Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	re: Stephen Kellison (partial) (1 page)	02/09/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

FOLDER TITLE:
Medicare [Folder 17]

2012-0463-S
rc792

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]

THE WHITE HOUSE

WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. ~~All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries~~. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). ~~It would save about $9 billion over 10 years~~ and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	**123.0**
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	**164.1**
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
$10,000 LIMIT *	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**141.6**
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**188.8**
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	**134.8**
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	**179.9**
Premiums		***$16***	***$20***	***$21***	***$24***	***$27***	***$34***	***$36***	***$39***	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.

- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A $0.50 tax (on top of your budget's $0.55 tax) would generate about $45 billion in revenue from 2000-09.

- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline ($240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

No-ex wage-index & MC reform subsidy

ILLUSTRATIVE PACKAGES. On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare Income-Related Premium ($80/100)	-14 -25	Modernize Medicare Income-Related Premium ($80/100)	-14 -25	Modernize Medicare Income-Related Premium ($80/100)	-14 -25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions:**		**Additions:**	
Income-Related Premium ($60/90)	-7	Tobacco Tax	-45	Surplus	**-90**
More Provider Cuts	-7	Income-Related Premium ($60/90)	-7		
Raise Deductible to $150 and index	-10				
Subtotal:	**-24**		**-52**		
Drug Benefit:		**Drug Benefit:**		**Drug Benefit:**	
$5,000 Limit 50% Premium: $24/$48*	**+123**	$5,000 Limit 67% Premium: $16/$32*	**+164**	$5,000 Limit 67% Premium: $16/$32*	**+154**
		$10,000 Limit 50% Premium: $31/$55*	**+142**	$10,000 Limit 67% Premium: $21/$36*	**+189**
		No Dollar Limit 50% Premium: $24/$58*	**+135**	No Dollar Limit 67% Premium: $16/$39*	**+180**
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-30**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

** This amount is a necessary "cushion" pending final cost estimates. Drug estimates assume about $5 billion in savings from state maintenance of effort.

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

THE WHITE HOUSE

WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). It would save about $9 billion over 10 years and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	**123.0**
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	**164.1**
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
$10,000 LIMIT*	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**141.6**
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**188.8**
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	**134.8**
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	**179.9**
Premiums		***$16***	***$20***	***$21***	***$24***	***$27***	***$34***	***$36***	***$39***	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.

- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A $0.50 tax (on top of your budget's $0.55 tax) would generate about $45 billion in revenue from 2000-09.

- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline ($240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

ILLUSTRATIVE PACKAGES. On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare	-14	Modernize Medicare	-14	Modernize Medicare	-14
Income-Related		Income-Related		Income-Related	
Premium ($80/100)	-25	Premium ($80/100)	-25	Premium ($80/100)	-25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions:**		**Additions:**	
Income-Related		Tobacco Tax	-45	Surplus	**-90**
Premium ($60/90)	-7	Income-Related			
More Provider Cuts	-7	Premium ($60/90)	-7		
Raise Deductible to					
$150 and index	-10				
Subtotal:	**-24**	**Subtotal:**	**-52**		
Drug Benefit:		**Drug Benefit:**		**Drug Benefit:**	
$5,000 Limit	**+123**	$5,000 Limit	**+164**	$5,000 Limit	**+164**
50% Premium: $24/$48*		67% Premium: $16/$32*		67% Premium: $16/$32*	
		$10,000 Limit	**+142**	$10,000 Limit	**+189**
		50% Premium: $31/$55*		67% Premium: $21/$36*	
		No Dollar Limit	**+135**	No Dollar Limit	**+180**
		50% Premium: $24/$58*		67% Premium: $16/$39*	
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-31**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

** This amount is a necessary "cushion" pending final cost estimates.

Drug estimates assume about $5 billion in savings from state maintenance of effort.

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

January 21, 1998

MEMORANDUM FOR: **GENE SPERLING, ASSISTANT TO THE PRESIDENT AND DIRECTOR OF THE NATIONAL ECONOMIC COUNCIL**

FROM: BOB J. NASH, ASSISTANT TO THE PRESIDENT AND DIRECTOR OF PRESIDENTIAL PERSONNEL

SUBJECT: BOARD OF TRUSTEES OF THE SOCIAL SECURITY AND MEDICARE TRUST FUNDS

I am writing to ask for your input on the President's two appointments to the Board of Trustees of the Social Security and Medicare Trust Funds. As you know, the Board, which is responsible for auditing and issuing an annual report on the status of the Trust Funds, is made up of the Secretaries of Treasury, Labor, Health and Human Services, and the Commissioner of Social Security, plus a Democrat and Republican appointed by the President and confirmed by the Senate. It requires about 30 days of work a year. The terms of the President's current appointees, Stephen Kellison (D) and Marilyn Moon (R), expire in June. Under the law, they could holdover until the Board issues its annual report in April 2000, but the chances of getting two new people confirmed to a four-term year term after this time are of course diminished. The Republican would have to come from Senator Lott.

I need your opinion on whether we should:

1) allow Kellison and Moon to holdover after June until April 2000.

2) ask the President and renominate them in the coming months.

3) work (with your help) to find new two new individuals for the Board.

Kellison's and Moon's resumes are attached. Thank you.

BN:hm

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	re: Stephen Kellison (partial) (1 page)	02/09/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

FOLDER TITLE:
Medicare [Folder 17]

2012-0463-S
rc792

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]

THE HOGUE ASSOCIATES • 543 HIGHTOWER TRAIL • OXFORD, GEORGIA 30267 • (404) 787-5345

[601]

STEPHEN G. KELLISON

Vice President and Actuary
Harcourt General Insurance Companies
Orlando, Florida 32887
Work: 407/345-2499; FAX: 407/345-2363

[redacted] P6/(b)(6)

Home: [redacted] P6/(b)(6)

An experienced actuary with over 30 years of broad-based experience in the actuarial profession. Experience has been in a variety of technical, educational, and managerial capacities. Employment has included the insurance industry, consulting actuarial practice, academe, and a professional association.

SUMMARY OF EXPERIENCE

Effective July 1, 1993 assumed a position as Vice President and Actuary at Harcourt General Insurance Companies.

- Serves as the company's appointed actuary. Responsible for all valuation issues, including statutory, GAAP, and tax reserves. Supervises all actuarial personnel in the valuation area.

- Currently responsible for the development of a full corporate model for the company. The model will include all lines of business.

- Maintains close ties with the Investment Department on a number of issues, including cash flow testing and asset-liability management for the company.

- Supervisory responsibility over the reinsurance area of the company.

- Supervisory responsibility over the health insurance rate review activity for the company.

- Participation in the implementation of a new administrative system for the company.

- Participation in a number of internal committees.

Vice President

GEORGIA STATE UNIVERSITY 1989-1993
Atlanta, GA

Chairman and Professor

- Served as Chairman of one of the largest and most highly-regarded Departments of Risk Management and Insurance in the United States with fifteen full-time faculty members. The Actuarial Science program is included in this department.
- Developed and implemented a strategic plan for the department.
- Expanded the Actuarial Science program to include an emphasis on casualty actuarial topics.
- Expanded programs in executive and continuing education.
- Revised a textbook, which was adopted for use on the actuarial examinations.
- Chaired a major national Panel of Actuaries and Economists to the Advisory Council on Social Security in Washington, D.C.
- Serves as the only actuary on the Task Force on Interest Methods of the Financial Accounting Standards Board in Norwalk, CT.
- Frequent writer and speaker.
- Active on a variety of boards and committees within the actuarial profession.

AMERICAN ACADEMY OF ACTUARIES 1976-1988
Washington, D.C.

Executive Director

- Chief staff position responsible for all program and administrative activities of the association.
- Opened the office in 1976. Staff grew from two to eighteen during that period.
- Active in developing and implementing new program activities in the areas of professional standards, government relations, and public relations.
- Extensive experience in representing the actuarial profession before a variety of governmental entities, both federal and state.
- Developed an ongoing network of relationships with other professional and trade associations.
- Actuarial support for many activities of volunteer committees of the association.
- Frequent writer and speaker.

STENNES AND ASSOCIATES 1975-1976
Dallas, TX

Consulting Actuary

- Opened Dallas office for the firm.
- Experience with clients in the areas of life insurance, pensions, and other employee benefits.

UNIVERSITY OF NEBRASKA 1966-1975
Lincoln, NE

Chair of Actuarial Science

- Responsible for developing and administering the Actuarial Science program. During this period the program grew to be one of the largest and most-respected actuarial programs in the United States.
- Extensive classroom experience teaching all the courses included in the program.
- Author of two textbooks, both of which were adopted for use on the actuarial examinations.
- Author of numerous articles, papers, and other communications.
- Consultant to the Nebraska Legislature on public employee retirement systems. Performed actuarial analysis of all pension bills being considered by the Legislature.
- Consultant to the Nebraska Insurance Department on various actuarial policy issues.

LINCOLN LIBERTY LIFE INSURANCE COMPANY 1965-1966
Lincoln, NE

Chief Actuary

- Hired as the first full-time actuary to start and build an in-house actuarial department.
- Responsible for all actuarial operations of the company, including product design, pricing, and valuation of liabilities.
- Handled actuarial aspects of major computer conversion implemented during this period.

OCCIDENTAL LIFE INSURANCE COMPANY 1963-1965
Los Angeles, CA

Actuarial Supervisor

PERSONAL AND PROFESSIONAL DATA

Age 51, excellent health, married, two children

Education:

- A.B. University of Nebraska-Lincoln — Major in Economics — 1963
- M.S. University of Nebraska-Lincoln — Major in Actuarial Science — 1967

Actuarial Credentials:

Fellow of the Society of Actuaries	FSA	1966
Member of the American Academy of Actuaries	MAAA	1968
Enrolled actuary under ERISA	EA	1976

Other Professional Memberships:

- Member of the International Actuarial Association
- Member of the Southeastern Actuaries Club
- Member of the Atlanta Acutarial Club
- Member of the National Academy of Social Insurance
- Member of the American Risk and Insurance Association
- Member of the Southern Risk and Insurance Association
- Member of the International Insurance Society

Major Publications:

- The Theory of Interest, Richard D. Irwin, Inc. (First Edition 1970, Second Edition 1991)—textbook for the actuarial examinations 1970-present
- Fundamentals of Numerical Analysis, Richard D. Irwin, Inc. (1975)—textbook for the actuarial examinations 1975-1984
- "Actuarial Functions as Expected Values" co-authored with John A. Fibiger, Transactions of the Society of Actuaries (1971)
- Numerous articles in various publications

Professional Activities:

- Board of Governors, Society of Actuaries 1973-1975, 1990-1993
- Board of Directors, American Academy of Actuaries 1975-1976
- Secretary, Actuarial Education and Research Fund 1988-1992
- President, Nebraska Actuaries Club 1970-1971
- Committees of the Society of Actuaries:
  - Committee on Papers 1968-1971
  - Committee on Educational Facilities 1969-1972
  - Committee on Continuing Education 1970-1971
  - Committee on Alternate Route 1971-1974
  - Advisory Committee on Education and Examinations 1971-75
  - Committee on Elections 1989-1993
  - Administration and Finance Committee 1990-1993
  - Education Policy Committee 1990-1993
- Committees of the American Academy of Actuaries:
  - Committee on Accreditation 1971-1975
  - Committee on Nominations 1974-1975
  - Ex-officio member of all committees as Executive Director 1976-1988
  - Committee on Social Insurance 1988-1993, Chairman 1990-1993
  - Committee on Relations with Accountants 1990-present
  - Specialty Committee of the Actuarial Standards Board, Chairman 1991-present
- Task Force on Interest Methods, Financial Accounting Standards Board 1989-present
- Chair, Panel of Actuaries and Economists, Advisory Council on Social Security 1989-1991
- Long Term Care Advisory Committee, National Association of Insurance Commissioners 1988-present
- Strategic Planning Committee, American Risk and Insurance Association 1989-1991
- Committee on Awards, American Risk and Insurance Association 1990-1991

Honors:

- Phi Beta Kappa University of Nebraska 1963
- Who's Who in America 1984-present

FAX TRANSMISSION

THE URBAN INSTITUTE
2100 M Street NW, Washington, DC 20037

From: Marilyn Moon
office: 202-857-8691
fax: 202-223-1149

April 5, 1995

To: Heather Berner, Julie Anderson

Fax number: 456-2259

Subject: Resume

MARILYN MOON

Marilyn Moon is a senior fellow with the Health Policy Center of the Urban Institute. Prior to this position, she served as the founding Director of the Public Policy Institute of the American Association of Retired Persons. She has also worked as a Senior Analyst in the Human Resources and Community Development Division of the Congressional Budget Office, and Associate Professor of Economics and Director of the Social Science Research Facility at the University of Wisconsin–Milwaukee. She has served as a consultant to the U.S. Bipartisan Commission for Comprehensive Health Care (the Pepper Commission) and as an informal advisor to the Clinton campaign and health care transition team. She is a Board member of the National Academy of Social Insurance and on the steering committee of the National Academy of Aging.

Dr. Moon has written extensively on health policy, policy for the elderly, entitlement issues, and income distribution. Her current work focuses on health system reform and financing. Her book, Medicare Now and in the Future, was published by the Urban Institute Press in 1993. With three colleagues, she is also author of a monograph entitled, Balancing Access, Costs and Politics: The American Context for Health System Reform. Recent published articles include, "The Prospects for Health Care Reform in the U.S." "Women and Long Term Care," "Are Social Security Benefits Too High or Too Low?" and "Can States Take the Lead in Health Care Reform?" A forthcoming study on entitlements and the elderly should be published in 1995. Since October 1993, she has been writing a weekly column for The Washington Post.

Marilyn Moon has a Ph.D. in economics from the University of Wisconsin-Madison.

FEDERAL HOSPITAL INSURANCE TRUST FUND, BOARD OF TRUSTEES OF THE

Independent

AUTHORITY: 42 U.S.C. 1395i(b)
P.L. 98-21, Title III, Sec. 341(b), April 20, 1983
P.L. 100-647, Title VIII, Sec. 8005, November 10, 1988
(adds holdover provision and vacancies to be filled for remainder of term)
P.L. 103-296, Title I, Sec. 108, of August 15, 1994
(adds Comm. of Social Security as ex officio)

METHOD: Ex officio and nominated to the Senate

~~FIVE~~ as follows:

Secretary of the Treasury
Secretary of Labor
Secretary of Health and Human Services
Commissioner of Social Security
and

Two who shall be nominated by the President from the public (both of whom may not be from the same political party). (BI-PARTISAN)

NOTE: A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Funds.

MANAGING TRUSTEE: Secretary of the Treasury

SECRETARY OF THE BOARD OF TRUSTEES: Administrator of the Health Care Financing Administration

(CONTINUED - PAGE TWO)

FEDERAL HOSPITAL INSURANCE TRUST FUND, BOARD OF TRUSTEES OF THE

Independent

TERM: FOUR YEARS. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) (See NOTE) after the expiration of the member's term. (LIMITED HOLDOVER)

NOTE: It shall be the duty of the Board of Trustees to: "(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;"

SALARY: No provision in the law. The Board meets at least once a year. Members serve without compensation, but receive per diem and expenses. (Part-time)

PURPOSE: It shall be the duty of the Board of Trustees to hold the Trust Fund, report to the Congress annually on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years, report to the Congress whenever the Board of Trustees is of the opinion that the amount of the Trust Fund is unduly small, and review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

Penn, Schoen and Berland
Polling on Medicare – 4/5/99

Medicare – Premium Support

Voters are supportive of a premium support proposal to reform Medicare. They do not believe that by itself such a change would be all that is necessary to reform Medicare, and they believe that its benefits are overstated.

However, there is a role for premium support (which seriously needs to be renamed to something more understandable). The proposal has support, but the other questions show that its benefits should not be overstated. Such a change merely keeps Medicare current.

The numbers show that current seniors want nothing to do with HMOs now that they already have fee for service, but younger voters, who are growing up on HMOs and health insurance, are very open to the change.

Premium Support

65/23% support/oppose a premium support system for Medicare, given that one component of a Medicare reform plan is a premium support system. Private plans would be allowed to compete with one another and with the government to provide Medicare services. Recipients could choose between buying into private plans or participating in the traditional government fee for service plans, and the government would pay a percentage of the premium.

65% support (**21%** strongly + **44%** somewhat)
23% oppose (**13%** strongly + **10%** somewhat)

D	R	I
78/12	*61/29*	*61/25*
<35	***35-64***	*65+*
80/13	*69/21*	*34/38*

41% agree that a premium support system will encourage efficiency in health care plans and save money, while **47%** agree that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare.

D	R	I
43/39	*30/60*	*45/47*
<35	***35-64***	*65+*
55/32	*45/50*	*13/58*

36% say that under a premium support system, the market will do a better job than the government in controlling costs and maintaining benefits, while **40%** agree that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare.

D	R	I
33/38	*45/35*	*36/46*
<35	**35-64**	*65+*
44/37	*39/34*	*21/68*

34% say that a premium support plan would improve Medicare, since it is modeled after the Federal Employee Health Benefits Program, the same plan that members of Congress are covered under, while **40%** say that it would not ensure access to adequate health care benefits for seniors regardless of their income, health, or location.

D	R	I
33/38	*31/44*	*38/39*
<35	**35-64**	*65+*
42/37	*36/38*	*20/51*

41% believe that a premium support plan would reduce the costs of health care by encouraging efficiency and competition among plans, while **42%** say that it has the potential to increase premiums for those in the traditional Medicare program.

D	R	I
45/41	*36/50*	*44/40*
<35	**35-64**	*65+*
50/40	*42/42*	*26/45*

Prescription Drugs

The two options we tested did not test well.

People do not want any plan that is just for catastrophic care. They also do not want a plan that runs out at $2000.

This points to a plan somewhere in the middle – focusing on a lower premium and a lower percentage contribution and a higher limit – i.e. $25/month, 50%,$5000 limit.

87% think that a plan to cover prescription drugs should be a part of any plan to reform Medicare, **9%** not.

D	R	I
95/1	*84/13*	*84/11*
<35	**35-64**	**65+**
90/8	*91/6*	*73/17*

33% think that a plan for prescription drugs should cover just seniors with lower incomes, **64%** all seniors.

D	R	I
36/62	*25/73*	*35/60*
<35	**35-64**	**65+**
23/70	*35/63*	*35/61*

46% think that the price that seniors contribution for prescription drugs should be the same for all seniors, **49%** think higher income seniors should pay more
and lower income seniors pay less.

	D	R	I	
	49/47	*49/45*	*39/56*	
<35	**35-64**	**65+**	**<35K**	**>35K**
49/49	*42/53*	*59/28*	*50/42*	*45/51*

40% think that the costs of all prescription drugs could be covered under Medicare, **52%** think limits are necessary to keep costs manageable.

	D	R	I	
	50/47	27/68	43/45	
<35	35-64	65+	<35K	>35K
40/52	43/51	29/64	36/55	44/50

69% think that any new prescription drug benefits should be structured primarily to handle seniors' everyday medication needs, 23% to cover only their extraordinary needs for medication.

D	R	I
80/18	66/27	65/24
<35	35-64	65+
64/25	76/17	55/45

40% would be willing to pay a higher premium if that meant they got a lower deductible and copayment, **43%** would rather have a lower premium, recognizing that it would increase the deductibles and copayments.

	D	R	I	
	42/41	37/49	41/42	
<35	35-64	65+	<35K	>35K
57/36	34/49	28/37	39/38	42/48

This plan requires nearly $1000 in drug expenses before it pays any benefit. Reception was lukewarm; seniors rejected it outright.

52%/39% support/oppose the following plan: One plan that has been proposed for prescription drug coverage for Medicare is a voluntary plan that would cost seniors $40 per month. It would have a $500 deductible, and would cover 75% of drug costs after the deductible was met with **no limit**.

52% support (**19%** strongly + **33%** somewhat)
39% oppose (**17%** strongly + **22%** somewhat)

	D	R	I	
	64/33	47/47	50/36	
<35	35-64	65+	<35K	>35K
64/26	53/40	30/61	34/46	59/37

But enthusiasm drops quickly:

43% agree that this plan would provide peace of mind for older Americans fearful of becoming a financial burden to their families since it would provide prescription drug coverage for the sickest beneficiaries who really needed it, while **41%** agree that because of the large deductible, almost half of the beneficiaries would receive no benefit in return for their investment, and that this plan doesn't do enough.

D	R	I
50/35	*39/48*	*42/41*
<35	***35-64***	*65+*
48/41	*41/43*	*29/46*

44% agree that this plan would be a great deal for seniors, and is cheaper and provides a greater benefit than any private plan, while **40%** agree that it would merely be a costly big government approach to dealing with health care problems. Which is closer to your view.

D	R	I
55/42	*27/57*	*43/31*
<35	***35-64***	*65+*
49/42	*41/41*	*39/44*

But although they did not want a catastrophic only plan, a $2000 limit plan did not even get a majority.

46%/40% support/oppose another plan that would also be voluntary with a premium of $40 per month, would have no deductible, cover 75% of drug costs, and have a $2000 limit on the benefit.

D	R	I
53/37	*51/43*	*41/41*
<35	***35-64***	*65+*
64/31	*44/45*	*37/45*

39% agree with supporters that this plan provides a simple, sizeable benefit to any beneficiaries with drug costs, while **61%** agree with opponents that this plan would not help those with major illnesses and high drug costs, giving them little help when they need it the most.

D	R	I
36/64	*37/63*	*45/55*
<35	***35-64***	*65+*
37/63	*41/59*	*33/67*

34% agree that this plan would be a great deal for seniors, and is cheaper and provides a greater benefit than any private plan, while **47%** agree that it would merely be a costly big government approach to dealing with health care problems.

D	R	I
27/51	*37/59*	*40/32*
<35	***35-64***	*65+*
55/39	*31/52*	*20/59*

Of these two plans, the first one is the favorite, but neither is as good as we typically devise:

68% prefer the $500 deductible plan that would cover all of the costs after the deductible was met, **32%** the no deductible plan that would have a $2000 limit on the benefit.

D	R	I
71/29	*66/34*	*68/32*
<35	***35-64***	*65+*
76/24	*68/32*	*63/37*

Premium Support/Prescription Drugs

1. One component of a Medicare reform plan is a premium support system. Private plans would be allowed to compete with one another and with the government to provide Medicare services. Recipients could choose between buying into private plans or participating in the traditional government fee for service plans, and the government would pay a percentage of the premium. Do you strongly support, somewhat support, somewhat oppose, or strongly oppose premium support plans?

1) strongly support
2) somewhat support
3) somewhat oppose
4) strongly oppose
9) don't know

SPLIT NEXT TWO

2. Some people say that a premium support system will encourage efficiency in health care plans and save money, while others say that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare. Which is closer to your view?

1) a premium support system will encourage efficiency in health care plans and save money
2) the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare
9) don't know DO NOT READ

3. Some people say that under a premium support system, the market will do a better job than the government in controlling costs and maintaining benefits. Others say that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare. Which is closer to your view?

1) under a premium support system, the market will do a better job than the government in controlling costs and maintaining benefits
2) the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare
9) don't know DO NOT READ

4. Some people say that a premium support plan would improve Medicare, since it is modeled after the Federal Employee Health Benefits Program, the same plan that members of Congress are covered under. Others say that it

would not ensure access to adequate health care benefits for seniors regardless of their income, health, or location. Which is closer to your view?

1) that a premium support plan would improve Medicare, since it is modeled after the Federal Employee Health Benefits Program, the same plan that members of Congress are covered under
2) it would not ensure access to adequate health care benefits for seniors regardless of their income, health, or location
9) don't know DO NOT READ

5. Some people say that a premium support plan would reduce the costs of health care by encouraging efficiency and competition among plans. Others say that it has the potential to increase premiums for those in the traditional Medicare program. Which is closer to your view?

1) a premium support plan would reduce the costs of health care by encouraging efficiency and competition among plans
2) it has the potential to increase premiums for those in the traditional Medicare program
9) don't know DO NOT READ

6. Do you think that a plan to cover prescription drugs should be a part of any plan to reform medicare or not?

1) yes
2) no
9) don't know DO NOT READ

7. Do you think that a plan for prescription drugs should cover just seniors with lower incomes or all seniors?

1) only seniors with lower incomes
2) all seniors
9) don't know DO NOT READ

8. Do you think that the price that seniors contribute for prescription drugs should be the same for all seniors or should higher income seniors pay more and lower income seniors pay less?

1) Same
2) higher income seniors pay more and lower income seniors pay less
9) don't know DO NOT READ

9. Do you think that the costs of all prescription drugs could be covered under Medicare or are limits necessary to keep costs manageable?

1) all drugs should be covered
2) limits are necessary to keep cost manageable
9) don't know DO NOT READ

10. Do you think that any new prescription drug benefits should be structured primarily to handle seniors' everyday medication needs or to cover only their extraordinary needs for medication?

1) everyday needs
2) extraordinary needs
9) don't know DO NOT READ

11. Would you be willing to pay a higher premium if that meant you got a lower deductible and copayment, or would you rather have a lower premium, recognizing that it would increase the deductibles and copayments?

1) higher premium if that meant you got a lower deductible and copayment
2) lower premium, recognizing that it would increase the deductibles and copayments
9) don't know DO NOT READ

12. One plan for prescription drug coverage would be voluntary. If seniors choose to participate, the drug premium would be about $40 per month. It would have a $500 deductible, and would cover 75% of drug costs after the deductible was met (with a 25% beneficiary co-payment), with no benefit ceiling. Do you strongly support, somewhat support, somewhat oppose, or strongly oppose this prescription drug plan?

1) strongly support
2) somewhat support
3) somewhat oppose
4) strongly oppose
9) don't know

13. Some people say that this plan would provide peace of mind for older Americans fearful of becoming a financial burden to their families since it would provide prescription drug coverage for the sickest beneficiaries who really needed it. Others say that because of the large deductible, almost half of the beneficiaries would receive no benefit in return for their investment, and that this plan doesn't do enough. Which is closer to your view?

1) this plan would provide peace of mind for older Americans fearful of becoming a financial burden to their families since it would provide

prescription drug coverage for the sickest beneficiaries who really needed it
2) because of the large deductible, almost half of the beneficiaries would receive no benefit in return for their investment, and that this plan doesn't do enough
9) don't know DO NOT READ

14. Another plan would also be voluntary with a premium of $40 per month, would have no deductible, cover 75% of drug costs, and have a $2000 limit on the benefit. Do you strongly support, somewhat support, somewhat oppose, or strongly oppose this plan?

1) strongly support
2) somewhat support
3) somewhat oppose
4) strongly oppose
9) don't know

15. Supporters say that this plan provides a simple, sizeable benefit to any beneficiaries with drug costs. Opponents argue that this plan would not help those with major illnesses and high drug costs, giving them little help when they need it the most. Which is closer to your view?

1) Supporters say that this plan provides a simple, sizeable benefit to any beneficiaries with drug costs
2) Opponents argue that this plan would not help those with major illnesses and high drug costs, giving them little help when they need it the most

16. Which plan do you prefer, the $500 deductible plan that would cover all of the costs after the deductible was met, or the no deductible plan that would have a $2000 limit on the benefit?

1) $500 deductible plan
2) no deductible plan with $2000 limit

17. If costs and benefits had to be cut elsewhere from the Medicare program to add a prescription drug benefit, would you still want to add a prescription drug benefit or would you want to leave Medicare as it is?

1) add a prescription drug benefit
2) leave medicare where it is
9) don't know DO NOT READ

Christopher C. Jennings
04/23/99 03:35:45 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP

cc:
Subject: revised final SS/Medicare speech

---------- Forwarded by Christopher C. Jennings/OPD/EOP on 04/23/99 03:37 PM ----------

Paul D. Glastris
01/27/99 12:10:08 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: revised final SS/Medicare speech

Revised final 01/26/99
Paul Glastris

PRESIDENT WILLIAM J. CLINTON
OPENING REMARKS
MEDICARE/SOCIAL SECURITY ROUND TABLE
THE WHITE HOUSE, EAST ROOM
WASHINGTON, DC
Wednesday, January 27, 1999

Acknowledgments: Secretary Rubin; Secretary Shalala; Commissioner Apfel; Gene Sperling; Sen. Craig Thomas; Rep. Xavier Becerra; Rep. Tom Bliley; Rep. Robert Borski; Rep. Ben Cardin; Rep. Rick Hill; Rep. Jerrold Nadler; Rep. Charles "Chip" Pickering; Rep. Rob Portman; Rep. Pete Stark; Rep. Ellen Tauscher; Rep. Jerry Weller.

Panelists (VP will introduce): VP Gore; Laura D'Andrea Tyson, Dean of the Haas School of Business at the University of California at Berkley; Uwe (ooh-veh) Reinhart, Princeton U. economist; Martha A. McSteen, Pres.National Committee to Preserve Social Security and Medicare; Hans Riemer, Founder and Director of the 2030, a public policy organization for young adults.

In my State of the Union address last week, I had the honor of reporting to the

American people that our nation is stronger, healthier, and more prosperous than ever before. But I also said that we have an historic responsibility to use the prosperity we have created to meet the challenges of the 21st Century. Today, we are here to talk about perhaps the most remarkable of those challenges: the aging of America.

On the verge of the new century, we are undergoing a profound, seismic demographic shift. Simply put: The baby boom will soon become the senior boom. The number of elderly Americans will double by 2030, and thanks to medical advances, more of us will be living longer. By the middle of the next century, the average American will live to 82, six years longer than today. These extra years of life are a great gift, but they present a problem--a high-class problem, but a problem none the less. To help Americans make the most of these added years, we must act now.

Fortunately, we are now in a strong position to act. Thanks to the hard work of the American people, and an economic strategy of fiscal discipline, we are now enjoying the longest peacetime expansion in our nation's history. Six years ago, federal budget deficits were $290 billion. Today, we have a budget that is not only in balance but in surplus--$70 billion last year, with an even bigger surplus projected for this year, and with surpluses projected for the next 25 years. This is a remarkable achievement. We should be proud. We should be thankful. But we should also be careful. We could easily fritter away our good fortune. We created our current prosperity not by spending rashly, but by facing boldly the challenge posed by budget deficits. We can create future prosperity by facing the challenge of an aging America.

That is why, in my State of the Union address, I set out a three part plan to invest most of the surplus in ways that will both strengthen our economy and meet the needs of a changing population in the 21st Century.

First, I proposed that we devote sixty-two percent of the surplus for the next fifteen years to saving Social Security. By doing so, we can guarantee the soundness of Social Security for the next 50 years. Over the course of the last week, I have been gratified to see leaders in both political parties, along with many eminent economists, join me in supporting the idea of dedicating a substantial portion of the surplus to saving Social Security. I hope we can build on this bipartisan agreement and put Social Security on a sound footing for 75 years. We should reduce poverty among elderly women, who are nearly twice as likely to be poor as our other seniors. And we should eliminate limits on what seniors on Social Security can earn. We can do this if we make tough choices and work hard, together.

To prepare America for the senior boom, we must do more than save Social Security. We must also assure that all Americans have quality health care as they grow older.

I want to say very clearly to members of both parties that we need to set aside enough of the surplus for Medicare and Social Security before we address

new initiatives like tax cuts. That is why the second part of my proposal calls for devoting 15 percent of the surplus over the next 15 years to the Medicare Trust Fund. If we do this and nothing else, we can extend the life of Medicare until the year 2020.

But let me also be clear on reform. We need to end this false choice of reform or surpluses. Medicare needs revenues to increase its solvency, and it needs reform to make sure that it is modern and competitive to gain additional savings to help finance a long-overdue prescription drug benefit. Reform and devoting the surplus go hand in hand.

There can be no more responsible use for our hard-won surplus than assuring that older Americans have a secure retirement and high-quality health care. This is something that members of both parties can and should agree on. Investing most of the surplus to save Social Security and Medicare is the right course--for ourselves, for our children, and for our nation.

The third part of my proposal is to dedicate $500 billion of the surplus to give working families tax relief by creating Universal Savings Accounts--USA Accounts--to help all Americans build nest eggs for their retirement. Under my plan, working Americans will receive a tax credit to contribute to their USA account, and an additional tax credit to match a portion of their savings, with a choice of how they invest their funds--and more help for those who will have the hardest time saving. By providing this new tax credit for retirement savings, we can make it easier for Americans to save for their own long term care needs. They will be further helped by the $1000 long term care tax credit I have proposed. With these USA accounts, we can also make it possible for all Americans to have a stake in the remarkable economic growth they have worked so hard to create.

We are living in an American renaissance. Our nation is more prosperous than at any time in our history. The best way to keep our economy strong is to invest, not spend, our good fortune. By saving the money we will need to save Social Security and Medicare, over the next 15 years we will achieve the lowest level of publicly-held debt since 1917. Paying down the debt will help keep interest rates low, fueling economic growth well into the 21st Century. The right thing to do for our seniors is the right thing to do for our nation.

To introduce our panelists and share his thoughts, I would like to turn now to someone who has been a leader in our efforts to make Medicare more responsive and flexible--Vice President Al Gore.

###

Message Sent To: _____

Final

PRESIDENT WILLIAM J. CLINTON
REMARKS FOR AARP EVENT
WASHINGTON, DC
February 3, 1999

Ack: Joseph Perkins, Pres., AARP; John McManus, Chair, AARP Nat'l Legislative Council; Tess Canja [CAN-ja], President-Elect, AARP. Horace Deets, Exec. Dir., AARP.

I want to begin by thanking you for inviting me to speak to you today. A couple of years ago, I nearly fainted when my first AARP card came in the mail -- it certainly drew my attention to the fact that I was turning 50. But for more than 40 years, AARP has been drawing all of our attention to the long-term challenges posed by the aging of America. I want to talk to you today about what I believe we must do as a nation to meet those challenges -- and to uphold our duty to future generations.

When I first ran for President in 1992, I spoke to you at your convention in San Antonio about the kind of America I wanted to work with you to build -- an American that honored its obligation to our older people without burdening its young people. An American with its fiscal house in order and its future shining brightly.

So when I took office, we charted a new course based on fiscal responsibility, smart investments in our people, and more trade. In the past six years, we have worked hard, and come far. Today, Americans have created the longest peacetime expansion in our history -- nearly 18 million new jobs, wages rising at twice the rate of inflation, the highest home ownership in history, the lowest welfare rolls in history, the lowest peacetime unemployment since 1957. And as you know, last year, for the first time in three decades, we turned red ink to black with a $70 billion surplus -- on course for a quarter century of budget surpluses.

I thank you for your hard work over these six years on behalf of America's seniors. I thank you for standing strong for bipartisan progress for our nation. And I am very proud to stand with AARP as we say, together: We must use this moment to save Social Security and strengthen Medicare for the 21st Century. There is no higher priority for our nation.

For as I said in my State of the Union address, our fiscal discipline gives us an unsurpassed opportunity to address a remarkable new challenge -- the aging of America. I laid out a four point plan -- saving Social Security, strengthening Medicare, providing tax relief to help Americans save for retirement, and a tax credit to help families with long-term care for aging and ailing loved ones -- that will help us to honor our duties to our people today, and uphold our responsibility to future generations.

On Monday, I sent to Congress my new balanced budget for the year 2000 -- the first budget of the 21st Century -- that embodies my plan by ensuring that we use the surplus to meet the challenge of the Senior boom.

I believe it is imperative that we dedicate the lion's share of the surplus to saving Social Security and Medicare. Here's why. We know that these are not just programs -- they reflect our deepest values, and the duties we owe to one another. Before President Franklin Roosevelt created social security, being old meant living in poverty and fear. Before President Johnson created Medicare, old age and illness were virtually synonymous.

We must act and act now to preserve these guarantees. So I have proposed that we invest 62 percent of the surplus for the next 15 years in Social Security. I am very pleased that members of Congress of both parties have agreed that this is the right thing to do. As you know, I have proposed investing a small portion of the trust fund in the private sector, just as any private or state government pension would do. I agree with AARP that we must insulate any investment of the surplus from political influence, and I believe we can. If we do all this, we will earn a higher return and keep Social Security sound for 55 years.

But from the beginning, we have measured the financial health of Social Security by asking if it will be sound for 75 years into the future. So we should aim higher, and take steps to strengthen Social Security for 75 more years. At the same time, as we do so, we should make changes to improve the program: We should help reduce poverty among elderly women, who are nearly twice as likely to be poor as our other seniors. And we should eliminate the limits on what seniors on Social Security can earn.

To do all this won't be easy. It will require difficult but achievable choices. It will require us to work together across party lines and across the generations. But by making hard choices and working together, we did the seemingly impossible when we balanced the budget. And I am confident we can do it again to save Social Security, now.

You know and I know that saving Social Security, alone, is not enough to prepare America for its future. We must use more of the surplus to do that. Take a look at this chart. Republicans and Democrats agree that investing 62 percent of the surplus to strengthen Social Security is the right thing to do. But our responsibility to the generations does not end there -- we must also agree to use our hard-earned surplus to strengthen Medicare. Some -- even those who agree we should save Social Security -- would use the rest of the surplus for tax cuts. But we must meet all our obligations to future generations. We must save Social Security and strengthen Medicare.

President Kennedy, who first proposed Medicare, famously said "to govern is to choose." And so we should have a great national debate on which course to choose as we enter the 21st Century. Just yesterday we learned of a proposal that would make fundamentally different choices with America's surplus. This plan would spend $743 billion -- nearly three-quarters of a trillion dollars -- on a tax proposal oriented towards the

wealthiest Americans; all before Medicare has been secured. That would be the wrong choice for America.

This is just the latest in a series of risky tax schemes that have been proposed over the years. And if we had adopted even one of them, we wouldn't have a surplus today. We must not return to the old, failed policies of deficit and debt. I believe Americans deserve tax relief, and in a few minutes I will tell you about the tax cuts I have proposed to help families, especially our targeted tax cut for savings called the USA Account. But anyone who hopes to spend the surplus has an obligation to first tell America's families how they plan to preserve and extend the Medicare trust fund into the next century. That's what I mean when I say: first things first.

I want to work with you and with lawmakers of both parties to strengthen Medicare -- including the Medicare Commission chaired by Senator Breaux. In the bipartisan balanced budget agreement of 1997, we extended the life of the Medicare trust fund by 10 years. To truly stabilize Medicare, we should extend its life until 2020. But it is plain that, to truly strengthen Medicare for the long term, we will have to take further steps ~~--and as we do so, we~~ can make sure that it is modern and competitive, and improve its service to America's seniors.

Here are the principles I believe should guide as us as we go forward.

First, Americans should be able to count on Medicare and know that it will be there for them when they need it. I have proposed to use one out of every $6 in the surplus for the next 15 years to guarantee the soundness of Medicare until the year 2020. Without these new resources, Medicare spending would have to plummet significantly below the private sector average -- which would seriously weaken a program that older Americans rely on.

Second, Americans on Medicare should be able to count on a modern, competitive system that maintains high quality care and top notch service by drawing on the best private sector practices.

Third, Americans on Medicare -- especially older Americans with lower incomes -- should be able to count on a defined set of benefits and protections, without having to worry about excessive new costs.

Fourth, Americans on Medicare should be able to count on a benefit they have long waited for: prescription drugs. I believe we should use the savings these reforms create to fund a new prescription drug benefit. I thank Senators Kennedy and Rockefeller for their leadership, and I look forward to working with members of both parties on this important issue. We have all heard the terrible stories of senior citizens making the impossible choice between skipping a dose of medicine or skipping meals. This step will help ensure no American on Medicare ever has to make that choice.

I believe that if we take these actions today, we will ensure that Medicare is there for the today's seniors, for Baby Boomers, and for generations to come.

As I said a moment ago, Americans have worked very hard to replace the era of budget deficits with a new age of budget surpluses. They deserve to benefit from it -- and they deserve tax relief.

I believe that we should use a percentage of the surplus to give Americans well-earned tax relief that strengthens working families, encourages savings, and increases wealth. That is why I have proposed $536 billion in tax credits to establish USA accounts that give working Americans a chance to save for the future. And I have also proposed a $1,000 tax credit to help pay for long term care needs for the aged, the ailing, and the disabled. We know that as America ages, long term care needs will increase -- and we must do more to help.

This is the kind of tax relief that is good for America. But if we squander the surplus before we honor our most profound responsibilities to our parents and our children -- before we save Social Security and strengthen Medicare -- we will waste a once-in-a-lifetime opportunity to build a stronger nation for the 21st Century.

Seven years ago, I told you that if we worked together, we could "leave our children a nation that is stronger, freer, and richer than the one we inherited." Today, I believe we can truly say that we are much closer to leaving this world better than we found it -- and I look forward to continuing our progress, together.

Thank you.

REFERENCES TO MEDICARE REFORM IN THE STATE OF THE UNION

Now, these changes will require difficult, but fully achievable choices over and above the dedication of the surplus. They must be made on a bipartisan basis. They should be made this year. So let me say to you tonight, I reach out my hand to all of you in both houses, in both parties and ask that we join together in saying to the American people, we will save Social Security now.

(APPLAUSE)

Now, last year, we wisely reserved all of the surplus until we knew what it would take to save Social Security.

CLINTON: Again, I say, we shouldn't spend any of it, not any of it, until after Social Security is truly saved. First thing's first.

(APPLAUSE)

Second, once we have saved Social Security, we must fulfill our obligation to save and improve Medicare. Already we have extended the life of the Medicare trust fund by ten years, but we should extend it for at least another decade.

Tonight I propose that we use one out of every six dollars in the surplus for the next 15 years to guarantee the soundness of Medicare until the year 2020.

(APPLAUSE)

Thank you.

But, again -- but, again, we should aim higher.

CLINTON: We must be wiling to work in a bipartisan way and look at new ideas, including the upcoming report of the Bipartisan Medicare Commission. If we work together we can secure Medicare for the next two decades and cover the greatest growing need of seniors -- affordable prescription drugs.

(APPLAUSE)

Thank you.

---- new section of speech ----

CLINTON: Saving Social Security, Medicare, creating USA accounts, this is the right way to use the surplus. If we do so, if we do so, we will still have resources to meet critical needs and education and defense.

And I want to point out that this proposal is fiscally sound. Listen to this: if we set aside 60 percent of the surplus for Social Security and 16 percent for Medicare over the next 15 years, that savings will achieve the lowest level of publicly-held debt since right before World War I in 1917.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release March 16, 1999

REMARKS BY THE PRESIDENT
UPON DEPARTURE
ON MEDICARE REFORM

Outside Oval Office

3:55 P.M. EST

THE PRESIDENT: Good afternoon. I would like to begin by saying that our thoughts and prayers are with all those people who were involved in this morning's Amtrak crash in Illinois. We've dispatched safety officials from the National Transportation Safety Board and other federal investigators to the site to lead the investigation. I want you to know that we will do everything we can to help the victims and their families, and to ensure that the investigation moves forward with great care and speed.

Now, before I leave for Florida I would also like to comment on an issue of vital importance to our future -- how to strengthen the Medicare program for the 21st century.

Today, Senator Breaux and Representative Thomas will hold a final meeting of their Medicare Commission. Although it did not achieve consensus, the commission has helped to focus long overdue attention on the need to modernize and prepare the program for the retirement of the baby boom generation, and for the present stresses it faces. The commission has done valuable work, work that we can and must build on to craft Medicare reform.

Make no mistake, we must modernize and strengthen Medicare. For more than three decades, it has been more than a program. It has been a way to honor our parents and grandparents, to protect our families. It has been literally lifesaving for many, many seniors with whom I have personally talked.

In my 1993 economic plan that put our country on the path to fiscal responsibility, we took the first steps to strengthen Medicare. In 1997, in the bipartisan balanced budget agreement, we took even more significant actions to improve benefits, expand choices for recipients, to fight waste, fraud and abuse, and to lengthen the life of the trust fund.

But as the baby boomers retire, and medical science

extends the lives of millions, we must do more -- we must take some strong and perhaps difficult steps to modernize Medicare so that it can fully meet the needs of our country in the new century. If we don't act, it will run out of funds. That would represent a broken promise to generations of Americans, and we cannot allow it to happen.

As I said in January, we must act, and when we do our actions should be grounded in some firm principles. We must seize the opportunity created by our balanced budget and surplus to devote 15 percent of the surplus to strengthen the trust fund.

We must modernize Medicare and make it more competitive, adopting the best practices from the private sector and maintaining high quality services. We must ensure that it continues to provide every citizen with a guaranteed set of benefits. And we must make prescription drugs more accessible and affordable to Medicare beneficiaries.

The plan offered by Senator Breaux and his colleagues included some very strong elements, which should be seriously considered by Congress. However, I believe their approach falls short in several respects. First it would raise the age of eligibility for Medicare from 65 to 67, without a policy to guard against increasing numbers of uninsured Americans.

I know that back in 1983, the commission voted in Social Security and the Congress ratified a decision to slowly raise the Social Security age to 67. But there is a profound difference here. Perhaps the fastest growing number of uninsured people are those between the ages of 55 and 65. We cannot simply raise the age to 67 without knowing how we're going to provide for health insurance options for those who are already left out in the cold between the ages of 55 and 65. It is simply not the right thing to do.

Also, the proposal has the potential to increase premiums for those in the traditional Medicare program beyond the ordinary inflation premiums that keep the percentage paid by the beneficiaries the same. It does not provide for an adequate affordable prescription drug benefit.

But most important of all, it fails to make a solid commitment of 15 percent of the surplus to the Medicare trust fund. That is the biggest problem. Even if all the changes recommended by the commission were adopted, because of the projected inflation rates in health care costs, it would not be sufficient to stabilize the fund. Only by making this kind of commitment can we keep the program on firm financial ground well into the next century.

Every independent expert agrees that Medicare cannot

provide for the baby boom generation without substantial new revenues. Beyond that, it is clear the it will also require us to make difficult political and policy choices. Devoting 15 percent of the surplus to Medicare would stabilize the program -- and improve our ability to modernize and improve its services, and to make those hard choices.

I want to thank the members of the Medicare Commission for their hard work and for their recommendations. Today, I am instructing my advisors to draft a plan to strengthen Medicare for the 21st century, which I will present to this Congress. I look forward to a good and healthy debate about how best to strengthen this essential program. We must find agreement this year. Medicare is too important to let partisan politics stand in the way of vital progress. I believe if we make the hard choices, if we work together, if we act this year, we can secure Medicare into the future.

Thank you very much.

Q Mr. President, your critics are suggesting that by not endorsing the Breaux plan you're simply assuring that there will be a campaign issue, something the Democrats can run on.

THE PRESIDENT: I want an agreement this year. I have given my best assessment of where we are now, of what my

objections are. I think it is now incumbent upon me to present an alternative proposal, and I will do that.

But I want to make it clear that I believe we owe it to the American people to make an agreement this year, and I'm going to do my dead-level best to get it done.

Thank you.

END 4:19 P.M. EST

Paul D. Glastris
03/30/99 12:20:45 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: new final trustees speech

Final 3/30/99 12:20 p.m.
Paul Glastris

PRESIDENT WILLIAM J. CLINTON
REMARKS ON SOCIAL SECURITY AND MEDICARE
TRUSTEES REPORT
ROSE GARDEN, THE WHITE HOUSE
March 30, 1999

Twice in the last six years, Americans have looked to the future by addressing great fiscal challenges. In 1993, we met the threat of mounting deficits and a stagnant economy with an economic plan of fiscal discipline, expanded trade, and investment in our people. Thanks to that action, the red ink of the federal budget has turned to black, and we are enjoying the longest peacetime expansion in our nation's history. In 1997, we reaffirmed our commitment to fiscal discipline with a bipartisan balanced budget agreement that also took important steps to improve Medicare, saving tens of billions of dollars in costs while expanding choices and benefits for recipients.

Today, we have new evidence that those determined actions were the right ones. I have just been briefed by the four Social Security and Medicare trustees for the administration: Secretaries Rubin, Shalala, Herman and Social Security Commissioner Apfel. The trustees have issued their annual report on the future financial health of these vital programs.

The trustees report shows that the strength of our economy has led to modest but real improvements in the outlook for Social Security. They project that economic growth today will extend the solvency of the Social Security trust fund to 2034, two years longer than was projected in last year's report. After that date, however, the trust fund will be exhausted and Social Security will not be able to pay the full benefits older Americans have been promised. Therefore we must move forward with my plan to set aside 62 percent of the budget surplus for Social Security, investing a small portion in the private sector for a better return, just as any private or state government pension plan would. And as I said in my State of the Union address, we must go further, with difficult but achievable reforms that put Social Security on a sound footing for 75 years and beyond.

The trustees have also told us today that the financial future for Medicare has improved even more. The trustees project that the life of the Medicare Trust Fund has been extended until 2015 --7 years longer than projected in last year's report. These improvements are only partially due to the strong economy. According to the trustees, they are also the result of the difficult but necessary reforms we made to Medicare in 1997, and to our successful efforts to fight waste, fraud, and abuse in the Medicare program.

The Trustees report is good news. We should be pleased. We should be proud. But we should not be lulled into complacency, because the improvements we see today did not happen not by accident. When I became President six years ago, Medicare was projected to go bankrupt this year. We worked hard in 1993 and 1997 to make sure that didn't happen. These were not easy actions. In fact, at the time, some of them were politically unpopular. But they helped strengthen Medicare while paying down the debt and allowing us room to increase investment in our children. And they laid the foundations for the difficult reforms we must still make.

Social Security and Medicare still face serious, long-term challenges, with the baby boom aging, with medical science extending the lives of millions, and with the number of elderly Americans set to double by 2030. Even with today's good news, Social Security will run out of money in just 35 years; Medicare in just 16 years. We cannot allow that to happen.

For three decades, Medicare has protected seniors and the disabled while expressing the values of care and mutual obligation that bind families and generations of Americans together. In my State of the Union address in January, I said we must seize the opportunity created by our prosperity by devoting 15 percent of the budget surplus to strengthen Medicare, while modernizing the program with real reforms and helping seniors with prescription drugs. When the Medicare Commission completed its work two weeks ago, I said we must build on its work by adopting the best practices from the private sector while also maintaining high quality services, continuing to provide every citizen with a guaranteed set of benefits, and making prescription drugs more accessible and affordable to Medicare beneficiaries.

Now, we must build on the good news we have received today. We must extend the life of Medicare even further, modernize the program even more, and make prescription drugs more accessible and affordable.

Medicare cannot remain static in the face of sweeping changes in our nation's health care system--a system that increasingly relies on prescription drugs. Today, 13 million seniors each spend more than a thousand dollars a year out-of-pocket for prescription medications. At the same time, seniors who have no drug coverage do not benefit from the lower prices that insurance firms negotiate from pharmaceutical companies. The higher prices seniors pay are like a hidden tax. We must find a way though Medicare to inject more competition into the health care system, and make the medications seniors need more affordable.

Some might say this good news means we can delay reform. Nothing could be further from the truth. Strengthening and modernizing Medicare will requires tough but achievable changes. Now is the time to make those changes, when our economy is strong and our people have renewed confidence. Nothing in this report lessens the need to devote 15 percent of the surplus to strengthening Medicare, make tough but achievable reforms, and help beneficiaries with prescription drugs. If we wait--if we turn the good news of today or the hard work that lies ahead into excuses for inaction--then we will be condemning ourselves to future changes that will be much more costly and wrenching.

Today, we face a choice, a test of our wisdom as a self-governing people: will we seize this moment of prosperity and devote some of the surpluses we have created to strengthen Medicare for the future? Or will we rush into a tax cut that avoids our generation's responsibility and puts the future of Medicare at risk? This Trustees report brings welcome news, and a clear lesson: with tough, disciplined action we **can** extend the life of Social Security and Medicare. Now we must apply that lesson by acting this year to strengthen Social Security and Medicare for the 21st Century.

###

Message Sent To:

Melissa G. Green/OPD/EOP
Jeff B. Liebman/OPD/EOP
Devorah R. Adler/OPD/EOP
Joshua S. Gottheimer/WHO/EOP
Loretta M. Ucelli/WHO/EOP
Tracy Pakulniewicz/WHO/EOP

April 30, 1999

Health Division

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to:	Dan Mendelson	**ACTION:**	**Needed By:**
Through:	Barry Clendenin BC 5/3 Mark Miller	Decision_____ Signature_____ Comment_____ As requested___ Information XX	Date:___/___/___ Time:___:___am/pm **Copies to**: HD/HFB chrons.; Medicare exs, Dick Emery, Ellen Balis, Jack Smalligan, Chris Jennings, Gina Mooers
Subject:	HI Trust Fund Report for March 1999		
From:	Bob Donnelly BD	Phone: 202/395-7844 Fax: 202/395-7840 Room: NEOB #7002	Post this Document on HD Intranet? NO

The attached charts display data from the Monthly Treasury Statement on outlays, revenue, and change-in-balance of the Hospital Insurance (HI) Trust Fund. The charts include March 1999 data which were released recently in the Monthly Treasury Statement for March.

Spending Up from Last March

Outlays from the Trust Fund in March were up about $1.6 billion relative to March, 1998. This is only the second month in FY 1999 that spending was higher than for the same month in FY 1998. Through the first six months of the fiscal year, outlays are still about $3.4 billion below last year (revenues are about what we would expect), whereas the FY 2000 Budget assumes Medicare *growth* of about 5.7% in 1999.

What is Going On?

The lower outlays in HI are coupled with SMI spending that is up by about $1 billion in the first six months of FY 1999 vs. the previous year. Thus, total Medicare spending is about $2.4 billion below the first six months of FY 1998. While this appears to be a large drop-off, note that as of the end of February total Medicare spending was running about $6 billion below last year. So, while we are still below FY 1998 the spending appears to be accelerating and may still show growth in FY 1999. The slowdown in overall Medicare spending appears to be driven by the following factors:

1. Slowdown in home health billing. There is some indication that home health agencies have delayed billing Medicare as they adapt to the new home health interim payment system. HCFA's actuaries expect that these bills will eventually arrive, and so this part of the reduced spending is not real – the baseline will catch up.

2. Lower inpatient case-mix. There is speculation that hospitals have responded to increased fraud

and abuse oversight by taking a more conservative approach in reporting the severity of the cases they treat. Since the cases are being reported as less serious than in previous years, Medicare's payments are reduced. If this is in fact driving part of the slowdown, it is not clear whether this trend will endure.

3. Home health shift. The BBA shifted funding for certain home health services from Part A to Part B. This effect will not reduce total Medicare spending (it just moves spending from one part of the program to another), but it will affect the growth of spending in each Trust Fund.

Performance Summary for March

HI outlays (summarized in Tables 1A and 1B) were 15 percent higher than the same time last year at $12,126 million. Revenues (summarized in Tables 2A and 2B) were 13 percent higher than the same time last year at $11,416 million. The combination of outlays and revenues yielded a shortfall in March of $710 million, compared to a shortfall of $448 million a year ago. Tables 3A and 3B illustrate this trend.

At the end of March 1999, the Trust Fund's balance was $124,181 million, compared to a balance of $116,904 million at this same time last year. Tables 4A and 4B illustrate the historical trend of the Trust Fund's balance.

Table 1A -- Gross HI Outlays: March 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Outlays	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126							64,807
FY 1998	13,033	9,005	13,515	10,800	11,211	10,563	12,166	10,718	11,068	14,578	9,392	11,259	137,298
FY 1997	11,377	11,517	10,972	11,583	11,281	10,448	12,017	13,222	9,977	12,476	12,769	9,916	137,884
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98	(838)	444	(1,186)	(2,208)	(1,095)	1,563							
% Difference	-7%	4%	-11%	-19%	-10%	15%							

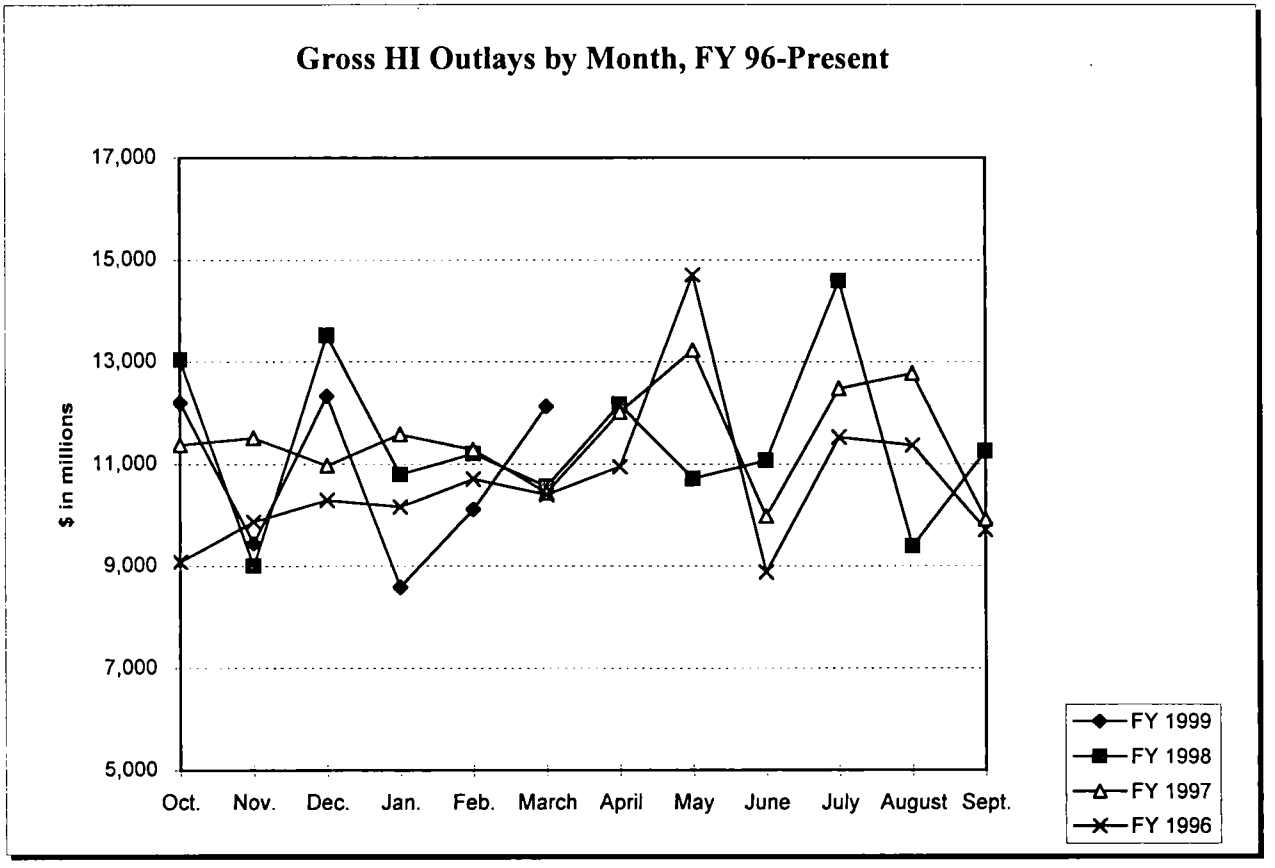


Table 1B -- Gross HI Outlays: March 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126							64,807
FY 1998	13,033	9,005	13,515	10,800	11,211	10,563	12,166	10,718	11,068	14,578	9,392	11,259	137,298
FY 1997	11,377	11,517	10,972	11,583	11,281	10,448	12,017	13,222	9,977	12,476	12,769	9,916	137,555
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98 Cumulative Difference	(838)	(394)	(1,580)	(3,788)	(4,883)	(3,320)							
Cumulative % Difference	-6%	-1.8%	-4.4%	-8.2%	-8.5%	-4.9%							

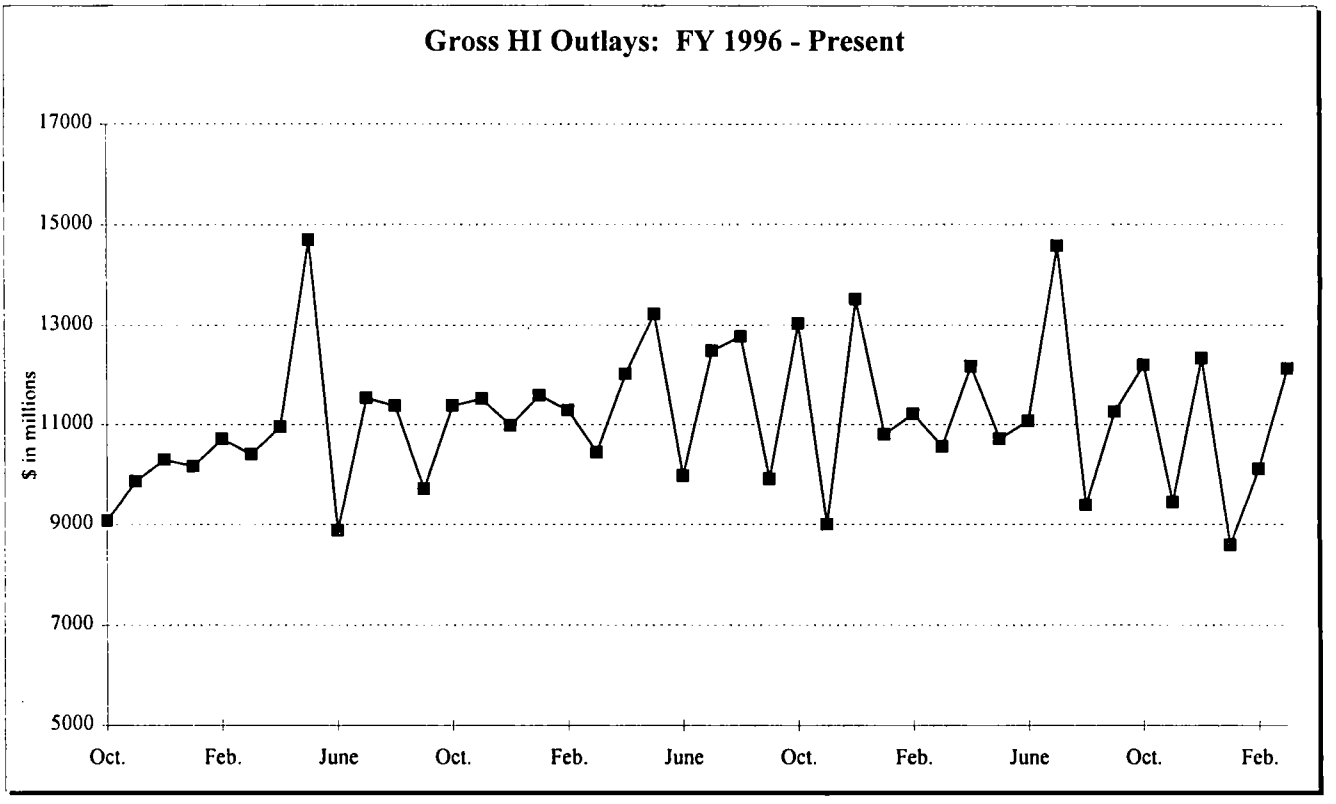


Table 2A -- HI Revenues: March 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Revenues	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416							72,097
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,548
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98	641	793	910	1,355	471	1,301							
% Difference	7%	8%	6%	11%	5%	13%							

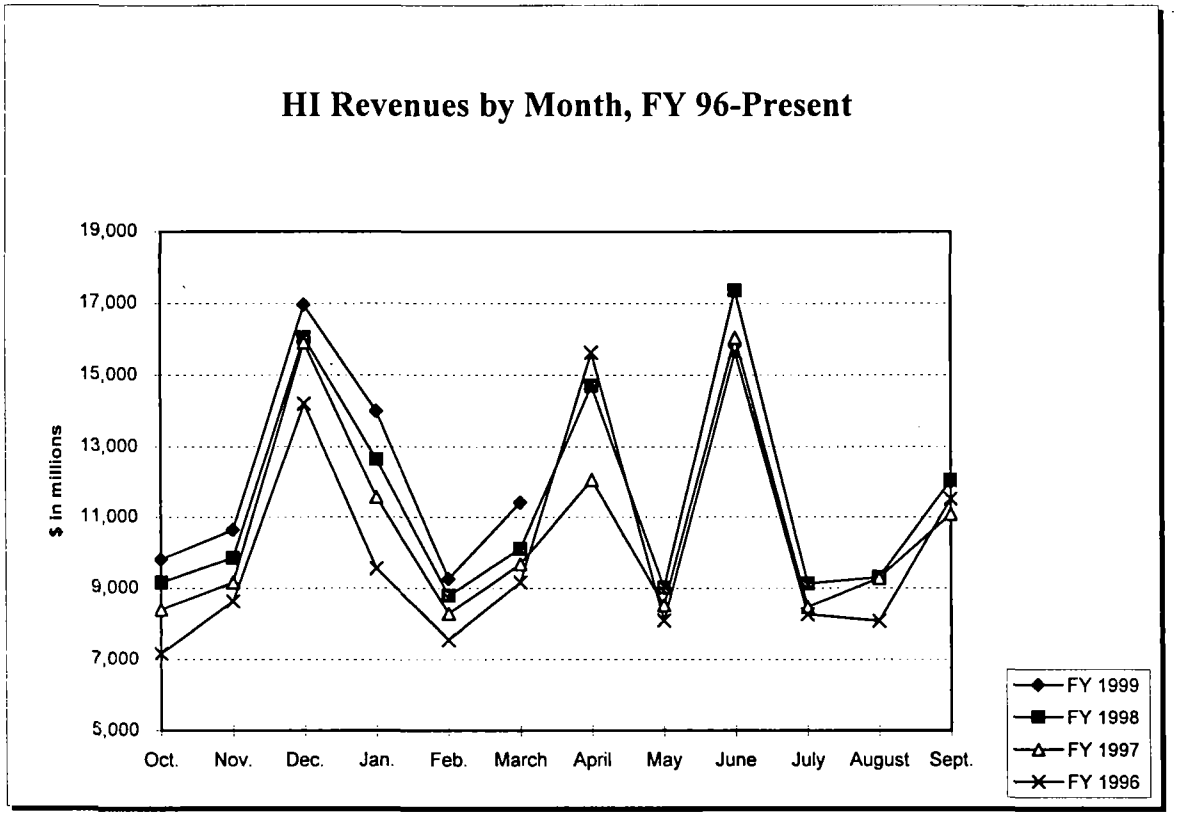


Table 2B -- HI Revenues: March 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416							72,097
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,502
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98 Cumulative Difference	641	1,434	2,344	3,699	4,170	5,471							
Cumulative % Difference	7%	7.5%	6.7%	7.8%	7.4%	8.2%							

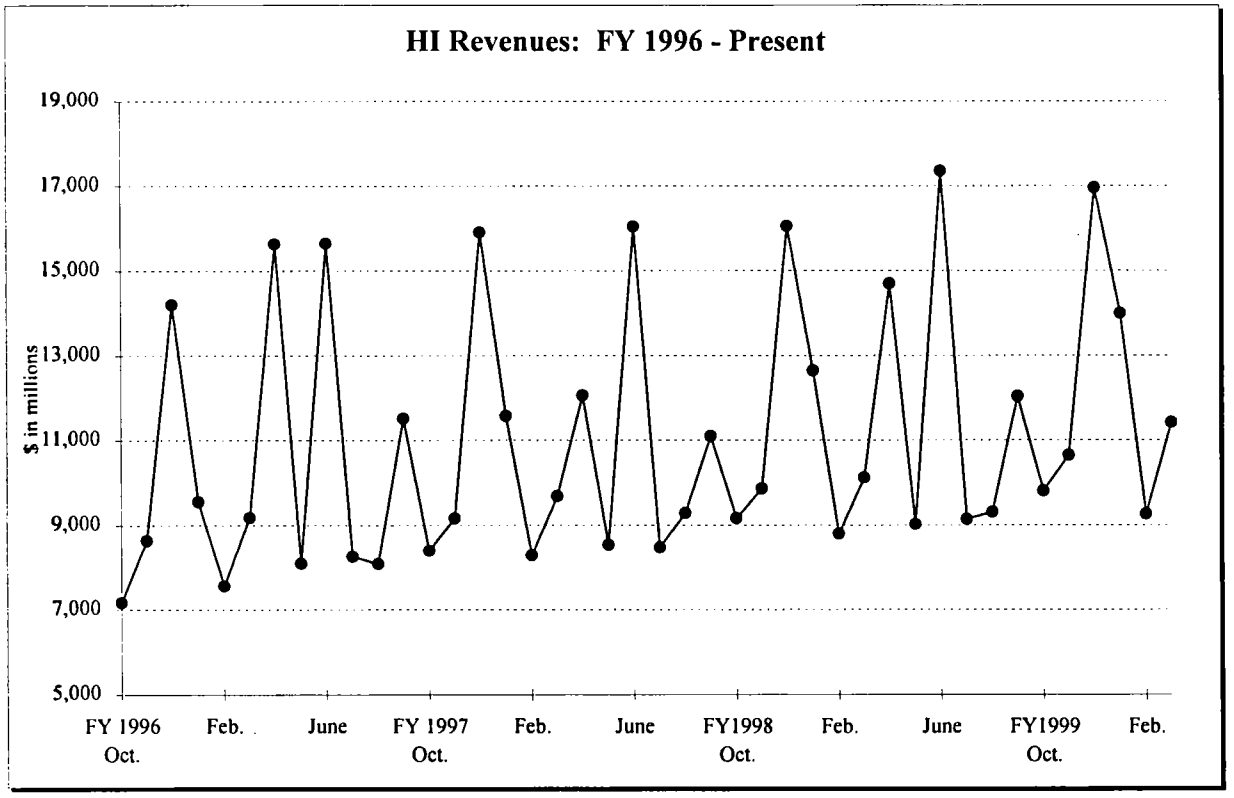


Table 3A -- Surplus (Shortfall) in HI Trust Fund: March 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Change	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)							7,290
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98	1,479	349	2,096	3,563	883	(262)							
% Difference	-38%	41%	83%	193%	-51%	58%							

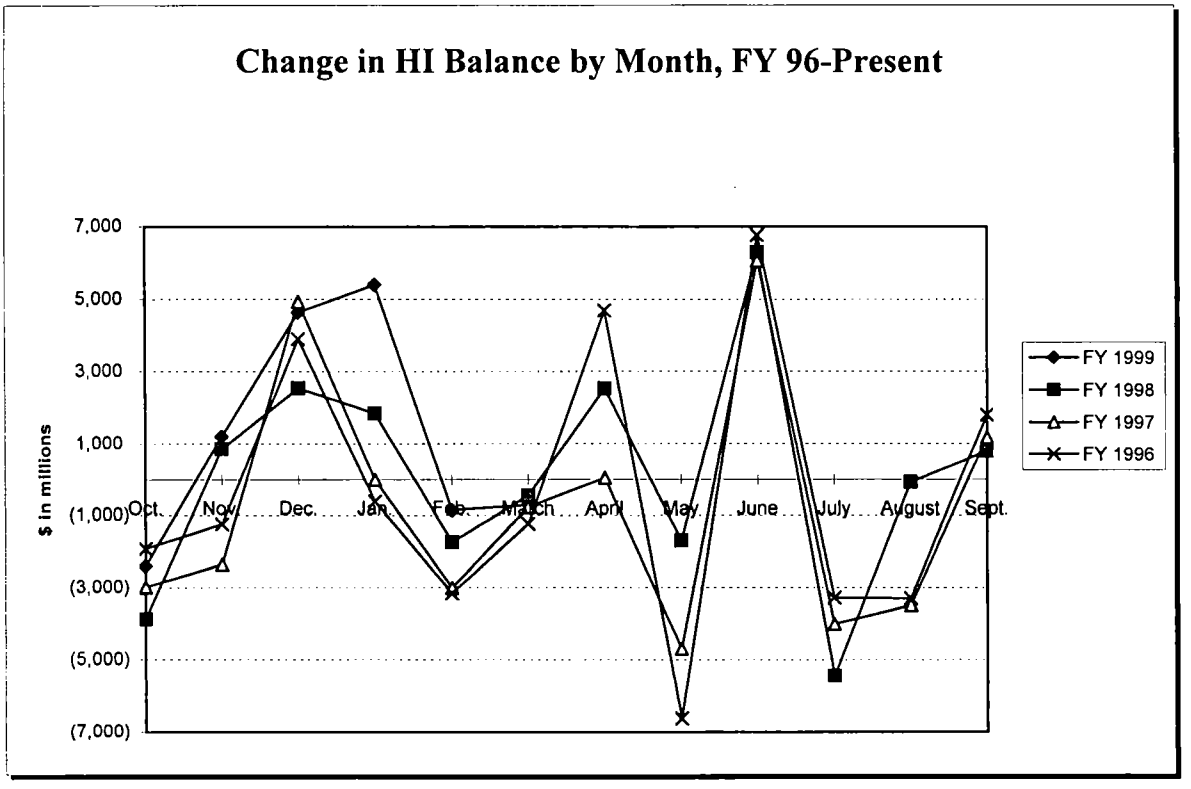


Table 3B -- Surplus (Shortfall) in HI Trust Fund: March 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)							7,290
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98 Cumulative Difference	1,479	1,828	3,924	7,487	8,370	8,108							
Cumulative % Difference	-38%	-61%	-821%	549%	-2262%	-991%							

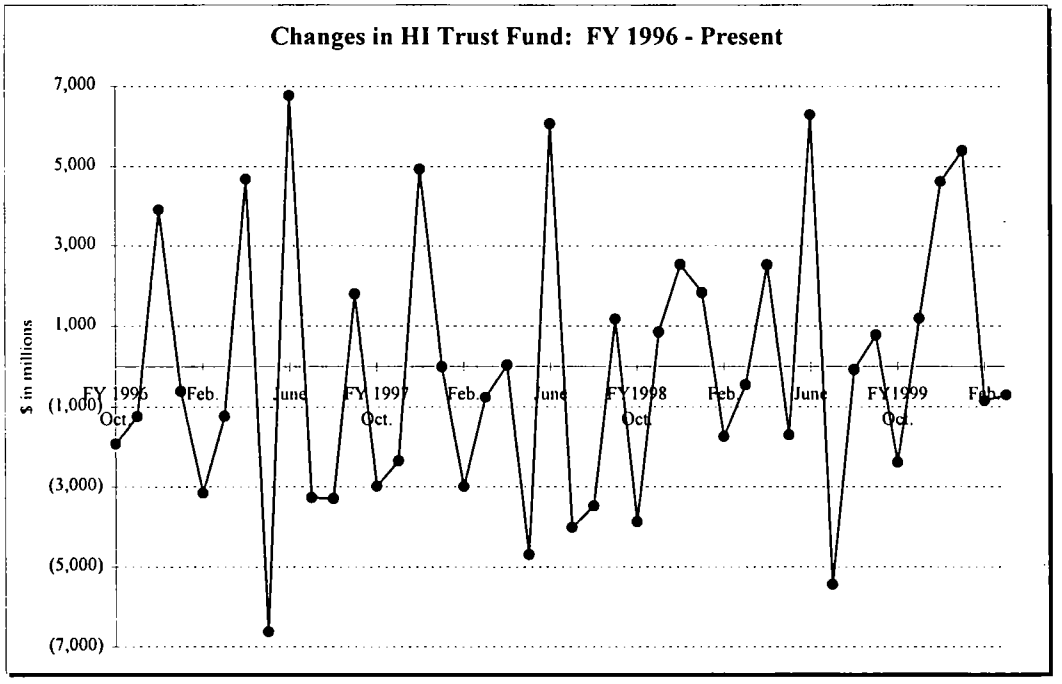


Table 4A -- HI Trust Fund Balance: March 1999 Report
Comparison of FY 1999 Monthly Balance to Previous Years
($ in millions)

Actual Change	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Average
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181							121,644
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,890
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610
FY 99 - FY 98	2,360	3,722	4,298	8,917	8,867	7,277							
% Difference	2%	3%	4%	8%	8%	6%							

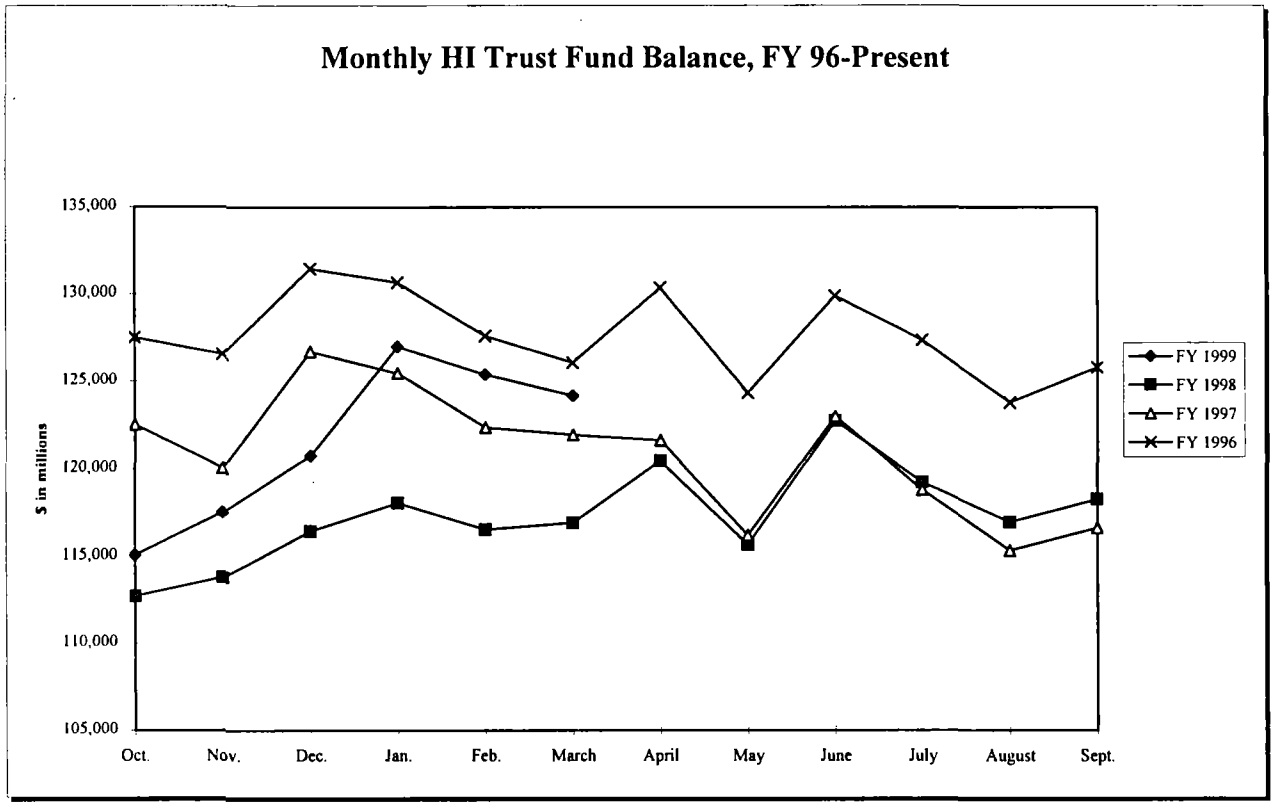
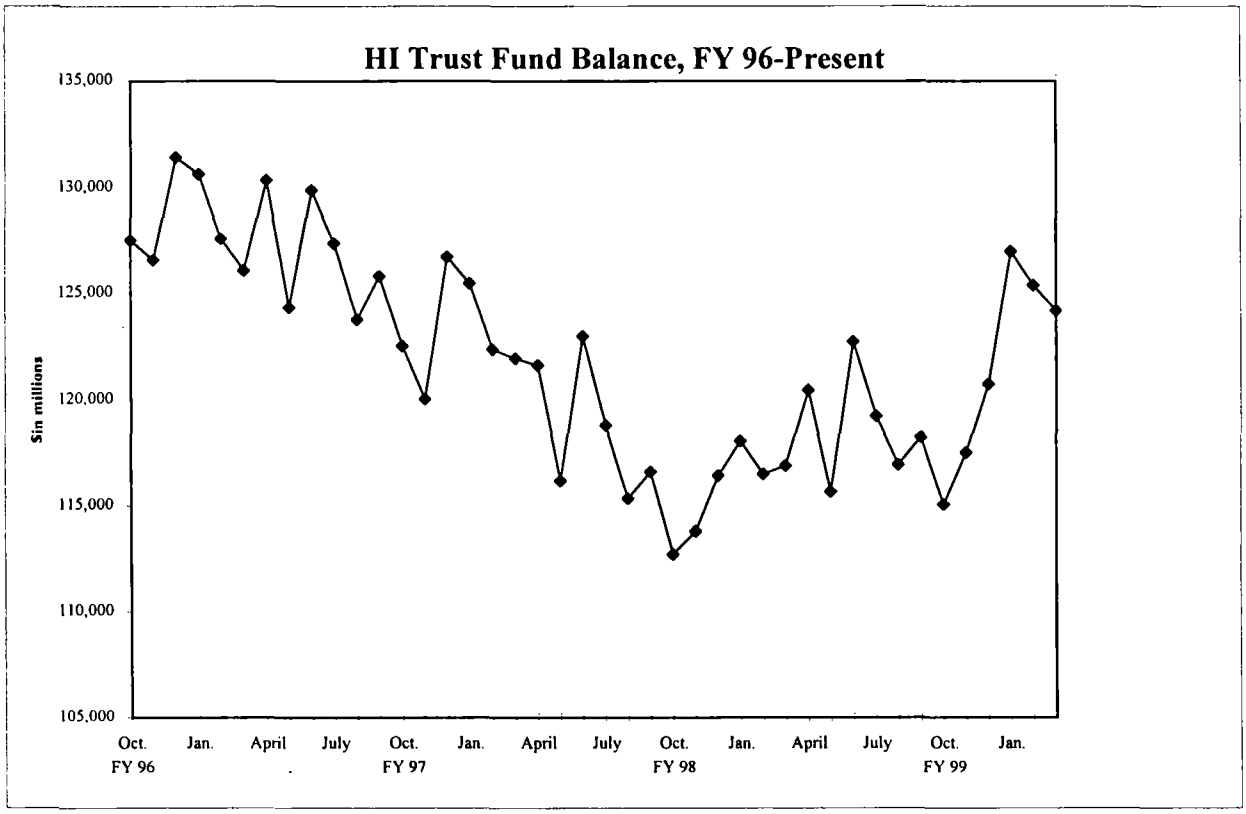


Table 4B -- HI Trust Fund Balance: March 1999 Report
Long-Term Comparison of FY 1999 Balance to Previous Years
($ in millions)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Average
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181							121,644
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,890
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610



Office of Legislation

HCFA
MEDICARE • MEDICAID

Number of Pages:_____ Date: 5/5/99

To:	From:
Mark Miller Chris Jennings Joanne Lamberton Mark McClellan Dan Mendelson	Bonnie Washington
Fax: _____	Fax: _____
Phone: _____	Phone: _____

REMARKS:_____

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

FAX

To:	**Barbara Washington**
Fax Phone:	**202-690-8168**
From:	**Gregory Savord, FSA, MAAA, Health Care Financing Administration**
Voice Phone:	**410-786-1521**
Subject:	**Medicare Impact of Kennedy Bill**
Pages:	**Cover + 2**

---

715 fax
to Mark Miller
Chris Jennings
Jeanne Lambrew
Mark McClellan
Treasury
Dan Mendelson Jonathan
+ Make 6 copies

Kennedya Model run 04/22/1999 05/05/1999 13:33

$200 Deductible (constant)
$0 Copayment per script
20% Coinsurance rate (2000)
$3,000 OOP Max
$1,200 Maximum benefit (2000)
RXINDEX Update index
25% Premium Rate (aged)
1.3 Under-reporting factor

KENNEDY RX LEGISLATION (Benefits and premiums start 7/1/2000.) — SLBMs and QI-1s Medicaid covered for premiums and cost sharing (up to 135% of poverty)

Medicare Cash Outlays

Fiscal Year	Total Cost	FFS Cost	M+C Cost	Medicare Premiums ($ millions)	Net Medicare Impact
2000	$2,342	$1,744	$597	$1,734	$608
2001	$29,161	$21,541	$7,620	$7,220	$21,942
2002	$31,636	$23,228	$8,408	$7,880	$23,756
2003	$34,984	$25,487	$9,497	$8,732	$26,252
2004	$38,884	$28,036	$10,849	$9,697	$29,188
2005	$43,295	$30,937	$12,358	$10,772	$32,523
2006	$48,123	$34,154	$13,969	$11,952	$36,170
2007	$53,488	$37,776	$15,712	$13,241	$40,247
2008	$59,435	$41,842	$17,593	$14,688	$44,747
2009	$66,197	$46,449	$19,747	$16,322	$49,874
2010	$74,320	$51,893	$22,427	$18,230	$56,090
2000-2004	$137,007	$100,036	$36,971	$35,262	$101,745
2005-2009	$270,537	$191,158	$79,379	$66,976	$203,561
2000-2009	$407,545	$291,194	$116,350	$102,238	$305,306
2001-2005	$177,961	$129,229	$48,732	$44,301	$133,661
2006-2010	$301,562	$212,114	$89,449	$74,434	$227,128
2001-2010	$479,523	$341,343	$138,180	$118,735	$360,789

Medicare Cash Outlays

Calendar Year	Total Cost	FFS Cost	M+C Cost	Medicare Premiums ($ millions)	Net Medicare Impact
2000	$9,366	$6,977	$2,389	$3,476	$5,890
2001	$29,515	$21,745	$7,770	$7,309	$22,207
2002	$32,343	$23,723	$8,621	$8,074	$24,269
2003	$35,864	$26,075	$9,789	$8,956	$26,909
2004	$39,891	$28,689	$11,202	$9,947	$29,944
2005	$44,430	$31,686	$12,743	$11,052	$33,377
2006	$49,353	$34,976	$14,377	$12,260	$37,094
2007	$54,866	$38,709	$16,157	$13,582	$41,284
2008	$60,958	$42,886	$18,072	$15,066	$45,891
2009	$67,943	$47,637	$20,306	$16,743	$51,200
2010	$76,446	$53,311	$23,135	$18,729	$57,717
2000-2004	$146,980	$107,209	$39,772	$37,762	$109,219
2005-2009	$277,550	$195,895	$81,655	$68,703	$208,847
2000-2009	$424,530	$303,104	$121,427	$106,465	$318,065
2001-2005	$182,044	$131,918	$50,126	$45,338	$136,706
2006-2010	$309,566	$217,520	$92,046	$76,380	$233,186
2001-2010	$491,610	$349,438	$142,172	$121,718	$369,893

Kennedya Model run 04/22/1999 05/05/1999 9:46

$200 Deductible (constant)
$0 Copayment per script
20% Coinsurance rate (2000)
3000 OOP Max
$1,200 Maximum benefit (2000)
RXINDEX Update index
25% Premium Rate (aged)
1.3 Under-reporting factor

KENNEDY RX LEGISLATION (Benefits and premiums start 7/1/2000.) — SLBMs and QI-1s Medicaid covered for premiums and cost sharing (up to 135% of poverty)

Medicare Incurred Outlays

Calendar Year	Total Cost	FFS Cost	M+C Cost	Medicare Premiums	Net Medicare Impact	Monthly Premium Rate	Maximum Benefit	Coinsurance Rate
			($ Millions)					
2000	$14,049	$10,465	$3,584	$3,476	$10,573	$15.55	$1,200	0.20
2001	$29,799	$21,908	$7,891	$7,309	$22,490	$16.19	$1,320	0.20
2002	$32,852	$24,086	$8,767	$8,074	$24,778	$17.72	$1,448	0.20
2003	$36,467	$26,473	$9,994	$8,956	$27,511	$19.44	$1,592	0.20
2004	$40,576	$29,132	$11,444	$9,947	$30,629	$21.33	$1,752	0.20
2005	$45,201	$32,197	$13,003	$11,052	$34,148	$23.40	$1,928	0.20
2006	$50,184	$35,532	$14,652	$12,260	$37,924	$25.59	$2,112	0.20
2007	$55,803	$39,344	$16,458	$13,582	$42,221	$27.88	$2,304	0.20
2008	$61,989	$43,595	$18,394	$15,066	$46,923	$30.33	$2,512	0.20
2009	$69,133	$48,446	$20,688	$16,743	$52,390	$33.05	$2,744	0.20
2010	$77,908	$54,284	$23,624	$18,729	$59,180	$36.31	$3,024	0.20
2000-2004	$153,743	$112,064	$41,679	$37,762	$115,981			
2005-2009	$282,310	$199,114	$83,196	$68,703	$213,606			
2000-2009	$436,053	$311,178	$124,875	$106,465	$329,588			
2001-2005	$184,894	$133,796	$51,098	$45,338	$139,557			
2006-2010	$315,018	$221,201	$93,817	$76,380	$238,638			
2001-2010	$499,912	$354,997	$144,915	$121,718	$378,194			

Medicare – Premium Support

Voters are supportive of a premium support proposal to reform Medicare. They do not believe that by itself such a change would be all that is necessary to reform Medicare, and they believe that its benefits are overstated.

However, there is a role for premium support (which seriously needs to be renamed to something more understandable). The proposal has support, but the other questions show that its benefits should not be overstated. Such a change merely keeps Medicare current.

The numbers show that current seniors want nothing to do with HMOs now that they already have fee for service, but younger voters, who are growing up on HMOs and health insurance, are very open to the change.

Premium Support

65/23% support/oppose a premium support system for Medicare, given that one component of a Medicare reform plan is a premium support system. Private plans would be allowed to compete with one another and with the government to provide Medicare services. Recipients could choose between buying into private plans or participating in the traditional government fee for service plans, and the government would pay a percentage of the premium.

65% support (**21%** strongly + **44%** somewhat)
23% oppose (**13%** strongly + **10%** somewhat)

D	R	I
78/12	*61/29*	*61/25*
<35	***35-64***	***65+***
80/13	*69/21*	*34/38*

41% agree that a premium support system will encourage efficiency in health care plans and save money, while **47%** agree that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare.

D	R	I
43/39	*30/60*	*45/47*
<35	***35-64***	***65+***
55/32	*45/50*	*13/58*

36% say that under a premium support system, the market will do a better job than the government in controlling costs and maintaining benefits, while **40%** agree that the savings under a premium support plan are overstated, and that such a plan would not do enough to fix Medicare.

D	R	I
33/38	*45/35*	*36/46*
<35	***35-64***	*65+*
44/37	*39/34*	*21/68*

34% say that a premium support plan would improve Medicare, since it is modeled after the Federal Employee Health Benefits Program, the same plan that members of Congress are covered under, while **40%** say that it would not ensure access to adequate health care benefits for seniors regardless of their income, health, or location.

D	R	I
33/38	*31/44*	*38/39*
<35	***35-64***	*65+*
42/37	*36/38*	*20/51*

41% believe that a premium support plan would reduce the costs of health care by encouraging efficiency and competition among plans, while **42%** say that it has the potential to increase premiums for those in the traditional Medicare program.

D	R	I
45/41	*36/50*	*44/40*
<35	***35-64***	*65+*
50/40	*42/42*	*26/45*

Prescription Drugs

The two options we tested did not test well.

People do not want any plan that is just for catastrophic care. They also do not want a plan that runs out at $2000.

This points to a plan somewhere in the middle – focusing on a lower premium and a lower percentage contribution and a higher limit – i.e. $25/month, 50%,$5000 limit.

87% think that a plan to cover prescription drugs should be a part of any plan to reform Medicare, **9%** not.

D	R	I
95/1	84/13	84/11
<35	35-64	65+
90/8	91/6	73/17

33% think that a plan for prescription drugs should cover just seniors with lower incomes, **64%** all seniors.

D	R	I
36/62	25/73	35/60
<35	35-64	65+
23/70	35/63	35/61

46% think that the price that seniors contribution for prescription drugs should be the same for all seniors, **49%** think higher income seniors should pay more and lower income seniors pay less.

	D	R	I	
	49/47	49/45	39/56	
<35	35-64	65+	<35K	>35K
49/49	42/53	59/28	50/42	45/51

40% think that the costs of all prescription drugs could be covered under Medicare, **52%** think limits are necessary to keep costs manageable.

	D	R	I	
	50/47	27/68	43/45	
<35	**35-64**	65+	<35K	>35K
40/52	43/51	29/64	36/55	44/50

69% think that any new prescription drug benefits should be structured primarily to handle seniors' everyday medication needs, 23% to cover only their extraordinary needs for medication.

D	R	I
80/18	66/27	65/24
<35	**35-64**	65+
64/25	76/17	55/45

40% would be willing to pay a higher premium if that meant they got a lower deductible and copayment, **43%** would rather have a lower premium, recognizing that it would increase the deductibles and copayments.

	D	R	I	
	42/41	37/49	41/42	
<35	**35-64**	65+	<35K	>35K
57/36	34/49	28/37	39/38	42/48

This plan requires nearly $1000 in drug expenses before it pays any benefit. Reception was lukewarm; seniors rejected it outright.

52%/39% support/oppose the following plan: One plan that has been proposed for prescription drug coverage for Medicare is a voluntary plan that would cost seniors $40 per month. It would have a $500 deductible, and would cover 75% of drug costs after the deductible was met with **no limit**.

52% support (**19%** strongly + **33%** somewhat)
39% oppose (**17%** strongly + **22%** somewhat)

	D	R	I	
	64/33	47/47	50/36	
<35	**35-64**	65+	<35K	>35K
64/26	53/40	**30/61**	34/46	59/37

But enthusiasm drops quickly:

43% agree that this plan would provide peace of mind for older Americans fearful of becoming a financial burden to their families since it would provide prescription drug coverage for the sickest beneficiaries who really needed it, while **41%** agree that because of the large deductible, almost half of the beneficiaries would receive no benefit in return for their investment, and that this plan doesn't do enough.

D	R	I
50/35	*39/48*	*42/41*
<35	***35-64***	*65+*
48/41	*41/43*	*29/46*

44% agree that this plan would be a great deal for seniors, and is cheaper and provides a greater benefit than any private plan, while **40%** agree that it would merely be a costly big government approach to dealing with health care problems. Which is closer to your view.

D	R	I
55/42	*27/57*	*43/31*
<35	***35-64***	*65+*
49/42	*41/41*	*39/44*

But although they did not want a catastrophic only plan, a $2000 limit plan did not even get a majority.

46%/40% support/oppose another plan that would also be voluntary with a premium of $40 per month, would have no deductible, cover 75% of drug costs, and have a $2000 limit on the benefit.

D	R	I
53/37	*51/43*	*41/41*
<35	***35-64***	*65+*
64/31	*44/45*	*37/45*

39% agree with supporters that this plan provides a simple, sizeable benefit to any beneficiaries with drug costs, while **61%** agree with opponents that this plan would not help those with major illnesses and high drug costs, giving them little help when they need it the most.

D	R	I
36/64	*37/63*	*45/55*
<35	***35-64***	*65+*
37/63	*41/59*	*33/67*

34% agree that this plan would be a great deal for seniors, and is cheaper and provides a greater benefit than any private plan, while **47%** agree that it would merely be a costly big government approach to dealing with health care problems.

D	R	I
27/51	*37/59*	*40/32*
<35	***35-64***	***65+***
55/39	*31/52*	*20/59*

Of these two plans, the first one is the favorite, but neither is as good as we typically devise:

68% prefer the $500 deductible plan that would cover all of the costs after the deductible was met, **32%** the no deductible plan that would have a $2000 limit on the benefit.

D	R	I
71/29	*66/34*	*68/32*
<35	***35-64***	***65+***
76/24	*68/32*	*63/37*

Penn, Schoen and Berland
Medicare Polling 3/29/99

47% think President Clinton has a plan to save Medicare, **29%** not.
(3/14: 56/37)

D	R	I
67/14	40/34	35/43

33% think Republicans in Congress have a plan to save Medicare, **50%** not.
(3/14: 35/55)

D	R	I
23/68	53/24	32/51

Reform

Medicare requires more than money:

33% think Medicare should be strengthened, **62%** reformed.

D	R	I
46/54	30/59	22/75

80% think Medicare should be reformed now, **13%** not.

D	R	I
81/17	76/11	88/8

25%/72% heard/did not hear anything about the Bipartisan Commission on Medicare announcing that it had failed to reach agreement on a Medicare reform proposal.

D	R	I
19/76	26/68	32/68

Few know about this, so responsibility falls along partisan lines

22% blame President Clinton for the failure of the commission to reach agreement, **37%** Republicans in Congress.

D	R	I
1/63	46/10	27/32

Given that the bipartisan commission on Medicare introduced a plan that would extend the life of Medicare by increasing the eligibility age for Medicare from 65 to 67, introduce private competition into Medicare to improve quality, provide a prescription drug benefit for low income seniors and base premiums on income, **58%/32%** support/oppose this plan.

58% support (**23%** strongly, **35%** somewhat)
32% oppose (**12%** strongly, **20%** somewhat)

D	R	I
55/34	56/29	63/33

President Clinton calls for setting aside 15% of the budget surplus, about $700 billion, to extend the life of Medicare, **74%/18%** support/oppose this plan.

74% support (**41%** strongly, **33%** somewhat)
18% oppose (**7%** strongly, **11%** somewhat)

D	R	I
89/6	57/29	71/24

19% think that President Clinton's proposal to put 15% of the surplus towards Medicare to extend the life of Medicare is an adequate plan, **63%** think President Clinton needs to introduce a more broad based Medicare reform plan now.

D	R	I
20/67	22/55	20/65

33% agree with Republicans in Congress that President Clinton is simply throwing money at the problem, and that real reform is needed, and **47%** agree with President Clinton that his plan will extend the life of the program, and that we must work together to secure the future of Medicare.

D	R	I
15/71	57/20	39/41

President Clinton has said we must build on the findings of the Medicare commission and continue to work together to find an adequate reform plan that ensures that all seniors continue to receive Medicare services, and that he says while we are working on a plan we must dedicate 15% of the projected budget surpluses towards Medicare to extend its life, **60%/28%** are more/less favorable towards the President Clinton.

60% more favorable (**23%** much, **37%** somewhat)
28% less favorable (**20%** much, **8%** somewhat)

D	R	I
83/15	29/53	59/26

59% think that any Medicare reform plan should include putting 15% of the surplus to Medicare to extend its life, **26%** think that is not necessary.

D	R	I
59/27	62/23	65/31

71% think that President Clinton should only accept a reform plan that includes putting 15% of the surplus to Medicare, **29%** think he should accept a plan that does not.

D	R	I
70/30	54/46	78/22

Components of the plan

Would you support or oppose a plan that...	All	D	R	I
A premium support plan that introduces more competition to Medicare by enabling seniors to choose between HMO's and traditional Medicare	70/19	73/25	70/15	74/13
Scales the amount seniors pay for their Medicare premium based on their income.	69/22	76/18	52/35	76/17
Provides a limited prescription drug benefit for those 35% above the poverty line.	65/25	74/21	62/25	61/27
Raises the eligibility age for Medicare from 65 to 67	31/**61**	24/70	45/43	30/62

Prescription Drug Benefit

60% think any reform plan should contain a prescription drug benefit for all recipients, **31% a prescription drug benefit for only low income seniors.**

D	R	I
69/27	54/33	56/36

32% think it would be better to accept a reform plan that contains a prescription drug benefit for only low income seniors now, **59%** think we work to reach a reform plan that gives all seniors a prescription drug benefit.

D	R	I
31/65	28/56	38/57

Competition - Premium Support

Given the arguments against premium support as introduced by the commission (does not guarantee coverage, does not ensure quality of care regardless of income, location and other factors, would increase costs for traditional programs), there is plenty of room to introduce our own plan with a similar policy concept without these shortfalls.

If the language is choice and competition, voters support it. But they don't want to be pushed into HMOs.

50%/36% support/oppose saving money for the program by promoting competition between health plans and encouraging seniors to enroll in HMOs.

D	R	I
39/45	50/47	56/25

NBC/WSJ Mar 4-7 1999

There is a proposal in Congress to change Medicare so that seniors would receive vouchers with which they could purchase private health insurance, instead of receiving insurance directly from the government as they do now. Supporters say that this plan will give seniors more choices in health care coverage and reduce costs. Opponents say that vouchers will not pay for the coverage Medicare now provides, so that seniors will have to pay more or receive less coverage under this plan.

Favor Medicare voucher plan	34%
Oppose Medicare voucher plan	52

48% believe that private competition should be introduced to give seniors the advantage of choosing the plan that suits them from among private HMO and government plans, and that it would be more cost effective, and **39%** believe that the new program would hurt seniors because traditional government fee-for-service plan premiums would rise 10-20%, and would be particularly harmful for rural beneficiaries who have no access to these plans.

D	R	I
42/41	*58/33*	*43/44*

(Kaiser/Harvard/PSRA, 8/14-9/20/98)

The HMO factor

Encouraging more seniors receiving Medicare to enroll in privately-run HMOs/managed care plans

> 38% say this would be a good thing for seniors, because many HMOs provide more generous benefits at a lower cost
>
> 56% say this would be a bad thing for seniors, because they might not be able to continue using their regular doctors and would need permission to see specialists and get certain medical procedures

Safeguards

73% think additional safeguards to ensure that seniors are receiving quality care regardless of income, health status or location should be included in a plan that increases competition among Medicare providers, **19%** think such safeguards are not necessary.

D	R	I
80/14	*63/26*	*76/20*

77%/9% support/oppose a reform plan that included safeguards so even with increased competition, certain qualities of care are guaranteed regardless of income, health status or location.

Income based premium

Premium at $24,000
41%/49 support/oppose an income related premium, under which individuals would pay
more for their Medicare premium as their income rose. In this plan, recipients with
income of $24,000 per year and higher would be subject to additional premiums.

Premium at $50,000
59%/35% support/oppose a plan with an income related premium that increased the
cost of Medicare premiums for those earning $50,000 per year or more.

Premium at $90,000
63%/30% support/oppose a plan that included an income related premium that increased the cost of Medicare premiums for those earning $90,000 per year or more.

Making sure all Americans have healthcare coverage	35	55	69	41	54
Improving the quality of healthcare Americans receive	31	57	51	66	56
Helping Americans afford long term care for themselves or an elderly parent	17	43	50	33	42
Covering prescription drugs in Medicare	8	25	17	29	30
Increasing the level of medical research	3	12	9	16	12

DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield
Assistant Secretary for Public Affairs
Phone: (202)690-7850 **Fax: (202)690-5673**

To: Chris Jennings
DPC

Fax: 456-5557 Phone: 456-5510

Date: 5/21 Total number of pages sent: 9

Comments:

this is draft #1 of NPC speech - DES has not seen yet - being faxed to her in Geneva.

M

200 Independence Avenue, S.W., Bldg. HHH, Room 647-D, Washington, D.C. 20201

5/21 draft

DRAFT

Thank you for that welcome.

A long time ago, I read a quote from Irving Berlin that the toughest thing about success is that you've got to keep on being a success.

I was thinking about that the other day, because when the subject is Medicare, we know we're not just talking about one more government program -- but one of America's longest-running success stories.

Let me share a few numbers with you.

Since Medicare was first enacted in 1965, the average life expectancy of senior citizens has grown by three years.

Access to care has increased by one third . . . while poverty among the elderly has dropped by nearly two-thirds.

Before Medicare, more than half of all older Americans were uninsured at the very point in their lives when their need for health care was the greatest. Now 100 percent are protected.

But if you really want to understand Medicare's success – and what that success means to America -- you can't just look at the numbers. You also have to listen to Americans like Anne Smilnak.

Now, Anne hasn't figured very prominently in the discussion about Medicare. But maybe she should.

Not because she's a major player on Capitol Hill. She isn't.

And not because she's written some new book on health care policy. She hasn't.

Anne is a 90 year-old widow living in Cleveland, Ohio. She was a homemaker who, together with her husband George, raised three children. But Anne lives alone now. In many ways, she's what Medicare is really all about.

You see, like most people her age, Anne has her share of health problems. Two of them are cataracts and glaucoma.

In fact, over the last few years she's needed surgery for both.

When asked where she'd be without her Medicare, Anne didn't need to think twice.

"When I saw the bill for my glaucoma surgery, I was frightened," Anne said, "but then my son told me that the Medicare would pay for most of it. If it wasn't for Medicare," she added, "I know I couldn't afford to pay the bills and keep living in my own home."

And she's not alone.

There's Lorraine Melton, a 75 year-old from Bradenton, Florida. Two years ago, she was in a car accident. Three broken ribs, a broken knee cap, and a broken leg.

She needed three operations -- and home health care during her convalescence. Thanks to Medicare, she was able to have it and today she's fully recovered.

And there's Jack Mertz, 74 years old, from Valley Stream, New York. Medicare helps pay for the treatment he's receiving for prostate cancer -- and that's allowed him to continue to lead an active life.

And the list goes on.

39 million ordinary Americans living healthier, longer lives thanks to an extraordinary idea called Medicare.

It began as one of the most ambitious initiatives this government has ever attempted, but it worked because it was grounded in three simple principles.

The first was the principle that the health care needs of older Americans are best met through a system of insurance: a system that spreads risks fairly and protects the rights of patients to choose their own health care provider.

The second principle was that this insurance had to be affordable and available to every older American. In short, it had to be a system that left no one behind.

And the third principle was that it was the federal government's responsibility to make it work: to see to it that all of America's elderly -- regardless of their income or their health -- were able to become stakeholders in this new insurance system.

Three small principles, but they add up to one very important idea: the idea that every older American has earned the right to quality, affordable health care.

But today I'm here to tell you that, unless we act now, Anne Smilnak's generation may be the last to enjoy the security, protection -- the success -- of Medicare as we know it today.

The reason? It's not that Medicare's principles have somehow grown obsolete.

No. There's only one reason: it's our failure to respond to the fact that the number of Medicare beneficiaries is growing as never before.

I'm not talking about an increased flow of new beneficiaries into the system -- I'm talking about a tidal wave.

I'm talking about the fact that for every Anne Smilnak, and Lorraine Melton and Jack Mertz, who depends on Medicare today, there will be twice as many by the year 2035.

You can call it changing demographics or the graying of America, but the plain truth is that the generation that made its name at Woodstock is slowly making its way to Leisure World and Sun City.

One in eight Americans depends on Medicare today, but, in just three decades, that number will swell to one in five. When you include disabled Americans -- who also depend on Medicare -- it grows to one out of every four Americans.

Is the future of Medicare in question? I think it is: but not because America lacks the resources to keep up with these changes.

No, the real threat is that in our zeal to prepare Medicare for the future, we may erode the principles that guided it in the past.

The threat is that we'll define the issue as too many beneficiaries drawing too many benefits, rather than understanding that the real problem is that our current financing scheme provides too few dollars to provide for them.

But, maybe the greatest threat of all is forgetting that measures to make Medicare healthier and stronger are of little consequence if they leave Americans sicker and weaker.

That's what's at stake in the Medicare debate. And, as the President pointed out last January, the time to resolve this question is now.

The time is now, because the only people worrying about the impact of Medicare on the next election are here in Washington. What really concerns Americans is whether Medicare's going to be there for the next generation.

Whether, to paraphrase Irving Berlin, it's going to keep on being a success.

The time is now, before the number of Americans 65-and-over doubles.

But, even more, the time for Medicare reform is now because, thanks to this President's leadership, we have just enough breathing room to do the job right. To take careful, prudent steps to:

- Make Medicare more efficient and competitive.

- To see to it that Medicare has the financial resources it will take to meet the enormous, new demands that will be placed on it in the future.

- And to improve and modernize Medicare benefits -- starting with a new benefit to provide for the cost of prescription medicines.

Can we make this happen? We have to -- we may not have another chance.

Just two short months ago, I was able to join with the other Medicare trustees in reporting that, since 1997, we have actually extended the life of the Medicare Trust Fund by 14 years-- and cut Medicare's actuarial deficit by a full 66 percent.

How were we able to do it?

For one, we balanced the budget for the first time in 30 years. We also began implementing the Medicare provisions of the Balanced Budget Act -- and, in the process, overhauled the way Medicare pays doctors, hospitals and other providers.

We made a lot of hard choices, but, in the process, we also made Medicare more efficient.

But our initiatives didn't stop there.

We launched the biggest crackdown on waste, fraud and abuse in Medicare's history. In fact, we restored over $1.2 billion dollars to the Medicare Trust Fund over these last two years alone.

But, we also decided that we didn't just want to run Medicare like a business -- we wanted to run it like a successful business. And we backed up our good intentions with good ideas.

As a result of these initiatives and others, the Medicare Trust Fund is now solvent through the year 2015.

Is this a significant achievement? You bet it is. But it's not an achievement to rest on, but to build on.

Because we have an awful lot more work to do to make sure Medicare is going to be there for the next generation.

And that's what our Medicare reform initiative is all about.

What are the components of our action plan for Medicare's future?

Well, I'm going to let the President announce that.

But I can tell you that it is based on the elements I just described: One, improving Medicare's efficiency and competitiveness. Two, bolstering Medicare's financial strength. Three, maintaining -- and improving -- the quality of its benefits. And, again, that includes a new benefit for prescription medicines.

Now, I know there will always be some people who'll ask whether we can afford to provide a benefit for prescription medicines.

The fact is we can't afford not to.

In recent years, we've expanded Medicare to cover flu shots, mammograms and prostate cancer screening. Why? Because we understood that investing in prevention makes sense.

It saves dollars, but, more importantly, it saves lives. And the same is true of prescription medicines.

Prescription drugs help people take care of themselves. Their safe use means fewer trips to the doctor -- fewer visits to the hospital -- and fewer admissions to nursing homes.

Now, back when Medicare was created, no one could have imagined the role prescription medicines play in improving health today. And for good reason: 30 years ago the science barely existed.

Well, that was then. And this is now.

Since 1980 alone, consumer spending on prescription drugs has increased by more than 600 percent. In 1997 it amounted to almost 79 billion dollars.

How are Medicare beneficiaries paying for the medicines they need? Well, the fact is a lot of them can't.

Over 14 million Medicare beneficiaries today have no prescription drug insurance coverage.

Who are they?

They're Americans like Lida Glover.

Lida lives in Detroit. She's an 84 year-old widow who receives $504 dollars from Social Security every month. But she has to spend about a quarter of that on medicine. She'll tell you she needs it to help control her blood pressure.

How is she able to do it? Well, she isn't always able to. She said: "It's very difficult. You get along with what you have, and trust the Lord for the rest."

Now, there may be some people who might say that as difficult as Lida's burden is, it would cost America too much to give her a helping hand.

But, I submit the cost to America is higher because we don't.

Gerald Brenan once wrote that "Old age takes away from us what we've inherited, and it gives us what we've earned."

Well, we believe that Americans like Lida have earned better than an old age where they can afford to visit their doctor -- but not the medicine their doctor prescribes.

They've earned better than having to depend on an occasional free sample from their doctors because they can't afford to go to the drugstore.

A prescription drug benefit is good health care. It's prudent policy. It's compassionate government. And the time for action is now!

The way to respond to the needs of beneficiaries like Lida isn't by undermining Medicare's core principles, it's by strengthening them.

Earlier this year, the work of Senator Breaux, Congressman Thomas and the Bipartisan Commission on the Future of Medicare made an important contribution to understanding the problems facing Medicare as it readies itself for the future.

The Breaux-Thomas plan, quite rightly, emphasized the need for Congress to give Medicare the tools to benefit from the competitive management practices of the private sector.

And, I should point out, the Breaux - Thomas proposal also recognized the need to expand coverage for prescription drugs.

But while the Breaux - Thomas proposal advanced the debate, I don't think it advanced a lasting solution.

Not only did the proposal fall short of strengthening Medicare, but by failing to address that pivotal issue of growth, it would actually weaken it.

As I mentioned a moment ago, over the next 30 years the number of Medicare beneficiaries is going to double.

Yet, rather than speak to the fact that we'll soon have twice as many beneficiaries who will need just as much care -- if not more care -- than those we have today, the Breaux-Thomas plan would instead cut back on the health care we already provide.

It would cut care first by raising the Medicare eligibility age. And it would also cut care by placing new cost burdens on beneficiaries -- including unlimited home health co-pays.

In addition to these cuts, the independent Medicare actuary suggested that traditional program premiums would rise 18 to 30 percent under the proposal released in February.

But even with all these measures, the staff of the Bipartisan Commission found that the Breaux -Thomas plan would still fall far short of ensuring Medicare's solvency for more than a few additional years.

Now, I know there's been a lot of discussion about the role this plan would give to managed care.

Let me be clear: this Administration is no enemy of managed care. In fact, we're convinced it's part of the solution. That's why we're working to make our Medicare+Choice program more flexible to better meet the needs of providers and beneficiaries alike.

We are absolutely committed to modernizing Medicare, continuing our tough management reforms, and giving beneficiaries more choices than ever as part of our new Medicare proposal.

But, the Breaux - Thomas plan is less about managing <u>care</u> than it is about managing <u>costs</u>. And, as Judith Feder and Marilyn Moon of Georgetown University point out, simply limiting government's liabilities for health care won't make those liabilities go away.

In the final analysis, Medicare's problem is not per-capita costs -- it's the number of capitas. And the way to address that isn't by restricting access; it's by expanding revenues.

That's what the President wants to do, and the bottom line is we don't have to raise taxes to do it.

As the President pointed out last January, by dedicating 15 percent of the budget surplus to Medicare for the next 15 years, we can extend the HI Trust Fund for at least another decade.

Now, I know some have suggested that maybe we ought to take that money and give it back to America's wage earners.

I think if they looked a little closer, they'd realize that's exactly what we're proposing. The difference is that instead of offering a few dollars today, our plan will provide Americans with something much more valuable: dependable, quality health care when they grow older.

I'm convinced that's what Americans want. I know that, to stay strong in the future, that's what Medicare needs. And that's what this President -- and this Administration -- is working to achieve.

A Medicare system for the next generation. A system that can continue to provide the kind of care people need when they're faced with heart disease or cancer or stroke.

The kind of care each of us would want if, someday, our doctor tells us we need to have surgery for cataracts the way Anne Smilnak did. Or, God forbid, have a car accident like Lorraine Melton's.

When President Johnson signed the law establishing Medicare, many believed it would become a Democratic legacy.

But I believe it's really much more than that.

It's a compact between the generations. The living embodiment of our values.

It's America's children telling our parents and grandparents that just as you worked hard and stood up for us, there will come a time when you'll be able to depend on us to stand up for you.

Well, our elders kept up their end of the bargain. Now it's time to hold up ours -- and see to it that this incredible success story called Medicare keeps on being a success.

Thank you.