for the most-well off or in which the budget is being balanced on the backs of seniors.

- **Still Haven't Seen their Budget -- Don't Know if Serious Effort to Reform Health Care, or cover to cut Taxes or slash Medicare for Campaign Promises:** We have still not seen their budget, however, and every indication we have is that they are trying to slash Medicare outside the context of health care reform, and indeed cut $305 billion in Medicare that would be unnecessary without their huge $345 billion tax cut over seven years. Our record demonstrates our commitment to work with them on this issue, but we cannot do that until they at least lay down a detailed budget that makes clear what their trade-offs are and whether they are really working on Medicare Trust Fund or just using it as a bank to pay for campaign promises.

2. QUESTION: WHAT IS WRONG WITH A BIPARTISAN COMMISSION?

ANSWER: The problem is that we still do not know the basic issues of whether they want to cut Medicare to pay for tax cuts and whether they want to slash Medicare outside of the context of health care reform. They need to fulfill their obligation to lay down a budget that makes clear their trade-offs and gives us the answer to the fundamental questions we have raised. Until we have seen their budget and have some of these answers, talk about Commissions is premature and in fact, seems to be being used to avoid laying out their budget as we have done three years in a row.

3. QUESTION: DO YOU SUPPORT TAKING MEDICARE OFF BUDGET?

ANSWER:

Accounting Gimmick: This is purely an accounting question that does nothing to address the fundamental questions of whether these are cuts to pay for tax cuts, and whether the approach they will take will be slashing Medicare and Medicaid, or addressing those programs in the context of serious health care reform.

They Are Seeking to Blur Fact they are Cutting Medicare to Pay for Tax Cuts for the Well-off: Right now, the Republicans have a seven year tax cut of $345 billion and are considering a $305 billion cut in Medicare -- the largest in history. They clearly want to create the perception of separate accounts or separate budget processes so as to hide from the American people the fact that their entire Medicare cut is going to pay for their tax cut -- or put another way, their entire Medicare cut would be unnecessary if they didn't have to pay for a huge tax cut that disproportionately benefits the most well-off Americans.

Gingrich Spokesperson Concedes will be Connected to Budget: Indeed, Gingrich's spokesperson Tony Blankley candidly admitted "At the end of the process, whatever solutions are reached on Medicare will be part of the budget's bottom line."

New York Times: "Little Meaning": As the New York Times said, "The Republicans will adopt new budget rules setting Medicare "off budget" and asserting that no cuts in Medicare could be used for anything but to shore up the Trust Fund. As a practical matter, this has little meaning. When the deficit is calculated, off budget items are counted the same as others.... The Republicans will still have to propose large cuts in projected spending for Medicare if they hope to balance the budget."

Q: BUT AREN'T THE REPUBLICANS TRYING TO BE RESPONSIBLE BY ADDRESSING THE MEDICARE TRUST FUND?

ANSWER: After Opposing all of President's Clinton's effort to strengthen the Trust Fund for over two years, Republicans only showed interest after a Trustee Report that showed the Medicare Trust Fund had slightly improved. It is clear that the crisis they discovered, is the one they created for themselves by promising a huge tax cut and excessive deficit promise that they could only achieve with the largest Medicare cut in history.

Let's Be Clear on the Record:

1993: When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

> **Republican Response:** Every Republican opposed these efforts and voted against the President's deficit reduction plan.

1994: Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform.

> **Republican Response:** Most Republicans fought health care reform and never seriously raised the Medicare Trust Fund issue as a reason to go forward on health care reform.

1995: The President repeated his offer to work with Republicans to control costs and expand coverage in his 1995 State of the Union speech.

> **Republican Response:** Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly ***weaken*** it by $27 billion over seven years and undo some of the progress made in 1993.

The President still Stands Ready to Work on the Medicare Trust Fund, But it Must be Clear whether Republicans will do this in the context of Health Care reform as opposed to using Medicare as a bank to pay for tax cuts: The President, of course believes more needs to be done on the Medicare Trust Fund, but that it must be done in the context of health care reform and certainly not as a cover to pay for tax cuts for well–off Americans. Until, they fulfill their legal obligation to lay out a detailed budget plan, there is no way for us or the American people to understand the trade–offs they are making.

May 15, 1995

Note to Chris Jennings

Subject: Your HI trust fund information request

1. President's Baseline compared to CBO and Trustees Baselines

	Level of cuts to maintain solvency 1995-2002	1995-2004
CBO	$164 B	
President's Budget	$126 B	$213 B
Trustees Report	$147 B	$252 B

Domenici used the CBO baseline and would cut $164 from Part A to maintain HI solvency until 2002. The level of savings is equivalent to a cap of 4.8% on the annual growth in Medicare spending.

The President's budget baseline is lower than both the CBO baseline and the Trustees' report. The President's budget has a lower CPI, marketbasket, and real wage growth than the Trustees report.

2. 100% trust fund ratio and negative cash flow

A trust fund ratio above 100% means that **at the start of each year**, there are sufficient funds available in the trust fund to pay anticipated expenses. Thus, a ratio above 100% provides a cushion in case payroll tax revenues collected over the course of the year are not sufficient to pay the bills.

Negative cash flow means that payroll tax revenues collected in a year are not sufficient to pay the bills and that interest received on prior payroll tax revenues needs to be tapped by the Treasury Department in order to pay the bills.

Domenici keeps the trust fund ratio above 100% in each year over the 1995-2002 period. Even though the ratio is above 100%, he has negative cash flow because payroll tax revenues collected over the course of the year are not sufficient to pay ALL the bills incurred during the year.

Bruce Vladeck

DRAFT

FOR RELEASE ON DELIVERY

STATEMENT ON

STATUS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND

BY
DR. SHIRLEY S. CHATER
COMMISSIONER OF
SOCIAL SECURITY

BEFORE THE
SENATE COMMITTEE ON FINANCE

May 9, 1995

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

April 25, 1995

The Honorable Shirley S. Chater
Commissioner of Social Security
Social Security Administration
613 Hubert H. Humphrey Building
200 Independence Avenue, S. W.
Baltimore, Maryland 20201

Dear Commissioner Chater:

As you know, I had invited the Trustees of the Medicare trust funds to appear at a hearing before the Committee on Finance to discuss the status of the Medicare trust funds on April 25, 1995. However, because only one of the Trustees was available on this date, and because of the seriousness of this issue, I have rescheduled this hearing for May 9, 1995, at 9:30 a.m.

The recent annual reports of the Trustees raise serious concerns about the future of the Medicare program. The costs of the Medicare Hospital Insurance (HI) program currently exceed the income to the Medicare HI Trust Fund from the HI payroll tax. The Medicare HI Trust Fund is projected to be totally exhausted by 2002. The Trustees call for "prompt, effective, and decisive action."

Whatever actions are taken to address this problem will involve all of the federal Departments and agencies represented by the Trustees. For this reason, I feel it is imperative that all of the Trustees attend this hearing and engage in a discussion with the members of the Committee on Finance who will be responsible for determining the course of action to be taken.

I would appreciate receiving confirmation of your attendance at the hearing as soon as possible. Please contact Lindy Paull, Staff Director and Chief Counsel, Committee on Finance, 202-224-5000.

Sincerely,

Bob

BOB PACKWOOD
Chairman

95 MAY -2 PM 2:24

Mr. Chairman and Members of the Committee:

The Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296, enacted on August 15, 1994), the law that established Social Security as an independent agency, also designated the Commissioner of Social Security as a Trustee of the Social Security and Medicare trust funds. The law became effective on March 31, 1995. As a Trustee, I was a signatory to the 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds which were issued on April 3.

Like my fellow Trustees, I am concerned with the findings reported for the growth of costs for both the SMI and HI programs. However, it is the HI fund which requires more immediate attention. The HI fund will be able to pay benefits for only about 7 more years, until 2002, and is out of balance for the long range as well. I agree with my fellow Trustees that effective and decisive action needs to be taken to address the financial imbalance in both the short range and the long range.

Trustees' Report Summary

The HI program pays for inpatient hospital care and other related care for those age 65 and over, and for the long-term disabled. In calendar year 1994, the HI program covered about 32 million aged enrollees and about 4 million disabled enrollees at a cost of $104.5 billion. Of this, $103.3 billion was for benefit payments, and $1.3 billion, or 1.2 percent of total outgo, was for administrative expenses.

As is the case with the Old Age, Survivors, and Disability Insurance programs, the HI program is financed primarily through payroll taxes, with the taxes paid by current workers and their employers used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and administrative expenses become assets of the HI trust fund. These assets may not be used for any other purpose. They are invested in interest-bearing obligations of the United States Government, and are backed by the full faith and credit of the Government.

Payroll taxes of 141 million workers and their employers, amounting to $95.3 billion (87 percent of total income to the fund), were collected during 1994. Interest income from investments by the trust fund amounted to 9.7 percent of total income. The remaining 3.3 percent of income consisted mostly of income from the taxation of Social Security benefits, a transfer from the railroad retirement program, transfers from the general fund of the Treasury, and premiums paid by voluntary HI enrollees.

The HI contribution rates which apply to taxable earnings are 1.45 percent for employers and employees, each, and 2.9 percent for self-employed workers. The maximum taxable annual earnings amount was eliminated for 1994 and later years, so that the HI contribution rates are applicable to all covered earnings.

The adequacy of the HI program's scheduled financing to support program costs in the future is examined under three sets of assumptions: low cost, intermediate cost, and high cost. The intermediate set of assumptions represents the Trustees' best estimate of future economic and demographic trends that will affect the financial status of the program. The low cost alternative is more optimistic, and the high cost alternative is more pessimistic. Under the intermediate assumptions, the trust fund is projected to be exhausted in 2002, and under the high cost and low cost alternatives, 2001 or 2006, respectively. These projections clearly indicate that under a range of plausible economic and demographic assumptions, the HI program is severely out of balance in the short range, and will become insolvent within the next 6 to 11 years under any of the three sets of assumptions.

Under the intermediate assumptions, the present financing schedule is sufficient to ensure the payment of benefits only over the next 7 years. The Trustees also project the status of the trust fund over the next 75 years--the period which is considered long range for program evaluation purposes. The HI program is out of what the Trustees call close actuarial balance for this period. Actuarial balance is essentially the difference between annual income and costs summarized over a given period. If the balance is negative, as it is now, the fund has an actuarial imbalance.

The deficit is generally expressed in terms of a percentage of taxable payroll. The deficit in this year's report is 3.52, slightly less than the difference of 4.14 in last year's report.

Currently, about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but the trust fund is projected to be exhausted before major demographic shifts begin to occur.

The Trustees noted that some steps to reduce the rate of growth in payments to hospitals have been undertaken, including a prospective payment system for most hospitals. It appears that this reimbursement mechanism, together with payment limitation provisions enacted by Congress, has helped to constrain the growth in hospital payments and improved the efficiency of the

industry. The Trustees estimated that extending this payment system to other HI providers and further legislation to limit payment increases could postpone the depletion of the HI trust fund for another 5 to 10 years. However, more substantial steps would be required to prevent the trust fund from being exhausted beyond 2010, when the baby boom generation begins to reach age 65.

Need for Urgent Action

Mr. Chairman, it is important that the basic structure of health care and delivery of government services be reformed. Although there is time to take measured and careful action to resolve Social Security's long-term imbalance, more immediate action is required to address the HI trust fund imbalance.

Clearly, it will not be easy to solve the problems in the Medicare program. The Administration will need to work closely with the Congress on a bipartisan basis, and with experts and advocates in the health care field, to take additional actions to control program costs and to address the projected imbalances through legislation as part of broad-based health care reform.

MEDICARE TRUST FUND TALKING POINTS

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

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

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

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

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

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

POSSIBLE Q&As

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

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

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

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

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

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

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

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

BACKGROUND ON MEDICARE TRUSTEES REPORT

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

Problematic findings

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

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

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

Moderating influences

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

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

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

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

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

SOCIAL SECURITY TALKING POINTS

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

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

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

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

MEMORANDUM

TO: Carol and Laura
FR: Chris J.
RE: Quadrennial Commission
cc: Gene, Bill, Jen, Jeremy, Tom

April 17, 1995

In this year's report, the Social Security Trustees recommended "legislation to reestablish the Quadrennial Advisory Council for the Medicare Program." (The authorization for the previous Commission was repealed in the legislation which established the independent Social Security Administration.) The stated intent of the recommendation was to establish a body to "provide information that will help lead to effective solutions to the problems of the program." Obviously, these "problems" relate to the Medicare solvency issues.

In their recommendation, the Trustees made no reference as to when recommendations would be due, nor as to the membership of the Commission, nor as to who would make the appointments to the Commission. Having said this, if the legislation authorizing this Commission is consistent with that of prior quadrennials, the language would read that the Secretary appoints all the members. While the Secretary would be directed to produce a non-political, balanced group, past authorizing language has given the Secretary (and therefore the Administration) fairly wide latitude. Lastly, if history is any guide, these Commissions' reports are usually due out 12-24 months AFTER appointments are made.

HHS has drafted up some authorizing language for the Commission. The current draft calls for a Chairperson and 12 other individuals who are to be made up of representatives of beneficiaries, providers, employers and employees. It directs the Commission to report not longer than 2 years after appointments are made. No final decision has been made as to whether and, if so, when such legislation should be sent up.

If you desire, we can make certain that all testimony and talking points prepared for Administration officials addressing the Medicare Trust Fund incorporate references to the Trustees' Commission recommendation. An argument can be made that references to the Quadrennial as a lead on the Medicare issue might sound a bit defensive and places the argument over Medicare on the Republicans' "Trust Fund" turf. As an alternative, we might want to suggest that discussions of the Commission should be limited to "pushy" questions and answers on this issue.

Donna Shalala has also asked that I advise you that she believes that we should turn the Trust Fund issue onto the Republicans. She thinks we can place Republicans on the defensive with a call for them to start delivering on their rhetoric with some specifics. She suggests that we should reference the President's repeated calls for them to take on the health reform issue, with the only response being either silence or suggestions of deep Medicare and Medicaid cuts -- outside the context of reform.

Regarding the above two paragraphs, if you have any preferences for what/how our message should be delivered, please advise. Lastly, do you wish for me to send around information on the Quadrennial Commission to interested parties inside the White House? Or, do you believe our revised draft talking points (see attached) will be sufficient?

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

SPECIAL

FROM: Bob Pellicci -- 395-4871

DATE: 4/28 **TIME:** 6:20 p.m.

Pages sent (including transmittal sheet): 8

COMMENTS: REVISED Treasury statement for May 9th's Senate Finance Ctt hearing on HI trust fund. Comments due by COB Monday, May 1st.

TO:
Nancy-Ann
Chris Jennings
Jennifer Klein

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

REVISED by TREASURY 5:30 P.M 4/28/95

For Release Upon Delivery
Expected at 9:30 a.m.
May 9, 1995

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

Mr. Chairman and Members of the Committee:

As Managing Trustee and Chairman of the Social Security and Medicare Boards of Trustees, I am pleased to provide this statement to the Finance Committee. As you know, the Boards, which meet twice a year, now consist of six members with the Social Security Commissioner added to the Secretaries of Treasury, Health and Human Services and Labor as government trustees, and two members of the public as public trustees. The Trustees are required by law to report annually to the Congress on the financial status of the Social Security and Medicare Trust Funds. The reports are prepared by actuaries in the Social Security Administration and the Health Care Financing Administration, using the Trustees' economic and demographic assumptions.

This statement summarizes the financial problems of the Medicare program and the Trustees' response as reported in the 1995 Annual Reports. Medicare is an integral part of the nation's network of programs that protect the financial security of older Americans. It was created because many retirees, unable to purchase health care insurance, faced the possibility of overwhelming health care costs on themselves or their children. Medicare has significantly reduced the potential for such outcomes, and with it, the anxiety of senior citizens and their children. Few issues are of greater concern to retirees and to working families than the spectre of covering health care costs in old age.

The reports show that the hospital insurance (HI) program will be exhausted by the year 2002 and that the costs of the supplementary medical insurance (SMI) program are rising rapidly as a percent of Gross Domestic Product (GDP). The Trustees have recommended prompt action to deal with the Medicare financing crisis. To facilitate such action, the Trustees have called for the reinstitution of the Quadrennial Advisory Council for the Medicare program.

The Administration believes the Medicare financing crisis would be best handled in the context of overall health care reform. Our judgment is that attempts to solve the

Medicare financing crisis in the absence of health care reform takes us several steps away from a good national health care system. Even if such attempts succeed in balancing Medicare's revenues and expenses, they will create and intensify other problems -- in public health, in the lack of insurance coverage, and in the cost of other government programs resulting in no net improvement in overall social well-being and, could perhaps end up leaving us worse off.

The Clinton Administration supports Medicare, and we support a solvent Medicare system. This Administration stands ready to work with Congress to solve current problems with the program.

Nature of Medicare Trust Funds

The Medicare program consists of two separate programs which pay hospital and supplemental medical benefits. The HI program pays for inpatient hospital care and other related care for those age 65 and over, and for the long-term disabled. In 1994, HI covered about 32 million aged and about 4 million disabled enrollees at a cost of $104.5 billion.

The HI program is financed primarily by payroll taxes, with the taxes paid by current workers and their employers used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI Trust Fund and is invested in certain interest-bearing obligations of the U.S. Government.

The SMI program is an optional program that pays for physician services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term disabled. It is financed by individual premiums and income contributed from general revenues by the federal government. The monthly premium for basic Part B benefits is $46.10 this year, an increase of $5.00 per month from 1994. In 1994, 35 million persons, about 98 percent of all HI beneficiaries, were covered by SMI. Program disbursements during the year amounted to $60.3 billion.

The SMI program is comparable to yearly renewable term insurance. This means that the SMI program is financed on an accrual basis with premiums and matching general revenue income established each year at a level intended to equal the costs for medical care services incurred in that year. The SMI Trust Fund holds all of the income not currently needed to pay benefits and related expenses. The assets of the trust fund should always be sufficient to cover the claims that have been incurred by enrollees but not yet paid by the program and, also, to provide an appropriate contingency level in case actual costs exceed projected costs. Trust fund assets may not be used for any other purpose; however, they may be invested in certain interest-bearing obligations of the federal government.

Financial Status of the Medicare Trust Funds

HI Trust Fund

On April 3, 1995, the Medicare Board of Trustees reported that the HI Trust Fund is expected to be exhausted in 2002, one year later than projected last year. This slight improvement reflects mainly the effects of OBRA93, the stronger-than-expected economy in 1994, and less than expected recent cost increases. Nevertheless, the HI Trust Fund fails the short-term (10- year) test of actuarial balance and the Trustees again notified the Congress of this fact under Section 709 of the Social Security Act. At the end of 1994, the trust fund held assets of about $130 billion, roughly 117 percent of annual outlays.

Over the long term, the 75-year actuarial balance (interpreted as the amount of payroll tax increase or benefit reduction needed to balance the trust fund over the next 75 years) was reduced substantially from last year's estimate of 4.14 percent of payroll to 3.52 percent of payroll. The 25-year balance was also reduced from last year's estimate of 1.61 percent of payroll to 1.33 percent of payroll. The reduction in the deficit measured over the 25- or 75-year horizon is largely the result of lower expected future increases in Medicare hospital costs, based on the recently observed slowdown in program expenditures.

The 1995 report continues to show the system with rising deficits throughout the projection period. Programs costs have exceeded payroll tax revenues since 1993 and are not expected to fall below revenues during the projection period. The projections show HI program outlays rising substantially in the future -- increasing from 1.6 percent of GDP in 1995 to 4.5 percent in 2069, the end of the projection period. At the end of the 75-year projection period, the gap between expected outlays and expected revenue will have risen to 6.8 percent of payroll. Thus, the Trust Fund is substantially out of long-run "close actuarial balance."

SMI Trust Fund

As indicated, the SMI Trust Fund is used to pay for physician fees, outpatient care, and certain related services. As noted above, it is financed by beneficiary premiums (recently, approximately 30 percent of costs) and general revenues. The concept of actuarial soundness used for SMI is closely related to the concept applied to many private group insurance plans. The actuarial soundness of the program is traditionally evaluated over the period for which the enrollees premium rate and the level of general revenue financing have been established. The primary tests of actuarial soundness are that: (1) the assets and income for years for which financing has been established should be sufficient to meet the projected benefits and associated administrative expenses incurred for that period, and (2) the assets should be sufficient to cover projected liabilities that will have been incurred by the end of that time but that will not have been paid yet.

The financing established through December 1995 is sufficient to cover projected benefits and administrative costs incurred through that time. This financing will maintain a level of trust fund assets that is adequate to cover a reasonable degree of variation between actual costs and projected costs in case actual costs exceed projected costs. On this basis, the SMI program is considered actuarially sound.

The Trustees continue to project rapid growth in SMI program costs well into the future. Outlays have increased 53 percent in the aggregate and 40 percent per enrollee just in the last five years. During the same period, the program grew about 19 percent faster than the overall economy. Although these increases are a little below the comparable rates reported last year, they are still substantial. The cost of the program is projected to rise from 1 percent of GDP in 1995 to 4.3 percent in 2069.

History of Medicare Costs

HI Program

The Hospital Insurance 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 of the program deteriorated between 1966 and 1972 leading to a significant 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 hospitals for services (from a reimbursement to a prospective basis). As a consequence, the growth in hospital costs was modest in the mid-1980s, but by the end of the decade was again increasing at a rate above 10 percent per year. During the 1990s, increases in program expenditures were lower than in the previous decade reflecting moderate increases in overall health care inflation and utilization. Home health care and skilled nursing facilities are currently the fastest growing components of HI expenditures.

The following table illustrates the changing financial status of the HI trust fund since 1980. The twenty-five year actuarial deficit has increased significantly over the period as hospital costs and utilization began rising rapidly. The fall in the imbalance between 1980 and 1985 reflects anticipated favorable effects of the 1983 legislation. The large increase in the deficit in the 1993 report is the result of incorporating rapidly increasing costs of home health and skilled nursing facilities into the estimates. The deficit then declined as a consequence of OBRA93 which included some Medicare spending cuts, removed the earnings limit for HI contributions, and increased the taxation of OASDI benefits -- the proceeds of which go to the HI trust fund. The last two annual reports also reflect the slower growth in medical inflation in the 1990s.

Changes in the twenty-five year actuarial balances primarily reflect changes in expected future medical cost increases based on the Health Care Financing Administration's (HCFA) actuaries assessment of recent historical trends. As shown in the table, the estimate of the actuarial balance more than tripled between 1985 and 1993, though it has declined recently. On the other hand, the projected year of trust fund exhaustion has varied within a comparatively narrow range over the past ten years. As we move closer to the projected year of exhaustion, more dramatic tax and or benefit changes will be required to extend the life of the trust fund.

Over the longer 75-year period, demographic changes are far more important. As the baby-boom generation begins to retire after 2010, the ratio of workers to retirees falls significantly which, combined with the high health care utilization rates of the elderly, results in large financial imbalances in the HI program.

Financial Status of Hospital Insurance Trust Fund

	Trustees' Report Year							
	1980	1985	1990	1991	1992	1993	1994	1995
25-Year Actuarial Balance[1]	-.99	-.68	-.79	-.96	-1.35	-2.11	-1.61	-1.33
Year Fund Exhausted	1994	1998	2003	2005	2002	1999	2001	2002

[1]As a percent of payroll. 1990 to 1995 numbers are based on present values of income, outgo, and payroll.

SMI Program

Though the SMI trust fund is actuarially sound because of its accrual-based financing, expenditures on physician services have grown more rapidly than hospital expenditures in recent years. This is partly due to institution of Medicare's prospective payment method for hospital services (established in 1983). In 1992, Medicare began to phase in a new method for paying physicians based on the estimated cost of resources needed for various physician services. This is expected to help restrain future growth of SMI expenditures. However, both SMI and HI face similar financial pressures because of medical care price inflation and growing utilization of services. In the long run, demographic changes (aging of the population) will have serious adverse consequences for both the SMI and HI programs.

Trustees' Recommendations

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 rising long-term program costs and the projected exhaustion of the HI fund in 2002, the Board of Trustees, as it has since 1993, is recommending prompt, effective, and decisive action on Medicare financing. To facilitate such action, the Trustees have specifically recommended the reinstitution of the Quadrennial Advisory Council for the Medicare program, which was eliminated when the Social Security Administration was made an independent agency. This Council would make recommendations as soon as possible to improve the financial condition of Medicare. The Board has also urged the Congress to take actions through broad-based health care reform designed to control Medicare costs and to address the financial imbalance in both the short range and the long range. If action is taken sooner rather than later, program changes can be more modest and still achieve saving sufficient to restore financial balance.

Passage of the Medicare recommendations contained in the Administration's 1996 Budget would be a good beginning. As you know, the Administration has recommended changes in the determination of Part B premiums, a tightening of Medicare secondary payer provisions, and the permanent capture of saving from the freeze on home health payments. All are extensions of elements included in OBRA93. If passed, the life of the HI Trust Fund would be extended into 2003. Recommendations from the Advisory Council would likely extend this date much further.

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, will worsen HI financing. Under current law, additional revenue from the income taxation of social security benefits goes into the HI Trust Fund where it benefits the same 65 and over population by helping to finance their Medicare benefits. If the House-passed bill were to become law, the HI Trust Fund would be depleted about eight to nine months sooner.

Medicare Financing and Health Care Reform

The most important point to bear in mind regarding the Medicare financing crisis is that Medicare cost containment must be done within the context of health care reform. The rise in Medicare costs is caused by the rise in overall health care costs that affect all parts of the health care sector. A dramatic attempt by government to contain cost growth in Medicare--through large reductions in payments to hospitals, for example--will cause significant distortions and inefficiencies elsewhere in the system unless such a reduction is undertaken in the context of health care reform.

Squeezing down government payments to Medicare providers will cause hospitals--which must cover their costs--to raise charges to private payers. As these higher costs are reflected in private insurance premiums, health insurance becomes more unaffordable and less available. Insurance company incentives to insure only those who will stay healthy increase. Private sector costs are more heavily loaded onto those likely

to become sick, many of whom will lose insurance coverage.

The net effect of a reduction in Medicare payments by government fiat, unconnected with health care reform, is the further undermining of our private sector insurance system. Private insurance coverage will fall and quality of service will be reduced as a result of cost increases imposed to offset the government's reduction in Medicare payments. With more Americans lacking insurance, the health of the nation will deteriorate, and costs of other government medical programs will increase. It is possible that Medicare savings in the absence of health care reform will prove totally illusory in terms of savings to the overall health care system.

By contrast, much can be done in the context of health care reform. A more competitive health care market--in which consumers had real choice among networks of doctors, hospitals, and insurers--would cause a flow of patients and insurance customers toward the most efficient, highest-quality health plans. Better information about the quality of different networks, and standardization of benefits so that consumers could comparison-shop, would add to the pressures on the health care system to avoid unnecessary, inappropriate, and expensive care.

Health insurance premiums would more directly reflect the cost of providing care. The rate of growth in overall health care spending would slow. And slower overall spending growth would lead to a reduction in Medicare costs.

Again, the Administration firmly believes that Medicare financing is best handled in the context of a health care reform plan. We are ready to work with Congress in a bipartisan manner to achieve that goal.

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

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MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to testify before you on the subject of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds.

Like you, I am concerned about the recent report by the Medicare Trustees which projects that the HI trust fund will be depleted in 2002. While the HI trust fund financial balance is a significant problem and deserves our serious attention, let me also remind you that (1) this is not a new problem and (2) the projected life of the trust fund has been extended for three years since 1993.

Due to the actions taken in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) and a stronger-than-expected economy in 1994, Trust Fund depletion has been delayed from 1999 to 2002. Even with these improvements, however, the Trustees continue to foresee financial problems in the future for the HI Trust Fund.

we have worked with Congress to

As I noted, the Trustee's trends and projections have occurred before and are not surprising. In the course of the past 15 years, the Trustees have predicted near-term financial problems for the trust funds and recommended that Congress take action to slow the growth of Medicare spending to assure trust fund solvency. While ~~Congressional changes have~~ improved the outlook of the trust fund, broader issues of health care cost and access limit how much more we can accomplish through Medicare cuts alone.

We are concerned

A ~~S~~olutions focused solely on Medicare would severely strain many of our fragile health care delivery systems in rural and inner-city communities and ~~would~~ result in cost shifting to small businesses and individuals. We must therefore consider this issue in the context of health reform, as the Trustees recommended.

could

The Trustees also urged Congress to enact legislation that reestablishes the Quadrennial Advisory Council as a vehicle to examine the Medicare program. ~~Timely legislation is needed to establish this Council so that they can begin to develop a strategy for securing the fund into the future.~~

Today, I will focus primarily on the solvency of the HI trust fund. Although the Trustees Report addresses cost growth in both the HI and the SMI trust funds, the issues of greatest concern is the HI trust fund's solvency. I look forward to working with Congress to ~~control~~ Medicare ~~expenditures~~ in the context of broader reforms to assure that Medicare remains stable now and in the future.

strengthen the program

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We believe that this recommendation is worthy of serious consideration by the Congress. However, the Council must be given the necessary time to report out well thought out recommendations to address this issue.

Description and Background Information on the Trust Funds.

Let me begin by describing the HI trust fund and the services it supports for Medicare beneficiaries. The HI Trust Fund primarily pays for inpatient hospital care, but it also covers expenditures for home health services, skilled nursing care, and hospice care. In 1994, the HI Trust Fund paid for $104.5 billion in services for 32 million aged and 4 million disabled beneficiaries.

The HI Trust Fund is financed primarily by payroll taxes. Employees contribute 1.45 percent of wages, and there is a matching contribution by employers. Self-employed individuals contribute 2.9 percent of ~~wages~~ self-employment income. OBRA 93 removed the ceiling on the amount of ~~wages~~ earnings that are taxable; consequently, this tax applies to all ~~wages~~ earnings. The Trust Fund also receives income from interest earnings on its assets, revenue from taxation of Social Security benefits, and from miscellaneous sources.

Trust Fund expenditures are projected to rise more rapidly than Trust Fund revenues. Anticipated increases in the number and complexity of medical services provided are expected to continue to increase expenditure growth rates. Driving the expected imbalance between expenditures and revenues 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.

What does this mean? The 1995 HI Trustees Report projects roughly another 7 years of solvency. ~~After 2000,~~ the fund is exhausted in 2002. Over the 75 year long-range projection period, the income as a percent of taxable payroll remains relatively level while the cost rate rises steadily.

These are well-understood trends; there is nothing new in this most recent Trustees Report. Over the past 15 years, the Trustees have projected the date of insolvency to be anywhere from 1987 to 2005, and each year they recommend that Congress take action to protect the fund. As, I noted earlier, in part due to provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Trust Fund depletion has been delayed to 2002.

OBRA 93 eliminated the maximum earnings cap for the HI program, so that the HI tax now applies to all earnings. It also achieved $55 billion in savings from the Medicare program, about $30 billion of which came from providers who are paid through the HI Trust Fund. In addition, OBRA 93 increased the maximum proportion of Old-Age, Survivors, and Disability Insurance

for only those beneficiaries with the highest incomes. Revenue generated by this provision is

(OASDI) benefits subject to Federal income taxes from 50 percent to 85 percent, ~~with the additional revenue~~ dedicated solely to the HI Trust Fund. Unfortunately, as part of its Contract with America, the House has voted to repeal the change in the taxation of OASDI benefits, thus ~~reducing some added revenue for the trust fund.~~

Therefore,

Effective Solutions Require Broader Health Care Reform

This administration believes that strong action to avoid depletion of the Hospital Insurance Trust Fund should not be undertaken by looking at Medicare alone. Any significant changes in the Medicare program, whether in the financing, eligibility, benefit provisions or payment rates, will affect the entire health care system.

Significant cuts in payments to providers would have significant effects on providers' overall financial condition. This is especially true for providers whose patients are predominantly Medicare beneficiaries or providers who also treat uninsured persons, whether located in inner cities or rural areas ~~because these providers have limited ability to shift costs onto other payers.~~

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care.
  - For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. While Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.
  - For these hospitals on average, in 1991 Medicare accounted for a bigger share of net operating revenues than private payers.
- Large reductions in ~~Reducing~~ Medicare payments could also endanger rural hospitals.
  - Nearly 10 million Medicare beneficiaires (25 percent of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to primarily serve Medicare patients.
  - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to

it is ironic that those who are suddenly interested in the plight of the Medicare trust fund have advocated provisions that ~~worsen~~ exacerbates the insolvency of the Medicare trust fund.

increase what are often substantial local subsidies.

- Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.

- Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

Other providers ~~who are able to will~~ may shift their costs onto payers who do not have the market power to negotiate advantageous rates. This means that ultimately many small businesses and individuals -- those Americans who are already paying the highest health insurance premiums in the nation -- will shoulder an even larger share of health care costs.

Large reductions in Medicare reimbursements to providers could also hurt beneficiaries. ~~Beneficiaries could also be affected~~. Significantly cutting payment rates to providers might restrict access for beneficiaries as providers would be less willing to provide services to them. Further, low income beneficiaries would be the hardest hit. Over 75 percent of Medicare beneficiaries have incomes below $25,000. For those with incomes below 100 percent of poverty, out-of-pocket health costs constitute 34 percent of income. Medicare reductions could increase the cost ~~sharing~~ burdens of the nation's most vulnerable elderly -- the low-income. Such increases become the equivalent of reducing their Social Security.

Attempts to restore the solvency of the trust fund can not undermine Medicare's commitment to access to care for elderly persons. We should take care that any efforts to extend the solvency of the trust fund do not put Medicare beneficiaries at undue risk, but at the same time protect the program for them in the future.

Only through focusing on the entire health system will we be able to address issues within Medicare and preserve access for Medicare beneficiaries and underserved populations.

~~A Medicare Advisory Council, replacing the Quadrennial Advisory Council that previously existed under the Social Security Act, should address this full set of issues. The new Medicare Advisory Council would focus specifically on the Medicare Trust Funds. The Council will recommend solutions for slowing cost growth, ensuring Medicare's solvency well into the next century.~~

The Administration takes seriously its responsibility to current and future Medicare beneficiaries to insure the solvency

of the trust fund. The Health Care Financing Administration (HCFA) continues to make many program changes to improve the efficiency of the Medicare system. For example, hospital prospective payment has contributed to slowing the increase in Medicare expenditures for hospital services. As a result, on a per enrollee basis, Medicare grew at a slower rate than the private sector between 1984 and 1991 -- 7.7 percent compared to the private sector's 9.8 percent.

As we address these issues, we must remember that Medicare does not stand alone. It is an integral part of a larger health care system, and its solvency should be addressed only in the context of that larger system. Broader health care reform will occur only if we work on a bipartisan basis. The Administration looks forward to working with the Congress to develop lasting solutions to Medicare's fiscal problems.