

DATE: \_\_\_\_\_

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Cover Sheet Plus 26 Pages To Follow

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**DEMOCRATIC STAFF -- COMMITTEE ON WAYS AND MEANS**

### Item J

Persons who are covered by Medicare Part A and who elect to enroll in Part B, will be eligible to select coverage provided by MediChoice health plans, the Medisave Option, or Employer, Union, or Association-sponsored health plans.

A greatly expanded choice of plan options will be made available to Medicare beneficiaries at time of initial eligibility and during subsequent coordinated annual open enrollment seasons, as follows.

#### Plan Enrollment Options At Time of Initial Entitlement to Medicare

Upon becoming eligible for Medicare benefits, beneficiaries may choose to enroll in any one of the following:

- original fee-for-service Medicare, hereinafter referred to as the fee-for-service (FFS) plan;
- a privately administered MediChoice health plan in their market area;
- a privately administered Medisave health plan; or
- an Employer-sponsored, Association-sponsored, or Union-sponsored health plan for which they are eligible.

#### Annual Coordinated Open Enrollment

Beneficiaries will have the opportunity to change their Medicare coverage once each year during a coordinated open enrollment period in which all qualified plans must participate, except Employer-sponsored plans.

Employer-sponsored plans would operate under continuous open enrollment procedures under which retired employees, also entitled to Medicare, could elect to continue in the Medicare-qualified Employer plan without a break in coverage.

During the annual open enrollment period, beneficiaries may elect to enroll in the FFS plan, any MediChoice health plan in their area, or any Association-sponsored plan or Union-sponsored plan for which they are eligible.

### Enrollment Exceptions

Beneficiaries may elect the Employer-sponsored plan option upon retirement and if eligible for Medicare.

A beneficiary enrolled in an Employer-sponsored plan who subsequently elects to disenroll from such a plan and enter a MediChoice health plan, the FFS plan, or an Association-sponsored plan, would be precluded from reentering the Employer-sponsored plan in the future.

Beneficiaries may elect the Medisave health plan option only upon initial entitlement to Medicare.

Beneficiaries initially electing the Medisave health plan would have a 120 day cooling-off period during which the beneficiary could reverse the election and choose instead to enroll in the FFS plan, until the following open enrollment period. If a beneficiary disenrolls at any time from the Medisave option, the beneficiary is precluded from re-selecting the Medisave option in the future.

### Special MediChoice Health Plan Disenrollment Conditions

Beneficiaries may petition the Secretary to disenroll from a MediChoice plan before the next open enrollment period, and return to the residual FFS plan or select a MediChoice plan, if the beneficiary can demonstrate that the plan committed any one of the following:

- violated the health plan's contract;
- misrepresented the health plan's benefits or operating procedures in marketing the plan to the beneficiary; or
- provided poor quality care to the beneficiary.

The Secretary must establish procedures that permit expedited disposition of such cases.

### MediChoice Plans

Through MediChoice plans, a variety of new delivery system options (such as

preferred provider organizations and point of service products) will be made available to Medicare beneficiaries.

Health plans must apply to the Secretary for certification to participate as a MediChoice plan.

The Secretary will establish and administer mandatory certification standards for MediChoice plans in the following areas:

- marketing;
- enrollment;
- disenrollment;
- benefits (covered services, and premiums and cost-sharing requirements, if applicable);
- emergency and out-of-plan services;
- reporting/disclosure;
- delivery system standards
  - service areas
  - plan capacity
  - access to providers;
- solvency;
- grievances and appeals;
- sanctions;
- quality assurance standards, both internal and external programs (see additional provisions);

The federal certification standards relate only to plans' participation in the Medicare program and do not preempt state regulation of health plans.

- The Secretary may impose user fees on MediChoice plans to finance the

costs of the certification program.

#### MediChoice Advisory Group

The President shall appoint a MediChoice Advisory Group to offer to the Secretary recommendations on certification standards.

The MediChoice Advisory Group shall include members with national recognition for their expertise in the business of insurance, health care delivery, health economics, and related fields.

#### Quality Accreditation

Health plans must be accredited as meeting quality standards in order to participate in the MediChoice program.

The Secretary will determine the frequency of quality accreditation.

The Secretary may provide that private accreditation by an approved organization is sufficient to deem a plan as meeting the quality assurance portion of the certification standards for participation in MediChoice.

To allow accreditation by a private agency, the Secretary must ensure that the agency's accreditation standards are at least equal to the quality assurance standards established by the Secretary.

The Secretary shall establish quality assurance standards covering:

- quality management and improvement processes;
- utilization management;
- credentialing;
- an internal grievance process;
- patient access to written and other information about the plan, its services.

providers of care, and patient rights and responsibilities;

- patient privacy; and
- medical records.

#### Quality Measurement

The Secretary shall establish quality measurement standards based on recommendations by a Working Group on Quality Measurement.

The Working Group shall be made up of experts in health care quality, data, and consumer reports.

The Working Group shall make recommendations to the Secretary on:

- establishing computer-based patient records, including issues regarding privacy;
- standardizing clinical data collection and transmission;
- standardizing consumer satisfaction data collection;
- appropriate uses of such data; and
- the format for informing beneficiaries regarding the quality performance of MediChoice health plans.

#### Financial Solvency and Capital Adequacy

--- The Secretary shall establish financial solvency and capital adequacy standards, based on recommendations made by the National Association of Insurance Commissioners by March 1, 1996.

#### Consumer Protections

All marketing materials must be approved under guidelines established by the Secretary. The Secretary shall establish "one-stop" approval procedures for any plan certified to offer benefits in more than one market.

The Secretary shall establish fair direct sales guidelines, including a prohibition against agents completing enrollment forms for beneficiaries.

### **Benefits**

Requirements for basic and supplemental benefit offerings by MediChoice plans would be established as follows:

MediChoice plans shall offer services equivalent to Medicare covered services in the FFS plan, but with discretion on delivery approaches.

MediChoice plans may establish cost-sharing appropriate to the delivery system.

MediChoice plans cannot place limitations on inpatient hospital days that are more restrictive than the FFS plan.

Any supplemental benefits offered by MediChoice plans are optional for the beneficiaries (they may elect to get only Medicare benefits).

Beneficiaries may select supplemental coverage offered by any qualified health plan.

Beneficiaries will select their supplemental coverage during the same enrollment period as for basic Medicare benefits.

### **Premiums and Payment Rates**

A series of rules on MediChoice plans' premium development, and the development of a market-based price will be established.

### **Health Plan Premium Submission Rules**

Health plans must submit premiums for the plan's benefit package and information on the plan's MediChoice enrollment capacity, for each market area, to the Secretary by a date determined by the Secretary.

- The premiums submitted by the plans for Medicare benefits shall be the total premium required by the plan.
- Once submitted, health plans may not change their premiums until the next year and must collect from the beneficiary the difference between the total premium and the MediChoice rate, if the MediChoice rate is lower.

Health plans must agree to serve all beneficiaries in a market area on a "first-come, first-serve" basis, up to plan capacity (except that current enrollees have priority over new enrollees).

#### Market-Based MediChoice Rates

In each market area, beneficiaries in MediChoice health plans will get a uniform MediChoice rate paid on their behalf to the plan of their choice.

The MediChoice rate will be the lower of:

- the market rate; or
- the FFS proxy premium.

The market rate will equal the average of premiums submitted by plans in the market area less a percentage of the difference between the average and the lowest priced plan.

#### Payments to MediChoice Health Plans

The MediChoice rate will be adjusted for demographic and risk factors before payments are made to MediChoice health plans.

#### MediChoice Premiums and Rebates

If a beneficiary enrolls in a MediChoice plan that charges less than the MediChoice rate, the plan will rebate the difference to the beneficiary in cash, or, at the beneficiary's option, apply the difference to supplemental coverage premiums.

If a beneficiary enrolls in MediChoice plan that charges a premium in excess of the MediChoice rate in the market area, the beneficiary must pay the additional premium to the plan.

#### Market Areas

The Secretary shall be required to establish the geographic boundaries of Medicare market areas according to guidelines set in legislation.

#### Place of Residence

Each Medicare beneficiary will be assigned to a market area based on place of principal residence.

#### Guidelines

The Secretary shall set the market areas in a manner that:

- creates market areas that are larger than counties, or the equivalent of counties in areas that use other designations; and
- covers all areas in the United States without overlap

In general, a metropolitan statistical area (MSA) should be included in one market area.

- However, the Secretary may make exceptions to this rule to allow smaller market areas when an MSA is large, but the sub-MSA market areas shall be set in a manner that does not segregate the Medicare population by health status.

#### State Boundaries

In general, the Secretary shall accept market areas that build upon boundaries established by States for private health insurance purchasing cooperatives or similar insurance purposes if:

- the State boundaries do not generally violate the rule regarding metropolitan statistical areas; and
- adopting the State boundaries will not conflict with market areas for bordering

States.

State boundaries that are used to establish Medicare market areas need not be contiguous areas.

#### **Administration**

The Secretary will be required to establish and administer a coordinated open enrollment system for Medicare beneficiaries encompassing all MediChoice and Medigap choices.

#### **Coordinated Enrollment**

The Secretary will establish a process through which beneficiaries will elect their coverage at initial eligibility and at subsequent annual, coordinated open enrollment periods.

Beneficiaries will select their Medicare and supplemental plans (including any Medigap coverage), during the coordinated open enrollment period.

#### **Default Enrollment**

Beneficiaries not submitting an enrollment form will be automatically enrolled in the same plan they were enrolled in for the prior year.

New beneficiaries not submitting an enrollment form will be automatically enrolled in the FFS plan.

#### **Contractor**

The Secretary shall contract with a neutral entity in each market area to provide information to beneficiaries about their coverage options.

- In general, the Secretary shall use existing carriers and intermediaries, unless a carrier or intermediary is offering a MediChoice health plan or Medigap insurance in the market area.

#### **Information for Beneficiaries**

Each market area contractor shall publish an information booklet that is provided timely to all Medicare beneficiaries to permit enrollment choices at initial eligibility

for Medicare and for subsequent enrollment periods.

The booklet will include information regarding:

- plan availability;
- the premiums beneficiaries will pay for the various options;
- quality information, including consumer satisfaction information;
- beneficiary rights and responsibilities under the options.

Each market area contractor will also:

- maintain an 800 number for beneficiary inquiries; and
- sponsor enrollment period fairs, with salespersons providing approved marketing materials from all area MediChoice health plans.

#### **Employment, Association, and Union-Sponsored MediChoice Plans.**

Medicare beneficiaries will have new choices in which, under selected conditions they are permitted to enroll in employer-sponsored, association-sponsored, or union-sponsored health plans.

Employers may establish MediChoice health plans for former employees and their spouses.

Former employees shall be defined by the employer but may not exclude persons based on health status.

Unions may establish a MediChoice health plan for Medicare-eligible union members.

Qualified Associations may sponsor a MediChoice health plan for members, and such plans must meet the same standards as other MediChoice plans, except that they may limit enrollment to members of the Association.

In general, qualified Association plans will:

- have a primary purpose that is not the provision of MediChoice coverage;
- not discriminate among members based on health status; and
- offer MediChoice coverage to all members who are eligible for Medicare.

#### MediChoice Payments

MediChoice payments to Employer, Association, and Union-sponsored plans shall be on the same basis as payments to other MediChoice plans in the market area in which a beneficiary resides.

Alternatively, such plans may negotiate a federal payment rate certified by the Secretary as budget neutral relative to payments that would have been made on behalf of the Medicare enrollees.

#### Medisave, Catastrophic Plans

Beneficiaries will have an option of enrolling in a private, catastrophic medical expense plan, combined with a medical savings account.

#### Eligibility Criteria

To be eligible to elect the Medisave option, persons must:

- be eligible for Medicare based on age;
- maintain a qualified Medisave account;
- maintain qualified catastrophic medical expense coverage;
- self-insure for the deductible and pay all medical expenses from the account; and
- forego other Medicare coverage options permanently, after the close of the initial cooling-off period.

#### Cooling Off Period

Persons electing the Medisave option will have a 120-day cooling off period during which they may elect to switch to the FFS or a MediChoice plan.

The Secretary shall recoup any unspent cash payments or credits made to the beneficiary during the time the beneficiary elected the Medisave option.

#### Qualified High Deductible Coverage

The Secretary will establish guidelines for certification of qualified catastrophic medical expense plan coverage, including rating requirements.

-- The \$ deductible shall be indexed to the CPI.

#### Medisave Payments

Medisave payments shall be made directly to the individual's Medisave account and will equal the MediChoice rate for the market area, adjusted for demographic factors.

#### Medicare Review Commission

A new Medicare Review Commission is established to replace ProPAC and PPRC.

#### Purpose

The commission will report to the House Committees on Ways and Means and Commerce, and the Senate Committee on Finance on all aspects of the Medicare program and make recommendations to the Committees for changes.

#### Membership

The Commission members will be appointed on the same basis as members are appointed to ProPAC under current law.

#### Authorization

The Commission is authorized at \$ million each year.

#### Required Annual Report

The Commission is required to provide a report by March 1 annually covering all aspects of the Medicare program, including analysis and recommendations.

The report should:

- assess fee-for-service payment systems (PPS and RBRVS);
- analyze the distribution of MediChoice payment rates across market areas;
- recommend adjustments in payments to MediChoice health plans for relative risks;
- recommend modifications to the MediChoice benefit package configurations;
- provide advice on improving the quality of care in MediChoice health plans; and
- provide advice on assuring access to care provided by MediChoice health plans.

#### Indexing Report

The Commission shall report by January 1, 1998 on recommendations regarding indexing the market area MediChoice rates.

The report shall include an analysis of moving to indexing instead of market-based pricing.

#### Transition Rules

- Initiation of reform options and changes to the current HMO program will require transition periods and rules.

A transition period of three years would be established during which blended payment rates would be paid to risk and cost contractors.

Cost contractors would be required to transition to risk contracts by the close of the transition period.

**Item II**

**Diabetic Self Responsibility**

Reimburse for diabetic education and care programs.

**Cardiac Disease Alternative Self Responsibility**

Reimburse for coronary heart disease (CHD) education and prevention programs.

**Screening Improvements**

Reimburse for colorectal cancer screening. Reimburse for prostate cancer screening.  
Address mammography utilization issues.

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Item III

**Cost Sharing Under Medicare Fee-For-Service Program**

Option I

A new program would be established to encourage beneficiaries to self-insure (not purchase Medigap coverage) for Medicare coinsurance liabilities. Corresponding modifications are made to current Medigap standard policies.

Beneficiaries enrolled in Part B and agreeing to self-insure for the Part B coinsurance would get:

- a reduction in Part B coinsurance from 20% to 15%; and
- annual out-of-pocket protection of \$5000 in 1996 (indexed to overall growth in Medicare expenditures).

→ Beneficiaries who continue enrollment in any type of Medigap plan covering the Part B coinsurance will pay a coinsurance rate of 25% instead of 20%. ✓

Option II

Beneficiaries who choose to enroll in any type of Medigap plan will pay a coinsurance rate of 25% instead of 20%. ✓

**Prohibit Insurance for Part B Deductible**

Medigap policies would be precluded from covering the Part B deductible expense.

--- **The Part B Deductible**

Increase the Part B deductible for 1996 and index annually thereafter. ✓

**Extension of Part B Premium**

Maintain beneficiary responsibility for the Part B premium at the current percentage (31%) of program costs (alternatively, increase it to 33% or 35%). ✓

### **Income-Related Reduction in Medicare Subsidy**

Medicare would be income-related by imposing an additional premium to cover part of the cost of Part B which is currently subsidized by the general fund. This additional premium would be collected annually with payment accompanying the April 15th filing of income taxes. All Part B enrollees would continue to pay the otherwise applicable premium in effect for the calendar year. />

### **Coinsurance for Home Health**

Impose a 20% coinsurance on home health services.

### **Coinsurance for Skilled Nursing Facility Services**

Impose a 20% coinsurance for skilled nursing facility services for the first 20 days of a skilled nursing facility stay.

### **Coinsurance for Clinical Laboratory Services**

#### Option I

Impose a 20% coinsurance requirement on all clinical laboratory services, or

#### Option II

Impose a 20% coinsurance requirement on bundled clinical laboratory services.

#### Item IV

##### Fraud and Abuse

##### Beneficiary Incentive Program

Specific qui tam ("whistle blower") provisions for Medicare beneficiaries.

Incentive program for beneficiaries reporting of overcharges in billing (non fraud) by providers, with beneficiaries sharing in savings.

Incentive program for beneficiaries' suggestions for improving program efficiency with beneficiaries sharing in savings.

##### Strengthening Legal Tools

Expand mail fraud statute to explicitly include Medicare and private health plans.

Expand mail fraud statute to include private mails (eg. FedEx).

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##### Improving Program Efficiency

Establish advisory opinions.

Privatization of Medicare Fraud screens.

##### Clarification of Current Provisions and Potential Penalties

Voluntary disclosure program for Medicare.

Clarify program exclusion provisions to include debarment periods for specific types of violations.

Clarify the "should have known standard".

Clarify intent standard and safe harbor concept.

Amend "one purpose test" to substantial or primary reason for referrals.

Clarify discount exception (include exception for capitated programs).

Amend formula for civil monetary penalties to assure that civil monetary penalties are appropriate.

Item V

**Regulatory Relief**

Repeal Medicare secondary payer data match.

**Physician Self-Referral**

Amend the Physician Self-Referral rules as follows:

- Moratorium on effective date;
- Repeal section on compensation arrangement;
- Eliminate the prohibition against physician's practices providing durable medical equipment and parenteral and enteral services;
- Eliminate the "site of service" restriction on in-office service;
- Amend the physician supervision requirements applicable to non-physician personnel to clarify that direct supervision is not required;
- Amend the "general supervision" requirement;
- Add a community need exception;
- Add "shared services" exception;
- Expand the prepaid exception to include state regulated and Medicaid plans;
- Expand the prepaid exception to include preferred provider organizations;
- Clarify the rural exception to include state regulated and Medicaid plans.

**Clarification of Medigap Non-Duplication**

Revise rules to allow coordination of benefits for long-term care, nursing home, home health, and community-based care policies.

Eliminate separate disclosure notices and require plans to outline the degree to which they may duplicate/coordinate with Medicare covered benefits.

Item VI

**Medicare Sustainable Growth Adjustment**

Specific growth rates in Medicare outlays for Part A and Part B would be set for each of the 7 years covered by the budget resolution.

The Secretary would estimate Medicare growth rates annually. If program spending exceeds growth rates set in law, then outlay reductions will be triggered. Growth rates for the capitated programs, MediChoice and Medisave, would be set in advance to meet the targets, so outlay reductions, if necessary, would be made only in the Medicare FFS program.

Item VI

**Market Basket Update**

Reduce Medicare prospective payment system hospital rate update to market basket minus [Potential range 0.5 - 2.0].

**Disproportionate Share**

Reduce Medicare's prospective payment system disproportionate share adjustment to hospitals by (20 - 30%).

**Inpatient Capital Related Costs**

Rebase Medicare's prospective payment system's federal and hospital-specific rates for capital payments.

**Indirect Medical Education**

Reduce payments under Medicare's prospective payment system indirect medical education adjustment.

**Non PPS Hospitals**

Rebase the long-term care hospitals cost-based payment system.

Transitional cost reduction for rehabilitation facilities (OBRA 1993 market basket reduction formula applied for years 1996, 1997, 1998).

Establish prospective payment system for rehabilitation facilities effective 10/1/1999.

**Reduction in Payment for Hospital Bad Debt**

Reduce payment for hospital bad debt to 50 percent.

**Extension of Skilled Nursing Facility Cost Limit**

Maintain savings from skilled nursing facilities cost limits included in the President's budget.

## Item VII

### **Process of Updating Physician Fees.**

#### Option 1

Adopt the Physician Payment Review Commission (PPRC) recommendations to correct the many structural problems that exist with the Medicare Volume Performance Standard (MVPS).

#### Option 2

Repeat the MVPS and return to the Medicare Economic Index (MEI) used prior to physician payment reform for updating physician payments as a mechanism for updating physician fees.

Replace separate conversion factors for surgical, nonsurgical and primary care services with a single conversion factor.

### **Establish a Hospital Outpatient Prospective Payment System.**

Establish a prospective payment system (PPS) for hospital outpatient department (OPDs) based on ambulatory patient groups (APGs), that would cover all hospital-based outpatient services.

Limit beneficiary coinsurance to 20 percent of the Medicare payment amount under the Outpatient PPS.

### **Reduce Payments to Physicians for Overhead.**

Under review.

### **Competitive Bidding for Durable Medical Equipment**

Develop a competitive bidding process for durable medical equipment contracts.

### **Competitive Bidding for Clinical Laboratory Services**

Develop a competitive bidding process for clinical laboratory services.

## Item IX

### **Extensions of Secondary Payer Payment Requirements.**

The Medicare secondary payer proposals are extensions of provisions that are set to expire at the end of 1998 included in the President's budget. The three MSP proposals would:

- extend the data match between HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare;
- extend the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance; and
- extend the provision requiring non-Medicare insurers to be primary payer for ESRD patients for 18 months before Medicare becomes the primary payer.

### **Improve MSP Program**

Develop a mechanism to prospectively identify individuals with other coverage.

### **Home Health Service Extension of Cost Limits**

Maintain savings home health services from OBRA 1993.

### **Establishment of Home Health Payment Limits**

Establish a per visit payment system, subject to a 120 day (not visit) per episode cap, with home health agencies sharing in any savings if total per episode payments are less than the cap.

Create an "Inlier policy" excluding short term use of home health care (such as 20 days) from the cap.

Create a "volume performance standard" methodology to reduce payment if savings from payment limit system are not achieved.

**MEDICARE AND MEDICAID:  
KEY ISSUES**

**October 10, 1995**

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## SECURING THE MEDICARE TRUST FUND

### THE CLAIM:

Republicans claim that they are cutting \$270 billion from Medicare in order to save the program from insolvency.

### THE FACTS:

#### The Republican \$270 Billion Medicare Cut Is Not Necessary

- **More than half of the cuts in the House and Senate bills have nothing to do with Part A and will not extend the life of the trust fund one day.**
- Under the House plan, only about \$130 billion of the \$270 billion Medicare cuts come from Part A. The remaining \$140 billion in Part B cuts go to general revenues.
  - They raise premiums -- and none of that money helps the Part A trust fund.
  - They lower payments to physicians and other providers of outpatient services -- and none of that money helps the trust fund.
- Under the Senate plan, only about \$120 billion of the \$270 billion Medicare cuts come from Part A. The remaining \$150 billion in Part B cuts go to general revenues.
  - The Senate plan raises premiums, doubles deductibles and lowers payments to health care providers
  - It imposes a new Part B premium on beneficiaries with incomes above \$50,000 (\$75,000 for couples) -- and none of that money helps the Part A trust fund.
  - It gradually raises the eligibility age for Medicare from 65 to 67 -- and very little of that money helps the trust fund.

#### The President's Plan to Secure the Trust Fund

- **The President's balanced budget proposal shows that we can balance the budget and secure the Medicare Trust Fund without cutting benefits or increasing costs for people on Medicare.**

- Part A of Medicare, which pays mostly for hospitalization, is financed through the Hospital Insurance Trust Fund. In April, the trustees of the fund reported that the trust fund would be unable to cover its expenses by 2002. The trustees have reported nine times that the fund would be insolvent in seven years or less. Each time, Congress has taken steps to extend the solvency of the trust fund.
- The President has acted three times since taking office to extend the life of the trust fund.
  - In 1993, the Medicare trustees projected that the trust fund would be exhausted in six years. The President offered a package of reforms -- opposed by every Republican in Congress -- that pushed back that date by three years.
  - In 1994, the Administration proposed a health reform plan that would have strengthened the trust fund for an additional five years.
  - Under the President's balanced budget proposal, payments from the trust fund would be reduced by \$89 billion over the next seven years. According to career actuaries, this would secure the trust fund until 2006.
- The President's plan secures the trust fund without imposing any new cost increases on beneficiaries.

## THE MEDICARE "LOCK BOX"

### THE CLAIM:

Republicans claim that their Medicare cuts are not being used to pay for their \$245 billion tax cut. House Republicans say that to prove that Medicare cuts are for Medicare alone, they plan to vote on Medicare cuts separately. Senate Republicans passed an amendment in the Finance Committee creating a so-called "lock box" to put all of the Part B beneficiary savings into the Part A Trust Fund.

### THE FACTS:

- Both of these proposals are merely gimmicks.
- The Republicans could lower their Medicare cut by \$150 billion -- take away every penny of extra premium increase, extra deductible -- by simply lowering their tax cut by \$150 billion. No accounting gimmick or separate account can hide that fact.
- Their reasoning is like a person who spends \$5,000 less on health care for his family to pay for a \$5,000 Las Vegas vacation but denies that he is cutting health care to pay for a vacation because he promises to put *that* \$5,000 in a special trust account to pay for food and rent. Anyway you slice it, if he didn't have to pay for a \$5,000 vacation, he wouldn't have to spend \$5,000 less on health care for his family. And, anyway you slice it, if the Republicans didn't have to pay for a \$245 billion tax cut, they wouldn't have to cut \$270 billion from Medicare -- \$150 billion more than is needed to secure the trust fund.
- The Senate Finance Committee amendment is also a gimmick. They create a so-called "lock box" to put all of the Part B beneficiary savings into Part A and claim that this means they will use Medicare cuts to save the trust fund, not to pay for their tax cut.
- By doing this, they are admitting that about \$150 billion of their Medicare cuts go to general revenues to pay for the tax cut -- not to strengthen the Medicare Trust Fund. Then they say that they will transfer that \$150 billion from general revenues to the trust fund.
- One could just as easily say that revenue from the income tax, for example, should go into the Medicare Trust Fund, but that would leave the government with nothing to pay for defense, education or the environment.
- This gimmick can not hide the fact that Republicans need \$270 billion from Medicare because they want to give a \$245 billion tax cut. If they simply lowered their tax cut by \$150 billion, they could lower their extreme Medicare cuts by the same amount.

## SPENDING UNDER THE REPUBLICAN MEDICARE PROPOSAL: INCREASE OR CUT?

### THE CLAIM:

The Republicans say that they are not cutting Medicare because they will spend \$6,700 per beneficiary in 2002 as compared to the \$4,800 that is spent today.

### THE FACTS:

- Under current law, the Congressional Budget Office (CBO) projects that Medicare spending per beneficiary will grow from to \$4,800 to \$8,400 by 2002. Even by their own assumptions, the Republican plan would cut spending per beneficiary from \$8,400 to \$6,700 in 2002 alone. **That is \$1,700 less per person than Medicare is projected to spend.**
- If Medicare spending were constrained to the projected rate of growth in private sector spending, Medicare would spend \$7,700 per person in 2002. **Under the Republican plan, Medicare will spend \$1,000 less per person.**
- This is a cut because spending in Medicare will not keep up with the private sector. According to data from CBO, annual spending per person in the private sector is expected to grow by 7.1% per year between 1996 and 2002. The Republican plan allows Medicare spending per person to grow by only 4.9% per year. That means that the increase in per person spending under Medicare will be 31% lower than the increase in spending in the private sector.
- The real question is whether \$6,700 will allow Medicare beneficiaries to keep the benefits in 2002 that they have today. It will not. Because spending in the Medicare program will not keep up with rising health care costs, Medicare will buy less than it does today. People on Medicare will either have to pay more out of their own pockets or get less.

## THE PRESIDENT'S MEDICARE SAVINGS: \$124 OR \$192 BILLION?

### THE CLAIM:

Republicans claim that the \$124 billion in Medicare savings in the President's balanced budget proposal amounts to \$192 billion off of the Congressional Budget Office (CBO) baseline.

### THE FACTS:

- The President's balanced budget proposal includes \$124 billion in Medicare savings as scored by the Office of Management and the Budget (OMB).
- CBO and OMB have consistently scored specific Medicare savings proposals almost the same. For example, OMB determined that the Medicare savings in the Health Security Act would be \$118.3 billion; CBO scored them at \$117.6 billion. OMB concluded that the Medicare "extenders" would save \$28 billion; CBO found that they would save \$30 billion.
- **CBO's only analysis of the President's balanced budget proposal (June 16, 1995) said that the Administration's Medicare savings would be \$128 billion over seven years.**
- Despite CBO's analysis, Republicans claim that if the President's Medicare savings were taken from the CBO baseline, the President's proposal would equal \$192 billion. They reach this number by: (1) subtracting the projected growth in spending over seven years under the Administration's (OMB) baseline from the projected growth in spending over seven years under the CBO baseline; and (2) adding the difference to the President's \$124 billion in Medicare savings.
- The Administration baseline assumes that Medicare spending over the next seven years will be \$70 billion lower than the CBO baseline. However, the baselines are different because CBO and OMB make different economic assumptions. It is not accurate simply to subtract the Administration's Medicare baseline from the CBO baseline and add that number to the President's Medicare savings number.
- To measure the President's savings off of the CBO baseline, the President's savings can be calculated as a percentage of the OMB baseline and that percentage can then be taken off of the CBO baseline. Calculated this way, the President's \$124 billion in Medicare savings equals \$130 billion on the CBO baseline.

## PREMIUM INCREASES UNDER THE REPUBLICAN PLAN

### THE CLAIM:

The House Republicans claim that the Republican plan to raise Medicare premiums would cost beneficiaries only \$4 more per month in 2002 than the President's proposal.

### THE FACTS:

- **Under the House plan, people on Medicare would pay \$18 more each month than they would if premiums stayed at 25% -- as under the President's plan. That is nearly three times the amount that the Republicans promise.**
- Medicare beneficiaries pay premiums to receive Medicare Part B (which covers doctor visits and other outpatient services). Those premiums are calculated as a percentage of the total spent on Medicare Part B. Under current law, beginning in January 1996 Medicare beneficiaries will pay 25% of program costs.
- Republicans are proposing to: (1) raise premiums permanently from 25% to 31.5% of program costs; and (2) cut spending in Part B.
- When Republicans claim that their 31.5% premium amounts to only \$4 more than the President's proposal, they are comparing apples to oranges. They are not applying the 25% premium and the 31.5% premium to the same size Medicare program. To compare the true premium increase -- apples to apples -- they must first take into account their spending cut and then apply the 31.5% premium and the 25% premium.
- Under the House plan, people on Medicare would pay \$87 per month in 2002. If premiums were maintained at the current 25% level as under the President's plan, beneficiaries would pay \$69 per month in 2002. That means that under the House plan people on Medicare would pay \$18 more each month.
- The President's balanced budget proposal extends current law and keeps premiums at 25% of program costs. Throughout the 1980s and early 1990s, Congress kept premiums at this level. However, in the early 90s, Congress became concerned that keeping premiums at 25% of program costs would make premiums too burdensome and voted to set a dollar level in law. The dollar level for fiscal year 1995 was \$46.10. But because health care costs have slowed, that amount was actually 31.5% rather than 25% of program costs. The Republicans would force beneficiaries to continue to pay this higher percentage. The President would leave current law in place, which automatically returns premiums to 25% of costs in January 1996.

## REPUBLICAN MEDICARE "CHOICES" DON'T SAVE MONEY

### THE CLAIM:

Republicans claim that new Medicare private plan choices will save money for the Medicare program and its beneficiaries. Specifically, the Republicans say that by making more managed care and medical savings accounts (MSA) available to beneficiaries, they will save \$30 to \$50 billion over seven years.

### THE FACTS:

Both House and Senate Republican Medicare plans include new managed care options and medical savings accounts (MSA) for beneficiaries. They claim that these options will produce Medicare savings through competition and efficiency. However, the plans they are establishing are paid within the context of an arbitrarily set and capped Medicare budget.

#### Republican Plan Achieves Savings Through Use of Spending Caps

- CBO confirms that the \$43 billion in "managed care" savings from the Senate Republican plan come from spending caps -- caps on Medicare payments for managed care set at 31 percent below private sector growth rates (September 27, 1995).
- The House Republican plan also relies on payment caps to reach their savings.
- Under both plans, if the cost of Medicare benefits exceed the tight price caps, then beneficiaries will either pay higher premiums or get fewer benefits. There is nothing in the Republican bills that protects people on Medicare from plans shifting costs to them.

#### Medical Savings Accounts Increase Medicare Costs

- MSAs use the savings from the reduced cost of a high deductible plan to fund a tax deferred grant to an individual which can be used to purchase health care. They are theoretically designed to encourage individuals to be more cost sensitive in using health services. However, they tend to attract healthy individuals who believe they will not need health care. As a result, when Medicare pays a fixed contribution for those beneficiaries (based on average Medicare payments), Medicare is likely to overpay.
- CBO has concluded that Medicare MSAs don't save money, they cost money. CBO says that MSAs "would cost about \$2.3 billion as a result of adverse selection" -- approximately \$1,000 per person per year for each beneficiary in an MSA (September 27, 1995). A Lewin-VHI Inc. study also just released says that MSAs cost between \$15 and \$20 billion.

## HIDDEN BENEFICIARY COSTS IN THE REPUBLICAN PLAN

- **The Republicans have admitted that their plan will force people on Medicare to pay more:**
  - Both the House and Senate plans will increase premiums.
  - The Senate plan also cuts benefits and doubles deductibles from \$100 a year today to \$210 a year in 2002.
  - The Senate plan also gradually delays Medicare eligibility from age 65 to 67 beginning in 2003.
- **But there are hidden costs as well. Republicans have said that they will not retain financial protections that exist today for those people on Medicare.**
- Today, when Medicare pays for physicians' services, it sets the Medicare payment rate for the doctor. Medicare also limits the amount above the Medicare payment rate that the doctor can charge the beneficiary. This limitation on so-called "balance billing" protects Medicare beneficiaries from excess charges that so many of them can't afford to pay.
- Republicans have said that they will continue current limitations on balance billing for traditional fee-for-service Medicare providers. However, beneficiaries in "Medicare Choice" -- many of whom will join these plans because they can't afford more expensive fee-for-service -- will not be protected. Republicans will allow "Medicare Choice" plans to charge beneficiaries these extra amounts. With deep cuts in federal Medicare payments, plans may respond by lowering their reimbursements to doctors. Doctors will in turn be free to charge people on Medicare more to make up their losses.

**MEDICARE AND MEDICAID:  
KEY ISSUES**

**October 17, 1995**

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## SECURING THE MEDICARE TRUST FUND

### THE CLAIM:

Republicans claim that they are cutting \$270 billion from Medicare in order to save the program from insolvency.

### THE FACTS:

**The President's balanced budget plan and the House Republican plan both extend the solvency of the Medicare Hospital Insurance (Part A) Trust Fund through 2006 -- but the President's plan does it with less than one-half of the cuts.**

- **According to the career Health Care Financing Administration (HCFA) actuaries and the Republican staff of the House Ways and Means Committee, the Trust Fund would be solvent until 2006 under the House plan -- just as under the President's plan.**
- House Republicans originally tried to claim that their balanced budget plan would extend the solvency of the trust fund beyond 2002.
- However, their original analysis ignores the fact that the House plan includes legislation already passed by the House that reduces the amount of income going into the trust fund. The legislation repeals a provision of the President's 1993 deficit reduction plan that helped strengthen the trust fund.
- Of the Republicans' \$130 billion in Part A cuts, \$36 billion merely offsets the trust fund losses caused by this legislation, yielding a net of \$93.4 billion to strengthen the Part A trust fund.
- Once this legislation is factored in, the HCFA actuaries project that the House plan will delay insolvency until 2006, the same year as the President's plan.
- Republican counsel to the House Ways and Means Committee acknowledged this publicly during the Committee's markup of Medicare legislation.

### **The Republican \$270 Billion Medicare Cut Is Not Necessary**

- **More than half of the cuts in the House and Senate bills have nothing to do with Part A and will not extend the life of the trust fund one day.**
- Under the House plan, only about \$130 billion of the \$270 billion Medicare cuts come from Part A. The remaining \$140 billion in Part B cuts go to general revenues.

- They raise premiums -- and none of that money helps the Part A trust fund.
- They lower payments to physicians and other providers of outpatient services -- and none of that money helps the trust fund.
- Under the Senate plan, only about \$120 billion of the \$270 billion Medicare cuts come from Part A. The remaining \$150 billion in Part B cuts go to general revenues.
  - The Senate plan raises premiums, doubles deductibles and lowers payments to health care providers -- and none of that money helps the trust fund.
  - It imposes a new Part B premium on beneficiaries with incomes above \$50,000 (\$75,000 for couples) -- and none of that money helps the Part A trust fund.
  - It gradually raises the eligibility age for Medicare from 65 to 67 -- and very little of that money helps the trust fund.

#### **The President's Plan to Secure the Trust Fund**

- **The President's balanced budget proposal shows that we can balance the budget and secure the Medicare trust fund without cutting benefits or increasing costs for people on Medicare.**
- Part A of Medicare, which pays mostly for hospitalization, is financed through the Hospital Insurance Trust Fund. In April, the trustees of the fund reported that the trust fund would be unable to cover its expenses by 2002. The trustees have reported nine times that the fund would be insolvent in seven years or less. Each time, Congress has taken steps to extend the solvency of the trust fund.
- The President has acted three times since taking office to extend the life of the trust fund.
  - In 1993, the Medicare trustees projected that the trust fund would be exhausted in six years. The President offered a package of reforms -- opposed by every Republican in Congress -- that pushed back that date by three years.
  - In 1994, the Administration proposed a health reform plan that would have strengthened the trust fund for an additional five years.
  - Under the President's balanced budget proposal, payments from the trust fund would be reduced by \$89 billion over the next seven years. According to career actuaries, this would secure the trust fund until 2006.

## THE MEDICARE "LOCK BOX"

### THE CLAIM:

Republicans claim that their Medicare cuts are not being used to pay for their \$245 billion tax cut. House and Senate Republicans have created so-called "lockboxes" -- claiming that these "lockboxes" separate the Part B Medicare spending cuts from other budgetary transactions and that they preclude Medicare cuts from being used to pay for tax cuts.

### THE FACTS:

- The House and Senate proposals use different mechanics. The House lockbox creates a new trust fund and transfers money out of general revenues into this new trust fund in an amount equal to the Part B spending cuts. The Senate transfers money out of general revenues and into the Medicare Part A trust fund in amount equal to the savings resulting from increases in the Medicare Part B premium and deductible. Both of these proposals are merely gimmicks.
- The Republicans could lower their Medicare cut by \$150 billion -- take away every penny of extra premium increase, extra deductible -- by simply lowering their tax cut by \$150 billion. No accounting gimmick or separate account can hide that fact.
- The Republicans' reasoning is like a person who spends \$5,000 less on health care for his family to pay for a \$5,000 Las Vegas vacation but denies that he is cutting health care to pay for a vacation because he promises to put *that* \$5,000 in a special trust account to pay for food and rent. Anyway you slice it, if he didn't have to pay for a \$5,000 vacation, he wouldn't have to spend \$5,000 less on health care for his family. And, anyway you slice it, if the Republicans didn't have to pay for a \$245 billion tax cut, they wouldn't have to cut \$270 billion from Medicare -- \$150 billion more than is needed to secure the trust fund.
- By creating these lockboxes, Republicans are admitting that \$150 billion of their Medicare cuts go to general revenues -- not to strengthen the Medicare trust fund. Then they say that they will transfer that \$150 billion from general revenues to the trust fund.
- One could just as easily say that revenue from the income tax, for example, should go into the Medicare trust fund. Or as the nonpartisan Concord Coalition (chaired by former Senators Warren Rudman and Paul Tsongas) says, "[w]hy not throw in the GOP savings in farm aid and AFDC? Or why not go even further and have the Treasury write a check for several million dollars to the HI trust fund so we won't have to worry about it again for the next half century?" [Fax Alert from The Concord Coalition, 10/12/95]

## SPENDING UNDER THE REPUBLICAN MEDICARE PROPOSAL: INCREASE OR CUT?

### THE CLAIM:

The Republicans say that they are not cutting Medicare because they will spend \$6,700 per beneficiary in 2002 as compared to the \$4,800 that is spent today.

### THE FACTS:

- Under current law, the Congressional Budget Office (CBO) projects that Medicare spending per beneficiary will grow from \$4,800 to \$8,400 by 2002. Even by their own assumptions, the Republican plan would cut spending per beneficiary from \$8,400 to \$6,700 in 2002 alone. **That is \$1,700 less per person than Medicare is projected to spend.**
- If Medicare spending were constrained to the projected rate of growth in private sector spending, Medicare would spend \$7,700 per person in 2002. **Under the Republican plan, Medicare will spend \$1,000 less per person.**
- This is a cut because spending in Medicare will not keep up with the private sector. According to data from CBO, annual spending per person in the private sector is expected to grow by 7.1% per year between 1996 and 2002. The Republican plan allows Medicare spending per person to grow by only 4.9% per year. That means that the increase in per person spending under Medicare will be 31% lower than the increase in spending in the private sector.
- The real question is whether \$6,700 will allow Medicare beneficiaries to keep the benefits in 2002 that they have today. It will not. Because spending in the Medicare program will not keep up with rising health care costs, Medicare will buy less than it does today. People on Medicare will either have to pay more out of their own pockets or get less.

- According to the Concord Coalition, "Republicans -- against the advice of their brightest staff -- are pushing the budget debate into fantasy land. . . The Senate would reallocate much of the proposed SMI [Part B] savings to the HI [Part A] trust fund. The House would create yet another trust fund which would be credited with all of the SMI savings. Both transactions are cynically devoid of economic meaning. . . Because all federal revenues are fungible, the balance of any particular trust fund is economically irrelevant. What matters is the net difference between all federal taxing and all federal spending . . . ." [Fax Alert from The Concord Coalition, 10/12/95 (emphasis added)]

## THE PRESIDENT'S MEDICARE SAVINGS: \$124 OR \$192 BILLION?

### THE CLAIM:

Republicans claim that the \$124 billion in Medicare savings in the President's balanced budget proposal amounts to \$192 billion off of the Congressional Budget Office (CBO) baseline.

### THE FACTS:

- The President's balanced budget proposal includes \$124 billion in Medicare savings as scored by the Office of Management and the Budget (OMB).
- CBO and OMB have consistently scored specific Medicare savings proposals almost the same. For example, OMB determined that the Medicare savings in the Health Security Act would be \$118.3 billion; CBO scored them at \$117.6 billion. OMB concluded that the Medicare "extenders" would save \$28 billion; CBO found that they would save \$30 billion.
- **CBO's only analysis of the President's balanced budget proposal (June 16, 1995) said that the Administration's Medicare savings would be \$128 billion over seven years.**
- Despite CBO's analysis, Republicans claim that if the President's Medicare savings were taken from the CBO baseline, the President's proposal would equal \$192 billion. They reach this number by: (1) subtracting the projected growth in spending over seven years under the Administration's (OMB) baseline from the projected growth in spending over seven years under the CBO baseline; and (2) adding the difference to the President's \$124 billion in Medicare savings.
- The Administration baseline assumes that Medicare spending over the next seven years will be \$70 billion lower than the CBO baseline. However, the baselines are different because CBO and OMB make different economic assumptions. It is not accurate simply to subtract the Administration's Medicare baseline from the CBO baseline and add that number to the President's Medicare savings number.
- To measure the President's savings off of the CBO baseline, the President's savings can be calculated as a percentage of the OMB baseline and that percentage can then be taken off of the CBO baseline. Calculated this way, the President's \$124 billion in Medicare savings equals \$130 billion on the CBO baseline.

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**ELIMINATION OF "BALANCE BILLING" PROTECTIONS:  
HIDDEN BENEFICIARY COSTS IN THE REPUBLICAN PLAN**

- **The Republicans have admitted that their plan will force people on Medicare to pay more:**
  - Both the House and Senate plans will increase premiums.
  - The Senate plan also cuts benefits and doubles deductibles from \$100 a year today to \$210 a year in 2002.
  - The Senate plan also gradually delays Medicare eligibility from age 65 to 67 beginning in 2003.
- **But there are hidden costs as well. Republicans have said that they will not retain financial protections that exist today for those people on Medicare.**
- Today, when Medicare pays for physicians' services, it sets the Medicare payment rate for the doctor. Medicare also limits the amount above the Medicare payment rate that the doctor can charge the beneficiary. This limitation on so-called "balance billing" protects Medicare beneficiaries from excess charges that so many of them can't afford to pay.
- Under the Republican plan, this balance billing protection will be eliminated. Doctors will be able to charge beneficiaries whatever they want in new private fee-for-service or high deductible medical savings account plans.

## **REPEALING PROTECTIONS FOR LOW-INCOME MEDICARE BENEFICIARIES**

The Republican Medicaid plan would repeal the requirement that states pay cost sharing (premiums, copayments and deductibles) for low-income Medicare beneficiaries.

### **Current Law Protects Medicare Beneficiaries Who Can't Afford Cost Sharing**

Under Medicaid, states pay Medicare premiums, copayments and deductibles for people with incomes below 100 percent of the federal poverty level -- about \$7,500 per year -- and minimal assets (known as "qualified Medicare beneficiaries" or QMBs). Medicaid also requires states to pay premiums for people on Medicare with incomes below 120 percent of the federal poverty level and minimal assets (known as "selected low-income Medicare beneficiaries" or SLMBs).

This year, typical Medicare beneficiaries paid about \$550 to cover Medicare Part B premiums and about \$1,460 for all additional cost sharing under Parts A and B. There were approximately 5.4 million low-income Medicare beneficiaries with Medicaid coverage. Medicaid paid about \$9 billion (including both the federal and state share) to cover premiums and cost sharing for these people.

### **Background and Legislative History**

These protections were enacted as part of the Medicare Catastrophic Coverage Act of 1988, and were one of the few provisions retained when the Act was repealed in 1989. The Senate voted 99-0 and the House voted 349-57 to retain them as well as a few other provisions.

### **Republican Medicaid Block Grant Ends Protection for Low-Income Medicare Beneficiaries**

The Republican Medicaid block grant repeals the requirement that states pay cost sharing for low-income Medicare beneficiaries. Because the Republicans will cut Medicaid by \$182 billion, most states will no longer be able to afford to pay for low-income Medicare beneficiaries' premiums, deductibles and copayments. As a result, these beneficiaries will be forced out of their fee-for-service plans into managed care. According to the Congressional Budget Office, "... eliminating the entitlement to cost-sharing for Medicaid eligibles and QMBs would increase enrollment as those beneficiaries sought out plans with lower cost-sharing requirements."

## **ENDING MEDICAID PROTECTIONS AGAINST SPOUSAL IMPOVERISHMENT**

The House Republican Medicaid plan would repeal the common ground law signed by President Reagan to protect spouses from having to *give up everything they have -- their car, their home, and all their savings* -- in order to pay for nursing home care for their sick spouse.

### **Current Law Protects Spouses and Their Families from Poverty**

Current federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:

- States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
- States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.

Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women. It also protects their families from being forced to pay the nursing home costs and from having to support the spouse not needing nursing home care.

### **Background and Legislative History**

Most Americans must pay for nursing home care with their own funds for as long as they can. Medicare provides minimal long-term care coverage, and Medicaid only covers nursing home care after one has "spent down" and meets Medicaid's eligibility requirements. Prior to enactment of the protections against spousal impoverishment in 1988, spouses, most often wives, of people needing nursing home care, were often forced into poverty before they qualified for Medicaid. To avoid poverty, many elderly couples were forced to take desperate steps, such as divorcing or suing their sick spouse for support.

These current protections against spousal impoverishment were enacted as part of the Medicare Catastrophic Coverage Act of 1988, and were one of the few provisions retained when the Act was repealed in 1989. The Senate voted 99-0 and the House voted 349-57 to retain the spousal impoverishment and a few other provisions.

## Republican Medicaid Block Grant Ends Spousal Impoverishment Protection

The House Medicaid block grants as introduced repeal the protections against spousal impoverishment. When House Democrats offered an amendment in the Commerce Committee to restore these protections, *the amendment was defeated on a party-line vote*. Senate Democrats offered a similar amendment in the Finance Committee and the amendment was adopted.

Medicaid is the largest payor of long-term care, covering *over two-thirds* of all nursing home residents. Without the current federal protections against spousal impoverishment, there would be no federal assurance that spouses could keep a minimum amount of their income and assets. The spouses and families of nursing home residents could be faced with the costs of their sick relatives' nursing home care -- care which now *costs an average of \$38,000 a year*. Nursing home costs could once again ruin the lives of spouses and their families.

Because Republicans also propose to slash Medicaid by \$182 billion over seven years, cutting federal Medicaid payments to states by 30% in 2002, states may be forced to offset the loss of federal funding by not protecting the income and assets of spouses of nursing home residents. Spouses could be forced to sell their home, car and other essential assets, and to spend everything including their Social Security check on their spouse's nursing home care.

## ENDING MEDICAID NURSING HOME QUALITY STANDARDS

The Republican Medicaid proposals repeal the common ground law signed by President Reagan that established quality standards for nursing homes and institutions caring for people with mental retardation.

### Background and Legislative History

President Reagan signed federal nursing home quality standards into law as part of the Omnibus Reconciliation Act of 1987. A 1986 report by the National Academy of Science's Institute of Medicine had documented an epidemic of substandard care in nursing home facilities around the nation. In 27 states, *at least one-third* of the facilities had care so poor that it jeopardized the health and safety of residents. Nursing home residents were sometimes found lying in their own waste, injured by rough handling, suffering with bed sores while tied to their beds at understaffed homes, verbally intimidated, and summarily evicted when their nursing home found a prospective patient willing to pay more for their bed.

### Current Federal Quality Standards

Current federal law provides minimum standards for nursing homes that protect residents from abuse and neglect including:

- limiting the use of drugs and restraints
- prohibiting nursing homes from "dumping" residents -- evicting them when they've run out of money and qualify for Medicaid
- giving nursing home residents the right to appeal decisions about their care
- ensuring that nursing aides are trained and do not have a history of abuse

The 1987 law and subsequent amendments have led to dramatic improvements in the quality of nursing home care. The use of physical restraints and psychotropic drugs has dropped sharply. The number of registered nurses on duty in nursing homes has increased, as has the training of nurses' aides. Nevertheless, more progress is needed. Inspectors from the Health Care Financing Administration continue to find substandard care at some nursing homes. For example, one resident was hospitalized after maggots and larvae were found in a foot wound - the nursing home said it did not have enough staff to give baths. *Repealing the federal quality standards would undermine the progress we have achieved and set us back.*

### Republican Medicaid Block Grant Repeals These Fundamental Protections

Under the guise of reform, Republicans propose to repeal the federal Medicaid quality standards, as well as the requirement that Medicaid cover nursing home care at all. Medicaid is now the largest payor of long-term care, covering *over two-thirds* of all nursing home residents. As many as 350,000 elderly and disabled Americans would lose nursing home coverage in 2002, and 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.

## Q&A FOR WHY INCREASE IN PER BENEFICIARY SPENDING IS A CUT

**How can you consider a \$1900 increase in Medicare spending a cut? The Congressional Majority say they will pay \$6,700 in 2002 per beneficiary, relative to the \$4,800 per beneficiary now being spent. How can you characterize this as a cut?**

- **This is a cut because you cannot buy today's Medicare benefits with this amount of money in 2002. Beneficiaries will pay substantially more or get less benefits. Nothing the Congressional Majority can do or say can dispute this fact.**
- **They say \$6,700. However, that is about \$1,000 less per person than what it would be EVEN IF Medicare spending were constrained to the private sector growth rate.\***
- **And remember, the Congressional Majority wishes to constrain the growth rate well below the private sector even though Medicare beneficiaries are, by any definition, a much more difficult to manage and expensive population than those with private insurance.**
- **To deny their proposal is a cut is like saying that reducing the Social Security cost-of-living adjustment (COLA) is not a cut. To deny their proposal is a cut is like telling workers who get a 3% raise that their salary will remain sufficient to maintain their standard of living in an economy that has an inflation rate of 5%.**
- **The real question is whether the \$6,700 advocated by the Congressional Majority would be sufficient to pay for the same benefits in 2002 that Medicare beneficiaries have today. Clearly, it is not.**

\* (NOTE: The 1996-2002 private sector per capita growth rate projection of 7.1% -- calculated from Congressional Budget Office data -- is 40% higher than the 4.9% growth rate the Republican budget allows for Medicare. Constraining the Medicare program to the 7.1% growth rate would reduce per beneficiary spending from its currently projected \$8,400 to \$7,600, and would produce substantial Federal savings. However, the Republican budget's 4.9% growth rate would reduce Federal spending per beneficiary by \$1,700 to \$6,630. This is \$1,000 per person less than even the private sector growth rate would allow and could only be achieved through unprecedented cost-sharing increases on beneficiaries.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



*Depe*

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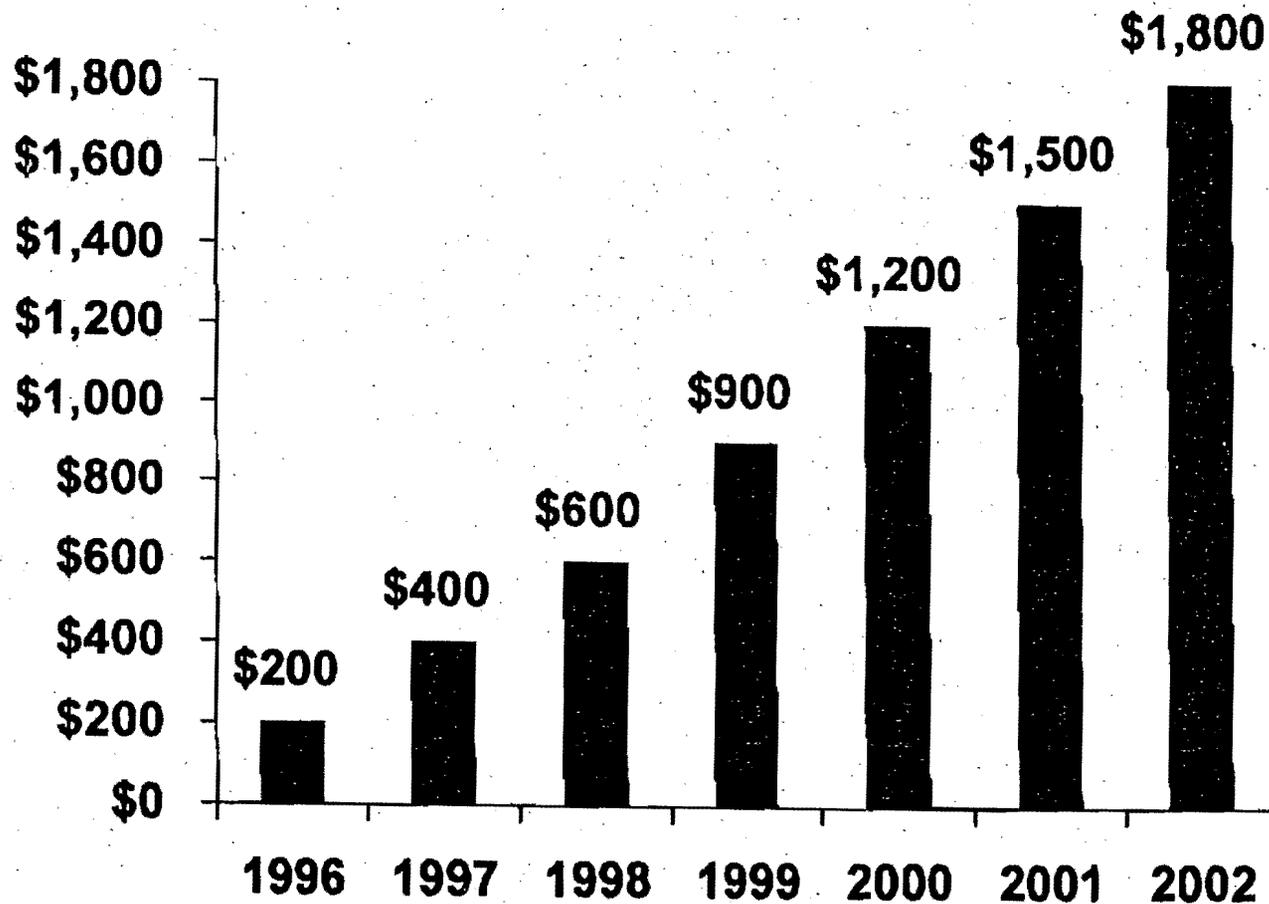
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REMARKS: **REVISED CHART-**

The CSO estimates show  
a different year-by-year savings  
than under the CONFERENCE Agreement

# Reduction in Medicare Spending Per Beneficiary Under the Senate Republican Plan



Note: Total Medicare spending reductions divided by projected number of beneficiaries; fiscal years  
Source: US Dept. of Health and Human Services, Revised 9/27/95