THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 18, 1993

MEMORANDUM FOR THE FIRST LADY

From: Donna E. Shalala

Subject: Medicare Cuts Under Reform

Background

We understand the necessity of significantly reducing health care inflation for health care reform financing, but we are convinced that the level of Medicare cuts Scenarios 1 and 2 call for would be bad policy and worse politics. The first impression of the health plan will be crucial to its success; the first impression of either Scenario 1 or 2 as applied to public programs will be deadly. Even Scenario 3 runs some serious risk of alienating our friends at the onset.

Serious further cuts in Medicare are necessary to make health reform work, provided these cuts are captured for reform purposes as opposed to deficit reduction. We can then use savings rather than substantial new revenues to help form the centrist coalition of Democrats and Republicans necessary to pass health reform. If Medicare cuts can serve the dual purpose of meeting entitlement caps and financing a portion of reform, the liberal Democrats could be mollified somewhat. The lesson of budget reconciliation is that a balanced financing package is essential. As Exhibit 1 shows, however, Scenario 1 Medicare cuts would exceed the cost of expanded Medicare benefits by $88 billion; Scenario 2 cuts exceed expansion by $62 billion. We believe both numbers are much too high.

The danger is that a proposal to use Medicare to finance so large a part of reform will raise a firestorm of immediate protest from our strongest supporters. Supportive physician groups such as the American College of Physicians and the American Academy of Family Physicians will face enraged members who view further Medicare payment cuts as another broken government promise. Members of the American Hospital Association will see themselves as unable to survive the twin onslaught of aggressive pricing from qualified health plans and continued Medicare erosion. The elderly will raise the very legitimate question of why they are paying more for reform than they will receive in benefits to themselves. A major change in the current positions of any of these supporters could doom the plan at the onset.

Provider and beneficiary response will greatly influence the Hill's reaction. Senator Moynihan and the Ways and Means members will be inclined to protect teaching and urban hospitals if they appear to be in danger. Both House and Senate rural caucuses will focus on the impact on providers, particularly hospitals, in their districts. Mr. Waxman will be sympathetic to the protests of physician groups.

In choosing the amount of financing to come from Medicare, we are operating in the context of new savings from Reconciliation, which have yet to take effect, that will total $56 billion over 5 years. Scenario 3 cuts in Medicare are more stringent than the entitlement caps in the Nunn/Domenici proposal and will be very difficult to achieve both technically and politically. If we move to Scenario 1 cuts we will be asking the Medicare program to provide, in new savings, an amount equal to four times the savings already achieved under the Reconciliation bill. Even Scenario 3 cuts would require almost three times the Reconciliation savings.

This is not just a political problem, but a technical one as well. Public programs simply cannot provide the same savings to support the plan as can the private sector, which has operated largely unchecked during a decade of Medicare restrictions. It would be inappropriate, from a policy point of view, to impose the same degree of expenditure limitation on Medicare and the private sector when the number of persons covered by Medicare is growing more rapidly than the rest of the population. Equal total growth rates for the two segments will mean lower per capita growth for Medicare. In addition, our strategy for achieving the targets for private sector savings relies very heavily on one time reductions in administrative costs, savings which are not available in Medicare.

One result of ten year's worth of cost containment efforts in Medicare is that provider payments under the program are already fully one third less than the private sector's with the result that the better group model HMOs are increasingly reluctant to accept Medicare capitation rates. In fact, bringing the private sector to current levels of Medicare spending, age and risk adjusted, by itself would save tens of billions of dollars.

The attached document reviews some of the most pertinent facts with respect to proposed Medicare savings.

Attachment

MANY RURAL AND INNER CITY HOSPITALS COULD GO OUT OF BUSINESS

- Almost 2/3 of all hospitals currently have negative Medicare margins -- that is, they spend more on Medicare patients than Medicare pays them. In 1991, Medicare losses nearly equaled losses for uncompensated care. Some hospitals make up these losses by charging private payers more. Under health care reform, however, hospitals will be experiencing cutbacks from private payers as well. Hospitals that are squeezed from all sides are likely to respond by reducing staff and/or services -- or closing altogether.

- About 30 percent of sole community hospitals, 39 percent of small rural hospitals, and 24 percent of large urban hospitals are currently operating in the red overall. Another 25 percent of large urban hospitals are teetering on the edge -- their margins are only .1 percent. While operating efficiencies may be possible, many hospitals will not be able to respond quickly enough. The additional Medicare payment cuts along with private reductions may force closures.

- Many inner-city hospitals, particularly public hospitals, are facing crumbling infrastructures. Taken together, the Medicare and private sector cuts will mean less capital to invest and rebuild. Given their deteriorating structures, quality problems will eventually surface. Such hospitals cannot compete in the health care market.

PROMISES TO PHYSICIANS, ESPECIALLY PRIMARY CARE PHYSICIANS, WILL BE BROKEN

- We are committed to increasing Medicare payments for primary care services. Significant cuts in Medicare physician payments under health care reform (on top of billions in reconciliation cuts) will prove politically very difficult to deliver if all physician fees must be reduced to the extent required to meet Scenario 1 or 2 levels.

- Further significant cuts in physician payments could allow gaps in access to develop in certain areas. Reconciliation essentially froze Medicare physician fees in real dollar terms and will lead to substantial geographic redistribution in order to keep our promises with respect to primary care. Reductions needed to reach Scenarios 1 or 2 would require substantial reductions in Medicare payment levels. While access to physicians by Medicare beneficiaries may not be a problem immediately or in all areas, pockets of problem areas are sure to crop up.

EMPLOYMENT COULD SUFFER

- Almost 4 million individuals are employed by community hospitals. The annual payroll (including fringe benefits) of these employees is about $140 billion year. Cuts in Medicare hospital payments could jeopardize the jobs of many of these workers and negatively affect the economy in their communities. Hospitals are now the largest employers in many distressed cities; their employees are disproportionately women and minorities so the job loss will worsen the effects of the current economy on the most vulnerable individuals and communities.

- Hospitals are also major employers in rural America. Studies show that the presence of a hospital in a rural area guarantees an inflow of funds. If hospitals significantly cut back on staffing or close, rural areas especially could be hard hit by layoffs.

STATES WOULD SPEND MORE

- Medicaid pays Medicare cost-sharing amounts for poor beneficiaries. If the Medicare cost-sharing is increased, the States would have additional liability. Each extra billion in beneficiary cost-sharing translates into $470,000 more in State dollars.

- Given the continued inadequacy of the Medicare benefit package compared to the comprehensive package under health reform, cuts of the Scenario 3 magnitude will make it impossible for any State to integrate Medicare beneficiaries into its system.

UNINTENDED CONSEQUENCES ON BENEFICIARIES

- It is difficult to predict the effect of increasing beneficiary cost-sharing on beneficiaries, since cost-sharing amounts depend on the type of service provided and whether or not the beneficiary is covered by supplemental insurance. However, we have concerns that some beneficiaries may be negatively affected.

    + For example, there are 240,000 elderly living in families with incomes $200 or less above the poverty line. 290,000 live in families from $200 to $250 above poverty. Policies requiring beneficiaries to pay $200 or $250 more out-of-pocket per year could be detrimental to individuals teetering above the poverty line.

Medicare in Health Care Reform

($'s in Billions)

Scenario 1

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-7	-17	-30	-45	-62	-161
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-9	-10	-10	-47
Sub-total	-2	-2	-18	-28	-42	-58	-75	-221
Total, Scenario 1	-2	-2	-2	-7	-16	-26	-36	-87

Scenario 2

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-6	-13	-25	-38	-52	-134
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-17	-24	-38	-51	-66	-196
Total, Scenario 2	-2	-2	-1	-3	-12	-19	-27	-62

Scenario 3

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-4	-10	-19	-30	-42	-105
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-15	-21	-32	-43	-56	-167
Total, Scenario 3	-2	-2	1	0	-6	-11	-17	-33

U.S. Department of Justice
Civil Division

Washington, D.C. 20530

June 15, 1993

MEMORANDUM:

TO: All DOJ Health Task Force Participants

FROM: John Euler, Doug Letter, Sheila Lieber 5CE

SUBJECT: Coordination of Unofficial Assistance

We have been asked by Nancy McFadden to coordinate informal efforts to be of assistance to the White House Health Care Task Force. While the Task Force is officially dissolved, work is continuing on the President's proposal and we have been getting inquiries or receiving information from time to time. Although it would not seem productive at this time for us to try to have meetings of everyone who has been involved at one stage or another, we would appreciate it if you would let one of us know if you are asked to provide any further help to the Task Force. On our part, we may be contacting you as we get requests from Greg Lawler (the Task Force point of contact) for unofficial assistance.

cc: Nancy McFadden