

MEDICAID BLOCK GRANT

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MEDICAID

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MEMORANDUM

TO: Distribution July 24, 1995
FROM: Chris Jennings and Jen Klein
RE: Updated Health Care Talking Points/Charts/Back-up Materials

Attached is a revised set of talking points/back-up materials that have been updated to reflect the two most important recent developments related to health care: a) the health care provisions included in the President's balanced budget proposal AND b) the Medicare/Medicaid cuts that the Republicans included in the final budget resolution passed June 29th. Enclosed you will find:

- 1) A one-pager on the Republican Medicare cuts and how they contrast with the President's proposal.
- 2) A separate one-pager focused on the Republican Medicare voucher issue.
- 3) A one-pager on the Republican Medicaid cuts and how they contrast with the President's proposal.
- 4) A chart illustrating Republican tax cuts versus Medicare cuts.
- 5) Two charts illustrating the out-of-pocket cost increases under the Republican plan as it relates to Medicare and the President's plan.
- 6) Medicare and Medicaid growth charts.
- 7) Two charts illustrating Republican Medicaid cuts.
- 8) A two-pager outlining President Clinton's health reform initiative.
- 9) A two-pager providing additional Medicare talking points.

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MEDICARE

- **REPUBLICANS' UNPRECEDENTED CUTS:** The Republican Budget Resolution Conference Agreement would cut \$270 billion from the Medicare program over the next seven years -- \$71 billion in the year 2002 alone. This approximately triples anything previously enacted.
- **CUTS ARE REAL:** Republicans will call their proposal an increase, not a cut, since spending will be higher in 2002 than it is today. But by that logic, reducing the Social Security cost-of-living adjustment (COLA) would not be considered a cut. In fact, the Republicans' out-of-pocket increases would have the effect of taking half of the Social Security (COLA) from the pockets of the average Medicare beneficiary.
- **BILLIONS ADDED TO OLDER AMERICANS' ALREADY HIGH COSTS:** The Republican Budget would increase beneficiaries' out-of-pocket costs by tens of billions of dollars. Assuming their cuts were equally divided between beneficiaries and providers:
 - o Over the seven-year period, beneficiaries would be forced to pay an additional \$2,825 (\$5,650 per couple) out-of-pocket relative to the President's proposal.
- **VOUCHERS AREN'T CHOICE, THEY'RE FINANCIAL COERCION:** Republican proposals that promise choice through Medicare "vouchers" actually threaten to undermine fundamental Medicare protections.
 - o Medicare guarantees beneficiaries that it will pay the cost of covered services, subject to fixed and predictable cost-sharing requirements. That's a benefit guarantee.
 - o A voucher would replace this benefit guarantee with a fixed dollar amount. This means that beneficiaries would be on their own to find a health plan, with a voucher that is losing value over time.
 - o Republicans claim you can keep the Medicare coverage you've got. How can you keep what you can't afford? The only way for Republicans to achieve the level of savings they are proposing is through requirements that beneficiaries have to pay much more to stay in the current Medicare program. That's not choice, that is financial coercion.
- **NO NEW BENEFICIARY CUTS IN THE PRESIDENT'S PROPOSAL:** While the Republicans would cut beneficiary protection to finance tax cuts for the well off, the President would strengthen Medicare financing without new burdens for beneficiaries. The President's proposal would:
 - o Reduce Medicare spending by \$124 billion -- less than half the Republican cuts;
 - o Ensure Medicare trust fund solvency through at least 2005, without any new beneficiary cuts;
 - o Accompany reductions in Medicare spending with: 1) new prevention and long-term care benefits; 2) more plan choices for beneficiaries; 3) aggressive pursuit of fraud and abuse; 4) insurance reform; and, 5) important new insurance affordability protections for small businesses and working families.

REPUBLICAN VOUCHER PROPOSALS OFFER FALSE CHOICES

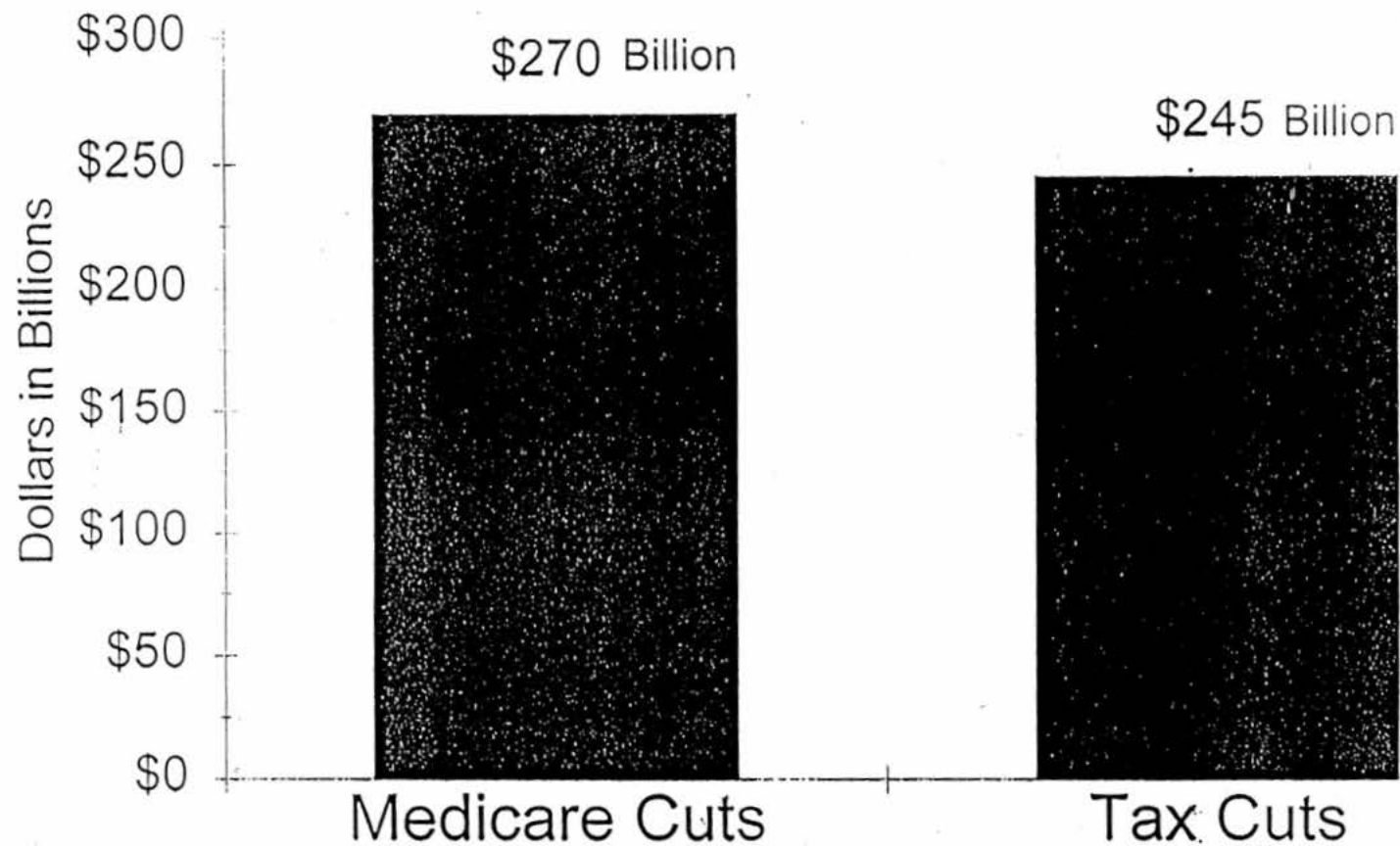
- **Republicans Offer the Ultimate False Choice: You Can Choose to Pay More OR You Can Choose to Get Less.** Under the Republican "voucher" plan, beneficiaries who wish to keep their fee-for-service plan and a guarantee of their choice of doctor will have to pay significantly more. Even those beneficiaries who go into managed care will have their current benefits threatened. This is because the Republicans' overly tight growth rates will, over time, diminish the value of the voucher and the type of coverage it can purchase.
- **The Republican Medicare working document provides a preview of what is in store for beneficiaries who want to keep their fee-for-service plans.** Specifically, preliminary estimates indicate that:
 - **The average Medicare recipient of skilled nursing home services will pay at least \$1,400 more.**
 - **The average beneficiary receiving home health care services will pay at least \$1,200 more in 2002.**
 - **Every beneficiary choosing to stay in the fee-for-service plan would pay at least \$2,825 more in premiums and copayments over 7 years; couples would pay at least \$5,650**
- **Republicans Slash Medicare Growth Rate Levels Far Below Private Sector.** The Republicans claim they want to emulate the health care cost containment successes of the private sector. Permitting Medicare to grow at a 7.1 percent pace -- CBO's projection of the per person growth rate in the private sector -- would save significant Federal dollars. However, the Republican \$270 billion in cuts would constrain Medicare to a much tighter and unrealistic 4.9 percent per beneficiary growth rate. That is not emulation; that is decimation.
- **Capped Vouchers Mean Cruel Medicare Birthday Present.** At best, on the eve of the 30th anniversary of Medicare's enactment, Republicans would force beneficiaries to pay much more to keep what they have today. Since 75% of these beneficiaries have incomes below \$25,000, it's hard to imagine how they could afford to do so. At worst, beneficiaries would be forced to buy coverage that doesn't meet their needs. That's not choice; that's financial coercion.
- **The President's Plan Offers Real Choice and Has No New Cost Increases.** The President's approach shows that you can strengthen the Medicare Trust Fund, offer more choice of plans, and provide new benefits without imposing new Medicare beneficiary cuts. **In contrast, Republican House Majority Leader Armey says that Medicare is "a program I would have no part of in a free world."**

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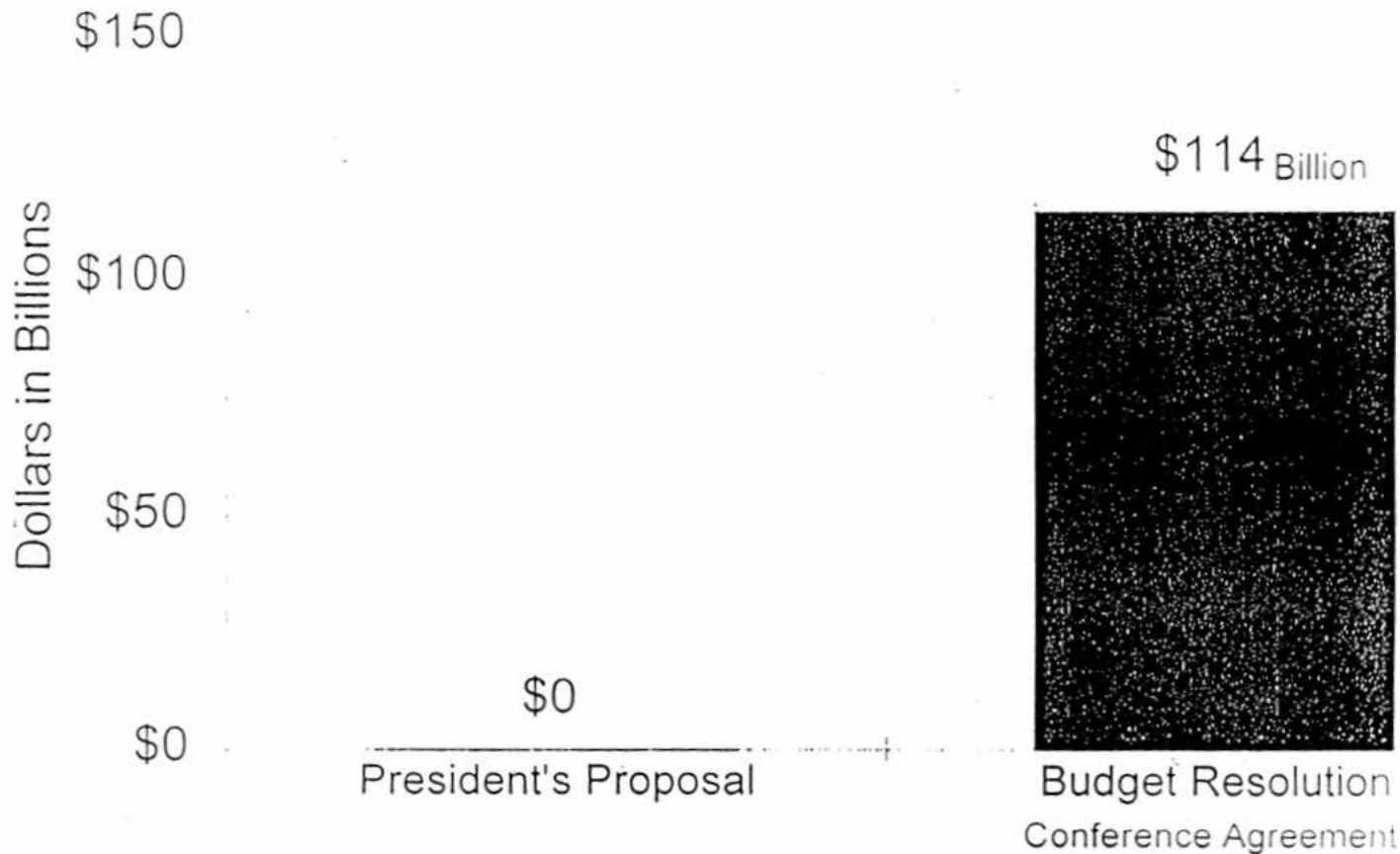
- **REPUBLICANS' UNPRECEDENTED CUTS:** The Republican Budget Resolution Conference Agreement would cut \$182 billion from Medicaid over the next seven years by making the program a block grant to states.
- **HEAVY BURDENS TO FAMILIES FACING LONG-TERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **LIKELY IMPACTS:** The Republicans argue that they are not cutting Medicaid since states will get an increase in the block grant every year. But, given that CBO projects that the number of people covered will grow by 3 percent and that the Republicans block grant will grow by only 4 percent by 1998, the funding does not even keep up with inflation. It's a cut in real terms.
 - o Assuming states would be forced to respond to these cuts by reducing services, provider payments and coverage in equal proportions:
 - ◆ **7 million children and nearly one million elderly and persons with disabilities could lose insurance coverage.** This would further worsen our nation's uncompensated care problem and create more incentives for cost-shifting to American businesses and families who still have insurance.
- **THE PRESIDENT'S PROPOSAL PROTECTS COVERAGE:** The President's proposal contains a mix of policies that save \$54 billion between now and 2002 -- less than a third of the Republican proposal. It promotes efficiency and gives states more flexibility while protecting coverage. Every single Democratic Governor has endorsed the President's Medicaid target as a reasonable and achievable savings number.
 - o Maintaining coverage under Medicaid is critical since it serves as a safety net for many Americans. Between 1989 and 1994, employer health coverage declined from 66 percent of the nonelderly population to 59 percent. Medicaid coverage increased from 9 to 14 percent during this same period.

Cutting Medicare to Pay for Tax Cuts, 1996 - 2002



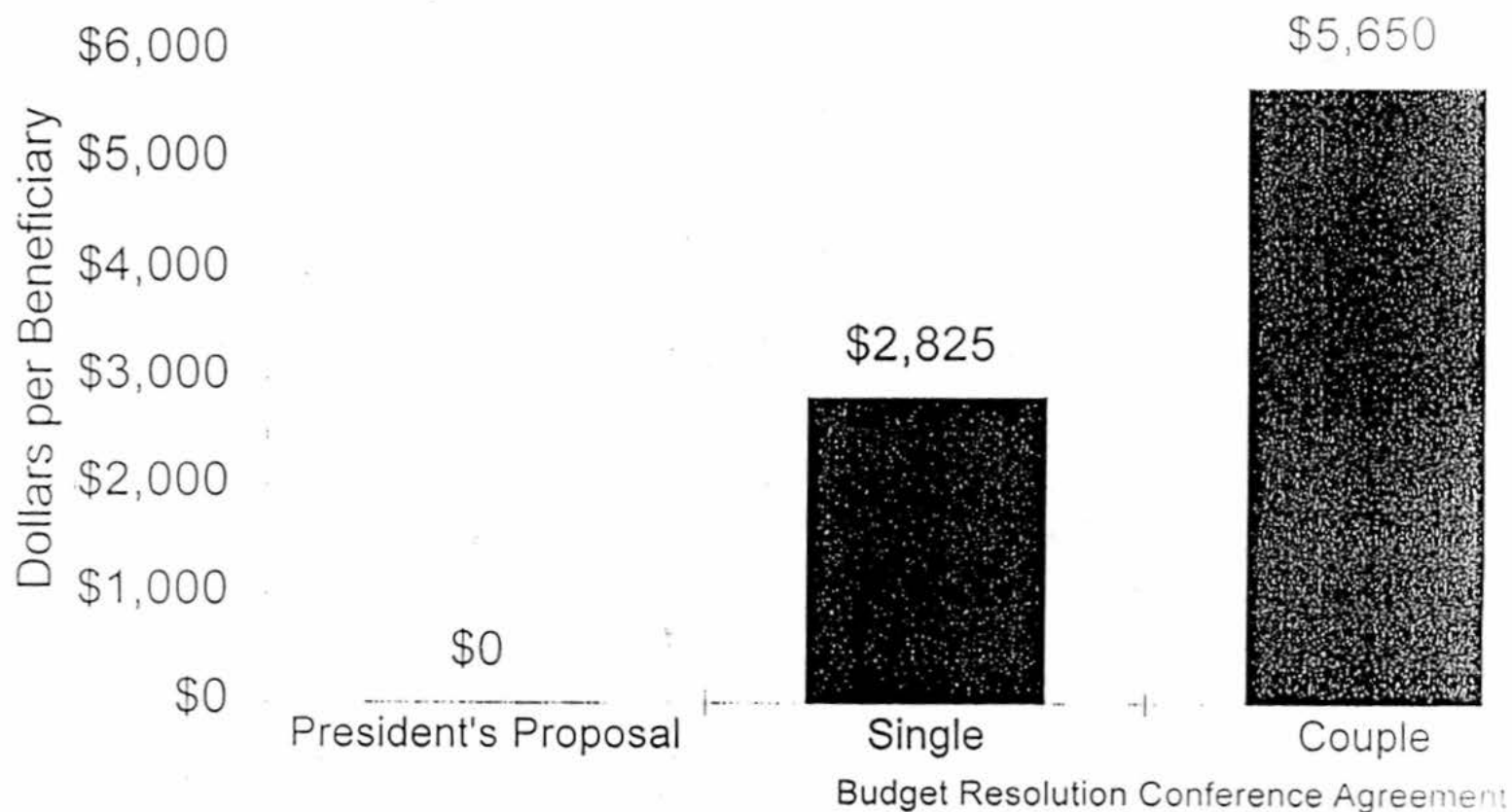
Conference Agreement estimates from CBO baselines

Increased Medicare Beneficiary Out-of-Pocket Costs, 1996 - 2002



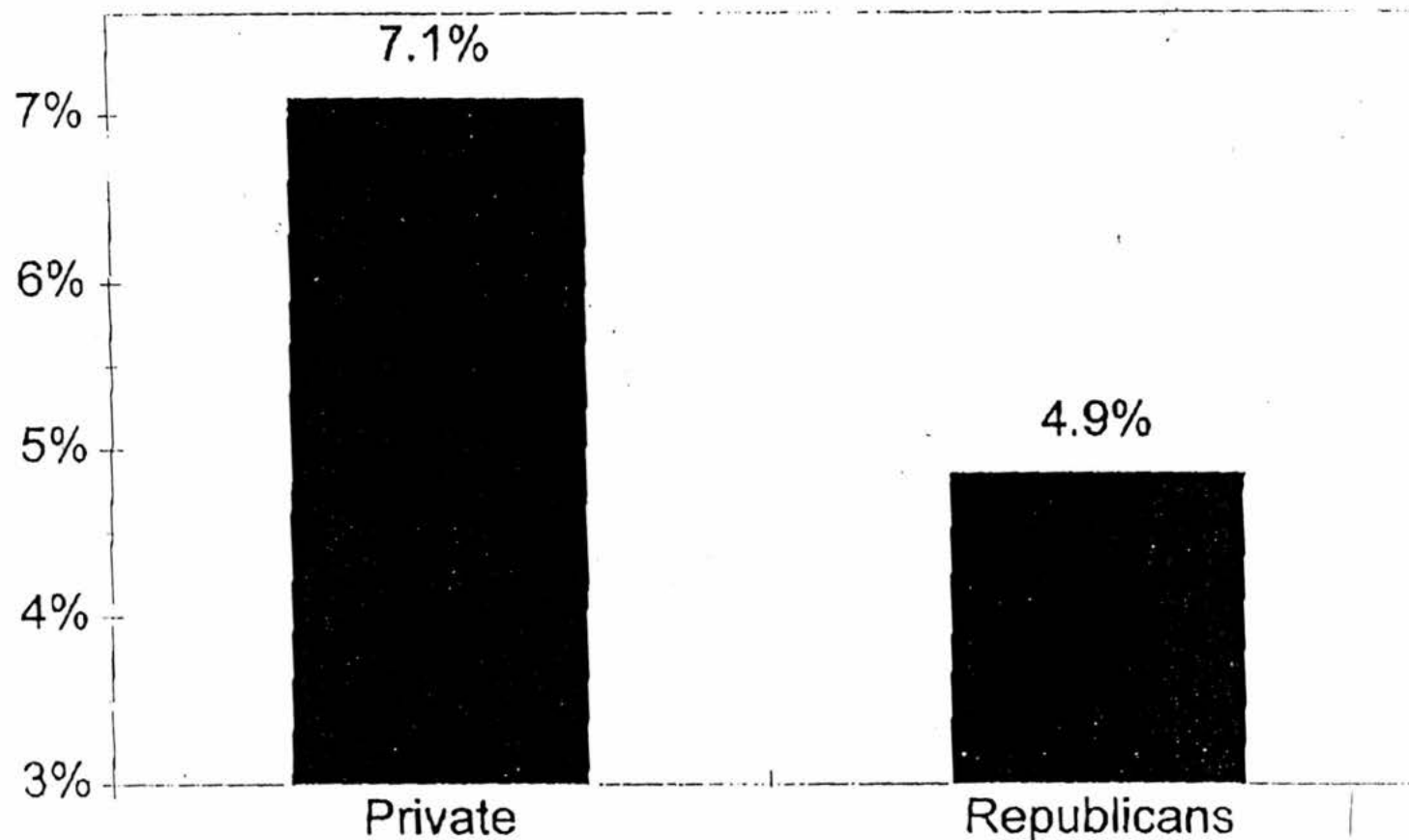
The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposals are assumed to reflect the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimate.

Increased Medicare Out-of-Pocket Costs Per Beneficiary, 1996 - 2002



The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposals, including the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimate.

Private Sector Health Plan versus Republican Medicare Growth per Beneficiary, 1996-2002

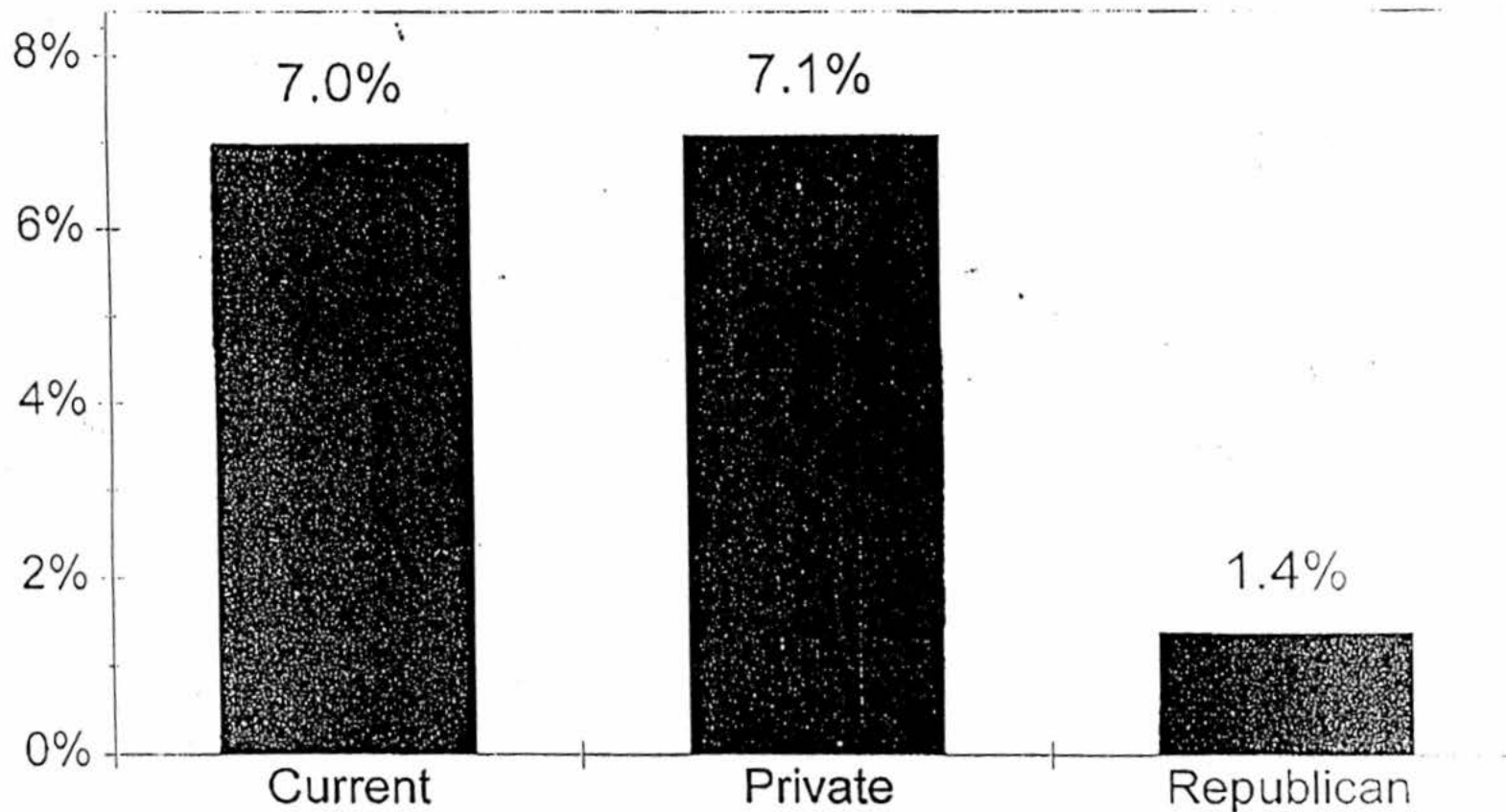


All estimates are calculated by the Administration using CBO data.

Medicaid Growth Per Recipient

Effect of the Republican Proposal

1996-2002



All estimates are calculated by the Administration using CBO data.

Employer Coverage Reduced, Medicaid Coverage Increased



Medicaid Cuts That States Would Be Forced to Make

2002

Eliminate coverage for dental,
screening services for kids,
and hospice and home care



Reduce provider payments
by almost \$13 billion

Eliminate coverage for
7 million kids

Eliminate coverage for
nearly one million elderly
and persons with disabilities

NOTE: Assuming 25% cut in each of these categories.

The President's Health Reform Initiative

1. Reforming the Insurance Market

Insurance reforms, based on proposals that both Republicans and Democrats supported in the last Congress, will improve the fairness and efficiency of the insurance marketplace.

- **Portability and Renewability of Coverage** -- Insurers will be barred from denying coverage to Americans with pre-existing medical conditions, and plans will have to renew coverage regardless of health status.
- **Small Group Market Reforms** -- Insurers will be required to offer coverage to small employers and their workers, regardless of health status, and companies will be limited in their ability to vary or increase premiums on the basis of claims' history.
- **Consumer Protections** -- Insurers will be required to give consumers information on benefits and limitations of their health plans, including the identity, location, and availability of participating providers; a summary of procedures used to control utilization of services; and how well the plan meets quality standards. In addition, plans would have to provide prompt notice of claims denials and establish internal grievance and appeals procedures.

2. Helping Working Families Retain Insurance After a Job Loss

Families that lose their health insurance when they lose a job will be eligible for premium subsidies for up to 6 months. The premium subsidies will be adequate to help families purchase health insurance with benefits like the Blue Cross/Blue Shield standard option plan available to Federal employees.

3. Helping Small Business Afford Insurance

- **Giving Small Employers Access to Group Purchasing Options** -- Small employers that lack access to a group purchasing option through voluntary state pools would get that option through access to the Federal Employees Health Benefits Program (FEHBP) plans. This would increase the purchasing power of smaller businesses and make the small group insurance market more efficient. Small firms would get coverage from plans that also provide coverage to Federal employees through FEHBP, but the coverage would be separately rated in each state, leaving premiums for Federal and state employees unaffected.
- **Expanding the Self-Employed Tax Deduction** -- The President's plan provides a fairer system for self-employed Americans who have health insurance. Self-employed people would deduct 50 percent of the cost of their health insurance premiums, rather than 25 percent as under current law.

4. Reforming and Strengthening Medicare

- **Strengthening the Trust Fund** -- The President's plan would reduce Medicare's Part A by \$79 billion over 7 years to ensure the solvency of the Medicare HI Trust Fund to 2005. The plan finds such savings by reducing provider cost growth, not raising beneficiary costs.

- **Eliminating the Co-Payment for Mammograms** -- Although coverage by Medicare began in 1991, only 14 percent of eligible beneficiaries without supplemental income tap this potentially lifesaving benefit. One factor is the required 20 percent co-payment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare co-payment.
- **Expanding Managed Care Choices** -- The President's plan expands the managed care options available to beneficiaries to include preferred provider organizations ("PPOs") and point-of-service ("POS") plans. The plan also implements initiatives to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal. Also included in his plan are important initiatives to streamline regulation.
- **Combatting Fraud and Abuse** -- "Operation Restore Trust" is a five-state demonstration project that targets fraud and abuse in home health care, nursing home, and durable medical equipment industries. The President's budget increases funding for these critical fraud and abuse activities.

5. Long-Term Care

- **Expanding Home and Community-Based Care** -- The President's plan provides grants to states for home- and community-based services for disabled elderly Americans. Each state, will receive funds for home- and community-based care based on the number of severely disabled people in the state, the size of its low-income population, and the cost of services in the state.
- **Providing for a New Alzheimer's Respite Benefit within Medicare** -- The President's plan helps Medicare beneficiaries who suffer from Alzheimer's disease by providing respite services for their families for one week each year.

6. Reforming Medicaid

The President maintains Medicaid, expanding state flexibility, cutting costs, and assuring Medicaid's ability to provide coverage to the vulnerable populations it now serves.

- **Eliminating Unnecessary Federal Strings on States** -- To let states manage their Medicaid Programs more efficiently, the President's plan substantially reduces Federal requirements.
 - States will be allowed to pursue managed care strategies and other service delivery innovations without seeking Federal waivers; and
 - The "Boren Amendment" and other Federal requirements that set minimum payments to health care providers will be repealed and restructured.
- **Reducing Medicaid Costs** -- The President proposes a combination of policies to reduce the growth of Medicaid spending, including expanding managed care, reducing and better targeting Federal payments to states for hospitals that serve a high proportion of low-income people, and limiting the growth in federal Medicaid payments to states for each beneficiary. Per-person limits, as opposed to a block grant on total spending, promote efficiency while protecting coverage.

ADDITIONAL MEDICARE TALKING POINTS

ADDING TO ALREADY HIGH COSTS FOR OLDER AMERICANS

- **Over \$40 Billion in Cost-Shifting:** Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians, and other providers would be targeted with a \$135 billion cut over seven years. In 2002 alone a \$35 billion cut in provider payments would be needed. Even if only one-third of Medicare providers cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion in increased premiums for health care costs between now and 2002.
- **Rural and Inner City Hospitals At Risk:** Cuts of this magnitude, combine with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result quality and access to needed health care would be threatened.

MAJOR BURDEN ON RURAL AMERICA

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

UNDERMINES ACADEMIC HEALTH CENTERS

- Large reductions in Medicare payments would have a devastating impact on academic health centers.
 - These research and training facilities are providing the bulk of medical advances in the United States. Deep Medicare cuts, combined with private sector cost cutting efforts that either undercompensate or don't compensate these institutions, will undermine our position as the world leader in developing new and more effective health care treatments and technology.

THE URBAN SAFETY NET

- Large reductions in Medicare payments could also have devastating effects on a number of urban safety net hospitals.
 - Urban safety net hospitals are already bearing a disproportionate share of the nation's growing burden of uncompensated care.

THE REALITY OF MEDICARE GROWTH

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

REPUBLICAN MEDICAID CUTS

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

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

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

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

Talking Points

on Republican Budget Proposals:

"A Broken Contract with American Families and Their Parents"

May 10, 1995

INTRODUCTION

- As you all know, Republicans made a big promise:

They promised to balance the budget without hurting anyone and without raising taxes -- while giving a huge tax cut to the wealthy.

- Guess what? They broke their promise.

-- In terms of cuts that will hurt people:

- The strongest evidence of the severe pain they would impose are their deep cuts in Medicare and Medicaid.
- They would cut discretionary programs -- from education to science and technology -- an average 30 percent across the board. They also have announced proposals to terminate specific programs, such as Americorps, that are important investments in the future.
- To find the remaining savings, Republicans also plan to make deep cuts in such other entitlements as veterans' and farm programs.

-- In terms of tax increases.

- Republicans are proposing to raise taxes on millions of working families.
- Why are they doing all this?
 - They want to finance a tax cut for the wealthy at the expense of average families.
 - House Republicans have adopted a huge tax cut as part of their budget program.
 - House Speaker Newt Gingrich has called the tax cut "the crown jewel of the Republican contract."

- Senate Republican leaders -- Bob Dole, Trent Lott, and others -- and Sen. Phil Gramm are committed to a tax cut and say they will push for one on the Senate floor.

- We believe that there is a right way, and a wrong way, to do deficit reduction.

-- In 1993, on our own, we did it the right way:

- We reduced the deficit by cutting unnecessary programs, but also invested in programs that will help working families build a more prosperous future.

-- Now, they want to do it the wrong way:

- They want to cut programs for working families and their parents, in order to fund a tax cut for the wealthy.

Medicare and the Budget

- House Speaker Newt Gingrich wants to treat Medicare apart from the budget, but that statement is meaningless and the promise is a lie.

- Late last month, he said,

"What we want to do is create an environment over the next three or four months where, standing by itself, there is a bill to save Medicare. That bill moves focused on Medicare. It has Medicare-related ideas. It's not tied up in the budget. It's not tied into getting to balance by 2002."

- Medicare is a federal program just like any other.
- And Republican plans rely heavily on it to get to balance.

-- Domenici's Medicare cut is the largest single cut in any one program.

-- Republicans need to cut Medicare to pay for their tax cut for the wealthy.

-- And more than half of the savings that Domenici claims comes from cutting Medicare and Medicaid.

Limits to Medicare/Medicaid Growth Rates

- Republicans imply that Medicare and Medicaid are growing out of control, but in fact they are growing at the same per-person rate as private health plans.

- Republicans are proposing to force Medicare spending down, but to ignore health reform in general.

- In effect, they are proposing to make Medicare a "second class" health care system -- it would provide low-quality care and restricted access.

-- These are cuts that will affect your own parents and grandparents, whether they now get Medicare or they eventually need the long-term care provided by Medicaid.

- Specifically, Medicare and Medicaid spending are rising 9-10 percent a year because of increases in the numbers of beneficiaries and the costs of medical services, including improvements in technology and care.

-- While that may seem high, on a per-person basis, Medicare spending is projected to grow at about the same rate as private health insurance costs.

• Thus, limiting the rate of growth of total (not per-person) Medicare and Medicaid spending to 7.1 percent, as Sen. Domenici proposes, is a real cut with real consequences.

-- It could mean limits on the numbers of elderly or low-income individuals served.

-- It could mean limits on the quality and quantity of services that the programs provide.

-- It could mean that the elderly and low-income have to pay more, themselves, for some of the services that they now receive.

-- These "savings" could be passed on to businesses and individuals who buy health insurance and health care services.

• In short, reducing Medicare's rate of growth would hold it below the growth in the private sector -- creating a growing "quality gap" between care for seniors and health services for others.

Medicare/Medicaid cuts

Medicare Cuts:

- If distributed evenly between providers and beneficiaries, the Republican Medicare cuts could force beneficiaries to pay:

- between \$745 and \$1,030 more in out-of-pocket costs in 2002; and

- between \$3,175 and \$3,445 more in out-of-pocket costs over 7 years.

- Republican Medicare cuts, in effect, amount to cuts in Social Security:

- By 2002, the typical Medicare beneficiary would see 40-50 percent of his or her Social Security COLA eaten up by increases in Medicare cost sharing and premiums.

- About 2 million beneficiaries would have 100 percent or more of the COLAs eaten up by increases in cost sharing and premiums.

Medicaid Cuts:

- Cuts in Medicaid are especially outrageous:

- Medicaid provides health insurance for the most vulnerable Americans.

- 2/3 of Medicaid costs go to the indigent elderly and disabled, who have no other available resources.

- Medicaid is also a vital protection for middle-income Americans.

- Working families with a parent who needs long-term care would face nursing home bills of an average of \$38,000 a year without Medicaid.

- Working couples who may need long-term care after retirement rely on Medicaid to get such care.

- If distributed evenly between eliminating eligibility for the elderly and disabled, eliminating eligibility for children, cutting services, and cutting provider payments, Republican cuts in 2002 alone would mean:

- 7 million children would lose coverage;
- 1 million elderly and disabled would lose coverage; and
- Tens of millions of Americans would lose important benefits, such as home care, hospice, and preventive screening services for children.
- Provider payments would be reduced by almost \$13 billion.

Managed Care and Savings

- Republicans claim that they can produce significant savings by giving beneficiaries more managed care choices simply are not true.

-- As CBO reported recently, achieving savings in Medicare without financial coercion would actually reduce managed care enrollment.

-- So, to get both more beneficiaries in managed care and large savings for Medicare, some form of coercion - such as making it more expensive for beneficiaries to stay in Medicare fee-for-service -- would be needed.

Impact on Providers

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals.
 - For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. According to the 1994 Special Report of the National Association of Public Hospitals, while Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.
- Large reductions in Medicare payments could also endanger rural hospitals.
 - Nearly 10 million Medicare beneficiaries (25 percent of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to serve primarily Medicare patients.
 - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

The Earned Income Tax Credit (EITC) and the Economic Implications of Republican Budget Plans

EITC:

- While Republicans cut Medicare and Medicaid to finance their tax cut for the wealthy, they also plan a tax increase on low-income, working families.
- Republican tax proposals reveal the sharpest possible distinction between the President's vision for America and that of Republicans.

-- The President wants to provide targeted tax relief for middle-income Americans who may not have shared in the economic recovery.

- He wants to help them raise their children, educate and train themselves and their children, and save for the future.

- Republicans want to cut taxes for the wealthy, and actually increase taxes on the very people who need and deserve it most.

- Republicans plan to raise \$13 billion over five years by rolling back part of the President's 1993 expansion of the EITC, which would ensure that working Americans do not have to raise their families in poverty.

-- Most EITC recipients are doing the hardest job in America -- playing by the rules, working at modest wages to support their children.

-- The 1993 law was designed to help those who are not benefiting from the current economic expansion.

-- The cut eliminates the EITC entirely to families without children.

-- Freezing the proposed EITC expansions could cost millions of moderate-income families with children up to \$350 a year in added taxes.

Economic Implications of Republican Budget Plans:

(to be provided by Laura Tyson)

Analysis of the Republican Plan: Medicaid

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Testimony of
Bruce C. Vladeck
Administrator
Health Care Financing Administration
Before the
Committee on Finance
U.S. Senate
July 12, 1995

*File
Vladeck*

Mr. Chairman and Members of the Committee:

I welcome the opportunity to be here this morning to discuss State flexibility under the current Medicaid program and this Administration's efforts in expanding and assisting States in using that flexibility. The Medicaid program was conceived as a Federal/State partnership, and this Administration has made major strides in strengthening the relationship. Nonetheless, we recognize the need for additional work to build on this partnership.

Introduction

Before beginning our discussion about State flexibility, I would like to highlight some essential facts about the Medicaid program.

First, Medicaid's spending growth has moderated. A widespread myth holds that Medicaid is growing out of control, far faster than other parts of the health care sector. Chart 1 shows the contrary. In fact, the growth in Medicaid spending on a per person basis has not exceeded the growth in private health insurance since the period between 1989 and 1992. At that time, States used provider taxes combined with disproportionate share hospital payments as a means of increasing Federal matching funds.

Second, the lion's share of Medicaid spending is devoted to the aged and disabled. As chart 2 indicates, the aged and disabled represent 30 percent of Medicaid recipients and account for 70 percent of the spending.

Third, Medicaid is a critical safety net for a wide variety of populations with very diverse health needs. State Medicaid programs cover prenatal care for low and moderate-income pregnant women, health care for children, and long-term care for low-income senior citizens. They also provide a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries. For many of these populations, whose disabling conditions or medical costs preclude them from purchasing insurance, Medicaid is the only system of care.

Chart 3 shows how Medicaid coverage increased between 1989 and 1994 while employer-based insurance declined. Medicaid brings an important stability to the health care marketplace by offsetting losses in private insurance coverage. Although different populations are involved, Medicaid coverage increases have leveled the overall percent of uninsured and thereby maintained an essential balance in the cost shift to the private sector.

State Flexibility Under Current Law

Medicaid was enacted in 1965 to provide access to coverage for low-income Americans. Medicaid represented a consolidation of several Federal grant programs administered by the States. The nation's most vulnerable populations -- low-income senior citizens, individuals with disabilities, and children -- are Medicaid eligible in every State.

Nevertheless, the current Medicaid program is actually 56 different programs. The States have tailored their programs to meet the varying specific needs of their individual populations. The diversity across States' Medicaid programs is a direct result of the inherent flexibility of the program.

The States' Medicaid programs are dynamic. In partnership with HCFA, States are continuing to find innovative ways to improve health care delivery, enhance access, and control rising health care costs.

Flexibility in Coverage

The original Medicaid statute only required States' Medicaid programs to provide a set of five core benefits, including inpatient hospital services, outpatient services, physician services, laboratory and x-ray services, and skilled nursing home services. States could also cover any of ten optional benefits.

Over the past 30 years, Congress has added seven services to the list of required benefits and has expanded the list of optional benefits that States may offer to include 30 services.

States use their flexibility to cover optional services to customize their Medicaid programs to serve the special needs of their vulnerable populations. For example, Utah provides 28 optional benefits to its Medicaid beneficiaries while Delaware offers 15

optional benefits. A few benefits, such as prescription drugs and clinic services, are offered by almost all the States. On average, the States cover about 24 optional benefits. Only 44 percent of Medicaid spending in 1993 was for mandatory services provided to mandatorily eligible individuals. Chart 4 shows that over 50 percent of the total Medicaid spending was for optional services and populations elected by the States.

Flexibility in Determining Eligibility

States have significant flexibility in determining who is eligible for their Medicaid programs. The largest portion of the caseload are those on the Aid to Families with Dependent Children (AFDC) program. The eligibility standards for this program are directly determined by States.

States may also extend Medicaid coverage to low-income families above the Federal minimum guidelines and to individuals with large medical expenses. The States use this flexibility to make their institutionalized aged and disabled populations eligible for Medicaid.

Medicaid statute requires States to cover pregnant women and children under age 6 up to 133 percent of the Federal poverty guideline. In addition, States must also phase-in coverage for all other children over age six born after September 30, 1983. Thirty-three States use Medicaid flexibility to expand coverage for pregnant women and children with family incomes beyond the Federal minimum guidelines. Twenty-seven of those States

cover pregnant women and infants to at least 185 percent of the Federal poverty guidelines.

In addition, States have further flexibility to liberalize financial eligibility criteria for certain high-priority populations under the authority of section 1902(r)(2) of the Social Security Act. Under this provision, States are able to apply more liberal financial eligibility standards by disregarding certain income and/or assets.

Several States have used the authority of section 1902(r)(2) as a means of expanding eligibility for children beyond 185 percent of the Federal poverty level and accelerating the phase-in coverage for children below the poverty level. For example, both Delaware and West Virginia have used the 1902(r)(2) authority to cover all children under age 19 up to the Federal poverty level.

Flexibility in Service Delivery and Financing

States have additional flexibility to design their Medicaid programs through various program and research waivers.

Managed Care Programs

Under freedom-of-choice waivers, States can establish primary care case management programs, require Medicaid beneficiaries to choose among managed care plans, and selectively contract with hospitals, nursing facilities, or other providers. States use this

flexibility to target coordinated and comprehensive managed care systems to their high-risk populations and to purchase services in a cost-effective manner.

States are taking full advantage of the flexibility to design managed care programs for their Medicaid populations. Thirty-nine States now operate 75 managed care programs covering 8 million Medicaid eligible individuals.

States have also developed managed care programs to target a number of specific priorities. For example, the Kansas Primary Care Network (PCN), which was established in 1984, was one of the first managed care programs to provide physician case management to beneficiaries. Under this program, the State assigns each Medicaid beneficiary in the seven most populous counties to a physician case manager. The case manager is responsible for managing all of the recipient's health care. Over 30 percent of the State's Medicaid eligibles are now enrolled in this PCN program. HCFA reviews have shown the program to be cost effective as well as providing better access to services for the participating Medicaid beneficiaries.

Similarly, Florida has developed MediPass, an extensive primary care case management program. The State pays MediPass primary care providers a \$3 per member per month case management fee to coordinate care for their MediPass enrollees. These providers manage many of their patients' health needs, including specialty referrals, but continue to be paid on a fee-for-service basis for the health care services they provide.

Utah has developed a ground-breaking prepaid mental health program for Medicaid beneficiaries. The State contracts with three community mental health centers to provide inpatient and outpatient psychiatric and related physician services. The first year results indicate that contractors were able to reduce utilization of inpatient psychiatric services while increasing the percentage of eligibles served in their catchment areas.

Home and Community Based Services Programs

Home and community based services waivers give States the ability to establish home and community based care programs that provide services to beneficiaries in the community setting rather than in nursing homes and hospitals. Home and community based services programs allow States to manage care provided to the elderly and disabled populations in an efficient manner while increasing the consumer's satisfaction with the services provided.

States have made extensive use of this authority as well. Over 205 programs are now operating. Every state is currently serving developmentally disabled and aged individuals under a home and community based services program. States are also serving people with HIV/AIDS, those with traumatic head injury, and medically fragile children.

HCFA is actively involved in encouraging and assisting States in using this flexibility. Recently, Alaska officials requested HCFA assistance in developing their home and community based services program. Our staff went to Alaska and helped the State

design four home and community based services programs to meet the unique needs of its citizens. The programs were quickly reviewed and approved. Other States are also increasingly seeing HCFA as a partner in the development of their programs.

Service Delivery and Financing Demonstrations

Medicaid's research and demonstration authority, section 1115, gives States much broader opportunities to develop and test new and innovative ideas. States can use this authority to develop sub-state and statewide demonstrations of new approaches to health care financing and delivery.

This Administration has approved ten statewide section 1115 demonstrations. Several additional States have submitted proposals that are currently being reviewed. No previous Administration had been willing to give States a comparable degree of flexibility as the Clinton Administration. We have actively encouraged States to develop innovative reform demonstrations including managed care approaches working with the private sector and public health providers.

One of the first acts of this Administration was to approve the Oregon Reform Demonstration. The Oregon request, which was the first approval of a statewide demonstration in 10 years, had been denied by the previous Administration.

Since that point, innovative reform proposals have been approved in Hawaii, Tennessee,

Rhode Island, Kentucky, Florida, Ohio, Massachusetts, Minnesota, and Delaware.

These States are experimenting with new ways of financing and delivering essential health care. For example, Delaware has created seamless coverage for those below the Federal poverty level. Rhode Island is testing the effectiveness of extending family planning benefits and contracting with an FQHC-based managed care system.

In addition, the Administration has approved twenty-three smaller, more targeted section 1115 demonstrations. Some of these demonstrations provide preventive services to children, test extended family planning services, and establish alternative delivery systems.

For example, under the Iowa Drug Utilization Review Program, the State conducts on-line prospective drug utilization review. There are 250 pharmacies participating in the project either as randomized control or experimental entities.

Further, the multi-State Nursing Home Case-Mix and Quality Demonstration which is operating in Kansas, Maine, Mississippi, New York, South Dakota, and Texas, will test a combined Medicare and Medicaid nursing home payment and quality monitoring system. This system will significantly enhance the quality assurance process in nursing facilities.

Flexibility in Program Administration

States have considerable flexibility in establishing provider participation criteria. Certification requirements for institutions such as hospitals and intermediate care facilities for the mentally retarded, physician qualification requirements, and requirements for other providers are determined primarily by the States.

Similarly, States have latitude in setting provider payment rates. Although the Boren Amendment and Medicare accounting principles provide general lower and upper bounds with respect to payments for hospitals and nursing homes, States have significant flexibility to establish payment rates for these providers. States have still greater flexibility for other classes of providers.

Another area in which States have flexibility is targeted case management. States use the Medicaid program to coordinate not only medical services but a range of social, educational, housing, or other services for Medicaid beneficiaries. States have the ability to use case management for as many segments of the Medicaid population as they believe would benefit from such coordination.

For example, States have established programs to coordinate the service needs of mentally retarded individuals, the mentally ill, individuals with HIV/AIDs, high-risk pregnant women, and at-risk children. In each case, the State is afforded the flexibility to define the level of service coordination provided, the target group, provider

qualifications, level of payment, and any limits on the scope of services. This has enabled States to develop individualized plans of care for their most vulnerable citizens that weave together a tapestry of support from the diverse threads of Federal, State, local, and private resources.

With HCFA cooperation and assistance, many States are collaborating with various health-related and community organizations to design and implement programs that meet a comprehensive range of health needs of children. Because children's health is frequently affected by a number of socioeconomic conditions such as poverty, substance abuse, and fragmented health resources, no single agency or program can address all of their needs. Increasingly, communities are using public/private arrangements to develop integrated services networks. These networks disseminate information and serve as referral links between women and children in the community and the State's Medicaid, Maternal & Child Health, Women Infants & Children, and primary care programs.

Further, States have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

- Introducing magnetic-strip cards to provide immediate access to information about eligibility and third-party liability; and
- Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. The President proposes a combination of policies to expand State flexibility and reduce the growth of Federal Medicaid spending. This combination includes expanding managed care, reducing and better targeting Federal payments for hospitals that serve a high proportion of low-income people, and limiting the growth in Federal Medicaid payments to States for each beneficiary. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. This improvement can best occur within the current Federal-State partnership. The Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities, and children are Medicaid eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise and assistance to achieve program goals.

The President's proposal seeks \$54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best

achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care a program option that States could elect without extensive Federal review.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be further enhanced. HCFA supports the NGA recommendations to repeal requirements for payment rates to obstetricians/pediatricians and to replace the HMO enrollment provisions called the "75/25 rule" (which requires HMOs to maintain at least 25 percent private enrollment) with more outcome-based quality assurance methods. We support provisions that would allow managed care entities to better serve rural areas. We are also evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment.

We recognize that the growth in Medicaid should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force

them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the reductions required in the conference agreement on the budget resolution would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the spending cut -- \$182 billion over seven years -- is too big to be absorbed through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither wholesale use of managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the conference agreement. As Chart 5 demonstrates, The Congressional Budget Office's (CBO) projections of Medicaid enrollment growth alone edge very close to the

proposed spending limits in the budget resolution. As you know, medical inflation impacts public health care spending as well as private spending. Inflation, added to CBO's anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the budget resolution. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the budget resolution.

The President's plan and the budget resolution are fundamentally different. We rely on per capita limits to allow for changes in enrollment, while the budget resolution cuts spending to the point that any unexpected change in enrollment would shift considerable cost to the States or force a reduction in coverage. We fear that States may be forced to reduce coverage, thereby adding to the number of uninsured at an alarming rate. The States and Congress can realize meaningful savings and additional flexibility without completely dismantling the Medicaid program.

Conclusion

The Medicaid program affords States a considerable amount of flexibility in the design of their individual programs. The Clinton Administration has worked with States to further increase flexibility and permit States' use of innovative means of service delivery and cost containment.

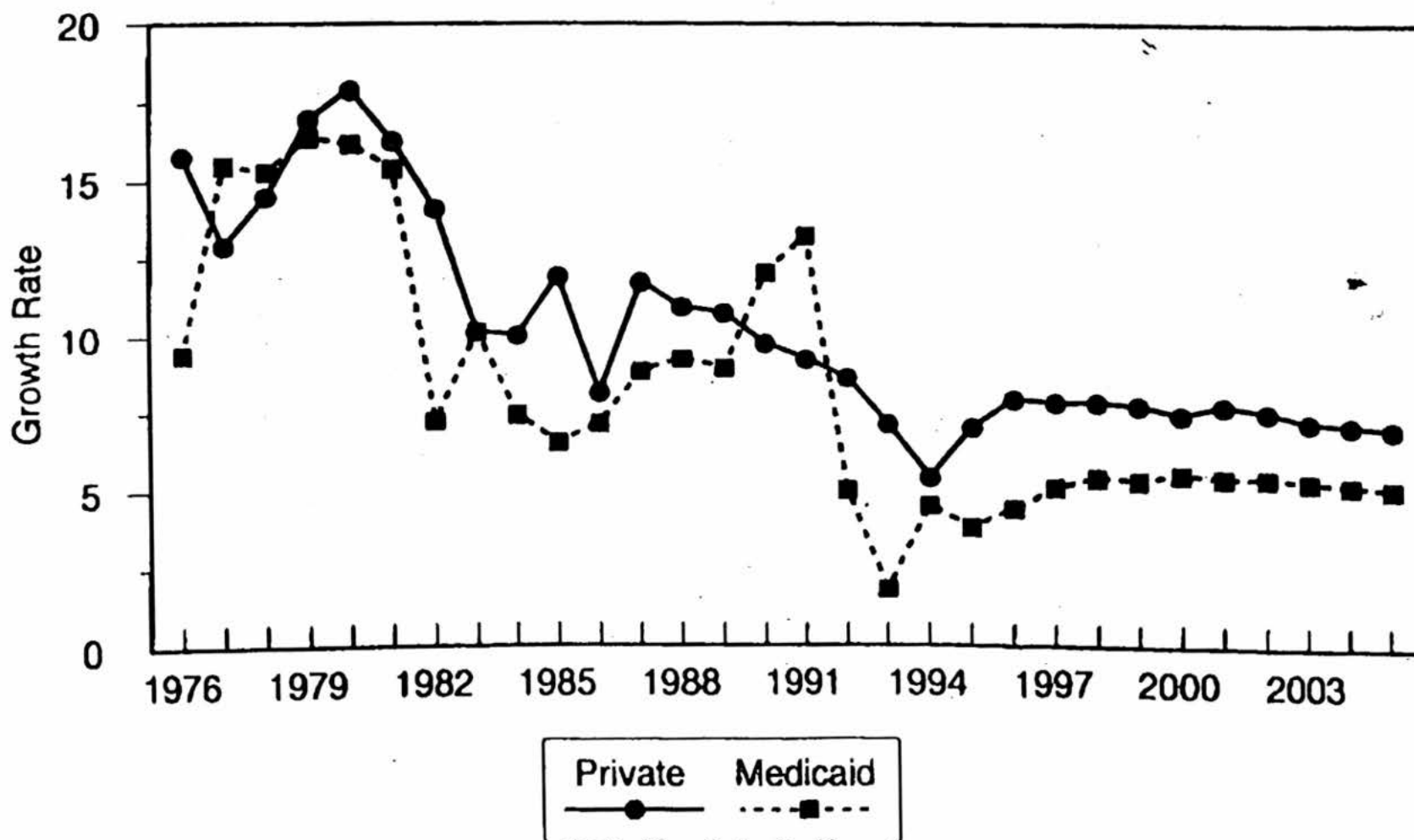
We believe that the President's plan is the right way to improve the Medicaid program. Flexibility can be achieved within the current program, without taking apart the structure of this program that has served as a critical safety net for populations without many alternatives.

Rather than simply block granting the program which, given the loss of Federal funds, may reduce flexibility for many States, we propose a more targeted approach; building upon the inherent program flexibility while also protecting coverage for the nations most vulnerable populations. We want to work with Congress to improve this program in ways that increase State flexibility, control costs and better serve beneficiaries, as the President has proposed.

Chart 1

Annual Percent Increase in Medicaid Expenditures per Enrollee vs. Private Health Insurance

1976-2005

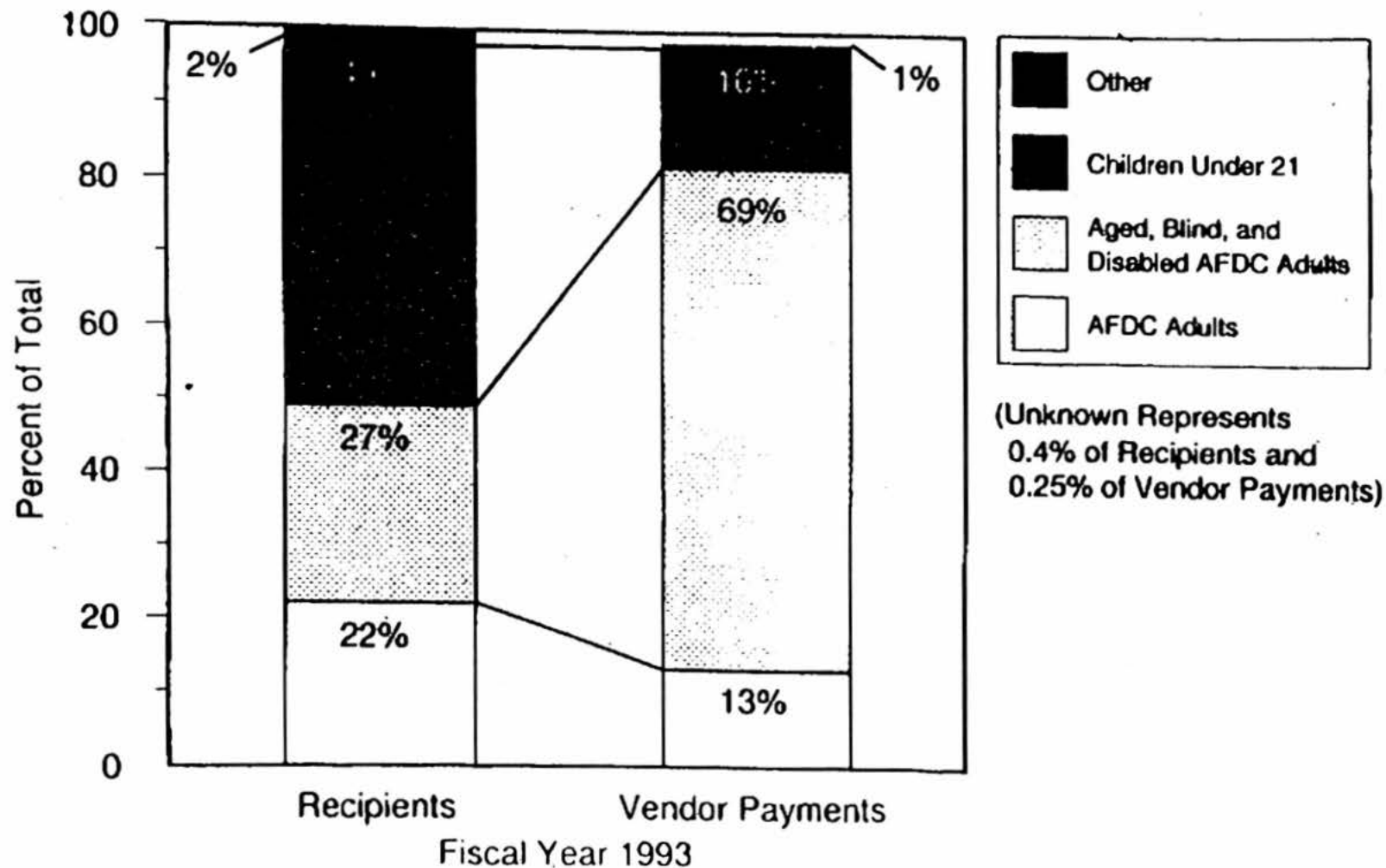


*Private health expenditures per insured person & Medicaid Expenditures per recipient
Source: HCFA/OAC1

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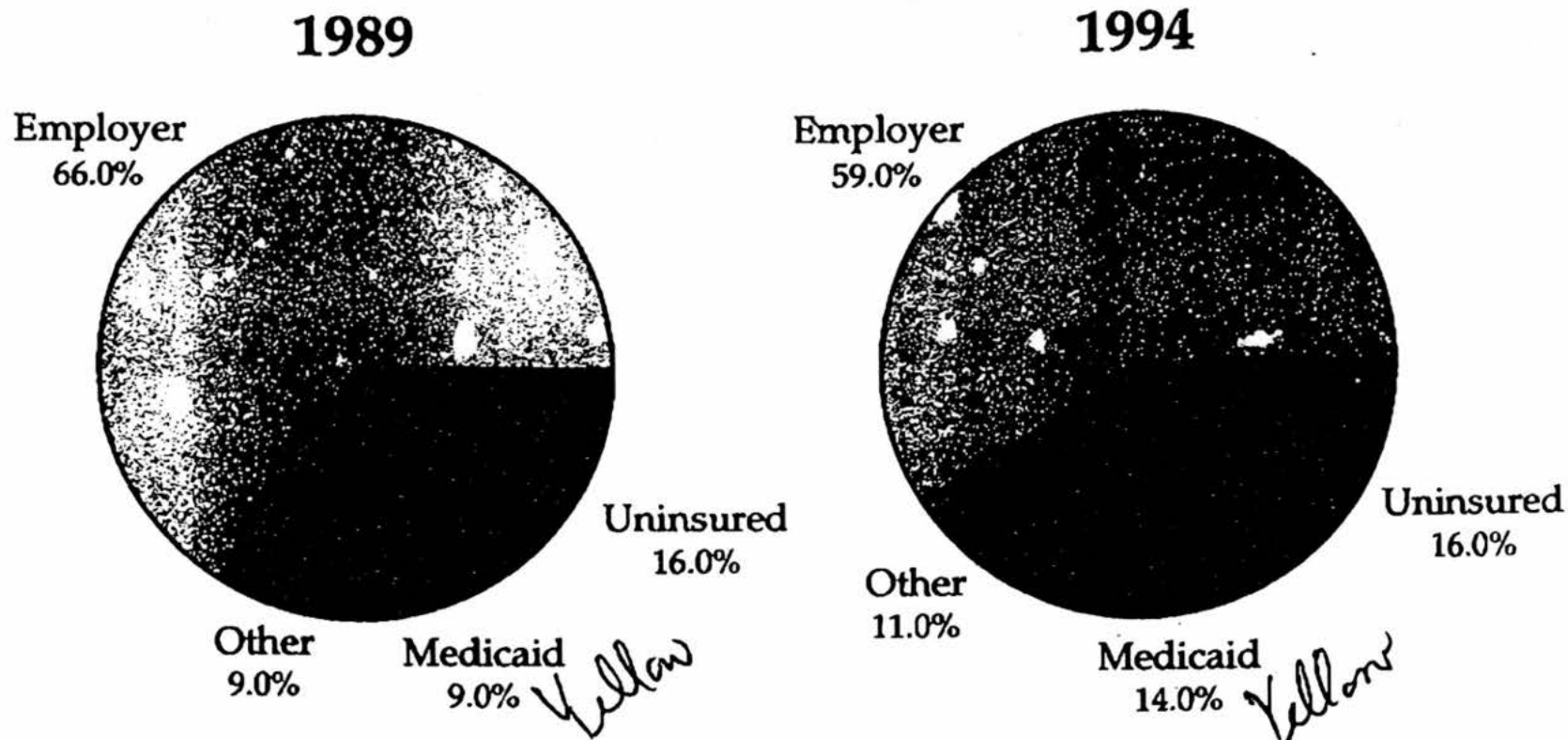
Chart 2

Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility



P8-1 AS618A

Medicaid is a Critical Safety Net



SOURCE: HCFA, Office of the Actuary and Urban Institute, 1995.

Chart 4

Total Expenditures for Mandatory and Optional Medicaid Services and Populations: FY 1993

(Dollars in Millions)

	Mandatory Services	Optional Services	Total
Mandatory People	47,885	23,681	71,566
Optional People	12,052	26,358	38,409
TOTAL	59,936	50,039	109,975

As A Percent of Total

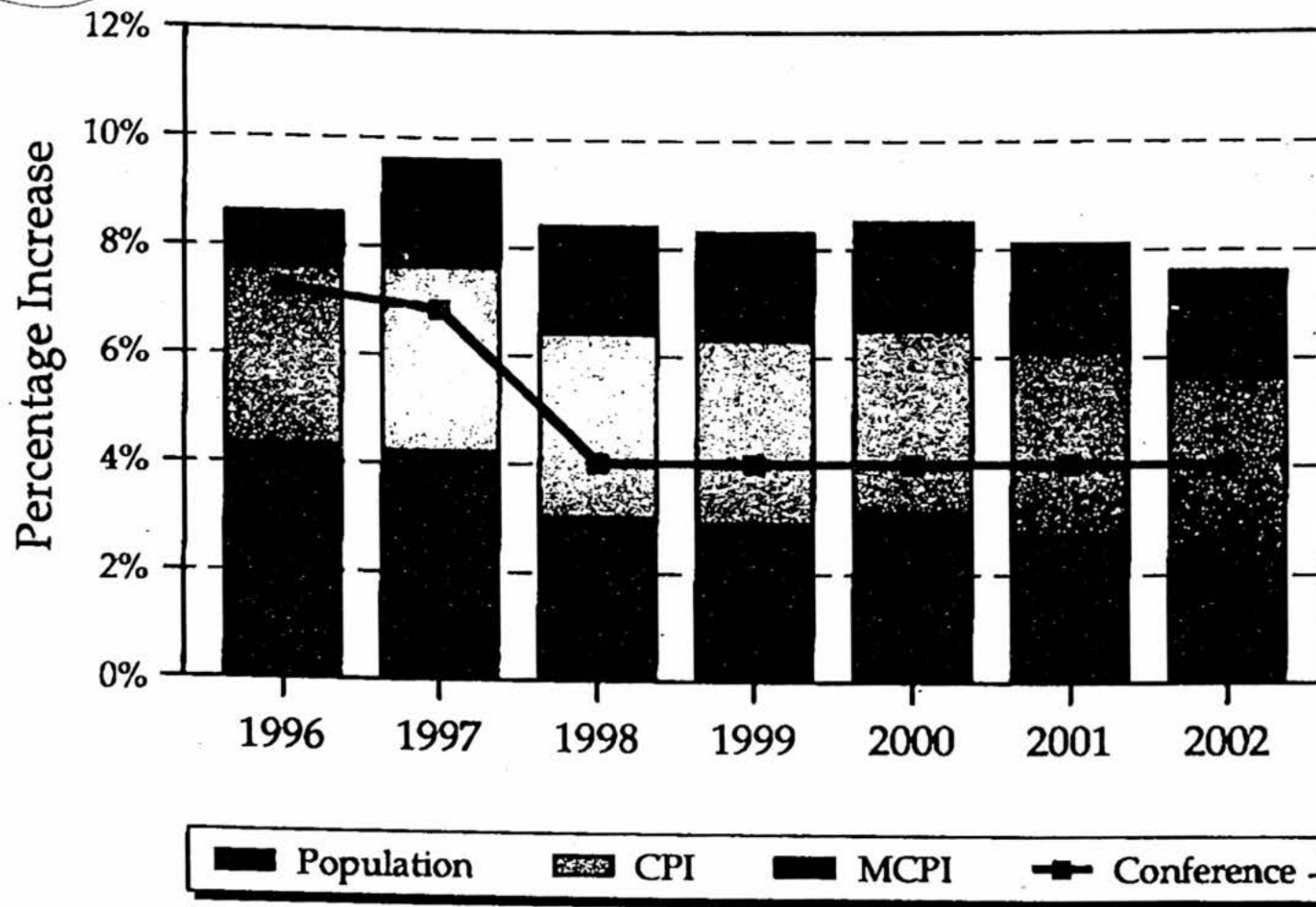
	Mandatory Services	Optional Services	Total
Mandatory People	43.5%	21.5%	65.1%
Optional People	11.0%	24.0%	34.9%
TOTAL	54.5%	45.5%	100.0%

Excludes DSH, collections and adjustments

13081/hchs93-4

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002 for All Beneficiaries



MEDICAID SPOUSAL IMPOVERISHMENT PROTECTIONS

CURRENT LAW

States are required to protect minimum amounts of a couple's income and assets for the at-home spouse when the other spouse enters a nursing home or other institution for a long-term stay.

Amounts above the protected levels of assets and, in some cases income, are expected to be used to defray the cost of nursing home care.

o Income.

States are required to protect a monthly income for the at-home spouse of at least \$1,230, at most, \$1,870. Figures are for 1995, and are updated annually for inflation.

How it works:

Income from Social Security and pensions typically "belongs" to the individual whose name is on the check, not the individual's spouse.

- + If the at-home spouse has no income in her own name, her institutionalized spouse may transfer income to the at-home spouse, up to the protected level.
- + If the at-home spouse has some income (e.g., her share of Social Security or a pension from her work), then the institutionalized spouse could transfer an amount sufficient to bring her total up to the protected level.
- + The at-home spouse can get even higher amounts in certain circumstances (e.g., exceptional shelter costs, petitioning for a hearing based on need.)

o Assets.

"Assets" include things like savings accounts, investments, but not such assets as the home, automobile, or certain limited insurance policies, which do not affect eligibility. In addition, persons can have up to \$2000 in savings (typical amount) and still be eligible for Medicaid.

The minimum amount of protected assets for the community spouse is \$14,964. The maximum is \$74,820. (States can

set their own minimums anywhere between those two numbers.) Community spouses can petition for more. Figures are for 1995, and are updated annually for inflation.

In calculating the protected spousal share, States are required to:

- Add all the couple's assets together, regardless of which spouse owns them.
- Divide the total in half.
- If one half equals or is less than the minimum, then the community spouse gets it all.
- If one half is greater than the minimum, then the community spouse keeps half, up to the Federal ceiling described above.
- States must protect more if ordered by a hearing officer or court.

Amounts above the share protected for the community spouse are considered to be available to the institutionalized spouse. If the institutionalized spouse's share exceed Medicaid eligibility limits on assets, then that spouse is ineligible until they are depleted down to Medicaid levels.

How it works:

Examples are illustrative. Real world configurations are infinite.

- + If the couple's total assets (his, hers, plus jointly owned) are \$20,000, and in a State where the minimum protected spousal amount is \$14,964, the community spouse's share gets that amount. Because the remaining \$5,036 is above the (typical) eligibility ceiling on assets of \$2,000, the institutionalized spouse will be eligible for Medicaid after depleting his share by \$3,036.
 - + If the couple's total assets are \$76,820, and if their State elects to use the highest minimum, then the community spouse can keep \$74,820, and the institutionalized spouse's share of \$2000 means that his assets are within Medicaid eligibility levels.
 - + If the couple's total assets are \$200,000, Federal law caps her share at \$74,820, so that is the amount she gets to keep. Her institutionalized spouse is ineligible until \$125,180 is spent down to \$2000.
 - + If their total assets are \$500,000 and produce necessary income, the community spouse may petition Medicaid hearing office or court and get the entire amount. The institutionalized spouse would have no asset spend-down at all.
-

REPUBLICAN MEDICAID PROPOSALS

ELIGIBILITY

POTENTIAL IMPACT ON PEOPLE

Overview:

What the proposals do.

All Federal eligibility requirements and protections would be abolished. No one would be entitled to anything. States could re-establish protections, but there would be no guarantees.

General implications for categories of coverable people:

Though the Republican proposals require States to spend a portion of their Medicaid on broad categories of persons, e.g., children, disabled, and the elderly, they permit States to restrict coverage to subgroups within those broad categories, e.g., only children in school or with up to date vaccinations, or only elderly in nursing homes.

General implications for financial rules:

States would have a completely free hand in defining eligibility. Even though the proposals set a ceiling on income, these ceilings have little real meaning because the States have the power to define income as they chose. The States decide what they count or ignore as "income" or "assets," in how they treat a person's home, and in how they consider income and assets of a person's relatives. They could be as stringent or generous as they chose on all aspects. Their rules could vary by eligibility group (State-defined) on the stringent-to-generous spectrum.

Examples -- Current Federal protections would be at State option:

Under the Republican proposals, no more eligibility floor on income or assets would be guaranteed:

o The home.

States generally cannot deny eligibility because a person/family owns a home of any value. States cannot force a person to sell or mortgage real property as long as it remains their (or their spouse's or children's) home.

The Republican proposals would leave this protection up to each State.

o Spousal impoverishment.

Since 1988, States have been required to allow spouses of institutionalized Medicaid beneficiaries to keep certain amounts of the couple's total income and assets. Only the remainder is considered when determining how much the couple pays and how much the State pays for nursing home or other long-term care.

Before 1988, attribution of ownership of income and assets followed the "name on the check" rule. Whose ever name was on the check or bank account, typically, that name was the husband's, was considered the owner. If the husband was in the nursing home, nearly everything "belonged" to the husband (though not the home) and was considered to be payable for nursing home care before Medicaid kicked in. These rules and their consequences could have been avoided by spouses with savvy, advance planning, or legal advice. The 1988 law established a set of spousal impoverishment rules.

Note that where the situation was reversed -- where the wife was institutionalized -- the husband might be required to pay nothing towards her care, even if his income or assets were substantial.

The Republican proposals would likely lead to a severe erosion of these protections. Many States have argued that the current rules are inequitable because they leave one particular group of Medicaid beneficiaries with substantially more income and assets than any other group. These States would be likely to completely restructure or even eliminate these protections.

o Liens.

Current law permits States to impose liens on the homes of Medicaid beneficiaries in nursing homes but only under very limited circumstances. Any lien must dissolve if the person reoccupies the home. (Note: A lien ensures that the State will be able to recover for past spending from the proceeds when the home is eventually sold.)

Under current law, States cannot recover from a lien until the death of the beneficiary (or spouse) or the departure from the home of certain other relatives who have lived there.

The Republican proposals would remove all restrictions on State's ability to impose liens. They would no longer be bound by current law restrictions and could, for example, impose a lien or even force a sale or second mortgage to recover from the lien when the spouse still lives in the home.

o Transfer of assets/estate recoveries.

Current law, established in OBRA 1993, was guided by the philosophy that said: permanently institutionalized people without surviving spouses or dependent children should pay, and their estates, if any, should repay after their deaths, for nursing home costs before Medicaid pays. Some States complain that OBRA 93 did not go far enough and left too many loopholes. Others have resisted implementation, preferring to protect inheritances for non-poor adult children, even if increased spending on nursing home costs cuts into spending on other, poorer groups.

Under the Republican proposals, given the politically charged nature of the issue, non-needy heirs could win, while children or others with less political clout could lose.

o Income for work expenses, child care.

Current law requires States, before finding an applicant's income and assets to be above or below eligibility thresholds, to subtract, or "disregard," certain amounts from gross income. The two most significant income disregards are for a person's work-related expenses and child care spending. These signify that working people with such expenses need/deserve assistance at higher levels of gross income than non-working people.

The Republican proposals would permit States to reduce or eliminate protections for working families.

o Other disregards, exclusions, exemptions.

Current law also requires States to subtract or ignore the value of a variety of items in determining whether a person is within eligibility thresholds: minimum levels of savings, personal effects, a wedding ring, household furnishings, life and burial insurance -- all within low limits.

All these protections would be left to States' choice under the Republican proposals.

o Financial requirements on beneficiaries' relatives.

Under current law, a person's eligibility for Medicaid depends on how much income or assets they and their spouse have, or, for minor children, how much their parents have. States are prohibited from considering income or assets of any other relative. That is, an elderly person's eligibility is not affected by income or assets of their adult children, nor is a disabled adult's eligibility affected by an elderly parent's financial circumstances. Similarly with siblings, grandparents, or others.

Under the Republican proposals, States could hold anyone they wanted to responsible for providing support to a person or paying their medical bills.

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REPUBLICAN MEDICAID PROPOSALS
POTENTIAL IMPOVERISHMENT OF SPOUSES

EXAMPLES

Before the enactment of "spousal impoverishment" protections in 1988, the following hypothetical situations demonstrate the plight of spouses -- typically women -- whose husbands had to enter a nursing home.

Rose S.

Rose S. is a full-time homemaker all her life. She is therefore economically dependent on her husband. On retirement, her share of the couple's Social Security (based on her status as a dependent wife), is \$400, or 50 percent of the amount her husband John's benefit of \$800. Their rent alone is \$400. The couple has no assets.

Her husband is admitted to a nursing home with a monthly cost of care was \$3000. He immediately becomes eligible for Medicaid.

- Before the 1988 spousal impoverishment protections:

Medicaid rules assumed that John S. would use virtually all of his income to pay a share of his nursing home costs, with Medicaid paying the remainder. Rose S. would be left with just her \$400 share of Social Security. Women in her situation often took their husbands to court to sue for additional support.

- After the 1988 protections:

Rose S. gets both her and her husband's shares (\$1200 total) of Social Security.

- Under the Republican proposals:

Rose S.'s fate is up to the State. So is the eligibility status of her husband.

Grace W.

Grace W. receives month Social Security of \$700 and a pension of \$600 based on her own work history. Her husband Art receives \$1000 Social Security but no pension. They own their own home and have mortgage payments of \$800. They also have \$200,000 saved up and invested in mutual funds, producing interest income which they use to pay monthly living expenses.

When Art enters a nursing home, he is not immediately eligible because of their savings.

- Before the 1988 spousal impoverishment protections:

Art W. was required to deplete their entire savings down to Medicaid eligibility levels before qualifying for Medicaid. Even after qualifying, he would be expected to pay most of his income for his care. Grace W. would be left with only her Social Security and pension. Her options would have been: sue Art W. for support; divorce him and have all assets awarded to her; or accept the Medicaid-dictated outcome, sell the house and move to a small apartment affordable on her own income.

- After the 1988 protections:

Grace W. gets, at a minimum in all States, nearly \$15,000 of the couple's assets, up to almost \$75,000 if her State has chosen the highest amount. In all States, she could exercise her rights to a fair hearing and conceivably get the entire \$200,000, enabling her to remain in their home. Grace W. would have no claim on Art W.'s Social Security because her own income is above the level protected for the spouses of institutionalized Medicaid recipients.

- Under the Republican proposals:

Grace W.'s fate is up to the State. She could end up with none of their lifetime savings. She might be able to get more by suing her husband for support or divorcing him.

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MEDICAID SPOUSAL IMPOVERISHMENT PROTECTIONS

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Under the Republican proposals, States could hold anyone they wanted to responsible for providing support to a person or paying their medical bills.

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REPUBLICAN MEDICAID PROPOSALS
POTENTIAL IMPOVERISHMENT OF SPOUSES

EXAMPLES

Before the enactment of "spousal impoverishment" protections in 1988, the following hypothetical situations demonstrate the plight of spouses -- typically women -- whose husbands had to enter a nursing home.

Rose S.

Rose S. is a full-time homemaker all her life. She is therefore economically dependent on her husband. On retirement, her share of the couple's Social Security (based on her status as a dependent wife), is \$400, or 50 percent of the amount her husband John's benefit of \$800. Their rent alone is \$400. The couple has no assets.

Her husband is admitted to a nursing home with a monthly cost of care was \$3000. He immediately becomes eligible for Medicaid.

- Before the 1988 spousal impoverishment protections:

Medicaid rules assumed that John S. would use virtually all of his income to pay a share of his nursing home costs, with Medicaid paying the remainder. Rose S. would be left with just her \$400 share of Social Security. Women in her situation often took their husbands to court to sue for additional support.

- After the 1988 protections:

Rose S. gets both her and her husband's shares (\$1200 total) of Social Security.

- Under the Republican proposals:

Rose S.'s fate is up to the State. So is the eligibility status of her husband.

Grace W.

Grace W. receives month Social Security of \$700 and a pension of \$600 based on her own work history. Her husband Art receives \$1000 Social Security but no pension. They own their own home and have mortgage payments of \$800. They also have \$200,000 saved up and invested in mutual funds, producing interest income which they use to pay monthly living expenses.

When Art enters a nursing home, he is not immediately eligible because of their savings.

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Art W. was required to deplete their entire savings down to Medicaid eligibility levels before qualifying for Medicaid. Even after qualifying, he would be expected to pay most of his income for his care. Grace W. would be left with only her Social Security and pension. Her options would have been: sue Art W. for support; divorce him and have all assets awarded to her; or accept the Medicaid-dictated outcome, sell the house and move to a small apartment affordable on her own income.

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Grace W. gets, at a minimum in all States, nearly \$15,000 of the couple's assets, up to almost \$75,000 if her State has chosen the highest amount. In all States, she could exercise her rights to a fair hearing and conceivably get the entire \$200,000, enabling her to remain in their home. Grace W. would have no claim on Art W.'s Social Security because her own income is above the level protected for the spouses of institutionalized Medicaid recipients.

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MEDICAID SPOUSAL IMPOVERISHMENT PROTECTIONS

CURRENT LAW

States are required to protect minimum amounts of a couple's income and assets for the at-home spouse when the other spouse enters a nursing home or other institution for a long-term stay.

Amounts above the protected levels of assets and, in some cases income, are expected to be used to defray the cost of nursing home care.

o Income.

States are required to protect a monthly income for the at-home spouse of at least \$1,230, at most, \$1,870. Figures are for 1995, and are updated annually for inflation.

How it works:

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- + If the at-home spouse has no income in her own name, her institutionalized spouse may transfer income to the at-home spouse, up to the protected level.
- + If the at-home spouse has some income (e.g., her share of Social Security or a pension from her work), then the institutionalized spouse could transfer an amount sufficient to bring her total up to the protected level.
- + The at-home spouse can get even higher amounts in certain circumstances (e.g., exceptional shelter costs, petitioning for a hearing based on need.)

o Assets.

"Assets" include things like savings accounts, investments, but not such assets as the home, automobile, or certain limited insurance policies, which do not affect eligibility. In addition, persons can have up to \$2000 in savings (typical amount) and still be eligible for Medicaid.

The minimum amount of protected assets for the community spouse is \$14,964. The maximum is \$74,820. (States can

set their own minimums anywhere between those two numbers.) Community spouses can petition for more. Figures are for 1995, and are updated annually for inflation.

In calculating the protected spousal share, States are required to:

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How it works:

Examples are illustrative. Real world configurations are infinite.

- + If the couple's total assets (his, hers, plus jointly owned) are \$20,000, and in a State where the minimum protected spousal amount is \$14,964, the community spouse's share gets that amount. Because the remaining \$5,036 is above the (typical) eligibility ceiling on assets of \$2,000, the institutionalized spouse will be eligible for Medicaid after depleting his share by \$3,036.
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REPUBLICAN MEDICAID PROPOSALS

ELIGIBILITY

POTENTIAL IMPACT ON PEOPLE

Overview:

What the proposals do.

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General implications for categories of coverable people:

Though the Republican proposals require States to spend a portion of their Medicaid on broad categories of persons, e.g., children, disabled, and the elderly, they permit States to restrict coverage to subgroups within those broad categories, e.g., only children in school or with up to date vaccinations, or only elderly in nursing homes.

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States would have a completely free hand in defining eligibility. Even though the proposals set a ceiling on income, these ceilings have little real meaning because the States have the power to define income as they chose. The States decide what they count or ignore as "income" or "assets," in how they treat a person's home, and in how they consider income and assets of a person's relatives. They could be as stringent or generous as they chose on all aspects. Their rules could vary by eligibility group (State-defined) on the stringent-to-generous spectrum.

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DRAFT

Sept. 25. 1955

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Comparison of Growth Rates: Republican Proposal v. Current Law

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
Alabama	Baseline	8.7%	9.3%	9.1%	9.2%	9.3%	9.5%	9.5%	9.3%
	Republicans	10.5%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
Alaska	Baseline	11.4%	11.6%	10.9%	10.6%	10.4%	10.8%	10.6%	10.8%
	Republicans	19.5%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%
Arizona	Baseline	11.2%	11.7%	11.1%	11.0%	10.8%	11.1%	10.8%	11.1%
	Republicans	9.1%	12.3%	5.2%	5.2%	5.2%	4.4%	1.3%	5.6%
Arkansas	Baseline	9.9%	10.5%	10.0%	10.3%	10.1%	10.5%	10.4%	10.3%
	Republicans	15.3%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
California	Baseline	8.4%	9.1%	8.7%	8.9%	8.9%	9.5%	10.5%	9.3%
	Republicans	2.6%	12.2%	6.8%	6.8%	6.8%	3.9%	4.3%	6.8%
Colorado	Baseline	6.9%	7.7%	7.4%	7.7%	7.7%	8.2%	8.2%	7.8%
	Republicans	-5.5%	12.3%	5.2%	5.2%	3.9%	3.3%	1.3%	5.2%
Connecticut	Baseline	7.9%	9.0%	8.6%	8.9%	8.8%	9.1%	10.0%	9.1%
	Republicans	8.2%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Delaware	Baseline	11.5%	11.5%	10.9%	10.9%	10.6%	10.8%	10.7%	10.9%
	Republicans	29.8%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%
District of Columbia	Baseline	12.1%	12.2%	11.6%	11.4%	11.1%	11.0%	10.9%	11.4%
	Republicans	13.2%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Florida	Baseline	12.3%	12.8%	12.2%	11.6%	11.5%	11.4%	11.1%	11.8%
	Republicans	12.8%	12.3%	6.8%	6.8%	6.8%	5.3%	4.3%	7.0%
Georgia	Baseline	11.9%	12.8%	12.2%	11.7%	11.4%	11.4%	11.2%	11.8%
	Republicans	3.6%	12.4%	5.2%	5.2%	3.9%	3.7%	1.3%	5.2%
Hawaii	Baseline	11.4%	12.1%	11.4%	11.1%	10.9%	10.9%	10.7%	11.2%
	Republicans	31.3%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Idaho	Baseline	9.7%	10.1%	9.4%	9.8%	9.3%	10.0%	9.9%	9.7%
	Republicans	10.4%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Illinois	Baseline	12.4%	11.9%	11.3%	11.1%	10.7%	11.0%	10.8%	11.2%
	Republicans	13.7%	12.3%	3.9%	5.7%	3.9%	2.9%	1.3%	5.0%
Indiana	Baseline	8.1%	9.2%	8.6%	9.8%	9.6%	10.2%	10.0%	9.6%
	Republicans	-2.5%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Iowa	Baseline	9.0%	10.1%	9.5%	10.0%	9.7%	10.3%	10.1%	10.0%
	Republicans	9.4%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%

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Republican spending from GAO's November 16 state tables, plus \$16 billion in transition funds allocated to states in proportion to their allotments.

Comparison of Growth Rates: Republican Proposal v. Current Law: Continued

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
Kansas	Baseline	11.2%	11.4%	10.9%	10.9%	10.6%	10.7%	10.6%	10.9%
	Republicans	19.7%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Kentucky	Baseline	10.0%	10.4%	10.0%	10.4%	10.2%	10.8%	10.6%	10.4%
	Republicans	1.9%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
Louisiana	Baseline	5.6%	10.2%	10.2%	9.9%	9.9%	9.7%	9.8%	10.0%
	Republicans	-19.7%	4.5%	-1.5%	-0.1%	-0.1%	5.2%	2.6%	1.7%
Maine	Baseline	9.3%	10.2%	9.9%	9.9%	9.8%	11.0%	10.8%	10.2%
	Republicans	8.7%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Maryland	Baseline	9.8%	10.4%	9.7%	10.1%	9.7%	10.5%	10.3%	10.1%
	Republicans	8.7%	11.9%	3.9%	3.9%	3.9%	3.5%	1.3%	4.7%
Massachusetts	Baseline	7.2%	8.4%	8.9%	9.4%	9.2%	10.0%	9.8%	9.3%
	Republicans	11.8%	6.7%	2.9%	1.9%	1.9%	1.6%	-0.6%	2.4%
Michigan	Baseline	10.9%	11.0%	10.5%	10.6%	10.3%	10.8%	10.6%	10.6%
	Republicans	14.2%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Minnesota	Baseline	11.4%	12.1%	11.6%	11.4%	11.2%	11.0%	10.9%	11.4%
	Republicans	16.7%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Mississippi	Baseline	10.0%	10.4%	11.2%	11.1%	10.9%	11.1%	11.0%	11.0%
	Republicans	8.1%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Missouri	Baseline	6.8%	8.0%	7.6%	8.0%	8.0%	8.5%	8.5%	8.1%
	Republicans	9.6%	12.4%	3.9%	5.2%	3.9%	3.9%	1.3%	5.0%
Montana	Baseline	12.3%	12.3%	11.8%	11.5%	11.3%	11.1%	11.0%	11.5%
	Republicans	12.3%	12.4%	4.6%	5.2%	3.9%	3.9%	1.3%	5.2%
Nebraska	Baseline	10.0%	11.1%	10.5%	10.6%	10.4%	10.6%	10.4%	10.6%
	Republicans	8.1%	30.9%	-15.1%	1.9%	1.9%	1.9%	-0.6%	2.6%
Nevada	Baseline	8.5%	9.0%	8.7%	9.0%	8.9%	10.6%	10.4%	9.4%
	Republicans	49.0%	9.2%	5.2%	-17.2%	6.9%	6.9%	4.3%	2.1%
New Hampshire	Baseline	5.9%	6.7%	6.6%	6.7%	6.9%	7.0%	7.0%	6.8%
	Republicans	-25.0%	3.1%	-0.1%	-0.1%	-0.1%	1.9%	-0.6%	0.7%
New Jersey	Baseline	8.3%	8.8%	8.6%	8.8%	8.7%	9.0%	8.9%	8.8%
	Republicans	6.4%	6.7%	2.9%	1.9%	1.9%	1.0%	-0.6%	2.3%
New Mexico	Baseline	12.3%	12.0%	11.4%	11.1%	10.9%	11.1%	10.9%	11.2%
	Republicans	15.1%	12.3%	6.8%	6.9%	6.9%	6.3%	4.3%	7.2%

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Republican spending from GAO's November 18 state tables, plus \$16 billion in transition funds allocated to states in proportion to their allotments.

Comparison of Growth Rates: Republican Proposal v. Current Law: Continued

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
New York	Baseline	7.5%	8.5%	8.1%	9.5%	9.2%	9.9%	9.7%	9.2%
	Republicans	10.6%	6.7%	2.9%	1.9%	1.9%	1.1%	-0.6%	2.3%
North Carolina	Baseline	10.7%	11.3%	11.8%	11.3%	11.1%	10.9%	10.7%	11.2%
	Republicans	9.7%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
North Dakota	Baseline	7.7%	9.2%	8.6%	9.3%	9.1%	9.7%	9.5%	9.3%
	Republicans	11.0%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Ohio	Baseline	8.6%	9.7%	9.0%	9.5%	9.2%	10.0%	9.7%	9.5%
	Republicans	9.5%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Oklahoma	Baseline	6.8%	8.5%	7.9%	8.7%	8.6%	9.6%	9.4%	8.8%
	Republicans	11.8%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Oregon	Baseline	13.4%	13.1%	12.4%	11.6%	11.3%	11.1%	10.9%	11.7%
	Republicans	32.3%	12.4%	3.9%	3.9%	3.9%	3.5%	1.3%	4.8%
Pennsylvania	Baseline	7.4%	9.7%	9.2%	9.5%	9.4%	9.9%	9.7%	9.6%
	Republicans	9.3%	10.7%	3.9%	3.9%	3.9%	3.9%	1.3%	4.6%
Rhode Island	Baseline	8.9%	9.4%	9.0%	9.3%	9.0%	9.3%	10.4%	9.4%
	Republicans	6.8%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
South Carolina	Baseline	9.6%	9.9%	9.7%	9.7%	9.6%	9.7%	9.7%	9.7%
	Republicans	10.7%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
South Dakota	Baseline	9.8%	10.5%	10.0%	10.3%	10.0%	10.4%	10.3%	10.2%
	Republicans	19.0%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Tennessee	Baseline	9.2%	9.7%	9.2%	9.3%	9.3%	9.8%	9.7%	9.5%
	Republicans	33.2%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Texas	Baseline	11.1%	11.5%	11.2%	10.7%	11.9%	11.5%	11.3%	11.3%
	Republicans	8.0%	12.3%	6.8%	6.8%	6.0%	2.9%	1.3%	6.0%
Utah	Baseline	9.7%	10.2%	9.5%	9.7%	9.4%	10.2%	10.0%	9.8%
	Republicans	11.5%	12.4%	5.2%	5.2%	5.2%	5.2%	2.4%	5.9%
Vermont	Baseline	9.0%	10.7%	10.2%	10.3%	10.1%	10.5%	10.3%	10.4%
	Republicans	20.6%	6.7%	2.9%	1.9%	4.1%	4.1%	1.5%	3.5%
Virginia	Baseline	10.2%	11.1%	10.6%	10.6%	10.4%	10.6%	10.5%	10.6%
	Republicans	8.3%	12.3%	6.8%	6.9%	3.9%	3.3%	1.3%	5.7%
Washington	Baseline	10.1%	10.3%	10.9%	10.8%	10.5%	10.8%	10.6%	10.6%
	Republicans	13.3%	6.7%	2.9%	1.9%	1.9%	1.5%	-0.6%	2.4%
West Virginia	Baseline	12.7%	12.6%	12.1%	11.6%	11.4%	11.3%	11.1%	11.7%
	Republicans	12.1%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Wisconsin	Baseline	7.8%	9.3%	8.8%	9.4%	9.3%	10.0%	9.8%	9.4%
	Republicans	14.6%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Wyoming	Baseline	10.2%	10.7%	10.1%	10.3%	10.0%	10.4%	10.2%	10.3%
	Republicans	12.0%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%

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Comparison of Growth Rates: Republican Proposal v. Current Law

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
Alabama	Baseline	8.7%	9.3%	9.1%	9.2%	9.3%	9.5%	9.5%	9.3%
	Republicans	10.5%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
Alaska	Baseline	11.4%	11.6%	10.9%	10.6%	10.4%	10.8%	10.6%	10.8%
	Republicans	19.5%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%
Arizona	Baseline	11.2%	11.7%	11.1%	11.0%	10.8%	11.1%	10.8%	11.1%
	Republicans	9.1%	12.3%	5.2%	5.2%	5.2%	4.4%	1.3%	5.6%
Arkansas	Baseline	9.9%	10.5%	10.0%	10.3%	10.1%	10.5%	10.4%	10.3%
	Republicans	15.3%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
California	Baseline	8.4%	9.1%	8.7%	8.9%	8.9%	9.5%	10.5%	9.3%
	Republicans	2.6%	12.2%	6.8%	6.8%	6.8%	3.9%	4.3%	6.8%
Colorado	Baseline	6.9%	7.7%	7.4%	7.7%	7.7%	8.2%	8.2%	7.8%
	Republicans	-5.5%	12.3%	5.2%	5.2%	3.9%	3.3%	1.3%	5.2%
Connecticut	Baseline	7.9%	9.0%	8.6%	8.9%	8.8%	9.1%	10.0%	9.1%
	Republicans	8.2%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Delaware	Baseline	11.5%	11.5%	10.9%	10.9%	10.6%	10.8%	10.7%	10.9%
	Republicans	29.8%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%
District of Columbia	Baseline	12.1%	12.2%	11.6%	11.4%	11.1%	11.0%	10.9%	11.4%
	Republicans	13.2%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Florida	Baseline	12.3%	12.8%	12.2%	11.6%	11.5%	11.4%	11.1%	11.8%
	Republicans	12.8%	12.3%	6.8%	6.8%	6.8%	5.3%	4.3%	7.0%
Georgia	Baseline	11.9%	12.8%	12.2%	11.7%	11.4%	11.4%	11.2%	11.8%
	Republicans	3.6%	12.4%	5.2%	5.2%	3.9%	3.7%	1.3%	5.2%
Hawaii	Baseline	11.4%	12.1%	11.4%	11.1%	10.9%	10.9%	10.7%	11.2%
	Republicans	31.3%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Idaho	Baseline	9.7%	10.1%	9.4%	9.8%	9.3%	10.0%	9.9%	9.7%
	Republicans	10.4%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Illinois	Baseline	12.4%	11.9%	11.3%	11.1%	10.7%	11.0%	10.8%	11.2%
	Republicans	13.7%	12.3%	3.9%	5.7%	3.9%	2.9%	1.3%	5.0%
Indiana	Baseline	8.1%	9.2%	8.6%	9.8%	9.6%	10.2%	10.0%	9.6%
	Republicans	-2.5%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Iowa	Baseline	9.0%	10.1%	9.5%	10.0%	9.7%	10.3%	10.1%	10.0%
	Republicans	9.4%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%

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Comparison of Growth Rates: Republican Proposal v. Current Law: Continued

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
Kansas	Baseline	11.2%	11.4%	10.9%	10.9%	10.6%	10.7%	10.6%	10.9%
	Republicans	19.7%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Kentucky	Baseline	10.0%	10.4%	10.0%	10.4%	10.2%	10.8%	10.6%	10.4%
	Republicans	1.9%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
Louisiana	Baseline	5.6%	10.2%	10.2%	9.9%	9.9%	9.7%	9.8%	10.0%
	Republicans	-19.7%	4.5%	-1.5%	-0.1%	-0.1%	5.2%	2.6%	1.7%
Maine	Baseline	9.3%	10.2%	9.9%	9.9%	9.8%	11.0%	10.8%	10.2%
	Republicans	8.7%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Maryland	Baseline	9.8%	10.4%	9.7%	10.1%	9.7%	10.5%	10.3%	10.1%
	Republicans	8.7%	11.9%	3.9%	3.9%	3.9%	3.5%	1.3%	4.7%
Massachusetts	Baseline	7.2%	8.4%	8.9%	9.4%	9.2%	10.0%	9.8%	9.3%
	Republicans	11.8%	6.7%	2.9%	1.9%	1.9%	1.6%	-0.6%	2.4%
Michigan	Baseline	10.9%	11.0%	10.5%	10.6%	10.3%	10.8%	10.6%	10.6%
	Republicans	14.2%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Minnesota	Baseline	11.4%	12.1%	11.6%	11.4%	11.2%	11.0%	10.9%	11.4%
	Republicans	16.7%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
Mississippi	Baseline	10.0%	10.4%	11.2%	11.1%	10.9%	11.1%	11.0%	11.0%
	Republicans	8.1%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Missouri	Baseline	6.8%	8.0%	7.6%	8.0%	8.0%	8.5%	8.5%	8.1%
	Republicans	9.6%	12.4%	3.9%	5.2%	3.9%	3.9%	1.3%	5.0%
Montana	Baseline	12.3%	12.3%	11.8%	11.5%	11.3%	11.1%	11.0%	11.5%
	Republicans	12.3%	12.4%	4.6%	5.2%	3.9%	3.9%	1.3%	5.2%
Nebraska	Baseline	10.0%	11.1%	10.5%	10.6%	10.4%	10.6%	10.4%	10.6%
	Republicans	8.1%	30.9%	-15.1%	1.9%	1.9%	1.9%	-0.6%	2.6%
Nevada	Baseline	8.5%	9.0%	8.7%	9.0%	8.9%	10.6%	10.4%	9.4%
	Republicans	49.0%	9.2%	5.2%	-17.2%	6.9%	6.9%	4.3%	2.1%
New Hampshire	Baseline	5.9%	6.7%	6.6%	6.7%	6.9%	7.0%	7.0%	6.8%
	Republicans	-25.0%	3.1%	-0.1%	-0.1%	-0.1%	1.9%	-0.6%	0.7%
New Jersey	Baseline	8.3%	8.8%	8.6%	8.8%	8.7%	9.0%	8.9%	8.8%
	Republicans	6.4%	6.7%	2.9%	1.9%	1.9%	1.0%	-0.6%	2.3%
New Mexico	Baseline	12.3%	12.0%	11.4%	11.1%	10.9%	11.1%	10.9%	11.2%
	Republicans	15.1%	12.3%	6.8%	6.9%	6.9%	6.3%	4.3%	7.2%

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Comparison of Growth Rates: Republican Proposal v. Current Law: Continued

		1996	1997	1998	1999	2000	2001	2002	Seven Years
United States	Baseline	9.2%	10.1%	9.8%	10.0%	9.9%	10.3%	10.3%	10.1%
	Republicans	8.7%	10.5%	4.2%	4.2%	4.1%	3.4%	1.5%	4.6%
New York	Baseline	7.5%	8.5%	8.1%	9.5%	9.2%	9.9%	9.7%	9.2%
	Republicans	10.6%	6.7%	2.9%	1.9%	1.9%	1.1%	-0.6%	2.3%
North Carolina	Baseline	10.7%	11.3%	11.8%	11.3%	11.1%	10.9%	10.7%	11.2%
	Republicans	9.7%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
North Dakota	Baseline	7.7%	9.2%	8.6%	9.3%	9.1%	9.7%	9.5%	9.3%
	Republicans	11.0%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Ohio	Baseline	8.6%	9.7%	9.0%	9.5%	9.2%	10.0%	9.7%	9.5%
	Republicans	9.5%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Oklahoma	Baseline	6.8%	8.5%	7.9%	8.7%	8.6%	9.6%	9.4%	8.8%
	Republicans	11.8%	12.4%	6.9%	6.9%	6.9%	6.9%	4.3%	7.3%
Oregon	Baseline	13.4%	13.1%	12.4%	11.6%	11.3%	11.1%	10.9%	11.7%
	Republicans	32.3%	12.4%	3.9%	3.9%	3.9%	3.5%	1.3%	4.8%
Pennsylvania	Baseline	7.4%	9.7%	9.2%	9.5%	9.4%	9.9%	9.7%	9.6%
	Republicans	9.3%	10.7%	3.9%	3.9%	3.9%	3.9%	1.3%	4.6%
Rhode Island	Baseline	8.9%	9.4%	9.0%	9.3%	9.0%	9.3%	10.4%	9.4%
	Republicans	6.8%	6.7%	2.9%	1.9%	1.9%	1.9%	-0.6%	2.4%
South Carolina	Baseline	9.6%	9.9%	9.7%	9.7%	9.6%	9.7%	9.7%	9.7%
	Republicans	10.7%	12.4%	5.2%	5.2%	5.2%	5.2%	2.6%	5.9%
South Dakota	Baseline	9.8%	10.5%	10.0%	10.3%	10.0%	10.4%	10.3%	10.2%
	Republicans	19.0%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Tennessee	Baseline	9.2%	9.7%	9.2%	9.3%	9.3%	9.8%	9.7%	9.5%
	Republicans	33.2%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Texas	Baseline	11.1%	11.5%	11.2%	10.7%	11.9%	11.5%	11.3%	11.3%
	Republicans	8.0%	12.3%	6.8%	6.8%	6.0%	2.9%	1.3%	6.0%
Utah	Baseline	9.7%	10.2%	9.5%	9.7%	9.4%	10.2%	10.0%	9.8%
	Republicans	11.5%	12.4%	5.2%	5.2%	5.2%	5.2%	2.4%	5.9%
Vermont	Baseline	9.0%	10.7%	10.2%	10.3%	10.1%	10.5%	10.3%	10.4%
	Republicans	20.6%	6.7%	2.9%	1.9%	4.1%	4.1%	1.5%	3.5%
Virginia	Baseline	10.2%	11.1%	10.6%	10.6%	10.4%	10.6%	10.5%	10.6%
	Republicans	8.3%	12.3%	6.8%	6.9%	3.9%	3.3%	1.3%	5.7%
Washington	Baseline	10.1%	10.3%	10.9%	10.8%	10.5%	10.8%	10.6%	10.6%
	Republicans	13.3%	6.7%	2.9%	1.9%	1.9%	1.5%	-0.6%	2.4%
West Virginia	Baseline	12.7%	12.6%	12.1%	11.6%	11.4%	11.3%	11.1%	11.7%
	Republicans	12.1%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Wisconsin	Baseline	7.8%	9.3%	8.8%	9.4%	9.3%	10.0%	9.8%	9.4%
	Republicans	14.6%	12.4%	3.9%	3.9%	3.9%	3.9%	1.3%	4.8%
Wyoming	Baseline	10.2%	10.7%	10.1%	10.3%	10.0%	10.4%	10.2%	10.3%
	Republicans	12.0%	6.7%	5.2%	5.2%	5.2%	5.2%	2.6%	5.0%

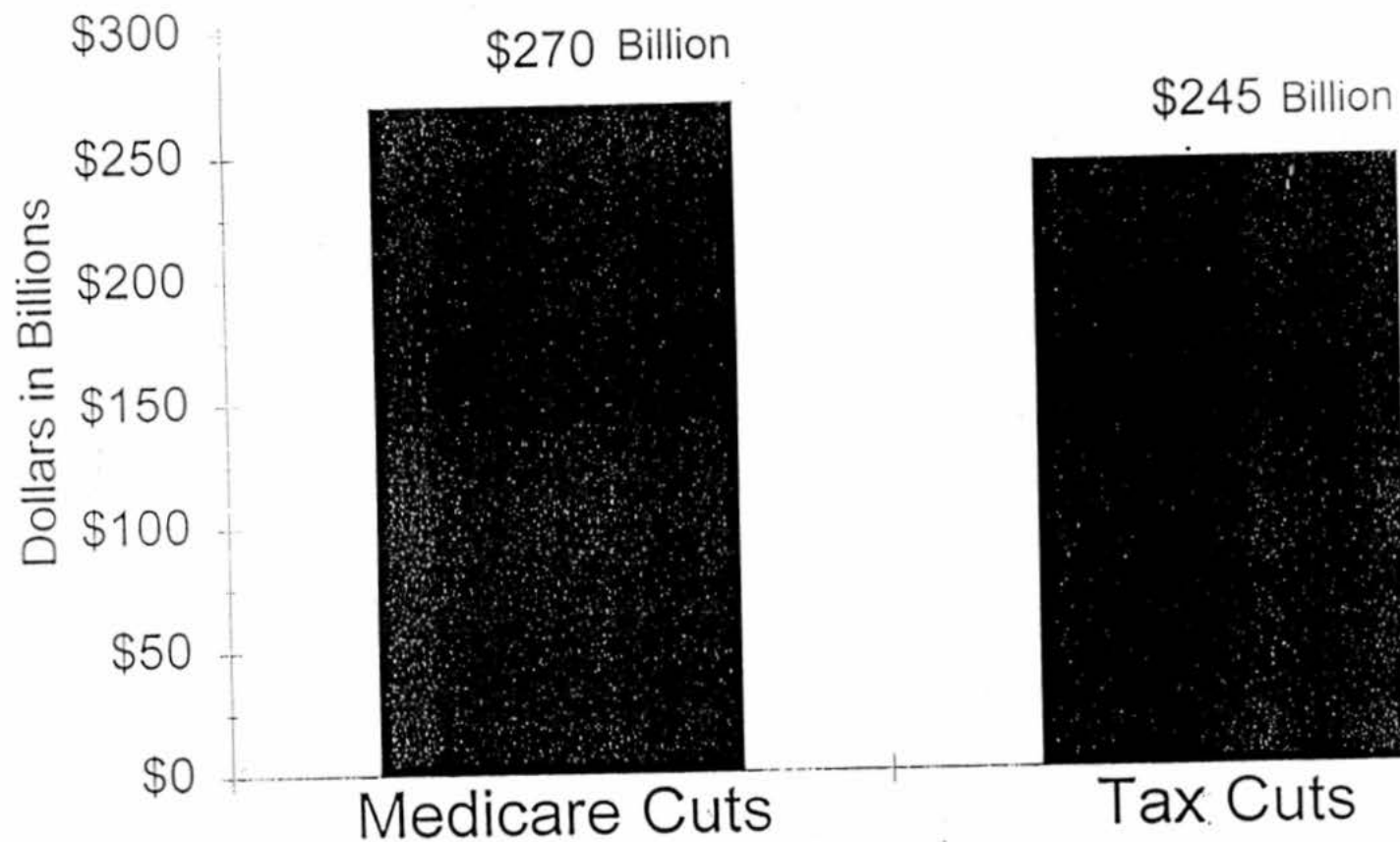
Baseline is the Urban Institute's Medicaid Expenditure Baseline, adjusted to control to the CBO December baseline.

Republican spending from GAO's November 16 state tables, plus \$16 billion in transition funds allocated to states in proportion to their allotments.

MEDICAID

- **REPUBLICANS' UNPRECEDENTED CUTS:** The Republican Budget Resolution Conference Agreement would cut \$182 billion from Medicaid over the next seven years by making the program a block grant to states.
- **HEAVY BURDENS TO FAMILIES FACING LONG-TERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **LIKELY IMPACTS:** The Republicans argue that they are not cutting Medicaid since states will get an increase in the block grant every year. But, given that CBO projects that the number of people covered will grow by 3 percent and that the Republicans block grant will grow by only 4 percent by 1998, the funding does not even keep up with inflation. It's a cut in real terms.
 - Assuming states would be forced to respond to these cuts by reducing services, provider payments and coverage in equal proportions:
 - ◆ **7 million children and nearly one million elderly and persons with disabilities could lose insurance coverage.** This would further worsen our nation's uncompensated care problem and create more incentives for cost-shifting to American businesses and families who still have insurance.
- **THE PRESIDENT'S PROPOSAL PROTECTS COVERAGE:** The President's proposal contains a mix of policies that save \$54 billion between now and 2002 -- less than a third of the Republican proposal. It promotes efficiency and gives states more flexibility while protecting coverage. Every single Democratic Governor has endorsed the President's Medicaid target as a reasonable and achievable savings number.
 - Maintaining coverage under Medicaid is critical since it serves as a safety net for many Americans. Between 1989 and 1994, employer health coverage declined from 66 percent of the nonelderly population to 59 percent. Medicaid coverage increased from 9 to 14 percent during this same period.

Cutting Medicare to Pay for Tax Cuts, 1996 - 2002



Conference Agreement estimates from CBO baselines

Medicaid Cuts That States Would Be Forced to Make

2002

Eliminate coverage for dental,
screening services for kids,
and hospice and home care



Reduce provider payments
by almost \$13 billion

Eliminate coverage for
7 million kids

Eliminate coverage for
nearly one million elderly
and persons with disabilities

NOTE: Assuming 25% cut in each of these categories.

The President's Health Reform Initiative

1. Reforming the Insurance Market

Insurance reforms, based on proposals that both Republicans and Democrats supported in the last Congress, will improve the fairness and efficiency of the insurance marketplace.

- **Portability and Renewability of Coverage** -- Insurers will be barred from denying coverage to Americans with pre-existing medical conditions, and plans will have to renew coverage regardless of health status.
- **Small Group Market Reforms** -- Insurers will be required to offer coverage to small employers and their workers, regardless of health status, and companies will be limited in their ability to vary or increase premiums on the basis of claims' history.
- **Consumer Protections** -- Insurers will be required to give consumers information on benefits and limitations of their health plans, including the identity, location, and availability of participating providers; a summary of procedures used to control utilization of services; and how well the plan meets quality standards. In addition, plans would have to provide prompt notice of claims denials and establish internal grievance and appeals procedures.

2. Helping Working Families Retain Insurance After a Job Loss

Families that lose their health insurance when they lose a job will be eligible for premium subsidies for up to 6 months. The premium subsidies will be adequate to help families purchase health insurance with benefits like the Blue Cross/Blue Shield standard option plan available to Federal employees.

3. Helping Small Business Afford Insurance

- **Giving Small Employers Access to Group Purchasing Options** -- Small employers that lack access to a group purchasing option through voluntary state pools would get that option through access to the Federal Employees Health Benefits Program (FEHBP) plans. This would increase the purchasing power of smaller businesses and make the small group insurance market more efficient. Small firms would get coverage from plans that also provide coverage to Federal employees through FEHBP, but the coverage would be separately rated in each state, leaving premiums for Federal and state employees unaffected.
- **Expanding the Self-Employed Tax Deduction** -- The President's plan provides a fairer system for self-employed Americans who have health insurance. Self-employed people would deduct 50 percent of the cost of their health insurance premiums, rather than 25 percent as under current law.

4. Reforming and Strengthening Medicare

- **Strengthening the Trust Fund** -- The President's plan would reduce Medicare's Part A by \$79 billion over 7 years to ensure the solvency of the Medicare HI Trust Fund to 2005. The plan finds such savings by reducing provider cost growth, not raising beneficiary costs.

- **Eliminating the Co-Payment for Mammograms** -- Although coverage by Medicare began in 1991, only 14 percent of eligible beneficiaries without supplemental income tap this potentially lifesaving benefit. One factor is the required 20 percent co-payment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare co-payment.

- **Expanding Managed Care Choices** -- The President's plan expands the managed care options available to beneficiaries to include preferred provider organizations ("PPOs") and point-of-service ("POS") plans. The plan also implements initiatives to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal. Also included in his plan are important initiatives to streamline regulation.

- **Combatting Fraud and Abuse** -- "Operation Restore Trust" is a five-state demonstration project that targets fraud and abuse in home health care, nursing home, and durable medical equipment industries. The President's budget increases funding for these critical fraud and abuse activities.

5. Long-Term Care

- **Expanding Home and Community-Based Care** -- The President's plan provides grants to states for home- and community-based services for disabled elderly Americans. Each state, will receive funds for home- and community-based care based on the number of severely disabled people in the state, the size of its low-income population, and the cost of services in the state.

- **Providing for a New Alzheimer's Respite Benefit within Medicare** -- The President's plan helps Medicare beneficiaries who suffer from Alzheimer's disease be providing respite services for their families for one week each year.

6. Reforming Medicaid

The President maintains Medicaid, expanding state flexibility, cutting costs, and assuring Medicaid's ability to provide coverage to the vulnerable populations it now serves.

- **Eliminating Unnecessary Federal Strings on States** -- To let states manage their Medicaid Programs more efficiently, the President's plan substantially reduces Federal requirements.

- States will be allowed to pursue managed care strategies and other service delivery innovations without seeking Federal waivers; and

- The "Boren Amendment" and other Federal requirements that set minimum payments to health care providers will be repealed and restructured.

- **Reducing Medicaid Costs** -- The President proposes a combination of policies to reduce the growth of Medicaid spending, including expanding managed care, reducing and better targeting Federal payments to states for hospitals that serve a high proportion of low-income people, and limiting the growth in federal Medicaid payments to states for each beneficiary. Per-person limits, as opposed to a block grant on total spending, promote efficiency while protecting coverage.

ADDITIONAL MEDICARE TALKING POINTS

ADDING TO ALREADY HIGH COSTS FOR OLDER AMERICANS

- **Over \$40 Billion in Cost-Shifting:** Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians, and other providers would be targeted with a \$135 billion cut over seven years. In 2002 alone a \$35 billion cut in provider payments would be needed. Even if only one-third of Medicare providers cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion in increased premiums for health care costs between now and 2002.
- **Rural and Inner City Hospitals At Risk:** Cuts of this magnitude, combine with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result quality and access to needed health care would be threatened.

MAJOR BURDEN ON RURAL AMERICA

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

UNDERMINES ACADEMIC HEALTH CENTERS

- Large reductions in Medicare payments would have a devastating impact on academic health centers.
 - These research and training facilities are providing the bulk of medical advances in the United States. Deep Medicare cuts, combined with private sector cost cutting efforts that either undercompensate or don't compensate these institutions, will undermine our position as the world leader in developing new and more effective health care treatments and technology.

THE URBAN SAFETY NET

- Large reductions in Medicare payments could also have devastating effects on a number of urban safety net hospitals.
 - Urban safety net hospitals are already bearing a disproportionate share of the nation's growing burden of uncompensated care.

THE REALITY OF MEDICARE GROWTH

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