PRESIDENT WILLIAM J. CLINTON
TALKING POINTS FOR HEALTH CARE CONFERENCE CALL
NOVEMBER 13, 1995

OPENING REMARKS:

- I'd like to thank you for joining me on this conference call to talk about the impact of the Republican Medicare and Medicaid cuts. I am so sorry that I was not able to come to Lawrence Memorial Hospital today, but I know that you understand.

- This is a critical moment of decision for our country. The issue is not *whether* we will balance the budget, but how. I do want to balance the budget. My balanced budget proposal would eliminate the deficit and reinforce our most important values: by meeting our obligations to our parents and children, and by giving all Americans the opportunity to make the most of their own lives. My proposal would secure the Medicare Trust Fund, while strengthening -- not gutting -- our Medicare program.

- The Republicans have made their intentions clear since last spring. They said then that they would force us to accept their extreme budget or risk shutting down the government and pushing America into default. Now they are implementing that strategy by attaching their budget conditions to legislation needed to keep the government running and able to pay its bills.

  -- The bill I vetoed today would, in effect, obligate us to pass the Republican congressional budget plan with its huge cuts in Medicare and Medicaid, education and technology, the environment, and with its tax increases on working families.

  -- In the bill to keep the government running, they would raise Medicare premiums by 25% for every single older American who uses Medicare -- $264 a year for the typical couple, beginning January 1. I have made it clear: I want to work with the Republicans, but not if they continue to insist on raising Medicare premiums as the cost of keeping the government running.

- This is a back-door effort on the part of the congressional Republicans to impose their priorities on the American people. It's not the right thing to do. I cannot, and I will not, accept it.

- As you know, I believe that the Republican budget -- by taking $440 billion out of Medicare and Medicaid -- would have particularly harmful consequences for our health care system. These cuts will mean that over 8 million Americans could lose Medicaid coverage, and that people on Medicare will be forced to pay more. They will threaten hospitals and nursing homes in both rural and urban areas. And they will have devastating effects on the communities that depend on these institutions.

- I'd now like to hear from you about how these budget cuts will affect you and your communities. (See attached list of participants.)

CONFERENCE CALL PARTICIPANTS

1. **Charles Johnson**, President, Lawrence Memorial Hospital
Medford, MA

TOPIC: Overall impact of cuts on his hospital and community.

2. **Philo ("Fi-lo") Hall**, President, Central Vermont Medical Center
Berlin, VT

TOPIC: Impact of cuts on vulnerable rural hospitals and the communities that depend on them.

3. **Barbara Corey**, Coordinator, North Quabbin Community Coalition (Senior Activist)
Petersham, MA

TOPIC: Impact of cuts on low-income elderly and on future generations who will need Medicare and Medicaid.

4. **Alan Solomont**, President, The ADS Group (Nursing Homes)
Andover, MA

TOPIC: Impact of Medicaid cuts on nursing home employees.

5. **Donald ("Don") McDowell**, President, Maine Medical Center
Portland, ME

TOPIC: Impact of cuts on hospitals that are already struggling to adapt to managed care.

6. **Leslie MacLeod**, President, Huggins Hospital
Wolfeboro, NH

TOPIC: The importance of Medicare for our nation's older Americans.

7. **Dr. Mitchell Rabkin**, President, Beth Israel Hospital
Boston, MA

TOPIC: Impact of Medicare cuts on medical education and impact of disproportionate share payment cuts on hospitals.

CLOSING REMARKS:

- Thank you all very much. What we've heard shows how important it is that we save Medicare and Medicaid. What is at stake here is nothing less than the quality of our health care system, and the well-being and security of American families and communities.

(3) Corey - cuts will cause suffering. Stand strong ag. Republican bullies. Local hospital will surely close. POTUS - people haven't grasped that older people have a decent life on Soc. Sec. & modest incomes bec. of Medicare. And their children. We don't have to do this. Creative people, not in govt, are ~~trying~~ finding ways to cut costs. Middle class issue.

PRESIDENT WILLIAM J. CLINTON
TALKING POINTS FOR HEALTH CARE CONFERENCE CALL
NOVEMBER 13, 1995

OPENING REMARKS:

- I'd like to thank you for joining me on this conference call to talk about the impact of the Republican Medicare and Medicaid cuts. I am so sorry that I was not able to come to Lawrence Memorial Hospital today, but I know that you understand.

- This is a critical moment of decision for our country. The issue is not *whether* we will balance the budget, but how. I do want to balance the budget. My balanced budget proposal would eliminate the deficit and reinforce our most important values: by meeting our obligations to our parents and children, and by giving all Americans the opportunity to make the most of their own lives. My proposal would secure the Medicare Trust Fund, while strengthening -- not gutting -- our Medicare program.

- The Republicans have made their intentions clear since last spring. They said then that they would force us to accept their extreme budget or risk shutting down the government and pushing America into default. Now they are implementing that strategy by attaching their budget conditions to legislation needed to keep the government running and able to pay its bills.

(4) Solomont - Medicaid cuts - real losers are middle-class families and lower-inc. workers. Part of generation that has more parents than children. 7 out of 10 depend on Medicaid. $170 B cuts will mean nursing homes will become warehouses. 95% of nursing home employees are women - new Ams, single parents, formerly on welfare. POTUS - Comb. of Medicaid investments & cuts. Fastest growing group of Americans are over 80. Both say we want to move people from welfare to work -- you're

(1) Johnson
POTUS comments -- Medicare
Lower admin costs.
Per person rate = inflation
More choices but preserve traditional program.

The bill I vetoed today would, in effect, obligate us to pass the Republican congressional budget plan with its huge cuts in Medicare and Medicaid, education and technology, the environment, and with its tax increases on working families.

(2) Hall
Vt
Employ 75% of physicians?
Infrastructure not in place to move to man. care.
POTUS - If move too far too fast, hospitals will close, or will have to cost shift onto priv. -- exacerbate problem that already exists.
1 million / yr losing coverage.
Trying to get small bus. & indiv. into pools.
Smaller % of people w/ insurance than 10 yrs ago.

In the bill to keep the government running, they would raise Medicare premiums by 25% for every single older American who uses Medicare -- $264 a year for the typical couple, beginning January 1. I have made it clear: I want to work with the Republicans, but not if they continue to insist on raising Medicare premiums as the cost of keeping the government running.

This is a back-door effort on the part of the congressional Republicans to impose their priorities on the American people. It's not the right thing to do. I cannot, and I will not, accept it.

As you know, I believe that the Republican budget -- by taking $440 billion out of Medicare and Medicaid -- would have particularly harmful consequences for our health care system. These cuts will mean that over 8 million Americans could lose Medicaid coverage, and that people on Medicare will be forced to pay more. They will threaten hospitals and nursing homes in both rural and urban areas. And they will have devastating effects on the communities that depend on these institutions.

I'd now like to hear from you about how these budget cuts will affect you and your communities. (See attached list of participants.)

doing what we need to do. Jobs in the caring professions. Their numbers pulled out of thin air | unrealistic economic assumptions.

CONFERENCE CALL PARTICIPANTS

(5) MidDowell
① Access
② Structure
③ Education
1/2 of hospitals have ~~not~~ less than 40 beds
Need freedom to Δ HC delivery | compete in managed care. Need antitrust relief.

1. **Charles Johnson**, President, Lawrence Memorial Hospital
Medford, MA

TOPIC: Overall impact of cuts on his hospital and community.

2. **Philo ("Fi-lo") Hall**, President, Central Vermont Medical Center
Berlin, VT

TOPIC: Impact of cuts on vulnerable rural hospitals and the communities that depend on them.

3. **Barbara Corey**, Coordinator, North Quabbin Community Coalition (Senior Activist)
Petersham, MA

TOPIC: Impact of cuts on low-income elderly and on future generations who will need Medicare and Medicaid.

* POTUS — 1 area where we can reach agreement w| Congress. Setting up networks -- can get good legislation

4. **Alan Solomont**, President, The ADS Group (Nursing Homes)
Andover, MA

TOPIC: Impact of Medicaid cuts on nursing home employees.

Also, drs did not stay in rural areas w|out adequate support. No rural doctors think we have too many doctors

5. **Donald ("Don") McDowell**, President, Maine Medical Center
Portland, ME

TOPIC: Impact of cuts on hospitals that are already struggling to adapt to managed care.

(6) MacLeod
- Medicare reduction = $300 million
- Part of community infrastructure as well as primary source of health care.

More gradual approach than simply cutting budgets.

6. **Leslie MacLeod**, President, Huggins Hospital
Wolfeboro, NH

TOPIC: The importance of Medicare for our nation's older Americans.

7. **Dr. Mitchell Rabkin**, President, Beth Israel Hospital
Boston, MA

TOPIC: Impact of Medicare cuts on medical education and impact of disproportionate share payment cuts on hospitals.

(7) Rabkin
House - does set up set aside for medical education
Thank POTUS for his position on these issues.
POTUS - most Ams, don't know about $ that goes to medical schools under Medicare.
Grave error to put highest qual. hc | teaching | best training at risk.

POTUS
2 observations
- Seniors are willing to do part, but don't want to be asked to jump off a cliff
- Comments from Maine, NH, Vermont - Yankee frugality is still imp. - but agreed that we need to live by basic values. Bringing down size of govt — but higher productivity. That's how we need to handle HC.

Cost issues - Providers need to bear resp. Seniors being asked to step up. Built country from bottom up. We owe them a huge debt of gratitude. Medicare K wasn't really a K.

CLOSING REMARKS:

- Thank you all very much. What we've heard shows how important it is that we save Medicare and Medicaid. What is at stake here is nothing less than the quality of our health care system, and the well-being and security of American families and communities.

THE WHITE HOUSE

WASHINGTON

November 10, 1995

NEW ENGLAND HEALTHCARE CONFERENCE CALL

DATE: Monday, November 13, 1995
TIME: 1:00 PM
LOCATION: Oval Office
FROM: Alexis Herman
Marilyn Yager

I. PURPOSE

To highlight the impact of the Republican Medicare and Medicaid cuts on New England providers, their patients, and communities.

II. BACKGROUND

MEDICARE AND MEDICAID

The House and Senate Budget bills cut Medicare by $270 -- three times larger than any Medicare cut in history. The most obvious impact will be on beneficiaries, who will be forced to pay more and may be forced to join managed care plans, and on providers who will be expected to maintain quality with far lower reimbursements. Private health care premiums may also be increased by cost-shifting.

The House and Senate bills eliminate the Medicaid program and replace it with a block grant. They cut Federal spending by $170 billion, an amount at least ten times more than any Medicaid cut in history. The Medicaid cuts will force states to eliminate coverage for over 8 million Americas, including: over 4 million children, about 900,000 elderly, and over 1 million people with disabilities.

Additional information, with specific impact numbers for the New England states, is attached.

Please note that Charlie Johnson, the President of Lawrence Memorial Hospital in Medford, Massachusetts, will be participating on the call. Mr. Johnson and Lawrence Memorial had been hosting the Boston roundtable discussion before it was cancelled.

III. PARTICIPANTS

Conference Call Participants

1. Charles Johnson, President, Lawrence Memorial Hospital Medford, MA

2. Philo ("Filo")Hall, President, Central Vermont Medical Center, Berlin, VT

3. Barbara Corey, Coordinator, North Quabbin Community Coalition, Petersham, MA (Senior Activist)

4. Alan Solomont, President, The ADS Group (Nursing Homes) Andover, MA

5. Donald McDowell, President, Maine Medical Center Portland, ME

6. Leslie MacLeod, President, Huggins Hospital Wolfeboro, NH

7. Mitchell Rabkin, M.D., President, Beth Israel Hospital Boston, MA

** Background information on each participant is attached.**

IV. SEQUENCE OF EVENTS

- You will open the conference call with a brief statement.

- You will call on each participant to briefly comment. Each participant is prepared (under 2 minutes) to highlight their most critical concerns about the impact of the Medicare and Medicaid cuts in Congress.

- You will have the opportunity to ask follow-up questions and to make additional comments.

V. MEDIA

Wire stills photo and audio only. Each participant will be doing additional press with their local media following the call.

VI. REMARKS

Provided by Communications.

ROUNDTABLE PARTICIPANTS

CHARLES JOHNSON (was hosting the cancelled event)
President, Lawrence Memorial Hospital
Medford, MA

BACKGROUND: Lawrence Memorial is a typical urban community hospital which provides a continuum of services, i.e. acute care, outpatient, surgery, and rehabilitation. With a nursing school and an affiliation with Tufts Medical School, Lawrence has strong concerns about Medicare reductions in medical education payments. Lawrence Memorial is heavily dependent on Medicare revenue with a growing elderly population in their surrounding communities.

FOCUS: Mr. Johnson will focus his comments on the overall impact of deep Medicare cuts on their facility and the resulting impact on their community.

****

BARBARA COREY (68 years old)
Coordinator, North Quabbin Community Coalition
Petersham, MA

BACKGROUND: Mrs. Corey has served as the coordinator of the North Quabbin Community Coalition for over eleven years. The North Quabbin Community Coalition addresses quality of life issues for individuals of all ages in the nine communities that surround the Quabbin Reservoir in Central Massachusetts.

FOCUS: Mrs. Corey's comments will focus on the impact of the Medicare and Medicaid cuts on already vulnerable low-income elderly. She believes these cuts will affect the quality of care in hospitals and nursing homes. As a grandmother, she is also concerned about the future of Medicare for her children and grandchildren and believes these cuts will weaken the program.

****

PHILO ("Filo") HALL
President, Central Vermont Medical Center
Berlin, VT

BACKGROUND: Central Vermont Medical Center is a regional hospital that serves 26 rural communities in central Vermont. The Medical Center includes an 122 bed hospital, an 153 bed nursing home, and a physician practice corporation. To attract and retain physicians in this highly underserved area, the hospital was asked by the state to set up a corporation to employ the physicians. The hospital has a revenue base of 44% Medicare, 11% Medicaid, 16% Blue Cross/Blue Shield, and the rest is a combination of self-pay and charity care.

FOCUS: Mr. Hall will focus his comments on the impact of these cuts on highly vulnerable rural hospitals like his own, who have zero reserves and few private pay patients, denying them the ability to cost-shift. Access to health care for 26 communities will be the first casualty if they are forced to close under the burden of these type of cuts.

****

ALAN SOLOMONT
President, The ADS Group (Nursing Homes)
Andover, MA

BACKGROUND: The ADS Group owns and operates 37 nursing homes in Massachusetts. Mr. Solomont has been an active local and national voice on long term care issues.

FOCUS: Mr. Solomont will focus on the assault on employees if these Medicaid cuts proceed. Most nursing home employees are low-income women, many are former welfare recipients, and many are immigrants. In recent years, nursing homes have tried to raise wages and benefits to improve the skills of their workforce, but cutbacks will imperil these efforts.

****

LESLIE MACLEOD
President, Huggins Hospital
Wolfeboro, NH

BACKGROUND: Huggins Hospital is rural regional medical center in a resort area of north-central New Hampshire. With a large retirement community, Huggins has a large Medicare patient revenue base. Along with the school system, Huggins is also the largest employer and its survival is viewed as key to attracting and retaining local businesses.

FOCUS: Mr. MacLeod plans to focus his comments on the Medicare commitment to our nation's seniors, and the insecurity these cuts would create for seniors. He plans to also comment on the economic impact these Medicare and Medicaid cuts will have on the whole community, not just the hospital.

****

DON MCDOWELL
President, Maine Medical Center
Portland, ME

BACKGROUND: The Maine Medical Center is the only medical school in Maine and serves the tertiary care center for the state. Flexibility in the antitrust regulations are especially important in states like Maine, where their ability to integrate hospitals and services will be key to their survival. The Maine Medical Center is 45% Medicare, 12% Medicaid, 6% free care, and the rest private pay or self pay.

FOCUS: Mr. McDowell will focus the impact of the cuts on hospitals at a time when they are already struggling to make the necessary changes to compete in a managed care environment. Maine hospitals are no longer competing with each other, but instead seeking ways to work together in a whole health care system for the state.

****

MITCHELL RABKIN, M.D.
President, Beth Israel Hospital
Boston, MA

BACKGROUND: Dr. Rabkin has been the President of Beth Israel Hospital for over 28 years and is viewed as a national expert on medical education issues. Beth Israel is a major teaching hospital affiliated with Harvard Medical School. In 1994, Dr. Rabkin hosted a small discussion for the President on medical education issues, which was followed by strong statements on behalf of the Health Security Act by Dr. Rabkin.

FOCUS: Dr. Rabkin's comments will focus on the impact of Medicare cuts to medical education and disproportionate share payments to hospitals.

****

NATIONAL MEDICARE AND MEDICAID INFORMATION

FACTS ON THE REPUBLICAN HEALTH CARE PROPOSALS

November 6, 1995

MEDICAID

1. Spending

- Under both the House and the Senate reconciliation bills, Medicaid spending will be cut by about $170 billion over seven years.

- Medicaid spending per person will grow at less than 2% per year. By comparison, the projected growth rate in private sector health expenditures is 7.1% per year.

2. Coverage

- **More than 8 million people could be denied Medicaid coverage.** The Department of Health and Human Services estimates that states will be forced to deny coverage for more than 8 million people in 2002, including:

    - Over 4 million children
    - Approximately 900,000 older Americans
    - Over one million individuals with disabilities

  About 2 million of the more than 8 million people denied coverage live in rural America.

3. Individuals with Disabilities

- More than 6 million people with disabilities are now served by Medicaid, including about 1 million children.

- Over one million individuals with disabilities could lose Medicaid coverage in 2002 under the Republican plans. Losing Medicaid would be particularly devastating to people with disabilities because they are often shut out of the private health insurance market.

- Republican Medicaid plans threaten nursing home quality standards and entirely repeal quality standards for intermediate care facilities for the mentally retarded. Not that long ago, most people with mental retardation were relegated to large institutions with substandard conditions. Federal standards have greatly improved conditions in institutions, but the House Republican plan repeals federal nursing home quality standards, and both plans repeal the federal standards for institutions caring for people with mental retardation and developmental disabilities. Neither requires states to issue standards to assure even the most basic rights.

4. Republican Budget Jeopardizes Fundamental Protections for Nursing Home Residents

- Under the guise of reform, the House Republican budget throws away decades of progress by repealing federal nursing home quality standards. Without these federal standards and enforcement, nursing home residents will be vulnerable to abuse and neglect, to being inappropriately restrained, and dumped onto the streets when they run out of money.
    - Since enactment of the federal quality standards, nursing home quality has improved dramatically: the use of physical restraints has declined 25%, dehydration among residents has declined 50%, and hospitalization rates have declined 31%. (Source: Research Triangle Institute and HCFA.)
- In response to criticism, Senate Republicans reinstated the federal standards, but allow states with "equivalent or stricter" standards and enforcement to receive Medicaid waivers. Yet the federal government would have *no way to ensure that states enforce these standards.*
    - Most recently, *federal surveyors found 14% of nursing homes out of compliance with the federal standards.* (Source: HCFA.) And states would have to enforce the standards with much less Medicaid funding than they receive under current law.
- Moreover, both House and Senate plans repeal the requirement that Medicaid cover nursing home care at all. Their cuts will force states to deny coverage to hundreds of thousands of nursing home residents by 2002.

5. Spousal Impoverishment

- Current law ensures that spouses of people needing nursing home care do not have to become impoverished in order to have their spouses qualify for Medicaid.
- Although Republicans claim that they maintain these protections, their proposals undercut them by removing tools for individuals or the federal government to enforce these rights.
    - House and Senate bills make it more difficult for the Federal government to ensure that states are complying with the protection requirements.
    - Under the House bill, eligible individuals who are not receiving the spousal impoverishment protections can no longer sue the State to obtain these protections.

6. Poor Elderly

- Under current law, Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100 percent of poverty (known as "qualified Medicare beneficiaries" (QMBs)). The House and Senate bills completely eliminate coverage of coinsurance and deductibles for QMBs, and set aside only 44% of the money needed to cover premiums in 2002.

    - The House and Senate bills completely eliminate:

        - the requirement that Medicaid pay Medicare coinsurance and deductibles for people below 100 percent of poverty; and

        - the requirement that Medicaid pay Medicare premiums for people between 100-120 percent of poverty.

    - The House and Senate bills set-aside for a portion of the MediGrant funding for Medicare *premiums* equal to 90% of the average spending on premiums between 1993 and 1995. But the set-aside is estimated to cover only 44 percent of the amount projected to be spent on Medicare *premiums* ($8.5 billion) for people in the QMB program in 2002. [This estimated spending includes the impact of the Republican's increase in Part B premiums.]

MEDICARE

1. **Spending**

- **Medicare will be cut $270 billion over seven years -- three times greater than any cut in history.**

- **Spending per person will be cut more than $1,700 per beneficiary below projected spending in 2002.**

  - Medicare currently spends $4,800 on each beneficiary. Because of the increasing cost of medical services, the Congressional Budget Office projects that, under current law, spending per beneficiary will be $8,400 per beneficiary in 2002.

  - In order to achieve their goal of $270 billion in savings, the Republican Medicare proposal limits spending to $6,700 per beneficiary in the year 2002 -- $1,700 below CBO's projection for spending per person under current law.

  - Put another way, the Republican proposal assumes a growth rate of approximately 5.1% a year, 30% below the private sector rate of 7.1% per beneficiary.

2. **Increased Out-Of-Pocket Costs for Beneficiaries**

- **Premiums will increase from $43 to $89.**

  - Under the Republican plan beneficiaries will pay 31.5% of Part B program costs. In contrast, the President's balanced budget maintains premiums at 25% of program costs.

  - Given the level of Medicare spending assumed in the Republican plan, their proposal translates into a premium of approximately $89 per month in 2002.

  - If premiums were set at a level that paid for 25% of the Part B expenditures projected under the Republican plan -- the percentage that applied historically and applies under the President's proposal -- premiums would rise to only $69 per month in 2002. As a result, premiums under Republican proposals would be, on an annual basis, $240 more in 2002 than if they were maintained at 25%.

- **Double deductibles.** The Senate Republican plan doubles deductibles from $100 a year today to $210 a year in 2002.

- **Limited protections from doctors overcharging.**

  - Under current law, Medicare limits the amount that a doctor can charge a Medicare patient above the Medicare payment rate.

  - This limitation on so-called "balance billing" protects beneficiaries from paying additional charges for medical services.

  - The Republican proposal does not extend the balance billing protections to the new physician networks that their proposal establishes outside the traditional fee-for-service system.

3. Cost-Shifting

- Lewin-VHI, an independent research firm, concluded that the Republican's $452 billion cut in Medicare and Medicaid will lead doctors and hospitals to raise their fees on private patients by at least $90 billion.

- This cost shifting will increase the cost of private health insurance, which would effectively reduce wage increases by 2.7%, and as much as 10% for lower-wage workers.

4. Managed Care

- Republican plans state that managed care programs will save $30 to $50 billion over seven years. The Congressional Budget Office, however, does not score savings from managed care.

- As a result, Republicans rely on a non-market-oriented mechanism for ensuring these savings -- a government imposed cap on spending that limits the growth rate for Medicare payments to managed care programs to a level that is 30% below private sector rates.

- If health care costs exceed these caps, beneficiaries will either get fewer benefits or be forced to pay higher premiums.

5. Medical Savings Accounts (MSAs)

- Republican Medicare proposals allow beneficiaries to withdraw a set amount of money from the Medicare program to buy health care insurance with a high-deductible. The individual may deposit any money left over after that purchase into a tax-preferred savings account.

- MSAs tend to attract only the healthiest individuals, who expect few medical expenses in the coming year and who typically cost the Medicare system little.

- To the extent that MSA vouchers are set at a level that exceeds the cost of these healthy beneficiaries under the current Medicare system, MSAs will increase spending on healthy beneficiaries. In fact, CBO estimates that MSAs will raise Medicare costs by $2.3 billion over seven years. Lewin-VHI concludes that MSAs will cost the Medicare system between $15 and $20 billion.

- Since the Republican spending caps mandate a fixed budget for all Medicare spending, MSA costs would have to be offset by further cuts in services for the less healthy beneficiaries remaining in the traditional fee-for-service Medicare pool.

REPUBLICAN MEDICAID BLOCK GRANTS

- The House and Senate-passed bills eliminate the Medicaid program and replace it with a new block grant. They cut Federal spending on the program by $170 billion, an amount at least 10 times more than any Medicaid cut ever enacted.

- The $170 billion cut would reduce Federal support for the Medicaid program and the 36 million Americans it serves, by nearly 20 percent between 1996 and 2002. By 2002, the cut will amount to a 29 percent reduction below the baseline in Federal support to States.

- The Republicans claim they would like the public sector health programs to grow at rates similar to the private sector. However, the unprecedented $170 billion cut advocated by the Congressional Majority translates into a per recipient growth rate of less than 2 percent over the 1996-2002 budget window. The 2 percent per capita growth rate their plan provides is 70 percent below the per person private health insurance growth rate assumed by the Congressional Budget Office (CBO).

- One fact is clear. Every state is a loser when the Medicaid program is block granted and cut by $170 billion, but many states lose much more than others. This fact is clearly illustrated by the attached state-by-state break-out of the $170 billion Medicaid cut.

- For example, the first chart shows that under the new Senate block grant proposals, state cuts range from 4 percent to 52 percent in the year 2002.

- The second chart shows how California, which was already projected to lose a staggering $13 billion between 1996 and 2002 under the old Senate formula, would now lose an additional $4.1 billion dollars under the new Senate Republican plan. Conversely, the new Senate formula still slashes the State of Texas by over $7 billion, but the cut is less than the $12 billion cut they would have received under the old Senate formula.

- This information helps explain why there is such a dispute within the Congress and in the states over the Medicaid formula.

Estimates of the Effects of the Senate Republican Medicaid Plan on States, 2002 and 1996 - 2002
Formula as of October 27, 1995
(Dollars in Millions, Federal Spending, Fiscal Years)

States	2002				1996-2002			
	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction
Total	$176,931	$124,838	($52,093)	-29%	$954,338	$777,840	($176,498)	-18%
Alabama	$2,485	$2,169	($316)	-13%	$13,823	$12,864	($959)	-7%
Alaska	$373	$280	($94)	-25%	$2,001	$1,660	($341)	-17%
Arizona	$2,436	$1,849	($587)	-24%	$12,903	$11,511	($1,391)	-11%
Arkansas	$2,084	$1,446	($638)	-31%	$11,081	$8,574	($2,507)	-23%
California	$17,955	$13,102	($4,853)	-27%	$95,663	$77,693	($17,970)	-19%
Colorado	$1,521	$1,039	($482)	-32%	$8,163	$6,343	($1,820)	-22%
Connecticut	$2,345	$1,613	($732)	-31%	$12,990	$10,650	($2,340)	-18%
Delaware	$323	$290	($33)	-10%	$1,728	$1,720	($8)	-0%
District of Columbia	$846	$576	($270)	-32%	$4,511	$3,802	($709)	-16%
Florida	$7,691	$5,272	($2,419)	-31%	$40,720	$31,262	($9,458)	-23%
Georgia	$4,900	$3,320	($1,580)	-32%	$26,050	$20,240	($5,810)	-22%
Hawaii	$506	$373	($135)	-27%	$2,732	$2,450	($281)	-10%
Idaho	$545	$412	($132)	-24%	$2,933	$2,445	($488)	-17%
Illinois	$6,207	$4,637	($1,570)	-25%	$33,242	$28,851	($4,392)	-13%
Indiana	$4,317	$2,545	($1,772)	-41%	$23,100	$15,841	($7,259)	-31%
Iowa	$1,440	$1,104	($336)	-23%	$7,807	$6,874	($933)	-12%
Kansas	$1,079	$943	($136)	-13%	$5,962	$5,874	($88)	-1%
Kentucky	$3,455	$2,243	($1,213)	-35%	$18,353	$13,298	($5,055)	-28%
Louisiana	$6,147	$2,935	($3,212)	-52%	$33,991	$18,818	($15,173)	-45%
Maine	$1,092	$782	($310)	-28%	$5,999	$5,155	($844)	-14%
Maryland	$2,532	$1,706	($826)	-33%	$13,478	$11,193	($2,285)	-17%
Massachusetts	$4,717	$3,005	($1,712)	-36%	$25,516	$19,835	($5,681)	-22%
Michigan	$5,992	$4,581	($1,411)	-24%	$32,153	$28,518	($3,635)	-11%
Minnesota	$2,701	$2,000	($704)	-26%	$14,666	$13,121	($1,544)	-11%
Mississippi	$2,342	$1,825	($517)	-22%	$12,640	$10,820	($1,820)	-14%
Missouri	$2,625	$2,512	($113)	-4%	$14,871	$15,338	$467	3%
Montana	$636	$434	($202)	-32%	$3,409	$2,590	($820)	-24%
Nebraska	$822	$558	($264)	-32%	$4,448	$3,662	($785)	-18%
Nevada	$540	$341	($199)	-37%	$2,899	$2,022	($877)	-30%
New Hampshire	$631	$376	($256)	-41%	$3,728	$2,542	($1,186)	-32%
New Jersey	$5,100	$3,279	($1,821)	-36%	$28,038	$21,646	($6,392)	-23%
New Mexico	$1,147	$940	($207)	-18%	$6,066	$5,577	($489)	-8%
New York	$22,034	$14,820	($7,214)	-33%	$119,527	$97,831	($21,696)	-18%
North Carolina	$5,406	$3,421	($1,985)	-37%	$29,014	$21,298	($7,716)	-27%
North Dakota	$457	$319	($138)	-30%	$2,491	$1,985	($506)	-20%
Ohio	$7,506	$5,275	($2,233)	-30%	$40,586	$32,948	($7,638)	-19%
Oklahoma	$2,060	$1,332	($729)	-35%	$11,074	$7,896	($3,179)	-29%
Oregon	$1,649	$1,439	($209)	-13%	$8,884	$8,960	$76	1%
Pennsylvania	$7,102	$5,474	($1,628)	-23%	$38,448	$35,910	($2,537)	-7%
Rhode Island	$1,004	$627	($377)	-38%	$5,465	$4,138	($1,327)	-24%
South Carolina	$2,756	$2,286	($471)	-17%	$15,252	$13,555	($1,697)	-11%
South Dakota	$442	$347	($94)	-21%	$2,380	$2,163	($217)	-9%
Tennessee	$4,587	$3,331	($1,256)	-27%	$24,576	$20,739	($3,838)	-16%
Texas	$11,358	$9,130	($2,228)	-20%	$61,167	$54,157	($7,010)	-11%
Utah	$960	$659	($302)	-31%	$5,128	$4,096	($1,031)	-20%
Vermont	$366	$300	($67)	-18%	$1,962	$1,868	($115)	-6%
Virginia	$2,434	$1,635	($798)	-33%	$13,022	$9,730	($3,293)	-25%
Washington	$3,381	$1,988	($1,393)	-41%	$18,203	$13,122	($5,081)	-28%
West Virginia	$2,591	$1,529	($1,061)	-41%	$13,723	$9,521	($4,203)	-31%
Wisconsin	$3,066	$2,260	($806)	-26%	$16,484	$14,069	($2,415)	-15%
Wyoming	$236	$180	($56)	-24%	$1,269	$1,067	($202)	-16%

Note: The savings do not total the savings from the CBO baseline because of the differences in the Urban Institute & CBO baselines.

(1) From The Urban Institute's *Medicaid Expenditure Growth Model* as reported in "The Impact of the Budget Resolution Conference Agreement on Medicaid Expenditures", July 1995.

(2) From the Senate Finance majority staff estimates as of October 27, 1995

Note: These estimates do not include supplemental amounts and may not be consistent with the bill language.

Source: U.S. DHHS

01-Nov-95

Comparison of the Senate Republican Medicaid Block Grant: 1996-2002
September 27 versus October 27, 1995 Formula
(Dollars in Millions, Federal Spending, Fiscal Years)

States	Baseline (1)	Older Formula Medicaid Block Grant		Newer Formula Reduction in Medicaid		Difference
		Reduction (2)	Percent Reduction	Reduction (2)	Percent Reduction	+: Smaller Loss Under Senate -: Larger Loss Under Senate
United States	954,338	$186,733	20%	$176,498	18%	
Alabama	13,823	2,607	19%	959	7%	1,649
Alaska	2,001	394	20%	341	17%	53
Arizona	12,903	2,517	20%	1,391	11%	1,125
Arkansas	11,081	2,860	26%	2,507	23%	353
California	95,663	13,801	14%	17,970	19%	(4,169)
Colorado	8,163	1,297	16%	1,820	22%	(523)
Connecticut	12,990	3,544	27%	2,340	18%	1,205
Delaware	1,728	115	7%	8	0%	107
District of Columbia	4,511	734	16%	709	16%	25
Florida	40,720	8,944	22%	9,458	23%	(514)
Georgia	26,050	5,904	23%	5,810	22%	94
Hawaii	2,732	267	10%	281	10%	(14)
Idaho	2,933	581	20%	488	17%	93
Illinois	33,242	2,902	9%	4,392	13%	(1,490)
Indiana	23,100	8,624	37%	7,259	31%	1,365
Iowa	7,807	1,082	14%	933	12%	149
Kansas	5,962	704	12%	88	1%	616
Kentucky	18,353	4,928	27%	5,055	28%	(127)
Louisiana	33,991	15,352	45%	15,173	45%	179
Maine	5,999	946	16%	844	14%	102
Maryland	13,478	1,536	11%	2,285	17%	(749)
Massachusetts	25,516	5,652	22%	5,681	22%	(29)
Michigan	32,153	4,692	15%	3,635	11%	1,057
Minnesota	14,665	1,019	7%	1,544	11%	(524)
Mississippi	12,640	1,251	10%	1,820	14%	(570)
Missouri	14,871	2,043	14%	(467)	-3%	2,509
Montana	3,409	948	28%	820	24%	128
Nebraska	4,448	692	16%	785	18%	(93)
Nevada	2,899	850	29%	877	30%	(27)
New Hampshire	3,728	1,164	31%	1,186	32%	(22)
New Jersey	28,036	7,172	26%	6,392	23%	781
New Mexico	6,066	615	10%	489	8%	126
New York	119,527	21,450	18%	21,696	18%	(246)
North Carolina	29,014	8,319	29%	7,716	27%	603
North Dakota	2,491	540	22%	506	20%	34
Ohio	40,586	6,683	16%	7,638	19%	(955)
Oklahoma	11,074	3,423	31%	3,179	29%	245
Oregon	8,884	35	0%	(76)	-1%	111
Pennsylvania	38,448	2,422	6%	2,537	7%	(115)
Rhode Island	5,465	1,141	21%	1,327	24%	(186)
South Carolina	15,252	2,954	19%	1,697	11%	1,257
South Dakota	2,380	240	10%	217	9%	23
Tennessee	24,576	4,165	17%	3,838	16%	327
Texas	61,167	12,187	20%	7,010	11%	5,176
Utah	5,128	1,052	21%	1,031	20%	21
Vermont	1,982	205	10%	115	6%	90
Virginia	13,022	3,079	24%	3,293	25%	(213)
Washington	18,203	5,579	31%	5,081	28%	499
West Virginia	13,723	4,615	34%	4,203	31%	412
Wisconsin	16,484	2,639	16%	2,415	15%	224
Wyoming	1,269	264	21%	202	16%	62

Note: The savings do not total the savings from the CBO baseline because of the differences in the Urban Institute & CBO baselines.

(1) From The Urban Institute's Medicaid Expenditure Growth Model as reported in "The Impact of the Budget Resolution Conference Agreement on Medicaid Expenditures", July 1995.

(2) From the Senate Finance Committee's estimates of the spending by state under the proposal released on September 27 & October 27.

Note: These estimates do not include supplemental amounts not be consistent with the bill language.

pe: U.S. DHHS

01-Nov-95

REPUBLICAN BUDGET WIPES OUT QUALITY STANDARDS FOR NURSING HOMES AND INSTITUTIONS CARING FOR THE MENTALLY RETARDED

November 6, 1995

Republican Budget Jeopardizes Fundamental Protections for Nursing Home Residents

- Under the guise of reform, the House Republican budget throws away decades of progress by repealing federal nursing home quality standards. Since enactment of these federal quality standards, nursing home quality has improved dramatically: the use of physical restraints has declined 25%, dehydration among residents has declined 50%, and hospitalization rates have declined 31%. (Source: RTI and HCFA.) Without these federal standards and enforcement, nursing home residents will be vulnerable to abuse and neglect, to being inappropriately restrained, and dumped onto the streets when they run out of money.

- Moreover, both House and Senate plans repeal the requirement that Medicaid cover nursing home care at all. Their cuts will force states to deny coverage to hundreds of thousands of nursing home residents by 2002.

- In response to criticism, Senate Republicans reinstated the federal standards, but allow states with "equivalent or stricter" standards and enforcement to receive Medicaid waivers. Yet the federal government would have *no way to ensure that states enforce these standards.* Most recently, *federal surveyors found 14% of nursing homes out of compliance with the federal standards.* (Source: HCFA.) And states would have to enforce their standards with much less Medicaid funding than they receive under current law.

Both Senate and House Republican Budgets Entirely Repeal Standards for Institutions Caring for People with Mental Retardation and Developmental Disabilities

- *Both eliminate federal standards, and do not require states to issue standards that would assure even the most basic rights,* such as protection from abuse and neglect, treatment designed to assist the person to achieving the greatest level of independence, and the right to adequate health care. States do not currently have such standards.

- Neither plan requires states to maintain their current level of services -- in facilities or in home and community-based care -- for people with mental retardation and developmental disabilities. And both plans eliminate the guarantee of anything more than custodial care.

Medicaid Currently Ensures Quality Nursing Home Care and Fundamental Protections
In 1986, a major report documented widespread substandard or poor care at nursing homes in every state. In response to these deplorable conditions, President Reagan signed into law federal minimum standards for nursing homes that: protect nursing home residents from abuse and neglect; limit the use of physical and chemical restraints; prohibit nursing homes from evicting residents when they run out of money and qualify for Medicaid; give nursing home residents the right to appeal decisions without retribution; and ensure that nursing aides are trained and do not have a history of abuse. The 1987 law has dramatically improved the quality of nursing home care, but more progress is needed.

Medicaid Currently Provides Standards for Institutions Caring for the Mentally Retarded Prior to the adoption of federal standards, people with mental retardation and developmental disabilities were routinely subject to abuse and lacked even minimally safe and sanitary living conditions. In response, federal standards were adopted in the 1970s and strengthened under President Reagan. *The federal presence has made a difference -- the federal process on average finds 17% of facilities out of compliance with the federal standards.* (Source: HCFA.)

THE REPUBLICAN MEDICAID PROPOSALS ONLY PRETEND TO PROTECT SENIORS FROM SPOUSAL IMPOVERISHMENT

I. **Current law protects spouses and their families from poverty. Federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:**

- States must let spouses keep income equal to 150% of the national poverty level -- about $15,000 per year.

- States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about $15,000 to $75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.

- Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.

II. **Earlier versions of the Republican Medicaid Block Grant proposals repealed these spousal impoverishment protections.** Under the initial House and Senate plans any state government could force people whose husbands or wives have to go into nursing homes to give up their car, their furniture -- even their home before their spouse can qualify for any medical support.

III. **The President protested the elimination of these protections.**

> "Congress should strip these outrageous provisions from the budget bill. They're inconsistent with our core values. They're not what America is all about, and they are certainly not necessary to balance the budget."
>
> -President William Jefferson Clinton
> Radio Address to the Nation, September 30, 1995

IV. **Responding to the President's criticisms, Republicans modified their plans. <u>But they only passed an empty shell -- their bill still does not protect against spousal impoverishment.</u>**

- Since both bills repeal the current Medicaid guarantee of nursing home care, there is also guarantee of spousal impoverishment protections.

- Both House and Senate bills repeal current national requirements for beneficiary rights to notification, administrative hearings, and appeals.

- Under the House bill, eligible individuals who are not receiving the spousal impoverishment protections can no longer sue the State to obtain these essential protections.

  -- Section 2117 of the House bill states: "no person (including an applicant, beneficiary, provider, or health plan) shall have a cause of action under Federal law against a State in relation to a State's compliance (or failure to comply) with the provisions of this title or of a MediGrant plan."

- Both bills make it more difficult for the Federal government to ensure that States comply with any beneficiary protection requirements.

REPUBLICAN HEALTH CARE PLANS
WILL NOT COVER ELDERLY IN POVERTY

NEWT GINGRICH CLAIMS THAT SENIOR CITIZENS AT THE POVERTY LEVEL, AND BELOW, WILL HAVE ALL OF THEIR PART B PREMIUM PAID FOR – 100 PERCENT.

> "I must say with some sadness that we are ending this debate in the same spirit of misinformation that has characterized our opponents consistently. The fact is there is a provision in the medigrant program which provides that senior citizens at the poverty level, and below, have all of their Part B premium paid for by the taxpayers, 100 percent."
>
> – Newt Gingrich
> Congressional Record
> 10/19/95
> Page H 10462

THE FACTS:

- Under current law, Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100 percent of poverty (known as "qualified Medicare beneficiaries or "QMBs").

- The House and Senate bills completely eliminate:

  - the requirement that Medicaid pay Medicare coinsurance and deductibles for people below 100 percent of poverty; and

  - the requirement that Medicaid pay Medicare premiums for people between 100-120 percent of poverty.

- Both the House and Senate bills create a set-aside for a portion of the MediGrant funding for Medicare premiums equal to 90 percent of the average spending between 1993 and 1995 on these premiums.

- The Department of Health and Human Services estimates that the set-aside equals about 1.8 percent of total Medicaid spending. This means that states have to spend 1.8 percent of their block grant funds for Medicare premiums.

- **Contrary to the Speaker's claims, in the year 2002, the set-aside amount is estimated to cover only 44 percent – or $3.7 billion – of the amount that is projected to be spent on Medicare premiums ($8.5 billion) for people in the QMB program.** [This estimated spending includes the impact of the Republican's increase in Part B premiums.]

REGIONAL AND HOSPITAL SPECIFIC INFORMATION

MEMORANDUM

DATE: November 9, 1995

TO: Marilyn Yager

FROM: Joe Kirkpatrick

RE: Estimated Impact of Proposed Congressional Medicare Cuts

Attached are five sheets reflecting MHA's impact analysis of the proposed congressional budget reconciliation Medicare provisions.

1. This chart shows the seven year impact of both House and Senate proposed cuts in payments to Massachusetts PPS hospitals. The chart shows what the CBO baseline assumptions mean in Medicare reimbursement under current law, the reimbursement hospitals would receive under proposed revisions, and the estimated revenue loss by component. Note that the House version is significantly worse for the states hospitals largely because of the "failsafe" adjustment which CBO projects will cut hospital payments by $17.9 nationwide on top of about $80 billion in "traditional" cuts.

2. This chart shows the year by year total cuts in the House bill affecting PPS hospitals in the Seventh Massachusetts Congressional District.

3. This chart shows the year by year total House cuts affecting Lawrence Memorial Hospital in Medford, Massachusetts.

4. This chart shows the year by year total cuts in the Senate bill affecting PPS hospitals in the Seventh Massachusetts Congressional District.

5. This chart shows the year by year total Senate cuts affecting Lawrence Memorial Hospital in Medford, Massachusetts.

If you or others have questions please feel free to call me at MHA, (617) 272-8000, extension 173, or at home, (508) 473-8628.

HOUSE CUTS

CURRENT LAW BASELINE	7-YEAR TOTAL
DRG PAYMENTS	$13,960,637,462
INDIRECT MED ED	$2,114,489,492
DISPROPORTIONATE SHARE	$511,262,366
INPATIENT CAPITAL	$2,125,064,996
OUTPATIENT CAPITAL	$3,614,448,276
BAD DEBT	$348,186,215
OVERPAYMENTS	$122,580,777
TOTAL	[illegible]

PROPOSED REVISIONS	7-YEAR TOTAL
DRG PAYMENTS	$13,112,634,575
INDIRECT MED ED	$1,487,401,700
DISPROPORTIONATE SHARE	$354,377,146
INPATIENT CAPITAL	$1,793,971,691
OUTPATIENT CAPITAL	$3,103,189,862
BAD DEBT	$189,862,614
OVERPAYMENTS	$0
FAILSAFE ADJUSTMENT	($480,994,502)
TOTAL	[illegible]

ESTIMATED REVENUE LOSS	7-YEAR TOTAL	% REVENUE LOSS
DRG PAYMENTS	$836,002,887	6.01%
INDIRECT MED ED	$627,087,792	29.66%
DISPROPORTIONATE SHARE	$156,886,220	30.69%
INPATIENT CAPITAL	$331,093,305	15.58%
OUTPATIENT CAPITAL	$511,258,414	14.14%
BAD DEBT	$158,323,601	45.47%
OVERPAYMENTS	$122,580,777	100.00%
FAILSAFE ADJUSTMENT	$480,994,502	2.11%
TOTAL	[illegible]	[illegible]

SENATE CUTS

CURRENT LAW BASELINE	7-YEAR TOTALS
DRG PAYMENTS	$13,960,637,462
INDIRECT MED ED	$2,114,489,492
DISPROPORTIONATE SHARE	$511,262,366
INPATIENT CAPITAL	$2,125,064,996
OUTPATIENT CAPITAL	$3,614,448,276
BAD DEBT	$348,186,215
OVERPAYMENTS	$122,580,777
TOTAL	$22,786,669,584

PROPOSED REVISIONS	7-YEAR TOTALS
DRG PAYMENTS	$12,952,429,960
INDIRECT MED ED	$1,382,020,837
DISPROPORTIONATE SHARE	$395,174,976
INPATIENT CAPITAL	$1,794,986,105
OUTPATIENT CAPITAL	$3,103,189,862
BAD DEBT	$348,186,215
OVERPAYMENTS	$0
TOTAL	[illegible]

ESTIMATED REVENUE LOSS	7-YEAR TOTALS	% REVENUE LOSS
DRG PAYMENTS	$996,207,502	7.16%
INDIRECT MED ED	$732,468,655	34.64%
DISPROPORTIONATE SHARE	$116,087,390	22.71%
INPATIENT CAPITAL	$330,078,891	15.53%
OUTPATIENT CAPITAL	$511,258,414	14.14%
BAD DEBT	$0	0.00%
OVERPAYMENTS	$122,580,777	100.00%
TOTAL	[illegible]	[illegible]

IMPACT OF PROPOSED HOUSE CUTS ON ACUTE HOSPITALS	SEVENTH DISTRICT
BASE YEAR FY'95	$215,420,423
FIRST YEAR 1996	
–PAYMENTS UNDER CURRENT LAW	$231,129,521
–PAYMENTS UNDER PROPOSED LAW	$222,056,507
–Dollar Impact	($9,073,014)
–Percent Loss	–3.93%
SECOND YEAR 1997	
–PAYMENTS UNDER CURRENT LAW	$244,812,490
–PAYMENTS UNDER PROPOSED LAW	$231,406,974
–Dollar Impact	($13,405,516)
–Percent Loss	–5.48%
THIRD YEAR 1998	
–PAYMENTS UNDER CURRENT LAW	$260,626,520
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$241,779,598
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$235,493,328
–Dollar Impact	($25,133,192)
–Percent Loss	–9.64%
FOURTH YEAR 1999	
–PAYMENTS UNDER CURRENT LAW	$277,667,344
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$251,425,283
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$241,619,697
–Dollar Impact	($36,047,647)
–Percent Loss	–12.98%
FIFTH YEAR 2000	
–PAYMENTS UNDER CURRENT LAW	$296,145,726
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$263,098,080
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$254,152,745
–Dollar Impact	($41,992,980)
–Percent Loss	–14.18%
SIXTH YEAR 2001	
–PAYMENTS UNDER CURRENT LAW	$315,231,485
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$274,909,425
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$265,287,595
–Dollar Impact	($49,943,890)
–Percent Loss	–15.84%
SEVENTH YEAR 2002	
–PAYMENTS UNDER CURRENT LAW	$336,186,754
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$287,855,389
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$279,219,727
–Dollar Impact	($56,967,028)
–Percent Loss	–16.95%
CUMMULATIVE	
–PAYMENTS UNDER CURRENT LAW	$1,961,799,840
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$1,772,531,256
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$1,729,236,574
–Dollar Impact	($232,563,266)
–Percent Loss	–11.85%

IMPACT OF PROPOSED HOUSE CUTS ON ACUTE HOSPITALS	LAWRENCE MEMORIAL
BASE YEAR FY 96	$21,229,535
FIRST YEAR 1996	
–PAYMENTS UNDER CURRENT LAW	$22,605,427
–PAYMENTS UNDER PROPOSED LAW	$21,992,370
–Dollar Impact	($613,057)
–Percent Loss	–2.71%
SECOND YEAR 1997	
–PAYMENTS UNDER CURRENT LAW	$23,875,887
–PAYMENTS UNDER PROPOSED LAW	$22,853,034
–Dollar Impact	($1,022,853)
–Percent Loss	–4.28%
THIRD YEAR 1998	
–PAYMENTS UNDER CURRENT LAW	$25,339,593
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$23,796,949
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$23,177,644
–Dollar Impact	($2,161,948)
–Percent Loss	–8.53%
FOURTH YEAR 1999	
–PAYMENTS UNDER CURRENT LAW	$26,908,173
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$24,694,814
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$23,731,717
–Dollar Impact	($3,176,456)
–Percent Loss	–11.80%
FIFTH YEAR 2000	
–PAYMENTS UNDER CURRENT LAW	$28,603,865
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$25,766,362
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$24,890,306
–Dollar Impact	($3,713,559)
–Percent Loss	–12.98%
SIXTH YEAR 2001	
–PAYMENTS UNDER CURRENT LAW	$30,354,193
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$26,638,854
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$25,899,494
–Dollar Impact	($4,454,699)
–Percent Loss	–14.68%
SEVENTH YEAR 2002	
–PAYMENTS UNDER CURRENT LAW	$32,260,522
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$28,001,956
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$27,161,896
–Dollar Impact	($5,098,625)
–Percent Loss	–15.80%
CUMMULATIVE	
–PAYMENTS UNDER CURRENT LAW	$189,947,660
–PAYMENTS UNDER PROPOSED LAW BEFORE FAILSAFE	$173,943,741
–PAYMENTS UNDER PROPOSED LAW WITH FAILSAFE	$169,706,463
–Dollar Impact	($20,241,197)
	–10.66%

IMPACT OF PROPOSED SENATE CUTS ON ACUTE HOSPITALS	SEVENTH DISTRICT
BASE YEAR FY'95	$216,420,423
FIRST YEAR 1996	
– PAYMENTS UNDER CURRENT LAW	$231,129,521
– PAYMENTS UNDER PROPOSED LAW	$222,880,806
– Dollar Impact	($8,248,715)
– Percent Loss	-3.57%
SECOND YEAR 1997	
– PAYMENTS UNDER CURRENT LAW	$244,812,490
– PAYMENTS UNDER PROPOSED LAW	$231,350,645
– Dollar Impact	($13,461,845)
– Percent Loss	-5.50%
THIRD YEAR 1998	
– PAYMENTS UNDER CURRENT LAW	$260,626,520
– PAYMENTS UNDER PROPOSED LAW	$241,172,553
– Dollar Impact	($19,453,967)
– Percent Loss	-7.46%
FOURTH YEAR 1999	
– PAYMENTS UNDER CURRENT LAW	$277,667,344
– PAYMENTS UNDER PROPOSED LAW	$249,827,541
– Dollar Impact	($27,839,803)
– Percent Loss	-10.03%
FIFTH YEAR 2000	
– PAYMENTS UNDER CURRENT LAW	$296,145,726
– PAYMENTS UNDER PROPOSED LAW	$260,669,598
– Dollar Impact	($35,476,128)
– Percent Loss	-11.98%
SIXTH YEAR 2001	
– PAYMENTS UNDER CURRENT LAW	$315,231,485
– PAYMENTS UNDER PROPOSED LAW	$271,454,780
– Dollar Impact	($43,776,705)
– Percent Loss	-13.89%
SEVENTH YEAR 2002	
– PAYMENTS UNDER CURRENT LAW	$336,186,754
– PAYMENTS UNDER PROPOSED LAW	$283,319,908
– Dollar Impact	($52,866,846)
– Percent Loss	-15.73%
CUMMULATIVE	
– PAYMENTS UNDER CURRENT LAW	$1,961,799,840
– PAYMENTS UNDER PROPOSED LAW	$1,760,675,832
– Dollar Impact	($201,124,009)
– Percent Loss	-10.25%

IMPACT OF PROPOSED SENATE CUTS ON ACUTE HOSPITALS	LAWRENCE MEMORIAL
BASE YEAR FY'95	$21,229,535
FIRST YEAR 1996	
– PAYMENTS UNDER CURRENT LAW	$22,605,427
– PAYMENTS UNDER PROPOSED LAW	$22,071,824
– Dollar Impact	($533,604)
– Percent Loss	–2.36%
SECOND YEAR 1997	
– PAYMENTS UNDER CURRENT LAW	$23,875,887
– PAYMENTS UNDER PROPOSED LAW	$22,882,648
– Dollar Impact	($993,239)
– Percent Loss	–4.16%
THIRD YEAR 1998	
– PAYMENTS UNDER CURRENT LAW	$25,339,593
– PAYMENTS UNDER PROPOSED LAW	$23,770,501
– Dollar Impact	($1,569,092)
– Percent Loss	–6.19%
FOURTH YEAR 1999	
– PAYMENTS UNDER CURRENT LAW	$26,908,173
– PAYMENTS UNDER PROPOSED LAW	$24,573,633
– Dollar Impact	($2,334,540)
– Percent Loss	–8.68%
FIFTH YEAR 2000	
– PAYMENTS UNDER CURRENT LAW	$28,603,865
– PAYMENTS UNDER PROPOSED LAW	$25,550,100
– Dollar Impact	($3,053,765)
– Percent Loss	–10.68%
SIXTH YEAR 2001	
– PAYMENTS UNDER CURRENT LAW	$30,354,193
– PAYMENTS UNDER PROPOSED LAW	$26,516,816
– Dollar Impact	($3,837,377)
– Percent Loss	–12.64%
SEVENTH YEAR 2002	
– PAYMENTS UNDER CURRENT LAW	$32,260,522
– PAYMENTS UNDER PROPOSED LAW	$27,568,480
– Dollar Impact	($4,692,042)
– Percent Loss	–14.54%
CUMMULATIVE	
– PAYMENTS UNDER CURRENT LAW	$189,947,660
– PAYMENTS UNDER PROPOSED LAW	$172,934,002
– Dollar Impact	($17,013,658)
– Percent Loss	–8.96%

Massachusetts Teaching Hospitals

Impact of House and Senate Medicare Reductions: FY 1996 - 2002

(in $ millions)	House	Senate
Indirect Medical Education (IME)	$410	$505
Graduate Medical Education (GME)	100	-
Market Basket Update	350	335
Disproportionate Share	75	50
Other	380	380
Subtotal	$1.32 billion	$1.27 billion
AAPCC Correction: Failure (House) / Delay (Senate)	$635	$60
GME Trust Fund (Offset)	($790)	
Total Loss: 1996 - 2002	**$1.2 billion**	**$1.3 billion**

See accompanying notes

BOTHFO
Revised 10/31/95

Beth Israel Hospital

Impact of House and Senate Medicare Reductions: FY 1996 - 2002

(in $ millions)	House	Senate
Indirect Medical Education (IME)	$45	$53
Graduate Medical Education (GME)	11	
Market Basket Update	35	33
Disproportionate Share	7	5
Other	38	38
Subtotal	$135	$129
AAPCC Correction: Failure (House) / Delay (Senate)	79	7
GME Trust Fund (Offset)	(98)	
Total Loss: 1996 - 2002	**$116 million**	**$136 million**

for info Estimate:

Revised / Updated: 11/2/95

BOTHFO

accompanying summary of provisions.

$115 million $152 million

What steps have Boston's teaching hospitals taken toward economy?

For the Boston Teaching Hospitals: Beth Israel Hospital~Boston University Medical Center~Brigham & Women's Hospital~Carney Hospital~Children's Hospital~Dana-Farber Cancer Institute~Deaconess Hospital~Massachusetts General Hospital~New England Medical Center Hospitals, Inc.~St. Elizabeth's Medical Center of Boston:

For FY 1994 through FY 1996 (the fiscal year begun in October '95), preliminary survey indicates a reduction in operating expenses of $350 million, about 5 percent of total, non-capital expenses. Full-time equivalent positions will have been reduced by an estimated 3,100, about 7 percent of the work force in place at the start of this three year period.

	Percentage change compared to prior year	
	FY94	FY95, 3rd quarter
Salaries, Wages, Benefits	- 0.4%	- 0.3%
Supplies and other expenses	+3.9%	+3.3%
Inpatient Admissions	- 4.2%	- 3.3%
Outpatient Visits	+2.4%	+5.1%

For more information, contact Anthony J. Santangelo, Jr., Director, Boston Organization of Teaching Hospital Financial Officers, 632-7197.

The Impact of Proposed Medicare Reductions on New Hampshire Hospitals 1996 - 2002

New Hampshire Hospitals, Location	Projected Medicare Payments Under Current Law 1996 - 2002	Medicare Payment Reductions 1996 - 2002	
		HOUSE Proposal	SENATE Proposal
Alice Peck Day Hospital, Lebanon	$ 12,728,000	$ -1,481,000	$ -1,809,000
Androscoggin Valley Hospital, Berlin	$ 51,799,000	$ -5,525,000	$ -4,925,000
Catholic Medical Center, Manchester	$ 358,905,000	$ -35,633,000	$ -31,963,000
Cheshire Medical Center, Keene	$ 110,242,000	$ -11,598,000	$ -10,339,000
Concord Hospital, Concord	$ 215,702,000	$ -22,378,000	$ -20,260,000
Cottage Hospital, Woodsville	$ 23,267,000	$ -2,437,000	$ -2,172,000
Elliot Hospital, Manchester	$ 181,042,000	$ -19,004,000	$ -17,687,000
Exeter Hospital, Manchester	$ 114,854,000	$ -12,290,000	$ -10,894,000
Franklin Regional Hospital, Manchester	$ 40,846,000	$ -4,182,000	$ -3,694,000
Frisbie Memorial Hospital, Rochester	$ 82,042,000	$ -10,292,000	$ -9,005,000
Huggins Hospital, Wolfeboro	$ 40,481,000	$ -4,281,000	$ -3,818,000
Lakes Region General, Laconia	$ 132,983,000	$ -13,747,000	$ -12,518,000
Littleton Regional Hospital, Littleton	$ 39,737,000	$ -3,681,000	$ -3,234,000
Mary Hitchcock Memorial Hospital, Lebanon	$ 660,206,000	$ -66,518,000	$ -59,984,000
The Memorial Hospital, North Conway	$ 27,022,000	$ -2,969,000	$ -2,698,000
Monadnock Community Hospital, Peterborough	$ 38,241,000	$ -4,018,000	$ -3,569,000
New London Hospital, New London	$ 30,518,000	$ -3,335,000	$ -2,959,000
HCA Parkland Medical Center, Derry	$ 49,474,000	$ -5,274,000	$ -4,698,000
HCA Portsmouth Regional Hospital, Portsmouth	$ 143,357,000	$ -15,460,000	$ -13,765,000
St. Joseph Hospital, Nashua	$ 153,939,000	$ -14,188,000	$ -12,655,000
Southern NH Regional Medical Center, Nashua	$ 92,893,000	$ -9,729,000	$ -8,677,000
Speare Memorial Hospital, Plymouth	$ 26,185,000	$ -2,618,000	$ -2,346,000
Upper Connecticut Valley, Colebrook	$ 10,229,000	$ -962,000	$ -862,000
Valley Regional Hospital, Claremont	$ 52,080,000	$ -5,717,000	$ -5,083,000
Weeks Memorial Hospital, Lancaster	$ 27,971,000	$ -2,915,000	$ -2,601,000
Wentworth-Douglass Hospital, Dover	$ 133,996,000	$ -15,659,000	$ -13,846,000
All New Hampshire Hospitals	$2,632,701,000	$ -326,624,000	$ -305,606,000

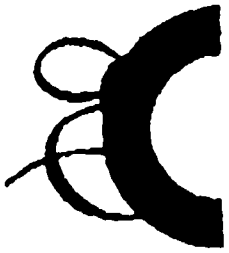
Source: American Hospital Association and the New Hampshire Hospital Association

John Hoyt
Congressional staff
Dave
10/17/95

Projection for Medicare Revenues 1996-2002
Under the Senate Finance Reconciliation Proposal
(in thousands of dollars)

Hospital: MAINE MEDICAL CENTER
Address: 22 BRAMHALL ST
PORTLAND, ME, 04102
Medicare Id: 200009

Fiscal Year	Current Law Revenue (in $1000s)	Proposed Payment Cuts (in $1000s)	Estimated Revenue Decrease (in $1000s)	MMC calculated impact
1996	$87,359	$83,944	$-3,415	(3,972)
1997	91,964	85,086	-6,878	(6,761)
1998	97,181	86,305	-10,875	(10,761)
1999	102,705	88,732	-13,973	(13,882)
2000	108,604	91,620	-16,984	(16,981)
2001	114,672	94,646	-20,026	(20,051)
2002	121,221	97,893	-23,328	(23,293)
Total 1996-2002	723,706	628,227	-95,479	(95,071)
MMC	726,124	631,063	(95,071)	



NURSING FACILITIES IN MASSACHUSETTS

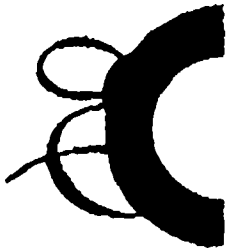
There are currently more than 580 nursing facilities in the Commonwealth of Massachusetts providing health care and social services to more than 55,000 frail elders and disabled individuals. Nursing facilities are the second largest health care employer in the state, providing direct jobs for more than 55,000 and indirect jobs for thousands more. In all, nursing facilities contribute more than $2 billion to the Massachusetts economy through wages and the purchase of goods and services.

The nursing facility industry in Massachusetts has changed dramatically over the past decade. It has moved from a residentially-based system to one that provides extensive nursing and rehabilitative services to a very disabled population. The typical nursing home resident in Massachusetts is a woman in her mid-80s with three or four chronic conditions who needs help with a number of activities of daily living, such as eating, dressing, toileting and bathing. About half of all nursing home residents have Alzheimer's disease or a related dementia. Increasingly, many nursing facilities are specializing in the provision of subacute care and operate as a transitional placement for individuals recovering from an acute illness or medical trauma and returning home after a brief period of rehabilitation.

Massachusetts nursing facilities are unique in many ways. First, they consistently rate among the highest in the country in the quality of patient care provided to residents, a testament to the strong commitment by providers to high quality care and the rigorous regulatory oversight. The Massachusetts nursing facility staffing ratio of one full-time employee for every resident is fifth highest of all the states. Secondly, Massachusetts facilities are much more dependent than other states on public funding. Seven out of every ten residents has his/her care reimbursed by the Medicaid program, while an additional one out of ten has his/her care paid by Medicare. Thirdly, Massachusetts nursing facility providers have worked hard to raise wage and benefit levels for direct service staff. The average hourly salary for a nursing assistant in Massachusetts is $8.75, seventh highest of all states. Massachusetts nursing homes have hired thousands of women as nursing assistants who were formerly on public assistance, providing them with decent wages, health insurance, and other important benefits such as day care.

As the population ages and the "new" elderly demand more choices for their long term care, Massachusetts providers are diversifying and moving up and down the health care continuum, providing additional services such as assisted living, home care, adult day care, and subacute care.

MASSACHUSETTS EXTENDED CARE FEDERATION
990 Washington Street, Suite 207 South, Dedham, Massachusetts 02026-6700 Phone: 617.326.8987 1.800.CARE.1OR Fax: 617.461.0809



ESTIMATED IMPACT OF HOUSE AND SENATE-PASSED MEDICAID CUTS ON MASSACHUSETTS NURSING FACILITIES

The cuts in Federal Medicaid payments to states recently passed by both the House and the Senate would have a devastating impact on access and quality of care for nursing facility residents in the Commonwealth of Massachusetts. Massachusetts's designation in the Medicaid distribution formulas as a "low growth" state and the state's high dependence on the Medicaid program to pay for the costs of nursing facility care (seven out of every ten nursing facility residents have their care reimbursed under Medicaid) make the state particularly vulnerable to wholesale cuts in federal Medicaid funds. If Medicaid cuts of this magnitude occur, Massachusetts will lose $4 billion in federal funding between 1996 and 2002, including an estimated $1.5 billion for nursing facility care. Approximately 40% of all Medicaid expenditures in Massachusetts go to reimburse care provided to indigent and disabled elders residing in long term care facilities. In both the House and Senate formulas, after the first year the annual rate of growth in federal Medicaid funds available to Massachusetts will be capped at 2%, less than the current rate of inflation and far less than what is needed to meet the needs of the state's 85+ population, which is growing at the rate of 4% a year.

If the Congressional proposals are enacted, Massachusetts will be forced to choose between a number of undesirable options such as limiting Medicaid-funded access to nursing facilities, reducing even further provider rates of payment, or raising taxes in order to compensate for the loss of federal dollars. Families may either have to pay significantly more of their own money to cover the cost of their relatives' nursing home care or take care of their relatives themselves. The jobs of many of the 55,000 people who work in Massachusetts nursing homes would be in serious jeopardy, many of whom are entry-level workers who might otherwise be on welfare. According to a recent study by former Bank of Boston economist James Howell, combined cuts in Medicaid and Medicare will result in the loss of 71,000 health care sector jobs in the state and an aggregate personal income loss of $2.1 billion.

To the typical 120 bed, 70% Medicaid-dependent, Massachusetts nursing facility, the impact of Congressionally-proposed federal Medicaid cuts will be dramatic. Unless access is radically restricted, payment rates will be effectively "frozen" for six years. This will result in a reduction in Medicaid funding for the six-year period of $1.9 million below what funding would have been assuming a 3 percent annual inflationary increase. By the year 2002, the annual Medicaid revenue shortfall for the typical facility would be $540,000. Put another way, this would be the equivalent of 24 full-time nurse aide positions. Nursing facilities would face the "Hobson's Choice" of freezing employee wages for six years (an impossibility given their eventual flight to other less impacted sectors of the economy) or laying off significant numbers of direct care staff despite the fact that the acuity and care needs of residents is expected to continue to increase during this period.

MASSACHUSETTS EXTENDED CARE FEDERATION
990 Washington Street, Suite 207 South, Dedham, Massachusetts 02026-6700 Phone: 617.326.8987 1.800.CARE FOR Fax: 617.461.0523

MEMORANDUM

TO: Marilyn Yager
FROM: Bea Grause
RE: Coalition Background
DATE: Thursday, November 9, 1995

I. MISSION STATEMENT

The Coalition for Responsible Medicare and Medicaid Reform is a group of health care providers and consumer advocates committed to preserving and improving the provision of care to Medicare and Medicaid recipients through responsible cost saving measures. The Coalition's work is premised on the preservation of access to care and quality of services. We support reforms which garner cost savings through improved efficiencies and better coordination of care.

II. HISTORY

The Coalition for Responsible Medicare and Medicaid Reform originated out of a conversation between myself and an ex-colleague of yours, Paul Moran, as a way to advocate against the Balanced Budget Amendment. After discussing the idea internally, we got the green light to investigate whether there was any interest. From the beginning, we were overwhelmed and inspired by the interest and commitment to this group.

Beginning in January a core group of about twelve individuals began meeting every two or three weeks. Within two months, our membership had grown to more to more than twenty five associations, and our mission had expanded to include Congress' budget bill. Today, there are 36 groups on our roster, with about 24 of them actively participating.

Today, the commitment to continue the Coalition's mission of preserving quality patient care remains strong. Coalition members are already discussing ways to work together once a budget bill has passed and is signed by President Clinton.

III. ACTIVITIES/ACCOMPLISHMENTS

Traditional grassroots coordination has been the linchpin of the Coalition's success, helping to further the Coalition's goal of educating the public and elected officials about the importance of responsible health care reform.

In addition to letter and fax campaigns, phone calling, Delegation meetings, newsletter articles, and Some of the coordinated activities include:

* The Howell Report - The Coalition sponsored a comprehensive study on the statewide and community impact of the proposed Budget bill on the Commonwealth's "knowledge-based" economy. This report has been widely cited, and Mr. Howell regularly appears to discuss the findings in this study. (He is a witness at the Lois Pines hearing 11/13).

* Local and Boston editorial Board meetings - The Coalition conducted editorial board meetings throughout the summer at dozens of dailies and weeklies in Massachusetts. This large scale effort kept the issue consistently in local papers throughout the summer and fall.

* Television Advertising prior to the Oct 19, vote on the House Medicare bill.

* A statewide poll to pinpoint consumer questions and concerns about the impact of the proposed budget bills. (To be released later this month).

Coalition efforts helped convince Congressman Torkildsen to vote against the Medicare portion of the reconciliation bill on October 19. (In fact, the New Jersey Hospital Association formed a Coalition modeled on ours (without their state medical society), and credited their Coalition's efforts with the four NJ Republican "no" votes on the reconciliation bills.)

COALITION FOR RESPONSIBLE MEDICARE AND MEDICAID REFORM

JOHN W. MCCORMACK POST OFFICE • P.O. BOX 2192 • BOSTON, MA 02106

November 7, 1995

Senator John Kerry
421 Russell Senate Office Building
Washington D.C. 20510

Dear Senator Kerry:

During the next few weeks, budget conferees will make many critical decisions on the details of the 1996 Omnibus Budget bill. As you know, this legislation will have a major impact on the delivery of health care in the Commonwealth.

As a Massachusetts-based coalition of concerned consumers, providers, and beneficiaries, we are writing to support conference language that includes the following principles below. In addition, we have included more specific proposals that we believe would help improve this legislation. We ask that you communicate our concerns to House and Senate conferees and review the final conference bill with these principles in mind.

OVERALL PRINCIPLES

* In light of the severe Medicare and Medicaid cuts, the Coalition opposes the $245 billion tax cut. Cutting federal taxes to this degree necessitate deeper cuts in Medicare and Medicaid than would otherwise be required to balanced the federal budget.

* A Medicaid formula should take into account such factors as the historic eligibility and service coverage in state Medicaid programs, recipient demographics, existing distribution of health care institutions and resources, and the prevalence of high cost illnesses such as AIDS. The coalition encourages other policy options to state block grants which still allow flexible funding, such as a capped entitlement or per capita cap.

SPECIFIC ITEMS

* Retain the federal nursing home standards as passed in the Nursing Home Reform Act of 1987. (Standards retained in the Senate bill)

* Retain a floor of mandatory coverage for poor pregnant women, children under 12 and individuals with disabilities.

* Maintain current financial protections for community spouses of nursing home residents.

* Retain the House language on provider-sponsored networks.

* Retain the Senate language that removes GME and DSH funds from Medicare payments to HMOs and pays those funds directly to the institutions providing the care. (AAPCC provision)

* Eliminate the "fail-safe" provision in the House bill.

* Retain Senate language pertaining to patient protection language, including information disclosure and due process protections.

* Retain Senate "point of service" amendment that would require Medicare Choice plans to offer a plan that would provide payment for covered services and items obtained out of network.

Thank you for your consideration. If you have any questions or need additional information, please contact me at (202) 863-0400.

Sincerely,

Bea Grause, Director, Federal Rel.
Massachusetts Hospital Association

DRAFT

Andrew is this Stacey's FAX!!

COALITION FOR RESPONSIBLE MEDICARE AND MEDICAID REFORM

JOHN W. MCCORMACK POST OFFICE • P.O. BOX 2192 • BOSTON, MA 02106

Facts About Medicare and Medicaid in Massachusetts

Medicare and Medicaid were established in 1965 under the Johnson administration to provide basic health care services to Americans who were not covered by private insurance, and who otherwise might be denied essential care.

The programs have improved quality of life and increased longevity for many. The average life expectancy has risen from 70.3 years in 1965 to 75 years in 1987. The programs also have kept many families from bankrupting themselves to finance health care for ill or disabled relatives. Below are some facts of note:

Medicare

- Medicare provides basic health care coverage to 32 million seniors and 4 million younger Americans with disabilities. Close to 1 million (932,000) Massachusetts residents receive Medicare.
- The House and Senate budget plans would cut Medicare by ~~$250-$280~~ 270 billion over seven years, a loss of $12-$15 billion for Massachusetts.
- Like Social Security, Medicare is funded through a payroll tax — a tax that today's beneficiaries paid throughout their working lives.
- The cost of Medicare is growing at an annual rate of 10 percent, largely because the population is aging. People over 85 are the fastest-growing segment of the population.
- Administrative costs of Medicare are about 3 percent of the Medicare budget, much lower than those of private insurers.
- Medicare covers about half of seniors' health care costs, with the rest paid out-of-pocket by recipients and by private insurance or Medicaid.

Medicaid

- Medicaid is funded by both the state and federal governments.
- Medicaid is a means-tested entitlement program that provides funding for health care and long-term care to low-income pregnant women, children, families, the elderly, and the disabled.
- The House and Senate budgets would cut Medicaid by $150-200 billion over seven years, a loss of more than $4-$5 billion to Massachusetts.
- Approximately 600,000 Massachusetts residents receive Medicaid benefits.
- About half of Massachusetts' Medicaid recipients are children.
- Approximately 70 percent of Medicaid dollars are spent on long-term and nursing home care for seniors and the disabled.
- Medicaid growth in Massachusetts is 4 percent per year, as compared to more than 10 percent nationally.