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EFFECTS OF CAPPING MEDICAID

IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
  - ▸ About 60% of Medicaid spending services are for the elderly and disabled. (This includes acute care services, such as hospitals, physicians, and prescription drug coverage.)
  - ▸ About 35% of Medicaid spending is for long-term care.
- Republicans have proposed (through the use of a block grant with a 5% cap on growth) to cut federal Medicaid funding by more than $190 billion between now and 2002 -- a 30% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting $190 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. Even under optimistic assumptions, managed care could produce only about $10 billion in savings between now and 2002. The remaining $180 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.
- *Finding $180 billion in Medicaid cuts without cutting provider fees -- which are already much lower than in the private sector -- would require massive reductions in health coverage or services.*
  - ▸ *To protect coverage for the elderly and disabled, Medicaid coverage for over 20 million kids would need to be eliminated in 2002.*
  - ▸ *To protect coverage for kids, Medicaid coverage for over 3.5 million elderly and disabled people would have to eliminate coverage for in 2002.*
  - ▸ *To avoid dramatically increasing the number of uninsured and protect coverage for all Medicaid recipients, states could eliminate a long list of services by 2002. Even eliminating coverage for prescription drugs, home health care and other home and community-based services, hospice care, dental care, and EPSDT screening services for children would still not offset the Republican cuts in 2002.*
- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, states could save money only if they cut more than $190 billion out of Medicaid.

VARIATION ACROSS STATES

- An across-the-board 5% cap on Medicaid spending does not recognize significant differences across states, leaving some states even harder hit than these numbers suggest.

- Growth rates vary significantly across states and over time in a given state. Across states, variation results from differences in population, regional medical costs, enrollment patterns, and service mix. Over time, a state's growth rate can change because of recession or other economic factors.

- When a recession occurs in a state, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. With a cap on Medicaid, states would bear this burden.

- Ironically, states with the most efficient programs are most penalized by a 5% cap -- because it is hardest for them to find additional savings.

- Retirement states with large numbers of elderly residents would bear a disproportionate burden as the population ages.

- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission of the Future of Medicaid finds that a 5% cap on the growth of federal Medicaid payments would cost states over $167 billion between 1996 and 2002. [Note: This estimate is less than the CBO baseline estimate].

  - New York, California, Texas, Florida and Ohio would lose the largest amounts. New York would lose $18.5 billion, California over $14 billion, Texas almost $11 billion, Florida $9.5 billion, and Ohio over $7 billion.

  - States in the South and Mountain regions would have the biggest percentage reductions in federal payments. Reductions during the period would average over 20% in states such as Florida, Georgia, Arkansas, Colorado, Montana, West Virginia and North Carolina.

NO EVIDENCE THAT THIS LEVEL OF GROWTH IS ACHIEVABLE WITHOUT SEVERE CUTS

- Republicans claim that managed care can generate enormous savings.

  - But, there is no evidence that managed care alone can achieve the level of cuts they are proposing.

  - States already are aggressively pursuing managed care, but the populations for whom care can readily be managed -- children and AFDC adults -- account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

  - Applying managed care techniques to the services typically used by the elderly and disabled (such as long-term care) is largely untried, making the potential for savings hard to predict.

- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care also is not a real option.

- Some may point to low Medicaid growth rates in certain states as evidence that a 5% cap on growth is achievable.

- While a few states may be able to hold growth down to 5% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.

- Since 1992, 19 states have applied for state-wide health reform demonstration waivers from the Department of Health and Human Services. Under these waivers, states are able to change their Medicaid programs to increase efficiency and expand coverage. No state has projected an annual growth rate over the period at or below 5%.

- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.

EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans have proposed to cut Medicare funding by $300 billion between now and 2002 -- a 24% cut in 2002 alone.

- Medicare managed care cannot produce the magnitude of savings being proposed by the Republicans. For example, Senator Gregg predicts that managed care could save $35-45 billion between 1996 and 2000, although there is no evidence that managed care can produce Medicare savings of this magnitude. But even this overly optimistic projection produces less than one-third of the cuts being proposed by Republicans.

  - Claims that substantial savings can be achieved through Medicare managed care actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.

  - CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the necessary changes to the existing payment system would be "difficult to specify."

  - Even with an improved payment methodology, the savings to Medicare would be only a small percentage of cuts being proposed by Republicans.

- Even if the level of savings suggested by Senator Gregg (extended through 2002) for Medicare managed care could be realized, the proposed cuts would have serious impacts on beneficiaries and providers. If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:

  - Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about $2,980 more for Medicare. In 2002 alone, they would be required to pay about $775 more.

  - In 2002 alone, a 9.3% cut in Medicare payments to hospitals, physicians and other health care providers would be needed.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.

  - There are now 40 million uninsured Americans, and this number will continue to grow.

- Huge Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

- *Republicans are talking about combined Medicare and Medicaid cuts of almost $500 billion dollars -- and, by necessity, a substantial portion of the cuts will come from payments to health care providers. Providers, in turn, will try to offset these cuts are passed on to private payers, businesses and families will be forced to pay $125 billion more for health care between now and 2002.*

- Reducing Medicare payments would disproportionately harm rural hospitals.

- Small rural hospitals -- often the only hospital in their county -- depend heavily on Medicare as a source of revenue. Many of these hospitals already are in financial difficulty and cannot absorb large Medicare payment reductions.

  - *Nearly 10 million Medicare beneficiaries (25% of the total live in rural America where there is often only 1 hospital in their county. These rural hospitals tend to be small and to primarily serve Medicare patients.*

  - *Significant reductions in their Medicare revenues will cause many of these hospitals, which are already in financial distress, to close or turn to local taxpayers to increase what are often substantial local subsidies.*

  - *Rural residents are more likely than urban residents to be uninsured, so offsetting Medicare cuts by shifting cost to private payers is more difficult for small rural hospitals.*

  - *Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.*

- In the last Congress, bills sponsored by both Republicans and Democrats contained large Medicare cuts. However, unlike current Republican proposals, the bills last year reinvested their savings into the health care system through subsidies to expand insurance coverage. Reinvesting the savings would have reduced the uncompensated care burden on provider and business and mitigated many of the adverse effects of Medicare cuts.

- Despite the current rhetoric, Medicare growth is comparable to the growth in private health insurance.

  - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is growing only about 1% faster than private health insurance.

  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

President Clinton Addresses White House Conference on Aging:
Vows to Reform Health Care "The Right Way."
Wednesday, May 3, 1995

Today, President Clinton will speak to the White House Conference on Aging where he will renew his commitment to fighting for America's seniors. The Clinton Administration is committed to addressing the concerns of older Americans, particularly making sure that they are economically secure. That is why President Clinton has taken steps to:

- o Ensure the long-term integrity of the Social Security Trust Fund;
- o Vowed to make sure that Social Security benefits are not used to balance the budget or pay for tax cuts for the wealthy;
- o Signed the Retirement Protection Act to make the pension system more reliable;
- o Proposed IRAs to allow Americans to save money and withdraw it tax-free for the cost of a major medical expense or the care of a sick parent;
- o Invested in the Older Americans Act that provides benefits to millions of Americans; and, **most importantly,**
- o Vowed to fight for real health care reform and against cuts in Medicare and Medicaid to fund tax cuts for the wealthy.

Medicare and Medicaid have provided a safety net for our nation's elderly for 30 years. Today, Medicare covers 37 million elderly and disabled Americans. And, while the myth is that Medicaid helps only low-income women and children, the reality is that about two-thirds of Medicaid funds are spent on services for older Americans and people with disabilities.

These programs are an example of government that works. This year, as we celebrate the 30th anniversary of their passage, we must remember that:

- o Medicare and Medicaid have lifted millions of older Americans out of poverty. Before Medicare, almost 30 percent of our nation's elderly lived in poverty -- as compared with 12 percent today.

- o Before Medicare, about 45 percent of the elderly had no health insurance and even more were underinsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise.

- o And Medicaid has helped middle class families who have exhausted their savings to manage the overwhelming costs of nursing home care. Without Medicaid, families with a parent or spouse who needs long-term care would face nursing home bills that average $38,000 a year.

We Must Address Health Care Spending. We cannot get hold of the deficit without addressing growing health care entitlement spending. This is a real problem that must be addressed. Federal health care costs are growing faster than the economy, faster than overall inflation, and faster than almost all other government spending. **We must contain costs in**

these programs, but there is a right way and a wrong way to do so.

- **The Wrong Way to Address Health Care Spending.** The wrong way is to:
  - Simply slash Medicare and Medicaid;
  - Use these programs to pay for tax cuts for the wealthy and campaign promises;
  - Increase Medicare out-of-pocket expenses so much that health care becomes unaffordable.
  - Go backward and reduce coverage; and
  - Make changes in Medicare that lead to coercion over choice.

- **The Right Way to Address Health Care Spending.** President Clinton has said that the right way to contain costs in Federal health programs and to deal with the deficit and the long-term problem of the Medicare Trust Fund is through health care reform. As we reform health care, we must ensure that changes to Medicare and Medicaid maintain coverage, choice, quality and affordability.

  President Clinton will have a simple test for every proposal. He will ask:

  (1) **Coverage.** Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans?

  (2) **Choice.** Does it expand choice in Medicare? Or does it financially coerce beneficiaries into managed care plans?

  (3) **Quality.** Will this proposal reform the Medicare and Medicaid programs to make them more efficient without harming the delivery system, threatening quality and increasing cost shifting to small businesses? Or are these simply arbitrary and excessive cuts used to pay for other priorities -- like tax cuts for the wealthy?

  (4) **Affordability.** Will this proposal increase costs for beneficiaries so much as to make quality medical care unaffordable for older Americans? Will it take responsible steps to contain costs?

Cracking Down on Fraud and Abuse. The Clinton Administration is taking steps now to reform our health care system and to improve our health care programs. Simply put, fraud jeopardizes the health of beneficiaries and rips off the government, and we must do all we can to stop it. Since the Clinton Administration began, we have vigorously cracked down on fraud and abuse in Medicare and Medicaid. In just another example of our consistent efforts to combat fraud and abuse -- as part of our "Reinventing Government" proposal -- we will create a partnership between government and private agencies to fight fraud in five states.

THE PRESIDENT'S APPROACH TO THE BUDGET: FIGHTING FOR WORKING FAMILIES

BUDGETS ARE ABOUT RAISING STANDARDS OF LIVING FOR WORKING AMERICANS--AND THE PRESIDENT'S BUDGETS HAVE MOVED TOWARD THAT GOAL. The test for a budget is whether it contains the balance of policies to enable more families to realize the American Dream. The budget is now beginning to approach balance only because President Clinton signed a plan--over strong Republican opposition--that is **reducing the deficit by over $1 trillion over 7 years**. (If not for the deficits accumulated during the Reagan/Bush years, the President would already be bringing the budget not only into balance, but to surplus.) Yet at the same time as he has reduced the deficit, the President has taken other steps that are essential to raise standards of living: dramatically expanding educational opportunity; providing a tax break to 15 million working families by expanding the Earned Income Tax Credit; and seeking to address the nation's health care challenges.

THE PRESIDENT WANTS TO MOVE TOWARD A BALANCED BUDGET--WITHIN A BALANCED APPROACH TO THE BUDGET. The status quo is not acceptable. The President is committed to achieving further deficit reduction in the context of serious, step-by-step health care reform. Yet as we reduce the deficit, the President believes we must also expand educational opportunity, preserve tax fairness for working families, and fulfill obligations to senior citizens.

THERE IS A RIGHT WAY AND A WRONG WAY TO REDUCE THE DEFICIT--AND REPUBLICANS WOULD DO IT THE WRONG WAY. WE ARE INSISTING ON THREE REASONABLE CONDITIONS FOR GOING FORWARD. President Clinton has proven that the deficit can be cut the right way. Republicans are proposing to cut Medicare and education in order to pay for tax breaks for the wealthiest. That is the wrong way. **The right way to reduce the deficit means three things:**

1. **NO TAX CUTS TARGETED AT THE WELL-OFF.** The Contract with America provides a $345 billion tax break targeted at the wealthiest--a $20,000 tax break for the top 1%. The President will not cut Medicare and student loans to pay for such a massive tax break for those earning over $230,000.

2. **ADDRESS MEDICARE AND LONG-TERM CARE IN THE CONTEXT OF HEALTH CARE REFORM.** We need to reduce health care costs in a way that treats seniors fairly and doesn't shift costs to the private sector--that is, with sensible but serious health care reform. By hitting Medicare and Medicaid in isolation--and with the deepest cuts in history--Republicans would transform Medicare into a second-class health care system, driving up out-of-pocket costs by $2000 per elderly couple in 2002 in order to pay for their tax cuts for the wealthy.

3. **CUT THE EDUCATION DEFICIT, NOT EDUCATION.** While we need a disciplined deficit reduction path, we must be equally disciplined about reducing the education deficit. Nothing is more important than investing in education if we care about raising our standards of living rather than fulfilling campaign promises. The GOP budgets assault education-- eliminating Goals 2000, national service, and interest subsidies for college loans, while gutting or sharply cutting School-to-Work Opportunities, Head Start, Pell Grants, Safe- and Drug-Free Schools, Chapter One, and Job Training.

FACT SHEET ON LIKELY REPUBLICAN MEDICAID CUTS

Wednesday, May 3, 1995

Congressional Republicans are currently considering cuts in federal Medicaid funding of $160 to more than $190 billion between 1996 and 2002. Republicans claim they are not cutting the program, but reducing its rate of growth. Yet, these technical number disputes avoid the real issue: how their proposals will affect real Americans; who will be hurt; who will lose coverage; and who will lose benefits if their cuts are made. It also ignores the fact that 3 to 4% of growth in Medicaid is due not to inflation but to additional children, elderly, disabled and others being insured under the program.

Impact on Working Families. Most people think Medicaid helps only low-income mothers and children. In fact, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

Insufficient Managed Care Savings. Savings from managed care cannot produce the magnitude of cuts Republicans have proposed. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. Because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

State Finances. Republicans say these cuts merely give states additional flexibility through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous cuts -- forcing them to choose between cuts in education, law enforcement, health care or other priorities.

Cuts in Eligibility, Benefits and Provider Payments. What do these cuts really mean? Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans cut $160 to $190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- 5 to 7 million children would lose coverage; and
- 800,000 to 1 million elderly and disabled beneficiaries would lose coverage; and
- Tens of millions of Americans would lose benefits, because all preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the cuts reach $190 billion; and
- Already low payments to health care providers would be reduced by $10.7 to $12.8 billion.

FACT SHEET ON LIKELY REPUBLICAN MEDICARE CUTS

Wednesday, May 3, 1995

Congressional Republicans are considering proposals that would cut Medicare funding by between $250 billion and $305 billion between now and 2002. Medicare cuts at this level translate into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

Choice or Coercion? Republicans claim their proposals would increase choice by giving vouchers to Medicare beneficiaries to buy insurance in the private market. In reality, the only way that this approach can achieve the magnitude of savings being contemplated is to significantly raise costs for traditional fee-for-service coverage, effectively forcing many beneficiaries to use vouchers to buy managed care. That would put Medicare's 37 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. That is simply a form of financial coercion.

Current Health Care Spending by Older Americans. Today, despite Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, typical Medicare beneficiaries already dedicate a staggering 21% (or $2,500) of their incomes to pay for out-of-pocket health care expenditures.

More Out-of-Pocket Payments: If these cuts are distributed evenly between providers and beneficiaries, Medicare beneficiaries would pay:

- o $815 to $980 more in out-of-pocket expenses in 2002.
- o Between $3,100 to $3,700 more in out-of-pocket over the 7 year period.

Social Security COLAs: The Republicans claim they aren't cutting Social Security, but these Medicare cuts would effectively do that. By 2002, the typical Medicare beneficiary would see 40 to 50% of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries would have 100% or more of their COLAs consumed by the cost increases.

Rural and Inner City Hospitals. Cuts of this magnitude, combined with the growing uncompensated care burden (exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. These cuts would threaten both the quality and access to needed health care in rural America.

MEMORANDUM

To: Laura Tyson
Carol Rasco

From: Chris Jennings CCJ

Date: May 11, 1995

Re: Kasich and Domenici Budget Proposals

CC: Gene Sperling
Bill Galston
Nancy-Ann Min
Jennifer Klein

Attached, for your information, is the final set of Medicare state by state analysis for both the Kasich and Domenici budget proposals. You will find three pages of information: the first is a beneficiary breakout by state; the second is the state by state analysis of the Kasich proposal; the third is the analogous state by state analysis of the Domenici proposal.

As you will note, the analysis provides both aggregate dollar loss breakouts, as well as per beneficiary impact breakout for both 2002, and the total seven year period.

Because the leadership, George, and Gene thought that 2 sets of analysis might be confusing, we are only circulating information on the Kasich proposal. Therefore, I advise that you be careful with any circulation of the Domenici Medicare analysis.

I hope you find the information useful. If you have any questions. please call me at 6-5560.

Projected Beneficiaries by State

	1995	2002
US	37,631,000	41,299,000
Alabama	641,971	703,082
Alaska	33,784	49,773
Arizona	598,737	743,525
Arkansas	422,580	450,365
California	3,638,311	4,034,936
Colorado	423,478	514,095
Connecticut	503,906	533,943
Delaware	100,545	115,722
District of Columbia	78,730	76,330
Florida	2,615,604	2,951,880
Georgia	832,454	953,079
Hawaii	150,818	184,336
Idaho	149,769	171,120
Illinois	1,625,786	1,690,497
Indiana	827,174	890,461
Iowa	476,142	484,783
Kansas	383,997	397,890
Kentucky	585,590	636,855
Louisiana	582,491	634,122
Maine	202,149	221,565
Maryland	604,202	677,465
Massachusetts	937,292	996,344
Michigan	1,354,523	1,481,749
Minnesota	632,457	671,394
Mississippi	395,768	421,671
Missouri	834,228	876,863
Montana	129,141	141,557
Nebraska	249,529	256,357
Nevada	194,035	295,417
New Hampshire	156,237	178,655
New Jersey	1,174,802	1,244,404
New Mexico	212,160	257,452
New York	2,645,176	2,718,120
North Carolina	1,028,054	1,202,196
North Dakota	103,477	106,274
Ohio	1,673,946	1,800,336
Oklahoma	487,058	519,526
Oregon	470,268	524,031
Pennsylvania	2,083,051	2,187,966
Rhode Island	168,503	175,375
South Carolina	508,854	593,614
South Dakota	117,061	122,172
Tennessee	769,041	853,930
Texas	2,090,369	2,419,444
Utah	188,349	228,000
Vermont	82,989	91,752
Virginia	818,458	936,837
Washington	687,136	771,781
West Virginia	330,115	348,402
Wisconsin	763,230	804,207
Wyoming	60,570	72,355
Puerto Rico	476,704	527,920
All Other Areas	330,201	357,073

NOTES: Based on historical state share of Medicare enrollees, trended forward with growth in the states' share of enrollees.
* Totals may not add due to rounding

Effects of the H :h care Proposal By State
Losses by State Under the Proposal
(Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect ($ / benef.)	
	2002	1996-2002	2002	1996-2002
US	84,900	279,200	1,028	3,447
Alabama	1,986	6,146	1,412	4,450
Alaska	50	171	502	1,689
Arizona	1,491	4,799	1,002	3,389
Arkansas	627	2,165	696	2,435
California	11,830	37,780	1,466	4,783
Colorado	1,147	3,579	1,116	3,630
Connecticut	1,247	4,103	1,167	3,885
Delaware	281	899	1,215	4,002
District of Columbia	1,431	4,001	NA	NA
Florida	9,314	29,258	1,578	5,082
Georgia	2,077	6,754	1,090	3,649
Hawaii	432	1,311	1,173	3,710
Idaho	149	532	436	1,603
Illinois	2,652	9,301	784	2,770
Indiana	1,569	5,253	881	2,994
Iowa	495	1,786	510	1,845
Kansas	834	2,741	1,048	3,464
Kentucky	968	3,318	760	2,652
Louisiana	1,590	5,235	1,254	4,201
Maine	231	825	521	1,900
Maryland	1,066	3,752	787	2,843
Massachusetts	3,072	9,828	1,542	4,989
Michigan	2,185	7,717	737	2,657
Minnesota	1,512	4,725	1,126	3,557
Mississippi	674	2,297	799	2,758
Missouri	1,531	5,219	873	3,004
Montana	157	551	553	1,986
Nebraska	338	1,158	659	2,266
Nevada	638	1,946	1,080	3,620
New Hampshire	292	956	816	2,755
New Jersey	2,320	7,945	932	3,229
New Mexico	249	866	484	1,761
New York	5,359	18,539	986	3,423
North Carolina	2,165	6,998	900	3,012
North Dakota	159	551	750	2,604
Ohio	2,584	9,083	718	2,562
Oklahoma	757	2,625	729	2,560
Oregon	1,010	3,213	963	3,135
Pennsylvania	4,526	15,479	1,034	3,570
Rhode Island	482	1,511	1,375	4,336
South Carolina	1,103	3,495	929	3,043
South Dakota	153	530	628	2,186
Tennessee	2,378	7,537	1,393	4,509
Texas	5,428	17,608	1,122	3,757
Utah	331	1,096	727	2,511
Vermont	105	365	573	2,034
Virginia	1,052	3,711	561	2,044
Washington	978	3,377	633	2,246
West Virginia	471	1,628	676	2,362
Wisconsin	914	3,254	569	2,044
Wyoming	49	182	337	1,313
Puerto Rico	457	1,488	433	1,440
All Other Areas	3	14	4	20

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences, (2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

NOTES: Assumes that increases in beneficiary out-of-pocket costs (e.g., premiuims and coinsurance) are equal to 50% of the total cuts.
Based on historical state share of Medicare outlays & enrollment, trended forward with growth in the states' share of outlays & enrollment.
Estimates based on Medicare outlays by location of service delivery. Thus, certain state estimates may be affected by part-year residency and state border crossing to obtain care (e.g., Florida & Minnesota).
State border crossing makes the District of Columbia estimates unreliable.
Technical reestimates of the aggregate savings may result in a 7-year total of $282 billion.

Effects of the Domenici Medicare Proposal On States
Losses by State Under the Proposal
(Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect ($ / benef.)	
	2002	1996-2002	2002	1996-2002
US	61,700	255,600	747	3,174
Alabama	1,443	5,534	1,026	4,027
Alaska	36	158	364	1,794
Arizona	1,083	4,367	729	3,125
Arkansas	456	2,007	506	2,266
California	8,597	34,302	1,065	4,369
Colorado	834	3,230	811	3,314
Connecticut	906	3,756	848	3,568
Delaware	204	816	883	3,665
District of Columbia	1,040	3,508	NA	NA
Florida	6,769	26,448	1,147	4,626
Georgia	1,510	6,161	792	3,356
Hawaii	314	1,174	853	3,361
Idaho	108	497	317	1,512
Illinois	1,928	8,659	570	2,584
Indiana	1,141	4,830	640	2,765
Iowa	360	1,676	371	1,733
Kansas	606	2,508	762	3,175
Kentucky	703	3,070	552	2,467
Louisiana	1,156	4,792	911	3,865
Maine	168	772	379	1,788
Maryland	775	3,497	572	2,669
Massachusetts	2,233	8,927	1,121	4,547
Michigan	1,588	7,199	536	2,492
Minnesota	1,099	4,265	818	3,222
Mississippi	489	2,122	580	2,558
Missouri	1,113	4,822	635	2,783
Montana	114	513	402	1,861
Nebraska	245	1,071	479	2,100
Nevada	464	1,746	785	3,331
New Hampshire	212	874	593	2,540
New Jersey	1,686	7,349	678	2,997
New Mexico	181	804	352	1,656
New York	3,894	17,196	716	3,180
North Carolina	1,573	6,375	654	2,770
North Dakota	116	511	545	2,418
Ohio	1,878	8,461	522	2,397
Oklahoma	550	2,436	529	2,385
Oregon	734	2,915	700	2,862
Pennsylvania	3,289	14,314	752	3,311
Rhode Island	350	1,365	999	3,925
South Carolina	802	3,167	675	2,783
South Dakota	112	491	456	2,032
Tennessee	1,729	6,829	1,012	4,110
Texas	3,945	16,055	815	3,456
Utah	241	1,005	528	2,329
Vermont	76	339	417	1,901
Virginia	764	3,461	408	1,923
Washington	710	3,131	460	2,098
West Virginia	342	1,510	491	2,197
Wisconsin	665	3,041	413	1,916
Wyoming	35	172	245	1,258
Puerto Rico	332	1,358	315	1,322
All Other Areas	2	14	3	20

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences, (2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

NOTES: Assumes that increases in beneficiary out-of-pocket costs (e.g., premiums and coinsurance) are equal to 50% of the total cuts.
Based on historical state share of Medicare outlays & enrollment, trended forward with growth in the states' share of outlays & enrollment.
Estimates based on Medicare outlays by location of service delivery. Thus, certain state estimates may be affected by part-year residency and state border crossing to obtain care (e.g., Florida & Minnesota).
State border crossing makes the District of Columbia estimates unreliable.

President Clinton Addresses White House Conference on Aging:
Vows to Reform Health Care "The Right Way."
Wednesday, May 3, 1995

Today, President Clinton will speak to the White House Conference on Aging where he will renew his commitment to fighting for America's seniors. The Clinton Administration is committed to addressing the concerns of older Americans, particularly making sure that they are economically secure. That is why President Clinton has taken steps to:

- o Ensure the long-term integrity of the Social Security Trust Fund;
- o Vowed to make sure that Social Security benefits are not used to balance the budget or pay for tax cuts for the wealthy;
- o Signed the Retirement Protection Act to make the pension system more reliable;
- o Proposed IRAs to allow Americans to save money and withdraw it tax-free for the cost of a major medical expense or the care of a sick parent;
- o Invested in the Older Americans Act that provides benefits to millions of Americans; and, **most importantly**,
- o Vowed to fight for real health care reform and against cuts in Medicare and Medicaid to fund tax cuts for the wealthy.

Medicare and Medicaid have provided a safety net for our nation's elderly for 30 years. Today, Medicare covers 37 million elderly and disabled Americans. And, while the myth is that Medicaid helps only low-income women and children, the reality is that about two-thirds of Medicaid funds are spent on services for older Americans and people with disabilities.

These programs are an example of government that works. This year, as we celebrate the 30th anniversary of their passage, we must remember that:

- o Medicare and Medicaid have lifted millions of older Americans out of poverty. Before Medicare, almost 30 percent of our nation's elderly lived in poverty -- as compared with 12 percent today.

- o Before Medicare, about 45 percent of the elderly had no health insurance and even more were underinsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise.

- o And Medicaid has helped middle class families who have exhausted their savings to manage the overwhelming costs of nursing home care. Without Medicaid, families with a parent or spouse who needs long-term care would face nursing home bills that average $38,000 a year.

We Must Address Health Care Spending. We cannot get hold of the deficit without addressing growing health care entitlement spending. This is a real problem that must be addressed. Federal health care costs are growing faster than the economy, faster than overall inflation, and faster than almost all other government spending. **We must contain costs in**

these programs, but there is a right way and a wrong way to do so.

- **The Wrong Way to Address Health Care Spending.** The wrong way is to:
  - Simply slash Medicare and Medicaid;
  - Use these programs to pay for tax cuts for the wealthy and campaign promises;
  - Increase Medicare out-of-pocket expenses so much that health care becomes unaffordable.
  - Go backward and reduce coverage; and
  - Make changes in Medicare that lead to coercion over choice.

- **The Right Way to Address Health Care Spending.** President Clinton has said that the right way to contain costs in Federal health programs and to deal with the deficit and the long-term problem of the Medicare Trust Fund is through health care reform. As we reform health care, we must ensure that changes to Medicare and Medicaid maintain coverage, choice, quality and affordability.

  President Clinton will have a simple test for every proposal. He will ask:

  (1) **Coverage.** Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans?

  (2) **Choice.** Does it expand choice in Medicare? Or does it financially coerce beneficiaries into managed care plans?

  (3) **Quality.** Will this proposal reform the Medicare and Medicaid programs to make them more efficient without harming the delivery system, threatening quality and increasing cost shifting to small businesses? Or are these simply arbitrary and excessive cuts used to pay for other priorities -- like tax cuts for the wealthy?

  (4) **Affordability.** Will this proposal increase costs for beneficiaries so much as to make quality medical care unaffordable for older Americans? Will it take responsible steps to contain costs?

Cracking Down on Fraud and Abuse. The Clinton Administration is taking steps now to reform our health care system and to improve our health care programs. Simply put, fraud jeopardizes the health of beneficiaries and rips off the government, and we must do all we can to stop it. Since the Clinton Administration began, we have vigorously cracked down on fraud and abuse in Medicare and Medicaid. In just another example of our consistent efforts to combat fraud and abuse -- as part of our "Reinventing Government" proposal -- we will create a partnership between government and private agencies to fight fraud in five states.

THE WHITE HOUSE

WASHINGTON
May 8, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

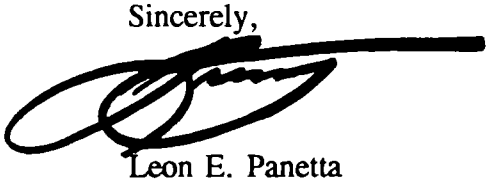
Dear Mr. Speaker:

This week both the House and Senate Budget Committees are reported to be laying down budget plans that include Medicare cuts totalling between $250-$300 billion. As the President stated at the White House Conference on Aging, while the status quo is not acceptable, we also must make sure that we are dealing with Medicare and the Medicare Trust Fund in the right way. The right way to address such health care issues is to ensure that the steps we are taking not only control costs but also expand coverage, preserve choice, and ensure quality and affordable health care for our people.

The wrong way, as the President stated, is to use Medicare and Medicaid as a bank to pay for tax cuts for well-off Americans. Regardless of what budget or accounting devices are used, it is clear that current proposals would mean that Medicare and long-term care are being cut dramatically in order to ensure that there are enough savings to fund a huge tax cut. It is unwise and unfair to ask senior citizens to bear the largest cuts in history in Medicare and long-term care in order to free up funds for a tax cut for our most well-off Americans. How could we justify asking hundreds of thousands of families to lose their long-term coverage and tens of millions of seniors to pay thousands more in out-of-pocket costs at the same time we give the top one percent a $20,000 tax cut and allow major corporations to pay no tax whatsoever?

The only way to guarantee that historic cuts in Medicare and Medicaid are not funding tax cuts for the wealthy is to drop such tax cuts now, clearly and unequivocally. Only when you have proposed and passed a specific budget that explicitly rules out tax cuts for the wealthy and ensures that health care savings are part of a sensible overall health reform effort that works for everyone, can we start the vital discussion of how to secure health care and responsible deficit reduction for the future.

Sincerely,



Leon E. Panetta
Chief of Staff

THE WHITE HOUSE

WASHINGTON

May 8, 1995

The Honorable Robert Dole
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

This week both the House and Senate Budget Committees are reported to be laying down budget plans that include Medicare cuts totalling between $250-$300 billion. As the President stated at the White House Conference on Aging, while the status quo is not acceptable, we also must make sure that we are dealing with Medicare and the Medicare Trust Fund in the right way. The right way to address such health care issues is to ensure that the steps we are taking not only control costs but also expand coverage, preserve choice, and ensure quality and affordable health care for our people.

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Sincerely,

Leon E. Panetta
Chief of Staff

U.S. Department of Health and Human Services

The Office of Disability, Aging and Long-Term Care Policy
Room 424-E, Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

FAX (202)401-7733

TO: Judy Feder *FAX NUMBER:* 456-7431

NUMBER OF PAGES: Hcover *DATE:* May 9, 1995

FROM:

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REMARKS/COMMENTS

REPUBLICAN MEDICAID AND MEDICARE CUTS HURT ELDERLY AND DISABLED WHO NEED LONG-TERM CARE

Medicaid is the largest public payor for long-term care. While most people think of Medicaid as a low-income health program, the fact is that in 1993 it paid for $25 billion dollars of nursing home care for 1.6 million elderly and disabled people. With nursing home costs averaging $38,000 per year, many of these people and their families simply could not meet these expenses without the benefit of the Medicaid safety net. This program also paid for over $7.1 billion of home and community-based care. In addition, Medicare paid for $10.7 billion of home health care for over 3 million elderly and disabled beneficiaries. Republican proposals to cut these programs seriously threaten these important lifelines for people with long-term care needs.

- **CUTTING MEDICAID WILL SLASH LONG TERM CARE SPENDING.** ~~Two out of five~~ Medicaid dollars are spent on long term care. Cuts of the magnitude proposed by the Republicans cannot be achieved without significant reductions in long-term care spending.

- **WITHOUT MEDICAID, MANY PEOPLE HAVE FEW OTHER LONG-TERM CARE OPTIONS.** Private insurance is largely unaffordable to middle income people, and unavailable to those already disabled. Medicare does not provide coverage for people with long-term chronic care needs.

- **REDUCING MEDICAID LONG TERM CARE SPENDING HURTS FAMILIES OF THE ELDERLY AND DISABLED.** Over 13 million family members have a disabled elderly parent or spouse. Many may need to turn to Medicaid to help with the catastrophic costs of nursing home care. Medicaid cuts put all these families at financial and emotional risk.

- **SPENDING FOR HOME AND COMMUNITY-BASED CARE SERVICES IS PARTICULARLY VULNERABLE.** Home and community based services are now expanding rapidly as older people and their families seek ways to avoid institutionalization. Expansion of these services will be stopped dead in its track by the Republican proposal.

- **MEDICARE CUTS PLACE OVER THREE MILLION HOME HEALTH CARE RECIPIENTS AND THEIR FAMILIES IN JEOPARDY.** These recipients are primarily women over age 75. Medicare home health cuts will result in increased out of pocket burdens for these beneficiaries and severe limitations on the services they now receive.

Pages 13
(including cover)

May 22, 1995

FAX COVER SHEET

TO: Nancy-Ann Min
Gene Sperling

FROM: Chris Jennings

I am sending you the attached from Kennedy's staff FYI.

from the office of

Senator Edward M. Kennedy

of Massachusetts

For Release: May 19, 1995
Contact: Theresa Bourgeois
(202) 224-4781

STATEMENT OF SENATOR EDWARD M. KENNEDY
ON THE AMENDMENT TO RESTORE MEDICARE AND MEDICAID FUNDING

This Republican budget resolution is an assault on Social Security -- and it deserves to be rejected for that reason alone. The Republican majority pretends to protect Social Security, while making harsh cuts in Medicare. But the distinction is a false one, because Medicare is part of Social Security. Like Social Security, Medicare is a compact between the government and the people that says "Pay into the trust fund during your working years, and we will guarantee good health care in your retirement years."

Any senior citizen who has been hospitalized or who suffers from a serious chronic illness knows there is no security without Medicare; the cost of illness is too high. A week in an intensive care unit can cost more than the total yearly income of many senior citizens.

In fact, the Republican attack on Social Security is even more direct. The Medicare Part B premium is deducted directly from the Social Security check. The Republican budget will raise those premiums and reduce Social Security checks by more than $1,750 per senior over the life of this budget plan. For an elderly couple, the reduction in the Social Security check will be a whopping $3,500. Next year alone, as a result of this Republican budget, the seniors will see a premium increase of $134 compared to current law. That will cut out more than half the average COLA increase of $237. Lower income seniors will lose 83% of their COLA. The last time the Republicans tried to cut the Social Security COLA they were forced to back down. Now they are trying to do it by stealth -- but it is not going to work.

It is not only through Medicare that the Republicans are attacking Social Security. In the House Budget, the Republicans have arbitrarily assumed an unprecedented, unilateral reduction of the CPI of .6%. The goal -- and the effect -- of this change is to rob seniors $23 billion in Social Security benefits over the next seven years.

-more-

It is the low and moderate-income elderly who will suffer most from Medicare cuts. Eighty-three percent of all Medicare spending is for older Americans with annual incomes below $25,000; two-thirds is for those with incomes below $15,000.

How can any budget plan that purports to be part of a Contract With America break America's contract with the elderly? It is bad enough to propose these deep cuts in Medicare at all. It is even worse to make these cuts in order to pay for an undeserved and unneeded tax cut for the wealthiest Americans.

The cuts in Medicare are unprecedented -- $256 billion over the next seven years. By the time the plan is fully phased in, the average senior citizen is likely to pay $900 more a year in Medicare premiums and out-of-pocket costs. An elderly couple would have to pay $1,800 dollars. Over the life of this budget, they have to pay $6,400 in additional costs.

Part B premiums, which are deducted right out of their Social Security checks, will rise to almost $100 a month -- at a cost of an additional $1,754 over the life of the budget plan.

A typical senior citizen needing home health services will have to pay an additional $1,200. Anyone who is sick enough to need the full home care benefit will have to pay $3,200.

The fundamental unfairness of this proposal is plain. Because of gaps in Medicare, senior citizens already pay too much for the health care they need. Average elderly Americans pay an astounding one fifth of their income to purchase health care -- more than they paid before Medicare was even enacted thirty years ago. And the reason we enacted Medicare was because the elderly faced a health care crisis then.

Lower income, older seniors pay even more than a fifth of their income for health care. Medicare doesn't cover prescription drugs. Its coverage of home health care and nursing home care is limited.

Unlike private insurance policies, Medicare doesn't have a cap on out-of-pocket costs. It doesn't cover eye care or foot care or dental care. Yet this budget plan piles additional medical costs on every senior citizen -- while the Republican tax bill that has already passed the House gives a tax break of $20,000 to people making more than $350,000 a year.

It is interesting to compare the generous benefits that the authors of this resolution enjoy under the FEHBP plan available to every member of Congress to the much less adequate benefits provided by Medicare. Medicare has no coverage at all for outpatient prescription drugs, but they are fully covered under Blue Cross-Blue Shield Standard, the most popular FEHBP plan. The combined deductible for doctor

and hospital services under Blue Cross/Blue Shield is $350. For Medicare, the combined deductible is $816. Blue Cross/Blue Shield covers unlimited hospital days with no co-payments. Under Medicare, seniors face a $179 per day co-payment after 60 days and $358 after 90 days. After 150 days, Medicare pays nothing at all. Medicare covers a few preventive services, but it does not cover screenings for heart disease, colorectal cancer, and prostate cancer -- all FEHBP benefits. Dental services are covered for members of Congress -- but not for senior citizens. Members of Congress are protected against sky-rocketing out-of-pocket costs by a cap on their total liability, but there is no cap on how much a senior citizen has to pay for Medicare co-payments on deductibles.

Members of Congress earn $133,600 a year. The average senior's income is $17,750. For the limited Medicare benefits they receive, seniors pay $46.10 a month, but for their comprehensive insurance coverage member of Congress will pay a grand total of $44.05 a month, while seniors actually pay $2.00 more out of incomes about one-eight as large.

The Republican sponsors of this resolution do not seem to understand that the average senior citizen has an income of only $17,750 a year. Because of this budget, millions of elderly Americans will be forced to go without the health care they need. Millions more will have to choose between food on the table, adequate heat in the winter, paying the rent, and paying for medical care. These proposals are cruel -- and they are unjust. Senior citizens have earned their Medicare benefits, they have paid for them, and they deserve them. Yet our Republican friends would deny them.

How do they explain this to senior citizens? This is a budget that Marie Antoinette would love -- "let them eat cake."

The Medicare cuts in this resolution harm more than senior citizens. These proposals will strike a severe blow to the quality of American medicine, by damaging hospitals and other health care institutions that depend heavily on Medicare.

These institutions provide essential health care for Americans of all ages, not just senior citizens. Progress in medical research and training of health professionals depend on the financial stability of these institutions. Academic health centers, public hospitals, and rural hospitals will bear an especially heavy burden. As representatives of the academic health centers that guarantee our world-renowned excellence in health care said of this budget, "Every American's quality of life will suffer as a result."

In addition, these massive cuts will inevitably impose a hidden tax on workers and businesses. They will face increased costs and higher insurance premiums, as physicians and hospitals shift even more costs to the non-elderly. According to recent statistics, Medicare now pays only 68 percent of what the private sector pays for comparable physicians' services; for hospital care, the figure is 69 percent. The proposed Republican cuts will widen this already ominous gap.

-more-

During the course of this debate we will hear a number of arguments that attempt to defend this fundamentally indefensible proposal. We can expect to hear them over and over again during the course of this debate -- as if repetition will somehow make them right.

The first argument is that deep cuts are needed to save Medicare from bankruptcy. The hypocrisy of this claim is astonishing. Just a few weeks ago -- before they began to feel the political heat on Medicare cuts -- the Republicans passed a tax bill through the House that took almost $90 billion in revenues out of the Medicare Hospital Insurance Trust Fund over the next 10 years -- and brought it that much closer to insolvency. We didn't hear a word then about the impending bankruptcy of Medicare.

We also didn't hear about it when last year's Medicare Trustee's report was issued. Republicans were too busy last year blocking health reform and pretending there was no health care crises at all.

This year's Trustees report actually shows the Medicare Trust Fund to be in a stronger financial position than last year. The new-found Republican concern for the solvency of the Medicare Trust Fund is a sham -- a convenient pretext to rob Medicare to pay for tax breaks for tycoons. Medicare is nowhere near as bankrupt as Republican priorities.

It is true that the April 3 report of the Medicare Trustees projects that the Medicare Hospital Insurance Trust Fund will run out of money by 2002. But few if any Republicans would be talking about Medicare cuts of this magnitude, absent the need to finance their tax cuts for the wealthy. As the Medicare Trustees themselves noted in their report, modest adjustments can keep Medicare solvent for an additional decade -- plenty of time to find fair solutions for the longer term.

Similar projections of Medicare insolvency have been made numerous times in the past, but adjustments enacted by Congress were able to deal with the problem without jeopardizing beneficiaries. Now is no different. For example, an estimated 20 percent of all Medicare hospitalizations could be avoided with better preventive services and more timely primary and outpatient care. As much as 10 percent of all Medicare expenditures may be due to fraud, and could be reduced or eliminated by better oversight. A simple technical change that would shift primary responsibility for home health services from the Hospital Insurance Trust Fund to the Supplementary Insurance Fund would keep the Hospital Insurance Fund solvent until 2008, without reducing benefits or increasing government costs. This single adjustment would keep the Trust Fund solvent three years longer than all the draconian Republican cuts put together.

Some Republicans have accused Democrats of attempting to scare America's senior citizens. Senior citizens do have reason to fear what this budget resolution will do to their Medicare benefits. But the real fear-mongers are those who attempt to cloak their unfair, misguided budget in phony dire warnings about the bankruptcy of Medicare.

We don't have to destroy Medicare in order to save it. Congress will never allow the Medicare Trust Fund to become bankrupt. I know it. The members on the other side of the aisle know it. And the American people know it.

Another false Republican argument in defense of Medicare cuts is that they are not really a cut, because the total amount of Medicare spending will continue to grow. The fact is that the Republican plan calls for spending $250 billion less on Medicare than the Congressional Budget Office says is necessary to maintain the current level of services to the elderly.

Every household in America knows that if the cost of your rent, the cost of your utilities, and the cost of your food go up -- and your income stays the same -- you have taken a real cut in your living standard.

Only in Washington could someone contend with a straight face that making senior citizens pay $900 a year more for their medical needs isn't a cut in their benefits. Every senior citizen understands that.

Republicans speak of a cut in defense, even though defense spending has stayed stable. Apparently, the same Republican logic doesn't apply to senior citizens that applies to defense. Well, I say to them -- a cut is a cut is a cut -- whether it's in Medicare or Social Security or national defense.

The third specious Republican argument is that Medicare costs can be cut by encouraging senior citizens to join managed care. True, such care may help bring Medicare costs under control -- in the long run. Enrollment by senior citizens in managed care is already increasing rapidly. It is up 75 percent since 1990. But no serious analyst believes that increased enrollment in managed care will substantially reduce Medicare expenditures in the time frame of the proposed Republican cuts.

In fact, according to the General Accounting Office, Medicare now actually loses money on managed care, because the healthiest senior citizens tend to enroll in managed care and the payment formula is too generous. This kind of problem can easily be worked out, and will help to restore the fiscal stability of the program. But the only way to save serious money in the short-term on managed care is to penalize those who refuse to join. This option has already been suggested by the Republican health task force in the House of Representatives.

But I say right now to my Republican colleagues -- it is wrong to force senior citizens to give up their freedom to choose their own doctors and hospitals. It is wrong to penalize them financially if they refuse to enroll in managed care.

The American people will never accept a policy that tells senior citizens they have no right to go to the hospital and doctor of their choice, or that puts unfair financial pressure on senior citizens to give up that right.

The fourth Republican argument is that deep cuts in Medicare are necessary to balance the budget. That argument refutes itself. It is nothing of the kind. All it proves is that Republican priorities are wrong. Democrats favor a balanced budget, and under President Clinton, we had been making real progress toward that goal. There is a right way to balance the budget, and a far-right way. And unfortunately, the Republicans have picked the latter.

It is true that we need to bring health care spending under control. But that applies to all health spending, not just Medicare. As President Clinton told the White House Conference on Aging last week, forty percent of the projected increase in federal spending in coming years will be caused by escalating health costs.

But what this Republican budget fails to recognize is that the current growth in Medicare spending is a symptom of the underlying problems in the entire health care system -- not a defect in Medicare alone.

In fact, Medicare has done a better job than the private sector in restraining costs in recent years. Since 1984, Medicare costs have risen at an annual rate that is 24 percent lower than comparable private sector health spending. As a result, Medicare now pays only 68 percent of what the private sector charges for comparable physicians' services; for hospital care, the figure is 69 percent.

Slashing Medicare unilaterally is no way to balance the budget. It will simply shift costs from the budget of the federal government to the budgets of senior citizens, their children, and their grandchildren. That's not a real saving.

Moreover, senior citizens will also face greater discrimination from physicians and hospitals less willing to accept them as patients, because Medicare reimbursements are already much lower than the reimbursements available under private insurance. Previous cuts in Medicare have already led to serious cost-shifting, as physicians and hospitals seek to make up their reduced income from Medicare patients by charging higher fees to other patients. The result has been higher health costs and health insurance premiums for everyone, as cost-shifting becomes a significant hidden tax on individuals and businesses.

The right way to slow rising Medicare costs is in the context of broader health reforms that will slow health cost inflation in the economy as a whole. That is the way to bring federal health costs under control, without cutting benefits or shifting costs to working families. In the context of broader reform, the needs of academic health centers, rural hospitals, and inner city hospitals can also be met. Unilateral Medicare cuts alone, by contrast, could reduce the availability and quality of care for young and old alike.

The President has said that he is willing to work for bi-partisan reform of the overall health care system, but the Republicans have said no. The only bi-partisanship they seem to be interested in is the kind that says, "Join us in slashing Medicare." That is not the bi-partisanship the American people want or the elderly deserve.

The cuts in Medicaid proposed in this budget are equally unfair -- a total of $175 billion over seven years -- a devastating 30% reduction from the current spending levels. The double whammy of huge Medicare cuts and huge Medicaid cuts will hit hospitals and other health care providers even harder than Medicare cuts alone. Struggling state governments and state and local taxpayers will also face heavy burdens. Massachusetts would lose $4.4 billion in Federal matching funds over the next seven years. By the year 2002, we would need to increase state spending by 26 percent to maintain current program levels.

Other states with higher Federal matching rates would be hit even harder. New Mexico would lose $1.3 billion, and would have to increase program spending by a massive 87 percent. Nationally, state and local taxpayers would have to increase program spending by 35 percent by the year 2002 to maintain program levels.

States can't afford these huge increases. And the impact of these arbitrary cuts on real people is even more disturbing. Medicaid is a key part of the safety net for senior citizens, the disabled, and children. Two-thirds of all Medicaid spending is for senior citizens and the disabled. If an elderly American becomes sick enough to need long-term nursing home care, Medicaid is the only source of funding after personal savings are exhausted. Cuts in Medicaid will mean that needed care for senior citizens is denied. Heavy additional burdens will be imposed on their children and grandchildren.

Children also depend on Medicaid. Eighteen million children -- more than a quarter of all children in our country -- receive health care under Medicaid. More than half of these children are members of working families. Their parents work hard -- most of them eight hours a day, forty hours a week, fifty-two weeks a year. Without Medicaid's help, all their hard work will not buy their children the health care they need.

We often hear that the reason to balance the budget is for America's children. A budget that denies health care to millions of children is the wrong way to express concern for their future.

In reviewing this budget, I was reminded of a hearing during the past Congress that the Labor and Human Resources Committee held in Quincy, Massachusetts. One of the witnesses was a retired veteran named Clifford Towne, who lived with his wife Marie in South Dartmouth.

Clifford Towne is a veteran who fought in World War II. He worked hard all his life in the textile business. When he retired, he had over $100,000 in the bank. He owned his own home, and he had a good pension from Social Security. But both he and his wife developed serious medical problems. High medical costs that Medicare didn't cover well enough -- especially prescription drugs -- had wiped out his savings. He had to run up large debts. As he told our committee, he tried to qualify for Medicaid, but his Social Security income was too high. "They told me," he said, "that the only way I could get help for my wife was to leave her. But after 48 years, I just couldn't do that. I'd rather kick the bucket than be forced to get a divorce. So my wife and I talked it over and decided that when we couldn't pay for the drugs any more, we just would have to stop taking the prescription drugs. We'd rather pass away together -- or at least as close together as we can. About three or four months ago, I already cut down on drugs for my blood pressure. I don't want my wife to have to cut down on her medications until we have no other choice."

The Medicare cuts in this budget will make life even harder for people who have a right to expect that their government will help them live out their lives in dignity. As the ceremonies on VE Day last week remind us, today's senior citizens have stood by America in war and peace, and America must stand by them now. Senior citizens have worked hard. They've played by the rules. They contributed to Medicare. They have earned their Medicare benefits, and they deserve to have them. Yet this Republican budget proposes to take those benefits away.

The amendment we are offering will restore a large part of these unfair cuts. I urge the Senate to adopt it.

###

95/91

Increase in Medicare Part B Premiums
Comparison of Dominici Proposal to Current Law
(Monthly and Annual)

	Monthly Premiums			Annual Premiums		
	Current Law (25%)	Dominici Proposal (31.5%)	Difference: Dominici-C.L.	Current Law (25%)	Dominici Proposal (31.5%)	Difference: Dominici-C.L.
1995	46.1	46.1	$0.00	553.2	553.2	$0.00
1996	43.5	54.7	$11.20	522.0	656.4	$134.40
1997	47.8	60.2	$12.40	573.6	722.4	$148.80
1998	52.5	66.2	$13.70	630.0	794.4	$164.40
1999	54.2	72.6	$18.40	650.4	871.2	$220.80
2000	55.9	79.6	$23.70	670.8	955.2	$284.40
2001	57.6	87.4	$29.80	691.2	1048.8	$357.60
2002	59.4	96.3	$36.90	712.8	1155.6	$442.80
Total (7yrs&6)	$417.00	$563.70	$146.10	$5,004.00	$6,757.20	$1,753.20
Average increase			$20.87			$250.46

Source: HCFA, Office of the Actuary

REPUBLICAN ATTACK ON SOCIAL SECURITY
1996 COLA MINUS MEDICARE PREMIUM INCREASE

SOCIAL SECURITY BENEFIT LEVEL	SOCIAL SECURITY COLA	PERCENTAGE CUT DUE TO PREMIUM INCREASE IN DOMENICI BUDGET	FINAL SOCIAL SECURITY COLA
$5,364/Year 25TH PERCENTILE	$161.	-83%	$27.
$7,874/Year AVERAGE	$237.	-57%	$103.
$10,043/Year 75TH PERCENTILE	$303.	-44%	$169.

"CAN'T BEAT THE REAL THING"

SOCIAL SECURITY COLA CUTS (1999-2002)

+$100 billion

House Republican Tax Breaks to the top 1% of Americans with incomes over $200,000 a year

Who Benefits: Wealthiest Americans

Who Pays: Social Security Recipients

House Republican 0.6% cut in the Consumer Price Index

$23.1 billion

FORTNEY PETE STARK
THIRTEENTH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

MEDICARE CUTS? LOOK WHAT REPUBLICANS SAID LAST YEAR!

Dear Democratic Colleague:

The Republicans are about to try to cut Medicare $250 to $310 billion over the next 7 years.

Last year all 14 Republican Members of the Ways and Means Committee signed the following minority views to HR 3600, the Health Reform bill:

> *"The reimbursement levels of medicare have reached potentially disastrous levels, as ProPAC's current report underscores.*
>
> *"Anyone who doubts this only has to look at the current Medicare program for the elderly and the Medicaid program for the poor. For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare and Medicaid patients--and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."*

As you remember, HR 3600 did cut Medicare spending $157 billion over 7 years but returned ALL the money to the health care system by insuring everyone (no more bad debt and uncompensated care for doctors and hospitals) and providing seniors with a prescription drug coverage and better Medicare benefits. The Republican cuts won't go for Medicare improvements or health care reform--they will just be cuts.

We should all remind the Republicans--often--of what they said last year.

Sincerely,

Pete Stark
Member of Congress

Rec 145

Protecting Medicare and Medicaid

WHEREAS Congress is beginning an historic debate on Medicare and Medicaid as the 1995 White House Conference on Aging deliberates on its recommendations to the Nation;

WHEREAS U.S. health care cost and coverage shortcomings continue to go unaddressed;

WHEREAS health care reform and the solvency of the Medicare Trust Fund are inextricably intertwined;

WHEREAS the opening session of the Conference heard statements of support for Medicare and Medicaid from both Democratic and Republican members of Congress;and

WHEREAS the President in his address challenged the delegates to come together on a multigenerational, bipartisan basis to address the problems facing the nation.

THEREFORE, BE IT RESOLVED by the 1995 White House Conference on Aging to support policies that:

Address problems facing the Medicare and Medicaid programs in the context of broad-based health care reform, as the President has proposed;

Oppose massive cuts soon to be considered in Congress;

Protect Medicare and Medicaid from any steps backwards by way of reduced health care or long term care coverage;

Apply any savings that may come from changes in Medicare and Medicaid as a result of health care reform to strengthen the programs and expand coverage, including long term care, rather than to meet arbitrary deficit reduction targets;

Prohibit additional costs being put on beneficiaries that would make health care unaffordable;

Maintain quality, preserve choice of provider and oppose proposals that have the effect of financially coercing beneficiaries into plans that do not guarantee access to their own physicians;

Prohibit the use of savings in Medicare and Medicaid for tax cuts for well off citizens.

President Clinton Addresses White House Conference on Aging:
Vows to Reform Health Care "The Right Way."
Wednesday, May 3, 1995

Today, President Clinton will speak to the White House Conference on Aging where he will renew his commitment to fighting for America's seniors. The Clinton Administration is committed to addressing the concerns of older Americans, particularly making sure that they are economically secure. That is why President Clinton has taken steps to:

- Ensure the long-term integrity of the Social Security Trust Fund;
- Vowed to make sure that Social Security benefits are not used to balance the budget or pay for tax cuts for the wealthy;
- Signed the Retirement Protection Act to make the pension system more reliable;
- Proposed IRAs to allow Americans to save money and withdraw it tax-free for the cost of a major medical expense or the care of a sick parent;
- Invested in the Older Americans Act that provides benefits to millions of Americans; and **perhaps most importantly**
- Vowed to fight for real health care reform and against cuts in Medicare and Medicaid to fund tax cuts for the wealthy.

Medicare and Medicaid have provided a safety net for our nation's elderly for 30 years. Today, Medicare covers 37 million elderly and disabled Americans. And, while the myth is that Medicaid helps only low-income women and children, the reality is that about two-thirds of Medicaid funds are spent on services for older Americans and people with disabilities.

These programs are an example of government that works. This year, as we celebrate the 30th anniversary of their passage, we must remember that:

- Medicare and Medicaid have lifted millions of older Americans out of poverty. Before Medicare, almost 30 percent of our nation's elderly lived in poverty -- as compared with 12 percent today.

- Before Medicare, about 45 percent of the elderly had no health insurance and even more were underinsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise.

- And Medicaid has helped middle class families who have exhausted their savings to manage the overwhelming costs of nursing home care. Without Medicaid, families with a parent or spouse who needs long-term care would face nursing home bills that average $38,000 a year.

We Must Address Health Care Spending. There are real problems in Medicare and Medicaid that must be addressed. We cannot get hold of the deficit without addressing growing health care entitlement spending. Federal health care costs are growing faster than the economy, faster than overall inflation, and faster than almost all other government spending. **We must contain costs in these programs, but there is a right way and a wrong way to do so.**

- **The Wrong Way to Address Health Care Spending.** The wrong way is to:
  - Simply slash Medicare and Medicaid;
  - Use these programs to pay for tax cuts for the wealthy and campaign promises;
  - Cut Medicare and Medicaid as a back door to reduce Social Security spending;
  - Go backward and reduce coverage; and
  - Make changes in Medicare that lead to coercion over choice.

- **The Right Way to Address Health Care Spending.** President Clinton has said that the right way to contain costs in Federal health programs and to deal with the deficit and the long-term problem of the Medicare Trust Fund is through health care reform. As we consider changes to Medicare and Medicaid this year, we must ensure that any proposed change maintains coverage, choice, quality and affordability.

  President Clinton will have a simple test for every proposal. He will ask:

  (1) **Coverage.** Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans?

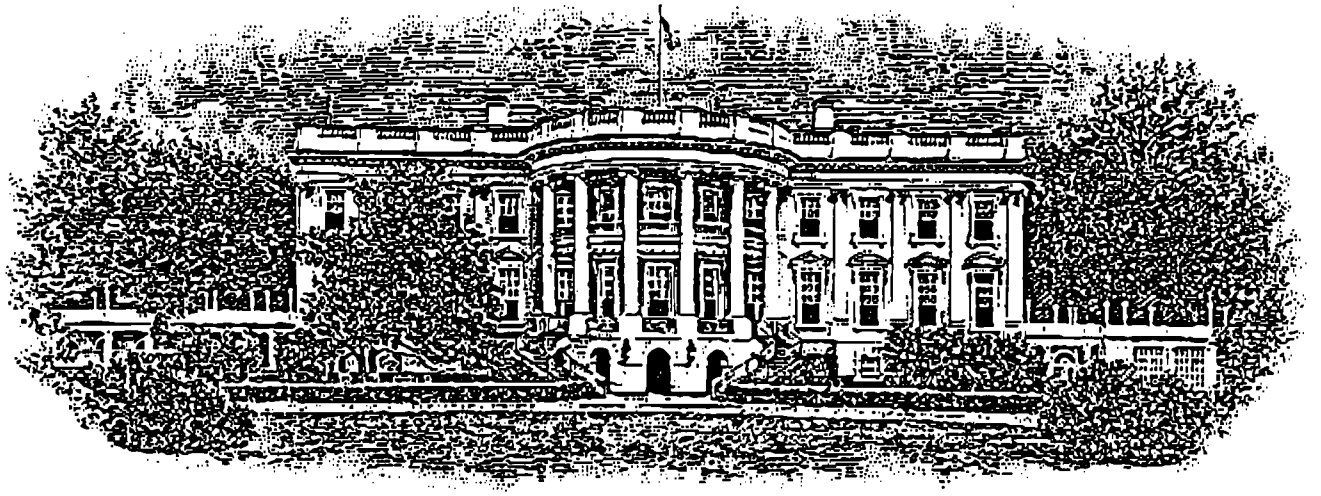
  (2) **Choice.** Does it expand choice in Medicare? Or does it financially coerce beneficiaries into managed care plans?

  (3) **Quality.** Will this proposal reform the Medicare and Medicaid programs to make them more efficient without harming the delivery system, threatening quality and increasing cost shifting to small businesses? Or are these simply arbitrary and excessive cuts used to pay for other priorities -- like tax cuts for the wealthy?

  (4) **Affordability.** Will this proposal increase costs for beneficiaries so much as to make quality medical care unaffordable for older Americans? Will it take responsible steps to contain costs?

Cracking Down on Fraud and Abuse. The Clinton Administration is taking steps now to reform our health care system and to improve our health care programs. Simply put, fraud jeopardizes the health of beneficiaries and rips off the government, and we need to end it. Since the Clinton Administration began, we have vigorously cracked down on fraud and abuse in Medicare and Medicaid. In just another example of our consistent efforts to combat fraud and abuse -- as part of our "Reinventing Government" proposal -- we will create a partnership between government and private agencies to fight fraud in five states.

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen

FAX NUMBER:

TELEPHONE NUMBER:

FROM: Stacey

TELEPHONE NUMBER:

PAGES (INCLUDING COVER):

COMMENTS: FYI

DRAFT

RURAL HEALTH

I. BACKGROUND

In the existing health care system, major financial and non-financial barriers reduce access to health care services for a significant number of individuals living in rural areas. Consequently, individuals living in rural areas are more likely to experience reduced health status and quality of life.

- More than 22 million Americans live in rural areas with a severe shortage of primary care doctors and close to 8 million do not have health insurance.
- There are significant shortage of health care providers in rural areas, and needed services are not always available.
    - In metropolitan areas, there are 225 doctors for every 100,000 residents, compared to 97 doctors for every 100,000 residents in non-metropolitan areas. Moreover, in 1990, there were estimated shortages of 45,000 registered nurses, 1200 psychiatrists, and nearly 1000 dentists in rural areas.
- A significant number of seniors with Medicare reside in rural areas. However, on average, rural hospitals lose money on their Medicare patients -- Medicare operating margins were a negative 5.6% in FY 1991 in these hospitals.

During the 103rd session of Congress, the Administration's Health Security Act made significant efforts to remove both the major financial and non-financial barrier to health care services for those residing in rural areas. In addition to guaranteeing private health insurance coverage to all Americans, the plan had proposed to improve the availability and quality of health care services in rural areas. Unable to reach a consensus, no reform initiative was enacted into law.

More recently in the 104th session of Congress, drastic cuts in the Medicare and Medicaid programs have been proposed -- combined Medicare and Medicaid cuts of almost $500 billion dollars. The consequence of such action could have severe effects on the already stressed, rural health delivery system.

- For example, rural hospitals that largely depend on Medicare would be forced to close their doors or turn to local taxpayers to sustain them.
- Rural hospitals are often the largest employer in their communities. Closing these hospitals will result in job loss and physicians leaving rural communities.

II. ADMINISTRATION ACCOMPLISHMENTS

Although a final consensus was not reached on health care reform, the Administration, on a separate but a parallel track, has worked with rural communities to improve the delivery of health care services.

- During the past two years, Medicare reimbursement to rural hospitals has been increased to eliminate the urban/rural distinction that was once as high as 25%. Now, the Medicare "standardized amount" payments to rural hospitals are equal to those of urban hospitals.

- Federal funding for programs that most help rural areas, such as community health center, migrant health centers, and the National Health Service Corps have been greatly increased during the past two years. These programs provide primary medical care to nearly 3 million rural Americans in some of the poorest communities in this country.

- With Federal encouragement and some matching funds, we have seen the number of rural health offices at the state level increase from 26 in 1992 to all fifty states today. These state offices are very active partners with their rural communities, their state, and with the federal government in designing new strategies to solve rural health problems.

- With encouragement from this Administration, several states have begun working on a regional and now a national rural recruitment network, to share a rural practitioner database and make referrals across recruitment programs.

- We have put the means for innovation right in the hands of rural communities. Last year, we made over 100 Rural Health Outreach Grant in 46 states to help rural communities to link institutional arms with other in their town and show how they would stretch scarce resources more efficiently to care for their residents. These communities, for example, have brought care to isolated residents in vans, medical training to the doorstep of weary rural volunteers, and linked isolated doctors with fax machines and backup support.

- Through a collaborative effort with representatives of rural managed care and other health care entities, efforts to encourage expansion of managed care plans into rural areas have been made.

- The Administration has commenced eleven telemedicine demonstration projects to support rural practitioners and enable them to provide state-of-the-art medicine to their patients.

- The development of more rural health clinics have been fostered by the Administration. Medicare supported rural health clinics have grown during the past two years, increasing from fewer than 800 to more than 2,000. These clinics use nurse practitioners, physician assistants, and nurse midwives in support of physicians. As a result, Medicare provides cost-based reimbursement to help support the use of these mid-level providers.

III. ADMINISTRATION'S RECOMMENDATIONS

- Increase the supply of health care providers and delivery sites in rural, underserved areas.

    - Promote training of health care providers in rural areas.

    - Provide incentives to attract health care providers to rural, underserved areas.

- Help community-based providers to form networks and plans.
- Preserve and strengthen the rural telemedicine programs.
- Oppose deep cuts in Medicare and Medicaid that would undermine the delivery systems and programs serving rural residents, (e.g., the closure of hospitals in underserved, rural areas).

6.4% CAP 96-00 75 b (12% hit) 96-02 148 b (16% hit 2000

The Dole/Packwood Medicaid Cuts Would Hurt Low-Income Older Americans

- Medicaid provides health insurance to about 32 million low-income Americans. About 4 million of them are also Medicare beneficiaries 65 and older. Medicaid provides coverage for preventive care, prescription drugs, and home and community-based long-term care -- all vital services that Medicare does not cover and low-income older Americans simply cannot afford. In addition, Medicaid assists low-income Medicare beneficiaries in paying their Medicare premiums, deductibles, and coinsurance. Medicaid is also the primary payer of nursing home care for frail, older Americans.

- The Dole/Packwood plan would cut projected federal Medicaid spending by approximately $75 billion over the 1996-2000 period and approximately $130 billion between 1996 and 2002. Cuts in federal Medicaid spending in the year 2000 alone would be $27 billion, or 18 percent of the program.

- The Dole/Packwood Medicaid spending cuts would result in a reduction in federal Medicaid spending of about **$5,000 per elderly Medicaid beneficiary** from 1996 to 2000 and about **$8,500 per elderly Medicaid beneficiary** from 1996 to 2002.

Prop $ Eld = 27% 75*.27/4 Assumes 100% Benef - Hit?

- Congressional leaders are also seriously considering turning Medicaid into a "block grant" and eliminating federal protections and the federal entitlement for vulnerable populations such as low-income children, elderly, and disabled.

- For older Americans, large budget cuts in Medicaid at the federal level combined with a block grant to states could have potentially devastating consequences, including:

  -- **Losing Medicaid Coverage Entirely**: States could reduce expenditures by eliminating entire categories of eligibility. For example, older Americans would be severely affected if a state chose to eliminate the "medically needy" program. Medically needy programs allow individuals who experience catastrophic medical expenses relative to their income to qualify for Medicaid

  -- **Eliminating or Severely Cutting Important Services**: States could eliminate coverage for optional services such as prescription drugs and home and community-based long term care, or could limit the number of covered hospitals days, physicians visits, or prescriptions a beneficiary could fill each month. Severe cutbacks in home care could force individuals into nursing homes prematurely.

-- **Jeopardizing the Quality of Nursing Home Care** -- States could ignore the successful, recently enacted nursing home quality improvement standards and procedures, making nursing homes truly dangerous places to live.

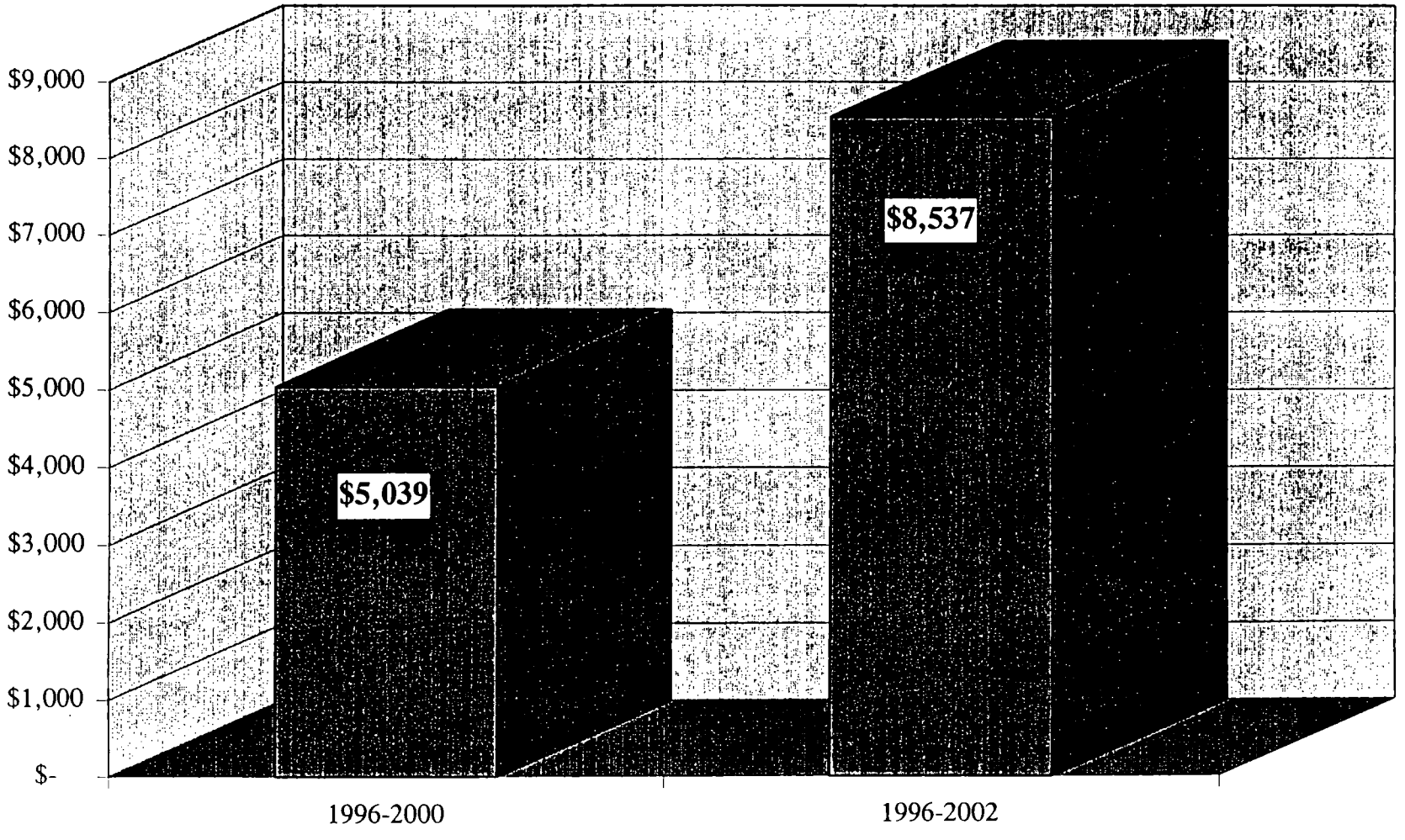
-- **Eliminating Critical Consumer Protections** -- States could ignore spousal impoverishment protections, bankrupting community spouses and taking away their homes if their husband or wife has to go into a nursing home and spends-down on to Medicaid. In addition, states could ignore protections under the Qualified Medicare Beneficiary (QMB) program, which requires Medicaid to pay the Medicare copayments, deductibles and premiums of low-income Medicare beneficiaries. These vulnerable seniors would no longer be able to afford even the most basic Medicare services and would likely be forced to go without them.

-- **Losing Eligibility for Nursing Home Care**: Eligibility for nursing home care is determined differently from eligibility for other Medicaid assistance. States determine eligibility based on special criteria for financial, physical, and mental needs. To reduce the number of nursing home residents on Medicaid, states could make these eligibility criteria more restrictive than they are today. This could force many vulnerable seniors into unlicensed board and care homes and require nursing home residents to further impoverish themselves in order to receive help from Medicaid.

-- **Forcing People into Managed Care**: States will rely even more heavily on managed care plans, like HMOs. It can be expected that the elderly and disabled, who until recently were typically not included in state managed care programs, will be targeted for enrollment in managed care plans, which restrict provider choice.

AARP
3/6/95

Medicaid Cuts Per Elderly Beneficiary
Senators Dole/Packwood Proposals



Source: Medicare and Medicaid cuts based on proposals by Senator Dole (Wall Street Journal, February 16, 1995) and Senator Packwood (Washington Post, February 28, 1995).
AARP, March 6, 1995.

Example of How Senators Dole/Packwood Medicaid Cuts Could Be Distributed

(Savings in Billions of Dollars)

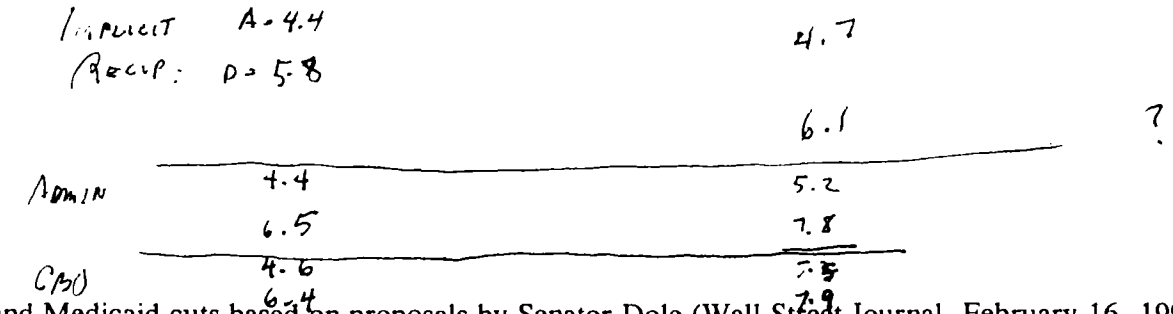
	1996	1997	1998	1999	2000	2001	2002	1996-2000	1996-2002
Elderly	1.3	2.5	4.6	6.5	8.3	8.6	→ 8.6	**23.3**	**40.5**
Disabled	1.6	3.1	5.6	8.0	10.2	10.5	→ 10.5	**28.5**	**49.5**
Families (incl. children)	1.3	2.5	4.6	6.5	8.3	8.5	8.6	**23.1**	**40.2**
Total Medicaid Cuts	4.2	8.2	14.8	21.0	26.7	27.5	27.7	**74.9**	**130.1**

Source: Medicare and Medicaid cuts based on proposals by Senator Dole (Wall Street Journal, February 16, 1995) and Senator Packwood (Washington Post, February 28, 1995). Specific cuts are illustrative.
AARP, March 6, 1995.

Example of How Senators Dole/Packwood Medicaid Cuts Could Be Distributed

Medicaid Cuts Per Beneficiary (in Dollars)

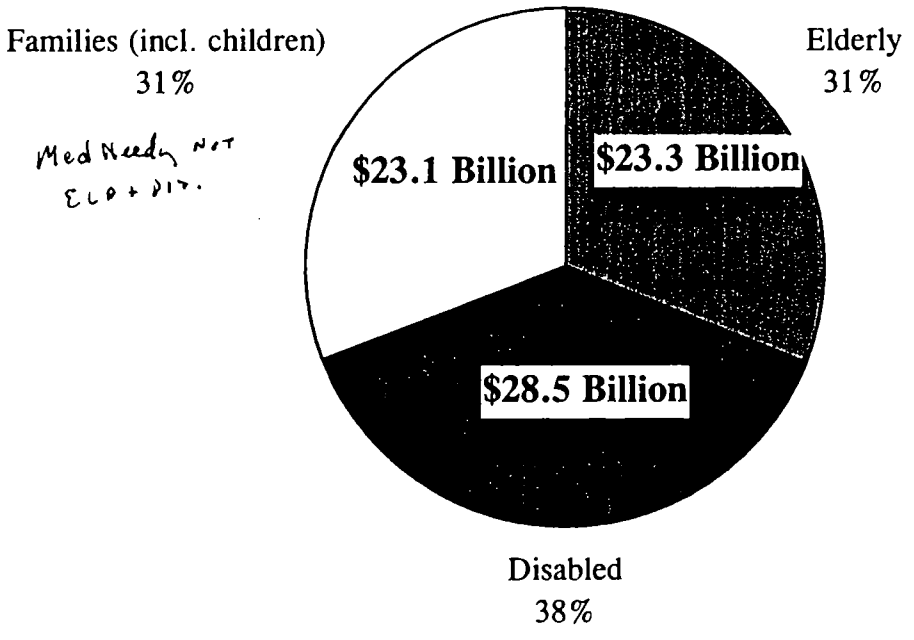
	1996	1997	1998	1999	2000	2001	2002	1996-2000	1996-2002
Elderly	$ 308	$ 579	$1,014	$1,395	$1,743	$1,761	$1,737	**$ 5,039**	**$ 8,537**
Disabled	$ 290	$ 574	$ 952	$1,311	$1,638	$1,655	$1,632	**$ 4,764**	**$ 8,051**
Families (incl. children)	$ 48	$ 91	$ 159	$ 219	$ 274	$ 277	$ 273	**$ 792**	**$ 1,342**
Total Medicaid Cuts Per Beneficiary	$ 115	$ 216	$ 378	$ 521	$ 650	$ 657	$ 648	**$ 1,880**	**$ 3,185**



Source: Medicare and Medicaid cuts based on proposals by Senator Dole (Wall Street Journal, February 16, 1995) and Senator Packwood (Washington Post, February 28, 1995). Specific cuts are illustrative.
AARP, March 6, 1995.

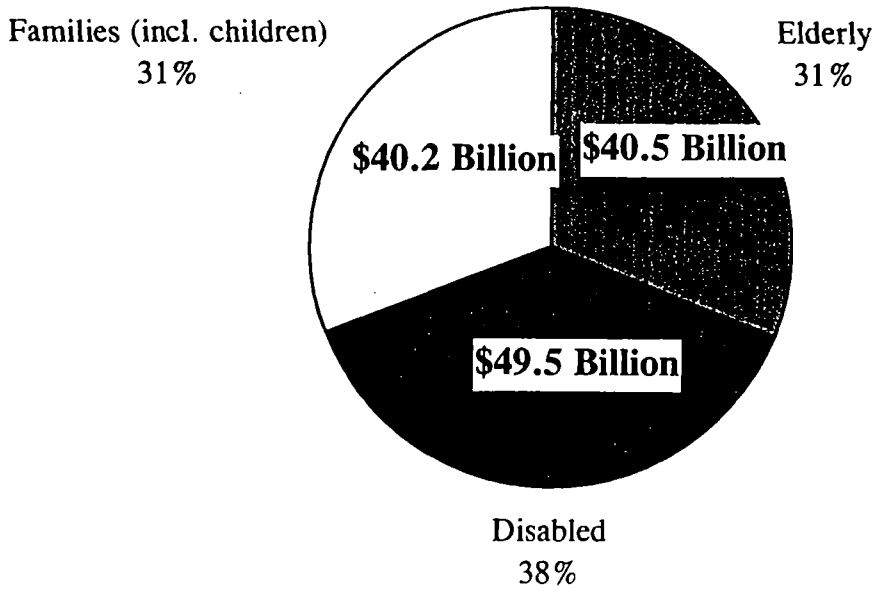
Impact of Dole/Packwood Medicaid Cuts on Elderly, Disabled, and Low-Income Families With Children FY1996-2000

NOTE:
These Prop = NonDSH % of Fed Mcd Exp. for these groups



Source: Medicare and Medicaid cuts based on proposals by Senator Dole (Wall Street Journal, February 16, 1995) and Senator Packwood (Washington Post, February 28, 1995).
AARP, March 6, 1995.

Impact of Dole/Packwood Medicaid Cuts on Elderly, Disabled, and Low-Income Families With Children FY1996-2002



Source: Medicare and Medicaid cuts based on proposals by Senator Dole (Wall Street Journal, February 16, 1995) and Senator Packwood (Washington Post, February 28, 1995).
AARP, March 6, 1995.

Doesn't include nursing home costs

Urban Institute -- this is for average elderly person

MEDICARE CUTS: OUT-OF-POCKET SPENDING TALKING POINTS

acc. to UI

↑ by X % $

- Older Americans already spend 21% of their incomes on out-of-pocket health care, not even including nursing home care. This is almost three times on average what families under 65 years old spend. But 12% if ave. o-o-p over ave. beneficiary

- Older Americans currently spend an average of $2,500 on health care out-of-pocket. The Republican cuts that total $250 billion between 1996 and 2002 would amount to $1,630 per beneficiary in the year 2002. — all benef.

① 250 - 305 B cuts
- Amt spending ↑
- COLA benefits

② Rural health

The Republicans say that they are not cutting Social Security. However, the effect of a Medicare cut is a back-door reduction in the Social Security benefits. Whereas the estimate increase in the median Social Security check will be $400 in 2002, the Republican cuts would average $1,600 per beneficiary in that year.

③ + cost shift → hidden tax on premiums for ave. Ams.

+ if half come from benefit cuts, it would = $___ per beneficiary

Home health would cost 75 yr old woman ~~was~~ $3800. This is ___ of Soc. Sec. benefit

Bruce Vladeck 2:30 pm

① For the "average" Soc. Sec. recipient... Rep. cuts would take
. About 1/3 to 75% of your COLA - depending on the split and the amount of the cuts

- Rep cuts est. to be between $250 and $305 B
- ~~$X per capita~~

$___ cuts and

- If you assumed that they divided the cuts evenly between prov. & ben, would = $___ over 7 yrs and in 2002 alone = $ ___

50 - 50 at $250
50 - 50 at $300

② How many elderly would lose their entire COLA benefit?
10 M

For 10 M of the frailest, oldest would wipe out entire COLA benefit?

Lewin → 75% benif.
25% prov.

MEDICAID LONG TERM CARE TALKING POINTS

- Long term care accounts for more than one-third of all Medicaid spending. Given the magnitude of the cuts proposed by the Republicans, states could not possibly respond without making deep reductions in eligibility for long term care, benefits, or payments to nursing homes and community-based providers.

- In 1993, 2.9 million people relied on Medicaid for nursing home or community-based long term care. According to an analysis by Lewin-VHI, cuts of the magnitude proposed by Republicans could reduce federal long term care spending by over $37 billion from 1996 to 2000. They predict that over 1.7 million long-term care beneficiaries would lose services or be unable to secure services by 2000. Don't use

- Cuts in Medicaid long term care coverage would hurt middle class people, not just the poor. Medicaid pays for 41% of all formal long term care, and for over half of all nursing home care.

  Elderly and disabled people are already paying too much out-of-pocket for nursing home care -- $23 billion in 1993, almost three times what they spent in 1980. Without Medicaid, the 13 million Americans with an elderly parent or spouse who is disabled would face nursing home bills that average $38,000 a year.

Use as lead in

50% of providers cig.
$5% on services
25% on providers

25% for kids
25% for elderly

out of $160 and $190

① Cuts
② Who people are
③ 1/4, 1/4, 1/4, 1/4
④ LTC

Managed Care
• 2/3 end $ dis — where little evid. that man. care
• 1/3 of the rest already in — much
∴ little savings left

to no evid

for elderly and disabled

• baseline proj. presume a growing # already going in.
• use CBO #?

Very little reason to believe that savings

TABLE 1A - 5.25% CAP SCENARIO

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05	7 YR TOTAL	10 YR TOTAL
AGGREGATE FIGURES													
BASELINE $ IN BILLIONS	$178	$199	$219	$240	$263	$288	$315	$345	$379	$416	$458		
BASE % GROWTH		11.7%	10.3%	9.6%	9.6%	9.4%	9.5%	9.5%	9.9%	9.8%	10.1%		
New BASELINE $ IN BILLIONS @ 5.25% GROWTH	$178	$187	$197	$207	$218	$230	$242	$254	$268	$282	$297		
TOTAL SAVINGS IN BILLIONS @5.25%		$11	$22	$33	$45	$58	$73	$91	$111	$134	$161	$333	$740
* FED SAVINGS IN BILLIONS @ 5.25% (NET		$10	$20	$30	$40	$52	$66	$82	$100	$121	$145	$300	$666

PER BENEFICIARY FIGURES

NATIONAL PER CAPITA MEDICARE SPENDING (PARTS A AND B COMBINED)	$4,725	$5,190	$5,638	$6,096	$6,598	$7,129	$7,713	$8,354	$9,069	$9,833	$10,688	
SPENDING CAP BASELINE PER CAPITA	$4,725	$4,890	$5,068	$5,263	$5,472	$5,688	$5,918	$6,160	$6,407	$6,661	$6,921	
TOTAL FEDERAL SAVINGS PER CAPITA		$300	$570	$833	$1,126	$1,441	$1,795	$2,194	$2,662	$3,172	$3,767	

(*)

family income vs individual

TABLE 1B – 6.15% CAP SCENARIO

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05	7 YR TOTAL	10 YR TOTAL
AGGREGATE FIGURES													
BASELINE $ IN BILLIONS	$178	$199	$219	$240	$263	$288	$315	$345	$379	$416	$458		
BASE % GROWTH		11.7%	10.3%	9.6%	9.6%	9.4%	9.5%	9.5%	9.9%	9.8%	10.1%		
New													
BASELINE $ IN BILLIONS @ 6.15% GROWTH	$178	$189	$200	$213	$226	$240	$254	$270	$287	$304	$323		
TOTAL SAVINGS IN BILLIONS @6.15%		$10	$19	$27	$37	$48	$61	$75	$92	$112	$135	$277	$616
FED SAVINGS IN BILLIONS @ 6.15%		$9	$17	$25	$34	$43	$55	$67	$83	$101	$122	$250	$555
Not													
PER BENEFICIARY FIGURES													
NATIONAL PER CAPITA MEDICARE SPENDING (PARTS A AND B COMBINED)	$4,725	$5,190	$5,638	$6,096	$6,598	$7,129	$7,713	$8,354	$9,069	$9,833	$10,688		
SPENDING CAP BASELINE PER CAPITA	$4,725	$4,932	$5,155	$5,399	$5,661	$5,935	$6,228	$6,538	$6,859	$7,191	$7,537		
TOTAL FEDERAL SAVINGS PER CAPITA		$258	$483	$697	$937	$1,193	$1,485	$1,816	$2,211	$2,642	$3,152		

TALKING POINTS ON
MEDICARE BENEFICIARIES AND PRESCRIPTION DRUG SPENDING

- In 1992, drug expenditures per non-institutionalized enrollee averaged $493 in 1992, with out-of-pocket spending averaging $278 or 56 percent of total spending.

- Out-of-pocket spending varied widely between the income categories, ranging from $242 (48 percent of total spending) for those with income under the poverty level to $324 (64 percent of total spending) for those with income between 121 and 150 percent of poverty.

  - The lower out-of-pocket expenses for those below the poverty level is likely to due to Medicaid coverage.

  - Beneficiaries with income just above the poverty level had the highest out-of-pocket spending in 1992:

    -between 121 and 150 percent $311 (61% total spending)
    -between 101 and 120 percent $324 (64% total spending)

    This group had the lowest levels of third-party coverage.

NOTE: The guidelines used to determine income levels as a percent of poverty were $6,810 for one person.

Prescription drug expenditures and out-of-pocket expenditures for drugs per non-institutionalized Medicare enrollee, by income stratum, 1992

Income as % of poverty	Distrib. by stratum	Total spending	Out-of-pocket spending	Percent out-of-pocket
Total	100.0%	$493	$278	56.3%
Unknown	3.1%	$263	$175	66.6%
100 or under	26.3%	$509	$242	47.5%
101 - 120	7.9%	$508	$311	61.2%
121 - 150	11.9%	$509	$324	63.7%
151 - 200	14.1%	$496	$304	61.3%
201 - 300	17.0%	$494	$286	57.9%
300 or more	19.8%	$492	$275	55.9%

DESCRIPTIVE PROFILES OF MEDICARE HOME HEALTH USERS

The following analysis of Medicare home health users is based on data from the 1992 Medicare Current Beneficiary Survey. Overall, this data shows that high users of Medicare home health services are more likely to be disabled, live alone, and fall into a low income group.

- Home Health users are concentrated in low-income groups. Seventy-nine percent of home health users who were single, and over 65 (the majority of home health users), had incomes that fell below $15,000 or 250% of the poverty level. Roughly 57% of home health users who were married, and over 65, had incomes that fell below $15,000 or 198% of the poverty level.

- More home health users were eligible for Medicaid relative to the rest of the Medicare population. Twenty-four percent of home health users were eligible for Medicaid in 1992, while 12% of non-users were eligible.

- Home health users who received more visits were more likely to be eligible for Medicaid. Forty-five percent of users who received over 200 visits in 1992 were eligible for Medicaid, while 22% of users who received under 200 visits in 1992 were eligible for Medicaid.

- Twenty nine percent of home health users with over 200 visits, and who were eligible for Medicaid, had three or more ADL limitations.

- High users of home health incur significantly higher than average total charges. The average total charges per home health user were $4,725 in 1992. The average total charges of home health users with less than 100 visits in 1992 amounted to $2,200. The average total charges for home health users with more than 100 visits in 1992 totaled $13,727. Approximately 28% of home health charges can be attributed to the charges over 100 visits.

- High users of home health are more likely to be disabled and live alone. The average home health user with over 200 visits had 2.67 ADLs relative to the average home health user with less than 200 visits who had 1.18 ADLs. Thirty-eight percent of home health users with under 200 visits were married, whereas 17 percent of home health users with over 200 visits were married. Similarly, 44% of home health users who had more than 200 visits lived alone, while 34% of home health users with under 200 visits lived alone.

DRAFT

April 28, 1995

NOTE TO: Debbie Chang
Office of Legislative and Intergovernmental Affairs

SUBJECT: Comparison of Social Security COLAs and Illustrative Increases in Out-of-Pocket Expenses Under Proposals To Reduce Medicare Costs

The attached table presents an illustrative comparison of Social Security benefit increases and increases in out-of-pocket expenses that could occur under proposals to reduce Medicare costs. The top section of the table shows:

(i) The percentage cost-of-living adjustments (COLAs) assumed in the 1995 OASDI Trustees Report;

(ii) The annual benefit amounts payable currently and in future years to individual retired worker beneficiaries at the 10th, 25th, 50th, 75th, and 90th percentiles of the distribution of such beneficiaries at the end of 1994; and

(iii) The annual amounts of the COLAs for the individuals.

The bottom section of the table shows an illustration of the increases in individual beneficiaries' out-of-pocket expenses that could occur under alternative proposals to reduce Medicare costs.[1] In practice, actual amounts could vary substantially from these illustrations, depending on the specific provisions of the legislation. Moreover, the amounts shown are *averages* for all beneficiaries who currently incur reimbursable charges—the effects on specific individuals could be somewhat lower than these amounts or considerably higher.

Please consider also these important limitations of the comparison:

- Social Security benefit increases merely keep beneficiaries even with the overall cost of living. Thus, if an individual's out-of-pocket costs increased by exactly the same amount as his or her OASDI benefit, then one should not consider that the beneficiary has "broken even" in any way. In fact, the individual's net purchasing power has declined.

- Some beneficiaries would be partially protected from the effect of legislated increases in the SMI premium as a result of the Social Security "hold harmless" provision.

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[1] The year-by-year patterns of savings under the illustrative proposals were assumed to match the pattern specified by the Treasury Department for a proposal to reduce costs by $150 billion over 7 years (see memorandum dated April 24 by Wayne Ferguson).

- Some beneficiaries would be protected from increased out-of-pocket costs as a result of the QMB and SLMB provisions.

- To the extent that savings are achieved in the SMI program, the effect on beneficiaries' out-of-pocket costs would be offset somewhat through lower SMI premiums.

Please let us know if you have any questions about this illustration (or would like any further caveats and limitations!)

Richard S. Foster, F.S.A.

cc:

Comparison of Social Security COLAs and illustrative increases in out-of-pocket expenses under proposals to reduce Medicare costs

Item	Calendar year							
	1995	1996	1997	1998	1999	2000	2001	2002
Social Security COLA (effective for December of year shown)	3.0%	3.2%	3.3%	3.4%	3.6%	3.7%	3.9%	4.0%
Annual Social Security benefit for retired worker beneficiaries in following percentile:								
10%	$ 4,213	$ 4,340	$ 4,479	$ 4,626	$ 4,783	$ 4,956	$ 5,139	$ 5,340
25%	5,679	5,850	6,037	6,236	6,449	6,681	6,928	7,199
50%	8,445	8,699	8,978	9,275	9,591	9,937	10,305	10,707
75%	10,588	10,907	11,257	11,628	12,025	12,458	12,920	13,425
90%	12,630	13,010	13,428	13,872	14,345	14,862	15,414	16,016
Annual amount of COLA for retired worker beneficiaries in following percentile:								
10%	—	$ 127	$ 139	$ 147	$ 157	$ 173	$ 184	$ 200
25%	—	171	187	199	213	232	248	270
50%	—	254	279	297	317	345	369	402
75%	—	319	350	372	397	433	462	504
90%	—	380	417	444	473	518	552	602
Illustrative increase* in out-of-pocket expenses for individual Medicare beneficiaries with covered services, under proposals that would increase aggregate cost sharing over the next 7 years								
$50 billion		$95	144	164	186	199	217	242
$100 billion		128	214	277	348	417	500	597
$150 billion		161	286	391	511	635	779	946
$200 billion		196	360	509	678	857	1,062	1,296
$250 billion		232	434	627	843	1,074	1,336	1,634
$300 billion		270	513	750	1,014	1,297	1,615	1,975

* The actual increase in out-of-pocket expenditures for individual Medicare beneficiaries would depend critically on (i) the specific provisions of the legislation, and (ii) the specific medical services used by the beneficiary. The increases shown here represent the average amount for all Medicare beneficiaries who would incur reimbursable charges under present law. Amounts for specific individuals could be substantially different.

Note: See accompanying memorandum concerning interpretation of these figures and their limitations.

Office of the Actuary
Health Care Financing Admin.
April 28, 1995

Congressional Research Service · Library of Congress · Washington, D.C. 20540

April 21, 1995

TO : Senate Committee on Finance
Attention: Kathy King

FROM : Jennifer O'Sullivan
Specialist in Social Legislation
and
Sharon Kearney
Technical Information Specialist
Education and Public Welfare Division

SUBJECT : **Solvency of Trust Fund for Medicare Part A (Hospital Insurance)**

Medicare is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Recent projections by the trustees of the Hospital Insurance Trust Fund show that Part A is confronting major financing problems. A Medicare trustee report in 1982 warned that the Hospital Insurance Trust Fund could become insolvent by 1987. Congress enacted many changes over the following years, which, when coupled with better economic conditions, improved the outlook somewhat. The 1995 report projects that the Fund will be insolvent by 2002, only a year later than that projected in the 1994 report.

The following table shows for each trustee report issued in the last 26 years the date the trustees projected that the Fund would become insolvent.

TABLE 1. Year in Which the Hospital Insurance Trust Fund was Projected to Become Insolvent in Past Trustees' Reports

Year of Trustees' Report:	Year of Insolvency:
1970	1972
1971	1973
1972	1976
1973	none indicated
1974	none indicated
1975	late 1990s
1976	early 1990s
1977	late 1980s
1978	1990

TABLE 1. Year in Which the Hospital Insurance Trust Fund was Projected to Become Insolvent in Past Trustees' Reports

Year of Trustees' Report:	Year of Insolvency:
1979	1992
1980	1994
1981	1991
1982	1987
1983	1990
1984	1991
1985	1998
1986	1996
1986 amended	1998
1987	2002
1988	2005
1989	*
1990	2003
1991	2005
1992	2002
1993	1999
1994	2001
1995	2002

*Contained no long-range projections.

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966-95.

CAPPING MEDICARE SPENDING

DRAFT

- Republican efforts to balance the federal budget may also lead to proposals to cap federal spending for the Medicare program. For example, Senator Dole has suggested a reduction in Medicare spending of about $150 billion between 1996 and 2000. This is approximately equivalent to capping annual growth in Medicare spending at about 5% beginning in 1996.

- Medicare is currently projected to grow at an average annual rate of 9.8% between fiscal years 1996 and 2002.

  On a per person basis, Medicare actually is projected to grow at about the same rate as private health spending. Between 1996 and 2002, per capita Medicare spending is projected to grow at 7.6% annually, while private health spending is projected to grow at 7.8% annually.

- Using CBO budget estimates, a 5% growth cap would reduce federal Medicare spending below baseline projections by $311 billion from fiscal years 1996 to 2002, and by $701 billion from 1996 to 2005.

- The following table shows the potential effects of a 5% growth cap on a state-by-state basis. This analysis assumes that Medicare spending in each state under the status quo would grow at same rate as overall Medicare spending is projected to grow.

Illustrative Effect of Medicare Capped Expenditures
Reduction in Federal Payments Assuming 5% Growth Cap
(Dollars in millions, fiscal years)

	1996 - 2002
US*	(311,000)
Alabama	(5,354)
Alaska	(212)
Arizona	(4,740)
Arkansas	(2,842)
California	(35,877)
Colorado	(3,111)
Connecticut	(4,467)
Delaware	(780)
District of Columbia	(2,419)
Florida	(25,507)
Georgia	(7,184)
Hawaii	(1,029)
Idaho	(744)
Illinois	(13,353)
Indiana	(6,257)
Iowa	(2,840)
Kansas	(2,938)
Kentucky	(4,262)
Louisiana	(5,673)
Maine	(1,222)
Maryland	(5,374)
Massachusetts	(9,764)
Michigan	(11,253)
Minnesota	(4,583)
Mississippi	(2,889)
Missouri	(6,794)
Montana	(804)
Nebraska	(1,500)
Nevada	(1,444)
New Hampshire	(1,006)
New Jersey	(10,335)
New Mexico	(1,211)
New York	(24,910)
North Carolina	(7,055)
North Dakota	(755)
Ohio	(13,243)
Oklahoma	(3,365)
Oregon	(3,141)
Pennsylvania	(20,174)
Rhode Island	(1,368)
South Carolina	(3,134)
South Dakota	(721)
Tennessee	(7,076)
Texas	(17,423)
Utah	(1,285)
Vermont	(496)
Virginia	(5,267)
Washington	(4,715)
West Virginia	(2,213)
Wisconsin	(5,016)
Wyoming	(302)

Federal payment reductions are allocated across states in proportion to the states' FY 1993 share of Medicare spending.

POTENTIAL RESPONSES TO ACCOMPLISH REDUCED MEDICARE SPENDING GROWTH

- Medicare Managed Care
- Reduction in Medicare Payments to Providers
- Reduction in Medicare Benefits
- Increases in Medicare Premiums

MEDICARE MANAGED CARE

The potential for achieving scorable savings in Medicare through managed care is uncertain.

- Currently, 74 percent of Medicare beneficiaries have access to a managed care option and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care plan.

- Managed care currently costs the Medicare program rather than achieving savings. Evaluations have determined that due to favorable selection, Medicare pays 5.7% more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service.

- CBO has testified that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

REDUCTION IN MEDICARE PAYMENTS TO PROVIDERS

Medicare payments to providers could be reduced in response to the growth cap.

- Because the size of the reductions under a Medicare cap grow each year, the percent reduction in Medicare spending for providers would also need to grow.

- If all the savings come from providers in proportion to their share of Medicare dollars:

  - In 1997, a 10 percent reduction in Medicare spending for hospitals, physicians and all other providers would be needed.

  - In 2002, a 25 percent reduction would be needed.

  - In 2005, a 34 percent reduction would be needed.

REDUCTION IN MEDICARE BENEFITS

Medicare covered services could be reduced or eliminated in response to the growth cap.

- For example, eliminating Medicare home health and hospice services would achieve the savings necessary in 1997 to offset a 5% cap on Medicare growth.

- However, by 2002, eliminating these benefits would achieve only about one-third of the necessary savings because the size of the reduction increases each year.

- In 2002, eliminating all of the following Medicare benefits would be necessary to offset a 5% cap: home health, skilled nursing facility, end-stage renal disease facility, hospice, hospital outpatient department and lab services.

INCREASES IN MEDICARE PREMIUMS

- Federal Medicare spending reductions resulting from a 5% growth cap could be offset by increases in beneficiary premiums.
  - In 1997, a beneficiary premium increase of $532 per year would be needed (about a 90% increase over projected premiums).
  - In 2002, a $2100 per year increase would be needed (about a 230% increase over projected premiums).
  - In 2005, a $3640 per year increase would be needed (about a 290% increase over projected premiums).
- States now pay Medicare premiums and cost sharing for low-income Medicare beneficiaries, and might feel pressure to shoulder at least some of these increases. This would be particularly burdensome for states if federal Medicaid payments were capped, as well.

COST SHIFTING AND BARRIERS TO ACCESS

- Between 1996 and 2002, 5% caps on the growth in Medicaid and Medicare would reduce federal health payments by $504 billion.

- This magnitude of reductions raises questions about how providers would respond, particularly as the number of uninsured and therefore uncompensated care continues to rise. Providers could respond by:

  - Increasing revenues from private patients.
  - Reducing their costs per patient.
  - Treating fewer uninsured, Medicare, or Medicaid patients.

- In the past, hospitals and physicians have been able to recoup shortfalls from Medicare, Medicaid and uncompensated care by charging increasingly higher rates to private payers. For example, as hospital shortfalls have increased from public sources, private hospital payments have grown from 120% of hospitals costs in 1980 to 131% of costs in 1992.

- Recently, it appears that private payers -- particularly large employers -- have intensified their cost containment efforts. These efforts appear to have forced hospitals to rely more heavily on reducing expenses.

- In the future, it is unclear how providers will respond to continued reductions in the growth of public revenues, coupled with increases in uncompensated care.

  - In areas without a strong managed care presence, private payers will likely continue to bear the burden of provider cost shifting. While large groups may be able to exert market power to reduce their cost shifting burden, small groups and individuals will remain vulnerable.

  - Beneficiary access may be jeopardized. To the extent that providers are constrained from cost shifting, they will be forced to reduce expenses and reduce access for the uninsured, and Medicare and Medicaid beneficiaries.

Illustrative Effect of a Medicaid Block Grant & Medicare Capped Expenditures Reduction In Federal Payments Assuming 5% Growth Cap: 1996 - 2002
(Dollars in millions, fiscal years)

	State Baseline Growth at National Rates	State Baseline Growth at State Projected Rates
US	(503,580)	(483,965)
Alabama	(8,133)	(6,063)
Alaska	(580)	5
Arizona	(7,277)	(8,104)
Arkansas	(4,685)	(2,998)
California	(57,053)	(40,952)
Colorado	(4,815)	(2,397)
Connecticut	(7,215)	(7,808)
Delaware	(1,157)	(1,041)
District of Columbia	(3,317)	(3,904)
Florida	(33,170)	(38,990)
Georgia	(11,962)	(13,416)
Hawaii	(1,614)	(1,892)
Idaho	(1,274)	(1,182)
Illinois	(19,844)	(16,830)
Indiana	(10,203)	(4,278)
Iowa	(4,438)	(3,978)
Kansas	(4,179)	(1,845)
Kentucky	(7,170)	(4,213)
Louisiana	(11,983)	(5,300)
Maine	(2,524)	(1,521)
Maryland	(8,325)	(10,306)
Massachusetts	(14,828)	(12,419)
Michigan	(17,817)	(16,082)
Minnesota	(7,826)	(8,654)
Mississippi	(5,291)	(4,585)
Missouri	(10,271)	(8,499)
Montana	(1,343)	(967)
Nebraska	(2,406)	(2,514)
Nevada	(1,915)	(1,334)
New Hampshire	(1,748)	(1,885)
New Jersey	(15,661)	(8,393)
New Mexico	(2,387)	(3,099)
New York	(52,136)	(90,898)
North Carolina	(12,129)	(15,708)
North Dakota	(1,181)	(729)
Ohio	(21,250)	(20,410)
Oklahoma	(5,060)	(3,094)
Oregon	(5,007)	(8,081)
Pennsylvania	(29,070)	(18,736)
Rhode Island	(2,376)	(819)
South Carolina	(6,318)	(2,845)
South Dakota	(1,204)	(1,262)
Tennessee	(12,107)	(9,534)
Texas	(30,141)	(38,289)
Utah	(2,202)	(2,147)
Vermont	(910)	(679)
Virginia	(7,535)	(6,424)
Washington	(8,091)	(8,290)
West Virginia	(4,197)	(2,497)
Wisconsin	(8,143)	(5,958)
Wyoming	(539)	(547)

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.
Assumes that Federal Medicare and Medicaid payments grow at the CBO projected national average growth rates (column 1) or the Medicaid average compound growth rates between FY 1993 (actual data) and states' projected expenditures for each state for FY 1996 (column 2).

Jen-

FYI

-Mark
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DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

April 6, 1995

MEMORANDUM FOR ALICIA H. MUNNELL

FROM: John S. Greenlees

SUBJECT: Medicare and Medicaid Charts

Attached are several draft charts demonstrating the effects of Medicaid and Medicare growth caps. The charts include three in the form we discussed earlier this week, as well as other improved (we think) versions.

Discussion

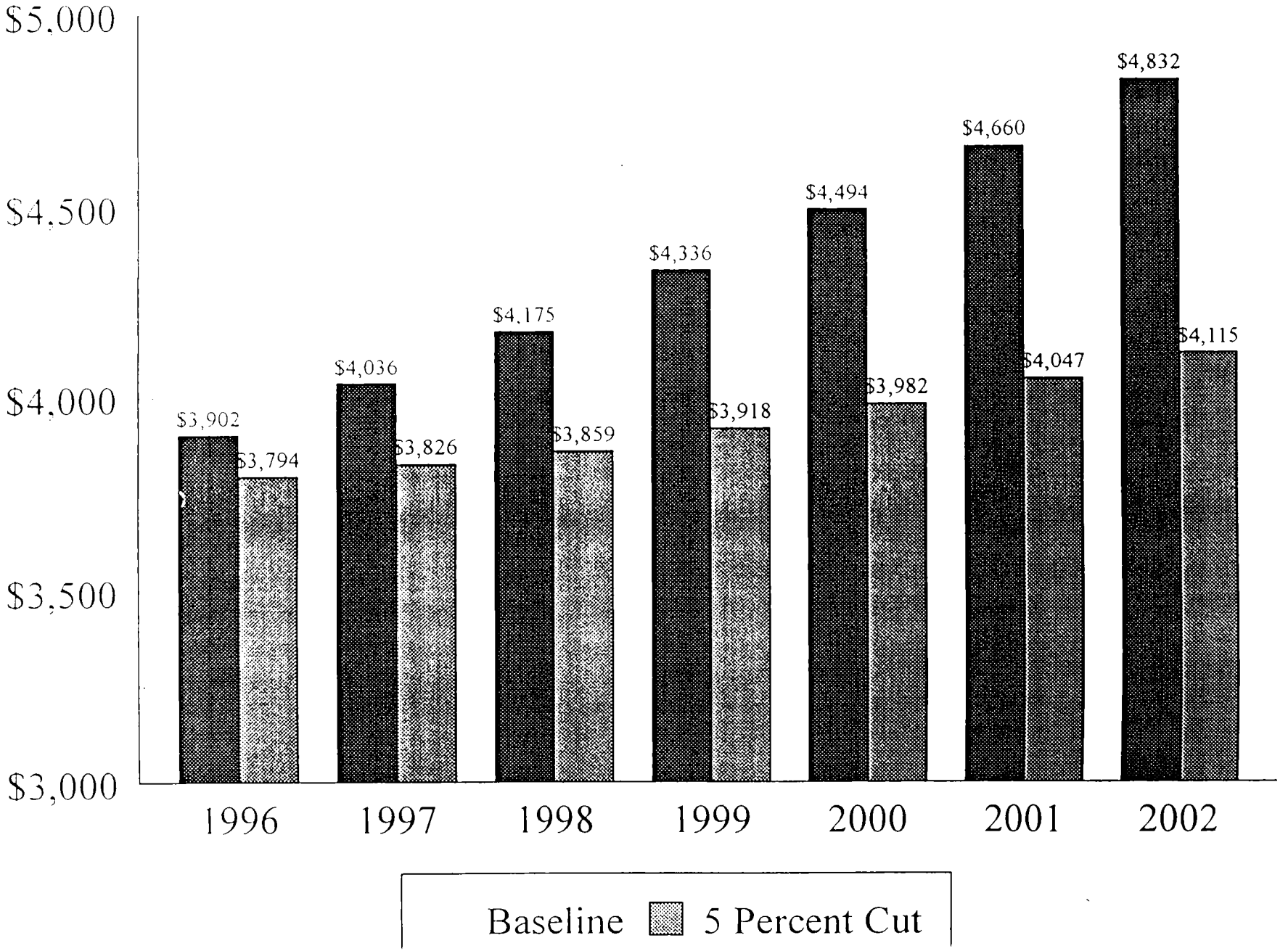
The attached charts demonstrate the effects of imposing caps on the growth rates of federal Medicaid and Medicare spending through FY 2002. For the Medicaid charts (prepared by Mike Compson), the baseline Medicaid spending is based on data from a recent Urban Institute report, and we compare that baseline to a 5 percent growth path. The Medicare charts (prepared by Jim Duggan) contrast baseline spending, estimated from the 1995 Trustees' reports, to a 7 percent growth path. We assume that the required cuts would be prorated across program components (e.g., Medicaid beneficiary categories).

The first three charts are in the form we discussed earlier this week. The first chart shows annual baseline and capped total (i.e., federal plus state) real Medicaid spending per beneficiary. Even with federal spending capped at 5 percent, real total per-beneficiary spending would increase slowly, assuming that state spending remained on its baseline path. The second and third charts show, for an illustrative beneficiary category (the elderly) the baseline and capped values in FY 2002. The charts reflect mutually exclusive means of achieving the cap: either cutting beneficiaries or cutting spending per beneficiary. Unfortunately, under our *pro rata* assumptions all such charts would look the same, because in every case the cut would have to be about 15 percent.

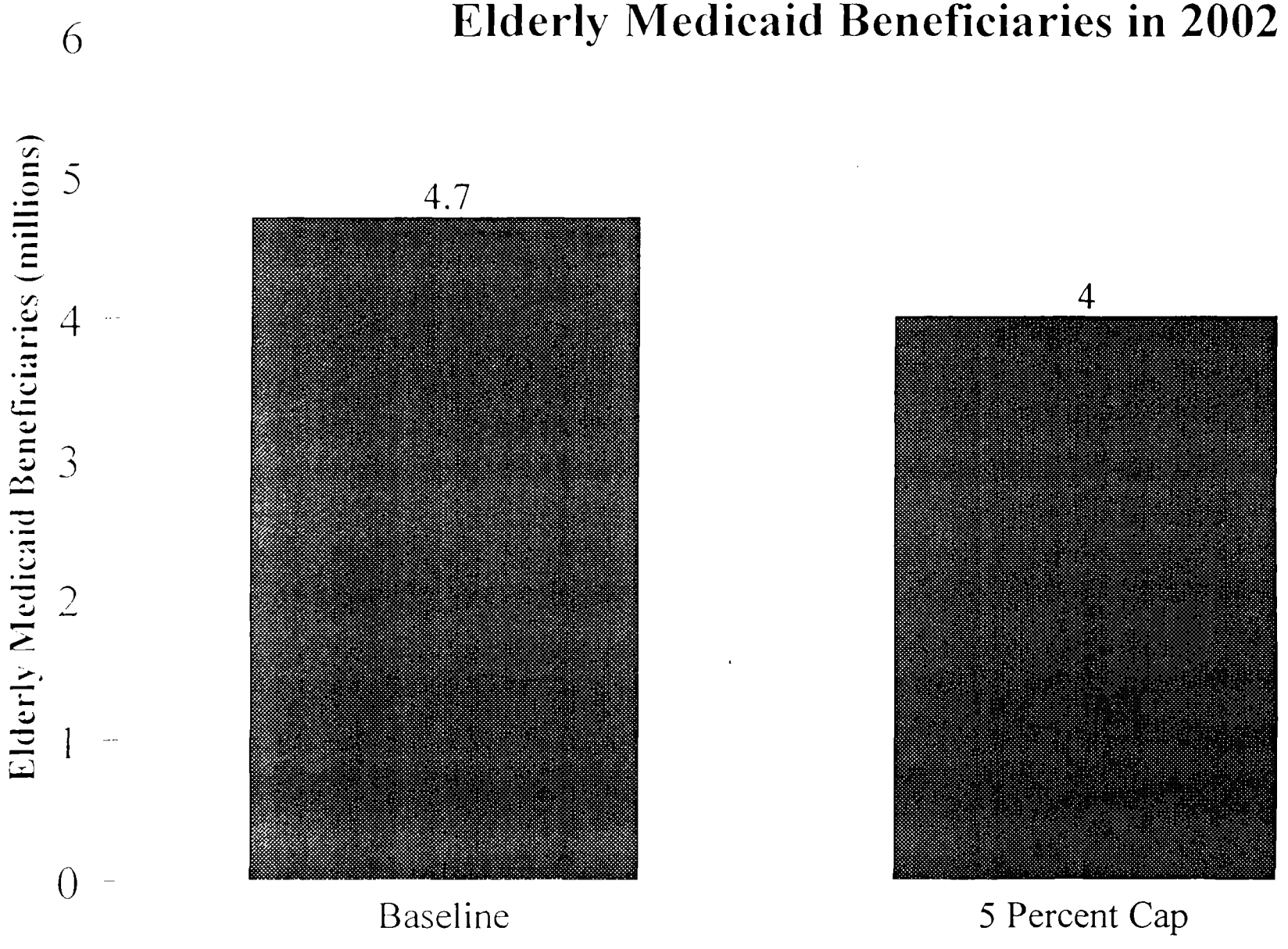
We therefore include six alternative charts. For Medicaid, we first show annual real *federal* spending per beneficiary, which does in fact decline under the cap. A parallel chart for Medicare still shows an increase under the 7 percent cap. We then combine on one chart the Medicaid beneficiary cuts for several beneficiary groups, and repeat this in the next chart for spending per beneficiary. Finally, we have two additional Medicare charts for FY 2002. One shows baseline and capped real spending per enrollee, and the other demonstrates the increase in Part B premiums required to offset the SMI spending cuts. (For this purpose, we assumed that total Medicare spending increases at 7 percent, and HI and SMI cut in proportion to achieve that constraint.)

Please let us know how we should proceed from here.

Medicaid Payments Per Beneficiary (1995 $)

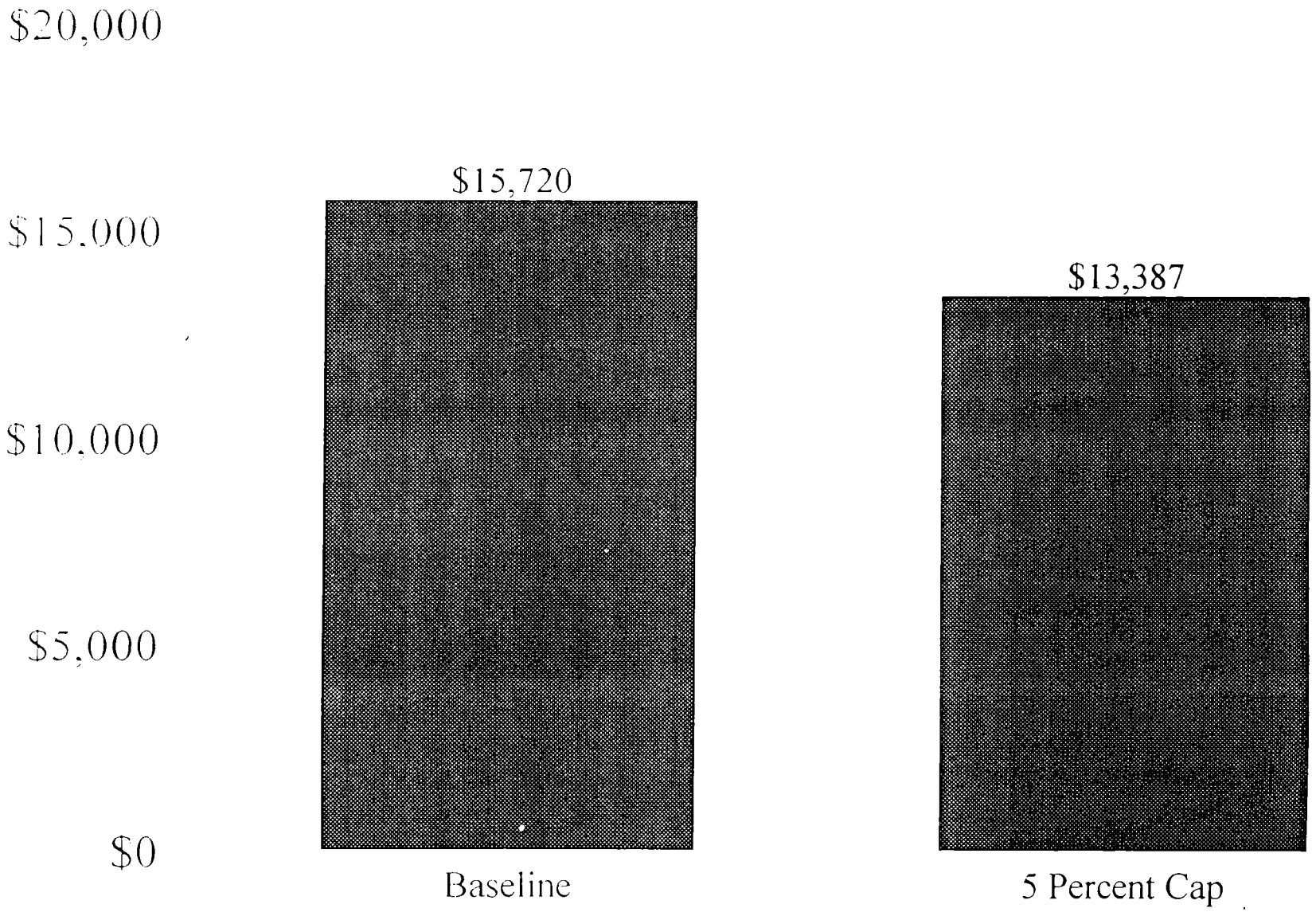


Approximately 700,000 Fewer Elderly Medicaid Beneficiaries in 2002



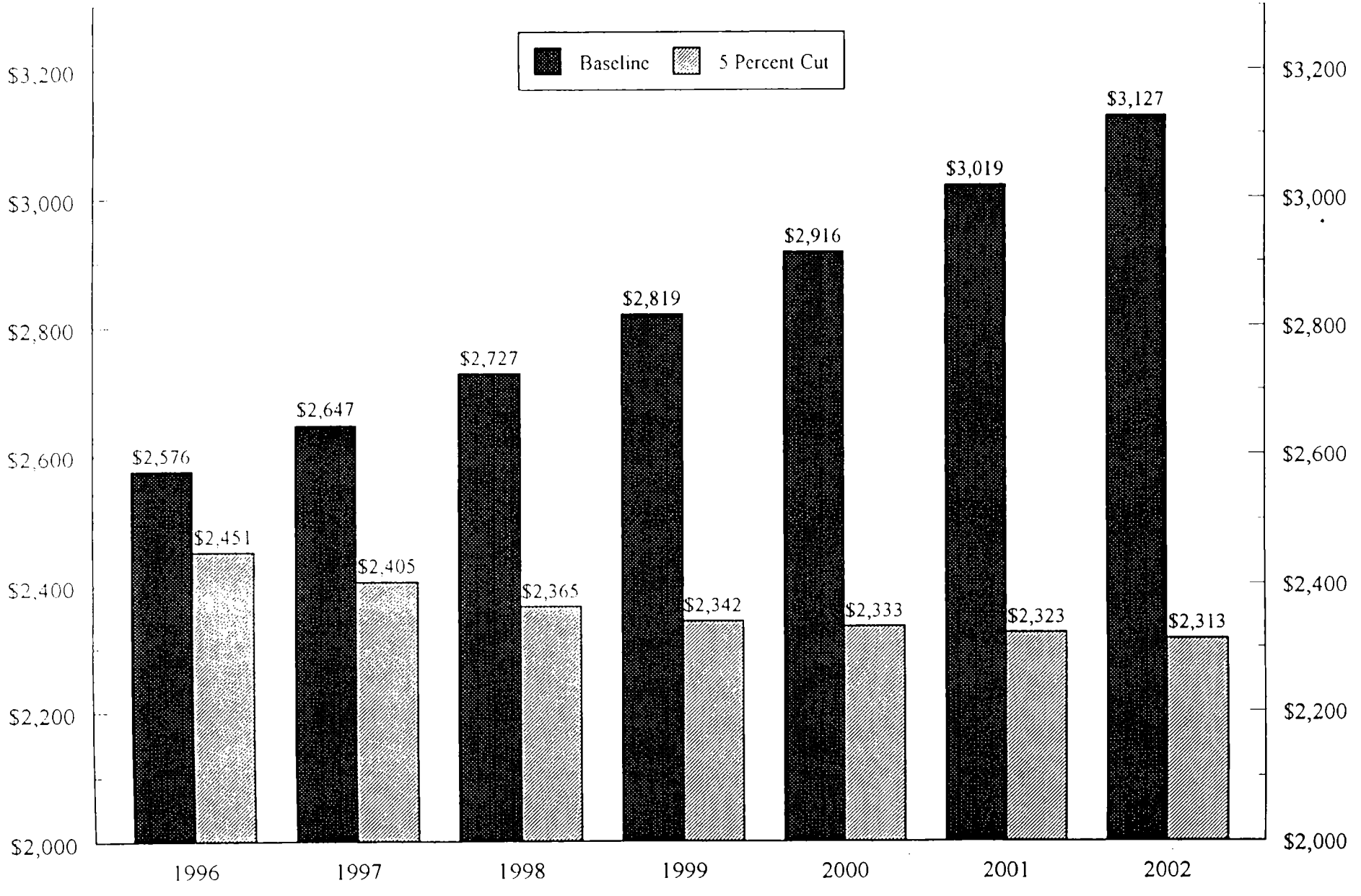
See attachment for methodological details.

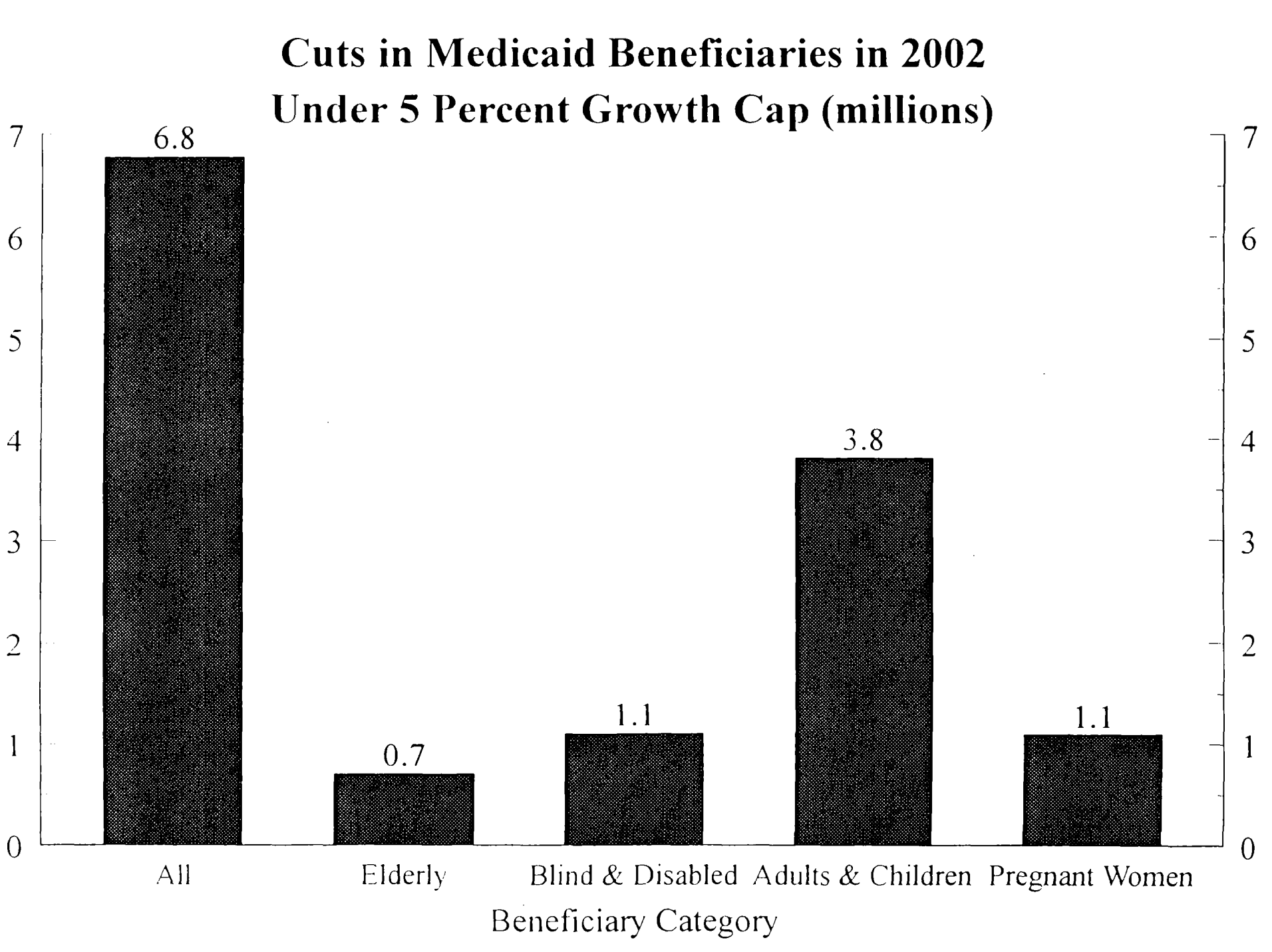
Almost $2,400 less in Benefits Per Elderly Medicaid Beneficiary in 2002



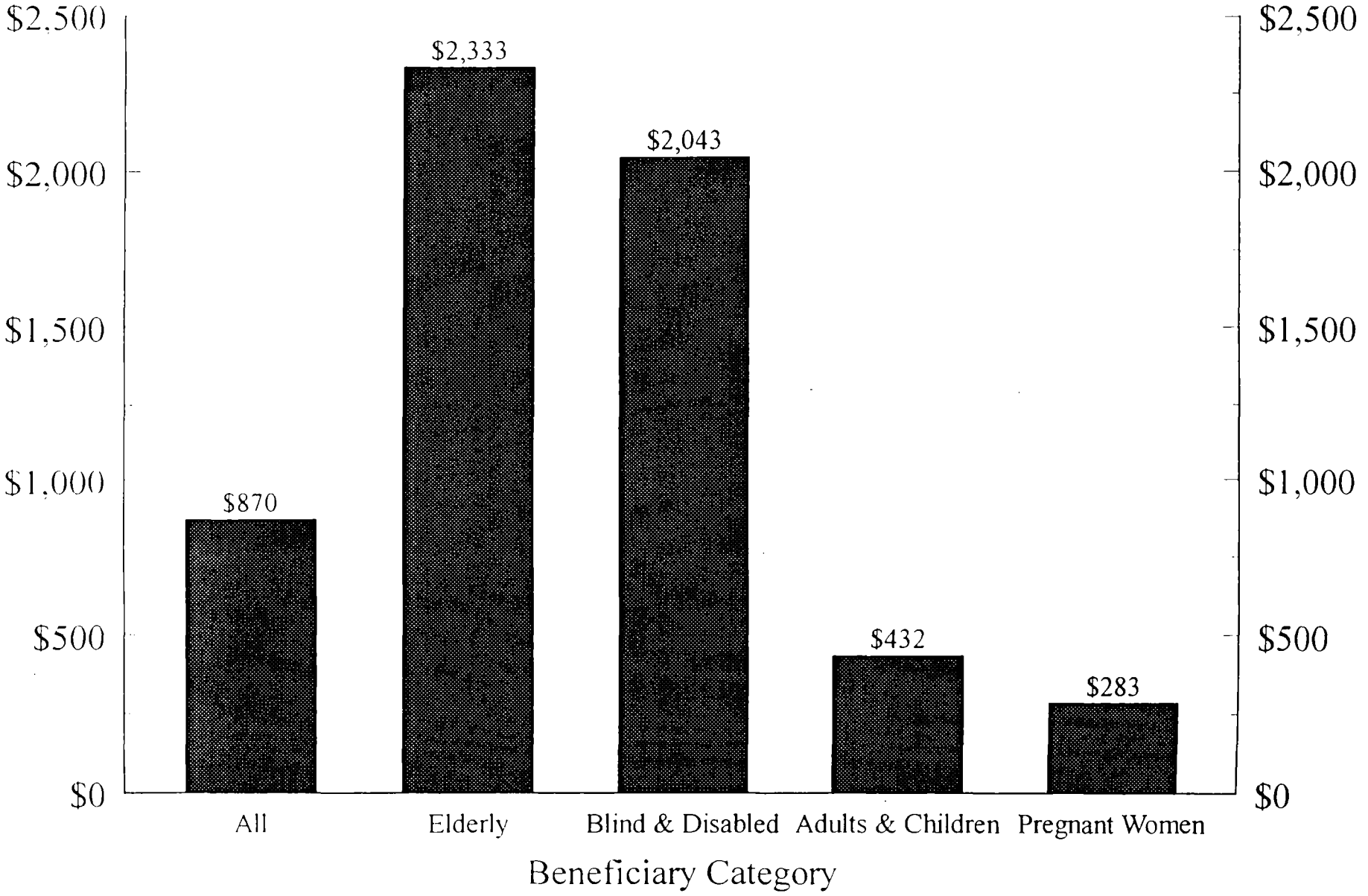
See attachment for methodological details.

Federal Medicaid Payments Per Beneficiary
(Constant 1995 $)

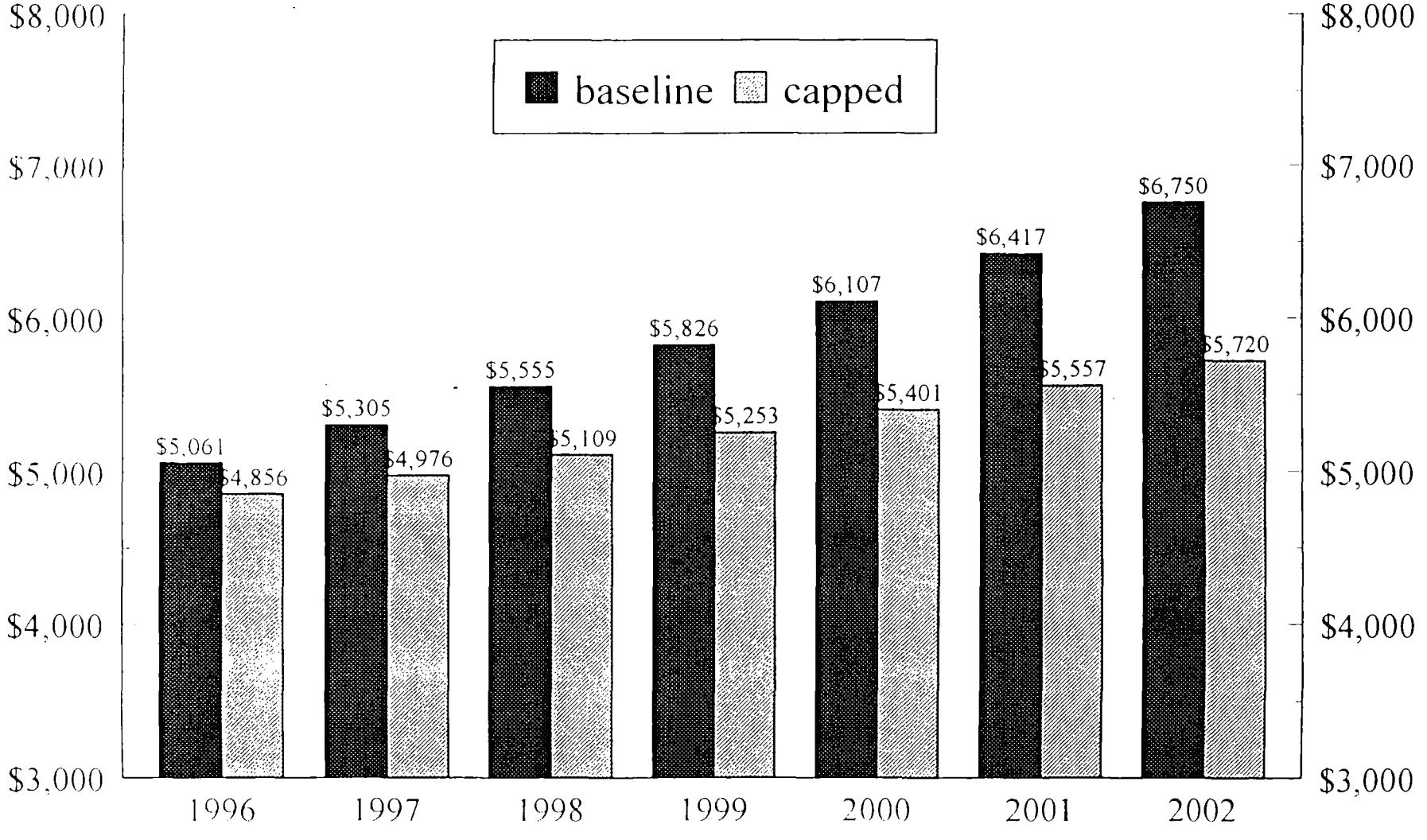



Cuts in Medicaid Beneficiaries in 2002
Under 5 Percent Growth Cap (millions)
7
6
5
4
3
2
1
0
6.8
0.7
1.1
3.8
1.1
All
Elderly
Blind & Disabled
Adults & Children
Pregnant Women
Beneficiary Category

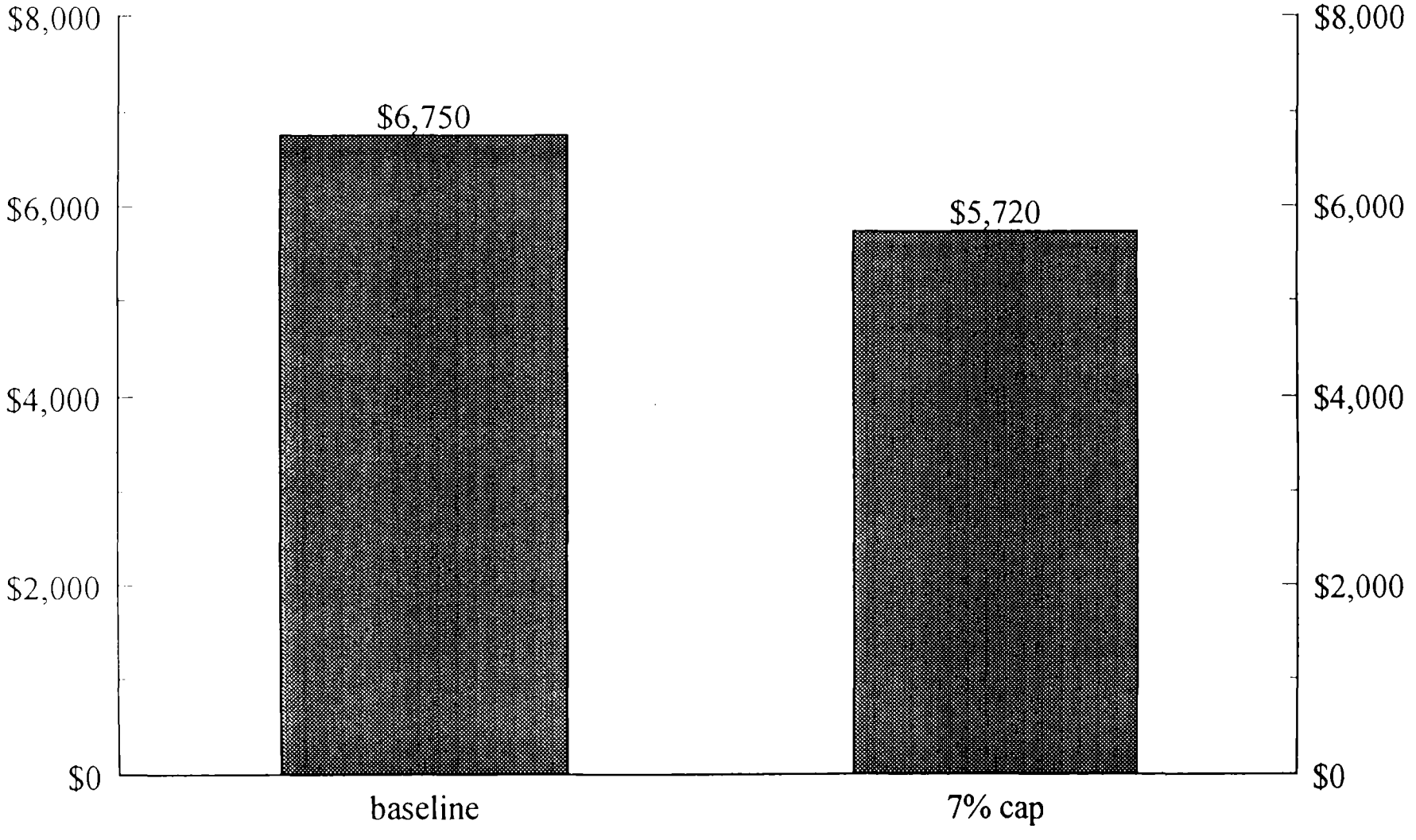
Cut in Benefits Per Medicaid Beneficiary in 2002 Under 5 Percent Growth Cap



Constant Dollar Medicare Expenditures Per Enrollee
Baseline Projections and 7% Cap



Real Per Enrollee Medicare Expenditures in 2002 Under Baseline Projections and 7% Cap



Annual Per Enrollee Part B Premiums in 2002 Under Baseline Projections and 7% Cap