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July 18, 1995

MEMORANDUM FOR **MOLLY BROSTROM**
CHRIS JENNINGS
JENNIFER KLEIN

FROM: Zoë Neuberger
Katie Smeltz

SUBJECT: Medicare

You will find attached the information and quotes we have gathered on Medicare. The material is divided into four sections:

- The original debate (Democratic statements in support of Medicare and Republican statements against it)
- Quotes from Congress (recent statements on Medicare and proposed spending cuts by Democrats and Republicans)
- Quotes from advocacy groups (statements on proposed Medicare and Medicaid spending cuts by health care, senior, child, and people with disabilities advocacy groups)
- The impact of Medicare and Medicaid on seniors

THE ORIGINAL DEBATE

The Social Security Act amendments establishing Medicare were approved by the House on April 8, 1965. The vote was 313-115. Republicans voted 65-73 and Democrats voted 248-42. Then Representative Bob Dole voted against Medicare.

Medicare was approved by the Senate on July 9 by a vote of 68-21. Democrats voted 55-7 and Republicans voted 13-14.

President Johnson signed Medicare into law on July 30, 1965.

The AMA opposed Medicare. (Source: *Congress and the Nation, Volume II*)

Democratic Statements For Medicare (1965)

Source: Democratic Policy Committee, United States Senate, Special Report: *Medicare's 30th Anniversary*, July 14, 1995. (DPC)

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

President Johnson before Congress:
"the specter of catastrophic hospital bills can (now) be lifted from the lives of our older citizens."

Democratic Rep. Cecil King (CA), introducing the first medicare bill:
"...We can no longer permit hospital costs - to deprive our elderly citizens of the security and peace of mind that should be their due after a lifetime of work."
"We will be able to take great pride in having had a hand in bringing financial security and peace of mind to millions of older Americans."

Democratic Senator Anderson:
"I feel certain that historians will mark this year as the turning point in our long struggle to solve . . . the problem of financing the costs of hospital care for the aged, costs which now represent the major remaining cause of personal financial disaster among our aged citizens."
"Every month that delay in providing the needed protection means that more and more elderly persons will be forced to look to public welfare programs for help in getting the health care they need."

Republican Statements Against Medicare (1965)

Source: Democratic Policy Committee, United States Senate, Special Report: *Medicare's 30th Anniversary*, July 14, 1995. (DPC)

They called it socialism.

Republican Representative James Utt (CA):
"Let me tell you here and now it is socialized medicine."

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

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

They said it would not work.

Republican Senator James B. Pearson:
"It would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices."

They said it was too bureaucratic.

Republican Senator Roman Hruska:
"With Federal funds come federal control. In the area of medical care, Federal interference presents frightening prospects."

Republican House Leader and future President Gerald Ford (MI): "We are going to find our aged bewildered by a multiheaded bureaucratic maze of confusion over what program covers what and who is on first base."

And they said it was a threat to Social Security.

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

QUOTES FROM CONGRESS

The leadership, then and now

Senator Bob Dole

Bob Dole voted against Medicare in 1965.

1965:
"The real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax ... Adequate medical protection should be made available to the aged but it should be voluntary and should reflect the ability to pay... This one provision poses an enormous threat to the cash benefit programs under the social security programs." (DPC)

July 30, 1985:
"Much of our significant gains and life expectancy, improvement in the quality of life, and decreases in infant mortality can be directly attributed to the passage of the Social Security Amendments of 1965. The Medicare and Medicaid programs have played a central role in improving both access to and quality of health care services for the country's elderly, poor, and disabled. Equally significant, it may be argued that Medicare and Medicaid have provided a foundation for the phenomenal growth and the dissemination of new medical technologies that now contribute to the well being of all the people of all nations." (DPC)

May 8, 1995:
Said "it's going to be very difficult" to save money without reducing benefits or raising premiums. (*The New York Times*, May 8, 1995)

Speaker Newt Gingrich

January 30, 1995:
"we are going to rethink Medicare from the ground up"
"We will make every decision within the context of a balanced budget"
"Everything is on the table except social security" (*The New York Times*, January 31, 1995)

April, 1995:
Described Medicare as "a centralized bureaucracy with all the inefficiency and all the obsolete technology and all the obsolete approaches and all the waste and fraud you would associate with a centralized bureaucracy." (*Newsday*, May 3, 1995)

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

May 7, 1995:
"Forget the budget pressure, let's find out what number saves Medicare. We'll plug that into the budget. We're not going to find out what number the budget needs and try to reshape Medicare to that effect." (Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*, May 8, 1995)

House Majority Leader Richard Armey

Describes Medicare as "a program I would have no part of in a free world" and "deeply resents the fact that when I'm 65 I must enroll in Medicare." July 10, 1995 (*Chicago Tribune*, July 11, 1995)

Republican Representatives during the 1994 health care reform debate

(Source: Democratic Staff of the Committee on Ways and Means, United states House of Representatives, *Previous Republican Statements on Cutting Medicare*, May 8, 1995.)

Members of the House Ways and Means Committee commented on the Health Security Act, which would have achieved $168 million in Medicare savings over seven years, all of which would have been redirected to expand health care coverage. Republicans now propose to reduce Medicare spending by $270 million over seven years and not reinvest the savings in health care.

Congress Member Bill Archer (June 25, 1994):
"Make no mistake about it for the elderly in this country, [these cuts are] going to devastate their program under Medicare."
"I just don't believe the quality of care and availability of care can survive these additional cuts. And that is the price that is going to have to be paid to pay for these cuts. "

Congress Member Clay Shaw (June 25, 1994):
"The Medicare cuts proposed by the President would devastate the Medicare program . . . The committee must not approve these destructive Medicare cuts." May 18, 1994
"The Republicans are attempting to secure the program which would be almost absolutely destroyed and trashed if the cuts that have been brought into the bill are established."

Congress Member Jim McCrery (June 25, 1994):
"I would love to believe that we could achieve the level of cuts that you have in this bill . . . But history tells us that this isn't possible."

Republican members of the House Ways and Means Committee (July 14, 1994):
"For more than a decade Congress has cut back on payments to doctors and hospitals until they no longer cover the cots of care for Medicare . . . patients--and the additional massive cuts in reimbursement to providers proposed in this bill [H.R. 3600] will reduce the quality of care for the nation's elderly. There will be no place else to shift."

Democratic statements supporting Medicare

President Clinton (October 23, 1994):
"My position is, I haven't and don't support cuts in Social Security, and I would support savings in the Medicare program only if they're used to advance the cause of health care."

Senator John D. Rockefeller IV (WVA) (April 22, 1995):
"Though they [the Republicans] claim they want to save the Medicare trust fund, they don't plan to put the savings in the fund. It's all for deficit reduction or tax cuts." (*Congressional Quarterly*)

QUOTES FROM ADVOCACY GROUPS

The Association of American Medical Colleges says:

"Massive reductions in Medicare reimbursement for activities related to graduate medical education will, when coupled with private sector losses, and other cuts in Medicare reimbursement, have a very negative impact on our continued excellence. Every American's quality of life will suffer as a result." (July, 1995)

"... budget proposals that could cut billions of dollars in funding will devastate academic medicine's ability to care for the American people and to ensure quality through medical education and research."(May 16, 1995)

"Funding cuts of this magnitude will push medical schools and teaching hospitals to the brink of financial ruin and put our nation's highest quality health care services in serious jeopardy."(May 16,1995)

Jordan Cohen, president of the Association of American Medical Colleges, said, *"We are concerned about the prospect of losing as much as 60 percent of the $5.2 billion a year that teaching hospitals get from Medicare for the 'indirect' and 'direct' costs of training residents and other health professionals." (July 15, 1995)*

The 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)

The American Medical Association says:

"A balanced budget cannot be 'balanced' on the back of one program and those who provide that program's services. Serious, and perhaps irreversible, consequences to patient care could flow from yet another series of ill-considered cuts." (April 6, 1995)

The Catholic Health Association says:

"If Medicare and Medicaid payments, which provide 40 to 60 percent of all reimbursements, are cut by more than 20 percent, the result will be nothing less than devastating...nursing and

physician staffs will have to be cut, research and training programs will need to be reduced, whole medical departments may even have to be eliminated, and purchases of new medical technologies may have to be postponed or foregone completely..." (March 16, 1995)

"Catholic Health Association opposes the severity of the Medicare and Medicaid spending reductions proposed in the congressional Budget Resolution. They are too large, unprecedented, and unacceptable. If enacted, they could threaten the viability of these two publicly-funded health insurance programs and endanger continuity of services to the elderly, vulnerable women and children, and people with disabilities." (July 17, 1995)

"Catholic Health Association opposes transforming Medicaid into a block grant program. Any attempt to restructure the Medicaid program should maintain federal minimum standards for Medicaid eligibility and services." (July 17, 1995)

The Federation of American Health Systems says:

"Cuts of this magnitude are far too severe for the system to handle." (July 15, 1995)

The American Association of Retired Persons says:

AARP has conducted numerous focus groups across the country in the last few months' and found that the elderly had little idea that the new Republican-controlled Congress wants to cut projected Medicare spending over the next seven years by as much as $300 billion dollars. (July, 1995)

AARP estimates that these proposals to reduce Medicare spending would mean that the average Medicare beneficiary would pay approximately $3,400 more out-of-pocket over the next seven years. Estimates are based on the assumption that one-half of proposed Medicare spending reductions come from beneficiaries. (July 15, 1995)

"Interest groups such as the AARP and the medical associations, as well as many Democrats, agree that Medicare's finances need urgent attention. So far, however, they have argued that the financial issues cannot be addressed alone but rather in the context of a broad health care reform effort." (July 15, 1995)

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

The National Committee to Preserve Social Security and Medicare says:

"Reductions of the magnitude discussed by Congressional leaders will jeopardize the viability of this important program and hurt society's most vulnerable citizens." (May 2, 1995)

The National Council of Senior Citizens says:

"What is being contemplated is the undermining of the cornerstone of the American health insurance system. We see a disruption of health services for millions and a threat to

thousands of health care institutions which depend on a stable Medicare system" (April 1995)

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button." (April 1995)

"The levels of the cuts in Medicare contemplated 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)

The Older Women's League says:

"We receive hundreds of letters from women who are already forced to choose between paying for food or 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. Medicare must be protected and strengthened. Efforts to control Medicare spending should be part of a system-wide approach to cost containment and should not simply shift costs to beneficiaries and providers." (July, 1995)

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)

Medicaid Specific:

20 major health care provider organizations including American Hospital Association, American Medical Association, American Health Care Association, Federation of American Health Systems, National Association of Children's Hospitals & Related Institutions, and Catholic Health Association say:

"Medicaid cuts could devastate families...by the end of the decade, drastic Medicaid cuts could result in 31% fewer Americans receiving financial help with long term care... dramatic reductions will seriously jeopardize the ability of doctors, hospitals, and others to continue providing high-quality health care to our nation's elderly, disabled, women, and children."(May 17,1995)

The Women's Legal Defense Fund says,

It would be devastating to women if in the effort to dramatically cut government spending, Congress destroyed Medicaid -- a health care program of unparalleled importance to women and their children. More than 25 million women and their children rely on Medicaid for essential health care services. They receive life-saving services like treatment for heart disease and cancer, long term care services, and critical preventive services such as prenatal care, immunizations, family planning services, Pap smears and mammograms.

The Alzheimer's Association says:

"The elderly who rely on Medicaid do not have options. Without these benefits, many would literally have to make impossible choices between food, shelter and health care. Their health problems are not going to go away, and they are not suddenly going to find hidden resources to pay their health bills. There are not any easy alternatives for meeting their health and long term care needs."(July, 1995)

"Medicaid is not perfect. But Congress will not solve the problems in the program by abdicating the federal role and sending the money out to the states in a block grant. It could just make matters worse." (July, 1995)

Families USA Foundation says:

"These cuts would pull the rug out from under the sick, the elderly, vulnerable women, children and people with disabilities who rely on health and long term care protection from Medicaid and Medicare." (July 15, 1995)

Karen Higginbotham of Opelousas, Louisiana, whose seven-year-old daughter, Alison, has a disabling illness, said:

> *"Deep cuts in Medicaid home care would force many families like mine to face financial ruin. A terrible illness can strike a family at any time. Disabilities know no boundaries and have no prejudice of sex, age, race, economic status or political affiliation. As members of Congress consider cutting Medicaid, they should remember this: Medicaid gives us the peace-of-mind of knowing that if something horrible happened it would not have to tear our families apart." (July 15, 1995).*

"Extreme and disproportionate cuts in the Medicaid program will push more Americans into a health crisis...cuts of this magnitude will endanger the millions of Americans who only have the Medicaid program to provide them with basic and essential health and long term care services." (May 1, 1995)

The Children's Defense Fund says:

"Some governors are seeking total state flexibility, through a Medicaid block grant, to determine eligibility and benefits, while projecting that they would continue to cover children and pregnant women at current eligibility levels. Maternal and child health advocates appreciate their commitments. However, we have several concerns. States will be forced to seek ways, in addition to managed care, to save money, including changes in eligibility and coverage, which disproportionately affect children." (July 15, 1995)

Medicaid now covers nearly one-third of the births in this country and covers more than 17 million children overall -- one in four children. Given the long-term trend of steadily eroding private health insurance, it is imperative to preserve the national Medicaid safety net for pregnant women and children. Doing otherwise could add significantly to the numbers of uninsured children and pregnant women. (July 15, 1995)

"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)

The Consortium for Citizens with Disabilities says:

"Proposals to significantly cut Medicaid would disproportionately affect people with disabilities and would have a devastating impact on them. For many people with disabilities, Medicaid is the only way they can access health services." (April 1995)

If Medicaid is no longer an entitlement, millions of people, including those on SSI, will lose access to critical health and long-term services and supports. For persons with disabilities the lack of services and supports may well lead to an exacerbation of existing health conditions, the emergence of additional health problems and secondary disabilities, and in some cases, to inappropriate institutionalization. (July, 1995)

THE IMPACT OF MEDICARE AND MEDICAID

Medicare

- Prior to the enactment of Medicare, 50% of America's elderly had no health insurance. Today, 97% of America's senior citizens are insured by Medicare. (HCFA)

- Medicare has dropped the poverty rate among America's elderly by 13.4 percent. (DPC)

- Before Medicare's enactment, hospital discharges for the elderly were 190 for every 1,000 admissions; by 1973, that number had climbed to 350 discharges. (HCFA)

- Medicare has contributed significantly to an increase in life expectancy. In 1960, men who survived to the age of 65 could expect to live to age 78; today, they would reach age 81. The gains for women are slightly higher. (HCFA)

- More than 36 million Americans are protected by Medicare. (DPC)

- Nearly 83% of Medicare spending is for seniors who live on annual incomes of less than $25,000. (HCFA) Only 3 percent goes to elderly individuals or couples with incomes in excess of $50,000. (DPC)

President Clinton:
- "In 1982 . . . it became true for the first time that older Americans were less likely to be poor than the average American." (White House Conference on Aging)

President Clinton:
- "since 1959, the poverty rate among the elderly has declined by more than 65 percent." (White House Conference on Aging)

- 89 percent of Americans want Medicare to continue. 75 percent of Americans oppose cutting Medicare in order to balance the budget. (DPC)

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

- Recent Kaiser Family Foundation research found that seniors have "peace of mind" because of Medicare, which they characterized as 'care without worries.' The Kaiser survey found that beneficiaries applaud the program because it is: "affordable," "provides secure health for most," and "offers easy, automatic enrollment." (HCFA)

Medicaid

- One out of every nine Medicaid beneficiaries are elderly, for a total of 4.1 million elderly people. In 1993, the average state Medicaid expenditure for each elderly beneficiary was $8,704, which is nine times what was spent on each enrolled child. Medicaid pays for half the nation's nursing home costs. (*Congressional Quarterly*, June 10, 1995)

NATIONAL COUNCIL OF SENIOR CITIZENS

Eugene Glover has been President of the National Council of Senior Citizens since September 1, 1989. Prior to serving as NCSC President, Glover was Secretary-Treasurer of the International Association of Machinists and Aerospace Workers (IAM) for eighteen years. He retired from that post on January 1, 1988.

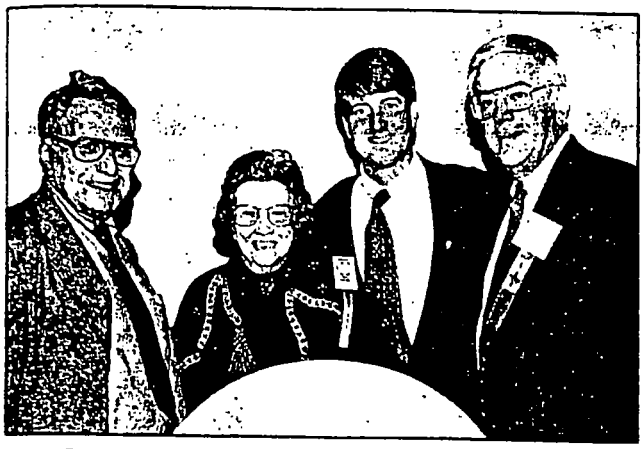
Glover serves on a number of Boards dealing with both senior and consumer issues. He is a Member of the Board of Directors of NCSC's Housing Management Corporation, which sponsors numerous housing projects designed specifically for the elderly and disabled. The projects are built under Section 202 of the Federal housing law, which grants low-interest loans for decent, affordable housing for eligible low-income persons.

He is also on the Board of Directors of the Consumer Federation of America and the Leadership Conference of Civil Rights.

Glover's interest in senior issues dates back to his days as negotiator for the IAM, when, as co-chairman of the union's national pension committee, he sought and won inclusion of pension provisions in all major contract settlements, later winning retiree health benefits as well.

Glover grew up in St. Louis, Missouri, following a family move from a farm near Jonesboro, Arkansas, where he was born in 1922. After military service in World War II, he worked as a machinist at McDonnell Aircraft in St. Louis, and, while there, served as a union steward and negotiating committee member for IAM Local 837. Glover became an International Representative for the IAM in 1964, and the following year was nominated and elected as a Vice President of the Union.

As President of NCSC, Glover is a champion of legislation to protect retiree pension and health benefits, preserve Social Security, and strengthen consumer and civil rights laws. NCSC is also in the forefront of the fight for enactment of a national health plan to insure universal and comprehensive care for Americans of all ages, a goal that Glover calls his "number one priority."



Rep. Patrick Kennedy (D-R. I.), second from right, talks with fellow New Englanders Manny Weiner (left) of Massachusetts, Dr. Mary Mulvey of Rhode Island, and Jim Griffin (right) of Connecticut.

benefit which could then be further squeezed down over time." He called on seniors to mount an aggressive campaign to protect the Medicare and Medicaid programs from those in Congress who would gut them.

Board members were given an update on legislative activities by Tim Foley, Director of the NCSC Legislative Committee, and the staff of the Legislative Department. The senior leaders were also briefed on the NCSC Regional Conferences scheduled around the country this year by Ed Braman, Director of Organization.

Jeanette Fields, Deputy Director of the Senior Environmental Employment (SEE) Program, reported on the continued success of

(continued on page 10)

Executive Director Lawrence T. Smedley presents NCSC's "Lifetime Achievement" award to former NCSC Third Vice President Everett Lehmann (left) in recognition of his "outstanding accomplishments on behalf of older men and women."

Smedley Announces Plans to Retire

Lawrence T. Smedley, Executive Director of the National Council of Senior Citizens, has announced his retirement, effective November 1. Smedley, who will be 66 in September, has served in the position since January, 1988.

In apprising the General Policy Board of his decision, Smedley praised Eugene Glover and the late Jacob Clayman, saying he had been "privileged to serve with two such outstanding Presidents—men of extraordinary dedication to NCSC's goal of a better life for all Americans."

President Glover expressed regret at Smedley's decision to retire but commended him for his "enormous contributions" to the success of NCSC. "His leadership has helped make the National Council one of the nation's most respected aging organizations," Glover said. "We will miss him very much but wish him great happiness in retirement."

Under Smedley's leadership, the National Council has strengthened its financial position and gained prestige within the aging community. Over the years, he has appeared as a spokesperson for NCSC on numerous radio and television programs. He has also testified before Congressional committees, championing the causes of older men and women before Senate and House panels considering legislation on senior issues.

In addition to serving as NCSC Executive Director, Smedley has also headed its Senior AIDES program which, as part of the Older Americans Act, provides jobs to more than 10,600 low-income elderly men and women in 149 locations around the country.

A Search Committee, appointed by the NCSC Executive Committee, will consider potential candidates to succeed Smedley.

GROWTH IN MEDICARE SPENDING

Statement of
Marilyn Moon

for the
Health Subcommittee
Committee on Commerce
U.S. House of Representatives

June 28, 1995

SUMMARY

- Medicare has contributed substantially to the well-being of America's oldest and most disabled citizens. It is the largest public health care program in the United States, providing the major source of insurance for acute care for the elderly and disabled.

- Medicare's share of total spending by the elderly has remained fairly constant over time. Thus, a typical older person will still spend 21 percent of his or her income on health care needs.

- A number of critical factors boost the costs of acute health care spending for disabled and older persons including the higher acute and chronic care needs of frail populations, demands on services at the end of life, the changing composition of the Medicare population, and the role of technology.

- Old and young Americans alike have been subject to the same pressures driving up health care spending--the introduction of new technology and high demands on use of health services.

- Medicare stacks up quite well with private insurance. In fact it is only in the last two years that private insurance looks better.

- Even if private insurance has several good years, we do not know whether it will be possible to sustain a low growth rate over time. Claims about the high rates of growth of Medicare as compared to private insurance are promising but premature.

- Even with optimistic assumptions, managed care and private sector innovations would be able to achieve only a small share of the savings sought for Medicare. It is likely that beneficiaries will be asked to bear a considerable increase in their out of pocket burdens.

GROWTH IN MEDICARE SPENDING

Statement of
Marilyn Moon[1]

for the
Health Subcommittee
Committee on Commerce
U.S. House of Representatives

June 28, 1995

Medicare has contributed substantially to the well-being of America's oldest and most disabled citizens. It is the largest public health care program in the United States, providing the major source of insurance for acute care for the elderly and disabled. However, it has also garnered substantial attention because of high rates of growth over time. Nonetheless, relative to total health care costs, Medicare has done rather well in the 1980s and early 1990s. My testimony today will focus on these issues about rates of growth in Medicare and how this growth compares to private insurance. I then consider issues related to Part B specifically.

PUTTING MEDICARE IN CONTEXT

Total spending on behalf of elderly and disabled beneficiaries under Medicare will total about $4850 per capita in 1995. How should we interpret this high level of health care spending by elderly persons? Is spending on health care out of line for these beneficiaries as compared with the rest of the population? For example, average acute care spending for persons over age 65 is about 3.8 times as high as that for those under age 65, and not all of

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[1]The views expressed in this statement are those of the author and do not necessarily represent those of the Urban Institute, its trustees, or its sponsors.

this spending is from the public sector. In fact, Medicare's share of total spending by the elderly has remained fairly constant over time. Thus, a typical older person will still spend 21 percent of his or her income on health care needs, for instance, indicating that spending is not just a concern for Medicare but also for beneficiaries as well.

A number of critical factors boost the costs of acute health care spending for disabled and older persons including the higher acute and chronic care needs of frail populations, demands on services at the end of life, the changing composition of the Medicare population, and the role of technology. Some of these are relatively unique to the Medicare population and create the need for specific protections.

Acute and Chronic Care Needs

Older persons are more likely to suffer chronic and acute care illnesses than are younger persons. The incidence of problems such as heart disease, cancer, arthritis, and diabetes rise with age. Rates of disability and the share of the population reporting poor or fair health status are also positively correlated with aging. International comparisons also show increasing health problems by age and that despite lengthening life expectancies, morbidity at older ages is still high. And for those with multiple health limitations, treatment of any particular problem is more complicated when other health conditions need to be taken into account. All of these factors contribute to higher rates of health care spending by age group, with particularly sharp rises after age 65. And, by definition, disabled persons have important health care needs.

The End of Life

Many casual observers of our health care system suggest that controlling use of

services in the last year of life may be the magic bullet for reining in the growth of health care spending. And since most of those who die each year are over the age of 65, this is particularly a problem for the Medicare program. Certainly, few statistics sound as compelling as the widely quoted statistic of 28 percent of Medicare spending concentrated on the 5 percent of enrollees in their last year of life.

But like most "magic bullets" for solving problems with the health care system, there is more to the story than just excessive spending on hopeless cases. First, if technology is being used extensively in futile cases involving the very old, the share of resources devoted to health care in the last year of life should be rising as technology has expanded. But high expenditures are not a new phenomenon; they even preceded the introduction of Medicare in 1965. Between 1976 and 1985, a period of enormous cost growth in health care, there was no increase in the share of Medicare resources going to those in the last year of life. The proportion of decedents increased slightly but the proportion of Medicare dollars fell slightly.

Further disaggregation of Medicare data also reinforce this analysis. While the fact that Medicare spending increases steadily by age seems to support claims about disproportionate spending on the very old, the data show exactly the opposite pattern for persons in their last year of life. Considerably more is spent on the 65 to 69 year olds who die in a given year than on decedents over age 85. That is, more is spent on younger Medicare beneficiaries who are more likely to recover--a result consistent with reasonable health care policy. Since life expectancy at age 65 is now about 17 years, spending on the younger old is not necessarily just cheating death for a few months, but rather treating patients with many useful years left.

These findings suggest several things. First, physicians do not always know that death is imminent when making health care spending decisions. And since people often die after being ill or requiring medical treatment, it is only natural to see extraordinary spending in the last year of life (as well as for those who survive major illnesses). The problem of excessive use of medical care by the elderly thus is likely overstated. It does mean, however, that Medicare faces some unique challenges in addressing the problems of assessing inappropriate care and in needing to find ways to manage a disproportionate number of high cost cases.

The Changing Composition of the Population

It is not just spending on the end of life or higher average costs compared to the young that lead to higher costs for Medicare than for the rest of the population. Medicare is a program in which the number of enrollees is growing more rapidly than the size of the rest of the population. Each year the number of enrollees is growing by about 1.9 percent. And much of that growth is occurring among the very old and the disabled who have higher than average levels of expenditure. As a result, we should expect not only that Medicare spending overall should grow more rapidly than health care spending for the population as a whole because of increases in the number of Medicare beneficiaries, but that growth should be higher on a per capita basis as well since the composition of the Medicare population is also changing. The share of beneficiaries with higher expenditure needs is rising as compared to those with lower average expenditures.

The aging of the population and increased share of disability beneficiaries seems to add only about 0.2 percentage point to the growth of Medicare spending each year relative to the rest of the population. This is not a very great amount in any one year, but it means that

just to keep Medicare on an even footing with the rest of the health care system, spending growth per capita likely should be higher for Medicare.

The Role of Technology

One of the important pressures on health care spending arises from use of new technology, but these pressures may be disproportionately large for the Medicare population. Technology has given us new tools such as CT scans and magnetic resonance imagers (MRIs) and new procedures such as endoscopies and arthroscopies. These new testing technologies are often less invasive and hence less risky than earlier means for detecting illness. For example, subjecting older or disabled patients to exploratory surgery might not be feasible, but giving them MRIs does not carry the same risks. Thus, it is not surprising that these new tests are particularly important for high risk Medicare patients. These tests constitute the fastest rising categories of services under Medicare.

Surgery and other technical procedures also continue to grow, while becoming increasingly more complex and expensive over time. For example, cardiac bypass surgery rates for men over the age of 65 rose from 2.6 per 1000 in 1980 to 10.4 per 1000 in 1989. The improved success of procedures such as hip replacements and cataract surgery mean that outcomes have improved relative to their risks. Thus, higher rates of use would certainly be expected and appropriate, with the increases disproportionately benefitting older and disabled patients.

While these issues are pervasive in the overall U.S. health care system, the role of technology may thus have an even greater impact on spending for the Medicare population, helping to explain high rates of growth of service use within this age group. The combination

of an aging population and the special benefits of new technology for frail populations underscores that Medicare will have difficulty in holding down its rate of growth both absolutely and relative to the rest of the population in the foreseeable future.

Is Medicare Itself a Source of the Problem?

A number of critics of the Medicare program blame it not only for the high costs of health care for the elderly, but for aggravating health care inflation in general. The rapid growth in the program in its early years--expanding well beyond predicted spending levels--is often cited as an example of why any government program could not be trusted. But the original goal of the legislation creating Medicare was to offer mainstream medical care to older persons and the early fears for the program were that it would not be accepted by doctors and hospitals. Thus, there was a conscious decision not to undertake cost containment efforts initially. Medicare likely did contribute to some inflation as it expanded demand for additional services, but no efforts to counteract this impact were undertaken.

And when cost containment efforts were undertaken in the 1980s, Medicare's track record improved substantially. Moreover, Medicare offers a number of advantages as well. Its administrative costs are low, especially as compared to many private plans. At present, Medicare's payment levels are below the amount allowed by most private insurers.

RATES OF GROWTH AND THE PRIVATE SECTOR

The above factors explain why spending is high and to some extent why Medicare has grown rapidly over time. But when looking at spending growth rates, it is also important to recognize that old and young Americans alike have been subject to the same pressures driving

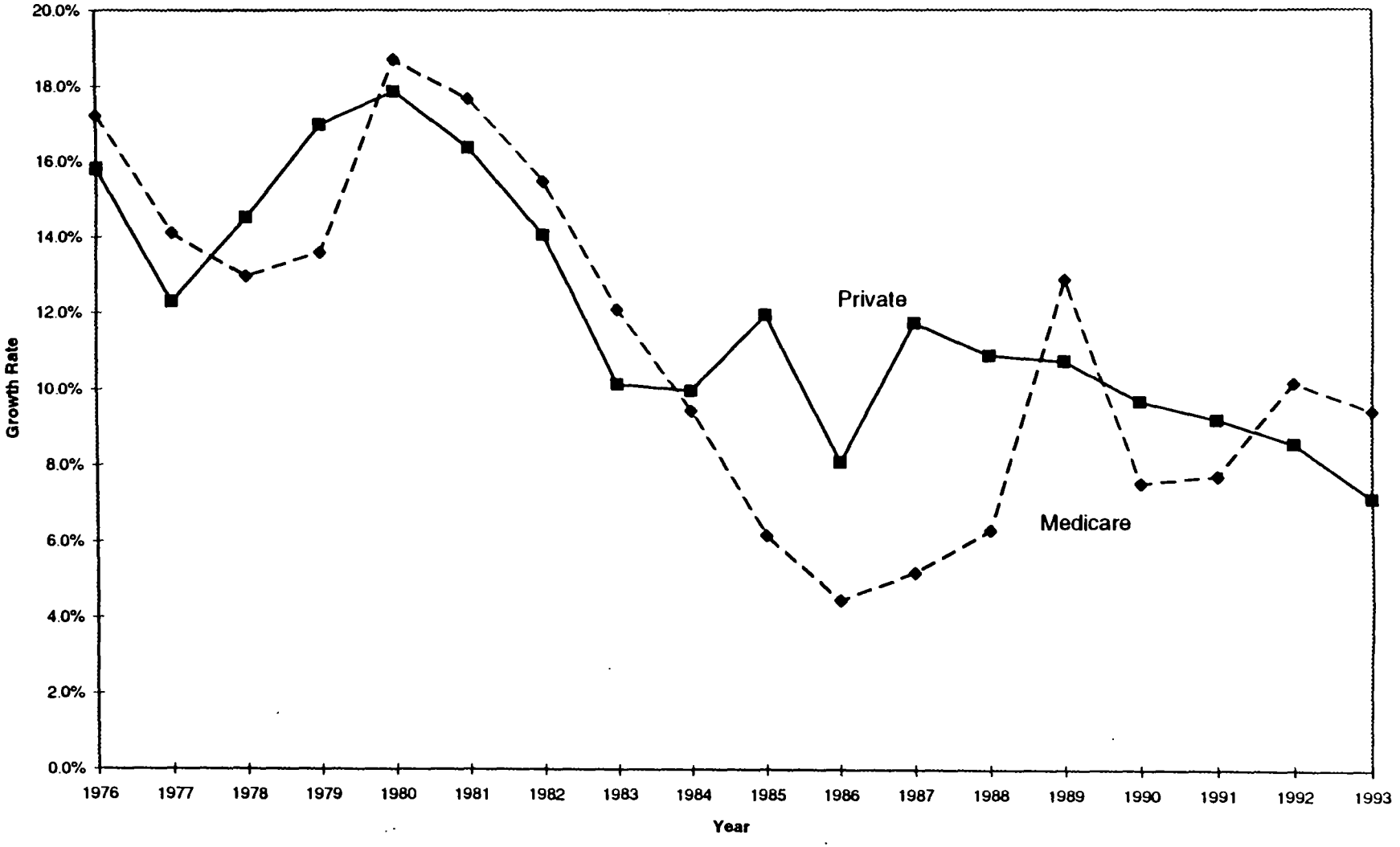
up health care spending--the introduction of new technology and high demands on use of health services. And depending upon just which years are used to make comparisons, Medicare has often done better than private insurance in holding down rates of growth (as shown in Chart 1). This chart compares national health expenditure data over time on private insurance and Medicare, using a consistent data base for comparing these two. Only one simple adjustment is used here compared to what many people report, and that is to translate these numbers into per capita figures. While the numbers of Medicare beneficiaries have been growing at about 1.9 percent per year, there has been little growth in the numbers of persons covered by private insurance and, in fact, the absolute numbers have been declining since 1990. Thus, it is simply not fair to use aggregate numbers for these types of comparisons. Without such an adjustment, aggregate Medicare spending would grow more rapidly than aggregate private insurance spending even if both payers experienced the same growth in costs per enrollee.

By this measure, Medicare stacks up quite well with private insurance. In fact it is only in the last two years that private insurance looks better. The most recent figure often cited of private insurance growth of 4.6 percent is not yet a final number. And since these figures do tend to move around over time, it is useful to compare a multi-year trend. Looking backward for seven years (and including the preliminary 1994 numbers), private insurance grew an average of 8.7 percent per year as compared to Medicare's 9.2 percent. Much of the differential reflects Medicare's growth in home health and skilled nursing benefits--which are largely not covered by private insurance for younger families.

Thus, even if private insurance has several good years, we do not know whether it will

Chart 1

Per Capita Growth Rates of Total Personal Health Expenditures
1976-1993



be possible to sustain a low growth rate over time. Claims about the high rates of growth of Medicare as compared to private insurance are promising but premature.

WHAT THESE NUMBERS MEAN FOR THE FUTURE

These numbers do not simply represent interesting historical artifacts. Rather, they have fed into the debate over whether it will be "easy" or "difficult" to rein in Medicare's rates of growth over time. And when these historical numbers are viewed in that context, they become highly charged tools subject to considerably different interpretations. Consider some of these numbers.

Since it is not yet clear exactly how spending reductions will be shared or what specifics will be applied, some assumptions are needed to be able to discuss these numbers. If we begin with a $270 billion savings target, assess that against projected spending, and translate these numbers into per capita growth rates, Medicare will be allowed to grow at an average annual rate of only 4.9 percent per year--as compared to 8.4 percent under the baseline assumptions. In other words, it will have to do almost as well in each of seven years as the one best year that private insurance has had in the last 20 years. That is quite a challenge indeed.

What about Part B itself? Part B will represent about 40 percent of all Medicare spending between 1996 and 2002. If Part B is scheduled to absorb a proportionate share of the spending reductions under Medicare, a total of about $108 billion in savings would have to be found over a seven year period. But even more challenging is the fact that as a share of Medicare spending these savings are scheduled to be "front loaded"--that is, they would

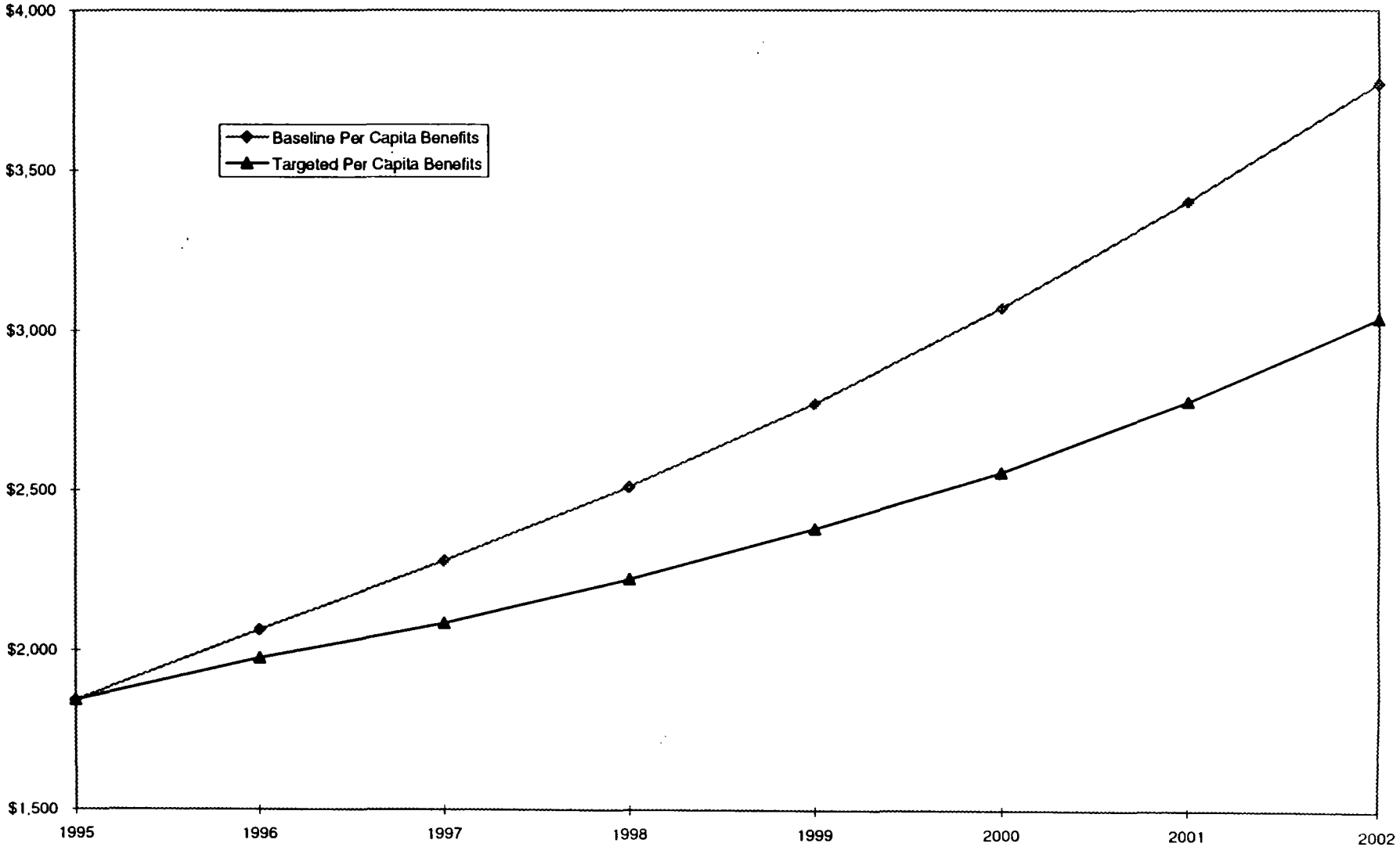
need to be higher as a share of total spending in the first three years. Reductions in 1996 through 1998 would be $3.2 billion, $7.2 billion and $10.8 billion respectively. The per capita rates implied by these numbers would be a growth of 7.4 percent per year on average as compared to 10.8 percent under the projected baseline numbers. This constitutes a 32 percent reduction in the allowed rate of growth--an ambitious undertaking. In the first three years, the rates would be 7.2, 5.5 and 6.7 percent--or reductions of 40, 47 and 35 percent (see Chart 2). And if it becomes difficult to achieve nearly $180 billion in savings from Part A, these reductions could be even more substantial.

How likely is it that these kinds of reductions can be achieved through competition and managed care? The Congressional Budget Office has found that managed care could reduce spending by 7 percent--and there is strong reason to believe that such managed care would only apply to a minority of Medicare spending. If participation in managed care plans grows only very slowly and if, as expected, the first beneficiaries to enroll are the healthier ones, they will account for less than a proportional share of all spending. Last year the CBO assumed that the Cooper plan with its strict incentives for managed care--considerably stricter than what would likely occur under Medicare--would be able to reduce the rate of growth by approximately one percentage point per year as compared to baseline projections. Since Medicare starts with payment rates well below those in the private sector, one source of savings from managed care will likely not be available. Thus, all reductions in savings would have to come through actually restructuring use of services.

Thus, a one percentage point reduction is probably a considerable overstatement of what could be saved under Medicare by adopting private sector innovations. At a minimum,

Chart 2

Projected Baseline Part B Benefits and Target Benefits assuming Proportionate Savings



a considerable period of transition would likely be needed before such savings could be realized. Nonetheless, if managed care could lower spending immediately by one percentage point, this approach would generate less than one third of the targeted $108 billion reduction for Part B (see Chart 3).

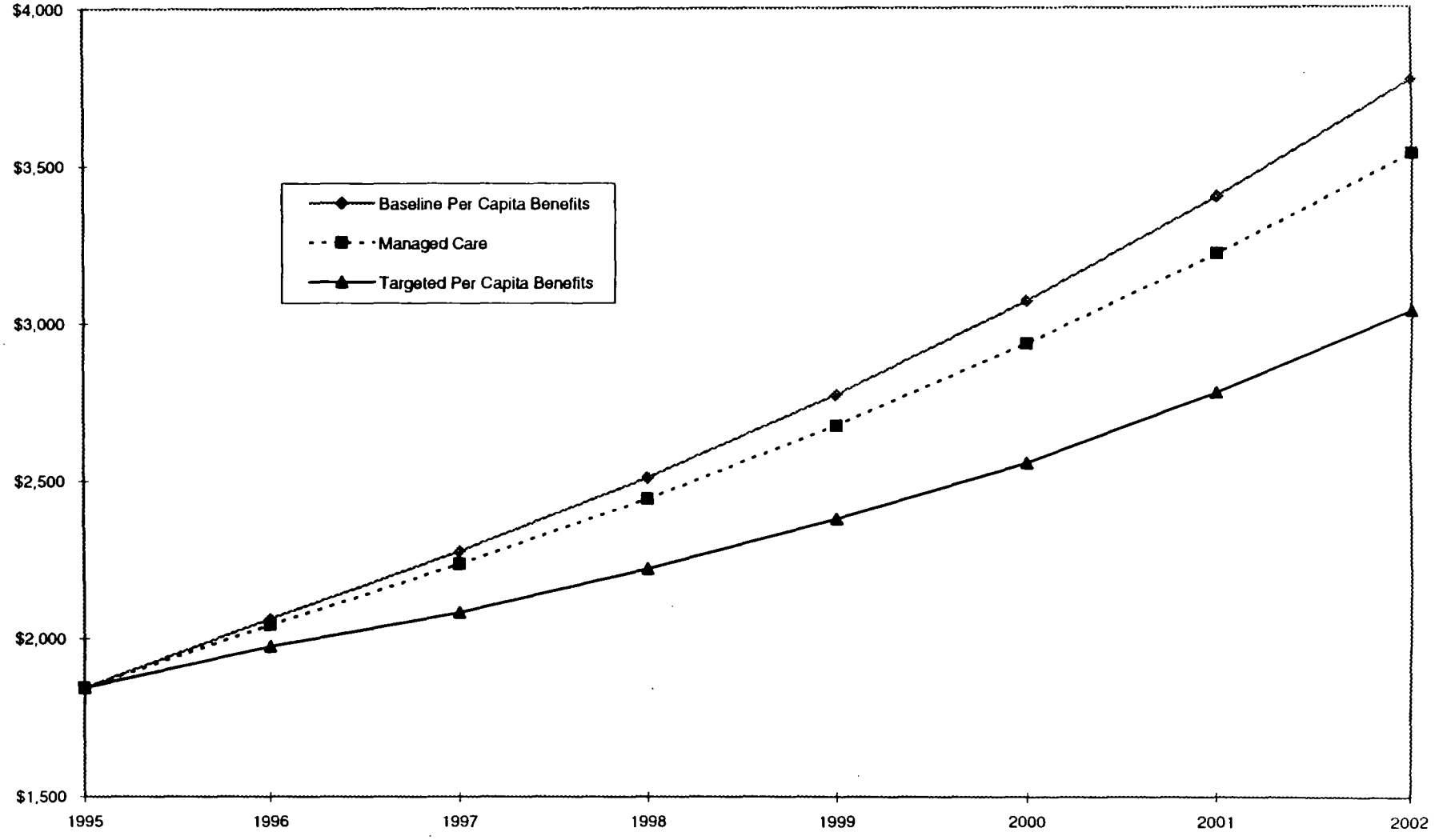
It is thus likely that substantial increases in beneficiary premiums or copayments would be needed to fill the remaining gaps. For many elderly and disabled persons who believe they have been promised "painless" changes, these increased burdens may come as a major surprise. Further, the most vulnerable beneficiaries who now rely on the Medicaid program either as traditional beneficiaries or as Qualified Medicare Beneficiaries may be particularly at risk if states choose to reduce support for such protections under block grants.

CONCLUSION

Contrary to some of the popular claims that all Medicare needs to do is emulate the private insurance market in order to achieve the scheduled $270 billion in savings, there is little evidence to suggest that the private sector has yet achieved such success nor that managed care and competition would offer savings of such a magnitude in the future. While it is possible to reach the $270 billion goal under Medicare, this will likely require considerable additional burdens on elderly and disabled beneficiaries who already bear substantial costs out of pocket.

Chart 3

Impact of Managed Care on Benefit Spending Using Optomistic Assumptions



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Public Affairs

Speechwriting Division

Status Quo not acceptable

right / way - / wrong way -

Partisanship / hard edge -

Medicaid - long term care

VP.

numbers -

Repub cuts - extreme

Pay

- rally -

No beneficiary savings

Our changes are different than theirs -

Comment you pay more is same if they cut 1/2 SS. Cost of living increase.

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I VP & Mrs. Gore
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and speak the hopes of his countrymen, that the Americas could ally themselves together in peace to better the life of man in all the Americas.

We see that spirit gaining substance and reality now in a good many lands. But nowhere do we see it more than in the lands of Central America—Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica. They have, in a series of acts of the highest statesmanship, embarked upon a process of integrating their economies which is one of the really most exciting undertakings of our world today.

Together these nations have created a common market. They have leveled their trade barriers. They have coordinated their efforts in higher education. They have done the same for their tax systems and their development planning. And they are all making an effort to cope with the problems created by the ancient enemies of all mankind—disease, poverty, and illiteracy.

And the results are already apparent and already gratifying. Trade among these nations has amounted to $20 million in 1958, but it reached $105 million last year, and the gross national product is rising at a rate of close to 7 percent a year. In support of these historic advances a key role is today being filled by the Central American Bank for Economic Integration. It is represented here today by its able and dynamic president, Dr. Delgado.

This Bank is capitalized by equal contributions from the five Central American countries. But as the governments have pledged mutual support to each other, so the members of the Alliance have pledged support to them.

In March 1963, in Costa Rica, our late beloved President John Kennedy pledged this country's support. And so today we have come here to fulfill that pledge by signing this loan agreement for $35 million.

Yes, great progress has been made in Central America, but the future offers greater promise, both there and throughout the hemisphere. The Central American Republics are providing all their neighbors and all the world what I would think is a very stirring example of what can be accomplished by free men with vision and with wisdom and with courage. And we of the United States are very proud to be fortunate enough to work with them in this very hopeful enterprise.

We are so grateful for your friendship, for your loyalty, for your cooperation in trying to solve the problems of this hemisphere and trying to be equal to the challenges of the 20th century. And we want you to know that, and we want your governments to know it.

And so this morning, to the distinguished representatives of Central America that may be present on this historic occasion, I would affirm again my country's deep respect and admiration and support for your efforts. And likewise, to the distinguished representatives of the Organization of American States, the CIAP, and the Inter-American Development Bank, I would reaffirm the interest and the support of the United States of America for economic integration throughout this hemisphere.

In all the world there are no dreams so stirring or so exciting or so inspiring as those that we can dream realistically and reasonably now in our own hemisphere. The day is no longer so dim and distant as once it seemed to be when those dreams begin to reach the lives of all our people, for we can truly believe that that day has already dawned and we are now working in its early morning. Long before the twilight of this century has come, we may believe that men and women of the Americas will come to know a much better life, a life of peace, a life of social justice, a life of liberty, a life of independence, a life where reason rules and where tyranny is vanquished.

And it is toward this happy hour that we work together now with a steady purpose and with a rising confidence and with a deep appreciation of what friendship and understanding really means.

I'm sorry I was late. Thank you so much for coming.

NOTE: The President spoke at 1:45 p.m. in the East Room at the White House upon signing the agreement under which the Agency for International Development loaned $35 million to the Central American Bank for Economic Integration. Following the President's remarks, Dr. Enrique Delgado, President of the Bank, addressed the group. The text of his remarks is printed in the Weekly Compilation of Presidential Documents (vol. 1, p. 23).

394 Remarks With President Truman at the Signing in Independence of the Medicare Bill. *July* 30, 1965

PRESIDENT TRUMAN. Thank you very much. I am glad you like the President. I like him too. He is one of the finest men I ever ran across.

Mr. President, Mrs. Johnson, distinguished guests:

You have done me a great honor in coming here today, and you have made me a very, very happy man.

This is an important hour for the Nation, for those of our citizens who have completed their tour of duty and have moved to the sidelines. These are the days that we are trying to celebrate for them. These people are our prideful responsibility and they are entitled, among other benefits, to the best medical protection available.

Not one of these, our citizens, should ever be abandoned to the indignity of charity. Charity is indignity when you have to have it. But we don't want these people to have anything to do with charity and we don't want them to have any idea of hopeless despair.

Mr. President, I am glad to have lived this long and to witness today the signing of the Medicare bill which puts this Nation right where it needs to be, to be right. Your inspired leadership and a responsive forward-looking Congress have made it historically possible for this day to come about.

Thank all of you most highly for coming here. It is an honor I haven't had for, well, quite awhile, I'll say that to you, but here it is:

Ladies and gentlemen, the President of the United States.

THE PRESIDENT. *President and Mrs. Truman, Secretary Celebrezze, Senator Mansfield, Senator Symington, Senator Long, Governor Hearnes, Senator Anderson and Congressman King of the Anderson-King team, Congressman Mills and Senator Long of the Mills-Long team, our beloved Vice President who worked in the vineyard many years to see this day come to pass, and all of my dear friends in the Congress—both Democrats and Republicans:*

The people of the United States love and voted for Harry Truman, not because he gave them hell—but because he gave them hope.

I believe today that all America shares my joy that he is present now when the hope that he offered becomes a reality for

I am so proud that this has come to pass in the Johnson administration. But it was really Harry Truman of Missouri who planted the seeds of compassion and duty which have today flowered into care for the sick, and serenity for the fearful.

Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people that they touch. Few can see past the speeches and the political battles to the doctor over there that is tending the infirm, and to the hospital that is receiving those in anguish, or feel in their heart painful wrath at the injustice which denies the miracle of healing to the old and to the poor. And fewer still have the courage to stake reputation, and position, and the effort of a lifetime upon such a cause when there are so few that share it.

But it is just such men who illuminate the life and the history of a nation. And so, President Harry Truman, it is in tribute not to you, but to the America that you represent, that we have come here to pay our love and our respects to you today. For a country can be known by the quality of the men it honors. By praising you, and by carrying forward your dreams, we really reaffirm the greatness of America.

It was a generation ago that Harry Truman said, and I quote him: "Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection."

Well, today, Mr. President, and my fellow Americans, we are taking such action—the great leadership of men like John McCormack, our Speaker; Carl Albert, our majority leader; our very able and beloved majority leader of the Senate, Mike Mansfield; and distinguished Members of the Ways and Means and Finance Committees of the House and Senate—of both parties, Democratic and Republican.

Because the need for this action is plain; and it is so clear indeed that we marvel not simply at the passage of this bill, but what we marvel at is that it took so many years to pass it. And I am so glad that Aime Forand is here to see it finally passed and signed—one of the first authors.

There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

And through this new law, Mr. President, every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will help meet the fees of the doctors.

Now here is how the plan will affect you.

During your working years, the people of America—you—will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about $1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing

And under a separate plan, which you are 65—that the Congress originated itself, in its own good judgment—you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay $3 per month after you are 65 and your Government will contribute an equal amount.

The benefits under the law are as varied and broad as the marvelous modern medicine itself. If it has a few defects—such as the method of payment of certain specialists—then I am confident those can be quickly remedied and I hope they will be.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.

And this bill, Mr. President, is even broader than that. It will increase social security benefits for all of our older Americans. It will improve a wide range of health and medical services for Americans of all ages.

In 1935 when the man that both of us loved so much, Franklin Delano Roosevelt, signed the Social Security Act, he said it was, and I quote him, "a cornerstone in a structure which is being built but it is by no means complete."

Well, perhaps no single act in the entire administration of the beloved Franklin D. Roosevelt really did more to win him the

happy that his oldest son Jimmy could be here to share with us the joy that is ours today. And those who share this day will also be remembered for making the most important addition to that structure, and you are making it in this bill, the most important addition that has been made in three decades.

History shapes men, but it is a necessary faith of leadership that men can help shape history. There are many who led us to this historic day. Not out of courtesy or deference, but from the gratitude and remembrance which is our country's debt, if I may be pardoned for taking a moment, I want to call a part of the honor roll: it is the able leadership in both Houses of the Congress.

Congressman Celler, Chairman of the Judiciary Committee, introduced the hospital insurance in 1952. Aime Forand from Rhode Island, then Congressman, introduced it in the House. Senator Clinton Anderson from New Mexico fought for Medicare through the years in the Senate. Congressman Cecil King of California carried on the battle in the House. The legislative genius of the Chairman of the Ways and Means Committee, Congressman Wilbur Mills, and the effective and able work of Senator Russell Long, together transformed this desire into victory.

And those devoted public servants, former Secretary, Senator Ribicoff; present Secretary, Tony Celebrezze; Under Secretary Wilbur Cohen; the Democratic whip of the House, Hale Boggs on the Ways and Means Committee; and really the White House's best legislator, Larry O'Brien, gave not just endless days and months and, yes, years of patience—but they gave their hearts—to passing this bill.

Let us also remember those who sadly

great Members of Congress that are not with us, like John Dingell, Sr., and Robert Wagner, late a Member of the Senate, and James Murray of Montana.

And there is also John Fitzgerald Kennedy, who fought in the Senate and took his case to the people, and never yielded in pursuit, but was not spared to see the final concourse of the forces that he had helped to loose.

But it all started really with the man from Independence. And so, as it is fitting that we should, we have come back here to his home to complete what he began.

President Harry Truman, as any President must, made many decisions of great moment; although he always made them frankly and with a courage and a clarity that few men have ever shared. The immense and the intricate questions of freedom and survival were caught up many times in the web of Harry Truman's judgment. And this is in the tradition of leadership.

But there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.

I said to Senator Smathers, the whip of the Democrats in the Senate, who worked with us in the Finance Committee on this legislation—I said, the highest traditions of the medical profession are really directed to the ends that we are trying to serve. And it was only yesterday, at the request of some of my friends, I met with the leaders of the American Medical Association to seek their assistance in advancing the cause of one of the greatest professions of all—the medical

And this is not just our tradition—or the tradition of the Democratic Party—or even the tradition of the Nation. It is as old as the day it was first commanded: "Thou shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land."

And just think, Mr. President, because of this document—and the long years of struggle which so many have put into creating it—in this town, and a thousand other towns like it, there are men and women in pain who will now find ease. There are those, alone in suffering, who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing poverty—despite their long years of labor and expectation—who will now look up to see the light of hope and realization.

There just can be no satisfaction, nor any act of leadership, that gives greater satisfaction than this.

And perhaps you alone, President Truman, perhaps you alone can fully know just how grateful I am for this day.

NOTE: The President spoke at 2:55 p.m. in the auditorium of the Harry S. Truman Library in Independence, Mo. In his opening words he referred to former President and Mrs. Harry S. Truman, Secretary of Health, Education, and Welfare Anthony J. Celebrezze, Senator Mike Mansfield of Montana, majority leader of the Senate, Senator Stuart Symington and Senator Edward V. Long of Missouri, Governor Warren E. Hearnes of Missouri, Senator Clinton P. Anderson of New Mexico, Representative Cecil R. King of California, Representative Wilbur D. Mills of Arkansas, Senator Russell B. Long of Louisiana, and Vice President Hubert H. Humphrey.

During his remarks the President referred to, among others, Representative John W. McCormack of Massachusetts, Speaker of the House of Representatives, Representative Carl Albert of Oklahoma, majority leader of the House of Representatives, Aime Forand, Representative from Rhode Island 1937–1939 and 1941–1961, Representative Emanuel Celler of New York, Senator Abraham Ribicoff of

and Welfare Wilbur J. Cohen, Representative [illegible] Boggs of Louisiana, Lawrence F. O'Brien, Special Assistant to the President, John D. Dingell, Representative from Michigan 1933–1955, Robert F. Wagner, Senator from New York 1927–1949, James E. Murray, Senator from Montana 1934–1961, and Senator George A. Smathers of Florida.

As enacted, the Medicare bill (H.R. 6675) is Public Law 89–97 (79 Stat. 286).

On July 25, 1965, the White House released a report to the President from Secretary Celebrezze in response to the President's request for organizational changes in the Social Security Administration in preparation for administering the Medicare program.

with special responsibility for hospital and supplementary medical insurance programs;

"It changes some existing units, giving them additional responsibilities under new programs;

"It centers data processing and transmission activities in a central headquarters in the Administration;

"It strengthens upper-level management in the Administration, makes the field service of the Administration more responsive to directions from headquarters, and improves coordination between Administration units."

The text of Secretary Celebrezze's report is printed in the Weekly Compilation of Presidential Documents (vol. 1, p. 6).

395 Remarks to Members of the Press at the LBJ Ranch. *August* 1, 1965

WE'RE delighted you could come by. Joe [1] thought that you might enjoy stopping by for a few moments before you go back to Austin, and before we go back to Washington.

We plan to leave tomorrow evening late, unless something changes our plans, and we anticipate there will be no changes—some time after the sun goes down tommorrow, so we have a chance to have a ride in a boat.

Appointment of Deputy Director, USIA

[1.] I have with me today, Bob Akers, who is being appointed Deputy Director of the USIA to succeed Don Wilson. It has been about a week trying to locate him in Europe. We traced him through Spain and finally located him in Greece, and brought him back Saturday. He's been interviewed by Mr. Macy [2] and the other appropriate people in Washington.

He's had 40 years in the newspaper business and 10 or more years as a commentator. He's traveled extensively and lectured at the USIA, on the Asian Continent, also in Europe. He's most recently been the managing editor of the Beaumont Enterprise and the Beaumont Journal, a commentator on KRIC–TV.

I had Mr. Laitin come down and he's going to give you some announcements a little later on in the day.

Effective Use of Military Personnel

[2.] I won't take your time now, but Joe Califano [3] and I have drafted a memorandum to Secretary McNamara,[4] which we have reviewed with him in the last few days following the appointment of our task forces on effecting economies.

The substance of the memorandum is that I asked him to set up some special people to recognize the need for deployment of addi-

[1] Joseph Laitin, an assistant press secretary.

[2] John W. Macy, Jr., Chairman of the Civil Service Commission.

[3] Joseph A. Califano, Jr., Special Assistant to the President.

[4] See Item 396.

WILLIE VELASQUEZ INSERT

". . . in negotiating the release of the two Americans who were imprisoned in Iraq. He is a great American" -- and a great voice for Hispanic Americans. His dedication to public service mirrors that of another great American whose work helped put people like the Congressman in office.

That man is Willie Velasquez. And it is my intention to honor him with the Presidential Medal of Freedom. I feel it is appropriate to honor the memory of a man who gave us all so much. For a long time, Latinos were deprived of the chance to serve in the highest levels of government. This was a loss for the Latino community and the nation. We are a rich nation. But we are not so rich that we can deprive ourselves of the intelligence, dedication, and insight of so many Americans. Willie Velasquez knew this, and his memory and legacy is alive in every corner of my Administration.

Jerry - please insert this into the speech.

Willie Velasquez was the founder & President of Southwest Voter ~~Education~~ Registration + Education Project.

SWVREP

Stephanie Jones - Minneapolis
Sec. Riley - Regional Rep.
312-353-5216

A BALANCED BUDGET FOR WORKING FAMILIES
Monday, July 17, 1995

In the days and weeks ahead, the President will lay out the advantages of his framework for a balanced budget. While some oppose balancing the budget and Republicans are pursuing an extreme agenda, the President's **balanced budget works for families** by raising standards of living and empowering people to be the winners, not the victims, of economic change. Both his plan and the GOP plan have serious spending cuts and reach balance, but there are four fundamental differences:

1. **Investing in Education and Training.** For Americans to win in the new economy, we must cut the budget deficit and the education deficit. The President plans to increase investment in education by $40 billion over 7 years--from Head Start to college loans. Republicans cut education by $36 billion.

   The President will have no choice but to veto appropriations bills now moving through the House which cut education to finance tax cuts for the wealthy. Cuts include:
   - Eliminating **AmeriCorps**--50,000 opportunities for national service in 1996.
   - Eliminating **Goals 2000**--for higher standards in 16,000 schools in 1996.
   - Cutting 50,000 children from **Head Start** in 1996.
   - Cutting 23 million students from **Safe and Drug-Free Schools** in 1996.

2. **Protecting Medicare Beneficiaries in the Context of Health Care Reform.** While both the President's and the Republican plan takes steps to secure the Medicare Trust Fund until 2005, there are deep differences between the two.
   - The Republicans cut over twice as much from Medicare.
   - Their Medicare proposal will require seniors to pay as much as **$5600 more per couple** in higher out-of-pocket costs by 2002. The President has **zero** beneficiary cuts.
   - Their Medicaid cuts will leave

millions of children without insurance. The President's per capita cap achieves limited savings the right way.

- While Republicans have no health care reform, the President is taking key steps toward reform: expanding benefits for mammograms and Alzheimer's respite care; reforming insurance markets to protect individuals changing jobs and stop discrimination for pre-existing conditions; and offering 6 months of coverage for those who lose their jobs.
- Republicans would not need one penny in Medicare beneficiary cuts if they accepted the President's targeted middle-class tax cut, rather than their tax cuts for the well-off.

3. **Ensuring Tax Fairness for Working Families**: The President supports a targeted tax cut to help working families invest in themselves and their education, including a tax deduction for education expenses. Republicans are proposing:

   - A huge tax cut largely targeted at the well-off--possibly including a tax loophole to allow some profitable corporations to pay zero taxes.
   - A proposal to raise taxes on up to 14 million poor families by hundreds of dollars each--rolling back the President's Earned Income Tax Cut expansion.

4. **Protecting Working Families**: The President believes we must balance the budget in a way that protects the economy--by reaching balance gradually over 10 years, not arbitrarily in 7 years. A top national forecaster (WEFA) found that the Republican plan would slow growth and raise interest rates by a third to over 8.5%, while still not getting to balance until 2004. We can't take risks with working families. The President has a prudent 10 year path to balance.

A BALANCED BUDGET FOR WORKING FAMILIES
Friday, July 21, 1995

Next week, the President will have several opportunities to outline the fundamental differences between his plan for a balanced budget and Republican plans in Congress.

A Budget Framework That Can Unite Americans. The President has a **balanced budget for working families** that will raise standards of living and empower people to be the winners, not the victims, of economic change. Both his plan and the GOP plan have serious spending cuts and reach balance, but there are some fundamental differences. The President's plan:

- Invests more, not less, in education and training;
- Protects Medicare beneficiaries while taking steps toward health care reform;
- Targets tax cuts only to working families, not the wealthiest;
- Protects working families from the dangers of an economic down-turn.

1. Investing in Education and Training Versus Gutting Education and Training. For Americans to win in the new economy, we must cut the budget deficit and the education deficit. The President would increase investment in education by $40 billion over 7 years--from Head Start to college opportunity. Republicans cut education by $36 billion.

He will have no choice but to veto appropriations bills now moving through the House which cut education to finance tax cuts for the wealthy. Cuts include:

- Eliminating **AmeriCorps** -- eliminating almost 50,000 opportunities for service in 1996.
- Eliminating **Goals 2000**--supporting higher standards in 16,000 schools in 1996.
- Cutting 50,000 children from **Head Start** in 1996.
- Cutting 23 million students from **Safe and Drug-Free Schools** in 1996.

2. Protecting Medicare Beneficiaries in the Context of Health Care Reform versus $5600 in Beneficiary Cuts per Couple to Pay For Tax Cuts for the Wealthy: While both the President's and the Republican plan take steps to secure the Medicare Trust Fund until 2005, there are deep differences between the two.

- The Republicans cut over twice as much from Medicare.
- Their Medicare proposal will require seniors to pay as much as **$5600 more per couple** in higher out-of-pocket costs by 2002. The President has **zero** beneficiary cuts.

- Their massive Medicaid cuts will leave **millions of children without insurance.** The President has a per capita cap that achieves limited savings the right way.
- While Republicans have no health care reform, the President is taking key steps toward reform: expanding benefits for mammograms and Alzheimer's respite care; reforming insurance markets to protect individuals changing jobs and stop discrimination for pre-existing conditions; and offering 6 months of coverage for those who lose their jobs.

Republicans would not need one penny in Medicare beneficiary cuts if they accepted the President's targeted middle-class tax cut, rather than their tax cuts for the well-off.

3. Tax Fairness for Working Families versus Huge tax Cuts for the Wealthy and Tax Hikes for the Working Poor: The President supports a targeted tax cut to help working families invest in themselves and their education, including a tax deduction for education expenses. Republicans are proposing:

- A huge tax cut largely targeted at the well-off--possibly including a tax loophole to allow some profitable corporations to pay zero taxes.
- A proposal to raise taxes on up to 14 million poor families by hundreds of dollars each--rolling back the President's Earned Income Tax Cut expansion.

4. Budget that Protects Working Families: The President believes we must balance the budget in a way that protects the economy--by reaching balance gradually over 10 years, not arbitrarily in 7 years. A top national forecaster (WEFA) found that their plan would slow growth and raise interest rates by a third to over 8.5%, while still not getting to balance until 2004. We can't take risks with working families. The President has a prudent 10 year path to balance.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Public Affairs

Speechwriting Division

Message

1. Balanced budget
2. Good for mid class — bad for higher income
3. I'm going to be tough — they're heading for a train wreck.

Medicare Dick

Army quote -

I think that medicare is totalitarian -

Alternate Medicare -

(Congressional)

Medicare 30th Anniversary, Passage of Medicare - 8 original signers there

Sunday - signing -

One of signers is a Repub.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Public Affairs

Speechwriting Division

Abortion - Minority
anger — ~~presidential~~
~~politics~~ -

Foster - good - not lose
lead national effort
to prevent teen pregnancy -

right way/
wrong way

Democratic
unity

1900 S

Natl Council of
Senior Citizens

Eric Iner

at the Capital

Gephardt

Daschle

signatories - House + Sen

Chuck Robb - Johnson

VP - CT - ? - VP father

Pres

Johnson

Larry Smedley - Pres
& the National Council
Senior Citizens

Marilyn Yeager -
acknowledgement

30th anniversary of
Medicaid - 7 8

1. start w/ Medicare -
2. also - Medicaid - long term
Care - (

Medicare in 60's
we established common
ground on protection
of elderly - some want
to snatch it away
to balance budget

seniors & 30s
Medicare -
had edged on Medicare
WH Conference on Aging -
use numbers -
ours has no beneficiaries cuts
theirs does -
62599 - Jennifer Klein

Keep your own doc.
voucher - limited money -
Senior has to decide
each year voucher bumps
less & less

Pres - balanced budget
right way -
wrong - $270 billion - force
to go into plans - no
choice of doc.
tax cuts for wealthy

right way - strengthen trust fund
cuts 1/2 tears -
no cost increases for beneficiaries
health spending under control
10 years -

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Cover Sheet for Schedule (1 page)	07/21/95	P6/b(6)

COLLECTION:
Clinton Presidential Records
Speechwriting
Terry Edmonds
OA/Box Number: 10983

FOLDER TITLE:
July 25, 95 [Medicare] [4]

2006-0462-F
ry625

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SCHEDULE OF THE PRESIDENT
FOR
FRIDAY, JULY 21, 1995
FINAL

tba — **MORNING RUN**

9:00 am-
9:15 am — **MEETING**
OVAL OFFICE
Staff Contact: Leon Panetta

9:15 am-
9:30 am — **BRIEFING**
OVAL OFFICE
Staff Contact: Pat Griffin

9:30 am-
10:15 am — **CONGRESSIONAL LEADERSHIP MEETING**
OVAL OFFICE
Staff Contact: Pat Griffin
CLOSED PRESS

10:15 am-
10:30 am — **MEETING**
OVAL OFFICE
Staff Contact: Laura Tyson

10:30 am-
11:30 am — **OFFICIAL PHOTOS**
OVAL OFFICE
Staff Contact: Colleen McCarthy

- **USTTI PHOTO**
  Staff Contact: Dan Wexler
- **PPD DEPARTURE PHOTOS**
  Staff Contact: Dave Carpenter
- **MARCH OF DIMES PHOTO**
  Staff Contact: Dan Wexler
- **MILITARY DEPARTURE PHOTOS**
  Staff Contact: Alan Sullivan
- **PARENTS DAY PHOTO**
  Staff Contact: Colleen McCarthy

11:35 am-
11:40 am — **BRIEFING**
OVAL OFFICE
Staff Contact: Marilyn Yager

11:40 am- 11:55 am	**AMA PHONE CALL** OVAL OFFICE Staff Contact: Marilyn Yager **CLOSED PRESS**
11:55 am- 12:00 pm	**MEETING** OVAL OFFICE Staff Contact: Billy Webster
12:00 pm- 2:00 pm	**HOLD** Staff Contact: Stephanie Streett

2:00 pm- 2:30 pm	**GIRLS NATION EVENT** EAST ROOM Remarks: Gabrielle Bushman Social Coordinator: Sarah Farnsworth Staff Contact: Dan Wexler **OPEN PRESS**

- The President is announced from the Blue Room and proceeds to stage.
- The President makes remarks and introduces Kristine Kalanges, Girls Nation President.
- Kristine Kalanges makes remarks and introduces Christina Sugg, Girls Nation Vice President.
- Christina Sugg presents the President with a gift.
- The President takes a group photo with girls.
- The President proceeds to Blue Room to take individual photos. (White House Photo Only)
- The President departs upon completion of photos.

2:30 pm	**DOWN FOR DAY**
3:00 pm	**THE PRESIDENT** departs White House via motorcade en route Bell Haven Country Club [drive time: 20 minutes]
3:20 pm	**THE PRESIDENT** arrives Bell Haven Country Club

3:30 pm	**GOLF TEE TIME** **BELL HAVEN COUNTRY CLUB**
tba	**THE PRESIDENT** departs Bell Haven Country Club via motorcade en route White House [drive time: 20 minutes]
tba	**THE PRESIDENT** arrives White House
	EVENING OFF
BC AND HRC RON	**WHITE HOUSE**

Fact Sheet

NATIONAL COUNCIL OF SENIOR CITIZENS

The History of the NCSC

1961 The NCSC opens its doors in a Washington, D.C. hotel. The space is so cramped, the mimeograph machine is located in the bathtub.

1962 President Kennedy speaks to an NCSC rally of 18,000 senior citizens in Madison Square Garden in support of Medicare. Simultaneous rallies are organized by the NCSC in 30 other states.

1963 President Kennedy and Vice President Johnson address the second NCSC convention and pledge their support for Medicare.

1965 Medicare is passed by the House and Senate and signed into law. President Johnson flies with NCSC Board members to Independence, Missouri, to sign the bill into law in front of former President Truman. The Older American Act is passed.

1968 U.S. Department of Labor selects the NCSC to operate its Senior AIDES program, a community service employment program for the elderly poor.

1975 National Council of Senior Citizens successfully advocates for reduced mass transportation fares for the elderly who are on fixed incomes.

1975 NCSC pickets HUD over Nixon Administration's freeze of funding for senior housing.

1977 NCSC creates NCSC Housing Management Corp. NCSC is now one of the largest sponsors of senior housing in the U.S.

1978 With support from the NCSC, the "Meals-on-Wheels" program passes Congress and begins to provide food to elderly shut-ins.

1981 NCSC rally to protest Social Security cuts brings 10,000 people to Capitol Hill steps.

1985 NCSC publishes a report on "Abusing the Elderly" which details drug experimentation on nursing home patients without their prior consent.

NATIONAL COUNCIL OF SENIOR CITIZENS
1331 F STREET, N.W. • WASHINGTON, D.C. 20004 • (202) 347-8800

1986 NCSC exposes how for-profit hospitals are routinely dumping patients after they can no longer afford to pay their bills.

1988 NCSC completes its 20th year of operating the Senior AIDES program for the U.S. Department of Labor; the program now employs over 10,300 low-income senior citizens.

1990 NCSC successfully pushes for increased regulation of Medigap insurance policies to prevent unscrupulous insurance salesmen from ripping off senior citizens.

1992 For the first time in its 31-year history, the NCSC endorses a Presidential candidate — Bill Clinton. NCSC prints and distributes millions of brochures explaining why Clinton is most likely to deliver on the issue of greatest concern to senior citizens — health care.

1993 President Clinton signs into law the Family Medical Leave Act which allows family members to take unpaid leave to care for seriously ill family members, including parents and grandparents.

1993 President Clinton meets with the NCSC Executive Committee to discuss health care reform. Later, NCSC is the first organization to testify for health care before the President's health care task force.

Fast Facts About NCSC

Senior Housing: The NCSC is one of the largest sponsors of housing for the elderly and handicapped, with more than 4,000 tenants in 30 buildings valued at more than $175 million.

Senior Jobs: In conjunction with the U.S. Department of Labor, the NCSC operates more that 149 Senior AIDES projects which employ more than 10,300 low-income senior citizens nationwide.

An Active Organization: The NCSC is one of the largest nonprofit organizations in the United States with over 5 million affiliated members and associates. With 5,000 senior clubs, the NCSC is able to keep its pulse on the concerns of older Americans and translate those concerns into real political muscle.

A Leadership Voice: The NCSC has been one of the leading voices for older Americans for more than 32 years. Lyndon Johnson said, "Without the National Council of Senior Citizens, there would have been no Medicare."

NOTES:

- Hit hard on beneficiary cuts v. protection
- Tax cut v. Medicare cut -- if they were not doing their tax cut they would not need to cut Medicare.
- We can protect the solvency of the Trust Fund. We can do a tax cut -- mention President's tax cut. And we can do it without taking money out of the pockets of Medicare beneficiaries.

- Medicare Event -

Date: July 25th

Preferred time: 10 a.m. or just past noon.

Hook: On the 30th Anniversary of Medicare, and on the eve of the Medicare budget battle, 10 of the original signers of Medicare, and other more recent Members of Congress, reaffirm their support for the nation's health insurance program for the elderly and seriously disabled by re-signing the First "Contract with America."

Event: Members of Congress are invited to "reaffirm" their support for Medicare on its 30th Anniversary by signing a copy of the original law signed by Lyndon Johnson in 1965. The idea is to renew the First "Contract With America" by vowing to preserve Medicare into the future. After a brief introduction and a symbolic signing of the old law by a few Members of Congress, the Birthday cake will be lit by passing a lighted candle from Dr. Arthur Flemming (on the right) and Mrs. Genevieve Johnson (on the left) through their assembled family members. The youngest children, along with someone from the disabled community, will light the candles (the children with parental help).

Visuals:

- Large birthday cake (triple decker) with 60 candles.
- The 12 original signers of Medicare legislation that are still in office.
- Dr. Arthur Flemming (age 90) and Mrs. Genevieve Johnson (age 96) and assorted family members spanning 5 generations.
  (With Dr. Flemming and Mrs. Johnson, we span a great deal of demographic ground: black and white, male and female, Republican and Democrat)
- Another Possible Feature: Lady Bird Johnson whom the new "contract" could be presented to.

In the room:

- Members of Congress
- Cake and families
- Camera crews
- Disabled Americans
- As many seniors as we need to fill the room.
- Selected seniors and disabled Americans to do intereviews about the importance of Medicare to them and their families
- Representatives from national organizations and agencies.

National Council of Senior Citizens

- [illegible] Caucus Room.

*** TOTAL PAGE.02 ***

Routing Slip

DATE: 7/13/95

July 25th ~~26th~~

FROM: Billy Webster
Director of Scheduling and Advance

SUBJECT: 30th Anniversary of Medicare Event

Don Baer	✓	Abner Mikva	
Erskine Bowles		Leon Panetta	
Peg Cusack		Laura Tyson	
Rahm Emanuel		John Podesta	
Mark Gearan	✓	Jack Quinn	
Jack Gibbons		Carol Rasco	✓
Pat Griffin		Paige Reffe	✓
Marcia Hale		Cheryl Rodman	✓
Alexis Herman	✓	Lee Satterfield	
Nancy Hernreich		Patti Solis	
Kitty Higgins	✓	Doug Sosnik	
Harold Ickes		G. Stephanopoulos	
Anthony Lake		Ann Stock	✓
Bruce Lindsey		Stephanie Streett	
Mike McCurry	✓	Kim Tilley	✓
Anne McGuire	✓	Jodie Torkelson	
Mack McLarty		Melanne Verveer	
		Anne Walley	✓
		Maggie Williams	

File: ACCEPT 7/26

Comments: Per BW 7/13

Jennifer Klein
Chris Jennings

ROUTING SLIP

DATE: 6/23/95

FROM: Billy Webster
Director of Scheduling and Advance

SUBJECT: 30th Anniversary of Medicare Event

Don Baer	✓	Abner J. Mikva	
Erskine Bowles		Laura Tyson	
Rebecca Cameron		Leon Panetta	
Peg Cusack		John Podesta	
Rahm Emanuel		Jack Quinn	
Mark Gearan	✓	Carol Rasco	✓
Jack Gibbons		Lee Satterfield	
Pat Griffin		Patti Solis	
Marcia Hale		Doug Sosnik	
Alexis Herman	✓	G. Stephanopoulos	
Nancy Hernreich		Ann Stock	
Kitty Higgins	✓	Stephanie Streett	
Harold Ickes		Kim Tilley	
Anthony Lake		Jodie Torkelson	
Bruce Lindsey		Melanne Verveer	
Mike McCurry	✓	Anne Walley	
Anne McGuire	✓	Maggie Williams	
Mack McLarty			

FILE: ✓ PENDING date near June 30th June Rasco

FYI ✓ ADVICE _____ ACTION _____

REGRET POTUS, suggest a surrogate is needed: _____

COMMENTS: Per BW 6/23 See where we are in the budget process

SCHEDULING REQUEST Date: 6/21/95

95 JUN22 A8:48

___ACCEPT ___REGRET ___PENDING

TO:	Billy Webster Director of Scheduling and Advance
FROM:	Carol H. Rasco Assistant to the President for Domestic Policy Alexis Herman Assistant to the President for Public Liaison Kitty Higgins Secretary to the Cabinet
REQUEST:	An event with the President to commemorate the 30th Anniversary of Medicare.
PURPOSE:	Given the importance of Medicare in the current budget debate, this event will allow the President to demonstrate his commitment to the program and to highlight Medicare as a program that has worked successfully for the elderly for thirty years. It is expected that this event will be part of a broader budget strategy.
BACKGROUND:	Medicare was signed by President Johnson on July 30, 1965 at the Truman Library in Independence, Missouri. At this point, the Health Care Financing Administration is planning its official commemoration of the program in July, 1996 -- 30 years after the first person received benefits from the program. Development of the event will obviously be in collaboration with HHS and in coordination with Congressional plans for the anniversary.
DATE AND TIME:	Close to July 30 (July 30 is Sunday)
DURATION:	One hour
LOCATION:	TBD
PARTICIPANTS:	TBD
OUTLINE OF EVENTS:	TBD

REMARKS REQUIRED:	Yes
MEDIA COVERAGE:	Open press
VICE PRESIDENT'S ATTENDANCE:	TBD
RECOMMENDED BY:	Carol Rasco, Alexis Herman, Kitty Higgins
ORIGIN OF THIS REQUEST:	White House Staff generated
CONTACT:	Jeremy Ben-Ami x65584 Molly Brostrom x65561

MEMO

To: Terry Edmonds
From: Angela Lee
Date: 18 July 1995

RE: Medicare

I found some useful background information from *Medicare: Now and in the Future*, published in 1993 by the Urban Institute, a non-profit think tank located here in Washington, D.C. They are faxing more recent findings.

What is Medicare?

Medicare is "the largest public healthcare program in the U.S., providing the major source of insurance for acute care for the *elderly* and *disabled* populations." (p.1) Medicaid, on the other hand, targets the financially needy and varies by state in terms of implementation.

Why is Medicare the focus of the budget cutting debate?

First, the size of the program, and second, its rapid growth: "The portion of the federal budget devoted to Medicare has been expanding rapidly since 1965, when Mediare was introduced..." (p.1)

All three 1992 presidential candidates proposed cuts in Medicare. During his campaign, Clinton suggested that higher-income Medicare beneficiaries should contribute more to the costs of their care.

Is the need for Medicare today as great as it was at its inception in 1965?

On average, older Americans are better off than they were 30 years ago. In 1962, for example, the poverty rate for elderly families was 47%, as opposed to 13% for families headed by someone aged 25 to 54. (p.25, data from Council of Economic Advisors 1964) Because past generations of older Americans were disproportionately poor, they were unable to obtain adequate health care.

But not every member of today's over-65 group is better off: "The dichotomy between the wealthiest and the poorest older Americans continues..." (p.9)

Furthermore, the proportion of income spent by senior citizens on health care is "at an all-time high and will increase further." (p.10) Even though older Americans are on average wealthier than they were 30 years ago, they are less able to meet skyrocketing

health care costs. (The reasons behind the astronomical rise in health care costs are many, complex, and controversial...)

How did Medicare evolve?

As early as 1945, the idea of public health insurance found supporters among both Democrats and Republicans. Most Republicans, of course, and the American Medical Association (AMA) stridently opposed all such initiatives.

President Truman proposed a national health insurance program, but the proposal was defeated by Congress. Presidential candidate John F. Kennedy promised during his campaign that he would propose health insurance for all elderly Americans; he failed to accomplish this goal before his assassination. In 1965, as both the number and political power of senior citizens swelled, the Democratic Congress passed Johnson's Medicare legislation along with other Great Society legislation.

Access No: 9300003015 ProQuest - The New York Times (R) Ondisc
Title: CLINTON, AT CONFERENCE ON AGING, ASSAILS G.O.P. MEDICARE PLANS
Authors: TODD S. PURDUM
Source: The New York Times, Late Edition - Final
Date: Thursday May 4, 1995 Sec: A National Desk p: 21
Length: Medium (594 words)
Subjects: MEDICINE & HEALTH; AGED; MEDICARE; MEDICAID; REFORM & REORGANIZATION
Names: CLINTON, BILL (PRES)

Article Text:

WASHINGTON, May 3 -- President Clinton rallied more than 2,000 people at a White House conference on aging today and vowed to oppose Republican plans to cut growth in Medicare and Medicaid spending that he said would threaten coverage for the elderly.

'The status quo is not an option,' the President said, acknowledging the financial pressures on the Medicare system. But he repeated his view that savings must come in the context of overhauling the health care system and insisted, 'I will not support proposals to slash these programs, to undermine their integrity, to pay for tax cuts for people who are well off.'

Unmoved by the request of the House Speaker, Newt Gingrich, and the Senate majority leader, Bob Dole, to draft a bipartisan solution, or by Mr. Gingrich's pledge to consider Medicare spending separately from the rest of the budget, Mr. Clinton sought to keep the Republicans on the run on an issue that the White House believes will damage whoever blinks first and offers specific proposals to cut costs.

The Administration says the trust fund, which pays nearly two-thirds of the cost of Medicare, will be insolvent by 2002 if nothing is done. But except for his broad requirements that any changes do no harm, the President declined to offer any details of his own. Instead, he called again on Republicans to spell out their budget proposals.

'I will not walk away from this issue,' Mr. Clinton told the audience of elderly people and health care experts at the White House Conference on Aging at the Washington Hilton. 'I watched from afar when I was a Governor and a citizen for 12 years while people here walked away from problem after problem. And I sustained, as President, an agonizing experience when large numbers of people walked away from problems that I asked them to face for short-term political gain.'

Precisely because the Clinton health care plan went down to defeat last year, the White House refuses to give Congressional Republicans a proposal they could pick apart to meet their own promises to cut taxes and balance the budget by 2002. Instead, it has moved swiftly to paint the Republicans as enemies of the sick and the elderly, and this week's long-scheduled conference -- the fourth on the topic since 1961 -- gave the President a forum for politicking with one of the nation's most powerful electoral constituencies.

Mr. Clinton said any proposed change in Medicare or Medicaid should not eliminate services or charge elderly people on fixed incomes 'more than they can possibly be expected to pay,' or force them to enter managed-care programs 'whether they're good ones or not.'

Almost all Americans over the age of 65 are enrolled in Medicare, which cost $159 billion last year. Republicans in Congress have said they intend

to reduce projected spending by up to $300 billion, and the White House contends that such cuts are the only way the Republicans could finance their their promised tax cuts and balance the budget. But the Administration believes all three ideas are unrealistic, and the President's spokesman suggested today that the price of cooperation would be high.

'If they come back and say, 'Look, all right, we overpromised, we admit it, we can't simultaneously balance the budget by the year 2002 and provide over $350 billion worth of tax cuts to the wealthiest Americans,' ' said the White House press secretary, Michael D. McCurry, 'and then they go further and they say, 'Because of that now we're going to have to get down to the serious work' ' of writing a budget, 'then you can move ahead.'

Mrs. Genevieve Johnson

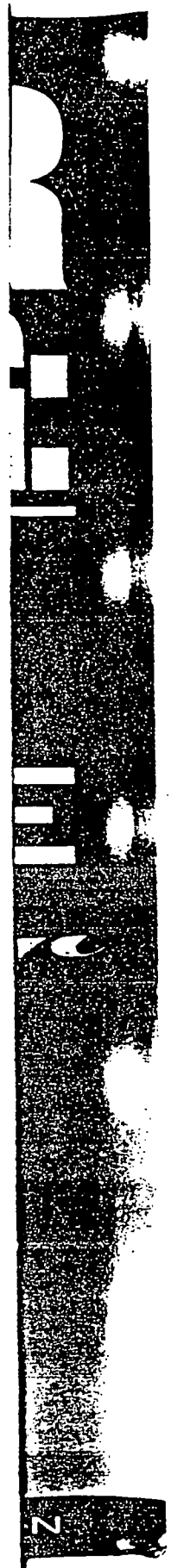
Mrs. Genevieve Johnson is President of NCSC's District of Columbia State Council of Senior Citizens, and a longtime member of its Executive Board.

Mrs. Johnson or "Mother" Johnson, as she is affectionately known, is the founder of the annual District-wide Senior Citizens Prayer Breakfast. The event, now in its 13th year, brings members from all segments of the community together in celebration of the enduring and continuing contributions of older citizens to the welfare of our city and nation.

"Mother" Johnson was one of the founding members of the D. C. Commission on Aging. She remains a leading advisor to public officials on such important concerns as housing, security, and medical assistance for the elderly.

Mrs. Johnson was the driving force behind NCSC's senior citizen housing project in Washington, D. C. In grateful recognition of her many contributions, NCSC named the building "Johnson Towers."

She is the recipient of numerous awards. Among them: the British Empire Medal from the Queen of England upon her retirement after a 34-year career with the British Embassy in the District, and "Mother of the Year" from the American Mothers Association of the District of Columbia.



Arthur Flemming:

[redacted]

[redacted]

[redacted]t Arthur Flemming [redacted]e has had a most astonishing career, see-sawing between high-level appointments in the federal government, three college presidencies, and all kinds of other responsibilities in wide-ranging fields. The single thread running through all of these activities is his concern for justice for *all* people.

Arthur was appointed by President Roosevelt to the U.S. Civil Service Commission in the spring of 1939. He was thirty-four years old, the youngest Civil Service commissioner since Theodore Roosevelt. Arthur left the commission in 1948 to become president of his alma mater, Ohio Wesleyan University.

In 1950, he began a commuting schedule between Washington and Delaware, holding a full-time job at the Office of Defense Mobilization and flying back to Delaware Fridays for almost round-the-clock meetings at Ohio Wesleyan. In 1953 President Eisenhower named Arthur the director of the Office of Defense Mobilization. Arthur served four years in that capacity.

In 1958, President Eisenhower asked Arthur to become secretary of Health, Education, and Welfare. In 1961, at the conclusion of that administration's term, Arthur took over the presidency of the University of Oregon. He remained at this post for seven years. A third college presidency was a three-year stint at Macalester College, in St. Paul, Minnesota.

Arthur left Macalester in 1971 to become the full-time chairman of the upcoming White House Conference on Aging. Later President Nixon appointed him a consultant to the president on aging, later United States commissioner on aging, and still later, chairman of the United States Commission on Civil Rights. Arthur insisted on a watchdog approach, which placed him in positions contrary to those of the Reagan administration. President Reagan summarily dismissed him in November of 1981.

Now, at [redacted] six, he is as busy and involved as ever, making speeches and going to meetings all over the country. "Can't" and "tired" are words he doesn't know how to say.

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Administration Criticizes GOP's Medicare Voucher Proposals

WASHINGTON (AP) Elderly and disabled Americans will be digging deeper into their pockets to keep health benefits if Congress moves ahead with plans to overhaul Medicare, the Clinton administration says.

The Republican effort to reform Medicare would ''turn back the clock 30 years to a time when the elderly and disabled struggled in a discriminatory and expensive insurance market to buy decent coverage with limited funds,'' Judith Feder of the Department of Health and Human Services, told a House subcommittee Tuesday.

The budget plan approved by Congress last month would pare the growth in Medicare spending by $270 billion over the next seven years.

House Republicans are considering a draft plan that would revamp the program by creating financial incentives to encourage people to join health maintenance organizations or other types of managed-care plans that are designed to reduce the growth in medical costs.

Participants would be given government-funded vouchers that could be used to pay for a variety of private health insurance plans, such as HMOs.

House leaders, however, have also pledged that Medicare recipients and future retirees who wish to remain in the traditional fee-for-service program, in which the government pays for each doctor's visit or hospital stay, may continue to do so.

Ari Fleischer, a spokesman for the House Ways and Means Committee, said the draft plan was an internal staff document describing a ''wide spectrum of options available to policy-makers'' and that it was far too soon to say which would be adopted.

But administration officials, including HHS Secretary Donna Shalala, were quick to attack the plan.

Shalala said it would ''force Medicare beneficiaries to reach deeper and deeper into their own pockets to maintain their current coverage.''

And Feder, a deputy assistant secretary of HHS, told the House Commerce subcommittee on health that moving into a voucher system as Medicare spending is being reduced by $270 billion ''can only be disastrous'' for the people who depend on it.

She said Medicare participants under a voucher system probably would have to pay more to keep the coverage they have today. But since three-fourths of them have incomes below $25,000, she said, ''it is likely that many seniors would not be able to pay more.''

''At worst, beneficiaries would be forced to buy coverage that is insufficient to meet their needs,'' Feder said. ''That's not choice, it's financial coercion.''

Fleischer, however, said Shalala and Medicare's other trustees have warned that unless reformed, the system will be ''gone, bankrupt, insolvent'' in seven years.

''We are prepared to move forward and make the decisions to save Medicare for present retirees and future retirees, and in doing so, seniors will have choices and all reforms will be done with an eye toward what is doable and what affordable,'' he said.

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Administration Criticizes Republican Medicare Voucher Proposals

(Capitol Hill) -- The Clinton administration warns that elderly and disabled Americans would be forced to pay more for their health insurance or buy coverage that fails to meet their needs under G-O-P Medicare plans.

Administration health official Judith Feder testified before a House subcommittee Tuesday. She charged that G-O-P Medicare overhaul plans would ''turn back the clock 30 years'' to when the elderly and disabled struggled to buy coverage.

The budget plan approved by Congress last month would pare the growth in Medicare spending by 270 (B) billion dollars over the next seven years.

House Republicans are considering a draft plan that would revamp Medicare by creating financial incentives to encourage people to join managed care plans. Participants would receive government-funded vouchers.

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July 7, 1995

PRESERVING AND STRENGTHENING MEDICARE

Summary

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Paper prepared for the American Association of Retired Persons conference on The Future of Medicare, Washington, D.C., July 20-21, 1995. The views are those of the authors and not the institutions with which they are affiliated.

PRESERVING AND STRENGTHENING MEDICARE

Marilyn Moon and Karen Davis

As Medicare turns thirty, it is an opportune time for a critical reexamination of the program. Medicare has opened the door to health care and greater economic security for the nation's elderly and disabled populations. It has improved access to health care and contributed to improved health and quality of life of millions of vulnerable Americans. Without Medicare, many of its chronically ill beneficiaries would quickly exhaust their financial resources.

Changes in the program, however, are dictated by the projected insolvency of the Medicare Hospital Insurance Trust Fund in 2002, the rapid growth in Medicare outlays in an era of federal budget deficits, and the looming retirement of the baby boom generation. Medicare now faces twin problems -- brought on in part by its own success -- of continuing to guarantee access to care and financial security for its beneficiaries while stemming an unsustainable rate of cost growth.

Grappling with the choices will be extraordinarily difficult. Yet, a reexamination affords an opportunity for creative restructuring of the program to meet the growing health and long-term care needs of an aging population, while being cognizant of competing demands for the nation's health care and budgetary resources. This paper argues that it is possible to build on the strengths and structure of the Medicare program, while undertaking long-term changes to assure its fiscal soundness and preserve its mission of affording health security for an aging population in the 21st century. We attempt to offer pragmatic suggestions on how to improve the program while recognizing the substantial fiscal responsibilities that will need to be faced.

THE ROLE OF MEDICARE

Any discussion of Medicare restructuring should begin with an understanding of why it came to exist, its role in assuring the well-being of America's oldest and most disabled citizens, and its strengths as a program, as well as areas which require strengthening. Medicare is the largest public health care program in the United States, providing the major source of health insurance for acute care for 37 million elderly and disabled beneficiaries. It came into being in 1965 because the nation's elderly lost their health insurance when they retired. Without health insurance, the nation's elderly and their families were at risk for financially ruinous health care expenses.

Why is Medicare so costly? The answer lies not in inefficiency, or a failure to adopt modern techniques of cost-savings. Its administrative costs, at two percent of program outlays, are far lower than those of private insurance and managed care plans.[1] It is a leader in electronic submission of claims -- 90 percent for hospital services and 67 percent for physician services --

[1]Health Care Financing Administration, *Medicare: A Profile* (Washington, D.C.: HCFA, 1995).

far in excess of private health insurers.[2] It imposes price discounts on hospitals and physicians unmatched by even the best managed care plans. It offers beneficiaries a choice of enrollment in health maintenance organizations (HMOs) or coverage under fee-for-service with unlimited choice of physician; 70 percent of all HMOs offer Medicare risk contracts.[3] .

In the 1980s Medicare expenditures per beneficiary grew more slowly than private health insurance per enrollee. After adjusting for the packages of health services covered by both private insurance and Medicare, Medicare has done better than private insurance between 1990 and 1992 and nearly as well in 1993.[4] In short, Medicare's costs have increased for the same reasons that health care costs generally have risen: health and quality of life enhancing technological change, excess capacity in the health care system, overspecialization, and an open-ended payment system that encourages doing more.

STRENGTHS OF THE MEDICARE SYSTEM

Medicare has many strengths that deserve to be retained, including some of the basic principles on which the program was founded.

Universal Social Insurance

Medicare provides universal health insurance coverage to nearly all people age 65 and over and those who are permanently and totally disabled for two years or more. At 98 percent of all the elderly, for example, this represents a percentage far in excess of the rate of coverage found for any other group in the population. By offering a uniform benefit package and ready access to most health care providers in the U.S., Medicare has achieved its promise of offering mainstream medical care even for the sickest and lowest income populations.

Medicare's Risk Pools

One of Medicare's strengths is its sharing of risks across a large group of the population. With 37 million beneficiaries, Medicare is the largest risk group for health insurance in the U.S. Effectively, costs for chronically ill 85 year-olds are averaged in with healthy 70 year-olds, making insurance less expensive than if these 85 year-olds were seeking insurance in the private market from a company that covered a much smaller number of persons. In addition, once a commitment has been made to treat all these beneficiaries alike, the costs associated with underwriting and differentiating risks can be foregone.

Medicare's Discounts

While Medicare has been criticized for not promoting aggressively enough managed care

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[2]Health Care Financing Administration, *Medicare: A Profile* (Washington, D.C.: HCFA, 1995).

[3]Health Care Financing Administration, *Medicare: A Profile* (Washington, D.C.: HCFA, 1995).

[4]Marilyn Moon and Stephen Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" Discussion paper, Urban Institute, 1995.

alternatives for its beneficiaries, the program is itself similar to a preferred provider managed care plan. With the recent reforms in provider payment, Medicare sets prospective prices for hospitals and physicians at a substantial "discount" to usual charges. Medicare's physician payment fees, for example, average 68 percent of fees paid under private health insurance plans.[5] All providers who are willing to participate at these rates are permitted to enroll. Even when compared with formal preferred provider organizations (PPOs)--which is the area of managed care now growing fastest in the U.S.--Medicare's payment levels remain substantially lower.[6] Similarly, hospital payments are below costs while private insurers continue to pay a premium for care. Medicare has already achieved the discounts that are just now helping to hold down premiums for private insurers.

BUILDING ON MEDICARE'S STRENGTHS

At present, too little attention is being focused on how to improve the functioning of the basic Medicare program, rather than departing radically from its basic structure. The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; capitated managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme.

Major issues include: 1) how to improve the fee-for-service option within Medicare; 2) how to expand Medicare managed care choices while assuring quality standards; 3) how to minimize the difficulties posed by risk selection; and 4) what financial contribution Medicare beneficiaries and taxpayers can reasonably be expected to make.

Improving Medicare's Fee for Service Option

Medicare's greatest strength as a social insurance program is the efficiency of its fee for service option. It has low administrative costs and low provider payment rates. It could appropriately be characterized as a PPO that takes any willing provider that meets quality standards. And it does so without sacrificing beneficiary choice of physician. It is not surprising that Medicare beneficiaries rate it highly, and that it has broad popular support.

Where the fee for service option falls short is the adequacy of its benefit package, and the difficulty of coordinating benefits with Medicaid and private supplemental coverage. This creates complexity and confusion among beneficiaries and providers. Any comprehensive examination of options for Medicare restructuring should include:

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[5]Physician Payment Review Commission, *Annual Report to Congress* (Washington, D.C.: PPRC, 1995).

[6]Stephen Zuckerman and Diana Verrilli, "The Medicare Relative Value Scale and Private Payers: The Potential Impact on Physician Payments." Prepared under Health Care Financing Administration Contract No. 500-92-0024, D.O. #4, 1995.

- Merger of Medicare Part A and Part B to simplify financing and administration of the program.
- Creation of two standardized Medicare benefit packages: the current benefit package with a unified deductible and ceiling on out-of-pocket costs and a comprehensive benefit package that covers current services with little or no cost-sharing and prescription drugs.[7]
- Beneficiaries preferring the comprehensive benefit package would pay an additional premium to cover the differential cost.[8]
- Federalization of Medicaid supplemental acute care coverage for Medicare beneficiaries; Medicare cost-sharing and premiums for poor and near-poor Medicare beneficiaries would be financed from federal general revenues and administered jointly with Medicare.[9]

Improvements in Medicare's fee-for-service environment also requires attention to further cost containment activities. This part of the program needs to improve its payment and oversight activities to remain a viable option. In some cases, Medicare could adopt innovations from the private sector to improve its operations. Thus, changes in Medicare could include:

- Expansion of prospective payment methods to all Medicare benefits, including consideration of expenditure targets that link future prices to performance in controlling the outlays
- Use of sophisticated computer techniques for profiling use of services, and thus identifying outliers and possible abuse
- Establishing and applying strict principles for appropriateness of care
- High cost case management.

Expanding Medicare's Managed Care Options

Medicare currently permits federally qualified HMOs and state-accredited competitive health plans to enter into Medicare risk contracts. Plans may make a profit on their Medicare beneficiaries, but only to the extent to which they make a profit on non-Medicare enrollment. Any additional savings must be returned to beneficiaries in the form of improved benefits,

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[7]A voluntary long term care insurance supplement financed by an income related premium might be another option that could be considered as well. For further description, see Karen Davis and Diane Rowland, *Medicare Policy: New Directions for Health and Long-Term Care* (Baltimore, Md.: The Johns Hopkins University Press, 1986).

[8]While such an option has considerable appeal to allow beneficiaries who wish to do so to opt for just one simple public program, there is the danger that sicker beneficiaries will opt for comprehensive benefits while healthier beneficiaries select basic coverage. If so, premiums will need to be risk adjusted--encountering the same methodological problems that managed care options create. See Marilyn Moon, "Adding a Long Term Option to Medicare," in *A Call for Action, Supplement to the Final Report*, The Pepper Commission, U.S.G.P.O., September 1990.

[9]For more details see Diane Rowland and Barbara Lyons, *Medicare's Poor* (Baltimore, Md.: Commonwealth Fund Commission on Elderly People Living Alone, 1987).

reduced cost-sharing, or reduced premiums.

Medicare could take several steps to expand its managed care options:

- Including PPOs and POS plans that meet quality and fiscal soundness standards and provide either the basic or comprehensive benefit package
- Informing Medicare beneficiaries of all managed care plan options available in their geographic area, providing beneficiaries with information on which to make an informed choice, and having beneficiaries enroll annually in either Medicare's fee for service option or a managed care option
- Beneficiaries could receive all or a portion of the savings of managed care plans with premiums below the Medicare fee for service option or pay all or a portion of the incremental cost of managed care plans with premiums above the Medicare fee for service option.

Minimizing Risk Selection

The primary problem with expanding Medicare managed care options is that it creates incentives to sort out healthier risks into managed care plans while poorer risks elect the fee for service option. If beneficiaries bear all of the financial cost of higher premiums, sicker, chronically ill patients may bear additional financial burdens not because they enroll in a less efficient plan but because the kind of care they need is only available in the fee for service option. The community rated character of Medicare could be destroyed, with each subgroup bearing its own risk.

Given the extreme variability in health outlays among Medicare beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries which they have very strong incentives to do, Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Medicare HMOs currently have the option of switching to a fee-for-service method of payment from a capitated risk contract if they experience adverse selection and would receive higher payment under Medicare's cost reimbursement rules. Monthly disenrollment by Medicare beneficiaries also means that managed care plans can encourage sicker patients to leave the plan and be cared for on a fee-for-service basis. In the case of network-model HMOs the same physician might even continue to care for the patient when he or she disenrolls.

This is such an overwhelming downside that it warrants a gradual approach to managed care, gaining experience with mechanisms used by plans to avoid bad risks. The following approaches may help to minimize adverse risk selection:

- Insurance market reforms such as open enrollment, same premium for all enrollees (or with age-gender adjustment only), no underwriting or exclusion of poor risks
- Regulation of marketing, enrollment, and disenrollment practices with Medicare managing the enrollment process and providing standardized information on plan choices
- Quality standards that assure that chronically or seriously ill patients get appropriate

specialty care

- Requiring all managed care plans to enter into risk contracts.

The most fundamental way of eliminating risk selection is setting capitation rates in a way that reflects the risk of enrolled populations. This is easily said, but we do not do this well now and there is, as yet, no consensus on how to solve this problem. The current method of paying HMOs for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status seems years away.

Financing Options

These improvements in Medicare's fee for service and managed care options may not generate substantial savings over the long term. They represent program improvements, and should be considered on their merits quite apart from their savings potential. Yet, their extensive uncertainties make them an unreliable foundation on which to assure the future fiscal soundness of the Medicare program.

There are two basic alternatives for financing Medicare benefit payments: direct beneficiary contributions and taxes. Ultimately, this is a public policy choice that the nation must make. There is no magic right combination of beneficiary financial responsibility and governmental financial responsibility.

If beneficiaries are asked to pay more, some options are more equitable than others. Consider cost sharing changes. While cost sharing makes theoretical sense as a means for controlling use of services, in practice it often results in lower use of services only for low income families.[10] In the case of Medicare beneficiaries, higher cost sharing will likely have only an indirect effect on most people since they have additional supplemental insurance that would insulate them for the direct impact. In addition, Medicare coinsurance and deductibles represent a complicated collection of mismatched requirements, some of which could be increased and some of which should be decreased. For example, the Part A hospital deductible ($716 in 1995) is very high by any standards while the Part B deductible ($100) is quite low. Hospital and skilled nursing coinsurance are also unreasonably high. It makes sense to rearrange this cost sharing along more rational lines, with perhaps a small net increase.[11]

Premiums for Medicare beneficiaries could be increased, and this is a reasonable way to require higher contributions if special efforts are made to protect low income beneficiaries. In particular, the Qualified Medicare Beneficiary (QMB) and the Specified Low Income

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[10]Newhouse, Joseph. Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance. The RAND Corporation, Santa Monica, 1982.

[11]Marilyn Moon, *Medicare Now and in the Future* (Washington, D.C.: Urban Institute Press, 1993).

Beneficiary (SLIMB) programs should be moved into Medicare.[12] This would likely help with low participation rates in this program. In addition, the eligibility cutoffs could be raised if premiums go up to ensure that moderate income families would not be hit too hard.

An income related portion of a premium increase also could be considered[13], but there are practical implementation problems that may render this a less desirable initial step. Implicitly, Part A already has an income-related premium via the taxation of Social Security benefits, a portion of which is dedicated to the Part A trust fund. This element could be retained, not eliminated as some have suggested.[14]

It seems likely, however, that the fiscal soundness of Medicare can only be guaranteed as the baby boom population reaches retirement if the tax base of the program is improved. To be dynamically sound, payroll tax revenues will need to be supplemented with other sources of revenues that grow with the aging of the population, such as premiums paid by beneficiaries. The regressive shift in financing by a greater reliance on premium financing could be offset by subsidies for poor and near poor beneficiaries, or through income-related premiums. With merger of Part A and Part B, a single trust fund could be established to receive payroll tax, premiums, and general revenue contributions.

One of the most fundamental long-term issues that must be considered is the extent to which costs of retired persons are borne by current workers. By the year 2030 under current projections, there will be two covered workers for every Social Security beneficiary.[15] The cost of Social Security and Medicare per worker could be staggering. The age of Social Security eligibility is gradually being increased to age 67; Medicare could do the same. The difficulty, however, is that those who are involuntarily retired because of limited job opportunities or health reasons can take Social Security at age 62, but at reduced actuarial rates. Medicare currently has no such option, and many early retirees become uninsured and are at great risk.[16] If Medicare retirement age were to be increased, consideration would need to be given to permitting early

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[12]They are currently part of the Medicaid program and likely to be at considerable risk if Medicaid becomes a block grant or even if states are given more discretion concerning coverage and eligibility. See Marilyn Moon, *Medicare Now and in the Future* (Washington, D.C.: Urban Institute Press, 1993).

[13]Karen Davis and Diane Rowland, *Medicare Policy: New Directions for Health and Long-Term Care* (Baltimore, Md.: The Johns Hopkins University Press, 1986).

[14]Marilyn Moon, "Taxation of Social Security Benefits," Hearing before the U.S. House of Representatives Committee on Ways and Means, January 19, 1995.

[15]1995 Annual Report of The Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds, April 3, 1995.

[16]Karen Davis, "Uninsured Older Adults: The Need for a Medicare Buy-in Option," testimony before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, June 12, 1990; and Marilyn Moon, "Expanding Medicare Coverage to the Near Elderly," testimony before the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, March 19, 1991.

retirees to purchase Medicare on a subsidized basis. Expansion of job opportunities for older people, or opportunities to earn Medicare premium credits through voluntary service to their communities should be considered.

CONCLUSION

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should not be hastily jettisoned in an ill-conceived and short-sighted effort to obtain federal budgetary savings. Instead a full array of options needs to be carefully analyzed, critiqued, and debated. We are pleased to be a part of this conference on the Future of Medicare that helps set this public debate in motion.

MEDICARE, ITS TRUST FUND, AND DEFICIT REDUCTION

by Marilyn Moon

The following perspective is that of the author and does not necessarily reflect the views of the Urban Institute, its board, or its sponsors.

Medicare has long been a tempting target for cutting the federal budget deficit because it is such a large and rapidly growing program. But recently another rationale for slowing the growth of the program has been raised in the guise of the pending financial crisis in Medicare's Part A trust fund. Part A pays for hospital, skilled nursing, and home health services, and is financed by a dedicated payroll tax. A trust fund was established to ensure that these revenues were used to pay Part A benefits.

Trust fund revenues are now about equal to the fund's payments; but revenues are growing at a considerably slower rate than are the outflows. Certainly this imbalance signals an important problem. But it is disingenuous to suggest that Medicare will soon be bankrupt and unable to pay benefits. For example, no one argues that we cannot pay defense contractors simply because we are running a federal deficit.

"Saving" the trust fund can be done in a number of ways, and none of them requires spending reductions of the magnitude or speed being discussed for purposes of deficit reduction (i.e., between $200 billion and $300 billion over seven years). A better approach would be to move cautiously, but to recognize the challenges facing Medicare as the baby boom ages.

In the short run a number of options could substantially slow the growth of Medicare. Limits on payments to hospitals and physicians, and more careful management of the use of services such as home health care and outpatient hospital services, can take us part of the way. Increased contributions by beneficiaries in terms of more cost sharing or higher income-related premium contributions also should be on the table.

"The Medicare program is too large and its benefits too important for reformers to move too rapidly."

Part A could be further protected in the short run by shifting its home health component into Part B, which covers physician and other ambulatory services. That would reduce trust fund outflows by more than $100 billion in the next five years. And although it would shift part of the burden onto general revenues, beneficiaries would also bear about 30 percent of the costs since this spending would be counted in setting the Part B premium.

In addition to these short-run changes, Medicare could begin to use managed care, benefitting from some of the recent private sector innovations. But we should be wary of moving too rapidly in this direction. Managed care will not provide an instant magic bullet. Health maintenance organizations (HMOs) and other types of managed care have more experience dealing with younger, healthier populations that may not translate easily into treatment of the aged and disabled. Policies such as limiting access to specialists may not work well with a population having multiple health problems, for example. Also, some savings from these arrangements often come from seeking discounted prices from service providers. But Medicare already has limited prices for many of its services.

Medicare's experience also suggests the need for consumer protections and oversight. Medicare HMOs often intentionally attract low-risk patients whose average costs will be lower than Medicare's per capita payment to the HMO. The easiest ways for an HMO to limit costs of Medicare enrollees is still to carefully market to the right patients. This selection process results in a perverse system in which Medicare now pays too much to its HMOs. This is not an easy flaw to fix, since there is great difficulty in determining a reasonable per capita payment to make to HMOs — a critical factor in assuring that competition among plans occurs fairly.

If managed care and private competition are to be strategies to restrain future Medicare growth, we should proceed slowly to ensure that the system offers protections for beneficiaries, providers, and the government alike. The Medicare program is too large and its benefits too important for reformers to move too rapidly.

See Medicare Now and in the Future, *by Marilyn Moon, Urban Institute Press, April 1993. For ordering information, see page 31.*

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dpc special report

Medicare's 30th Anniversary

- ❑ A Democratic Vision
- ❑ An American Success

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Medicare's 30th Anniversary

❑ A Democratic Vision
❑ An American Success

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

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

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

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

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

A Democratic Vision from the Start

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

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

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

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

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

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

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

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

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

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

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

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

Again, no action was taken.[9]

Democrats Focus on Seniors

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

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

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

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

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

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

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

Hearings were held, but there was no further action.

President Kennedy Persists

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

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

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

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

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

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

They called it socialism.

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

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

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

They said it would not work.

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

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

They said it was too bureaucratic.

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

They said it would wreck the Social Security System.

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

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

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

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

The Democratic Victory

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

President Johnson went before Congress to proclaim:

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

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

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

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

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

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

And they said it was a threat to Social Security.

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

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

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

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

Medicare—An American Success

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

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

- By 1970, nearly all the Nation's elderly were enrolled in the Medicare program.
- Today, more than 36 million Americans are protected by Medicare.

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

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

Medicare is an efficient health program.

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

Medicare benefits all Americans regardless of income status.

- Eighty-three percent of Medicare outlays go to beneficiaries with incomes of $25,000 or less.[54]
- Only three percent goes to elderly individuals or couples with incomes in excess of $50,000.[55]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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