

MEDICARE

- **Detailed Background**

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PREMIUMS

MEDICARE PART B PREMIUMS

December 28, 1995

CURRENT LAW:

The Medicare Part B program, which covers physician, lab, and other services, is financed by both general revenues and beneficiary premiums. Since 1984, the Part B premium has been set so as to finance 25% of program costs.

In an effort to protect beneficiaries from excessive increases in Medicare premiums, premiums were set at specific dollar amounts for the years 1991-1995 in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), rather than at 25% of program costs. The 1995 premium was set at \$46.10 a month. As a result of the difficulties in estimating program costs far in advance, this premium actually financed 31.5% of program costs, even though Congress never intended to raise premiums above 25% of program costs.

In OBRA '93, Congress returned to the traditional approach of setting premiums at 25% of program costs rather than writing fixed monthly premium dollar levels into the statute. Thus, for 1996 through 1998, OBRA '93 set premiums at 25% of program costs. In 1996, 25% of program costs will amount to \$42.50 a month.

All Part B enrollees pay the same premium, with the exception of beneficiaries who enroll late in the program. Premium levels are not related to the beneficiary's income. There is no premium for the Medicare Part A program, which covers hospital services, for individuals entitled to benefits.

BASIC PREMIUM

PRESIDENT'S PROPOSAL: Maintains the current policy of setting premiums at 25% of program costs, and permanently extends the policy for years after 1998.

REPUBLICAN PROPOSAL: Phases in an increase in the Part B premium, raising premiums to 29.5% of program costs in 1997 and phasing up to 31.5% in 2001. In addition, the Republican proposal transfers the money from increasing premiums to the Part A Trust Fund. After 2002, the share of the program financed by premiums would decrease over time because increases in the premium could not grow faster than increases in the Social Security COLA.

ANALYSIS:

Fairness for Beneficiaries. Beneficiaries are currently paying a higher percentage of program costs than Congress intended. Because total program costs were less than projected, the fixed dollar premium set in the statute for 1995 equaled 31.5% of program costs, even though Congress never intended to raise the premium above 25%. This projection error should not be the basis for changing a policy which has been in place for over a decade.

Impact on Low-Income Medicare Beneficiaries. Under current law, Medicaid pays for the Medicare premiums of low-income Medicare beneficiaries. The Republicans' higher Medicare premiums would increase costs for those States that wish to continue to cover Medicare premiums for low-income elderly and disabled Medicare beneficiaries. However, because the Republican Medicaid block grant provides States with \$117 billion less funding over 7 years than under current law, many States may be forced to cut back their coverage of these poor Medicare beneficiaries' premiums. The Republican proposal requires States to set aside funds to cover these premiums, but the set-aside is so small that it would allow States to reduce their premium coverage by more than half in 2002 compared with current law. (For more information, see the separate explanation of "Medicaid Coverage of Poor Medicare Beneficiaries' Premiums, Deductibles, and Copayments.")

De Facto Premium for the Part A Program. The Republican proposal to transfer receipts from the Part B premium increase to the Part A Trust Fund effectively establishes a premium for the Part A. Transferring premium receipts to the Part A program means that beneficiaries effectively pay twice for their Part A coverage; once through their payroll contributions and again through their premiums.

INCOME-RELATED PART B PREMIUMS

PRESIDENT'S PROPOSAL: Retains current law and does not relate premiums to income.

REPUBLICAN PROPOSAL: The reconciliation bill establishes an income-related Part B premium. Individuals with annual adjusted gross income (AGI) between \$60,000 and \$110,000 and couples with annual AGI between \$90,000 and \$150,000 would pay a premium that covers a higher share of Part B program costs. Individuals with AGI of \$110,000 or more and couples with AGI of \$150,000 or more would pay a premium that covers 100% of program costs.

The premium would automatically be deducted from beneficiaries' Social Security checks. HHS would determine the premium liability based on AGI information supplied by the Treasury Department. Affected beneficiaries would be notified and given an opportunity to provide updated information before the higher premiums begin to be deducted from their Social Security checks. The resulting revenue will be transferred to the Part A Trust Fund.

ANALYSIS:

Encourages Wealthy, Healthy Beneficiaries To Leave Traditional Medicare. By requiring some beneficiaries to pay 100% of program costs, the Republican proposal will lead high-income beneficiaries to leave the traditional Medicare fee-for-service program. Because these beneficiaries are often in good health, their disenrollment will weaken the Medicare fee-for-service program and increase costs for those beneficiaries remaining in the program.

Differences from the Health Security Act. While the President's comprehensive health care reform plan, the Health Security Act, had an income-related premium proposal, there are some notable differences from the Republican proposal:

- **Would Not Lead Beneficiaries To Leave the Medicare Part B Program.** The HSA required beneficiaries at the highest income level to pay a maximum total premium of 75% of program costs, rather than the 100% of program costs proposed by Republicans. The HSA also expanded Medicare benefits (prescription drug and long-term care coverage), which increased the desirability of maintaining Part B coverage to also obtain these new benefits.
- **Used Revenue to Expand Health Care Coverage, Not to Finance Tax Cuts.** It is reasonable in principle to ask higher income beneficiaries to pay a higher share of costs, but the Republican proposal reduces Medicare spending per beneficiary and shifts costs to beneficiaries as a means to finance an excessive \$240 billion tax cut. The HSA did so in order to strengthen the Medicare program and expand health care coverage and benefits. The President's plan demonstrates that it is possible to balance the budget and strengthen the Medicare Trust Fund without any new beneficiary costs.

Inefficient Administrative Mechanism. The Republican proposal creates a duplicative bureaucracy within HHS to determine beneficiary income, rather than using the income tax system. The Republican proposal would increase federal administrative costs by close to \$200 million over 7 years, and require beneficiaries to report income to two government agencies.

MEDICAID COVERAGE OF POOR MEDICARE BENEFICIARIES' PREMIUMS, DEDUCTIBLES, AND COPAYMENTS

December 28, 1995

CURRENT LAW: Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100% percent of poverty (known as "qualified Medicare beneficiaries or "QMBs"). Medicaid also covers Medicare premiums for people between 100-120% of poverty (known as "SLIMBs"). The poverty line for an elderly person living alone is currently \$7,470. In 1995, 5.4 million very low-income elderly and disabled people have their Medicare premiums, deductibles, and copayments covered by Medicaid.

Medicaid coverage of Medicare premiums, deductibles, and copayments ensures that poor elderly and disabled people can afford to participate in the Medicare Part B program and do not become uninsured.

PRESIDENT'S PROPOSAL: Retains current law.

REPUBLICAN PROPOSAL:

Deductibles and Copayments. The reconciliation bill completely eliminates the requirement that States cover Medicare coinsurance and deductibles for poor elderly and disabled people under Medicaid.

Premiums. The bill sets aside some money within the Medicaid block grant for Medicare premiums. The set-aside equals 90% of the average percentage of mandated State spending on premiums from FY1993 to FY1995. This amount turns out to be less than half of what States would be required to spend under current law on poor Medicare beneficiaries' premiums in 2002. States would decide whether to continue to cover premiums and whom to cover.

ANALYSIS:

Inadequate Set-Aside for Premiums. While the reconciliation bill sets aside 90% of the average percentage of mandated State spending on premiums from FY1993 to FY1995, this amount turns out to be *less than half* of what would be needed under current law to cover poor Medicare beneficiaries' premiums in 2002. This is because the set-aside is calculated based on State spending on *mandated services* for mandatory eligibles instead of on spending on all services for all eligibles. Thus, under the block grant States will be forced to reduce the level of assistance with premiums, restrict eligibility for the assistance, or pay for the premiums with State funds, or a combination of the three. HHS estimates that hundreds of thousands of poor elderly and disabled people could lose funding for their Medicare premiums by 2002 -- at the same time that the Republican proposal increases these premiums.

No Set-Aside for Copayments and Deductibles. The reconciliation bill eliminates the requirement that States cover poor beneficiaries' copayments and deductibles, and does not set aside *any* funds for this purpose. States could voluntarily continue to cover poor beneficiaries' copayments and deductibles, but with the reductions in Federal Medicaid assistance to States reaching 26% in 2002, millions of poor people now receiving assistance with their copayments and deductibles could lose it.

Impact on Enrollment in Fee-for-Service Plans. Under the Republican proposal, poor Medicare beneficiaries who lose Medicaid coverage of their premiums, deductibles, and copayments may be forced to leave the Medicare fee-for-service plan and enroll in a managed care plan that does not require cost-sharing -- if one exists in their area. These poor Medicare beneficiaries would effectively lose their choice of plan.

ISSUES CONCERNING NEW PRIVATE PLAN OPTIONS

MEDICAL SAVINGS ACCOUNTS AND OTHER PRIVATE PLAN OPTIONS

December 20, 1996

CURRENT LAW: Medicare can contract with "federally-qualified HMOs," which have been certified by HCFA as meeting relevant eligibility standards, and other similar private-sector organizations.

PRESIDENT'S PROPOSAL: The President's proposal would expand the range of eligible private plans to include new managed care options, such as Provider Sponsored Organizations (which are plans organized by a group of physicians or hospitals) and Preferred Provider Organizations (which are network plans that give enrollees the option of receiving services from providers outside the network).

REPUBLICAN PROPOSALS: The Republican proposal authorizes the same kinds of private plan options as the President does, but adds a few highly controversial others, including Medical Savings Accounts (MSAs) and private fee-for-service plans.

ANALYSIS:

The President's proposal expands choice while protecting the traditional fee-for-service medicine. While both proposals expand the range of private health care options, the President's proposal expands the range of options in a responsible manner -- allowing only those plans that preserve and protect the existing Medicare system. The Republican proposal, however, offers new plans -- such as Medical Savings Accounts -- that could undermine the fee-for-service program by dividing the Medicare system into separate pools of healthy and sick beneficiaries. Here's how that would occur.

- **Medical needs of beneficiaries vary widely.** The cost of providing medical care to beneficiaries varies dramatically: The healthiest 50% of Medicare beneficiaries account for only 5% of the Medicare spending, while the sickest 2% account for nearly 30% of Medicare spending. Given this disparity, private plans typically have a financial interest in "segmenting" the market, attracting the healthiest and least-costly beneficiaries, while leaving the sicker beneficiaries for the traditional fee-for-service program. While health care plans are generally prohibited from targeting ("cherry picking") the healthiest beneficiaries, MSAs offer an indirect way of achieving the same effect.
- **Republican options appeal principally to the healthiest beneficiaries.** Under the Republican MSA proposal, a beneficiary is permitted to withdraw a set amount of money from the Medicare program to buy health insurance with a very high deductible. Individuals may deposit any money left over after the purchase into a tax-preferred medical savings account (MSA). MSAs tend to attract only the healthiest beneficiaries, who expect few medical expenses in the coming year, and thus expect to be able to keep a portion of the funds deposited into their medical savings account.

- **MSA's offer benefits to a select few -- at a cost to everyone else.** Because Medicare's payments to MSAs healthy beneficiaries will be more than what the traditional fee-for-service program would have spent on these individuals, MSA plans typically increase Medicare spending. For that reason, the Congressional Budget Office estimates that MSAs will raise Medicare costs by nearly \$5 billion over seven years, and VHI-Lewin projects MSAs will increase costs by \$15-20 billion over that same period. Moreover, because of the way the Republican budget "cap" mechanism is structured, the increased costs due to MSAs would have to be offset by further cuts in the traditional fee-for-service program. (For additional information, see Medicare Budget "Cap"). As a result, the fee-for-service system would be left with fewer dollars to spend on a sicker and more costly pool of beneficiaries.
- **Current risk adjustment methods cannot remedy the problem.** The principal way to limit this kind of segmentation is to adjust payments to MSAs so that contributions more accurately reflect the low health care costs of these healthy enrollees. However, no reliable risk adjustment method is available today. While the capacity exists to adjust plan payments for factors which are broadly associated with higher costs, such as age, sex, and welfare status, we do not have well developed mechanisms to adjust for health status differences **within** these broad age, sex, or welfare groups. HHS is now planning to test potential improvements in risk adjustment methods. However, until a reliable method is found, Medicare MSAs pose an unacceptable risk to the fee-for-service program.

PROTECTION FROM BALANCE BILLING AND RELATED ABUSES

December 20, 1995

CURRENT LAW:

Balance billing protection. "Balance billing" occurs when a provider charges a beneficiary more than the amount Medicare has agreed to pay for a medical service. Under current law, balance billing is generally prohibited in both the traditional fee-for-service program and in Medicare managed care plans.

- **Fee-for-service program.** Physicians participating in the fee-for-service program must accept Medicare's payments as payment in full and cannot charge beneficiaries any amount beyond the required coinsurance and deductible expenses. Non-participating physicians cannot bill beneficiaries for charges in excess of 115% of Medicare approved amounts. Additional limitations are placed upon hospitals, skilled nursing facilities, and certain suppliers.
- **Managed care plans.** Under current law, beneficiaries are protected from balance billing for any service authorized by a Medicare HMO. Current law, however, does not place any restrictions on balance billing for non-authorized services.

Supplemental benefits. Supplemental benefits refers to extra benefits that are not provided as part of the basic Medicare package (or otherwise required by law). Virtually all managed care plans offer supplemental benefits of some sort, such as routine physicals and prescriptions. Current law requires private Medicare plans to set premium rates for supplemental benefits at a level consistent with the rates they charge commercial (non-Medicare) enrollees.

PRESIDENT'S PROPOSAL:

Extends balance billing protection to new private health plans. The President's proposal extends protection against balanced billing to all private plan options for authorized services. In addition, for non-authorized services, the President's proposal broadens existing protections, prohibiting balance billing in private plans to the same extent as in the current fee-for-service program.

Maintains financial safeguards on supplemental benefits. The President's proposal maintains existing safeguards that prevent private plans from charging excessive premiums for supplemental benefits.

REPUBLICAN PROPOSAL:

Does Not Extend Balance Billing Protection. The Republican proposal would allow balance billing for high deductible MSA plans and for private fee-for-service plans. Balance billing would also be allowed in network plans when subscribers seek services from providers who are not under contract with the health care plan.

Repeals prohibition on over-charging for supplemental benefits. The Republican proposal has no limit on the premiums that beneficiaries could be charged for supplemental benefits.

ANALYSIS:

The Republican proposal weakens balance billing protections, increasing beneficiary costs and undermining the fee-for-service program.

- **Higher costs.** By failing to extend balance billing prohibitions to the new health care options, beneficiaries who enroll in private plans could face unexpected costs. Physicians and other providers would be permitted to bill them for amounts in addition to the plans' premiums and cost-sharing.
- **Weaker fee-for-service program.** By relaxing the balance billing protections for private plans, the Republican proposal gives doctors another reason to abandon the traditional fee-for-service program. Doctors may see the opportunity to balance bill in these private plans as a way to compensate for reduced Medicare payments under the Republican plan. If doctors drop out of the traditional program, the GOP proposal could actually reduce -- rather than increase -- access and choice for beneficiaries who wish to stay in the fee-for-service program. Beneficiaries might be forced, as a practical matter, to follow their providers into Medicare Plus plans, losing balance billing protections in the process.

The Republican proposal results in excessive premiums for supplemental benefits. The Republican proposal does not limit the premiums charged for supplemental benefits. Because most beneficiaries purchase supplemental benefits of one sort or another, this change could have a wide-ranging effect on the Medicare population.

PRIVATE PLAN QUALITY STANDARDS

December 20, 1995

CURRENT LAW:

- o **Federal Oversight.** The Secretary of Health and Human Services is charged with evaluating whether an HMO is eligible to contract with Medicare. Plans must meet standards for quality, access, consumer protection, marketing, fiscal soundness, and solvency.
- o **Quality Review.** HMOs are required to establish internal quality assurance programs and comply with external quality reviews.
 - **Internal review** ensures that the HMO has the appropriate processes in place to ensure quality (e.g., the HMO has a quality assurance team that meets regularly, develops quality improvement programs and reports to the senior HMO executives).
 - **External review** is generally conducted by independent peer review groups under contract with HHS, which monitor and evaluate the HMO to ensure that it is actually providing medically necessary, appropriate, and effective health care services for its enrolled population.
- o **Appeal Process.** An HMO must have a process for addressing, in a fair and timely manner, enrollee appeals of an HMO's coverage and payment decisions.
- o **Commercial Enrollment Requirement.** Current law requires HMOs to have no more than 50% of its enrollees funded by Medicare and Medicaid. The 50/50 rule, as it is called, is designed to serve as an additional quality check on private health care plans. The assumption behind this rule is that private plans will have to maintain relatively high standards if they are to continue to attract private paying customers.

PRESIDENT'S PROPOSAL:

- o **Maintains federal oversight.** The President's proposal retains current law.
- o **Allows plans to meet internal quality review through private accreditation.** The President's proposal follows current law in requiring plans to comply with both internal and external review requirements. However, in contrast to current law, plans would be permitted to meet the internal quality assurance requirement by receiving accreditation from a private organization.
- o **Establishes expedited appeals process.** The President's plan strengthens the current appeals process by requiring expedited appeals in cases where delayed treatment would (1) place the health of the individual in jeopardy, (2) risk serious impairment of bodily functions, or (3) limit medically appropriate treatment options.

- o **Reexamines commercial enrollment requirement.** The President proposes to eliminate the 50/50 rule once the Secretary, in consultation with the industry, develops a system for quality measurement. Until that time, the Secretary would have additional flexibility to suspend the 50/50 rule through the wider use of waivers.

REPUBLICAN PROPOSAL

- o **Establishes state oversight.** Except for "limited enrollment" plans (e.g., plans associated with unions), states would determine whether a plan is eligible to have a contract with Medicare.
- o **Weakens quality review standards for new plan options.** High deductible Medical Savings Account plans and private fee-for-service plans would not be required to meet quality standards. In addition, plans with private accreditation would be deemed to meet both internal and external review requirements, essentially making them exempt from independent oversight of quality standards.
- o **Enacts limited expedited review.** Expedited appeals would be limited to life threatening situations.
- o **Repeals commercial enrollment requirement.** The Republican proposal would repeal the 50/50 rule entirely as of January 1, 1996.

ANALYSIS :

- o **Federal oversight is necessary for uniform and effective oversight.** The President's proposal continues federal enforcement of private plan quality standards, ensuring consistent and uniform oversight of new private options.
- o **Weakened quality standards put beneficiaries in harms way.** By exempting high deductible and private fee-for-service plans from quality review requirements, the Republican proposal puts enrollees at risk. For other private plans, the Republican proposal relies entirely on private accreditation to meet quality standards, ignoring the need for some independent external verification of the quality of care.
- o **Expedited Appeals Should Be Broader.** The scope of the Republican's expedited appeals provision is far too narrow, failing to cover delays that pose a serious health risk or that limit treatment options, regardless of whether such delays are life threatening.
- o **Repeals quality measurement system prematurely.** Since no system of quality measurement is yet in place, the elimination of the 50/50 rule -- which provides additional quality protections -- is premature.

LOCKING BENEFICIARIES INTO PRIVATE PLANS

December 20, 1995

CURRENT LAW:

Enrollment. Beneficiaries may enroll in a managed care plan that has entered into a contract with the Medicare program.

- Private Medicare plans must have an advertised open-enrollment period of at least 30 days duration at least once a year. During an open enrollment period (or any other time at which enrollments are accepted), a plan is required to accept all beneficiaries who apply, without restrictions, up to the limits of its capacity.
- Plans are permitted to sign up beneficiaries directly; they are not required to use a third-party intermediary.

Termination. Beneficiaries are permitted to terminate enrollment at any time -- with termination effective as of the first of the first month following the request for termination.

PRESIDENT'S PROPOSAL:

Enrollment through third parties required. Beneficiaries wishing to enroll in a private plan would do so through a third-party designated by the Secretary of Health and Human Services -- much the same way that federal employees now enroll in health plans through the Office of Personnel Management.

Flexible Termination. The President's proposal retains current law, allowing beneficiaries to terminate enrollment from plans at any time.

REPUBLICAN PROPOSAL:

Enrollment through individual plans. As under current law, beneficiaries could enroll in private plans during an annual open enrollment period, and they would be permitted to enroll in private health care plans through individual plans rather than through a third-party.

Limited Termination. With a few exceptions, beneficiaries could disenroll only during an open enrollment period. As a result, after enrolling, a beneficiary would be "locked-in" to a plan for a year.

ANALYSIS:

Third-party enrollment provides safeguards. By requiring enrollment through a third-party, the President's plan reduces the likelihood that private plans will undertake impermissible marketing practices, such as attempts to target ("cherry pick") healthy, low-cost beneficiaries for enrollment.

Flexible termination protects beneficiaries. By restricting beneficiaries' ability to terminate their enrollment in a private plan, the Republican proposal would "lock-in" a beneficiary to an unsatisfactory plan for up to one year. This restriction also obstructs effective oversight of private health plans. Significant increases in the rate of disenrollment for a plan is a good indicator of management or quality problems and typically triggers an external review. Under the Republican proposal, HHS would have to wait a year to get comparable disenrollment information. This delay would disadvantage enrollees receiving poor quality care.

CASH REBATES

December 20, 1995

CURRENT LAW:

Cash rebates prohibited. Current law requires an HMO to offer its beneficiaries the same "financial value" offered beneficiaries in the traditional Medicare program. If a private plan calculates that it is able to offer the standard Medicare benefit package at less than the amount Medicare pays for the package, the plan is required to provide additional benefits or to reduce its out-of-pocket expenses to make up the difference. Significantly, if a plan has already reduced its out-of-pocket expenses to zero, it may only offer additional benefits: Current law prohibits private plans from offering cash rebates to attract new enrollees.

PRESIDENT'S PROPOSAL:

Retains current law. The President's proposal follows current law in prohibiting private plans from offering cash rebates to attract new enrollees.

REPUBLICAN PROPOSAL:

Repeals current law. The Republican proposal allows private plans to offer cash-rebates.

ANALYSIS:

The Republican proposal worsens the segmentation of the Medicare market by allowing plans to offer cash rebates. Cash rebates are prone to abuse, since they can be used as a marketing tool to attract ("cherry pick") the healthiest, low-cost beneficiaries from the pool of Medicare beneficiaries. In this way, the Republican proposal to permit the use of cash rebates could exacerbate the segmentation of the Medicare system into sick and healthy pools of beneficiaries.

OTHER KEY ISSUES

MEDIGAP REFORMS

December 20, 1996

CURRENT LAW:

Open enrollment. Medigap plans offer an open-enrollment period only once-in-a-lifetime for each beneficiary -- when the beneficiary reaches the age of 65 or older and enrolls in Part B Medicare. During the open enrollment period, the Medigap insurer cannot refuse to issue a policy, place conditions on the policy, or discriminate in the price of the policy because of health status, claims experience, receipt of health care, or medical condition. Medigap insurers may offer policies at other times, but open enrollment safeguards do not apply.

Premium pricing. While a Medigap insurer may not discriminate on the basis of health status during the open enrollment period, it may use whatever other pricing methodology it prefers, including adjusting premiums based on the age of a beneficiary.

Duplicative policies. Current law permits the sale of duplicative policies only if each policy pays without regard to the other.

Medigap standards. All Medigap plans must meet loss-ratio requirements and must provide a standardized benefit package.

Comparison among plans. Current law defines ten standard Medigap benefit packages, and insurers who market Medigap policies must choose one of these. The standardized packages make it easier for beneficiaries to compare premiums.

PRESIDENT'S PROPOSAL:

Requires annual open enrollment. The President's proposal would require Medigap plans to hold an open enrollment period annually, not once a lifetime.

Implements premium pricing protection. The President's proposal prohibits Medigap companies from adjusting premiums based on the age of the enrollee -- a pricing method that disadvantages beneficiaries as they age. The President's proposal requires Medigap plans to offer all subscribers in a given area the same Medigap rates, regardless of age. This practice, called "community rating," is currently required of all other Medicare plans at the present time.

Retains Existing Medigap standards. The President's proposal follows current law, requiring all Medigap plans to meet loan loss, coverage, and other standards

Retains prohibition against duplication. The President's proposal retains current prohibitions against the sale of duplicative Medigap policies.

Expands availability of comparative materials. The President's proposal develops comparative materials on all options and make these materials available to all beneficiaries. Plans would be required to contribute funding to the production and distribution of these materials. The ten standard Medigap packages also would be revised to facilitate ease of comparison.

REPUBLICAN PROPOSAL:

Weakens restrictions on duplication. The Republican proposal substantially weakens restrictions prohibiting the sale of policies that duplicate Medicare or other health insurance policies.

Eliminates Federal Medigap standards for certain beneficiaries. Under the Republican proposal, Medigap policies sold to private health care enrollees would be exempt from meeting any federal standards (including loss ratio and coverage requirements).

ANALYSIS:

By mandating annual enrollment periods for Medigap coverage, the President's proposal expands choice. Under current law, a beneficiary that fails to enroll in Medigap upon turning 65 may not be able to obtain coverage later, since subsequent applications are subject to health screening and underwriting. This rule discourages beneficiaries in private plans from ever switching back to the traditional program, since Medigap coverage may no longer be affordable or available. In this way, the current "once-in-a-lifetime" enrollment period undermines seniors' choice. The President's proposal expands choice by establishing annual open enrollment periods for Medigap policies.

The President's proposal prevents Medigap plans from discriminating based on age. Medigap plans are currently allowed to offer premiums that increase as the subscriber ages. This feature makes Medigap more attractive to beneficiaries when they first enter the Medicare program. But it also discourages seniors from switching from private health care plans to the fee-for-service program, since they might face higher Medigap premiums as they get older. To enhance beneficiary choice, the President's proposal prohibits age-based premium methodologies. The Republican plan, by comparison, makes no change in current law.

The Republican proposal exempts certain Medigap policies from federal standards, permitting the sale of inferior insurance policies. Although exemptions from federal standards might be justified in limited circumstances, compliance with these standards provides critical protection to purchasers and should not be eliminated.

Republican proposal permits the sale of duplicative and illusory policies. Under current law, carriers may sell a policy providing the same coverage as another insurance policy owned by a beneficiary, so long as the policy pays without regard to the other. The Republican proposal removes this restriction on the sale of overlapping policies. As a result, beneficiaries can be sold policies that provide the same coverage as Medicare but which never pay -- because the plans withhold payments whenever Medicare pays first. Alternatively, beneficiaries can hold a Medigap policy that duplicates other policies a beneficiary has purchased and so never pays a single dollar in benefits. These "illusory" policies were a major problem prior to the creation of the initial federal Medigap standards. The Republican proposal brings them back.

Only the President's plan makes it easy to compare policies. Although both the President's and the Republican's Medicare proposals provide comparative materials on plan choices, only the President's plan would include information on the full range of options --- plans contracting with Medicare and Medigap plans. Moreover, only the President's proposal redesigns the standard Medigap policies to facilitate meaningful comparison across the range of options. Finally, only the President's proposal provides a way to fund this information campaign. Without funding, ideas such as the toll free number proposed in the Conference agreement are unlikely ever to be implemented, given other Republican budget constraints.

MEDICARE BUDGET "CAP"

December 20, 1995

CURRENT LAW:

Under current law, Medicare spending reflects numerous factors, including the need for medical services by eligible beneficiaries and the cost of those health care services during the year. Current law spending is not constrained by any budget "cap," which would limit spending regardless of medical need, growth in beneficiary population, or health care costs.

PRESIDENT'S PROPOSAL: The Administration's proposal offers specific policy changes to achieve savings in the Medicare program. Following current law, it does not adopt a budget "cap" as an enforcement mechanism to limit Medicare spending.

REPUBLICAN PROPOSAL:

The Republican Plan imposes a "budget cap" that constrains fee-for-service spending in Medicare. This enforcement mechanism follows a 5-step process:

- First, the overall spending allocation is set in statute for the Medicare system as a whole.
- Second, the spending allocation for the private health care plans (MedicarePlus plans) is calculated. This allocation is determined, in part, by the per capita growth rate permitted for the MedicarePlus plans. This number is set by statute. Since the MedicarePlus growth rate represents a per capita (per person) growth rate, the actual allocation for the MedicarePlus plans depends also on the number of beneficiaries who choose the private plans; the greater the participation in these plans, the greater the spending allocation on the MedicarePlus system.
- Third, the allocation for the fee-for-service program is calculated by subtracting the allocation for the MedicarePlus plans from the total spending allocation for the Medicare system as a whole. The fee-for-service allocation is subdivided into nine smaller allocations according to a legislatively-created formula. These allocations impose spending limits on the nine separate fee-for-service sectors identified in the Republican proposal: inpatient hospital, home health, extended care, hospice, physicians, hospital outpatient, DME, diagnostic tests, and other.
- Fourth, projected spending in each of the nine fee-for-service sectors is compared to the sector's allocation. If spending is projected to be greater than a sector's allocation, the Republican proposal reduces payments to that sector by an appropriate amount.

- Fifth, after the year has ended, the actual spending on the total fee-for-service program is compared to the program's allocation. If the allocation is exceeded, a "look-back" provision is triggered, reducing spending in subsequent years for those sectors that exceeded their suballocations. This "look-back" mechanism starts in fiscal year 1999, and looks back to spending in fiscal year 1997.

Example of look-back adjustment. In FY 1997, assume that the total spending on the fee-for-service program exceeds its budgetary cap by \$1 billion. Assume, too, that this amount reflects overspending of \$2 billion by two sectors -- physician services and home health services -- and underspending of \$1 billion in the other seven sectors.

- Specifically, physician services exceeded its cap by \$1.2 billion and home health services exceeded its cap by \$800 million -- for a total of \$2 billion -- while the other seven sectors achieved below-budget spending of \$1 billion.
- In this scenario, physician services and home health services would be required to make up the \$1 billion fee-for-service excess. The specific amount each sector would contribute would be determined as follows.
- The excess spending by physician services and home health services excess would be multiplied by the ratio of (1) the total amount the fee-for-service program exceeded its allocation and (2) the sum of the excess spending of the two sectors that exceeded their suballocation. Thus, for physician services, the sector's excess spending (\$1.2 billion) would be multiplied by the ratio of total fee-for-service spending (\$1 billion) to the sum of the excess spending by both physician services and home health services (\$2 billion). The result is that physician payments would be lowered by \$600 million in the following year. A similar analysis demonstrates that payments to home health services would drop by \$400 million in the following year.

ANALYSIS:

Budget caps make arbitrary limits and distinctions: Program savings under the Administration's proposal come from specific policy changes designed to achieve necessary savings. The Conference agreement relies on arbitrary budget-driven caps that bear little relationship to the cost or demand for medical services. No matter what the health needs or medical contingencies, the fee-for-service program will receive a fixed amount of funding.

Budget caps could discourage proper medical care of patients. The Republican proposal arbitrarily divides the fee-for-service allotment by sector. These divisions could discourage efficient treatment of patients. For example, technological advances might make it possible to treat illnesses at home rather than in a hospital, but home health agencies as a group might nonetheless resist taking on these patients for fear of exceeding their spending limit.

Budget caps pose a particular threat to the traditional fee-for-service program since they exacerbate the negative effects of risk segmentation. Republican proposals to expand the range of health care options are designed in a way that creates risk selection problems. Medical Savings Accounts, for example, will likely attract healthy beneficiaries, boosting Medicare spending on these individuals. That's one reason why CBO projects MSAs will cost Medicare about \$5 billion. The existence of the budget cap means that increased spending on MSAs and other private plans must be offset by additional cuts in the fee-for-service allocation. This will leave the traditional program with fewer dollars to spend on a pool of beneficiaries that is, on average, sicker and more costly than before.

PREVENTIVE CARE AND OTHER NEW BENEFITS

December 20, 1995

CURRENT LAW:

Under current law, Medicare covers some, but not all, expenses for important preventive services, such as limited mammography and preventive injections. Current law does not cover any costs for respite care for beneficiaries with Alzheimer's disease.

PRESIDENT'S PROPOSAL

- o **Preventive Care.** The President's proposal expands assistance for mammograms, sigmoidoscopies and preventive injections.
 - o **Mammography.** Currently, Medicare pays for screening mammography -- including biannual screenings for beneficiaries over age 65 -- but beneficiaries must pay deductibles and coinsurance fees for these services. To promote the early detection of breast cancer, President Clinton's proposal eliminates cost-sharing for mammography services and provides for *annual* screening mammograms.
 - o **Sigmoidoscopies and other tests.** Under current law, Medicare pays for fecal-occult blood tests, flexible sigmoidoscopies and colonoscopies when these tests are required by a physician to make a specific diagnosis. The President's proposal, in contrast, provides annual *screening* for fecal-occult blood tests and five-year screenings with flexible sigmoidoscopies for beneficiaries over 65. Less frequent screenings are authorized for younger beneficiaries. In addition, the proposal authorizes colonoscopy screenings every four years -- earlier if determined by the Secretary -- for individuals with a high risk of developing colorectal cancer.
- o **Preventive Injections.** The President's plan increases payments for certain preventive injections provided in physician offices.
 - o **Hepatitis B.** Current law requires beneficiaries to pay deductible and coinsurance payments for the Hepatitis B vaccine, even though those costs are waived for other important vaccines, such as for influenza and pneumonia. The President's proposal would waive the deductible and coinsurance for the hepatitis B vaccine.
 - o **Payments for certain injections.** To encourage the use of immunizations, the President's proposal would, among other things, increase the amount Medicare pays for preventive injections provided in physician offices from the current average of \$4 to a uniform national payment of \$9.

- o **Balance-billing protection.** The President's proposal would establish balance-billing limits for preventive injections so that beneficiaries can not be charged more than Medicare allows for these services.
- o **Respite Benefits for beneficiaries with Alzheimer's disease.** The President's proposal creates, for the first time, a "respite" benefit for families of beneficiaries with Alzheimer's disease or other irreversible dementia, covering up to 32 hours of care per beneficiary per year. These services may be administered through home health agencies or other entities in a home or day-care setting.

REPUBLICAN PROPOSAL

Limited Expansion. The Republican proposal does not provide for any of the new benefits contained in the President's plan. The Republican proposal adds one new benefit: coverage of oral anticancer nonsteroidal antiestrogen for the treatment of breast cancer.

ANALYSIS:

The Administration's proposal increases the chances of cure. By expanding colorectal screening and screening mammograms, the President's proposal increases the early detection of breast and colon cancer, resulting in enhanced quality of life and, in some cases, greater likelihood of a cure. By increasing payments for preventive injections provided in physician offices, the proposal encourages physicians to immunize beneficiaries and help prevent pneumonia, influenza, and hepatitis B.

The Administration's proposal can lower costs. The early detection of cancer and preventive injections can result in less costly treatment and lower medical bills in the long run. In addition, the new respite benefit gives families a chance to take a brief rest from the effort of caring for family members, allowing them to continue that care in a home or day-care setting, rather than in a more costly institution.

The Administration's proposal levels the playing field between private plans and the traditional medicare system. Currently, Medicare does not cover the array of preventive benefits now offered at little or no charge by many private plans, particularly managed care plans. The President's proposal updates the Medicare benefit package to make it more comparable to private sector benefit packages.

MEDICAID

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I. Main Affirmative Points

II. Republican Main Charges and our Responses

- Not a cut, actual funds increase
- Per capita cap: an unfunded mandate, shifts costs to the states, and continues inequities across states
- States will have inadequate flexibility to manage their programs
- CBO will not give savings to a per capita cap policy

III. Main Specific Policy Differences

- Entitlement to coverage of meaningful benefits v. block grant
- Eligibility and benefits
- Protections for the elderly and middle income families
- Funding for vulnerable providers--DSH
- Quality protections and enforcement

MEDICAID

I. MAIN AFFIRMATIVE POINTS:

Our Medicaid plan:

- **Maintains the guarantee of coverage:** The plan maintains the entitlement to meaningful benefits for low-income children, pregnant women, seniors, and individuals with disabilities, and adequately funds this guarantee.
- **Continues the shared federal-state financial partnership:** Per capita limits on the rate of increase in spending would maintain the federal financial commitment even if states need to expand coverage, unlike an arbitrary block grant that simply caps funding.
- **Provides substantial state flexibility:** States are given significant new flexibility in managing their Medicaid programs through changes to provider payment rules, managed care requirements and other administrative requirements. For example, the Boren amendment is repealed and states can use managed care without waivers.

II. REPUBLICAN MAIN CHARGES AND OUR RESPONSES:

- A. **Republican Claim:** The Republican proposal does not cut Medicaid; funds for Medicaid grow in each of the seven years. The proposal simply slows the rate of growth.

Response:

- The Republican plan reduces federal Medicaid spending growth far below projected inflation and growth in the number of elderly, disabled, and low income people who will need help from Medicaid.
 - Federal Medicaid spending per capita would increase less than inflation (less than 2% per year) under the Republican plan.
 - Federal spending is reduced by more than 25% below CBO's estimate of current law Medicaid spending in 2002.
- The states are left to make up the funding shortfall on their own. Federal Medicaid payments would be pre-set in law, totally disconnected from state funding needs.

B. Republican Claim: The per capita cap on federal Medicaid payments creates an unfunded mandate, shifts costs to the states, and maintains current inequities.

Response:

- It is the GOP plan that arbitrarily caps federal payments, leaving states at financial risk in the event of economic hard times. It unfunds Medicaid.
- The per capita cap approach continues to protect states financially -- federal matching funds will increase as the states' needs expand and enrollment grows.
- The Administration's proposal provides new flexibility, not new mandates.
- The Republican block grant could exacerbate existing inequities across states. Because the block grant formula bears no relationship to population trends and case mix changes in the real world, states with greater needs will be hit hardest.

Republican Claim: Under the Administration's plan, states will have inadequate flexibility to run and improve their Medicaid programs. The President's plan continues to bind states to rigid and obsolete federal rules that stand in the way of efficiency and innovation.

Response:

The Administration's proposal preserves the beneficiary entitlement to Medicaid, and provides states with broad new flexibility.

The Administration's plan is directly responsive to the states' requests for increased flexibility on managed care (e.g., no requirement that states get waivers), eligibility simplification, use of home and community-based care, and provider payment levels (e.g., Boren is repealed).

- The Republican plan, by vastly underfunding the program, undermines the ability of states to take advantage of real flexibility in designing their program to meet the needs of beneficiaries. Instead, it ~~forces~~ ^{could} states to cut eligibility and coverage.

D. Republican Claim: CBO will not give savings to a per capita cap policy.

Response:

CBO has given preliminary estimates of significant savings under a per capita cap to Congressional staff.

Our plan builds on current match structure which gives higher fed m to higher per capita inc. st. and builds on st. current level of fund. per person.

- CBO has stated that they did not score the per capita cap in the President's plan because the wording in the setting of the per capita cap index was not explicit enough; that is being changed.
- All of the issues named to date are easy to address and we anticipate that CBO will offer significant savings to a per capita cap policy.

III. MAIN SPECIFIC POLICY DIFFERENCES:

A. Entitlement to guaranteed coverage of meaningful benefits v. block grant

Objectionable Republican Proposal: Ends individual entitlement to meaningful Medicaid benefits and replaces it with a block grant.

Republican Claim: Medicaid spending cannot be controlled effectively as long as there is an individual entitlement.

Response:

Spending under a per capita cap:

- Medicaid reflects a national commitment to a basic health care for vulnerable individuals and families -- a commitment that the nation cannot breach.
- The per capita cap allows us to restrain the growth in federal Medicaid outlays, without penalizing states and low-income individuals during economic downturns, periods of inflation, and other circumstances beyond their control.
- The new flexibility in our Medicaid plan gives the states the tools to control costs.

Spending under a block grant:

- The block grant proposal underfunds the federal-state partnership and leaves states with no protection from economic or enrollment changes.
 - States with growing populations will be at greater financial risk. The arbitrary limits particularly threaten states with rapidly aging populations, since the block grant methodology does not reflect the number of high-cost beneficiaries in a state.
- Federal and state support for low-income individuals and families will be dramatically reduced under the Republican plan, but the medical needs of this population will not go away.

- The cost of caring for the uninsured and low-income Americans would fall to local-level public health care systems and, through cost-shifting, to the privately insured.

B. Eligibility and Benefits

Objectionable Republican Proposal: No real eligibility standards or guarantee of coverage for basic benefits.

Republican Claim: States need relief from federal mandates and federal oversight of the Medicaid program.

- While state flexibility is vitally important in a federal-state partnership, certain basic federal standards are appropriate in a program supported with billions of federal tax dollars.
- The administration plan protects basic national standards for eligibility and benefits, and gives substantial new flexibility to states to provide these guarantees at an affordable cost.
- By contrast, the GOP pays only lip service to the federal eligibility and benefit guarantees:
 - they claim to “guarantee” coverage for poor pregnant women, children, and the disabled;
 - they claim to protect low-income elderly.
- But in fact, they undermine this “guarantee” by eliminating the entitlement to coverage, eliminating nearly all benefit requirements, and eliminating the ability of individuals to legally enforce their right to Medicaid coverage in federal courts.

C. Protection for the elderly and middle income families

Objectionable Republican Proposal: The Republican plan repeals all current law protections except the provision on spousal impoverishment which, though nominally still in effect, is unenforceable.

Republican Claim: They retain these protections.

Response:

- The Republican plan maintains spousal impoverishment protections in name only. Because eligibility and coverage are not guaranteed, and because protections are not legally enforceable, spouses of nursing home residents will still be threatened by poverty.
- The Republican plan permits imposition of liens on homes and family farms as a condition of Medicaid eligibility.
- Under the Republican plan, middle class adult children could be forced to pay for their elderly parents' nursing home care.

D. Funding for vulnerable providers - disproportionate share funding

Objectionable Republican Proposal: The Republican proposal folds the disproportionate share hospital (DSH) program into the block grants. They do not treat DSH separately.

Republican Claim: States should be free to allocate Medicaid dollars as they see fit.

Response:

- We believe that it is important to maintain a DSH program as a means of preserving funding for states and safety net providers with disproportionately large shares of indigent patients. We are simply reducing and retargeting this program.
- Given the decline in employer sponsored health coverage, states and providers will become more vulnerable to increases in the numbers of uninsured people and uncompensated care.

E. Quality

Objectionable Republican Proposal: Permit dismantling of current quality protections for nursing home residents.

Republican Claim: They kept the quality protections.

Response:

They undermine quality standards for nursing homes by providing no federal enforcement role; the Administration retains current law.

Frail nursing home residents are particularly vulnerable. National quality standards -- enacted with bipartisan support -- have improved nursing home care and should not be undermined.

The Republicans specifically eliminate standards concerning patient quality of life, privacy and dignity, and receipt of necessary treatments and therapies.

MEDICARE

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I. Main Affirmative Points

II. Republican Main Charges and our Response

- Medicare Spending is out of control
- Not Cutting Medicare
- The Part A Trust Fund is in crisis
- The cuts are not severe
- The Republican plan modernizes Medicare
- Administration resorts to frightening the elderly

III. Main Specific Policy Differences

- Beneficiary Premiums: 25% v. 31.5%
- Arbitrary cap to limit payments
- Level of cuts: \$124 v. \$200 billion
- Impact of choice options: MSAs, association plans, private fee for service plans
- Beneficiary financial protections
- Fraud and abuse
- Double hit on poor elderly: less Medicaid contribution for increased Medicare cost sharing

MEDICARE

I. MAIN AFFIRMATIVE POINTS

Our Medicare plan:

Maintains beneficiary financial protections: the plan keeps the Medicare premium at its traditional level of 25 percent, and protects beneficiaries enrolling in private health plans from being charged extra amounts when they see their physician, and assures (through Medicaid) payment for the premiums, copayments and deductibles for very low income beneficiaries.

Modernizes Medicare and Provides real choice for beneficiaries: The plan provides real choices of managed care and innovative delivery models that operate in a market environment in which plans compete by providing quality, cost effective care--not by attracting healthy populations and avoiding the sick. Such reforms should not lead, as some of the Republican proposals do, to a system in which insurers discriminate against less healthy and poorer beneficiaries.

Provides savings that secure the Trust Fund without arbitrary caps: the plan includes real savings that secure the Trust Fund through 2011 -- but without arbitrary budget caps that bear no relationship to the projected cost of services for beneficiaries.

II. REPUBLICAN MAIN CHARGES AND OUR RESPONSES:

- A. **Republican Claim: Medicare spending is out of control** -- it is one of the fastest growing entitlements and a major contributor to the high deficit. We are simply trying to control the rate of growth.

Response:

The rate of growth in Medicare can be reduced, but not in ways that damage the program or protections for the elderly.

The CBO baseline estimate is 8.1 percent per beneficiary annually.

Our plan limits growth in federal spending per beneficiary to 6.3 percent annually.

The GOP plan limits federal spending per person to less than 5 percent annually.

- B. **Republican Claim:** They are not cutting Medicare --they are increasing it over today's levels.

Response:

The Republican plan does cut Medicare. According to CBO, the \$5,900 in federal spending per beneficiary in 2002 is a cut of \$1400 per beneficiary below what Medicare would have spent in 2002.

That is a cut of 19 percent below the 2002 current law spending projection.

- C. **Republican Claim: Medicare Health Insurance Trust Fund is in crisis** and is expected to go broke in the year 2002. Our plan will save the trust fund.

Response:

This is not a new problem. On nine separate occasions over the past 20 years the trust fund was projected to go broke within 7 years.

At the beginning of the Clinton Administration, the Trust Fund was projected to go broke by 1999. The President's 1993 five-year deficit reduction package (OBRA '93) extended the life of the trust fund by an additional three years--to 2002.

The President's plan will extend the life of the trust fund for 16 years, until 2011 which would give us adequate time to address the larger problem--changing demographics--on a bipartisan basis.

The President's plan puts the Trust Fund in better shape than it has been in for 19 of the last 20 years.

- D. **Republican Claim: These Medicare cuts are not severe.**

Response:

According to the American Hospital Association and 40 state hospital associations, these deep cuts will "jeopardize the ability of hospitals and health care systems to deliver quality health care, not just to Americans who rely on Medicare and Medicaid, but to all Americans."

The Republican cuts could also lead to a massive cost-shift onto the private sector.

-- A study by Lewin-VHI estimates that when the Republican Medicare and Medicaid cuts were \$270 and \$163 billion respectively, they could add as much as \$85 billion to private sector costs as health care providers hike the bills they charge privately insured individuals to compensate for public program cuts.

- E. **Republican Claim: The GOP plan modernizes Medicare - expanding choices for seniors -- and introducing competition to control costs.**

Response:

We agree beneficiaries should have more choice, but the Republican proposal is not modernization -- it puts the choice in the hands of insurance companies and providers.

The GOP creates an uneven playing field between Medicare Plus plans (private health plans) and traditional fee-for-service Medicare.

- Private health plans, including MSAs, fee-for-service, and association plans, would pick off the good risks.
- No major employer allows the degree of risk segmentation that would result from the range of plans proposed under the Republican proposal.
- These new plans do not protect beneficiaries against extra billing by providers.

The Administration's plan would:

- expand managed care and innovative delivery options in Medicare in order to permit beneficiaries a broader range of choices that promise real reform of the health system;
- allow provider networks to participate in a responsible manner, without allowing the physician-only plans that would not represent comprehensive, integrated care options;
- maintain beneficiary protections against balance billing or extra premiums, while revising quality assurance mechanisms to reflect improvements in this area.

F. Republican Claim: the Administration is resorting to frightening the elderly to defend their Medicare positions.

Response:

We have called the public's attention to the facts about the Republican plan and its impact, and will continue to do so.

The elderly have good reason to fear plans to raise out-of-pocket costs and shift Medicare to a voucher-like program in which the federal payment is not linked to the value of benefits--leaving them exposed to the consequences.

III. MAIN SPECIFIC POLICY DIFFERENCES

A. Beneficiary premiums

Objectionable Republican proposal: raise the beneficiary premium to 31.5 percent of program spending, from the President's level of 25 percent.

Republican claim: Republicans' Medicare premium is within dollars of the President's.

Response:

- About \$40 billion, nearly one out of every five dollars saved by the Republican Medicare plan, comes out of the pockets of Medicare beneficiaries in the form of increased premium payments.
- The Congressional Budget Office (CBO) estimated that the Republican premium would be \$84.60 in the year 2002.
- This premium is at least \$12 per month higher than the estimated premium under the President's plan. This means that Republicans would force beneficiaries to pay more than \$140 more in premiums in 2002 than would the President's plan.
- Seniors already pay more than one fifth of their income on health care.
- These increases will hit low-income Medicare beneficiaries especially hard since the Republican's Medicaid plan ends guaranteed Medicaid coverage of Medicare premiums.

B. Hard budget cap: the Republican plan includes an arbitrary cap on Medicare spending that is used to limit payments to Medicare health plans and to limit traditional Medicare provider payments if the arbitrary level is not reached.

Republican claim: The cap simply guarantees the savings levels envisioned in the Conference Agreement.

Response:

- An arbitrary cap breaks the link between Medicare funding and guaranteed Medicare benefits, changing the underlying nature of the program.
- The cap takes no account of unanticipated changes -- in inflation, in health care costs, or other factors -- any of which could trigger deep Medicare spending cuts under the plan -- meaning that Medicare would be held hostage to macroeconomic forces.

Over time, benefits could be eroded, beneficiary out-of-pocket payments increased, and/or payment rates to providers reduced -- all threatening benefits, quality, and access.

C. Level of cuts:

Objectionable Republican Proposal: More than \$200 billion in Medicare cuts over the next 7 years.

Republican Claim: This level of cuts is needed to preserve Medicare and the HI Trust Fund.

Response:

The cuts are unnecessarily high. The Administration plan, with only \$124 billion in Medicare cuts, preserves the HI Trust Fund until 2011. This leaves us with plenty of time to deal with the longer term demographic changes facing Medicare.

The magnitude of cuts will force Medicare beneficiaries to pay more through higher premiums and balance billing. The cuts will also result in privately insured, working Americans facing higher charges from providers to make up for cuts in Medicare and Medicaid.

Moody's Investor Service indicated (New York Times, November 3, 1995) that it "might have to downgrade its ratings of many major hospitals, and that some of them might not survive the financial ordeals ahead."

D. Medicare reform - real choices

Objectionable Republican Proposal: The GOP would create new options that could de-stabilize Medicare financing, including medical savings accounts, association plans, and private fee-for-service plans.

Republican Claim: New options will provide beneficiaries more choice and more responsibility for their health care.

Response:

We agree that beneficiaries need more choices, but the GOP plan moves backward, not forward. Medicare will be seriously undermined. In contrast, the Administration proposal modernizes Medicare through additional choices of managed care and innovative delivery arrangements, but avoids options that are experimental or that threaten the stability of the program or financial protection of beneficiaries.

The GOP's new options are constructed in a way that would create risk selection problems, leading healthy beneficiaries to leave the program and sick ones to stay. CBO has estimated the costs of MSAs alone at \$4 billion. No private employer would permit the degree of risk segmentation allowed in the Republican proposal among health plan options offered to its employees.

Beneficiaries who elect these new plans will not be adequately protected against high out-of-pocket costs. Providers will be able to balance bill in instances where they cannot in current Medicare. Premiums for supplemental benefits are not constrained in the GOP plan, while they are in current law.

The new options, combined with lack of balance billing protections and deep provider cuts, give doctors and other providers strong incentives to leave traditional Medicare. The result could be less, rather than more, choice for beneficiaries.

Beneficiaries electing another option may not be able to return to traditional Medicare easily, because supplemental Medigap coverage may not be available without medical exams. (The Administration proposal addresses this problem.)

E. Beneficiary protections

Objectionable Republican proposal: GOP permits more balance billing under private health plans than under traditional Medicare.

Republican claim: GOP claims that their balance billing rules are adequate and that seniors retain the choice of traditional Medicare with its balance billing rules undisturbed.

Response:

Hospitals and doctors will have an incentive to move out of traditional Medicare and into private insurance plans -- not managed care arrangements -- where they can balance bill.

Tight budget cuts fuel this incentive, as providers will want to shift costs to seniors.

F. Fraud and abuse

Objectionable Republican Proposal: Make it easier to defraud Medicare by relaxing anti-kickback and penalties.

Republican Claim: New mandatory funding has been provided to crack down on those who defraud or abuse Medicare and other Federal health care programs.

Response:

Despite the increased anti-fraud and abuse resources, it will be more difficult to identify and successfully prosecute criminals because new loopholes are created that will encourage more creative ways to abuse and defraud the program.

Providers could get away with defrauding Medicare by claiming that they did not know that they were filing a false claim against the program. Prosecutors would have to prove that such providers acted in "deliberate ignorance" or "reckless disregard" of the law in order to make charges stick.

Providers could evade anti-kickback statutes by forming managed care organizations.

Medicare beneficiaries could be placed at risk by physicians who refer them for care based on compensatory arrangements.

Providers could use bankruptcy protections to avoid repaying monies that they legitimately owe to the program.

G. Double jeopardy for low income seniors

Objectionable Republican Proposal: Eliminate requirement that states pay Medicare premiums and cost sharing for selected low income elderly.

Republican Claim: Low income elderly will be protected by requirements that States continue to set aside and target a portion of spending, based on 90 percent of their base year spending for Medicare premiums.

Response:

States' actual set-asides would be significantly lower than current law spending. States would set-aside 90 percent of Medicaid spending for premiums. The Republican plan contains no set-aside for copayments and deductibles.

At the same time, the Medicare premium is increased under the Republican plan.

In actuality, the set-asides will cover less than half of Medicaid spending for these groups.

Medicaid Issues

- **General Spending Limits**
- **Federal Entitlement**
- **Eligibility**
- **Benefits**
- **State Flexibility: General**
- **State Flexibility: Payment Flexibility**
- **State Flexibility: Delivery System Flexibility**
- **State Flexibility: Cost Sharing**
- **Formula & Funding Issues: Allocations Across States**
- **Formula & Funding Issues: Federal Matching Rate**
- **Formula & Funding Issues: Provider Taxes and Donations**
- **Disproportionate Share Hospital Payments**
- **§1115 Waivers**
- **Abortion**
- **Qualified Medicare Beneficiaries (QMBs)**
- **Nursing Home Regulations**
- **Spousal Impoverishment**
- **Special Populations (VFC and IHS)**

General Spending Limits

- **Administration Proposal** - reduces federal spending by \$54 billion over seven years. See the table below for savings estimates and growth rate comparisons. (Note that because the per capita cap language was not clear, CBO scored only the DSH reductions at \$38 billion in savings over seven years.) The per capita cap allows for growth in beneficiaries, inflation, and growth in the general economy.
- **Conference Agreement** - reduces federal spending by \$133 billion over seven years, limits aggregate growth to an average of 4.6 percent over seven years. If states maintain projected coverage levels, per capita growth would be limited to an average of 1.6 percent over seven years, less than half of the projected growth in nominal GDP per capita.
- **Coalition Proposal** - reduces federal spending by approximately \$85 billion over seven years (scored off of the March CBO baseline). (Note that because the per capita cap language was not clear, CBO scored only the DSH reductions at \$46 billion in savings over seven years.) The per capita cap allows for growth in beneficiaries and inflation.

Recommended Position

Under either a block grant or a per capita cap, the growth in federal Medicaid funds should allow for growth in the eligible population, as well as growth in inflation and the general economy. An aggregate growth rate which incorporates growth in recipients and growth in nominal GDP per capita would be a better index than the Conference Agreement formula which establishes arbitrary aggregate growth rates in the legislation.

Medicaid Growth Rates, Fiscal Years 1996 - 2002
(CBO December 1995 Baseline)

	Baseline	Conference	Administration ¹
Aggregate Growth:	10.0%	4.6%	8.6%
Recipient Growth:	3.0%	3.0%	3.0%
Per Capita Growth:	6.9%	1.6%	5.5%
Savings:		\$133 billion	\$54 billion

CBO scoring of Coalition proposal unavailable.

¹Pricing of Administration proposal assumes per capita cap and DSH proposals yield \$54 billion in savings over 7 years.

Federal Entitlement

- **Administration Proposal** - Preserves the individual federal entitlement to health care coverage for low-income individuals. This means that individuals who qualify for Medicaid under today's federal rules would be guaranteed coverage for a minimum benefit package. Individuals may sue in state or federal court to enforce their entitlement to Medicaid coverage and services.
- **Conference Agreement** - Explicitly repeals an individual's federal entitlement to health care coverage. Individuals would not be able to sue in federal court if denied eligibility by a state.
- **Coalition Proposal** - Same as Administration proposal.

Recommended Position

The Administration should maintain a federal commitment to providing health care services to low income individuals by retaining the federal entitlement to health care coverage. People who are currently eligible for Medicaid services would retain their federal guarantee of health care coverage. Individuals would retain the right to sue in State or Federal court to enforce their entitlement to Medicaid coverage and services.

Alternative Position

In order to give states more flexibility, the Administration could maintain the Federal entitlement to health care coverage, but compromise on eligibility and benefit coverage (see attached issues).

Eligibility

- **Administration Proposal** - Retains current law guaranteed coverage for mandatory and optional eligibility groups, including AFDC and SSI groups, poverty level children and pregnant women, medically needy and Qualified Medicare Beneficiaries (QMBs). Retains current law requirement for provision of medical assistance to low-income pregnant women, children under age 21, the disabled, and the elderly.
- **Conference Agreement** - States would be required to cover poor pregnant women, children under 13, and the disabled (as defined by the state). No other populations would be guaranteed coverage. States would determine eligibility requirements.
- **Coalition Proposal** - Same as Administration Proposal. Certain expansion populations (1902(r)(2)) would not be allowed after October 15, 1995.

Recommended Position

Under either a block grant or per capita approach, a federal commitment to low income individuals should be maintained by retaining current law coverage of mandatory and optional eligibility groups.

Alternative Position

Under a per-capita cap or a block grant approach, a minimum federal guarantee of eligibility could be defined for specified groups (i.e. QMBs, other low-income elderly, the disabled, and families and children under 100% of poverty). A minimum benefits package could also be defined under approach.

Alternatively, in order to give states more flexibility, current federal categorical and other mandatory eligibility rules could be replaced with guidelines which require states to demonstrate that certain specified groups are guaranteed coverage, e.g., states must cover all families with children below 100 percent of poverty.

Benefits

- **Administration Proposal** - Retains current law which requires states to cover mandatory services: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. States may also cover optional services: podiatrist, optometrist, dental, physical therapy, prescription drugs, ICF/MR, rehabilitative services, etc.
- **Conference Agreement** - States are not required to provide a minimum benefit package to beneficiaries (except immunizations to children and pre-pregnancy planning services and supplies). States would determine covered benefits and benefit levels.
- **Coalition Proposal** - Retains current law which requires states to cover mandatory services: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. The Secretary would define treatment under EPSDT. States may also cover optional services: podiatrist, optometrist, dental, physical therapy, prescription drugs, ICF/MR, rehabilitative services, etc.

Recommended Position

Retain all current mandatory and optional benefits.

Alternative Position

Under the per-capita cap or the block grant approach, the Administration could guarantee eligibility to health care services, but give states more flexibility by defining a minimum (and possibly limited) benefit package. The minimum benefit package could consist of most current mandatory services, plus prescription drugs, which all states current cover. In addition, the Administration could also allow EPSDT to be defined by the Secretary, as proposed by the Coalition proposal. The Administration could also propose to change the mix of mandatory and optional benefits.

State Flexibility: General

- **Administration Proposal** - Provides States with flexibility in delivery systems by eliminating 75/25 rule for managed care contracts, and allowing states without a waiver to pursue 1 type of managed care model, direct beneficiaries to providers, and establish a home and community based program. Allows flexibility in payment systems by eliminating the Boren amendment, 100% cost reimbursement for most FQHCs and RHCs, and repealing provider requirements for physicians who serve pregnant women and children. Finally, repeals some state administrative requirements for cooperative agreements and State Medicaid personnel. However, retains current requirement that states cover all medically-necessary treatment for conditions uncovered in a well child visit (EPSDT screen).
- **Conference Agreement** - Repeals Medicaid Statute, including mandated benefit package, eligibility, provider payment, delivery system requirements and reimbursement requirements, and EPSDT coverage requirements. Creates set-aside standards of 85% of mandatory spending in 1995 for low income families, the elderly and disabled (this amount does not change over time). Requires states to cover pregnant women and children below age 13 and state-defined disabled.
- **Coalition Proposal** - Allows states to implement all types of managed care models, including fully-capitated risk models, as a state plan amendment, eliminating current contract requirements (75/25, lock-in, etc...) and establishing new quality and payment standards for managed care contracts. Allows Secretary to define those treatment services that must be covered under EPSDT. However, retains Boren payment standard and extends Boren to hospital payment in managed care arrangements. Also retains 100% cost reimbursement for FQHCs and RHCs.

Recommended Position

Under a per capita approach, the Administration should pursue state flexibility while preserving quality and access to a defined set of services. Modifying payment requirements, and allowing states to pursue managed care without a state plan amendment provides incentives for states to control their costs under the cap.

A block grant approach should, at a minimum, maintain a federal commitment to providing health care services to low income individuals by defining minimum federal guaranteed eligibility for specified groups (i.e. QMBs, other low-income elderly, the disabled, and families and children under 100% of poverty) and specifying a minimum benefit package.

Alternative Position

The Administration could provide increased flexibility by eliminating or modifying EPSDT requirements, and by allowing states to pursue more than 1 model of managed care as a state plan amendment, as long as states were held to quality standards for their managed care contracts.

State Flexibility: Payment Flexibility

- **Administration Proposal** - Allows flexibility in payment system by eliminating the Boren amendment and 100% cost reimbursement for most FQHCs and RHCs. Retains 100% FMAP for IHS facilities, and related non-IHS facilities would get 100% cost reimbursement.
- **Conference Agreement** - Repeals provider payment requirements, but retains 100% FMAP for IHS facilities. Requires states to describe their method for determining payment rates in the State plan.
- **Coalition Proposal** - Retains Boren payment standard and extends Boren to hospital payment in managed care arrangements. Requires states to submit reports on hospital payment. Also retains 100% cost reimbursement for FQHCs and RHCs.

Recommended Position

Under a per capita cap or block grant approach, either the Administration's proposal or the Conference Agreement provisions would be acceptable. Note, however, that the Coalition proposal provides states less flexibility for hospital payment. Such an approach is not recommended.

State Flexibility: Delivery System Flexibility

- **Administration Proposal** - Allows states to pursue one managed care model (primary care case management), and home and community based services as a state plan option. Eliminates Medicaid participation standard (e.g., “75/25 rule”) for managed care contracts.
- **Conference Agreement** - Repeals Medicaid statute, including managed care waivers. States are required to describe their actuarial methods for setting capitation rates for HMOs or other managed care organizations in their state plan. Does not require any state quality standards.
- **Coalition Proposal** - Allows states to implement all types of managed care models, including fully-capitated risk models, as a state plan amendment. Eliminates all Medicaid managed care contract standards (e.g., 75/25, lock-in) and establishes new quality and payment standards for Medicaid managed care. Review must be completed in within 90 days for all waivers, and retains home and community based waivers. However, extends Boren payment requirement to hospitals in managed care contracts.

Recommended Position

States could be allowed to pursue additional types of managed care models without waivers, (e.g., at risk capitation, selective contracting, etc...). At a minimum, a per capita or block grant approach should ensure that there are adequate access and quality standards in Medicaid managed care, and that there is some degree of federal oversight of managed care contracts.

Alternative Position

An alternative position would be to accept the Coalition provisions with respect to managed care and quality standards. The provision extending Boren payment requirements to hospitals in managed care contracts should not be accepted.

State Flexibility: Cost Sharing

- **Administration Proposal** - No change to current law restrictions on cost-sharing liabilities --Under allowable circumstances, cost-sharing must be reasonably related to income; cost-sharing may not be more than “nominal.” However, states may not require cost sharing for HMO enrollees; States may not impose any cost-sharing requirements on children, pregnant women, or spend-down eligibles; States may not require cost-sharing for emergency services, family planning, or hospice.
- **Conference Agreement** - States may impose cost-sharing requirements on Medicaid enrollees, with certain exceptions. States may not impose premiums on families which include a pregnant woman or child with incomes below 100% of poverty; cost sharing for primary and preventive care for children and pregnant women must be nominal. States would have broad flexibility to develop cost-sharing schedules.
- **Coalition Proposal** - Maintains current law prohibitions on cost sharing. If states choose to implement cost sharing, they would do so pursuant to a public schedule.

Recommended Position

Retain current law.

Alternative Position

Alternatively, the Conference Agreement provision would be acceptable. States that already impose premiums for beneficiaries under 100% of poverty should be grandfathered.

Formula & Funding Issues: Allocation Across States

- **Administration Proposal** - Under the Administration's per capita cap proposal, the federal limit for each state is based on the state's historical Medicaid spending level. All states receive the same growth rate, thus there is little redistribution of federal funds across states.
- **Conference Agreement** - Under the Conference agreement, each state's block grant depends partly on historical costs and partly on arbitrary adjustments to a state's historical costs. Each state's growth rate is dependent upon a number of factors (e.g., number of people in poverty, input costs, etc.). The overall effect of the Conference Agreement's block grant allocations is to favor lower-income, high population growth states at the expense of higher-income, low population growth states.
- **Coalition Proposal** - Concept is the same as the administration proposal, however, the specific methodology differs significantly. As with the Administration proposal, there is little redistribution of federal funds across states.

Recommended Position

Under either a per capita cap or block grant approach, for equity purposes and to minimize formula fights, federal spending limits in each state should be dependent upon each state's historical Medicaid spending -- without any arbitrary adjustments. All states also should receive the same growth rates.

Alternative Position

Under either approach, federal spending limits in each state should be dependent upon each state's historical Medicaid spending. However, differential growth rates could be given to certain states (e.g., lower-income states or states with a high proportion of elderly).

Formula & Funding Issues: Federal Matching Rate

- **Administration Proposal** - The Administration's proposal retains the current law federal matching rate (Federal Medical Assistance Percentage -- FMAP). Under current law, the matching rate is dependent upon a state's wealth (as measured by per capita income) relative to the nation. By law, the minimum federal match is 50% while the maximum federal match is 83%. The current FMAP is viewed by many as inequitable because without the 50% floor, some richer states would receive less than a 50% match.
- **Conference Agreement** - Under the Conference agreement, each state can choose its own FMAP from among several choices. The agreement also raises the minimum FMAP from 50% to 60%. The effect of the Conference agreement is to lower the amount of state dollars necessary to draw down federal funds. This could lower total (state and federal) funds spent on Medicaid.
- **Coalition Proposal** - The Coalition proposal also retains the current law FMAP.

Recommended Position

Under either a per capita cap or block grant approach, the current law FMAP should be retained.

Alternative Position

Under either approach, a more equitable FMAP can be developed (such as the new FMAP proposed in the Conference). However, we would not support allowing states the option of choosing among three FMAPs, which would create an irrational and complicated system for determining federal reimbursement. We also would not recommend raising the minimum FMAP from 50% to 60%.

Formula & Funding Issues: Limits on Provider Taxes & Donations

- **Administration Proposal** - Retains current law which requires that provider taxes meet federal standards that assure basic fairness among providers and that the state funds produced to support Medicaid are real. Prior to Medicaid laws passed in 1991 and 1993, states were able to game the system to generate additional Federal funds at little or no cost to the state.
- **Conference Agreement** - Repeals current law, allowing states to replace real state spending with funds generated through these schemes. Unlike in the early nineties, the cycling of funds will not increase federal funds, as they are capped under a block grant; but will effectively reduce the total funds for the program.
- **Coalition Proposal** - Retains current law.

Recommended Position

Under either a per capita cap or block grant approach, current law should be retained in order to assure that the state share of Medicaid funding is real.

Disproportionate Share Hospital Payments

- **Administration Proposal** - Federal DSH spending is reduced by \$38 billion over seven years. DSH payments are phased down gradually, and combined with two special transition pools. States are granted increased flexibility to determine which hospitals are eligible for DSH payments and expands the definition of eligible providers to FQHCs, RHCs and other inpatient and outpatient providers.
- **Conference Agreement** - The DSH program does not continue under the block grant, but states can make supplemental payments to hospitals within their block grant allotments.
- **Coalition Proposal** - imposes a lower limit on federal DSH spending than the Administration's proposal. The Coalition proposal reduces federal DSH spending by \$46 billion over seven years¹. States' DSH allotments are based on the state's proportion of the national total of low-income patient days. This allotment system represents a substantial redistribution of DSH funds among states from both the current distribution and the Administration's proposal. Providers within a state eligible for DSH payments are limited to those hospitals whose low-income utilization rate exceeds 25 percent (with some exceptions).

Recommended Position

Under a per capita cap approach - Federal DSH spending should be reduced between 30 and 45%. These reductions should be phased in and the current distribution of DSH funds should be maintained to ensure that state programs face the minimum disruption. States should be given flexibility to designate which providers are eligible for payments.

Under a block grant approach - A separate federal fund for supplemental payments to hospitals serving a disproportionate share of low-income or uninsured payments should be maintained to provide financial protections to these essential providers.

Alternative Position

Under a per capita cap approach - Federal DSH spending could be reduced and redistributed as under the Coalition proposal, as long as there is an adequate transition period (2 or 3 years) for states to move from current DSH levels to those specified in the Coalition proposal.

¹CBO scoring appears to be in error, the correct savings amount may be \$42 billion.

§1115 Waivers

- **Administration Proposal** - States would not need a waiver to set up one type of managed care system. Special calculation of base year expenditures for States with waivers implemented in 1995, but no special growth rates for waiver States.
- **Conference Agreement** - No special growth rate provisions for waiver states (i.e. waiver states would be subject to state-specific growth rates and aggregate caps on Federal funds). Tennessee and Oregon would receive an increase in their base year allotment.
- **Coalition Proposal** - States with §1115 and §1915 waivers implemented in 1995 have a choice of how to calculate per capita expenditures in the base year. No special growth rates for waiver States, but the Secretary has discretion to allow special growth rates for waiver States. States can also expand eligibility in a budget neutral manner within the per capita limits.

Recommended Position

Under both a per capita cap and a block grant approach, waiver states should not receive special growth rates. However, for those States that have implemented their waivers in FY 95, a special provision increasing the base year expenditures should be included under either approach to account for increased enrollment.

Abortion

- **Administration Proposal** - No provision on abortion
- **Conference Agreement** - The Conference Report would make Hyde restrictions (no funding for abortions except if the life of the mother is threatened, or if pregnancy is a result of rape, incest) permanent law. Current law has no such restriction.
- **Coalition Proposal** - No provision on abortion

Recommended Position

Similar restrictions on funding for abortion can usually be found in the L/HHS/Ed appropriations language only, which allows the restriction to be debated every year. The Administration should continue to keep the Hyde provision out of permanent law.

At a minimum, if the Hyde restriction becomes permanent law, the Administration should consider modifying the Hyde language, such as including an exception for the health of the mother as well.

Qualified Medicare Beneficiaries (QMBs)

- **Administration Proposal** -QMBs are excluded from the calculation of the per capita limits. Medicare cost sharing and premium payments for QMBs are not subject to the per capita limits.
- **Conference Agreement** - Requires states to spend a minimum percentage for Medicare premiums - which is 90% of proportion of state spending on mandatory eligibles for the years FY 93 to FY 95.
- **Coalition Proposal** -Same as Administration Proposal.

Recommended Position

Under either a per capita cap or block grant approach, QMBs should be excluded.

Alternative Position

Under either the per capita cap or block grant approach, States should be required to reflect actual costs of this population in the base year and allow the growth in expenditures on this population to keep up with growth in the Medicare program.

Nursing Home Regulations

- **Administration Proposal** - The Administration retains current law. Current law contains federal requirements for 1) quality of care 2) survey and certification and 3) enforcement of standards.
- **Conference Agreement** - Retains the framework of uniform standards but severely reduces the federal role in validating state survey efforts and enforcing state and facility compliance.
- **Coalition Proposal** - Retains current law.

Recommended Position

Under either a per capita cap or block grant approach, retain current law.

Alternative Position

Under A Per Capita Cap Approach or Block Grant Approach -

- Increase state flexibility in the survey process -- Allow states to vary the length, intensity and cycle of surveys based on a facility's past performance. Allow states to waive federal survey requirements (not quality requirements) if they can offer a more innovative and less expensive process.
- Re-examine the necessity of certain regulations -- State flexibility may be enhanced by the elimination of certain regulations such as the requirement that facilities offer snacks and that facilities with more than 120 beds employ a social worker.
- Retain a strong federal enforcement role -- State flexibility is a desirable goal as long as the federal government has the authority to enforce state and facility compliance with a minimum set of standards.
- Retain federal standards in resident assessment -- A national, uniform resident assessment will decrease burden on nursing home companies with facilities in more than one state and allows the federal government to monitor quality of care across the nation.

Spousal Impoverishment

- **Administration Proposal** - The Administration retains current law provisions that 1) protect the income and assets of a nursing home resident's spouse, 2) protect a nursing home resident's home and 3) protect the adult children of nursing home residents from financial liability.
- **Conference Agreement** - Retains protection of income and assets for nursing home resident spouses but eliminates protection of nursing home resident homes. Only protects adult children of nursing home residents whose incomes fall below the state median.
- **Coalition Proposal** - Retains current law.

Recommended Position

Under either a per capita cap or block grant approach, retain current law.

Special Populations (VFC and IHS)

- **Administration Proposal** - The Administration's proposal retains special treatment for certain populations. The Administration's proposal would retain the current Vaccines For Children (VFC) program, which provides a 100% federally-funded entitlement for vaccines for Medicaid eligible, uninsured, underinsured, and Indian children. Medicaid funds for VFC would not be included under the per-capita cap. The Administration's proposal would also exclude Medicaid funds for Indian Health Service (IHS) facilities and certain related facilities, which provide health care services to Native Americans, from the per-capita cap.
- **Conference Agreement** - The Conference Agreement would repeal the current VFC program, but require states to cover immunizations for all eligible children. Medicaid funds for IHS and IHS related facilities are included in the block grant.
- **Coalition Proposal** - Same as the Administration.

Recommended Position

Under either a per-capita cap or block grant approach, both programs should remain as under current law -- outside of any cap.

Alternative Position for VFC

Under either a per capita cap or block grant approach, VFC should be retained as a 100% Federally funded program. However, current law spending could be reduced by scaling back VFC to only cover Medicaid children (i.e. do not provide coverage to uninsured and underinsured children).

MEDICAID

- **Detailed Background**

December 30, 1995

MEDICAID OVERVIEW

December 21, 1995

CURRENT LAW:

Medicaid provides health care coverage for 36 million low-income older Americans, pregnant women, people with disabilities, and poor children through a Federal-State partnership. Medicaid provides a guarantee of meaningful health benefits for certain eligible individuals. States have considerable flexibility to design their Medicaid programs within the Federal requirements.

The Federal government matches State Medicaid expenditures, based on a matching formula, as long as these expenditures are made on behalf of eligible individuals and services. States that spend more on a per person basis, cover a broader range of their low-income population, or experience greater growth in their Medicaid programs, receive a proportionately larger share of Federal matching payments than States with less generous programs or low growth. The only element of the Medicaid program that is currently subject to a limit on Federal matching payments is the disproportionate share hospital (DSH) payment program.

PRESIDENT'S PROPOSAL:

Coverage and Benefits. The President's proposal would retain the Medicaid program's guarantee of health care coverage and the Federal commitment to matching State spending.

Level and Form of Savings. The President's plan would achieve \$54 billion in savings by placing an annual per capita cap on Federal matching payments and by reducing and retargeting DSH payments. Under a per capita cap, each State would receive Federal matching payments up to an aggregate limit. This limit would be determined by multiplying a capped amount (which would be different for each Medicaid eligibility group) by the number of enrollees; the limit would therefore respond to changes in the number of enrollees and the composition of enrollment.

Flexibility. The President's plan would also make substantial changes to Federal Medicaid rules that would give States new flexibility.

REPUBLICAN PROPOSAL:

Coverage and Benefits. The Republican proposal repeals the guarantee to meaningful Medicaid benefits. It would repeal virtually all Medicaid eligibility rules, benefit guarantees, and DSH payments, among other provisions in Federal Medicaid law.

Level and Form of Savings. The Republican proposal would establish a Medicaid "block grant," reducing Federal Medicaid funding by \$117 billion over 7 years. Each State would receive a fixed Federal block grant. This grant amount would not vary based on enrollment, inflation, recession, natural disaster, or any other factor.

Flexibility. The Republican proposal would eliminate most current Federal guidelines and requirements, providing States with an unprecedented level of flexibility to administer the Medicaid program, while providing no countervailing beneficiary protections.

ANALYSIS:

Adequacy of Resources.

- **Payments to States.** The Republican proposal block grants the program and reduces Federal Medicaid payments to the States by \$117 billion over 7 years. States could not absorb cuts of this magnitude without limiting eligibility or benefits, or both. The President's proposal achieves \$54 billion in Federal savings -- less than half the savings from the Republican proposal.
- **Reductions in State Spending.** Furthermore, under the Republican block grant the combined Federal and State Medicaid reductions could be *more than double* the Federal reductions. Both the Center on Budget and Policy Priorities and the Urban Institute estimated based on the Republican reconciliation bill that the combined Federal and State reductions would exceed \$400 billion over 7 years if States spend only what is required to receive their full Federal block grant allocation. Based on the latest Republican proposal, HHS estimates the combined cuts could *exceed \$300 billion over 7 years*.
- **Per Capita Growth.** The Republican plan would limit average annual per capita spending growth far below the projected rate of 7.0% or the projected private sector rate of 7.1% (projected based on CBO data). In contrast, the President's plan would moderately reduce annual Medicaid spending growth to an average of about 5.5% per person over the same time period.

- **Elimination of Guarantee to Meaningful Benefits.** The Republican proposal would provide States with extensive administrative flexibility, but at the cost of the Medicaid guarantee of meaningful benefits. The depth of their Medicaid cuts, combined with the reductions in other federal assistance to States, will force States to use this flexibility to reduce coverage and benefits.

The Republican proposal eliminates the Medicaid guarantee of meaningful health benefits for poor elderly, pregnant women, low-income children, and disabled Americans. While it requires States to cover poor children under the age of 13, pregnant women, and people with disabilities, *States would have complete discretion to determine the level of benefits provided and to define eligible disabilities.* The only required benefits would be immunizations and restricted family planning.

The elimination of the guarantee combined with the steep reductions in Federal support under the Republican proposal could force States to deny meaningful coverage to 4 to 8 million Americans in 2002 alone, including 2 to 4 million children, according to HHS estimates based on a study by the Urban Institute. This means people could lose coverage of nursing home care, preventive check-ups for children, and treatments or wheelchairs for people with disabilities. A recent Lewin-VHI analysis of the reconciliation bill proposal found that more than 8 million people could lose Medicaid coverage in 2002.

By contrast, the President's plan maintains the current guarantee to meaningful health benefits for poor children, pregnant women, individuals with disabilities, and older Americans; service guarantees; and quality protections. It does this while giving States enhanced flexibility to run efficient Medicaid programs.

- **Shifting of Costs to States, Localities, and Families.** The Republican proposal would place States, localities, providers, families and taxpayers at risk for the uncovered cost of health care for poor children and their families, people with disabilities, and older Americans. Only the Federal government would be protected from the costs of increases in enrollment, health care costs, natural disasters, and economic changes. By contrast, the President's plan maintains the Federal partnership with States to help States respond to changes in enrollment and enrollment composition.
- **Repeal of Federal Enforcement of Nursing Home Quality Standards and Key Quality Protections.** It would repeal key federal quality standards and all federal enforcement of nursing home quality standards. While States may want to maintain these standards, inadequate resources could lead them to fail to set and enforce adequate quality standards. The Republican proposal also eliminates Federal quality standards for facilities that serve individuals with mental retardation or developmental disabilities, without requiring States to develop equivalent standards. In contrast, the President's proposal maintains the current quality standards.

- **Repeal of Financial Protections.** Under the Republican proposal, people could be forced to give up their home, family farm, car, and all their savings in order to qualify for Medicaid. States could put liens on family homes, increase cost-sharing for Medicaid benefits, and allow nursing homes to charge residents for services now covered by Medicaid. While Republicans retain the current spousal impoverishment protections for spouses of Medicaid beneficiaries, spouses could no longer enforce these protections in federal court. In contrast, the President's proposal maintains current financial protections.

GUARANTEE OF MEDICAID COVERAGE FOR PEOPLE WITH DISABILITIES, ELDERLY, PREGNANT WOMEN, AND POOR CHILDREN

December 21, 1995

CURRENT LAW:

Medicaid guarantees coverage of certain basic health care services in every State for people with disabilities, the elderly, pregnant women, and children meeting certain financial criteria. States are allowed to cover some additional categories of people, either under State plan options or under waivers. Each State must provide comparable services in all parts of the State. Individuals may seek redress in Federal court for violations of these basic protections.

PRESIDENT'S PROPOSAL:

Coverage and Benefits. The President's proposal retains the guarantee of basic health benefits for those currently covered, who include people with disabilities, the elderly, pregnant women, and poor children. It also significantly increases State flexibility and streamlines eligibility procedures.

Level and Form of Savings. The President's proposal achieves \$54 billion in savings over 7 years by establishing an annual per capita growth cap for federal matching payments, and by reducing and retargeting payments to Disproportionate Share Hospitals (DSH).

Geographic Comparability of Benefits. The President's proposal ensures equity by retaining requirements that States provide comparable services in all geographic areas of the State.

Due Process. Individual beneficiaries would retain the due process safeguard of being able seek redress in Federal court for violations of these minimum requirements.

REPUBLICAN PROPOSAL:

Coverage. The Republican proposal *repeals* the guarantee of coverage for those currently receiving benefits and provides States with virtually complete flexibility in defining eligibility and benefit levels. While it requires States to cover poor children under the age of 13, pregnant women, and people with disabilities, *States would have complete discretion to determine the level of benefits provided and to define eligible disabilities.* In addition, they would have complete discretion in setting income and asset limits for eligibility for other categories of people.

Although the Republican proposal establishes "set asides" that require States to devote specified minimum percentages of total State spending to certain categories of people, *the set-aside amounts cover only about 45% of State Medicaid spending for these groups*. Specifically, their proposal establishes set asides for low-income families, the elderly, individuals with disabilities, poor Medicare beneficiaries (known as qualified Medicare beneficiaries or QMBs), and services provided by Federally qualified health centers and rural health centers.

In general, the set-aside percentage is 85% of the State's spending for *mandatory services* for that group in 1992-1994. For QMBs, the set-aside percentage is 90% of the 1993-1995 spending on premiums. Nevertheless, the set-asides cover less than half of current Medicaid spending for these groups because they are calculated based on spending on *mandated services* for mandatory eligibles instead of on spending on all services for all eligibles. In addition, exceptions would be allowed for States to provide lower set-aside amounts.

Benefits. The Republican proposal eliminates the guarantee of a minimum set of benefits for those who receive coverage. States could eliminate almost any benefit currently covered by Medicaid. The only required services would be immunization and restricted family planning.

Level and Form of Savings. The Republican proposal creates a Medicaid block grant that would provide States with \$117 billion less federal assistance than under current law. Each State's block grant is fixed and will not vary with changes in costs or need.

Geographic Comparability of Benefits. The Republican proposal eliminates all requirements that comparable services be provided across the different geographic areas of a State.

Due Process. Individuals would lose the right to seek redress in Federal court to enforce the remaining Federal safeguards.

ANALYSIS:

Inadequacy of Resources Will Force States To Reduce Coverage and Benefits.

While both plans contain savings, the President's proposal protects coverage by limiting spending growth *per capita*, creating incentives to increase efficiencies but not to eliminate coverage.

The Republican block grant would reduce average annual per capita spending growth from 7.0% to less than 2% -- below both the private sector growth rate and the general inflation rate. Per capita spending growth in the private sector is projected to grow at 7.1% per year, based on CBO data. By comparison, under the President's proposal, average per capita spending growth would be constrained to about 5.5% per year.

With spending rising far below the private sector rate, it will be *impossible* for States to maintain current eligibility and benefit levels. States will not be able to achieve the required level of savings through increased efficiencies from managed care and reductions in payments to providers alone:

- **Managed Care Will Not Produce Enough Savings.** Benefits for the elderly and disabled people account for more than two-thirds of Medicaid spending. Yet there is little evidence that managed care will produce significant savings for these populations. Current Medicaid projections already assume that 33%-50% of poor children and their families will be in managed care, so expanding managed care is unlikely to yield significant additional savings.
- **Medicaid Payments to Providers Are Already Low.** Medicaid already reimburses providers at a significantly lower rate than Medicare. Much deeper reductions will likely lead more doctors and hospitals to turn away Medicaid patients.
- **States Will Therefore Be Forced to Reduce Coverage and Benefits.** The Urban Institute concluded that even if States could absorb half of the cuts by reducing services and provider payments, States would still have to deny meaningful coverage to millions of Americans by 2002. Based on the Urban Institute analysis, HHS estimates that 4 to 8 million people, including 2 to 4 million children, could be denied coverage in 2002.
- **Total Federal and State Medicaid Cuts Could Exceed \$300 billion.** While the Republican proposal reduces Federal Medicaid spending by \$117 billion, the total Medicaid cuts could ultimately exceed \$300 billion, according to HHS. Based on the reconciliation bill proposal, both the Center on Budget and Policy Priorities and the Urban Institute estimated that if States provide only the funding required to receive their full block grant allocation and provide no additional funding, the total reduction in Federal and State Medicaid funds would *exceed \$400 billion over 7 years*, compared with current law.

No Guarantee of Coverage or Meaningful Benefits. Although the Republican proposal requires States to cover pregnant women, children under 13, and people with disabilities, the sharp reduction in Federal assistance may force States to provide *minimal* health benefits. The block grant set-asides cover only about 45% of State Medicaid spending for these groups, allowing States to more than cut their spending in half in each of the specified areas. Financially strapped States could be forced to eliminate coverage of valuable services such as well-child care, prenatal care and long-term care for chronically-ill seniors and disabled individuals.

Elimination of Comparability Requirements May Lead to Serious Inequities. The lack of requirements that benefits be comparable across a State could lead a State to short-change certain needy but politically weak populations or geographic areas and shift benefits to others.

Republican Proposal Abolishes Due Process Protections. Eliminating the right of an individual to sue a State in Federal court removes any meaningful ability of beneficiaries to seek legal protection from possible State abuses of their broad new discretion. Moreover, the *minimal* required services and procedural "guarantees" in the Republican proposal are meaningless for those who are ineligible under new State rules.

MEDICAID STATE FLEXIBILITY

December 20, 1995

CURRENT LAW:

States administer their Medicaid programs under broad Federal guidelines. These Federal guidelines address major aspects of the Medicaid program including eligibility, covered services, delivery systems, provider payment levels, and beneficiary cost-sharing. The Federal guidelines serve as protections for Medicaid beneficiaries and the health care providers who serve them.

PRESIDENT'S PROPOSAL:

The President's proposal would maintain current law regarding eligibility and benefits, while changing Federal requirements regarding delivery systems, waiver requirements, and provider payments to give States increased flexibility to manage their Medicaid programs.

The President's flexibility provisions would:

- Repeal the Boren Amendment which establishes reimbursement standards for hospitals and nursing homes;
- Permit mandated enrollment in certain types of managed care (beneficiaries must have a choice of plan or delivery system, with an exception for rural areas);
- Simplify Medicaid eligibility;
- Allow home and community-based service programs without Federal waivers; and
- Relax managed care contract requirements.

REPUBLICAN PROPOSAL:

The Republican proposal would eliminate most current Federal guidelines and requirements, providing States with an unprecedented level of flexibility to administer the Medicaid program, while providing no countervailing beneficiary protections.

ANALYSIS:

The Republican plan provides maximum flexibility to States at the expense of coverage. The combination of deep federal cuts and broad flexibility will compromise services and protections for Medicaid beneficiaries.

- The Republican proposal allows States to define eligibility, benefit levels, and provider payment levels, and to require out-of-pocket costs by family members.
- The depth of the cuts in Medicaid, combined with reductions in other federal assistance to States, will force States to use this flexibility to deny coverage and benefits to millions of children, pregnant women, elderly, and Americans with disabilities.

The President's plan provides the flexibility and resources needed to provide guaranteed coverage more efficiently.

- The President's plan is premised on the notion that with modest reductions in spending and increased flexibility, States can reduce health care spending while still providing a guarantee of meaningful coverage to those who are eligible today.
- The flexibility provisions under the Administration's proposal would allow States to achieve program efficiencies to help them meet the Federal per capita payment limits.

The Republican plan would also allow States to cut their spending at the expense of coverage.

- Under the Republican plan, States could reduce their spending by billions of dollars compared with projections under current law and still receive their full Federal block grant allocation. Thus, based on the reconciliation bill proposal, both the Center on Budget and Policy Priorities and the Urban Institute estimated that total Federal and State cuts could exceed \$400 billion if States only spend what is required to receive their block grant allocation. Based on the latest Republican proposal, HHS estimates that the total Medicaid cuts could *exceed \$300 billion over 7 years*.
- Total reductions could be *still deeper* because the Republican plan would allow States to use financing gimmicks to spend even less and still receive their Federal block grant allocation. For example, States could tax providers, then refund the money to the providers, but still count the refund towards their required State Medicaid spending. Such Medicaid financing gimmicks were once common but are now prohibited under current law. According to the CBO, these financing mechanisms allowed States to claim federal dollars "for what were often illusory Medicaid expenditures." [CBO testimony before the Senate Finance Committee, June 21, 1995.]
- In the past these financing schemes shifted costs to the Federal government, but under a block grant they would shift costs to the elderly in nursing homes, pregnant women, people with disabilities, and ultimately also to people with private insurance through cost-shifting.

- **Some of the new options for savings offered by this new flexibility raise serious concerns:**

Tightening of Eligibility:	Reduced eligibility based on income and disability could deny meaningful coverage to 4 to 8 million people in the year 2002.
Reduced Benefits for the Disabled and Elderly:	Because nearly 70% of Medicaid spending is for the elderly and people with disabilities, financially strapped States could be compelled to limit benefits for the most expensive elderly and disabled recipients.
Excessive Reductions in Provider Payments:	The deep reductions in Federal funding to States could force States to lower payments to providers to levels that reduce providers' willingness to participate in the Medicaid program, reducing beneficiaries' access to medical services. Federal Medicaid and Medicare reductions combined could force many of the nearly 700 vulnerable hospitals that derive two-thirds of more of their net patient revenues from these programs to close.
Lower Nursing Home Quality Standards:	While States may want to maintain quality, inadequate resources combined with the repeal of key federal quality standards and all federal enforcement of quality standards could lead to State failure to set and enforce adequate quality standards.
Reduced State Spending and Financing Gimmicks:	States could dramatically reduce their projected spending and still receive their full federal block grant allocation. State reductions could be <i>still deeper</i> because States could use financing gimmicks -- once common but now prohibited under current law -- to receive their full federal block grant while spending still fewer State funds.
Discrimination:	State discretion to define benefits and the repeal of requirements that States provide comparable services in all parts of the State could lead to inequitable coverage and possibly discrimination.
New Options That Shift Costs To Beneficiaries And Family Members:	New State authority to impose unlimited cost-sharing requirements on the low-income elderly and disabled Medicaid beneficiaries could discourage low-income Americans from seeking necessary medical care or even applying for Medicaid coverage.

MEDICAID NURSING HOME QUALITY STANDARDS

December 29, 1995

CURRENT LAW:

Nursing Home Quality. The Omnibus Budget Reconciliation Act of 1987, signed into law by President Reagan, established Federal minimum standards for nursing homes that:

- Protect nursing home residents from abuse and neglect;
- Limit the use of physical and chemical restraints;
- Prohibit nursing homes from evicting residents when they run out of money and qualify for Medicaid;
- Give nursing home residents the right to appeal decisions without retribution; and
- Ensure that nursing aides are trained and do not have a history of abuse.

These OBRA '87 Federal standards and enforcement system have dramatically improved quality of care in nursing homes. Since the 1987 reforms were implemented, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31% (Research Triangle Institute; HCFA).

ICF/MR Quality. In addition, to be reimbursed by Medicaid, institutions caring for people with mental retardation and developmental disabilities (ICF/MRs) must meet Federal Medicaid quality standards adopted in the 1970s and strengthened by President Reagan. Prior to the adoption of these Federal standards, people with mental retardation and developmental disabilities were routinely subject to abuse and neglect and lacked even minimally safe and sanitary living conditions.

PRESIDENT'S PROPOSAL: Retains current law

REPUBLICAN PROPOSAL:

Nursing Home Quality. The Republican proposal retains some of the 1987 nursing home standards, but repeals certain key protections and eliminates Federal enforcement, leaving enforcement entirely to the States. Their proposal would significantly diminish the Secretary's "look-behind" authority.

ICF/MR Quality. The Republican proposal entirely eliminates the current Federal standards.

ANALYSIS:

1. NURSING HOMES.

Repeal of Federal Enforcement. The Republican proposal repeals Federal enforcement of nursing home standards. These standards were enacted in 1987 in response to a major report that documented widespread substandard or poor care at nursing homes in every State. Yet the Republican proposal repeals key Federal standards and Federal enforcement:

- **No Federal Enforcement.** The federal government would have no way to ensure that States enforce the standards. Most recently, *federal surveyors found 14% of nursing homes out of compliance with the federal standards.* (Source: HCFA.)
- **States Could Leave Enforcement to Private Organizations.** States could turn over their survey and enforcement responsibilities to private accreditation organizations with no Federal review, thereby reducing accountability and increasing variations in quality and enforcement.
- **Inadequate Resources to Enforce Standards.** States would have to set and enforce quality standards with significantly less Medicaid funding than they receive under current law. While States may want to maintain nursing home quality, inadequate resources combined with repeal of Federal enforcement could lead them to fail to set and enforce adequate quality standards.
- **Quality May Decline With Payments.** Nursing homes may find it difficult or impossible to maintain the current quality with significantly reduced Medicaid payments. Nursing homes would have to significantly lower their costs, lower services and quality, drop out of the Medicaid program, or shift costs to residents and their families, diminishing Medicaid beneficiaries' access to quality care.
- **Access to Nursing Home Care Could Be Limited.** Most facilities (70 percent of total) would be burdened with having to meet different standards and enforcement rules for Medicare and Medicaid. As a result, providers could withdraw from Medicare, thereby limiting access to care. Under current law, Medicare and Medicaid have the same rules to maintain high quality of care.

Elimination of Key Federal Quality Standards. The Republican proposal repeals key Federal quality standards, allowing the States to set their own standards within broad Federal guidelines. For example, Federal law would no longer guarantee the following protections:

- **Services.** Nursing homes would no longer be required to optimize individual residents' health and well-being. Nursing homes would no longer have to provide services to "attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident." As a result, residents could be denied skilled nursing and rehabilitative services needed to improve their ability to function.

- **Training.** Federal training requirements for hands-on caregivers would be eliminated; each State could determine who would be trained and how.
- **Needs Assessment.** Residents would no longer be guaranteed the same comprehensive assessment of their health and functional status now required nationally.

Strikes Major Financial Protections for Beneficiaries. Under the Republican proposal, facilities could deny admission to those with limited private resources (e.g. those who might become eligible for Medicaid). Facilities could also charge beneficiaries and their families large up-front payments as the price of admission.

2. INSTITUTIONS CARING FOR PEOPLE WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (ICF/MRs)

Repeal of Federal Standards. The Republican proposal eliminates federal standards and does not require States to issue standards that would assure even the most basic rights, such as protection from abuse and neglect, treatment designed to assist the person to achieving the greatest level of independence, and the right to adequate health care. States do not currently have such standards of their own.

- The federal presence has made a difference -- the federal process on average finds 17% of facilities out of compliance with the federal standards. (Source: HCFA.)
- The Republican proposal does not require States to maintain their current level of services -- in facilities or in home and community-based care -- for people with mental retardation and developmental disabilities. Moreover, it eliminates the guarantee of anything more than custodial care.

include certain provisions that make such protection enforceable. In particular, it repeals the right of individuals to seek redress in federal court if they believe they have been wrongfully denied protections. The Federal government would have no way to ensure that States were enforcing the federal protections.

Copayments: The Republican proposal generally allows States to impose premiums and costsharing on low-income beneficiaries, with the exception of families with low-income children and pregnant women. It also allows States to impose requirements on Medicaid enrollees, except that States may only require "nominal" cost sharing for low-income children and pregnant women for primary and preventive services.

Homes, Family Farms, and Liens:

ANALYSIS:

Loss of Guarantee: The Republican plan contains no guarantees of coverage or benefits at even a minimum level, potentially shifting costs of care to people who can ill afford them.

Higher Out of Pocket Costs Through Denial of Eligibility: People whom States define as no longer "poor enough" to qualify for medical assistance would be faced with paying all their medical costs themselves, or seeking help from relatives or charity. In the worst cases, families would have to mortgage or sell their homes to be able to pay for care, or elderly people needing long-term care would have no choice but to turn to their children for help.

Higher Out of Pocket Costs through Less Scope of Benefits: Reductions in the scope of benefits would also shift costs from the program to people. For example, cuts in the scope of the nursing home benefit could mean that families of poor patients will pay for such services as personal hygiene, laundry, or various therapies, that States now pay for.

Spousal impoverishment: Despite appearances, the Republican plan fails to adequately protect spouses of persons in nursing homes from being impoverished by the high cost of long-term care because: (1) The infirm spouse may lose entitlement to benefits in the first place. (2) Procedural safeguards and beneficiaries' right to judicial redress if the State has acted improperly are repealed. (3) Federal tools for enforcing State compliance are severely weakened. The President's plan would continue current law protections.

Copayments: The Republican plan would remove all restrictions on how large a share of the costs of medical care States can require from eligible individuals, other than children and pregnant women. As revealed by the Rand Health Insurance Experiment, imposition of copayments can discourage people from seeking medical care and, in the case of low-income persons, may negatively affect health status. The President's plan would continue current law protections that require copayments to be nominal and exempt particularly vulnerable classes altogether.

Liens: The Republican plan would give States unlimited license to decide whether and how to (1) use liens on people's homes and other property, (2) recover before or after a beneficiaries (or spouse's) death, (3) adjust the State's payments for care based on home equity. States could use this flexibility to require a person to sell or mortgage a home and use the proceeds either to repay the State or to finance the cost of their care even while they, a spouse, or child is still living in the home. The President's plan would continue current law protections.

DRAFT

MEDICAID SPOUSAL IMPOVERISHMENT

CURRENT LAW: States are required to protect minimum amounts of a couple's income and assets for the at-home spouse (and dependent children) when a spouse enters a nursing home or other institution for a long-term stay. Amounts that are not protected for the individual or spouse are expected to defray the cost of long-term care offsetting what Medicaid pays.

Income: States must protect monthly income for the at-home spouse of up to \$1,870. The institutionalized spouse may keep small amounts (at least \$30) for incidental expenses.

Assets: Certain assets, including a home, automobile, or certain limited insurance policies do not count as "assets" for Medicaid purposes. These exemptions apply to both single individuals and married couples, including couples separated by the institutionalization of one spouse.

Other assets, such as savings accounts or investments, are counted. Certain amounts are protected as follows:

- The institutionalized individual can keep up to \$2000 in savings (more in some cases).
- The minimum amount of protected assets for the community spouse is \$14,964 (higher at State option). The maximum is \$74,820. Community spouses can petition for more.

(Figures are for 1995, and are updated annually for inflation.)

PRESIDENT'S PROPOSAL: Retains current law.

REPUBLICAN PROPOSAL: Retains current law provision specifically related to spousal impoverishment, but allows home and care to be counted against an elderly couple for assets test and repeals certain current law provisions that make spousal impoverishment protection an enforceable right.

ANALYSIS:

Denial of Eligibility Could Force Some Spouses into Poverty: The Republican proposal would leave it entirely up to States to determine which persons in which institutions would receive Medicaid assistance in the first place. Individuals could be denied coverage for long-term care services altogether. Spouses of individuals denied coverage would receive no protection from the "spousal impoverishment" provision of the Republican proposal.

Spouses Could Be Forced To Lose Home: Under current law, the spouse is not forced to sell-off all of their assets -- or critical assets such as their home or car -- before their disabled spouse can be eligible for nursing home care. Yet, under the Republican plan, the value of a car or house can be counted for the asset level. If a couple has a house that takes them over the asset level, the healthy spouse may be forced to sell their house or car, and spend down the proceeds before their spouse can become eligible for nursing home care. In this way, a healthy elderly woman could be forced to choose between maintaining ownership of their home or giving their spouse needed health care.

Increasing Costs to Healthy Spouse by Narrowing Definition of Institutionalized Care: States would define what the term "institutionalized services" mean. They could employ a narrow definition that excludes components of services that States now cover, for example, personal hygiene, laundry services, or various therapies. Spouses could be left with choice to pay for these services with ostensibly protected funds or allow the institutionalized spouse to do without.

Denial of Individual Protections Against Abuse of Spousal Impoverishment Laws: The Republican proposal would eliminate Federal guarantees of the rights of individuals to seek redress when they believe that their State has acted wrongly. The proposal would prohibit individuals from suing their State on the grounds that the State has failed to comply with this or any other requirement of law. It also repeals current beneficiary rights to notification, administrative hearings, and appeals. Determining whether and what kinds of rights would exist for beneficiaries would be left to States.

DRAFT

MEDICAID REFORM: HOMES, LIENS, ESTATE RECOVERIES

CURRENT LAW:

Ownership of homes and family farms: States must not deny eligibility to a person or base the amount of assistance it will pay on a person's behalf because that person owns real property that is the principle residence of the individual, a spouse, child, or certain other relatives. Family farms may be included in this protection since the "home" typically includes the land on which the dwelling stands and outbuildings. Farm equipment is also typically excluded if it is used to produce farm income.

Liens: States are generally prohibited from imposing liens on the homes of Medicaid beneficiaries. However, States are permitted to impose liens on homes of Medicaid beneficiaries who are permanently institutionalized and who do not have a spouse, child, or certain other relatives living in the home. If the institutionalized person returns home, the lien must be dissolved.

Estate recoveries: States are required to recover from the estates of deceased Medicaid beneficiaries, up to the amount spent by the State on an elderly (age 55 or older) person's behalf for nursing home and related services. "Estate" is defined by each State. Typically, the main asset in the estate is the person's former home. However, States must not recover if the person has a surviving spouse or dependent child.

PRESIDENT'S PROPOSAL: Retains current law.

REPUBLICAN PROPOSAL: Repeals all current protections.

ANALYSIS:

Removal of protection for Homes: Current law balances fiscal prudence with protection of beneficiaries whose families own a home and still need it to live in. The Republican proposal would remove those Federal protections. While States have under the current system, tended to be sensitive to the importance of protecting people's homes, the magnitude of the Republican spending cuts would encourage States to consider cost shifting to home owners in the following ways: a) denying eligibility to homeowners by counting the value of their home under the asset tests; b) requiring homeowners -- either spouses or adult children -- to pay a portion of nursing home care; c) putting liens on home to recover costs where there is a family member or descendent who is living in the home.

Ownership of a home or family farm: Under the Republican plan, a State could count a portion of the value of a home when deciding whether a disabled individual or spouse is within the asset test (\$14,000-\$70,000). This could force spouses or family members to choose between living in a home they have possessed for decades or getting care for their spouse or family member. It could force the sale of a home, either to spend down on medical costs, as an indirect effect of loss of eligibility for any assistance at all.

Liens: Current law permits liens only in cases where the individual no longer needs the home and has no family dependents who need the home to live in. The Republican plan would give States unlimited license to decide whether and how to use liens on people's homes and other property, even if the home owner is a family head with small children. They could impose a lien even though the individual or relatives were still living in the home. Liens make it undesirable or very difficult to sell a home if the family wants to move to another.

Estate recoveries: The Republican proposal would permit States to recover from a beneficiary's estate, even if a spouse or dependent child is the estate's beneficiary. Since these estates typically consist mainly of the home, recovering from an estate could translate into loss of the home for spouses and young or disabled children of Medigra beneficiaries.

DRAFT

MEDICAID REFORM: SPOUSAL IMPOVERISHMENT

CURRENT LAW:

- **States are required to protect minimum amounts of a couple's income and assets for the at-home spouse (and dependent children) when a spouse enters a nursing home or other institution for a long-term stay.**
- **Federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:**
 - States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
 - States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.
 - Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.
- **Amounts that are not protected for the individual or spouse are expected to defray the cost of long-term care offsetting what Medicaid pays.**
- **Assets:** Certain assets, including a home, automobile, or certain limited insurance policies do not count as "assets" for Medicaid purposes. These exemptions apply to both single individuals and married couples, including couples separated by the institutionalization of one spouse.
 - Other assets, such as savings accounts or investments, are counted. Certain amounts are protected as follows:
 - The institutionalized individual can keep up to \$2000 in savings (more in some cases).
 - The minimum amount of protected assets for the community spouse is \$14,964 (higher at State option). The maximum is \$74,820. Community spouses can petition for more.

(Figures are for 1995, and are updated annually for inflation.)

PRESIDENT'S PROPOSAL:

- **Retains current law.**

REPUBLICAN PROPOSAL:

- **Retains current law provision specifically related to spousal impoverishment,**
- **But, repeals certain current law provisions that make spousal impoverishment protection an enforceable right.**

ANALYSIS:

- **Spouses of individuals denied coverage would receive no protection from the “spousal impoverishment” provision of the Republican proposal.**
- **States would define what the term “institutionalized services” mean.**
 - They could employ a narrow definition that excludes components of services that States now cover. for example, personal hygiene, laundry services, or various therapies.
 - Spouses could be left with choice to pay for these services with ostensibly protected funds or allow the institutionalized spouse to do without.
- **The Republican proposal would eliminate Federal guarantees of the rights of individuals to seek redress when they believe that their State has acted wrongly.**
 - The Republican plan would prohibit individuals from suing their State on the grounds that the State has failed to comply with this or any other requirement of law.
 - It also repeals current beneficiary rights to notification, administrative hearings, and appeals.
 - Determining whether and what kinds of rights would exist for beneficiaries would be left to States.

DRAFT

MEDICAID QUALITY OF CARE PROTECTIONS

CURRENT LAW:

- **The Medicaid statute includes explicit, outcomes-oriented quality of care protections for nursing home residents and mentally ill and mentally retarded beneficiaries who live in institutions.**
- **These provisions were created by the landmark nursing home reform language signed into law by Ronald Reagan in 1987.**
- **Medicaid Managed Care.** Federal Medicaid contracting rules for Medicaid managed care plans use proxy measures -- such as enrollment composition requirements (the "75/25 rule") -- that are vaguely, at best, related to quality of care for Medicaid beneficiaries who are enrolled in managed care systems.

PRESIDENT'S PROPOSAL:

- **The Administration would retain current Federal quality standards for nursing homes that protect residents from abuse and neglect and that have dramatically improved quality of care in nursing homes.**
- **The President's plan would replace out-dated statutory rules with real quality of care protections for managed care enrollees -- quality improvement programs that have been field-tested in several States and enjoy broad industry support.**

REPUBLICAN PROPOSAL:

- **The Republican proposal would significantly diminish the Federal government's authority to enforce nursing home quality standards.**
- **The Republican proposal would eliminate Federal quality standards for facilities that serve mentally ill and mentally retarded individuals, without requiring States to develop equivalent, State-level standards.**
- **The Republican proposal includes no quality of care standards for managed care systems -- even though 23 percent of all Medicaid enrollees received their health care through managed care programs in 1994, and a even greater proportion are enrolled in managed care in 1995.**

ANALYSIS:

- **Republicans Would Dismantle Nursing Home Quality Protections And Diminish The Quality Of Nursing Home Care.**
 - Under the Republican proposal, nursing home residents could be denied skilled nursing and rehabilitative services because nursing homes would no longer be required to optimize individual residents' health and well-being.
 - Because the Republican proposal cuts Federal Medicaid spending so severely, States may have insufficient resources to establish, monitor and enforce quality standards to protect the elderly and disabled in nursing homes.
 - States would be able to turn their standard-setting and enforcement responsibilities over to private organizations, therefore exacerbating variations in quality and enforcement.
- **The Republican proposal Could Cause Many Medicaid Beneficiaries To Be Discriminated Against.**
 - The Republican proposal would delete all current protections against discrimination in admission.
 - Nursing facilities could extort additional payments from residents or their families in order to be admitted, or in order to continue living in the facility.
- **The President's Plan Makes Significant Improvements to Managed Care Quality Requirements.**
 - The President's proposal repeals out-dated quality proxies and replaces these statutory rules with improved, beneficiary-oriented protections that enable States and the Federal government to monitor quality of care.
 - Under the President's proposal, States and health plans would need to ensure that access standards, physician capacity and internal quality assurance rules are upheld. Currently, the Federal government uses these guarantees as benchmarks for managed care waiver programs.
- **The Republican proposal Ignores Managed Care Quality Standards.**
 - Under the Republican proposal, States would not be required to establish or enforce quality standards for capitated managed care plans.
 - The Federal government would have no authority to enforce managed care access standards or quality requirements.

DRAFT

MEDICAID PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS

CURRENT LAW: States are required to make adjustments to inpatient payment rates to certain hospitals which serve disproportionately large numbers of indigent patients (DSH). Hospitals which meet certain thresholds for Medicaid and low-income utilization must receive DSH adjustments. In addition, States have considerable flexibility to determine which hospitals are eligible for DSH adjustments as long as the hospitals have at least 1 percent Medicaid utilization.

PRESIDENT'S PROPOSAL: The President's plan would gradually reduce and freeze Federal DSH spending while providing special transition pools to States with special needs. In addition, States would be given additional flexibility to determine which providers are eligible for DSH payments (both inpatient and outpatient providers) and how much those providers would receive.

The special needs funds would be available to States with a significant number of undocumented immigrants, as well as to States with providers with large amounts of uncompensated care.

REPUBLICAN PROPOSAL: The reconciliation bill would essentially eliminate the DSH program while creating a pool for States with large numbers of undocumented immigrants. States spending on DSH would be included in the block grants.

ANALYSIS:

No protections for States and providers with large indigent populations. The reconciliation bill would not maintain a DSH program as a means of preserving funding for States and providers with disproportionately large shares of indigent patients. Also, given the decline in employer-sponsored health coverage, States and providers will become increasingly more vulnerable to changes in the indigent population.

Transition pools not sufficient. Fortunately, the reconciliation bill adopts the undocumented immigrants proposal that was included in two previous budgets submitted the President. However, a pool to assist those States with large percentages of uncompensated care is also necessary.

DRAFT

CHANGES IN FEDERAL MATCH RATES IN MEDICAID

CURRENT LAW: States receive Federal matching payments for all Medicaid reimbursable expenditures. While there is a limit on the Disproportionate Share Hospital payment portion, Medicaid is essentially an open-ended program which responds to States' changing needs. The Federal match rate for Medicaid expenditures in each State depends upon the individual State's per capita income relative to the nation. States with lower per capita incomes receive higher Federal match rates. The Federal match rates can range between 50 percent and 83 percent (actual calculated match rates currently range between 50 percent -- 14 States -- and 79 percent -- Mississippi).

PRESIDENT'S PROPOSAL: Retains current law

REPUBLICAN PROPOSAL:

The reconciliation bill would give States the option of three methodologies in determining their Federal match rates:

- (1) the current law methodology;
- (2) the lesser of a new formula based on total taxable resources in the State or the current law methodology plus 10 percentage points; or
- (3) 60 percent.

For most states, this means an increase in their Federal matching rate.

ANALYSIS:

Gives false appearance of more equity. Many States have argued that the current Medicaid formula is inequitable in that 1) the formula is based on per capita income which is not a good measure to States' need and 2) the 50 percent floor on match rates allows wealthier States to pay less than their calculated share of expenditures. The reconciliation bill essentially raises the floor to 60 percent. While this appears more equitable for States like New York, California, and Illinois which have disproportionately large poverty populations, the change is made in the context of an absolute limit on Federal funds. Essentially, the change in the Federal match rates allow the States to reach their allotments faster, which does not address the issue of equity across States.

Masks risk of inflation and recessions. The change in the Federal matching rates give the appearance that Federal funding for States would increase. However, the absolute limit on Federal funding puts States at risk for changes in demographics, inflation, and recessions. The growth rates proposed in the reconciliation bill would not be sufficient to cover the growth in populations and inflation. In addition, the reconciliation bill would not allow for adjustments in growth rates due to recessions or economic slowdowns. On the other hand, the President's proposal would allow Federal funding to increase at a level sufficient to cover inflation and allow enrollment to change as economic and demographic changes warrant. States would be truly protected.

DRAFT

MEDICAID STATE INNOVATIONS AND DEMONSTRATIONS

CURRENT LAW: States may seek Federal demonstration waivers expand Medicaid eligibility to population groups that are not eligible under current law, to test innovative approaches to financing and delivering health care services to Medicaid beneficiaries, and to enroll Medicaid beneficiaries in managed care delivery systems without regard to certain contracting requirements in current law.

PRESIDENT'S PROPOSAL: The President's per capita methodology would protect States that operate innovative programs under our current demonstration authority and the expanded eligibility groups these programs serve. States would also have substantial new flexibility to develop innovative programs and utilize managed care delivery systems under the Administration's proposal.

REPUBLICAN PROPOSAL: States with demonstration programs would be treated the same as all other States -- they could continue their demonstrations -- but within the constraint of the block-grant and funding limits. Their ability to continue covering demonstration eligibles is uncertain.

ANALYSIS:

The President's Plan Protects Demonstration Programs. The per capita methodology and the lower overall savings target guarantee that demonstration programs would have the financial flexibility they need to continue their programs under a per capita methodology. States with existing demonstration programs could include new eligibles in their per capita base so that Federal funding for these eligibility expansions would continue. States with pending programs -- either approved but not implemented, or still under review -- could finance eligibility expansions in a budget-neutral manner under the per capita cap.

The Republican Medicaid Cuts Threaten States' Eligibility Expansions. State allotments under the Conference provisions are far too low. States could, in theory, continue covering demonstration eligibles, but block-grant funding would be insufficient to maintain these eligibility expansions. If a State chose to maintain its innovative demonstration elements and eligibility expansion, the State would be forced to reduce spending for non-demonstration populations and services. Most demonstration programs do not include long-term care, so elderly and disabled beneficiaries who use these services could be hurt the most.

The President's Proposal Provides State Flexibility While Protecting Medicaid Beneficiaries. Under either option, States would no longer need Federal waivers to develop mandatory managed care programs. The Administration's plan would protect managed care enrollees by establishing States' responsibility to monitor quality of care, creating new statutory requirements for quality improvement programs, and retaining current access standards. The President's plan would also repeal the out-dated requirements for managed care contractors that frequently cause States to seek Federal waivers. The Republican plan does not include any beneficiary protections for managed care systems.

DRAFT

MEDICAID PROTECTIONS FOR SPECIAL NEEDS

CURRENT LAW: Medicaid contains a number of provisions designed to address the special needs of various beneficiaries and/or providers with special needs.

Medicare/Medicaid Dual Eligibles. Individuals eligible for both programs must receive benefits from both. Qualified low-income elderly and disabled dual eligibles have State Medicaid programs pay their Medicare premiums and cost-sharing.

American Indians/Alaska Natives (AI/AN). Similar to dual eligibles above, low-income AI/AN individuals who are eligible for both Medicaid and the programs of the Indian Health Service (IHS) must receive benefits from both. State Medicaid programs pay IHS facilities a cost-based rate, and receive 100% Federal reimbursement. States pay Tribal and urban Indian facilities their standard provider rates and receive the standard Federal matching rate of reimbursement.

Undocumented Immigrants. States must pay providers for emergency medical services for undocumented immigrants and receive the standard Federal matching rate of reimbursement. Any non-emergency services provided to such individuals are ineligible for Federal reimbursement.

Disproportionate Share Entities. States that have hospitals which serve a disproportionate number of low-income and uncompensated care patients receive an additional Federal payment to help maintain the viability of such hospitals.

PRESIDENT'S PROPOSAL:

Dual Eligibles. Retains current law protections requiring Medicaid payment of Medicare premiums and cost-sharing for Medicare/Medicaid dual eligibles. The funds for this program would be placed outside the per capita cap limits.

American Indians/Alaska Natives. Retains current law protections for Medicaid/IHS eligibility and Federal matching rates for Indian health program services. Provides an incentive for States to continue to use Indian health programs by placing Federal expenditures for these services outside the per capita cap funding limits.

Undocumented Immigrants. Retains current law requirement that States pay providers for emergency medical care for undocumented immigrants and reimburses most States at the standard Federal matching rate. Provides additional Federal funds to help pay the State share of emergency medical costs for the 15 States with the largest number of undocumented immigrants. Retains the prohibition on Federal funding for non-emergency services for such individuals.

Disproportionate Share Entities. States will be given greater flexibility in their use of additional Federal funds, which may be targeted to a variety of health care providers (including, but no longer limited to hospitals) serving a disproportionate number of low-income and uninsured individuals.

REPUBLICAN PROPOSAL:

Dual Eligibles. Guaranteed coverage of dual eligibles and Medicaid payment of Medicare premiums and cost-sharing would be limited (see section on QMBs) under the Republican proposal.

American Indians/Alaska Natives. Under the Republican proposal, States with an IHS facility would be required to consult with them and with Tribes, but would not have to use them as providers, pay them a cost-based rate, or allow AI/AN individuals to use them under managed care arrangements. The 100% Federal reimbursement to a State for services in an IHS facility under current law would be retained and slightly expanded to a few Tribal facilities, but the 100% Federal funds would all be counted toward the State's block grant funding limit.

Undocumented Immigrants. The Republican proposal repeals the Federal requirement that States provide emergency medical care for undocumented immigrants and the requirement that if they do, they must provide funds to match the Federal share. For most States (as with the 100% Federal funding for AI/AN) these funds are under the State limit for Federal block grant funds, so there is a strong disincentive to provide the services and use up Federal funds faster.

For the 15 States with the largest number of undocumented immigrants, separate, 100% Federal funds are provided outside the block grant amount, which could serve as an incentive for these States to offer this service. Retains and re-emphasizes the current law restriction that Federal funds cannot pay for non-emergency services.

Disproportionate Share Entities. The Republican Republican proposal repeals the program of special Federal payments for disproportionate share hospitals and folds historical level of funding into each State's overall block grant Federal funding amount.

ANALYSIS:

Dual Eligibles. Under the Republican approach, low-income Medicare beneficiaries may be faced with paying their own Medicare premiums and cost-sharing. This could lead many to forego Medicare coverage and depend solely upon Medicaid, which would not be cost-effective either for the beneficiaries or for the Medicaid program.

American Indians/Alaska Natives. IHS's already limited funding amounts are based upon the assumption that the program will receive reimbursement for AI/AN Medicaid eligibles at the cost-based rate. Under the Republican proposal, if States choose not to use IHS as a provider or to pay lower rates, then many AI/AN individuals with few or no financial and health resources may go without health care. States may adopt mandatory managed care enrollments and assign AI/AN individuals to other providers. However, the individuals will return to their customary IHS providers, which cannot turn them away and may not receive payment for services provided. By placing the 100% Federal payments for IHS facilities under the block grant funding limit, what was a positive incentive under current law is turned upside down. Now, the State to move toward the limit faster whenever it used an IHS facility than if it used other providers reimbursed at the standard Federal rate.

Undocumented Immigrants. As with AI/AN funding above, the Republican proposal's removal of the State match serves as a disincentive to providing emergency medical care to undocumented immigrants because States not receiving additional funds would move toward their block grant funding limits faster.

Disproportionate Share Entities. Disproportionate share hospitals would, under the Republican proposal, no longer be guaranteed payments to help make up for the extra financial burden they carry due to serving so many low-income and uninsured individuals. States could use the funds, now buried in their overall block grant amount, for a wide variety of other purposes. Disproportionate share hospitals, by definition, lack sufficient alternatives for shifting uncompensated or inadequately reimbursed care elsewhere. Some may have to close their doors, leaving areas already under served with even fewer health care resources.

December 28, 1995

MEMORANDUM FOR CHRIS JENNINGS

cc: Jen Klein
FROM: Pauline Abernathy
RE: Questions regarding briefing materials for budget negotiations

We may need to resubmit for *tomorrow* the briefing materials that were put together last week for the budget negotiations. The materials are excellent, especially given the severe time pressure. In reviewing them with more time today, however, I had a few questions.

Medicare Trust Fund. The document says "The President's plan puts the Trust Fund in better shape than it has been in for 19 of the last 20 years." When you and I last spoke, we had concluded that the plan put it in "better or as good" a shape as it's been in "18 of the last 20 years." Which is right?

Per Capita Medicare Spending. The document says the Republican proposal cuts spending growth to "about 5% per person in 2002, more than 20% below the projected private sector rate of 7.1%." Can we compare the 2002 estimate to the 7-year average of 7.1% -- or is the 2002 private sector rate also 7.1%? Also, later we say the Republican per person spending growth is "over 20% less than what is needed to keep up with costs in the private health care market." Is this still true for their \$200 billion Medicare proposal? Is their per capita spending growth now *lower* than under their previous proposal (5.5%)?

Cost Shifting. The document says "The Republican plan, according to Lewin-VHI would cost shift \$60-80 billion to the private sector." Lewin concluded the reconciliation bill would lead to \$85 billion in shifted costs; Emil used Lewin's methodology to estimate that \$300 billion in Medicare and Medicaid would lead to approximately \$60 billion in shifted costs. If HHS signs off on Emil's estimate, should we say "HHS estimates based on the Lewin study that the latest proposal would lead to \$60 billion in cost-shifting"? Do you care?

Medicare Premiums. The document says they raise premiums by about \$40 billion, and then says "This is nearly five times more than President's plan needs to protect the Trust Fund until the year 2011." I'm confused by this statement. Also, I understand their latest proposal increases premiums to 31.5% in 2001 and 2002 only -- should we acknowledge this change in any way? Does it affect the \$40 billion figure?

Balance Billing. The document says "GOP permits more balance billing under private health plans than under traditional Medicare." Should we delete the word "more"?

Medicaid Per Capita Spending. The document says "Federal Medicaid spending per capita would increase less than inflation (less than 2% per year)" -- is this still true for their \$117 billion Medicaid proposal?

QMBs. If Republicans have not changed their proposal regarding QMBs, I will try to explain in more detail why the 90% set-aside amounts to less than half of spending on premiums.