

Medicare Republican Fly

News From the

MEDICARE COMMUNICATIONS GROUP

A Project of the House Republican Conference

June 8, 1995

Dear Republican Colleague:

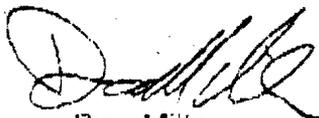
During the Memorial Day recess Frank Luntz attended several town hall meetings and focus groups on Medicare. The attached memo summarizes the key findings from these meetings.

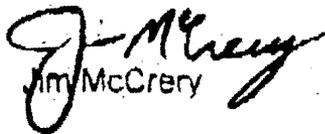
The Frank Luntz memo underscores that we must continue to stress our four basic themes:

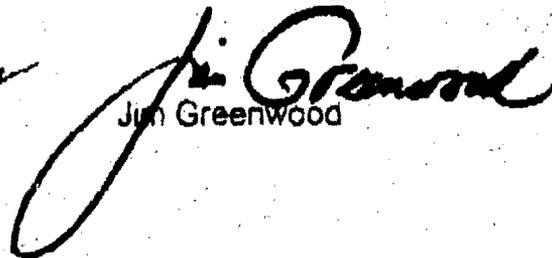
1. Medicare is going bankrupt
2. Republicans are committed to saving Medicare
3. We will spend more money — an additional \$1600 per person
4. We are listening and want ideas from constituents.

We hope this information is helpful and please give any us a call if you have any questions.

Sincerely,


Dan Miller


Jim McCrery


Jim Greenwood

Republicans are committed to protecting, preserving and strengthening Medicare

LUNTZ RESEARCH COMPANIES

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Memorandum

To: Interested Parties
From: Frank Luntz
Re: Everything You Ever Wanted to Know About Communicating Medicare
Date: June 7, 1995

"We have a problem with the national attitude. There is a feeling that, if I can get it, why not take it. You see it in Medicare every day."

"We are the patriots of America. We're the ones who hang our flags out on Memorial Day. Why should we be the ones who are asked to sacrifice yet again?"

With the help of the *United Seniors Association*, we have conducted more than a half dozen focus groups and three town hall meetings with pre-retirees and current Medicare recipients during the Memorial Day recess and over the past few weeks. This memo summarizes our key findings. We hope it will assist you in future communication efforts.

AT THE BEGINNING

1. You MUST communicate to your supporters as well as the overall senior community. Keep in mind that seniors are very "pack-oriented" and are very susceptible to following one very dominant person's lead. You must ensure that balance exists at each town meeting, and be careful to keep individual anecdotes or isolated incidents from dominating (and driving) the process.
2. Distribute the Summary of the Trustees' Report to everyone over age 50. If you can't get a hold of enough copies of the actual summary, xerox the key passages and distribute them to your constituents as they arrive for your meetings, or place them on their seats before they arrive. Nothing is more credible and powerful than the report itself, and informing your constituents of the Trustees' findings (reading to them word-for-word the most egregious conclusions) must be at the core of your communication strategy.

3. You absolutely must tell people at the outset that the Trustees include high-level Clinton Administration officials -- list who they are by name. Your audience will recognize many of the names, and that will give credibility to your defense that your efforts to strengthen Medicare are non-partisan. Remind your constituents that these Trustees warned in last year's report that Medicare was headed for bankruptcy. We cannot wait any longer to begin the rescue of the system.
4. Personalize YOUR interest in Medicare. This must take place at the very beginning of your presentation. Reassure your seniors that this issue affects you personally, and not just in theory (otherwise you may come across as an accountant rather than a human being). Talk about your parents, relatives or life-long friends currently on Medicare. For those of you in your late 50s or early 60s, you can talk about your own countdown to the day you yourself will qualify.
5. Your Number One Priority is to save Medicare. "Saving, preserving and strengthening" Medicare needs to be repeated as the central theme at the beginning, during the session and at the close. Let your seniors know that you personally will not allow a program for 37 million people to go bankrupt by ignoring its current problems.

GENERAL COMMUNICATION TIPS

There are certain communication *rules* that apply to Medicare that don't apply to other issues. Words are especially important, and setting the right tone at the outset is critical.

1. You MUST appear bi-partisan. The responses in our recent Town Halls say it all:

-- *"We sent you all to Washington to work for us, not play sides! We want the best for all people, Democrats and Republicans. You need to work together for the good of all the country."*

-- *"The unity of both parties is essential. A new broom sweeps cleaner."*

Partisanship also affects whether or not people trust the Medicare numbers you offer. Right now, the Trustees' Report is the most credible source because it lacks partisan identification (CBO credibility is questionable because of the word "Congressional" -- and no one knows what the initials mean by themselves). Be careful not to come across too harshly against the Dems, but it is acceptable to ask rhetorically for President Clinton's help.

2. Don't talk about "improving" Medicare -- you are strengthening it! We cannot afford to raise expectations, but that's exactly what you will do if you tell seniors you're going to "improve" Medicare. When seniors hear the words *improve* and *Medicare* in the same sentence, they immediately think of lower deductibles, free prescription drugs, subsidized hearing aids and eye glasses, cheaper in-home care, and reductions in everything else they now have to pay for. *The quickest path to defeat is to overpromise seniors.*
3. The newspaper is still very important to seniors. Seniors diligently read the newspaper, and they often clip articles about fraud and abuse involving Medicare. This is one issue where print media is as important as television or radio -- if not more so. Consequently, clip several local newspaper articles about Medicare waste and/or fraud and bring them to your town hall meetings to distribute to attendees. The word will spread rapidly.
4. Seniors read their mail and scrutinize their hospital and doctor bills. Everyone has a story to tell, though none as poignant as this one:

"I went in for eye surgery and they charged me for an autopsy. I complained and they came back and said, 'I'm sorry Mrs. Colby but that should have been for an EKG.' I told them I didn't have one of those either."

We were bombarded with anecdotes of over-billing, double-billing and false-billing. Ask your constituents to write your office with their accounts of abuse and also devote the first fifteen minutes of your meeting to "fraudtoids." Beginning this way helps pave the way for the following arguments about the need for change, while also letting you know at the outset who's with you and who's against you.

THE EDUCATIONAL PROCESS

The public in general, and the older population in particular, is moving in our direction, but it has been and will continue to be a slow, deliberate process. Seniors are distrustful of Washington, know their own strength as a political constituency, and simply do not believe their elected officials will turn their back on a such a strong voting block.

Knowledge

1. No one believes Medicare will actually go bankrupt. A growing number of seniors are familiar with the current Medicare debate, but they still enter the room skeptical. They have great difficulty trusting the government's numbers when they feel they've been lied to in the past (and proposed changes in how COLAs are calculated are making it worse).
2. Seniors will not even consider changes in Medicare until they're convinced the system's going broke. Before talking about new options the need for reform must be clarified. *Between now and the July 4th recess, you need to concentrate on educating the public on the problems with Medicare rather than talking about your solutions.* We will be hit hard in September if we have not laid the groundwork for our ultimate proposals. ✓
3. Explain what bankruptcy really means, and why dipping into general revenues to sustain Medicare is not an option.
4. The difference between Medicare and Medicaid is still not widely known. As a recent front page *Washington Times* headline can attest, few people distinguish between Medicare and Medicaid. It is therefore not surprising that even when quoting written articles, seniors also don't know the difference between the two. Make sure you explain the difference early in your presentation. Seniors particularly hate the idea that legal and illegal aliens are receiving government benefits in general, and Medicare or Medicaid in particular. ✓
5. Remind audiences about changes in retirement patterns over the past thirty years. Seniors know their life expectancy is significantly longer now than it was in the 1960s. They recognize they will be spending more years in retirement, and are therefore taking more out of the system. This begins to build the case for Medicare transformation.

Cost/Financing

"I know I live in a never-never land. I don't care about the medical charges because I'm not paying for them."

"The hospital tells me, 'Why are you worried about costs. You don't pay for it Medicare does.' It's that attitude that causes prices to go up."

This is at the crux of our argument. If we can't prove that Medicare is going bankrupt, we'll never be able to sell our solutions. Plan on spending no less than 30 minutes -- and up to an hour -- discussing the numbers alone. You cannot move on until your audience fully understands the financial ramifications.

1. Seniors realize that they're getting a great deal. Understandably, they're reluctant to give it up. It is therefore necessary to explain that while they may like what they have *now*, it won't be there *in the future* unless real changes are made. This is why so much effort must be devoted to the simple task of explaining that Medicare is going broke.
2. Seniors use specific figures to make their points. So should we. When discussing waste and over-billing, a surprising number of seniors point to \$10 aspirins, \$150 eye exams, and can remember the cost of their hospital bill to the penny. They have the ability to remember the cost of a single drug and a particular procedure because they *personalize* rather than *globalize* their medical care. We must do the same. Informing Medicare recipients that the average couple will take out over \$100,000 more from Medicare than they have contributed to the system personalizes Medicare's impending bankruptcy (use exact numbers) in the same manner as a \$10 aspirin personalizes its abuses.
3. The potential need for increasing premiums by 300% is the "Killer Stat." No one knows this, but the information is believed. After seniors are presented with the financial information on Medicare, they will inevitably ask for the consequences. Showing them the chart about what happens to Medicare if it goes bankrupt immediately disrupts the complacent atmosphere. The possibility that Medicare premiums will increase by 300% is simply not acceptable to seniors -- and they will do anything to prevent this from happening. (Note: The other options, such as increasing taxes on working class families, produce virtually no reaction.)
4. Even if YOU keep Medicare and the budget separate, your constituents may not. Be prepared. As more than one participant volunteered, "Republicans say they're going to balance the budget in seven years, but they also tell us that Medicare is going broke in seven years. Is this just a coincidence?" We are strengthening Medicare because we are committed to its survival. We are balancing the budget for our children and the next generation of Americans. We will succeed on both counts because we must succeed on both counts.

Waste, Fraud & Abuse

The same people who believe eliminating foreign aid will balance the budget also believe that eliminating waste, fraud, and abuse will solve the Medicare problem. For seniors, the government may be the enemy, but the real emotional venom is reserved for doctors and hospitals. What a paradox -- the very people who help keep them alive are the very people they hate the most. Everyone has a story or complaint:

- *"The doctors they all want a piece of the pie. Just yesterday, the doctor charged me \$150 just to look at my nose."*
- *"The medical profession is milking Medicare the doctors, drug suppliers and others in the medical industry. They're making too much money. They all don't need to drive a Mercedes or BMW. Some should be driving Chevys."*

1. Separate waste (defensive medicine) from fraud (deliberate defrauding) from abuse (double billing, mis-billing). When seniors complain about "waste, fraud and abuse," they actually mean three very distinct problems with the current Medicare system. To seniors:

Waste involves the unnecessary and costly tests and procedures that recipients have to undergo because the doctors and hospitals are practicing defensive medicine. Seniors have only limited sympathy for doctors and hospitals in this situation. *"Why don't we go after the medical community to decrease their fees, or at least stop recommending so many tests."*

Fraud is the deliberate attempt by doctors and hospitals to milk Medicare for every dime. Seniors want these people prosecuted to the fullest extent of the law. *"Some of these doctors keep having their patients come back and come back and come back, and it's positively unnecessary."*

Abuse is the non-deliberate billing mistakes that Medicare recipients believe take place all the time. Well over half of all seniors have personal experience with Medicare abuse -- and they all want to talk about it. *"Why can't the government train personnel to pull medical records like the income tax and check to see if doctors or hospitals overcharge? Maybe doctors and hospitals would be more careful if they thought they would be checked."*

Understand that the combination of "waste, fraud and abuse" has produced a virulent anti-physician mentality in the eyes of seniors.

- 2. Waste, fraud, and abuse cuts two ways. We must be careful not to suggest to seniors that Medicare will be fine if we eliminate all the waste, fraud and abuse in the system. Seniors are willing to accept the need for reform because of the many problems they see with the system, but they will not understand why they have to pay more for what they have now even after all the waste, fraud and abuse is eliminated.

OTHER FINDINGS

- 1. "Choice" is not a high priority with seniors. Medicare recipients are less concerned with choice of plans than they are with stability and maintaining their current doctor-patient relationship. This is especially true with older seniors. They must be told again and again that they will be able to maintain their current Medicare situation if they so choose.
- 2. Don't raise the Social Security issue. Seniors with good memories recall when Congress told them Social Security was going broke. They remember that Congress made changes to the system, and they don't expect to have to revisit it anytime soon. Any mention of future problems with Social Security only angers seniors and makes them less willing to discuss changing the Medicare system.

AT THE END

- 1. Let your constituents know that other seniors' groups exist. Show your seniors that AARP is not the only seniors' representative on Capitol Hill or nationwide. Bring information about the United Seniors Association and other groups who are doing good work on behalf of the elderly, and encourage people to investigate alternative points of view. The more we educate seniors to AARP alternatives, the more successful we will be.
- 2. Remind your audience that Republicans want to "INCREASE spending but at a slower rate." This language works. Remind your constituents that only in Washington is an increase from \$4,800 to \$6,400 (a 33% increase) per recipient defined as a cut.
- 3. Republicans must be seen as the party of hope: the party that took on the problems of Medicare head-on. It is the Democrats who are using "scare tactics" by allowing a program to go broke, to be riddled with waste and fraud, to become overly bureaucratized without offering a solution or even acknowledging a problem -- all just to score political points. Republicans *will* find a solution. For our efforts to be successful, we have to make the status quo a worse option than change.

4. You must solicit citizen input. "Government seems to be trying and is willing to listen to us old guys," said one town hall participant. Public opinion and input must be a key component of the process. Allowing seniors -- and not just Washington insiders -- to work on creating a strengthened Medicare system will help these seniors accept changes to the system.
5. You must have the last word in this debate.

*"I have gone from a negative opinion to a more positive one
I think you will make progress on this matter."*

This is what we need to hear. For too many seniors, it will be the last word that ultimately sways them. We need it to be ours. Don't end your town meetings, interviews, or public communication efforts on a down note. Do not assume that just because AHA or AARP hasn't targeted your district, or that only two people came up and talked to you about Medicare last week, that you are out of the woods. This issue is live and will remain so right up until Election Day.

Response to Republican Recess Medicare Presentation

Medicare Republican Talk Points / Response
file

House Republicans have prepared a presentation on Medicare for use at town meetings during the August recess. The theme of this presentation is that Medicare is going broke and that the Republican plan will save the program and increase choice of coverage options, all without imposing significant new burdens or financial obligations on beneficiaries.

The Republican presentation is replete with half truths and outright misstatements. Overall, it is designed to create a false impression of unprecedented, looming fiscal crisis in the Medicare trust fund. The clear purpose is to alarm senior citizens and trick them into supporting the Republican proposals for Medicare reform. The presentation then goes on to describe the Republican "solution" to this crisis as benign, even beneficial to senior citizens when, in fact, it would have the effect of destroying Medicare's protection.

Below are some of the most egregious claims included in the Republican presentation and the truthful responses to them.

Claim: Medicare is in serious financial crisis that threatens its viability. Unless action is taken soon, Medicare won't be there for those who need it.
(Charts 1-4)

Truth: Reports of Medicare trust fund bankruptcy are being distorted by Republicans for partisan gain.

The problem of projected insolvency is not new. In virtually every year since the trustee reports began, insolvency has been projected. In 12 of those years, insolvency was projected within a 10 year time frame.

Following each such projection, Congress and the Administration acted to secure the trust fund and extend its life. That is precisely what President Clinton has proposed this year.

Claim: Medicare's financial crisis is a new problem that begins next year. It has never happened before in the history of the program. (Charts 5-6)

Truth: There have been several other times in history when Medicare spending has exceeded Medicare revenues. That is what reserves are for. In raising this issue, Republicans are creating a false impression of crisis.

What matters is whether there are sufficient funds in the trust fund to pay Medicare claims. There are sufficient funds for at least the next 7 years. The President and Congressional Democrats already acted in 1993 -- without one Republican vote -- to extend the life of the Medicare trust fund for 3 years. The President's balanced budget proposal would ensure that the Medicare trust fund can continue to pay its bills for more than a decade (11 years) from today. Consistent with many times in our history, this allows adequate time to adapt to the future.

Claim: Medicare is structurally flawed so that spending is out of control. Evidence of this is the difference between what workers contribute to Medicare and the value of Medicare benefits. (Chart 7)

Truth: This is a tremendous distortion of the truth. Of course Medicare pays out more per beneficiary than workers contribute during their working lives. That is because health care costs are growing much faster than wages, not because Medicare costs are out of control.

In fact, what matters is that Medicare keeps its cost growth on a par with the private sector. From 1984-1993, Medicare per capita cost increases were lower than growth in the private sector. In the future, according to CBO, Medicare costs per capita are projected to grow only about 1 percentage point faster than private per capita costs.

Claim: The retirement of the baby boomers will exacerbate the problem of Medicare's out of control spending. That is why we must take action today to seriously curtail Medicare spending. (Charts 8-9)

Truth: As the baby boomers turn 65, starting in 2010, Medicare does have financing problems. These problems have been with us since Medicare began. The question is how to deal responsibly with this demographic reality. The President's proposal would buy us better than 10 years to develop responsible responses. The Republican proposal would destroy the program.

Claim: Medicare spending is rising more than twice as fast as private sector health care costs. (Chart 11)

Truth: Medicare spending per capita is most certainly not increasing at twice the rate of the private sector. As noted earlier, CBO data show spending

growth rates are comparable.

The particular portion of the private sector Republicans are comparing with Medicare rates doesn't take into account large employer savings achieved at the expense of workers and ignore large segments of the private sector where individuals have been shut out of the health insurance market.

Finally, this chart compares aggregate -- not per capita -- growth rates, another unfair distortion. Medicare's rolls are constantly growing while privately insured Americans are losing their coverage at an alarming and consistent rate.

Claim: Medicare spending will continue to grow at rates adequate to protect seniors under the Republican plan. No Medicare cuts are envisioned. (Charts 12-13)

Truth: While Republicans would allow Medicare to grow at 4.9% per person per year, private sector health care costs are expected to grow at 7.1% per year. That means Medicare's buying power would erode every year for every beneficiary. That is a cut, no matter how you look at it.

While the Republicans say beneficiary spending would be \$6650 in 2002, costs of coverage would be \$1000 higher even if Medicare grew at precisely the rate of private sector per capita health costs.

Claim: Republicans will give Medicare beneficiaries greater choice of plans, similar to that enjoyed by Members of Congress. (Chart 14-15)

Truth: While Republicans promise beneficiaries a choice of plans, all of these choices will be worthless with the Republican Medicare cuts. The cost of coverage will rise 40 percent faster than the value of the vouchers Republicans will give beneficiaries. The real choice beneficiaries will face will be to pay more or get less coverage. That's not choice, it's financial coercion.

The choice Republicans promise Medicare beneficiaries is not the choice Members of Congress now enjoy. Under Members of Congress' health plan, the government's contribution rises with the cost of health coverage. For Medicare beneficiaries, though, Republicans would tie vouchers to a fixed growth rate that would not keep pace with rising health insurance costs. Medicare beneficiaries deserve at least the same level of financial protection as Members of Congress.

Claim: If you don't want to choose different coverage, Republicans guarantee you can keep your traditional Medicare. (Chart 16-18)

Truth: If you want to keep your Medicare, you can certainly stay in Medicare under the Republican's plan. Sadly, that Medicare will buy you less and less protection. Between 1996 and 2002, Republicans would have you pay \$2825 (or \$5650 per couple) more in premiums and cost sharing.

THE WHITE HOUSE
Office of Media Affairs

September 14, 1995

Contact: 202/456-7150

THE UNITED STATES

**The Republican Budget Resolution Conference Agreement:
Medicaid Cuts Will Force States to Reduce Health Coverage**

Republican's Proposal: Reduce Medicaid Payments to States by 30 Percent in 2002

Republicans are proposing to cut more than \$182 billion from Federal Medicaid spending between 1996 and 2002: a cut of 20 percent over seven years and 30 percent in 2002. Even if states absorb half of the cuts by reducing services and provider payments, they would still have to eliminate coverage for 8.8 million people in 2002, according to the Urban Institute. Over 40 percent of all people losing coverage would be concentrated in five states: California, Florida, New York, Texas and North Carolina. The 8.8 million who lose coverage includes:

- 920,000 older Americans;
- 1.4 million people with disabilities; and
- 6.3 million children and their families.

The Republican proposal would force states to eliminate coverage for about 350,000 nursing home residents and another 330,000 people needing home care in 2002.*

Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Currently, Medicaid covers 68 percent of the nation's 1.3 million nursing home residents. Medicaid also serves about 1.4 million older Americans and people with disabilities using home care. Without Medicaid, families could not afford nursing home care that costs an average of \$38,000 per year.

The Republican proposal would force states to eliminate coverage for 4.4 million children in 2002.* Currently, over 20 percent of the nation's children rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 18 million children.

States could avoid these difficult choices only by increasing their Medicaid spending by 40 percent in 2002 -- by raising property or sales taxes, or cutting other critical state spending.

The President's Balanced Budget Proposal

The President's proposal saves \$54 billion over seven years from Medicaid, less than one-third the Republican cut and still a significant contribution toward deficit reduction. The President's Medicaid policy produces savings by reducing and retargeting disproportionate share payments, increasing state flexibility, and limiting the growth in Federal Medicaid spending per recipient. This policy constrains Federal spending but allows states to respond to unexpected changes in the number of people covered. It does not put states at risk and dismantle a program that has served as a critical safety net -- as would happen under the Republican proposal.

* U.S. Department of Health & Human Services estimates based on the Urban Institute data; numbers may not sum to totals due to rounding.

Methodology for the Medicaid State Estimates

The following describes the sources for the estimates in the September 14, 1995 White House Medicaid document.

Most of the estimates come from the July 1995 report by the Urban Institute entitled: "The Impact of the Budget Resolution Conference Agreement on Medicaid Expenditures" (July 1995). This report and supplemental analyses by the Urban Institute are the source for:

- Dollar and percent reduction in Federal Medicaid payments by state;
- Number of total people losing coverage, number of people in families, elderly, and disabled losing coverage under the proposal.

The estimates for the number of children and nursing home residents and home health users losing coverage were calculated by the Department of Health and Human Services based on the Urban Institute data. Both sets of estimates were derived by: (a) calculating the number of children and nursing home residents and home health users in 1993 as a percent of people in families and the aged and disabled, respectively; and (b) applying those percentages to the number of people in families and aged and disabled losing coverage in 2002. For example, in California, 62.3 percent of people in families were children in FY 1993. It was assumed that within families there is no disproportionate reductions in coverage of adults or children -- people are cut in proportion to their representation the group. This percent of children was multiplied by the Urban Institute estimate of the number of people in families losing coverage -- 918,095 -- to estimate that about 571,700 children in California could lose coverage in 2002.

The estimated increase in state spending to offset the loss of Federal funds was also calculated by the Department of Health and Human Services based on the Urban Institute data. This percentage increase was based on the Urban Institute's estimates of Federal baseline spending in 2002 and the reduction resulting from the proposal. Using the 1996 FMAPs, the state share in 2002 was estimated. Then, the reduction resulting from the proposal was added to the estimated state share to calculate the percent increase in state share if the state increased its spending to offset the loss of Federal funds.

Other facts in the document come from secondary sources. The percent of children covered by Medicaid by state comes from the March 1994 Current Population Survey. The number of children and home care users covered by Medicaid by state comes from the 1994 Health Care Financing Administration tabulation of 2082 data, submitted by states. The data on nursing home residents come from Harrington, Thollaug and Summers' report: "State Data Book on Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991 - 1991" (January 1995).

**The Republican Budget Resolution Conference Agreement:
Estimated Number of People Losing Health Coverage, 2002**

STATE	TOTAL	Aged	Disabled	Families: Adults & Kids	Long-Term Care Users	Children
U.S.	8.8 million	920,000	1.4 million	6.3 million	680,000	4.4 million
Alabama	102,000	12,300	25,500	64,500	11,000	45,800
Alaska	22,000	1,200	1,900	19,200	na	12,700
Arizona	110,000	na	na	na	na	na
Arkansas	122,000	16,200	29,200	76,900	13,300	53,100
California	1.2 million	95,000	145,800	918,100	34,400	571,700
Colorado	97,000	10,700	16,800	70,000	9,200	48,000
Connecticut	74,000	7,500	12,300	54,200	11,800	37,100
Delaware	21,000	1,400	3,200	16,800	1,900	12,100
District of Columbia	20,000	1,500	4,400	14,400	1,500	10,100
Florida	706,000	78,900	94,900	532,100	49,100	423,000
Georgia	383,000	41,200	63,900	277,800	24,600	188,900
Hawaii	36,000	3,400	5,600	27,500	1,500	18,700
Idaho	34,000	3,100	5,500	25,500	2,400	17,800
Illinois	274,000	22,000	55,900	196,100	25,800	137,900
Indiana	112,000	11,800	17,400	83,200	11,000	56,800
Iowa	69,000	8,700	11,700	49,100	8,500	32,800
Kansas	40,000	4,500	6,100	29,200	4,500	19,700
Kentucky	171,000	17,700	43,200	110,600	22,400	73,400
Louisiana	154,000	16,600	26,800	111,000	3,900	79,000
Maine	34,000	4,300	7,200	23,000	3,500	15,400
Maryland	116,000	10,600	22,200	83,200	7,400	58,900
Massachusetts	210,000	24,100	43,600	142,200	22,900	94,700
Michigan	215,000	15,200	42,400	157,000	22,900	100,700
Minnesota	88,000	11,300	12,100	64,300	47,000	43,900
Mississippi	141,000	18,200	29,900	92,900	5,700	67,300
Missouri	83,000	10,200	13,000	59,600	7,900	39,300
Montana	27,000	3,000	5,600	18,300	2,100	10,100
Nebraska	41,000	4,700	5,500	31,000	4,200	23,100
Nevada	26,000	2,900	4,100	19,000	1,800	12,900
New Hampshire	1,100	na	na	na	na	na
New Jersey	166,000	15,300	29,000	121,600	16,700	79,600
New Mexico	80,000	8,000	17,100	55,300	4,200	37,500
New York	645,000	66,400	100,400	478,200	71,300	343,700
North Carolina	455,000	79,300	64,000	312,300	40,900	204,600
North Dakota	18,000	2,700	2,300	12,600	2,300	8,800
Ohio	292,000	32,200	50,100	209,800	28,000	143,100
Oklahoma	125,000	14,000	16,400	94,200	3,700	65,800
Oregon	118,000	8,900	15,400	94,100	8,600	62,700
Pennsylvania	308,000	31,600	67,300	209,400	22,200	150,800
Rhode Island	51,000	7,800	11,200	32,100	12,000	21,600

Continued...

**The Republican Budget Resolution Conference Agreement:
Estimated Number of People Losing Health Coverage, 2002**
Continued

STATE	TOTAL	Aged	Disabled	Families: Adults & Kids	Long-Term Care Users	Children
U.S.	8.8 million	920,000	1.4 million	6.3 million	680,000	4.4 million
South Carolina	149,000	21,300	24,700	102,600	7,800	73,300
South Dakota	19,000	2,300	3,300	13,300	2,100	9,600
Tennessee	246,000	27,800	61,000	157,000	5,800	112,000
Texas	687,000	66,800	68,500	551,600	43,100	394,100
Utah	53,000	3,200	6,200	43,800	3,100	29,000
Vermont	20,000	2,400	3,500	14,200	1,900	9,000
Virginia	236,000	32,400	36,400	167,100	17,800	117,000
Washington	183,000	12,900	29,500	140,500	8,200	91,200
West Virginia	140,000	13,200	26,100	100,300	5,400	60,200
Wisconsin	94,000	12,800	23,000	58,000	11,300	42,600
Wyoming	15,000	1,000	1,700	12,200	1,600	8,500

NOTES:

Numbers are rounded to the nearest hundred or thousand; as a result numbers may not sum to totals due to rounding. "Long-term care users" include residents of skilled nursing facilities and users of home care. The "aged", "disabled" and "families: adults & kids" columns sum to the total recipients. The number of long-term care recipients and children losing coverage are subsets of the "aged", "disabled" and "families: adults & kids" estimates and thus cannot be added to these estimates. The first four columns are from the Urban Institute's Medicaid Expenditure Growth Model. The last two columns are U.S. Department of Health and Human Services' estimates based on the Urban Institute's estimates. All are based on the assumption that states could achieve approximately half of the savings target through reducing their growth rate per recipient to inflation plus 1.9 percent. Data for Arizona, Alaska and New Hampshire were insufficient for these analyses.

THE WHITE HOUSE
Office of Media Affairs

September 14, 1995

Contact: 202/456-7150

ALABAMA

**The Republican Budget Resolution Conference Agreement:
Medicaid Cuts Will Force States to Reduce Health Coverage**

Republican's Proposal: Reduces Medicaid Payments to States by 30% in 2002

Republicans are proposing to cut more than \$182 billion from Federal Medicaid spending between 1996 and 2002: a cut of 20% over seven years and 30% in 2002. Alabama would lose \$2 billion over the seven years, a 22% reduction in 2002 alone. Even if Alabama could absorb half of the cuts by reducing services and provider payments, it would still have to eliminate coverage for 102,000 people in 2002, according to the Urban Institute, including:

- 12,300 older Americans;
- 25,500 people with disabilities; and
- 64,500 children and their families.

The Republican proposal would force Alabama to eliminate coverage for about 11,000 people needing long-term care in 2002.* Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Currently, Medicaid covers 72% of the 19,500 nursing home residents in Alabama. Medicaid also serves about 37,400 older Americans and people with disabilities using home care in Alabama. Without Medicaid, families of the elderly and disabled could not afford nursing home care that costs an average of \$38,000 per year nationally.

The Republican proposal would force Alabama to eliminate coverage for 45,800 children in 2002.* Currently, 16% of the children in Alabama rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 244,000 children in Alabama.

Alabama could avoid these difficult choices forced by the Republican proposal only by increasing its Medicaid spending by 51% in 2002 -- by raising property or sales taxes, or cutting other critical state spending.

The President's Balanced Budget Proposal

The President's proposal saves \$54 billion over seven years from Medicaid, less than one-third the Republican cut and still a significant contribution toward deficit reduction. The President's Medicaid policy produces savings by reducing and retargetting disproportionate share payments, increasing state flexibility, and limiting the growth in Federal Medicaid spending per recipient. This policy constrains Federal spending but allows states to respond to unexpected changes in the number of people covered. It does not put states at risk and dismantle a program that has served as a critical safety net -- as would happen under the Republican proposal.

* U.S. Department of Health & Human Services estimates based on the Urban Institute data; numbers may not sum to totals due to rounding.

THE WHITE HOUSE
Office of Media Affairs

September 14, 1995

Contact: 202/456-7150

ALASKA

**The Republican Budget Resolution Conference Agreement:
Medicaid Cuts Will Force States to Reduce Health Coverage**

Republican's Proposal: Reduces Medicaid Payments to States by 30% in 2002

Republicans are proposing to cut more than \$182 billion from Federal Medicaid spending between 1996 and 2002: a cut of 20% over seven years and 30% in 2002. Alaska would lose \$429 million over the seven years, a 32% reduction in 2002 alone. Even if Alaska could absorb half of the cuts by reducing services and provider payments, it would still have to eliminate coverage for 22,000 people in 2002, according to the Urban Institute, including:

- 1,200 older Americans;
- 1,900 people with disabilities; and
- 19,200 children and their families.

The Republican proposal would force Alaska to eliminate coverage for a significant number of people needing long-term care in 2002.* Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Currently, Medicaid covers 86% of the 500 nursing home residents in Alaska. Medicaid also serves about 1,000 older Americans and people with disabilities using home care in Alaska. Without Medicaid, families of the elderly and disabled could not afford nursing home care that costs an average of \$38,000 per year nationally.

The Republican proposal would force Alaska to eliminate coverage for 12,700 children in 2002.* Currently, 20% of the children in Alaska rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 39,000 children in Alaska.

Alaska could avoid these difficult choices forced by the Republican proposal only by increasing its Medicaid spending by 32% in 2002 -- by raising property or sales taxes, or cutting other critical state spending.

The President's Balanced Budget Proposal

The President's proposal saves \$54 billion over seven years from Medicaid, less than one-third the Republican cut and still a significant contribution toward deficit reduction. The President's Medicaid policy produces savings by reducing and retargeting disproportionate share payments, increasing state flexibility, and limiting the growth in Federal Medicaid spending per recipient. This policy constrains Federal spending but allows states to respond to unexpected changes in the number of people covered. It does not put states at risk and dismantle a program that has served as a critical safety net -- as would happen under the Republican proposal.

* U.S. Department of Health & Human Services estimates based on the Urban Institute data; numbers may not sum to totals due to rounding.

THE WHITE HOUSE
Office of Media Affairs

September 14, 1995

Contact: 202/456-7150

ARIZONA

**The Republican Budget Resolution Conference Agreement:
Medicaid Cuts Will Force States to Reduce Health Coverage**

Republican's Proposal: Reduces Medicaid Payments to States by 30% in 2002

Republicans are proposing to cut more than \$182 billion from Federal Medicaid spending between 1996 and 2002: a cut of 20% over seven years and 30% in 2002. **Arizona would lose \$3 billion over the seven years, a 33% reduction in 2002 alone.** Even if Arizona could absorb half of the cuts by reducing services and provider payments, it would still have to eliminate coverage for 110,000 people in 2002, according to the Urban Institute.

The Republican proposal would force Arizona to eliminate coverage for a significant number of people needing long-term care in 2002.* Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Currently, Medicaid covers 59% of the 10,500 nursing home residents in Arizona. Medicaid also serves about 11,700 older Americans and people with disabilities using home care in Arizona. Without Medicaid, families of the elderly and disabled could not afford nursing home care that costs an average of \$38,000 per year nationally.

The Republican proposal would force Arizona to eliminate coverage for a significant number of children in 2002.* Currently, 15% of the children in Arizona rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 310,000 children in Arizona.

Arizona could avoid these difficult choices forced by the Republican proposal only by increasing its Medicaid spending by 63% in 2002 -- by raising property or sales taxes, or cutting other critical state spending.

The President's Balanced Budget Proposal

The President's proposal saves \$54 billion over seven years from Medicaid, less than one-third the Republican cut and still a significant contribution toward deficit reduction. The President's Medicaid policy produces savings by reducing and retargetting disproportionate share payments, increasing state flexibility, and limiting the growth in Federal Medicaid spending per recipient. This policy constrains Federal spending but allows states to respond to unexpected changes in the number of people covered. It does not put states at risk and dismantle a program that has served as a critical safety net -- as would happen under the Republican proposal.

Note: Due to data limitations, specific estimates for Arizona are not available.

* U.S. Department of Health & Human Services estimates based on the Urban Institute data; numbers may not sum to totals due to rounding.

DRAFT

REPUBLICAN MEDICAID PLAN ELIMINATES NURSING HOME QUALITY STANDARDS

September 27, 1995

"Do we really want to eliminate all quality standards for nursing homes?...can anybody remember what it was like to go in those places when there were no quality standards?"

-- President Clinton, September 26, 1995

The Republican Medicaid plan throws away decades of progress by repealing the common ground law signed by President Reagan that established quality standards for nursing homes and institutions caring for the mentally retarded. Nursing home residents were found lying in their own waste, injured by rough handling, developed bed sores while tied to their beds at understaffed homes, and summarily evicted when their nursing home found a prospective patient willing to pay more for their bed. We should not go back. We should not balance the budget by lowering the quality of care for seniors and the mentally retarded.

Current Law Ensures Quality Care and Fundamental Protections

In response to deplorable conditions in some nursing homes, President Reagan signed into law federal minimum standards for nursing homes that:

- protect nursing home residents from abuse and neglect
- limit the use of drugs and restraints
- prohibit nursing homes from "dumping" seniors -- evicting them when they've run out of money and qualify for Medicaid
- give nursing home residents the right to appeal decisions without retribution
- ensure that nursing aides are trained and do not have a history of abuse

Republican Medicaid Block Grant Repeals Fundamental Protections

Under the guise of reform, Republicans propose to repeal these federal Medicaid quality standards, as well as the requirement that Medicaid cover nursing home care at all. As many as 350,000 elderly would lose nursing home coverage in 2002, and once again, nursing home residents would be vulnerable to abuse and neglect, to being inappropriately restrained and drugged, and dumped onto the streets when they run out of money and qualify for Medicaid.

We have federal quality standards for airplanes, cars, and drinking water, and we should certainly have them for our nursing homes and institutions caring for the mentally retarded. We should not balance the budget by reducing the quality of their health care. We should instead honor our parents and grandparents, and improve nursing home care.

NURSING HOME QUALITY PROTECTIONS

Current Law:

- States are required to cover nursing home services.
- In response to deplorable nursing home conditions, President Ronald Reagan signed OBRA '87, a bipartisan agreement that contained comprehensive nursing home reforms including requirements that:
 - nursing home residents attain and maintain their highest level of functioning;
 - limit the use of chemical and physical restraints;
 - each resident be guaranteed certain rights and protections, including the participation in planning care and treatment, prohibitions on "dumping", and rights to grieve and appeal decisions without retribution;
 - each resident is entitled to care based upon needs identified through a comprehensive standardized assessment;
 - only trained and qualified nurse aides provide care;
 - protect residents from nurse aides with a history of abuse and neglect; and
 - establish monitoring and enforcement processes to ensure that residents are not abused and their rights are protected.

Impact of Republican Medicaid Block Grant

The Republican Medi-Grant proposal will:

- eliminate the requirement that States provide nursing home services;
- eviscerate all OBRA '87 nursing home reforms, leaving nursing home residents vulnerable to:
 - + violations of their basic human rights such as freedom from abuse and neglect and inappropriate chemical and physical restraints; and
 - + not achieving their maximum potential by not receiving needed services.
 - + care provided by unqualified and potentially abusive and dangerous staff.

The Republican Medi-Grant proposal could permit the continued operation of nursing homes that threaten resident health and safety.

FAX MESSAGE COVER SHEET

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<i>Pauline Abernathy</i>
<i>456-2223</i>
David A. Super
<i>2</i>

Comments:

~~XXXXXXXXXX~~ I was not sure how clear I was on some of what I said, esp. on the Medicare point, so I tried to put it down on paper. Feel free to use anything here that's helpful. quite obviously, this is not written in the style to be a CBPP report.

Good luck,

DS

The House and Senate Republican reconciliation bills would repeal the Nursing Home Residents' Bill of Rights and other quality of care protections from the Medicaid program. These reforms were enacted with broad bipartisan support in 1987 and signed into law by President Reagan in response to evidence of widespread abuse and neglect of the elderly in nursing homes. The public cried out for action after numerous investigations documented nursing home residents left to lie in their own waste, injured by rough handling, developing life-threatening bed sores while tied to their beds at understaffed homes, and summarily evicted when their nursing home found a prospective patient willing to pay more for their bed.

Under the Nursing Home Reform Act, a nursing home must meet minimal quality of care standards and respect certain basic rights of patients in order to receive payments under the Medicaid program. The Republican bills would roll back these hard-won gains for the frail elderly.

In theory, states could attempt to reestablish some of these standards. In reality, the strength of the nursing home lobby in most state capitals makes this unlikely. Congress acted in 1987 precisely because states had been unable to implement similar measures themselves. The strength of the nursing home lobby in state governments is evidenced by the fact that nursing home costs and reimbursement rates have been among the fastest-growing components of many states' Medicaid programs over recent years.

Republicans also have argued that quality standards will remain in force for nursing homes that participate in the Medicare program. This is far less significant than it might first appear. Although many nursing homes currently participate in both Medicaid and Medicare, few depend on Medicare for a significant portion of their revenues.¹ If the standards for participating in Medicare became significantly more exacting than those under Medicaid — through the repeal of Medicaid's nursing home quality standards — many nursing homes are likely to simply drop out of Medicare and continue to receive Medicaid dollars without having to meet quality of care standards.

Children denied health care under the Republicans' Medicaid reforms cannot speak or vote for themselves. All too often, the same will be true of the frail elderly and disabled people whose who depend on Medicaid to assure them safe, decent nursing home care.

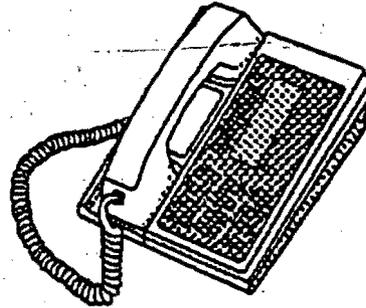
¹ Medicare pays for only a small fraction of nursing home care given in the United States; Medicaid is the largest single source of nursing home financing. In fiscal year 1992, for example, Medicaid paid nursing homes about \$38 billion; Medicare paid them only about \$4 billion. Medicare covers nursing home costs only for 100 days per spell of illness, only for patients discharged to a nursing home directly from an in-patient hospitalization, and only for patients needing intensive ongoing skilled nursing care. Most patients with chronic illnesses such as Alzheimer's disease or debilitation due to strokes will not qualify under these criteria. For them, Medicaid is the only available payer.

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age, household size, family income (consistent with Medicaid, not AFDC, deeming rules), resources (if the State imposes a resource test), and any third party liability for the woman's pregnancy-related medical expenses. Collecting only this information would require a far shorter and simpler form than that used for AFDC purposes, and should enable States to process applications in a far more timely fashion.

Subpart A.—Improvements for nursing home residents

In fiscal year 1986, the Federal government spent an estimated \$6.83 billion, or more than one-quarter of the total Federal Medicaid budget, buying services on behalf of roughly 1.4 million elderly and disabled Medicaid residents in about 15,000 nursing homes. The Congressional Budget Office projects that, if the proportion of nursing home expenditures as a percent of total Medicaid spending remains constant, this \$6.83 billion will increase to roughly \$11.6 billion by 1992. The Committee had been deeply troubled by persistent reports that, despite this massive commitment of Federal resources, many nursing homes receiving Medicaid funds are providing poor quality care to elderly and disabled Medicaid beneficiaries.

On May 12, 1987, the Subcommittee on Health and Environment heard the following testimony from Mrs. Mary Fitzpatrick, an underwriting assistant at a large insurance company, regarding the death of her 75-year-old mother, a Medicaid resident, at the Belmont Health Care Center in Nashville, Tennessee:

My mother had been in the facility for two days when the first problems appeared. I visited her and found that she was seated in her own wastes in a wheelchair. I went to ask for an aide's help in changing her, but the aide on the floor said she was too busy. I then went to the chapel, where I had found the staff usually congregated to sit around and talk. The staff, who were sitting there chatting with each other, said they were too busy. A couple of other patients said my mother had not been moved after she had had the bowel movement and had been sitting in her own wastes for at least an hour and a half. I then went back and changed Mother's clothing and cleaned her up myself.

Problems immediately showed up with the food. When my mother first went into the facility she weighed about 180 pounds. By Christmas she was down to 120. Not only was the food unpalatable, but efforts were not made to feed her. She would eat for her children, and retained a good appetite. She became unable to feed herself and there were inadequate staff to take the time to sit and feed her. The facility refused to change her diet to include more of the foods that she willingly ate for us.

My daily routine quickly became one of cleaning up my mother's wastes, bathing her and changing her linens as soon as I arrived each afternoon. Not only would the facility not provide such basic care, but I had to fight for supplies to be able to provide that care myself. I came in the Wednesday before Thanksgiving and was unable to find

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any clean linens for mother, who had been lying in her wastes for some time. I was told by the staff that there was a new policy that allowed each patient only two sets of linens. I demanded to speak personally to the facility's owner. He confirmed that that was the policy and justified it on the basis that he was not making enough money from Medicaid. I became angry and raised so much sand that he finally relented and allowed me to have fresh linens for Mother that afternoon. However, there was always a shortage of clean linens and other supplies. Keeping Mother clean, even when the family was providing the labor, was a constant battle. Of course, most of the other patients in the 210-bed facility lacked the family support that my mother had, and they simply lay in their own wastes indefinitely.

The first bedsores appeared after my mother had been at Belmont for about six weeks. The first couple of sores showed up on her back close to her tailbone. Neither of the sores ever went away. By the time of her death eight months later, one of the original sores measured about three inches across and a half inch deep.

New sores continually developed, and the ones that she had got worse. It got to the point where there was no way that she could lie that she would not be lying on a bedsore. The staff simply never complied with the instructions about turning her regularly, and she was physically unable to turn herself. The family would of course turn her while we were there, but she was supposed to have been turned every two hours. One of her worst sores was on an ankle that had been badly injured when a staff member had lowered a bed rail on it. When the family came in the day the injury occurred and found what had happened, I asked three separate members of the nursing staff to write up the incident, but it never found its way into Mother's medical chart.

As with the constant battles over obtaining linen, the family faced a constant struggle keeping Mother stocked with needed medical supplies. We brought from home a couple of sheepskins, and they disappeared the second day Mother was at Belmont. Next to go were a necklace given to her by my brother, and then her earrings. Most of her Christmas presents had disappeared within the first week after the holidays. The family was constantly having to supply new gowns to replace the ones that disappeared. In order to pad the growing number of bedsores and chafed places all over my mother's body, the family kept bringing pillows, but they too would disappear.

Not only would the staff not turn my mother as required, or bathe her bedsores and keep them free from waste, but the family had to dress the sores themselves. Because there was so little staff, two sympathetic nurses taught me how to clean the bedsores and gave me the name of a medical supply company where I could get special dressings. I bought and used these dressings on a regu-

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lar basis. The nursing home administration kept offering the alibi that they couldn't find out whether the pharmacy carried these dressings. I was later told by the pharmacists that such dressings were routinely supplied to Belmont's skilled nursing wards, but that the administration was unwilling to spend the money for dressings for the intermediate level patients.

In late February of 1984, I came to the facility and found my mother in what was apparently a state of shock. There was never any explanation for what had happened, but one of her legs was almost entirely black and blue from the knee down. We were told that Mother would probably not survive the night, but she did. Thereafter she was moved to a skilled bed, where she remained until her death in July. The reason for moving her, it was said, was that she was refusing to eat and needed to be tube fed.

The tube feeding process was unattended by staff in the same way that other nursing functions were neglected. The tube goes through the patient's nose down to the stomach. A pump pushes the food through the tube. The bags would go empty, but no one would come around to close them off so the patients would lie there with the tubes down their throats and the pump motors running. My brother and I would turn off Mother's tube feeder and do the same for the other patients in her room.

One of the things that bothers me the most is that I know that my mother was aware of what was going on, even though she could not express herself other than through gestures and facial expressions, until shortly before her death.

We started looking for somewhere we could move my mother to after she had been at Belmont about a month and it was clear that the problems were not going to be addressed. However, by that time she had a staph infection, and no other facility would take her. After that, she just continued to get worse and worse, so there was never any possibility of persuading another facility to accept her; although we tried.

On Thursday afternoon, July 5, when I came in, I could see from the doorway that Mother's sheets were all soaked with blood. She was lying on her side crying, I pulled back her covers and found that her bedsores had been debrided right there in the nursing home. (Debridement is cutting away of dead tissue in bedsores so that good tissue can come back). Her blood-soaked bandages had not been changed. Debridement is not necessarily a procedure that requires hospitalization, but due to the depth of Mother's bedsores, and so many of them, I was shocked that the doctor had done hers at the nursing home, and even more so when we turned her and I realized he had done both hips. She couldn't lie on her back so she had to lie on one side or the other. She must have been in agony. I asked what they could do for the pain and the nurse said, 'Tylenol is all we can give.'

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I stayed with Mother until 11:00 that night and we lifted her and turned her every two hours. Between turnings my brother and I went looking for a hospice or someplace we could take her to. I wanted to get her a waterbed and just take her home. She was in such bad shape that I went to the nurse in charge and also the aide for her room and asked them to please relay the message that the bedsores had been debrided and when they turned Mother to please make sure they didn't drag her, to pick her up. It would take two people. When I came back the next morning at 7:00 a.m. she was in exactly the same position as I had left her the night before.

I think Mother probably went into shock, but in any event she died the following day, July 7, 1984.

When I was getting ready to go to the funeral home, I received a call at home from the State inspector. He said he was calling to let me know that they had just been out a few days ago to investigate the allegations I had made three weeks earlier, and that I would be pleased to know that they had found that most of my complaints were substantiated. I told him that it was too late, and that Mother was dead.

The undertaker said that he had never seen a body in such bad condition, and he had to enclose the lower half of her body in a plastic bag.

The Committee is informed that the Belmont Health Care Center, now known as the Stratford Hall Health Care Center, continues to participate in the Medicaid program. Since 1983, it has received over \$8 million in Medicaid funds. The State has temporarily suspended payment for new Medicaid admissions to the facility on four separate occasions since the death of Mrs. Fitzpatrick's mother, most recently in April, 1987.

A recent report by the General Accounting Office, "Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed" (July, 1987), confirms that the Belmont nursing home's repeated noncompliance with Medicaid requirements is not an isolated event. Based on a review of the compliance histories of nearly 8,300 skilled nursing facilities and 6,000 intermediate care facilities participating in Medicare and Medicaid in November, 1985, GAO found that 41 percent of skilled nursing facilities and 34 percent of intermediate care facilities were out of compliance during three consecutive inspections with one or more of the Medicaid requirements most likely to affect patient health and safety. The GAO concluded: "Nursing homes can remain in the Medicare and Medicaid programs for years with serious deficiencies that threaten patient health and safety by taking corrective action to keep from being terminated each time they get caught."

In the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, the Congress imposed a 6-month moratorium on the implementation of any changes in Medicare or Medicaid regulations relating to the conditions of participation or survey and certification requirements for skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). The moratorium came in response to proposed

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LIBRARY SYSTEMS

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rules published by the Secretary on May 27, 1982, which would have made major revisions in the current requirements. HCFA subsequently requested that the Institute of Medicine (IOM) of the National Academy of Sciences undertake a study of the policies and regulations governing the certification of nursing homes participating in Medicare and Medicaid. In March, 1986, the IOM Committee on Nursing Home Regulation issued its comprehensive 415-page report, "Improving the Quality of Care of Nursing Homes."

The IOM Committee found a "broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation." The IOM Committee observed that many nursing facilities throughout the country deliver "excellent care." However, the Committee noted that "in many other government certified nursing homes, individuals who are admitted receive very inadequate—sometimes shockingly deficient—care that is likely to hasten the deterioration of their physical, mental, and emotional health." The IOM Committee concluded that "the poor-quality homes outnumber the very good homes."

The Committee is deeply troubled that the Federal government, through the Medicaid program, continues to pay nursing facilities for providing poor quality care to vulnerable elderly and disabled beneficiaries. The IOM report suggests a major overhaul of all three elements of the current regulatory system: the conditions of participation in Medicaid, which define compliance; the survey and certification process, through which compliance is monitored; and sanctions, with which noncompliance is remedied and deterred. Using the IOM report as a starting point, the Committee amendment would make major revisions in the three main elements of the current regulatory system. The central purpose of these amendments is to improve the quality of care for Medicaid-eligible nursing home residents, and either to bring substandard facilities into compliance with Medicaid quality of care requirements or to exclude them from the program.

The Committee observes that HCFA has begun to make some changes in current regulatory policies. In response to a court order, HCFA has revised the current survey process to enable it to determine whether Medicaid facilities are providing high quality care. The proposed Long-Term Care Survey Process, 52 Fed. Reg. 24752 (July 1, 1987), is intended to shift the focus of annual surveys from facility characteristics to resident outcomes and the actual provision of services. At the hearing held by the Subcommittee on Health and the Environment on this matter in May, 1987, HCFA testified that it was in the process of developing regulatory revisions of the current conditions of participation to improve the quality of care in Medicaid nursing homes. As of September, 1987, the Secretary had not published any proposed regulations. Even if the Secretary does eventually publish new regulations, the Committee is persuaded that many of the changes necessary to improve the quality of care for Medicaid residents in nursing homes are beyond the scope of the Secretary's authority under current law, and will require the following statutory changes.

2313-272

Improving
the Quality of
Care in •
**Nursing
Homes**

INSTITUTE OF MEDICINE



1
Introduction and Summary

PURPOSE OF THE STUDY

This is the report of a study of government regulation of nursing homes (excluding intermediate care facilities for the mentally retarded). The study's purpose was to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care.

In May 1982, the Health Care Financing Administration (HCFA) announced a proposal to change some of the regulations governing the process of certifying the eligibility of nursing homes to receive payment under the Medicare and Medicaid programs. The changes were responsive to providers' complaints about the unreasonable rigidity of some of the requirements. The proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized states, if they so wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of state inspection as a basis for certifying that Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) are in compliance with

the federal conditions of participation and operating standards.

The HCFA proposal was strongly opposed by consumer groups and most state regulatory agencies because the proposed changes were seen as a movement in the wrong direction—that is, towards easing the stringency of nursing home regulation—and because they did not deal with the fundamental weaknesses of the regulatory system. The controversy generated by the proposal caused Congress in the fall of 1982 to order the HCFA to defer implementing the proposed changes until August 1983 and ultimately resulted in a HCFA request to the Institute of Medicine (IOM) of the National Academy of Sciences to undertake this study. The contract between the HCFA and the IOM became effective on October 1, 1983. The charge to the IOM Committee on Nursing Home Regulation was to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible."¹

THE PUBLIC POLICY CONTEXT OF THE STUDY

There is broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. The implicit goal of the regulatory system is to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. This happens in many nursing homes in all parts of the country. But in many other government-certified nursing homes, individuals who are admitted receive very inadequate—sometimes shockingly deficient—care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be

subject to physical abuse. The apparent inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them is the underlying circumstance that prompted this study.

In the past 15 years many studies of nursing home care have identified both grossly inadequate care and abuse of residents.²⁻²³ Most of the studies revealing substantial evidence of appallingly bad care in most parts of the country have dealt with conditions during the 1970s. However, testimony in public meetings conducted by the committee in September 1984, news reports published during the past 2 years, recent state studies of nursing homes, and committee-conducted case studies of selected state programs have established that the problems identified earlier continue to exist in some facilities: neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the committee and of resident advocacy organizations, is that these disturbing practices now occur less frequently.

Residents and resident advocates, both in public hearings and in a study of resident attitudes conducted by the National Citizens' Coalition for Nursing Home Reform,²⁴ expressed particular concern about the poor quality of life in many nursing homes. Residents are often treated with disrespect; they are frequently denied any choices of food, of roommates, of the time they rise and go to sleep, of their activities, of the clothes they wear, and of when and where they may visit with family and friends. These problems may seem at first to be less urgent than outright neglect, but when considered in the context of a permanent and final living situation they are equally unacceptable.

The quality of medical and nursing care in many homes also leaves much to be desired. Geriatrics is becoming, in the mid-1980s, an area of concentration within internal

medicine, family medicine, and psychiatry. (Both the American Academy of Family Practice and the Board of Internal Medicine have decided to establish certificates recognizing geriatric competence.) Many conditions that were once accepted as inevitable consequences of old age now can be treated or alleviated. Physicians and nurses in nursing homes are not always aware of advances in geriatrics so that even in pleasant and humane institutions examples may be found of residents whose disability could be reduced, whose pain could be controlled, or whose depression could be treated if they received proper medical care. A lower standard of medical and nursing practice should not be accepted for nursing home residents than is accepted for the elderly in the community. Given the fragility of nursing home residents and their dependence on medical care for a satisfactory life, practice standards should even be higher. Thus, physicians, as well as nurses, have substantial responsibility for quality of care in nursing homes.

These observations do not mean that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership. Such facilities serve both as evidence that overall performance can be improved and as markers for how that improvement can be accomplished.

The question asked by the committee was: How can the problems observed in nursing homes in the 1980s best be addressed? The current national tone is antiregulatory. Nursing homes are a service industry. Could not the observed problems be solved by decreasing regulation and allowing market forces to work? This viewpoint was advocated by some who spoke at public meetings or submitted ideas to the committee. Those who wished to see a freer market were particularly anxious to have restrictions on bed supply lifted.

A freer market was not considered by the committee to be a serious alternative to more effective government regulation for two reasons.

First, under present circumstances, a free market for nursing home care will remain a theoretical concept until such time, if ever, that a major portion of the financing of long-term care services has shifted from public sources (primarily Medicaid) to private insurance. This is not likely to occur very soon. About half of current nursing home revenues come from appropriated state and federal funds through state-controlled Medicaid programs. Most people enter nursing homes as private-pay residents and soon "spend down" their income and assets until they become eligible for Medicaid. With few exceptions, community-based or home-based long-term care services—that might keep some people who require long-term care from entering nursing homes—are not eligible for Medicaid or other sources of public support. Most states maintain tight control on bed supply to control growth of their Medicaid budgets. They have learned that if they allow uncontrolled growth of nursing home beds, the additional beds would quickly be filled with residents now being cared for privately and informally in the community. Such residents would initially be private-pay, but would soon "spend down" to Medicaid eligibility.

Second, historical experience hardly supports an optimistic judgment about the effects on quality of care of allowing market forces, to exert the primary influence over nursing home behavior. Nursing homes were essentially unregulated in most states prior to the late 1960s. Their operations were governed almost entirely by market forces, and the quality of care was appalling. (See Appendix A.)

Persons needing nursing home care generally suffer from a large array of physical, functional, and mental disabilities. A significant proportion of all residents are mentally impaired. The average resident's ability to choose rationally among providers and to switch from one provider to another is therefore very limited even if bed occupancy rates are low enough to make such choices feasible. But they are not. In most communities, bed availability is the controlling factor because occupancy rates are very high. Moreover, some who reside in nursing homes lack close family to act as their advocates. Even

if they have family, the choice of a nursing home is usually made relatively hastily in response to a new illness or disability level; once in an institution, the opportunities for transfer to another nursing home are very limited.²⁵

The difficulties inherent in choosing among nursing homes are further exacerbated by the financial status of many residents. Because of the cost, few individuals or families can afford a prolonged nursing home stay.²⁶ As a result, government programs, primarily Medicaid, assist in paying for more than 60 percent of all care. In most states, Medicaid rates are lower than those paid by private residents. As a result the nursing home market is in fact two markets—a preferential one for those who can pay their way and a second, more restricted one, for those whose stays are paid by Medicaid.²⁷

Regulation is essential to protect these vulnerable consumers. Although regulation alone is not sufficient to achieve high-quality care, easing or relaxing regulation is inappropriate under current circumstances.

The federal regulations now governing the certification of nursing homes under the Medicare and Medicaid programs have been in place, essentially unchanged, since the mid-1970s. Their central purpose is to assure that nursing home residents²⁸ receive adequate care in a safe facility and that they are not deprived of their civil rights. The regulations have a number of conceptual and technical weaknesses that were recognized almost from the time the regulations were promulgated. And, the regulations are administered and enforced very unevenly by the states. Yet there is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers, and state regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement.

Providers, consumer advocates, and government regulators all are dissatisfied with specific aspects of the

regulations and the way they are administered.²⁹ Consumer advocates (nursing home residents, their families, and representatives of organizations concerned with protecting the interests of nursing home residents) contend that the standards are inadequate and their enforcement is too lax because too many nursing homes that pass inspection still provide unacceptably poor or only marginally adequate care. Moreover, they contend that violations of residents' rights occur in many homes and that often such violations either are not detected or are ignored by the regulatory authorities. The providers (nursing home operators, administrators, and professional staff) are concerned with the excessive attention to detailed documentation, the emphasis on structural specificity with the inherent (and sometimes irrational and costly) inflexibility that such specificity implies, and with the ambiguity of some of the standards (for example, the use of such words as "adequate") that result in inconsistent, subjective interpretations by state and federal surveyors. Some government regulators at both state and federal levels believe there is merit in both sets of contentions.

Since the present regulatory framework was set in place about 10 years ago, there have been developments that make possible a more effective regulatory system. There is deeper understanding of what is meant by high-quality care for nursing home residents and how to provide it, more knowledge of how to assess quality of care objectively, and better understanding of what it takes to operate a more effective quality assurance system. The nursing home industry itself has grown in managerial capability and professionalism. These developments make it possible now to redesign the regulatory system so that it will be much more likely to assure that all nursing homes provide care of acceptable quality.

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The cost effects of strengthening the ombudsman program are not entirely clear. The federal and state contributions to the ombudsman program are now too small; they will have to be increased if the program is to become more effective. But the effects of an improved ombudsman program on state survey agency costs are not clear. One possibility is that it could increase the number of complaints that have to be investigated by the survey agency. But another is that it could have the opposite effect: The volume of complaints could go down as ombudsmen work more effectively in resolving problems within nursing homes. Probably both types of effects will occur, but it is clearly impossible to make any quantitative forecasts of the net effect on costs.

Program Costs

The recommendation to eliminate ICFs will increase the costs of care in some states more than in others, but it is not clear by how much. In many states that have mainly ICF facilities, the actual average staffing is already well above the minimum federal requirements because the homes have had to accommodate a growing proportion of heavy-care residents. Nevertheless, requiring compliance with SNF standards almost certainly will increase costs in some nursing homes in some states. This may lead to increases in Medicaid budgets in some states.

The costs to the nursing homes of the resident assessment system are not likely to be significant. All nursing homes should be doing resident assessments as a basis for care planning anyway. The good nursing homes have been conducting very comprehensive assessments of their residents as part of their normal resident care activities. The federal requirement to do so in a standard way should not add significantly to resident care costs.

In sum, the regulatory changes recommended in this report will increase both regulatory and program costs in the short term, but the benefits to society and to the nursing home residents will be well worth the additional costs.

Notes

CHAPTER I

1. The original contract specified a 22-month study. The contract completion date was subsequently extended 7 months.
2. U.S. Senate Special Committee on Aging. 1974. *Nursing Home Care in the United States: Failure in Public Policy*. Washington, D.C.: U.S. Government Printing Office.
3. Mendelson, Mary Adelaide. 1974. *Tender Loving Greed*.
4. Moss, Frank, and Val Halamanderis. 1977. *Too Old, Too Sick, Too Bad—Nursing Homes in America*. Germantown, Maryland: Aspen Systems Corporation.
5. Arkansas Legislative Joint Performance Review Committee. 1978. *Nursing Home Study—1978: Evaluation of State Regulation of the Nursing Home Industry*.
6. Commission on California State Government Organization and Economy. 1983. *The Bureaucracy of Care: Continued Policy Issues for Nursing Home Services and Regulation*.
7. Auditor General of California. 1982. *The Department of Health Services. Long-Term Care Facilities*.

8. Colorado Attorney General's Office. 1977. Report of the Attorney General Concerning the Regulation of the Nursing Home Industry in the State of Colorado.
9. Governor's Blue Ribbon Nursing Home Commission. 1976, 1980. Report of the Blue Ribbon Committee to Investigate the Nursing Home Industry in Connecticut.
10. Office of the Inspector General, Florida Department of Health and Rehabilitative Services. 1981. Nursing Home Evaluative Report.
11. Office of the Inspector General, Florida Department of Health and Rehabilitative Services. 1983. An Evaluation of the District XI Long-Term Care Unit.
12. Illinois Legislative Investigating Commission. 1984. Regulation and Funding of Illinois Nursing Homes.
13. Maryland Commission on Nursing Homes. 1973. Report of the Governor's Commission on Nursing Homes.
14. Plante and Moran Consultants Inc. 1981. Michigan Department of Public Health, Bureau of Health Care Administration, Division of Health Facilities Certification and Licensure Management and Operations Review.
15. Minnesota House and Senate Select Committees on Aging. 1976. Final Report, Nursing Home Study.
16. New Jersey State Nursing Home Study Committee. 1978. New Jersey Report on Long-Term Care.
17. New York State Moreland Act Commission. 1975. Regulating Nursing Home Care: The Paper Tigers.
18. New York State Moreland Act Commission. 1976. Long-Term Care Regulation: Past Lapses, Future Prospects.
19. Ohio General Assembly Nursing Home Commission. 1978. A Program in Crisis: An Interim Report.
20. Ohio General Assembly Nursing Home Commission. 1979. A Program in Crisis: Blueprint for Action.
21. Oregon Joint Interim Nursing Home Task Force. 1978. Report of the Joint Interim Task Force on Nursing Homes.
22. State of Texas Nursing Home Task Force. 1979. Report on Nursing Homes to the Attorney General of the State of Texas.
23. Joint Legislative Audit and Review Commission. 1978. Long-Term Care in Virginia.

24. Spalding, Joy. 1985. A Consumer Perspective on Quality Care: The Residents' Point of View. Analysis of Residents' Discussions. National Citizens' Coalition for Nursing Home Reform. Washington, D.C.
25. Weisbrod, B. A., and M. Schlesinger. December 1983. Public, Private, Non-Profit Ownership and the Response to Asymmetric Information: The Case of Nursing Homes. Unpublished paper.
26. U.S. House of Representatives. Select Committee on Aging. July 1985. America's Elderly at Risk. Washington, D.C.: U.S. Government Printing Office.
27. Scanlon, William J. 1980. Nursing Home Utilization Patterns: Implications for Policy. *Journal of Health Politics, Policy and Law* 4(4):619-641.
28. The terms "patients" and "residents" often are used interchangeably when referring to the recipients of care in nursing homes. The current federal regulations pertaining to Skilled Nursing Facilities use the term "patients." The Intermediate Care regulations refer to "residents." The committee prefers the term "residents" for those being cared for in nursing homes because it more clearly conveys the idea that most people admitted to nursing homes live in them for many months or years.
29. The committee received testimony to this effect from dozens of witnesses at the public meetings it conducted in Philadelphia, Atlanta, Dallas, Minneapolis, and Los Angeles in September 1984. Similar testimony was recorded in public hearings conducted by the HCFA in 1978.
30. Katz, S., and C. A. Akpom. 1976. A Measure of Primary Sociobiological Function. *International Journal of Health Sciences* 6(3):493-507. The "activities of daily living" are bathing, dressing, toileting, transfer, continence, and feeding.
31. Scanlon, W. J., and J. Feder. January 1984. The Long-Term Care Marketplace: An Overview. *Health Care Financial Management*. Pp. 1-13.
32. These pressures are attributable primarily to demographic trends—the rapid growth in the numbers of very old and very frail elderly persons in the population, and the constraints on nursing home bed

- supply which have resulted in a nursing home bed shortage in most parts of the country. Unfortunately, good recent data to demonstrate the increasing proportion of heavy-care residents are not available. The last national nursing home survey was conducted in 1977. The National Center for Health Statistics now plans to conduct its next national survey of nursing homes in 1986. The most recent analysis of the available data is contained in: U.S. General Accounting Office. 1983. *Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly*. Report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives. GAO/IPE-84-1, October 21, 1983.
33. Health Care Financing Administration. 1985. Unpublished data based on "cleaned" 1984 Medicare/Medicaid data.
 34. U.S. Department of Health and Human Services, Office of Inspector General. April 1982. *Board and Care Homes: A Study of Federal and State Actions to Safeguard the Health and Safety of Board and Care Home Residents*. Washington, D.C.
 35. Sirrocco, A. 1983. *An Overview of the 1980 National Master Facility Inventory Survey of Nursing and Related Care Homes*. National Center for Health Statistics.
 36. National Center for Health Statistics. 1981. *Utilization Patterns and Financial Characteristics of Nursing Homes in the United States: 1977 National Nursing Home Survey*. Data from the National Health Survey Series B, No. 53, HHS Pub. No. (PH5) 81-1714.
 37. U.S. Senate, Special Committee on Aging. 1984. *Developments in Aging: 1983*. Vol. 1. Washington, D.C.
 38. Arnett, R. H. III, C. S. Cowells, L. M. Davidoff, and M. S. Freeland. Spring 1985. *Health Spending Trends in the 1980s*. Health Care Financing Review.
 39. U.S. Department of Labor, Bureau of Labor Statistics. 1984. *Employment Projections for 1995*, Bulletin 2197. Washington, D.C.
 40. U.S. Department of Health, Education, and Welfare. 1974. *Enforcement of Life Safety Code Requirements in*

- Skilled Nursing Facilities*. Office of Nursing Home Affairs, Public Health Service. January.
41. *Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984). *Smith v. O'Halloran*, 557 F. Supp. 289 (D. Colo. 1983), *rev'd sub nom.*
 42. Kemanis, V. 1980. *A Critical Evaluation of the Federal Role in Nursing Home Quality Enforcement*, 51 *University of Colorado Law Review* 607.
 43. Estimated. The actual fraction may be larger. In states with "medically needy" programs, many of the residents with private incomes below the "medically needy" eligibility ceiling share the costs of nursing home care with Medicaid.
 44. National Center for Health Statistics. 1979. *The National Nursing Home Survey: 1977 Summary for the United States*, Vital and Health Statistics. Data from the National Health Survey Series 13, No. 43. HHS Pub. No. (PHS) 79-1794.
 45. U.S. General Accounting Office. October 1983. *Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly*. Report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives.
 46. Systemetrics, Inc. December 1983. *The MMACS Long-Term Care Data Base: Construction of a New Research File and an Assessment of Its Quality and Usefulness*. Report prepared for the Health Care Financing Administration.

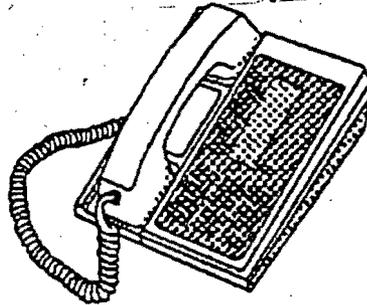
CHAPTER 2

1. National Center for Health Statistics. April 1981. *Characteristics of Nursing Home Residents, Health Status, and Care Received: National Nursing Home Survey, United States, May-December 1977*. U.S. Department of Health and Human Services Pub. No. (PHS) 81-1712.
2. Linn, M., and J. Mossey. Summer 1980. *The Role of Payment Sources in Differentiating Nursing Home Residents, Services and Payments*. Health Care Financing Review.

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LOM report (March 1986)

**REPUBLICAN MEDICARE PLAN:
PAY MORE FOR SECOND-CLASS HEALTH CARE**

- 1. ANY WAY YOU SLICE IT, THE REPUBLICAN MEDICARE CUT IS THREE TIMES LARGER THAN ANY CUT IN HISTORY AND MEANS YOU WILL PAY MORE TO GET LESS.**

- 2. MEDICARE RECIPIENTS WILL PAY MORE OUT-OF-POCKET -- TO FUND A TAX BREAK FOR THE WEALTHY:**
 - \$1,700 less per beneficiary in 2002
 - Double Deductibles
 - Raise Premiums
 - Raise the Medicare eligibility age to 67

- 3. MEDICARE RECIPIENTS WILL PAY MORE, YET THE CUTS WILL MEAN AN INFERIOR, SECOND-CLASS MEDICARE PROGRAM:**
 - Private health premiums increased by cost-shifting
 - Hospital closings threatened
 - Doctors driven out of the program and turning away recipients

REPUBLICAN MEDICARE PLAN: PAY MORE FOR SECOND-CLASS HEALTH CARE

Pay More and Get Less -- For Tax Cuts for the Wealthy. Any way you slice it, the Republican Medicare cuts will force you to pay more to get less -- just to fund a tax cut for the wealthy. The GOP plan will increase out-of-pocket costs for all seniors -- regardless of their income or health. Medicare *benefits per beneficiary will be cut \$1,700* in 2002, forcing spending to grow *33 percent slower than in the private sector*. Both the House and Senate plans increase premiums, and the Senate plan also cuts benefits and doubles deductibles from \$100 a year today to \$210 a year in 2002. And not one penny of the increased premiums will go to the Medicare trust fund. Instead, seniors will pay more out-of-their-pockets to fund a huge tax cut for the wealthy.

Pay Taxes for Two More Years and Wait Two More Years for Benefits. The Senate plan would gradually *delay the Medicare eligibility age from 65 to 67* beginning in 2003. Tens of millions of Americans would have to work longer and pay more taxes to get fewer years of Medicare. For someone working a desk job in Washington, that may not seem too bad, but to millions of Americans with physically demanding jobs, it is not just bad -- it is unfair.

Everyone's Premiums Will Increase From Cost Shifting. Lewin-VHI, an independent research firm, found that the Republican \$452 billion cut in Medicare and Medicaid will lead doctors and hospitals to *raise their fees on private patients by at least \$90 billion -- essentially a new \$90 billion tax on everyone with private health insurance*. This cost-shifting will increase the cost of private health insurance, which would effectively reduce wage increases by 2.7%, and by as much as 10% for lower-wage workers.

Gambling with Medicare to Benefit the Healthiest and Wealthiest. Republicans would experiment with Medicare by creating Medical Savings Accounts (MSAs) under which the healthiest and wealthiest could gamble at the expense of everyone else. Under the MSA proposal, healthy seniors who could afford to risk paying a high deductible would have incentives to elect catastrophic health insurance with a very high deductible. This would leave the less healthy seniors with higher average health care costs -- and who cannot afford to gamble with deductibles starting at \$3,000 -- in the traditional Medicare program. A new study by Lewin-VHI found that MSAs would substantially increase traditional Medicare program costs.

Hospitals Will Close and Doctors May Refuse Medicare Patients. Many rural and urban hospitals depend on Medicare for a large share of their income. By making the deepest cuts in health care provider payments in history, the Republican plan would force many rural and urban hospitals to close. Lower payments to doctors also would create huge incentives for physicians to refuse to take Medicare patients.

Raises Taxes on Working Americans. The Senate plan imposes new payroll taxes on many state and local government employees at a time when the Republicans are cutting taxes for the wealthy. Medicare does not currently cover government workers in many states who began work before 1986 and they therefore are not subject to the Medicare payroll tax. Republicans would require all state and local workers to pay Medicare payroll taxes, raising taxes on workers and imposing an "unfunded mandate" on state government in violation of the unfunded mandates law that Congress enacted earlier this year.

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.

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.

BUDGET
TALKING
POINTS

BUDGET TALKING POINTS
Tuesday, May 16, 1995

**THE REPUBLICAN BUDGET: Medicare Cuts For Seniors and
Tax Hikes for Working Families To Pay for Tax Cuts for the Wealthy**

"I believe that deficit reduction is good for our economy. It lowers interest rates. It promotes growth if it's done in the right way."

President Clinton
Tuesday, May 16, 1995

President Clinton has voiced concerns about the budgets proposed by Republicans in Congress:

Medicare Cuts. We should not cut Medicare deeply to pay for tax cuts for upper income citizens. We do have to slow the growth of Medicare, and it is refreshing to hear the majority in Congress acknowledging that after two years of denying that there is a crisis in Medicare. But the proper way to do slow Medicare growth is within the context of health care reform.

The Education Deficit. In cutting the budget deficit, we must not ignore our other deficit, the education deficit. The most significant thing about America in the last 15 years is the stagnant wages of working people and the growing inequality among middle class people because they do not have the skills they need to compete in the global economy. We should not cure the budget deficit by enlarging America's education deficit.

Republicans have repeatedly promised that they could provide a huge tax cut targeted at the wealthy, balance the budget by 2002--and not hurt the elderly or raise taxes on working families. Their budgets show that these were false promises. Republicans have broken their contract with:

- Historically severe cuts in Medicare and
- Tax hikes for working families,
- To finance their tax break for the wealthy.

Republicans are Making the Largest Medicare Cut in History to Pay for Their Tax Cut and Campaign Promises. On April 28, Speaker Gingrich said that Medicare would not be a part of the Republican budget cuts. He could not have been more wrong. Medicare takes the largest single cut in the Republican budget. By their accounting, nearly 25 cents out of every dollar that Republicans cut is from Medicare. The cut is three times larger than the largest previous Medicare cut in history.

Their Medicare Cut Is About Paying for Tax Cuts and Hitting Arbitrary Deficit Targets --Not About the Economy or Health Care Reform. The proposed Medicare cuts of \$250 billion to \$300 billion are needed to make room for most--but not all--of a \$345 billion tax cut that provides a tax break of over \$20,000 for the wealthiest 1 percent. Speaker Gingrich and Majority Leader Dole have rejected the White House's call to renounce tax breaks for the wealthy; instead, Speaker Gingrich calls the Contract tax cuts his "crown jewel," while Senate Majority Leader Dole and Senator Gramm have insisted they will make room for the tax cut. However the tax cuts are officially paid for, the fact remains that the entire Medicare cut would be totally unnecessary if Republicans did not need to pay for their tax cuts.

When It Comes to Health Care, Republicans Single Out Seniors for Pain --Cutting Growth Per Person in Their Medicare Below Growth in Private Health Care. Republicans claim that they are just slowing the "exploding" rate of growth in Medicare. In fact, the cost *per person* in Medicare is about the same as the private sector, even though Medicare deals with a population more prone to have health problems. The Republican approach ignores health care costs generally, and simply cuts the average growth rate for a Medicare recipient far below that for other Americans not on Medicare. *Medicare was designed to provide health insurance for senior citizens, not get turned into a second-class citizen program in order to meet arbitrary campaign promises.*

By 2002, Republican Cuts Would Increase Out-of-Pocket Costs by About \$900 a Year and Devastate Rural Hospitals. If cuts are distributed evenly between providers and beneficiaries, they represent about a \$900 increase in out-of-pocket costs per beneficiary per year. That is equivalent to eliminating 40%-50% of the Social Security cost-of-living allowances for each Medicare beneficiary between now and 2002. As reimbursement rates decline, many rural hospitals that rely on Medicare would have to close down.

Republican Medicaid Cuts Would Drastically Raise Long-Term Care Costs for Working Families. If the Republican cuts were divided evenly among eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, they would force states to cut off coverage for 5 to 7 million children and 800,000 to 1 million elderly and disabled Americans. The House and Senate budgets include a \$160 billion cut in Medicaid. They would limit growth to 4% per year--even though Medicaid's beneficiary growth alone is nearly that high. As a result, millions of Americans will be cut off while the costs of long-term care drastically increase. Two-thirds of Medicaid funds are spent on services for elderly and disabled Americans; without Medicaid, working families with a parent or spouse who needs long-term care would face nursing home bills averaging \$38,000 per year.

BUDGET TALKING POINTS

Tuesday, May 16, 1995

THE REPUBLICAN BUDGET: Medicare Cuts For Seniors and Tax Hikes for Working Families To Pay for Tax Cuts for the Wealthy

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Medicare Cuts. We should not cut Medicare deeply to pay for tax cuts for upper income citizens. We do have to slow the growth of Medicare, and it is refreshing to hear the majority in Congress acknowledging that after two years of denying that there is a crisis in Medicare. But the proper way to do slow Medicare growth is within the context of health care reform.

The Education Deficit. In cutting the budget deficit, we must not ignore our other deficit, the education deficit. The most significant thing about America in the last 15 years is the stagnant wages of working people and the growing inequality among middle class people because they do not have the skills they need to compete in the global economy. We should not cure the budget deficit by enlarging America's education deficit.

Republicans have repeatedly promised that they could provide a huge tax cut targeted at the wealthy, balance the budget by 2002--and not hurt the elderly or raise taxes on working families. Their budgets show that these were false promises. Republicans have broken their contract with:

- Historically severe cuts in Medicare and
- Tax hikes for working families,
- To finance their tax break for the wealthy.

Republicans are Making the Largest Medicare Cut in History to Pay for Their Tax Cut and Campaign Promises. On April 28, Speaker Gingrich said that Medicare would not be a part of the Republican budget cuts. He could not have been more wrong. Medicare takes the largest single cut in the Republican budget. By their accounting, nearly 25 cents out of every dollar that Republicans cut is from Medicare. The cut is three times larger than the largest previous Medicare cut in history.

Their Medicare Cut Is About Paying for Tax Cuts and Hitting Arbitrary Deficit Targets --Not About the Economy or Health Care Reform. The proposed Medicare cuts of \$250 billion to \$300 billion are needed to make room for most--but not all--of a \$345 billion tax cut that provides a tax break of over \$20,000 for the wealthiest 1 percent. Speaker Gingrich and Majority Leader Dole have rejected the White House's call to renounce tax breaks for the wealthy; instead, Speaker Gingrich calls the Contract tax cuts his "crown jewel," while Senate Majority Leader Dole and Senator Gramm have insisted they will make room for the tax cut. However the tax cuts are officially paid for, the fact remains that the entire Medicare cut would be totally unnecessary if Republicans did not need to pay for their tax cuts.

When It Comes to Health Care, Republicans Single Out Seniors for Pain --Cutting Growth Per Person in Their Medicare Below Growth in Private Health Care. Republicans claim that they are just slowing the "exploding" rate of growth in Medicare. In fact, the cost *per person* in Medicare is about the same as the private sector, even though Medicare deals with a population more prone to have health problems. The Republican approach ignores health care costs generally, and simply cuts the average growth rate for a Medicare recipient far below that for other Americans not on Medicare. *Medicare was designed to provide health insurance for senior citizens, not get turned into a second-class citizen program in order to meet arbitrary campaign promises.*

By 2002, Republican Cuts Would Increase Out-of-Pocket Costs by About \$900 a Year and Devastate Rural Hospitals. If cuts are distributed evenly between providers and beneficiaries, they represent about a \$900 increase in out-of-pocket costs per beneficiary per year. That is equivalent to eliminating 40%-50% of the Social Security cost-of-living allowances for each Medicare beneficiary between now and 2002. As reimbursement rates decline, many rural hospitals that rely on Medicare would have to close down.

Republican Medicaid Cuts Would Drastically Raise Long-Term Care Costs for Working Families. If the Republican cuts were divided evenly among eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, they would force states to cut off coverage for 5 to 7 million children and 800,000 to 1 million elderly and disabled Americans. The House and Senate budgets include a \$160 billion cut in Medicaid. They would limit growth to 4% per year--even though Medicaid's beneficiary growth alone is nearly that high. As a result, millions of Americans will be cut off while the costs of long-term care drastically increase. Two-thirds of Medicaid funds are spent on services for elderly and disabled Americans; without Medicaid, working families with a parent or spouse who needs long-term care would face nursing home bills averaging \$38,000 per year.

Republican Managed Care Proposals Will Not Lead to Significant Savings Unless They Cut Benefits and Coerce Seniors. There is no evidence that simply shifting to managed care can achieve significant savings among the populations that Medicare and Medicaid overwhelmingly serve--the elderly and disabled. Republican voucher proposals would overspend on younger, healthier seniors, while achieving limited savings only by dramatically raising costs, cutting benefits, and limiting choice for the seniors who need Medicare and Medicaid most.

While Cutting Taxes for the Wealthy, Republicans also Raise Taxes for 12 Million Low-Income Workers and Their Families By Slashing the Earned Income Tax Credit. The EITC helps families move from welfare to work and makes work pay for hard-working, lower-income Americans, providing a tax cut averaging nearly \$1,400 per year for over 21 million workers and their families earning up to \$28,500. Senate Republicans have proposed a major cut in the EITC that will raise taxes by an average of \$235 for 12 million of these workers and their families. Thus, 12 million low-income working families will pay \$235 more under the Republican budget.

**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.

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

- o **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.

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



ADDITIONAL MEDICARE TALKING POINTS

ADDING TO ALREADY HIGH COSTS FOR OLDER AMERICANS

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

MAJOR BURDEN ON RURAL AMERICA

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

UNDERMINES ACADEMIC HEALTH CENTERS

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