

MEMORANDUM

TO: Hillary Clinton

FR: Chris Jennings

RE: (Republican Medicare Proposals)

October 20, 1995

The President requested the attached quick summary analysis of the House Republican Medicare Structural plan that was passed yesterday through Harold Ickes. I thought you might find it helpful as well.

The first document is a two page narrative of the highlights of the plan. The second document is a more detailed analysis of those provisions that are likely to be of particular concern.

This document is written in such a way as to be critical of the Republican plan. I hope the President and you find it useful. Please call with any questions or any further requests on this issue. I can be reached at 456-5560.

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HOUSE REPUBLICAN MEDICARE RESTRUCTURING PACKAGE

Yesterday the House of Representatives passed H.R. 2425, legislation to transform the Medicare program and reduce its spending by \$270 billion over seven years. Though this bill is generally consistent with legislation reported earlier this week by the House Ways and Means and Commerce Committees, it did incorporate some last minute changes designed to shore up Republican votes.

Trust Fund

Although Republicans defend the bill as necessary to save the Medicare Part A trust fund from bankruptcy, the majority of savings come from Part B. Through last minute budgetary gimmickry, Republicans credited the Part A trust fund with an additional \$90 billion of savings (see discussion below of "11th hour amendments"). This does not change the fact, however, that all of their Medicare savings will be scored as revenue that could be used to offset the cost of their tax cut.

Beneficiary impact and the expanded choices issue

H.R. 2425 claims to offer beneficiaries broader choice, but will in fact, undermine beneficiary protections. The bill establishes a new program, called MedicarePlus. Seniors can elect to remain in traditional Medicare or choose coverage from an array of new plans, such as medical savings accounts (MSAs) and provider sponsored plans (PSOs), under MedicarePlus.

However, different rules apply to these two programs. For example, balance billing that is prohibited in Medicare is permitted under the new MedicarePlus physician fee-for-service option. Insurance companies establishing themselves as "associations" (one can imagine the elderly joggers health plan) can cherry-pick under MedicarePlus; this is prohibited under Medicare. Medigap insurance is regulated in Medicare, but not MedicarePlus. And a widely disproportionate number of the budget cuts in provider payments come from those health providers participating in the current Medicare program.

The net effect of these uneven rules is to make traditional Medicare less attractive to providers and MedicarePlus more expensive to beneficiaries. In addition to direct increases in their Part B premiums, the skewed rules will raise beneficiary costs and limit their choice. For example, if providers migrate to MedicarePlus to escape fee cuts and limits on balance billing, beneficiaries will be forced to follow them. However, if insurers are permitted to charge more for coverage in MedicarePlus, low income beneficiaries may be stranded in whatever is left of traditional Medicare.

Provider Impact of the new "choices"

By contrast, health insurance plans and providers will benefit from the uneven rules. For example, balance billing in MedicarePlus would permit certain providers to shift some of the Medicare budget cuts onto seniors. Relaxed antitrust rules for certain MedicarePlus plans could permit price-fixing by physicians. In addition to these "hidden" benefits, H.R. 2425 offers direct relief to providers to soften the impact of the deep budget cuts. The AMA, for example, won antitrust relief, caps on malpractice damages, and other regulatory relief (see below). For-profit hospitals won a small increase in their Medicare capital payments. Teaching hospitals were rewarded by a new graduate medical education trust fund.

Fraud and abuse

H.R. 2425 also claims to crack down on Medicare fraud and abuse. However, the bill includes a number of so-called regulatory relief provisions that will, in fact, make it easier for providers to abuse the program and harder for law enforcement to stop them. For example, the bill eliminates prohibitions against physicians referring patients to entities they own and raises the standard of proof for prosecuting kickbacks and false claims.

Eleventh-hour amendments

In the last 48 hours before the vote, H.R. 2425 was amended, reportedly to shore up uncertain Republican votes. In particular, Republicans responded to the charge that their plan and Administration's plan yield the same net savings to the Part A trust fund. Two last minute changes added \$90 billion to this trust fund. One transferred \$36.6 billion in general revenue funds to the Part A trust fund to offset the social security tax cut passed by the House this spring fund. The second transferred approximately one-third of the Medicare Part A home health benefit to Part B of the program, thereby reducing Part A outlays by about \$54 billion according to CBO estimates. (This may enable the Republicans to claim that they have "strengthened" the trust fund beyond 2010.)

Another last minute amendment increased MedicarePlus payments to health plans in rural areas. (This was apparently paid for through cuts in payments to HMOs and other managed care plans in areas of the country, such as California and Florida, whose current payment rates have enabled them to provide additional benefits for Medicare beneficiaries.) Physicians also received a last minute change that reduced their payment cuts by \$300 million. Northeastern states, especially New York and New Jersey, would benefit from a change increasing payments to teaching hospitals training foreign doctors. Finally, a new section imposing criminal penalties on some fraudulent behavior was added, though this would not change the regulatory relief provided elsewhere in the bill.

A summary of some key provisions in H.R. 2425 that cause particular concern follows.

Summary of Key Provisions and Concerns in H.R. 2425

Medicare spending cuts are excessive

H.R. 2425 cuts \$270 billion from Medicare spending over the next seven years. It would constrain the Medicare per person growth rate to 30 percent below what the Congressional Budget Office projects the per person private sector rate to be over the next seven years. (CBO projects 7.1 percent for the private sector and projects the Republican cuts to reduce Medicare from 8.2 percent per person to 5.1 percent).

Republicans use gimmicks to strengthen the trust fund and justify their Medicare cuts

The legislation seeks to inflate its protective impact on the Part A trust fund and deflect criticisms about the Republican tax cut through gimmickry. First, H.R. 2425 transfers \$36 billion from general revenues to the Part A trust fund to offset the Social Security cut passed by the House this spring.

H.R. 2425 also transfers about one-third of the Part A home health benefit into Part B. For patients needing extended home health care, visits after 165 days would be paid for by Part B. This would have the effect of reducing Part A outlays by \$54 billion. Beneficiary premiums and coinsurance would not be affected by this benefit transfer.

Finally, H.R. 2425 establishes a so-called "lock box" that would deposit remaining savings from H.R. 2425 into a new trust fund. It has been claimed that the "lock box" will prevent excess Medicare savings from financing the Republican tax cut for the wealthy. However, under the Congress' own budget rules these monies would, in fact, offset the cost of the tax cut. In addition, under H.R. 2425, the "lock box" funds could, in fact, be used for purposes unrelated to Medicare after several years.

Beneficiaries bear the burden of Republican Medicare cuts

The Medicare cuts in H.R. 2425 also are excessive relative to beneficiaries' ability to pay. The bill imposes \$54 billion in new financial burdens on beneficiaries in the form of higher Medicare Part B premiums. Most of this increase results from setting the Medicare Part B premium to cover 31.5 percent of program costs. In addition, higher income Medicare beneficiaries will see their Part B premiums more than triple. H.R. 2425 then compounds these direct new burdens on beneficiaries by many hidden cuts that will force them, over time, to pay much more for their health care services.

Republican false promise of choice obscures threats to beneficiaries

Though it claims to offer beneficiaries a broader choice of health plan options, H.R. 2425 actually creates divisions and inequalities within Medicare that will cripple the program and coerce beneficiaries into either paying more or making do with less.

H.R. 2425 establishes a new program, called MedicarePlus, which will be available in addition to traditional, fee-for-service Medicare. Alternative fee-for-service and managed care plans will be offered under MedicarePlus, as will new types of specifically structured health plans such as provider sponsored organizations (PSOs), medical savings accounts (MSAs), and association plans.

Republicans promise Medicare beneficiaries will have free choice between traditional Medicare and all the plan options under MedicarePlus. However, the legislation applies distinctly uneven rules to Medicare and MedicarePlus with the effect of making traditional Medicare much less attractive to providers than MedicarePlus. These incentives would reduce the willingness of providers to serve beneficiaries in traditional Medicare, leading to coercion of beneficiaries into MedicarePlus plans, thus restricting beneficiary choice rather than enhancing it.

Balance billing is permitted in MedicarePlus

Traditional Medicare protects beneficiaries from "balance billing," the practice whereby providers charge beneficiaries more than Medicare approves. Traditional Medicare permits no balance billing by hospitals and only limited balance billing by physicians. However, balance billing will be widely permitted under MedicarePlus plans. Providers in fee-for-service MedicarePlus plans will be permitted to charge patients any amount they want for health care services. The same will be true for patients electing MSA plans.

Balance billing will be permitted in managed care plans, as well, whenever patients receive non-emergency care outside of the plan, even if such care is authorized by the plan or permitted under a point-of-service option. Given the very tight budget imposed by H.R. 2425, provider pressure to balance bill will grow. If providers begin to move to MedicarePlus plans in order to escape balance billing limits, beneficiaries will be faced with the choice of following them and paying more, or remaining in traditional Medicare where fewer doctors and hospitals are able to care for them.

Provider payment cuts caused by the "failsafe" are deeper in traditional Medicare

The Medicare budget is enforced by a "failsafe" mechanism that triggers automatic cuts in payments to doctors, hospitals, and other providers whenever Medicare spending rises above the permitted amount. While growth caps will apply to Medicare

premiums paid to MedicarePlus plans, the "failsafe" cuts only apply to traditional Medicare provider payments.

Further, by law these cuts must be 133 percent of the level necessary to keep Medicare spending within the budgeted amounts. As the "failsafe" drives traditional Medicare payments down, providers will have even greater incentives to move to MedicarePlus where the cuts can be shifted, at least in part, to beneficiaries.

Republicans place an arbitrary cap on Medicare spending

H.R. 2425 establishes in law the absolute dollar amounts available for Medicare each year. Effectively, the bill constrains Medicare spending growth to an average rate of about 5 percent per person per year from 1996 to 2002, or about 30 percent less than growth rates projected in the private sector. The absolute dollar amounts do not vary to accommodate changes in enrollment, medical inflation, technology or health care needs; the very essence of the Medicare entitlement. Critics charge that limiting Medicare in this way has great potential to place beneficiaries' access and quality of care at risk.

New "MSAs" in MedicarePlus will raise Medicare costs to benefit the wealthiest

A new option under MedicarePlus will permit beneficiaries to enroll in health plans with a deductible as high as \$10,000. Medicare will deposit the difference between the cost of such a plan and regular Medicare coverage in a tax favored Medical Savings Account, or MSA. If people in MSAs don't get sick, they would be rewarded with a tax break. The MSA option is likely to attract the healthiest and wealthiest beneficiaries who would otherwise require little or no health care services in a year. Indeed, preliminary CBO estimates indicate that MSAs will cost Medicare between \$2 and \$4 billion over seven years. It is ironic that legislation, professing to save critically needed Medicare funds, would introduce such a costly new feature to the program.

In addition to the financial cost, risk selection caused by MSAs threatens to undo Medicare's protection for all beneficiaries. As the healthiest individuals are drawn out of the Medicare program, the average cost of those remaining will climb. The resulting growth in spending for traditional Medicare spending will trigger more failsafe cuts, further weakening the program.

"Association plans" will fuel risk selection in MedicarePlus

MedicarePlus also permits the introduction of new "association" plans. Unlike other MedicarePlus plans, association plans may restrict enrollment to association members

only. However, the association is not required to bear risk; it can contract with an insurance company or a PSO. Therefore, insurance companies and PSO could "shop" for associations with healthier-than-average members in order to maximize their health plan profits. Such risk selection, again, would raise the average cost of traditional Medicare for other beneficiaries.

Medigap rules will not protect beneficiaries in MedicarePlus

Today, insurance that supplements Medicare, or Medigap, must meet minimum standards that guarantee value and that facilitate plan comparison. Under H.R. 2425, these rules will not apply to the portion of MedicarePlus plans that supplement basic Medicare benefits. Absence of these rules will make it harder for beneficiaries to make apples-to-apples comparison of health plans. Further, beneficiaries will not be assured that the premium charged for MedicarePlus plan for extra benefits (if any) does not go to pay for excessive health insurer profits and bureaucracy. In fact, insurers could raise the portion of their MedicarePlus premium that pays for Medigap benefits to offset losses they might experience from the limited premium Medicare pays for basic coverage under the Republican bill.

If Medigap insurers become attracted to the less stringently-regulated MedicarePlus market, beneficiary access to traditional Medigap policies could suffer. Again, this disparity could affect the real coverage choices available to beneficiaries.

At the same time H.R. 2425 changes Medigap rules for MedicarePlus plans, it leaves in place rules for traditional Medigap policies that will further frustrate beneficiary choice. Under current law, Medigap plans must offer open enrollment to beneficiaries only when they first become eligible for Medicare. Under H.R. 2425, if a beneficiary tries to return to traditional Medicare after leaving for MedicarePlus, there is no guarantee that Medigap coverage will again be available. Once a beneficiary has developed a significant health care problem, barriers to finding supplemental coverage could severely constrain choice of health plans.

Severe provider cuts and other changes threaten quality and access

While the structure of MedicarePlus is designed to shift costs onto beneficiaries, the magnitude of cuts in H.R. 2425 also threatens some providers. Of particular concern are those providers who constitute the safety net of our health care system. Rural hospitals and clinics, already in precarious financial condition, will be hard pressed to absorb reductions required in H.R. 2425. In addition, cuts in Medicare DSH payments will impact urban safety net hospitals.

The legislation's cuts in Medicare home health payments are structured to create incentives for providers to avoid patients with the most costly home health needs.

Similarly, cuts in payments for "heavy-care" patients in skilled nursing facilities could endanger quality of care for the frailest Medicare beneficiaries.

In another threat to quality, H.R. 2425 exempts physician office laboratories from the quality requirements under the Clinical Laboratory Improvement Act of 1988 (CLIA). Even though surveys have shown that some of the most severe lab testing quality problems are found in physician office labs, "regulatory relief" takes precedence over quality of care concerns in H.R. 2425.

Finally, the provisions relating to quality of care in skilled nursing facilities abandon the recently-developed bipartisan nursing home quality assurance program and replaces it with an untried system involving state regulation. In light of the financial burdens placed on States by the Medicaid Transformation Act, States will be hard pressed to find the resources to carry out these new nursing home quality responsibilities.

AMA sweetheart deals will invite fraud, raise health costs, and harm beneficiaries

The authors of H.R. 2425 have declared war on fraud and abuse, but have conceded the battle on some of the most significant fronts. In particular, in the name of "regulatory relief," H.R. 2425 relaxes critical rules that today outlaw kickbacks and that require providers to exercise due diligence in submitting accurate and true Medicare claims. CBO has determined that these provisions of H.R. 2425 will cost the Medicare program over \$1 billion from 1996 to 2002.

The AMA also won antitrust relief. H.R. 2425 immunizes a broad range of anticompetitive conduct by physicians. Law enforcement would find it difficult, if not impossible, to challenge medical society activities, such as boycotts of insurance companies, as long as they were undertaken in the name of promoting quality or policing professional conduct. H.R. 2425 also affords special antitrust treatment for provider service networks.

Finally, H.R. 2425 imposes a \$250,000 cap on medical malpractice damages, a change long sought by the AMA.

**The Number of Poor Elderly Medicare Beneficiaries
Affected by the Medicare Cuts in the
Republican Budget Resolution Conference Agreement**

- Under the Republicans' proposed \$270 billion in Medicare cuts, the average beneficiary would pay \$625 more in premiums and copayments for health care in 2002, \$2,825 more over the seven-year period.
- This cut would be particularly burdensome for the poor elderly.
 - Currently, about 75 percent of Medicare beneficiaries have incomes below \$25,000.
 - Poor elderly already pay more in out-of-pocket costs than the average senior. While the average Medicare beneficiary pays 21 percent of his or her income on out-of-pocket health care, the poor elderly person pays 34 percent of income.
- In 2002, about **half a million Medicare beneficiaries** would effectively be put into poverty by the increases in out-of-pocket costs for health care. This could be more if states limit coverage for the elderly under a Medicaid block grant.

ANALYSIS OF THE EFFECT OF THE REPUBLICAN MEDICARE CUTS ON THE POOR ELDERLY

The estimate that the increase in out-of-pocket costs would effectively put approximately 500,000 elderly Medicare beneficiaries below the poverty threshold is based on the following assumptions and analyses.

1. It was assumed that the average beneficiary's out-of-pocket health care costs would increase by \$625 per beneficiary in the year 2002. This estimate is based on the assumption that 50% of the cuts would affect beneficiaries, and is relative to a 25% Part B premium. This estimate was deflated to 1993 using the CPI.
2. It was assumed that this amount per beneficiary is a uniform change in current levels of disposable income. Income in this analysis is defined as cash income plus cash transfer payments.
3. The number of elderly for whom the change puts them below the poverty line was calculated using TRIM2 data.
4. Those elderly without Medicare coverage, with Medicaid coverage and with employer-sponsored insurance were subtracted from this number. It was assumed that beneficiaries with Medicaid would have their increase in out-of-pocket spending paid for by Medicaid. Note that there are two alternative assumptions that could be used. One is that the Medicaid reductions proposed by the Republicans could have the effect of limiting eligibility for the elderly. A second is that current eligibility rules remains constant, and that more elderly will participate because they are facing higher out-of-pocket costs. Both assumption were rejected for two reasons: (1) because it is not clear how states will change eligibility under a block grant, e.g., would states eliminate coverage for poor elderly before that for children or AFDC adults; and, (2) in the absence of any clear evidence of the states' likely behavior, this is the mid-range assumption, and may thus be more defensible. The Medicare beneficiaries with a retiree health plan were eliminated from the count since the employer, not the beneficiary, will likely bear the cost (note: the number of poor Medicare beneficiaries with retiree health plans is negligible).
5. The 1992 estimate was projected to 2002 using the projected growth for Medicare beneficiaries.

ESTIMATE OF THE NUMBER OF PERSONS PUSHED INTO POVERTY BY REPUBLICAN MEDICARE CUTS

Republican Medicare cuts would push 721,000 people age 65 and over into poverty in 2002. If family members below the age of 65 (in families with a 65-year-old present) are included, the number affected rises to 819,000. This estimate is focused on the Medicare eligible 65 year-old and older population and therefore omits disabled beneficiaries who also might be pushed below the poverty line. The calculations were based on the assumption that the Medicare cuts are equivalent to a dollar-for-dollar reduction in family income. The estimate was calculated as follows:

- Annual cuts of \$625 per person (in 2002) for the Republican plan were used in the estimation assuming that half of the \$270 billion of Republican cuts fall equally on all beneficiaries. The per person dollar cuts were deflated to 1993 dollars using the projected CPI increases in the Budget.
- The number of persons pushed into poverty by the cuts was simulated using the 1994 CPS (1993 income). The number of persons in families including a person age 65 or older, both above and below the poverty line, was determined. Income for those families was reduced by the per person amount of the Republican Medicare cuts. The effect of the Republican cuts on the number of persons in poverty was obtained by subtracting the number of persons in families below the poverty line after the cuts from the number in families below the poverty line before the cuts.
- Persons age 65 and older pushed into poverty were projected to 2002 by multiplying the CPS estimates by the ratio of projected Medicare beneficiaries (age 65 and over) in 2002 to the number of beneficiaries in 1993.
- In 2002, 721,000 persons age 65 and older would be pushed into poverty under the Republican plan. A similar calculation for all persons, regardless of age, in families with at least one person age 65 or older would push an additional 98,000 persons into poverty for a total of 819,000.

Caveats

It is unrealistic to characterize Medicare cuts as equal dollar-for-dollar reductions in income for all beneficiaries. Rather, this is the average effect on beneficiaries if all cuts were reflected in additional out-of-pocket expenditures by the elderly population, even though that is unlikely to be the case. In particular:

- Some out-of-pocket expenses for lower-income beneficiaries will be picked up by Medicaid which covers deductibles, coinsurance, and Part B premiums.

- Medigap premium increases may not reflect the full increase in out-of-pocket expenses from Medicare cuts because some portion of the increase may be passed on to the non-elderly insured population. In some cases, former employers may absorb Medigap premium increases.
- Providers, particularly physicians, might shift some of the cost to other patients or absorb it directly, particularly for some low-income patients.
- Other family members, in particular, the children of beneficiaries, might cover some or all of the increased cost to their parents.
- Some beneficiaries may respond to the cost increases by choosing to reduce "unnecessary" medical expenses to avoid higher out-of-pocket expenses while maintaining an acceptable level of medical care.

MEDICARE SPENDING AND GROWTH RATES UNDER THE REPUBLICANS' BALANCED BUDGET PROPOSAL

The Republicans have proposed that Medicare spending can be reduced by \$270 billion between 1996 and 2002 in their Balanced Budget Proposal.

MAGNITUDE OF THE CUTS

- **Medicare cuts are 33% of all spending reductions under the Republicans' Proposal.** Although the Medicare beneficiaries represent about 13% of the U.S. population and Medicare is 11% of the Federal outlays, Republicans have proposed that over 33% of the savings from policy change leading to deficit reduction will come from Medicare.
- **Almost all Veterans's Benefits would have to be eliminated to equal the size of the Medicare cuts.**
To get a sense of how large \$270 billion is, the Congressional Budget Office projects that Veterans' Benefits will cost about \$280 billion between 1996 and 2002. Ninety-five percent of government spending on Veterans would need to be eliminated to equal the size of the Medicare cuts.
- **Republicans would reduce Medicare spending by 14%.**
The cuts proposed by the Republicans represent a 14% reduction in Medicare spending between 1996 and 2002. This is 20% in 2002 alone. If service reductions were the only way to achieve \$270 billion dollars in savings, then Medicare could no longer cover home health and the skilled nursing facility services under the Republican proposal.

SPENDING PER BENEFICIARY

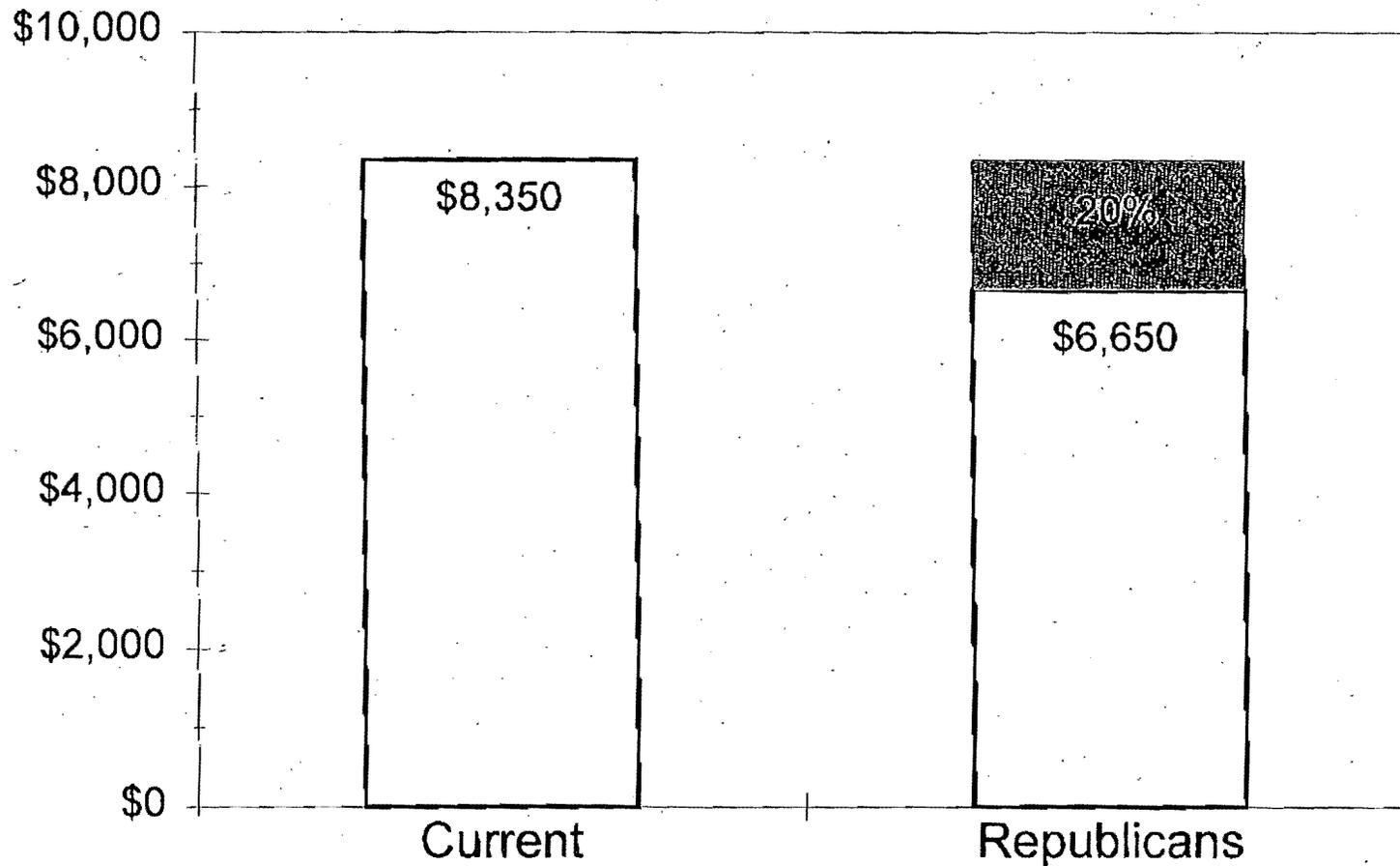
- **Medicare spending per beneficiary will fall by \$1,700 by 2002 under the Republican Proposal.**
Under current law, total Medicare spending will be \$274 billion in 2002, or \$8,350 per beneficiary. The projected Medicare spending per beneficiary after the Republican cuts would be \$6,650, or \$1,700 less.
- **Republicans cuts would add billions to older American's already high costs.**
Currently, older Americans spend 21% of their income on out-of-pocket health care costs. Assuming that the Republican cuts are divided equally between beneficiaries and providers:
 - In the year 2002 alone, each beneficiary could pay \$625 more in out-of-pocket costs than under the President's proposal; couples could pay \$1,250 more.

- Over the seven-year period, beneficiaries could pay an additional \$2,825 (\$5,650 per couple) out-of-pocket relative to the President's proposal.

GROWTH RATES

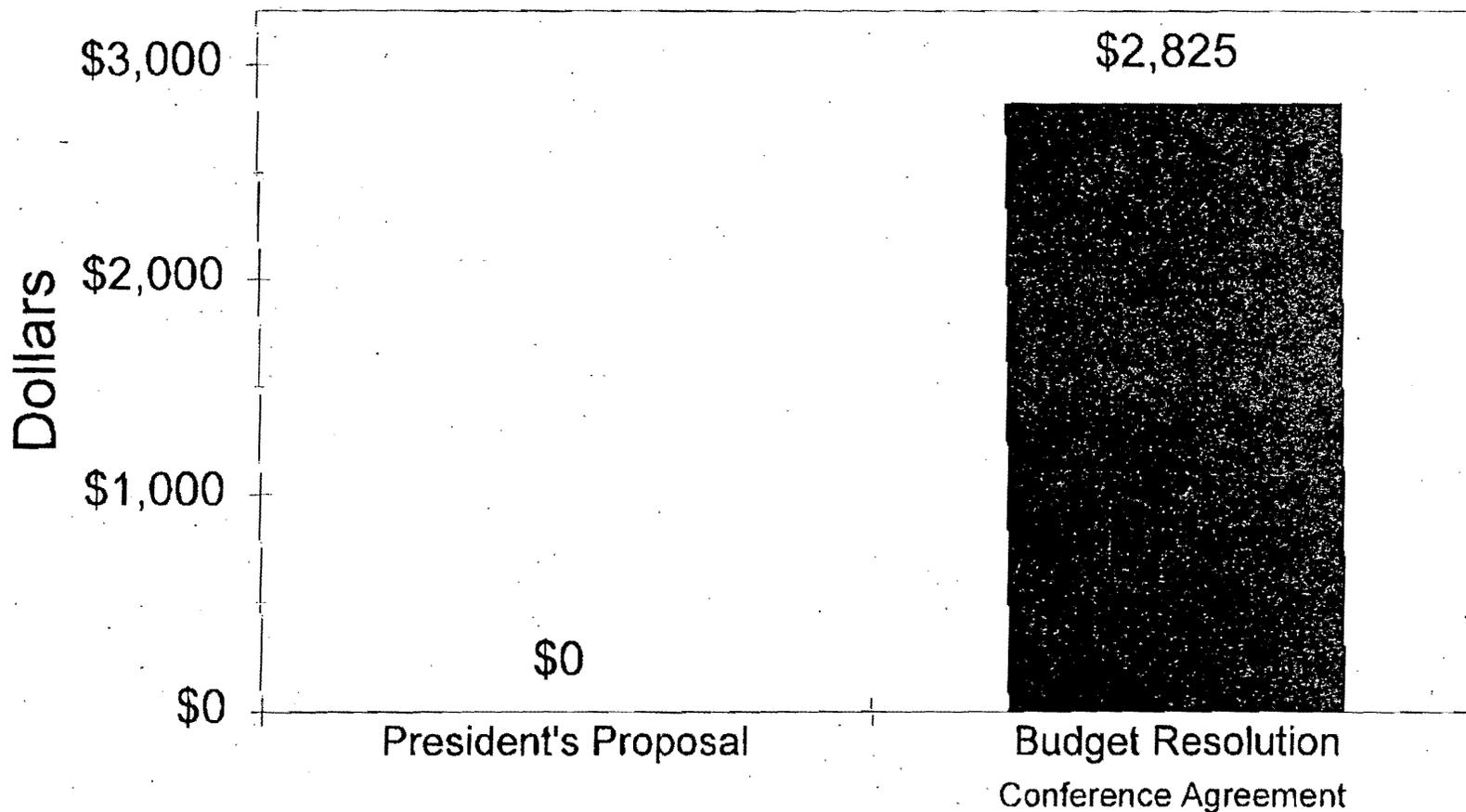
- **Republicans would reduce growth in spending per beneficiary by more than one-third.**
Growth in expenditures per recipient is expected to average 8.2% under the CBO baseline between 1996 and 2002. The Republican proposal would reduce this rate by over one-third to 4.9% over this same period.
- **Republicans' Medicare growth would be significantly slower than that of private spending per beneficiary.**
The Republican growth rate per beneficiary of 4.9% would be significantly lower than the private per recipient growth rate of 7.1%.
- **Republicans' Medicare growth would also be lower than medical inflation.**
Medical inflation (the medical component of the consumer price index (CPI)) is projected to be 5.3%, which is higher than the 4.9% projected under the Republicans' Proposal.

Effects of the Republican Cuts on Medicare Spending per Beneficiary 2002



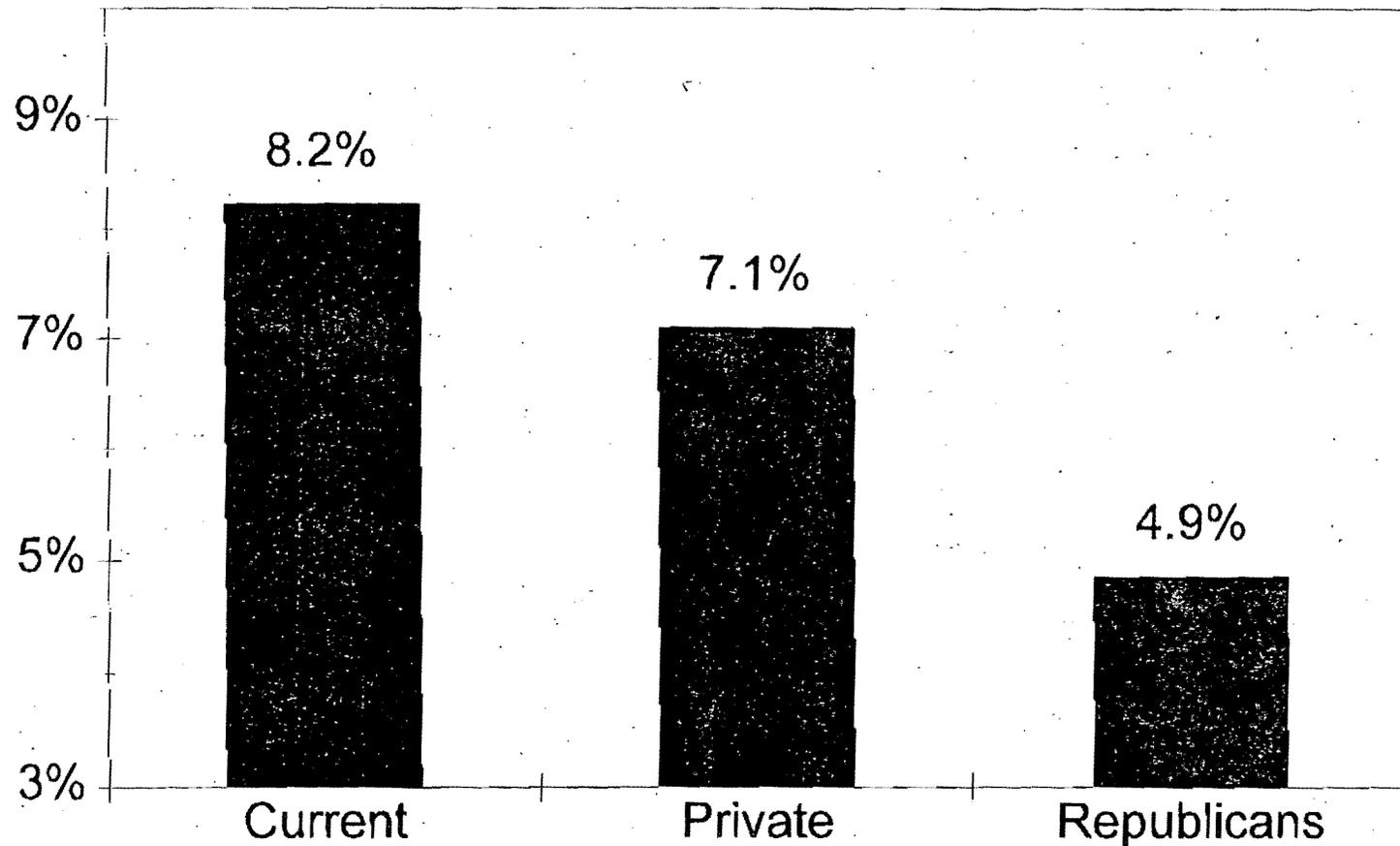
All estimates are calculated by the Administration using CBO data.

Increased Medicare Out-of-Pocket Costs Per Beneficiary, 1996 - 2002



The new Medicare proposals included in the President's June 14, 1995 budget announcement do not include any new beneficiary costs. Republican proposal adjusted to reflect the Part B premium extender in the President's FY 1996 budget. This chart assumes 50% of Republican cuts affect beneficiaries. US DHHS Estimates

Medicare Growth Per Beneficiary: Effects of the Republican Proposal 1996-2002



All estimates are calculated by the Administration using CBO data.

CR/IT/10
RC:01
T70/ T04 7070
RE/7/10/01
COST/STAT/01 444

For OMB/Clearance

NOTES:

Medicare beneficiaries as a percent of the population: CBO 1995 projected coverage of the population (used in their National Health Expenditures estimates)

Medicare spending as a percent of total outlays: CBO's 1995 gross outlays divided by total outlays including deposit insurance, net interest and offsetting receipts.

Medicare cuts as a percent of savings from policy changes: \$270 billion divided by \$756, the savings in the Conference Agreement from total policy changes. (see press release year-by-year table).

Veterans' benefits: Spending from adding the changes under the Conference Agreement, as reported in the Congressional Daily and the proposed savings. This estimate is comparable to that found when the same addition was done for the Senate Resolution.

Medicare service cut: The CBO February baseline spending on home health and SNFs was projected to 2002 using the 1999-2000 growth rates. These were summed and compared to \$270.

BACKUP

Comparison of President's Proposal and Republican Conference Agreement

	Baseline	President	Republicans
Medicare savings as a percent of spending changes		30%	33%
Percent Reduction from Baseline:			
1996-2002		11%	20%
2002		7%	14%
Spending per beneficiary*	\$8,350	\$7,425	\$6,650
Growth Per beneficiary, 1996-2002	8.2%	6.4%	4.9%

*Adjusts to CBO baseline by subtracting Admin. estimated savings from CBO baseline spending

**ANALYSIS OF THE
DOMENICI BUDGET RESOLUTION**

May 11, 1995

Overview

The budget resolution that Senate Budget Chairman Domenici released this week is designed to balance the budget by 2002 with \$961 billion in savings over 7 years. That includes \$806 billion in programmatic changes and \$155 in interest savings.

Domenici would cut Medicare and Medicaid, cut such other entitlements as farm and veterans' programs, cut about 30 percent from domestic discretionary spending, and raise taxes on working Americans by rolling back some enacted expansions of the EITC. For defense, he also relies on the President's 1995 enacted defense plan through 2000, with approximately a freeze in 2001 and 2002 at the 2000 level.

Domenici does not explicitly include a tax cut in his budget resolution. But he includes a procedural tool that would allow Congress to pay for a tax cut by allocating the assumed "fiscal dividend" of lower interest rates that would result from a balanced budget.

Domenici's cuts in Medicare and Medicaid account for 45 percent of his savings. But he does not provide details on how he plans to make those cuts. Nor does he provide much programmatic detail about cuts in other entitlements or in domestic discretionary programs.

Previously, Domenici was expected to need \$1.4 trillion in savings to reach balance by 2002. The reason the cuts now add to \$961 billion is not because they are smaller, but because he has lowered the baseline by assuming a non-defense discretionary freeze.

For the most part, Domenici uses CBO estimates of baseline spending on entitlements, deposit insurance, other mandatory programs, and economic assumptions. His baseline for non-defense discretionary spending removes all inflation. This presentation disguises the level of cuts to non-defense discretionary programs; he freezes all programs at 1995 levels and then applies cuts below the freeze.

Domenici proposes to save a total of \$961 billion in the following ways:

- \$256 billion from Medicare;
- \$175 billion from Medicaid;
- \$209 billion from other entitlements;
- \$190 billion from non-defense discretionary spending (as measured from a 1995 freeze extended through 2002; defense is increased by \$25 billion); and
- \$155 billion from reduced debt service.

The following is a more detailed analysis of what the cuts mean in the major programmatic categories:

I. Medicare -- \$256 billion

Depending on the mix of policies, the \$256 billion in savings could amount to a 19 percent cut by 2002 from Domenici's baseline. He assumes an annual growth of 7.2 percent over the next 7 years, compared to his baseline of 9.8 percent. But he would not impose the cut uniformly each year; he would reduce the rate of growth to 5.2 percent in 1996 and 5.5 percent in 1997 -- much more than the average 7.2 percent.

Domenici does not provide specific policies to generate \$256 billion in savings. He calls for a "special bipartisan commission" to address the long-term solvency of Medicare by reviewing the program's financing, benefit provisions, and delivery mechanisms. Without specific policies, one way to view these savings is to treat them as asking each of the 39.8 million Medicare beneficiaries to bear part of the burden. Using this analysis, the cuts are equivalent to \$6,415 per Medicare beneficiary over fiscal 1996-2002.

Press reports indicate that Domenici assumes \$163 billion of Part A savings. This figure appears close to CBO's estimates of savings needed to comply with the Trustees' solvency standards. To achieve these savings would require deep reductions in the hospital annual update, hospital capital payments, disproportionate share and graduate medical education payments. Lower Medicare payments to hospitals, physicians, and other providers could disproportionately harm rural hospitals.

Press reports also indicate that Domenici's plan assumes beneficiaries in Part

B will continue to pay 31.5 percent of program costs from fiscal 1996-2002, rather than 25 percent under current law, saving a reported \$60 billion. Assuming Domenici saves \$163 billion from Part A and \$60 billion from the Part B premium, he needs to save only \$33 billion more from Part B. He could find these savings through physician payment or outpatient department reductions, among other sources.

II. Medicaid -- \$175 billion

The Medicaid cuts are even more devastating than Medicare's, and would hit the most vulnerable of Americans. The \$175 billion figure implies a cut of 30 percent off of his baseline in 2002. These savings result from an average annual growth rate of 4.5 percent over the next 7 years, compared to his baseline of 10.2 percent.

Savings from higher enrollment in managed care and "traditional" savings proposals (e.g., CBO options for deficit reduction) do not reach \$175 billion. For example, since the CBO baseline projections already assume a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings available.

To find savings of this size would require more dramatic steps. Domenici's plan suggests two approaches. The first is to cut each State's Medicaid matching rate by 18.7 percent across-the-board. The only other way is to turn the program into a block grant, with a cap on growth phased down from 8 percent in 1996 to 4 percent in 2000 and thereafter. To offset the cut in Federal funding, States that wanted to maintain their current services would have to absorb most of these cuts or reduce coverage and benefits.

Even accounting for some managed care savings, the reductions could mean deep cuts in eligibility, benefits, and payments to doctors, hospitals, nursing homes, and other health care providers. Using the projections in the President's budget, if Federal Medicaid spending were cut \$160-\$190 billion over 7 years, and those cuts were split evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, in the year 2002 alone:

- 5 to 7 million children would lose coverage;
- 800,000 to 1 million elderly and disabled would lose coverage;
- All 45 million beneficiaries would lose benefits: all preventive and diagnostic screening services for children, home health care, and hospice services would be eliminated (and dental care if one assumes \$190 billion in savings); and

- Already low payments to health care providers would be cut between \$10.7 and \$12.8 billion.

III. Other Entitlements -- \$209 billion

Domenici's plan calls for \$209 billion in savings from entitlements other than Medicare and Medicaid, in the following categories:

Welfare:

Domenici's budget includes \$47 billion in welfare-related cuts over 5 years -- about \$15 billion less than the House-passed welfare reform bill -- and \$80 billion over 7 years.

- **AFDC and JOBS.** The size of the savings assumed from block granting AFDC is unclear. Were it capped at levels in the House-passed bill, poor families might face benefit cuts of up to 14 percent because capped spending levels would not cover current benefits. Poor families would fall further below the poverty level. Due to the cap, people in States with economic downturns or recessions could lose even more help as more people lose jobs, join the welfare rolls and compete for the same fixed dollars.
- **Food Stamps and Child Nutrition:** While the amount of cuts is unclear, they could reach \$20 billion over 5 years. Domenici has said he will hold School Lunch and School Breakfast harmless, while instituting a geographic income test for Family Day Care Homes in the Child and Adult Care Feeding Program. He proposes to maintain "the safety net of Food Stamps" while better targeting it to lower income beneficiaries (perhaps meaning he would not turn it into a block grant).

EITC:

Domenici would raise \$13 billion over 5 years by rolling back part of the President's 1993 expansion, which sought to ensure that working Americans need not raise their children in poverty. These changes would raise taxes on over 12 million families.

The cut would eliminate the EITC for 4.4 million low-income working families without children, raising their taxes by up to \$324 each in 1996. In total, their taxes would go up by \$3.3 billion over five years, and \$5 billion over seven years.

A repeal of the 1996 changes would raise taxes on 7.8 million low-income working families with two or more children; their taxes would rise by up to \$354 per family. This would raise taxes on families with two or more children by \$8.9 billion over 5 years, \$13.8 billion over 7.

Farm Programs:

Domenici would reduce mandatory outlays (including the CCC programs, crop insurance, and the farm loan program's liquidating account) by \$14 billion over 7 years, or 16 percent. The plan includes no specific recommendations to achieve the mandatory reductions. Rather, it states that "the spending reductions could be accommodated under the 1995 farm bill when reauthorized."

Student Loans:

Domenici calls on the Labor and Human Resources Committee to find \$9.2 billion in savings over 5 years, some of which would come from increasing student loan debt burden. He would:

- eliminate Federal in-school interest subsidies for graduate and professional students, saving \$2.25 billion and affecting 2.4 million borrowers; and
- eliminate the reduction in borrower interest rates scheduled to take place for loans made in 1998 and thereafter, producing no net savings.

Civil Service Retirement:

Federal Employee Health Benefits: Domenici's proposal for FEHB sets an annual dollar amount that the Federal government would contribute for Federal employee/annuitant health benefits and adjusts the amount annually by inflation. Because premiums are expected to rise faster than inflation, CBO estimates mandatory savings of \$2.2 billion over 5 years; 7 years should yield about \$4.6 billion. (In addition, discretionary savings of \$2.3 billion over 5 years reflect lower agency contributions for active employees than under current law.)

Civil Service Retirement: Domenici would change the base used to compute retirement annuities from the highest 3-year average to the highest 5-year average salary, producing savings of \$570 million over 5 years and \$1.2 billion over 7 years. The proposal also conforms Congressional pensions to those of regular civilian employees, reducing their benefits and contributions

for future service.

Veterans Affairs Entitlements:

Domenici proposes to cut VA's mandatory spending by \$6.3 billion by:

- adopting the OBRA savings provisions in the President's budget;
- proposing legislation to overturn the Supreme Court case which mandates compensation for adverse medical situations not resulting from VA malpractice;
- increasing the veterans' contribution rate for GI Bill education benefits;
- increasing the co-payment for prescription drugs for higher-income veterans; and
- limiting future disability compensation awards to only those applicants whose disabilities were incurred in the performance of duty, not merely in the military.

The last provision in particular will be very controversial.

IV. Non-defense discretionary spending -- \$190 billion

Domenici would cut non-defense discretionary programs \$190 billion below a 1995 freeze, the equivalent to a \$301 billion cut below the non-defense discretionary levels in the President's budget.

Domenici proposes to kill the Commerce Department, Office of Personnel Management, and Interstate Commerce Commission; end the Americorps and Learn and Serve America programs; cut deeply into School-to-Work and other education and training programs; privatize FAA air traffic control services; cut the Community Development Block Grant in half; cut the National Endowments for the Arts and Humanities by half; phase out EPA's wastewater and drinking water grant programs over three years; freeze Head Start; fully fund law enforcement programs of the Violent Crime Reduction Trust Fund; and add major funds for WIC.

The specific proposals include:

Education

Domenici would require significant cuts in most of the Education Department's discretionary programs. He "protects" several important programs, including Pell Grants and Title I, by freezing them at the 1995 level.

Cuts would fall hard on such remaining programs as Goals 2000 and education for disabled students, requiring the equivalent of a 20 percent cut across the board.

National Service and VISTA

Domenici would eliminate AmeriCorps and the Learn and Serve America programs, saving more than \$4 billion over 5 years. For 1996, 40,000 young Americans would not be able to devote a full year to making their communities a better place to live, and 550,000 students in American schools would not get service learning opportunities in and out of the classroom.

Domenici would maintain current-law funding for VISTA, a reduction of almost \$50 million below the President's request, or \$240 million over 5 years.

Labor

Domenici would consolidate and cut by 25 percent Labor Department job training programs, wiping out 170,000 jobs in 1996 for the Summer Jobs Program and 8,300 training slots under the Job Corps for 12,200 severely disadvantaged youth.

Domenici would cut School-to-Work by 53 percent, from \$400 million to \$188 million (including both Education and Labor Department funding), stopping progress toward reaching all States with implementation "seed capital" grants in 1997.

Domenici would cut funding for OSHA and MSHA each by half. This would slash OSHA's compliance assistance to help businesses have safe workplaces, matching funds to the 25 state-run OSHA programs, and enforcement activities; and it would impede MSHA's congressionally mandated inspections -- quarterly for underground mines, and semi-annually for surface mines.

WIC

Domenici adds \$1.9 billion to WIC, though it is unclear whether that's over 5 or 7 years.

Head Start

Domenici freezes Head Start at the 1995 level.

Justice

Domenici fully funds the law enforcement programs within the Violent Crime Reduction Trust Fund. He also:

- provides \$7.8 billion for Federal law enforcement activities in 1996, compared to \$8 billion in the President's budget;
- cuts funds for the Legal Services Corporation by 65 percent; and
- provides \$2 billion less for the Administration of Justice than in the President's budget for 1996, and \$10.5 billion less over the next 5 years.

Transportation

Domenici would terminate the Interstate Commerce Commission, consolidate transportation programs, and eliminate highway demonstration programs; these proposals are either the same as or similar to the Administration's proposals.

But he would phase out operating assistance for Amtrak and mass transit, likely bankrupting Amtrak and reducing bus and transit services in smaller cities. And he would privatize the FAA's air traffic control services, saving \$14.7 billion over 5 years.

Housing

Domenici assumes a 50 percent cut in the \$4.6 billion Community Development block grant. Though he claims that he can find the savings by ending aid to non-distressed places, cuts of this size also would affect many cities under fiscal stress.

Domenici also assumes \$6.7 billion in efficiency savings through new block grants for public housing and other assisted housing. Such cuts likely will

mean reductions in level of assistance, numbers of households served, or both.

International Affairs

Domenici would cut State Department operational accounts and drastically reduce funding for U.S. international broadcasting, which would terminate language broadcasts. He also would cut arms control funding and assume that the Arms Control and Disarmament Agency would be merged into the State Department.

In addition, Domenici would cut funds to pay assessed contributions to United Nations peacekeeping operations back to 1991 levels, and cut funds for Aid for International Development (AID) programs by \$3.9 billion over 7 years. Cuts in AID's operating expense budget would reduce the direct-hire workforce by close to 1,000 (more than 25 percent) in the next year.

Veterans Affairs

Domenici proposes to cut discretionary spending by \$3.2 billion. He would freeze VA Medical Care at the 1995 level and cut other programs by more than \$1.1 billion over 5 years. In particular, he would virtually eliminate construction by 1999.

Natural Resources and the Environment

Domenici would cut natural resources and environmental programs by 30 percent by 2002.

He would:

- phase out EPA's wastewater and drinking water grant programs over three years;
- cut funds for NOAA Fisheries and Species Protection programs by 5 percent;
- accept most of the President's proposed cuts for the Corps of Engineers;
- reduce and freeze operations at National Parks by 10 percent through 2002;
- dissolve the National Biological Service; and

- eliminate lower priority and duplicative programs.

Commerce

Domenici proposes to eliminate the Commerce Department, saving over \$1 billion a year but shifting about two-thirds of the department (e.g., Patent and Trademark Office, Census Bureau, National Oceanic and Atmospheric Administration, and parts of Bureau of Export Administration) to other agencies.

He would eliminate the National Institute of Standards and Technology, including the Advanced Technology Program and the Manufacturing Extension Partnership, and Commerce's export promotion efforts that have helped U.S. companies capture \$25 billion in foreign contracts over 1993 and 1994.

Office of Personnel Management

Domenici would "devolve" OPM down to a Civil Service Commission, keeping employee benefit and retirement functions centralized while delegating most other functions to the agencies.

Treasury

Domenici would repeal the \$405 million annual IRS allowance provided in the 1995 budget resolution, reducing resources available to IRS by that amount.

USDA

Domenici would cut Agriculture programs by 11 percent by 2002. Specifically, he would:

- Cut Agricultural Research Service and Cooperative State Research, Education, and Extension Service by 10 percent;
- Eliminate the Foreign Agriculture Service cooperator program and Cochran fellowship program.
- Centralize servicing of rural housing loan program, either by centralizing within USDA or contracting out; and
- Create rural development program block grant.

Public Health and Health Research

Domenici would cut Public Health Service and other health spending by \$2.8 billion in 1996 and \$15.1 billion over 5 years. The plan assumes "full-funding" of the Food and Drug Administration; Centers for Disease Control; Indian Health Service; Substance Abuse and Mental Health Services Administration; and all HIV/AIDS-related programs.

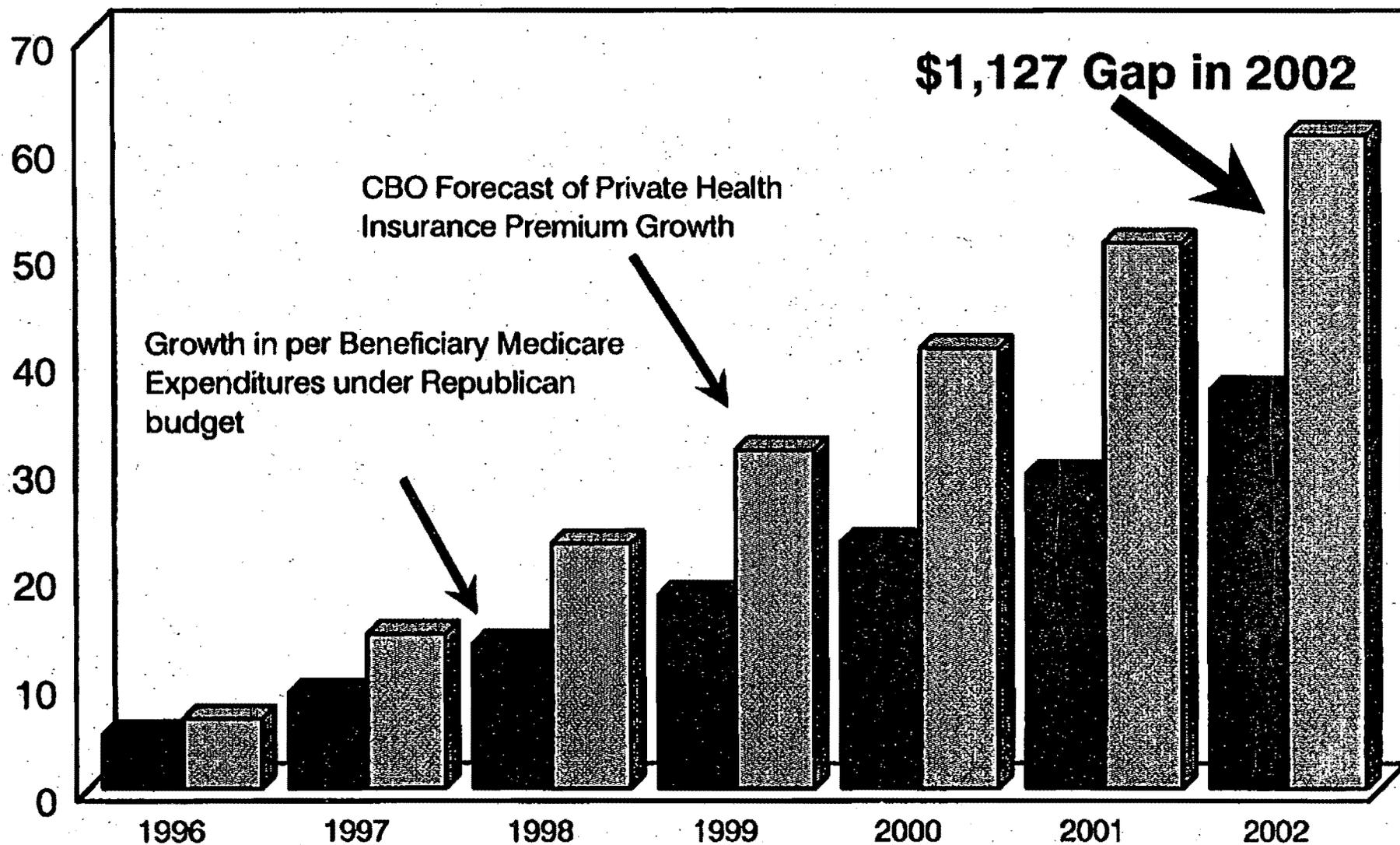
He does not list NIH and several other programs as "fully-funded." Achieving the \$2.8 billion cut in 1996 could require a cut of roughly 17 percent in non-HIV portions of NIH and health service programs for the disadvantaged, including Community and Migrant Health Centers and the National Health Service Corps.

Science

Domenici would cut science and space technology programs by about 10 percent between fiscal 1995 and 2002. These cuts roughly parallel the President's budget by the year 2000, but are deeper in the earlier years. Although his budget document is vague, the cuts seem to come mostly in NASA and the Energy Department, with few reductions in the National Science Foundation.

The Republican Road to Second-Class Health Care

The Steady Erosion of Seniors' Benefits Under the Republican Budget



Democratic staff of the Committee on Ways and Means, analysis of the Republican Budget Resolution, adjusted for age and enrollment, June 26, 1995; projections of private health insurance costs from CBO baseline, 3/95

Proposed Republican Options for Medicare Cuts

(Items appeared in draft House Republican Budget document [5/95] and/or the draft Ways and Means Medicare proposal [7/95])

Republican Savings Estimates	Change in Medicare Policy
no estimate provided	Convert Medicare to Capitated Voucher System
\$26,300,000,000	Establish PPO option
\$0	Allow beneficiaries to remain in employer provided plans
\$6,400,000,000	Extend Secondary Payer Provision
\$0	Lock-in Medicare beneficiaries in HMOs
\$0	Allow plans price flexibility and rebates
\$0	Eliminate the 50/50 requirement
\$0	Allow plans to sell more products
no estimate provided	Medisave option (Medical Savings Accounts)
\$36,300,000,000	Increase Part B premium \$60/year (1996-1999), \$84/year (2000-)
\$3,800,000,000	Increase premium for new beneficiaries who choose fee for service
\$15,200,000,000	Increase Part B deductible 50%
\$18,000,000,000	Income relate Part B premiums
\$25,800,000,000	Impose home health and clinical laboratory copayments
no estimate provided	20% coinsurance for home health services
no estimate provided	20% coinsurance for skilled nursing facility services for first 20 days
no estimate provided	20% coinsurance requirement for all clinical laboratory services
no estimate provided	20% coinsurance requirement on bundled clinical lab services
no estimate provided	Increase the coinsurance up to 25% for those who purchased Medigap coverage
no estimate provided	Increase Part B deductible and index it annually
no estimate provided	Increase Part B premiums to equal 31% (or 33% or 35%) of program costs
no estimate provided	Cash incentives to join cheaper Medichoice plans
no estimate provided	Disincentives to join more expensive Medichoice plans
\$2,500,000,000	Freeze physician payment in 1996 and reduce future update by 3%
\$3,400,000,000	Lower physician reimbursement through MVPS formula
\$900,000,000	Reduce payments to physicians for overhead
\$5,800,000,000	Reduce fee updates for surgeons
\$6,000,000,000	Limit payments to hospital physicians

**Republican Savings
Estimates**

Change In Medicare Policy

no estimate provided	Repeal MVPS
no estimate provided	Use PPRC recommendations in MVPS
\$6,100,000,000	Reduce direct graduate medical education payments
\$21,100,000,000	Reduce indirect medical education payments
\$25,900,000,000	Reduce hospital update
\$5,400,000,000	Reduce inpatient hospital payments
\$2,700,000,000	Eliminate bad debt payments to hospitals
\$28,800,000,000	Eliminate disproportionate share payments to hospitals
\$7,000,000,000	Further reduce hospital capital costs
\$19,300,000,000	Bundle post-acute care
no estimate provided	Reduce payment for hospital bad debt to 50%
no estimate provided	Reduce Medicare PPS hospital rate (Market basket minus 0.5-2.0 percentage points)
no estimate provided	Reduce hospital disproportionate payments by 20-30%
no estimate provided	Rebase the long-term care hospitals cost-based payment system
\$16,000,000,000	Reduce payments for outpatient services
\$3,100,000,000	Payment limits for outpatient hospital services
\$2,000,000,000	Savings from skilled nursing facility cost limits
\$3,100,000,000	Savings from home health cost limits
\$9,900,000,000	Reduce Medicare payments to HMOs
\$1,600,000,000	Competitive clinical labs & durable medical equipment
no estimate provided	Establish a home health payment system with a cap of 120 days (not visits) per episode
no estimate provided	Volume performance standard for home health care
no estimate provided	PPS system for rehabilitation facilities
no estimate provided	Transitional cost reduction for rehab facilities
\$0	Inform beneficiaries of options
no estimate provided	Incentives for beneficiaries suggesting improvements
no estimate provided	Incentives for beneficiaries to report fraud

FACTS ON THE REPUBLICAN HEALTH CARE PROPOSALS

November 6, 1995

MEDICAID

1. Spending

- Under both the House and the Senate reconciliation bills, Medicaid spending will be cut by about \$170 billion over seven years.
- Medicaid spending per person will grow at less than 2% per year. By comparison, the projected growth rate in private sector health expenditures is 7.1% per year.

2. Coverage

- **More than 8 million people could be denied Medicaid coverage.** The Department of Health and Human Services estimates that states will be forced to deny coverage for more than 8 million people in 2002, including:
 - Over 4 million children
 - Approximately 900,000 older Americans
 - Over one million individuals with disabilities

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

3. Individuals with Disabilities

- More than 6 million people with disabilities are now served by Medicaid, including about 1 million children.
- Over one million individuals with disabilities could lose Medicaid coverage in 2002 under the Republican plans. Losing Medicaid would be particularly devastating to people with disabilities because they are often shut out of the private health insurance market.
- Republican Medicaid plans threaten nursing home quality standards and entirely repeal quality standards for intermediate care facilities for the mentally retarded. Not that long ago, most people with mental retardation were relegated to large institutions with substandard conditions. Federal standards have greatly improved conditions in institutions, but the House Republican plan repeals federal nursing home quality standards, and both plans repeal the federal standards for institutions caring for people with mental retardation and developmental disabilities. Neither requires states to issue standards to assure even the most basic rights.

4. Republican Budget Jeopardizes Fundamental Protections for Nursing Home Residents

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

5. Spousal Impoverishment

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

6. Poor Elderly

- Under current law, Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100 percent of poverty (known as "qualified Medicare beneficiaries" (QMBs)). The House and Senate bills completely eliminate coverage of coinsurance and deductibles for QMBs, and set aside only 44% of the money needed to cover premiums in 2002.
 - The House and Senate bills completely eliminate:
 - the requirement that Medicaid pay Medicare coinsurance and deductibles for people below 100 percent of poverty; and
 - the requirement that Medicaid pay Medicare premiums for people between 100-120 percent of poverty.
 - The House and Senate bills set-aside for a portion of the MediGrant funding for Medicare *premiums* equal to 90% of the average spending on premiums between 1993 and 1995. But the set-aside is estimated to cover only 44 percent of the amount projected to be spent on Medicare *premiums* (\$8.5 billion) for people in the QMB program in 2002. [This estimated spending includes the impact of the Republican's increase in Part B premiums.]

MEDICARE

1. Spending

- Medicare will be cut \$270 billion over seven years -- three times greater than any cut in history.
- Spending per person will be cut more than \$1,700 per beneficiary below projected spending in 2002.
 - Medicare currently spends \$4,800 on each beneficiary. Because of the increasing cost of medical services, the Congressional Budget Office projects that, under current law, spending per beneficiary will be \$8,400 per beneficiary in 2002.
 - In order to achieve their goal of \$270 billion in savings, the Republican Medicare proposal limits spending to \$6,700 per beneficiary in the year ~~2002~~ -- \$1,700 below CBO's projection for spending per person under current law.
 - Put another way, the Republican proposal assumes a growth rate of approximately 5.1% a year, 30% below the private sector rate of 7.1% per beneficiary.

2. Increased Out-Of-Pocket Costs for Beneficiaries

- Premiums will increase from \$43 to \$89.
 - Under the Republican plan beneficiaries will pay 31.5% of Part B program costs. In contrast, the President's balanced budget maintains premiums at 25% of program costs.
 - Given the level of Medicare spending assumed in the Republican plan, their proposal translates into a premium of approximately \$89 per month in 2002.
 - If premiums were set at a level that paid for 25% of the Part B expenditures projected under the Republican plan -- the percentage that applied historically and applies under the President's proposal -- premiums would rise to only \$69 per month in 2002. As a result, premiums under Republican proposals would be, on an annual basis, \$240 more in 2002 than if they were maintained at 25%.
- **Double deductibles.** The Senate Republican plan doubles deductibles from \$100 a year today to \$210 a year in 2002.
- **Limited protections from doctors overcharging.**
 - Under current law, Medicare limits the amount that a doctor can charge a Medicare patient above the Medicare payment rate.
 - This limitation on so-called "balance billing" protects beneficiaries from paying additional charges for medical services.
 - The Republican proposal does not extend the balance billing protections to the new physician networks that their proposal establishes outside the traditional fee-for-service system.

3. Cost-Shifting

- Lewin-VHI, an independent research firm, concluded that the Republican's \$452 billion cut in Medicare and Medicaid will lead doctors and hospitals to raise their fees on private patients by at least \$90 billion.
- This cost shifting will increase the cost of private health insurance, which would effectively reduce wage increases by 2.7%, and as much as 10% for lower-wage workers.

4. Managed Care

- Republican plans state that managed care programs will save \$30 to \$50 billion over seven years. The Congressional Budget Office, however, does not score savings from managed care.
- As a result, Republicans rely on a non-market-oriented mechanism for ensuring these savings -- a government imposed cap on spending that limits the growth rate for Medicare payments to managed care programs to a level that is 30% below private sector rates.
- If health care costs exceed these caps, beneficiaries will either get fewer benefits or be forced to pay higher premiums.

5. Medical Savings Accounts (MSAs)

- Republican Medicare proposals allow beneficiaries to withdraw a set amount of money from the Medicare program to buy health care insurance with a high-deductible. The individual may deposit any money left over after that purchase into a tax-preferred savings account.
- MSAs tend to attract only the healthiest individuals, who expect few medical expenses in the coming year and who typically cost the Medicare system little.
- To the extent that MSA vouchers are set at a level that exceeds the cost of these healthy beneficiaries under the current Medicare system, MSAs will increase spending on healthy beneficiaries. In fact, CBO estimates that MSAs will raise Medicare costs by \$2.3 billion over seven years. Lewin-VHI concludes that MSAs will cost the Medicare system between \$15 and \$20 billion.
- Since the Republican spending caps mandate a fixed budget for all Medicare spending, MSA costs would have to be offset by further cuts in services for the less healthy beneficiaries remaining in the traditional fee-for-service Medicare pool.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
MEDICARE	<ul style="list-style-type: none"> • Size of Cuts. Cuts Medicare by an unprecedented \$270 billion, more than twice the President's cuts, and three times greater than any previous cuts in history. Cuts spending per person more than 20% below the private sector growth rate. • Premiums. Raises premiums to 31.5% of program costs -- hiking premiums by \$264 for an elderly couple in 1996 alone. • Spending Per Person. Medicare beneficiaries will pay more and get less. In 2002, couples will pay \$286 more per year than under the President's budget while spending per couple will be \$1,600 less. • Traditional Fee-For-Service Plans. Undermines traditional Medicare by initially cutting spending in the fee-for-service program far more than in the new plan options. Gives doctors additional incentives to leave the program by allowing them to overcharge in the new plan options. • Choice. Offers new options such as Medical Savings Accounts that will undermine the traditional Medicare fee-for-service program by drawing the healthiest beneficiaries away. • Beneficiary Costs. Allows doctors in the new plan options to overcharge by repealing "Balance Billing" protections. • Lock-in. Generally, locks beneficiaries into new plans for a year -- even if they are dissatisfied and want to change back. • Fraud and Abuse. Reduces penalties for defrauding Medicare and puts obstacles in the way of enforcing fraud and abuse laws. 	<ul style="list-style-type: none"> • Size of Cuts. Cuts Medicare by \$124 billion over the next seven years, less than half of the Republican cuts, while ensuring the fiscal integrity of the Trust Fund through 2011. • Premiums. Maintains premiums at the current policy level of 25% of program costs. • Spending Per Person. Spending per person keeps pace with the private sector while adding new preventive benefits, respite care for families of people with Alzheimer's, and annual mammograms. • Traditional Fee-For-Service Plans. Protects the traditional fee-for-service program by providing sufficient funds and not allowing doctors to overcharge in the new plan options. • Choice. Expands choice without undermining the traditional Medicare fee-for-service program and without forcing any beneficiaries to change their doctor. • Beneficiary Costs. Extends current protections against extra charges to the new plan options. • Lock-in. Retains current law and allows beneficiaries to leave a plan at any time. • Fraud and Abuse. Provides additional tools and resources to crack down on fraud and abuse in the Medicare program.

ISSUE	REPUBLICAN 7 YEAR BALANCED BUDGET	PRESIDENT CLINTON'S 7 YEAR BALANCED BUDGET
<p>MEDICAID</p>	<ul style="list-style-type: none"> • Guarantee. Replaces Medicaid guarantee with a deeply underfunded "block grant" which will deny meaningful health benefits for older Americans needing nursing home care, pregnant women, individuals with disabilities, and poor children and their families. • Coverage. Could deny coverage for nearly 8 million people in 2002 alone, including: <ul style="list-style-type: none"> - 3.8 million children - 1.3 million disabled persons - 850,00 elderly - 330,000 nursing home residents - 150,000 veterans • Size of Cuts. Cuts \$163 billion by limiting annual per capita growth to 1.6% -- 70% less than the private sector (7.1%). • States. Block grant will leave states vulnerable to economic downturns. Total state and federal Medicaid cuts could more than double if states do not spend more than required to receive their full block grant. • Nursing Homes. Denies nursing home coverage for as many as 330,000 persons in 2002 -- 75% of whom are likely to be women. Repeals enforcement measures that protect nursing home residents from abuses and inadequate treatment. • Homes and Family Farms. Could force the sick to sell their homes and family farms to qualify for Medicaid. • Poor Elderly and Disabled. Eliminates guarantee that ensures that 5.4 million elderly and disabled people can afford Medicare physician services. • Spousal Impoverishment. Weakens spousal impoverishment protections. 	<ul style="list-style-type: none"> • Guarantee. Retains Medicaid guarantee of meaningful health benefits for older Americans needing nursing home care, pregnant women, individuals with disabilities, and low-income children and their families. • Coverage. Ensures Medicaid health benefits for each of the 36 million people currently receiving coverage. • Size of Cuts. Cuts Medicaid \$54 billion -- one third as much as Republicans -- while ensuring through a per capita cap that no current Medicaid recipient is denied coverage in the future. • States. Maintains 30-year federal partnership with the states, protecting states during economic downturns and increasing state flexibility. • Nursing Homes. Maintains current guarantee of nursing home coverage. Maintains current nursing home protections. • Homes and Family Farms. Maintains law that protects beneficiaries from having to sell their homes and family farms to qualify for the program. • Poor Elderly and Disabled. Retains current guarantee of assistance for poor elderly and disabled Medicare beneficiaries. • Spousal Impoverishment. Maintains current spousal impoverishment protections.

PRESIDENT'S MEDICARE PROPOSAL

The Medicare savings and structural reforms included in the President's balanced budget proposal have been carefully designed to strengthen the Medicare Trust Fund, expand health plan options for beneficiaries and assure that Medicare benefits continue to be affordable for the 37 million elderly and people with disabilities the program serves.

The Medicare Trust Fund is Strengthened through 2011. The savings and structural changes assure the financial health of the Medicare Trust Fund through 2011 -- placing the Fund in a better position than it has been in 18 out of the last 20 years.

Savings Achieved Without Any New Beneficiary Cost Increases or Arbitrarily Imposed Budget Caps. The Administration's proposal has specific and scorable policy changes that assure program efficiency and produce \$124 billion in savings. This is achieved without undermining the structural integrity of the program, imposing new costs on beneficiaries, or arbitrarily capping the program's growth to an index that has nothing to do with health costs.

The Cuts are Significantly Smaller than the Republican Conference Agreement. The Administration proposes smaller cuts for all major categories of the Medicare program (i.e., beneficiaries, hospitals, physicians, home health care providers and nursing homes). The differences in beneficiary and hospital cuts are particularly significant. The Administration has \$42 billion less in beneficiary cuts and \$44 billion less in hospital cuts than the Republican conference agreement. (See attached charts.)

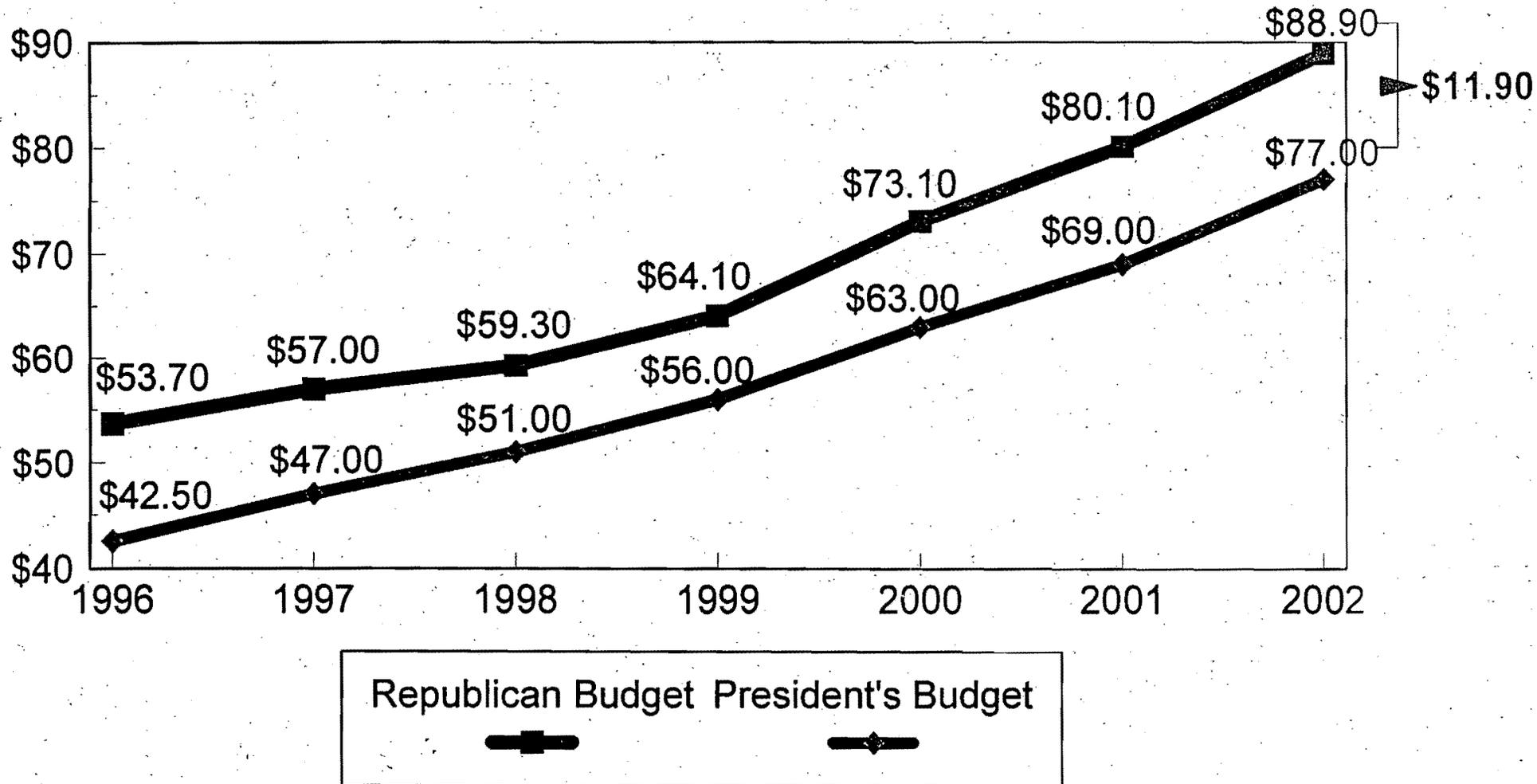
The Reforms Hold the Medicare Per Beneficiary Program Growth Rate to Approximately that of the Private Sector. On a per person level, the President's proposal holds the Medicare program to a growth rate that is slightly lower than the 7.1 percent per person private sector growth rate as estimated by the Congressional Budget Office. In contrast, the Republican Conference Medicare cuts would constrain Medicare growth per beneficiary to over 20 percent below the private sector per person growth rate. (See attached chart.)

Republican Cuts Will Lead to Cost Shifting or Access and Quality Problems. The Administration believes that cuts of the magnitude advocated by the Republicans would result in significant cost-shifting (\$84.7 billion according to the bipartisan National Leadership Coalition on Health Care) or reduced quality and access to needed health care providers. This is why the American Hospital Association has stated: "the reductions in the conference report will jeopardize the ability of hospitals and health systems to delivery quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

Choices of Plans are Expanded Under Medicare in a Pragmatic, Responsible Way. The President's plan retains a strong Medicare fee-for-service program and significantly increases choices of alternative health plans, including new managed care options (PPOs and HMOs with point of service options) as well as provider networks. In contrast, the Republican approach -- which includes Medical Savings Accounts and other options that tend to manage risk rather than manage costs -- will fragment the Medicare risk pool.

Medicare is Improved by Expanding Preventive Programs, including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

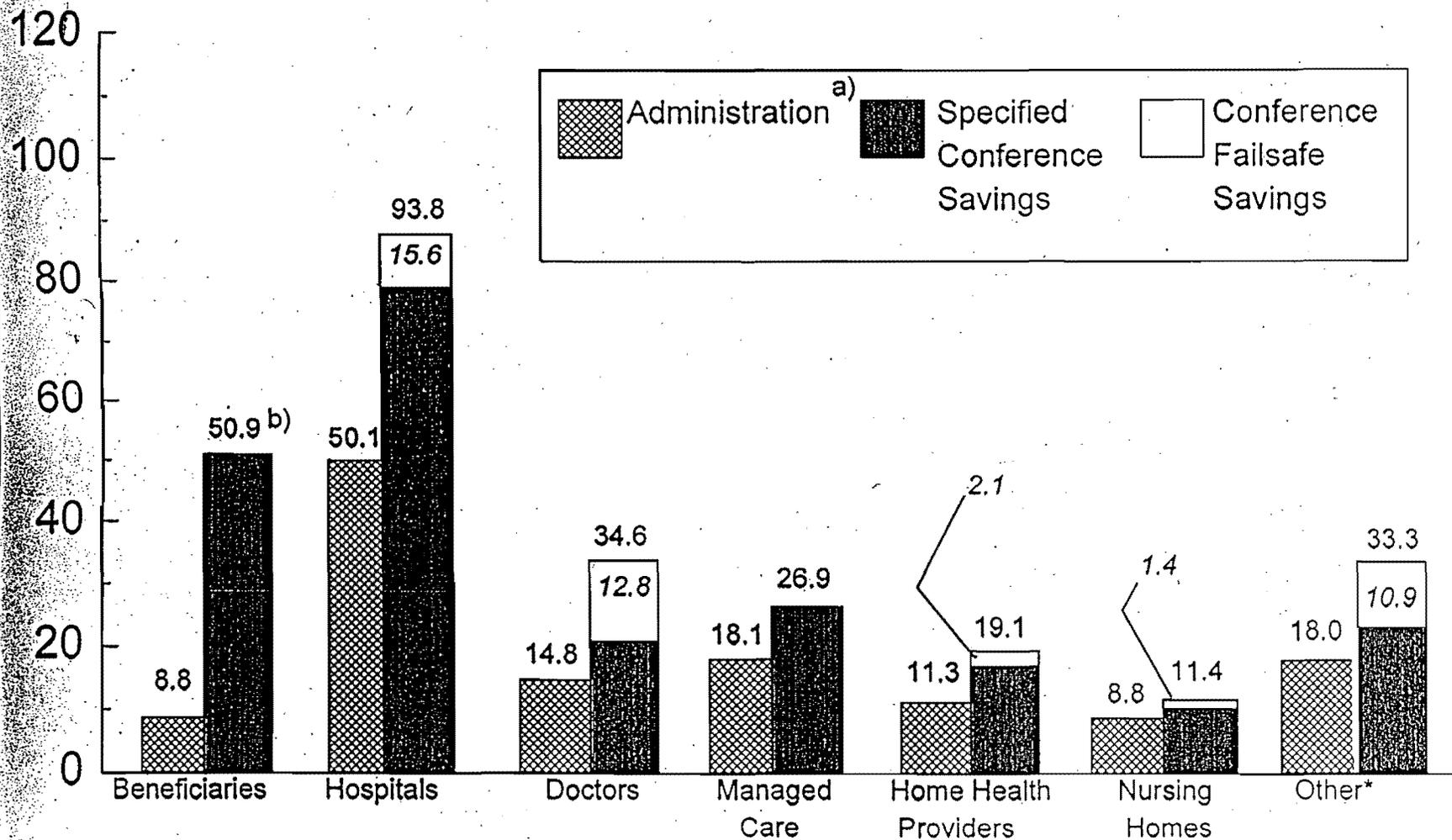
Medicare Monthly Premiums



CBO estimates of Republican premiums, as published in the November 16 letter to Senate Domenici; HCFA's estimates of premiums under the President's proposal. SOURCE: US DHHS.

**Administration vs. Republican Conference Agreement Medicare Cuts By Category
(7-yr. OMB and CBO Pricing, respectively)**

Dollars in Billions

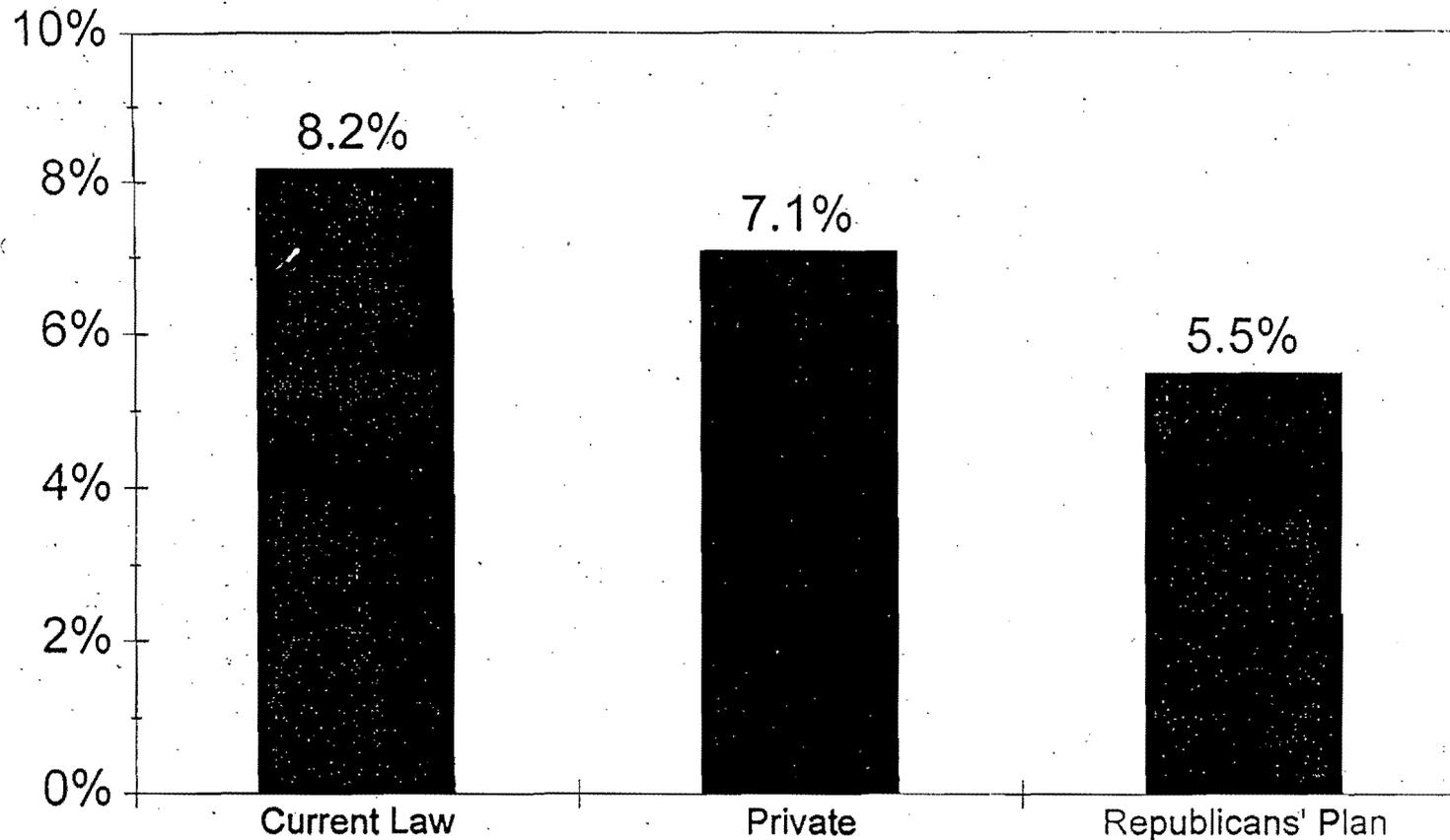


* Other includes interactions, Medicare secondary payer, lab services, durable medical equipment, ambulatory surgical centers, fraud and abuse provisions, and centers of excellence.

^{a)} Administration managed care savings include both direct managed care payment reductions and the indirect effect of fee for service cuts on managed care. All Conference managed care savings are direct because the link between fee for service expenditures and managed care payments is severed. Administration savings do not include \$5.3 billion cost of additional preventive benefits

^{b)} The indirect reduction in Part B premiums due to failsafe spending reductions is reflected in the Conference Agreement "Beneficiaries" total.

Comparison of Growth in Total Medicare Spending Per Beneficiary, 1996-2002



CBO baseline as of October 1995; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of beneficiaries. Administration estimates of private health spending per insured person, using CBO data. DHHS estimates of the President's proposed rate of growth in spending per beneficiary: 6.8%. Source: US DHHS.

	President's Proposal	Republican Proposal
Options	Medicare Fee-for-service, Provider Service Organizations (PSOs), HMOs, and PPOs	Same as President but also private fee-for-service plans, Taft-Hartly trusts, Association plans and MSA/high deductible plans
Benefits	All plans required to provide additional benefits or reduced premiums if payment exceeds plan premium. Additional benefits would be standardized to aid comparison. No cash rebates allowed	All plans required to provide additional benefits or reduced premiums if payment exceeds plan premium. Cash rebates allowed.
Beneficiary Financial Protections	Beneficiaries choosing fee-for-service are not penalized. Beneficiaries choosing private options cannot be worse off financially. Payments to plans tied to program growth. Extra-billing protection on provider and physician services in fee-for-service and private options.	Beneficiaries choosing fee-for-service pay higher deductible (Senate). Beneficiaries choosing private options could be worse off financially because of extra-billing. Payments to plans subject to arbitrary limit below anticipated growth in private health insurance. Extra-billing protection on provider and physician services in fee-for-service but not on private fee-for-service, high deductible and out-of-network services.

	President's Proposal	Republican Proposal
Payment to Plans	<p>Payment based on fee-for-service after adjusting over five-year period for extreme variation in regional payment. Payments related to medical education and disproportionate share removed IN 1998. Health adjusters added after adequately tested. Payment based on competitive pricing would be demonstrated starting in 1997.</p>	<p>Payment based on current AAPCCs. All regional variation not based on price and payments for medical education and disproportionate share would be eliminated over transition. Updates based on arbitrary budget targets.</p>
Enrollment	<p>All plans including Medigap plans would be required to be open for the same 30-day period each year. Plans could also be open outside the 30 day period. No change in lock-in. Comparative materials would be developed by third party and all plan enrollment (except for Medigap) would be through a third party. Plans would pay for enrollment process.</p>	<p>All MedicarePlus or Medicare Choice plans would participated in a annual 30-day coordinated open enrollment period. After free-look period enrollees would be locked-in for year. Comparative materials would be developed by third party and all plan enrollment would be through a third party (House would maintain enrollment through plans). No funding mechanism provided. No requirements on Medigap plans.</p>

	President's Proposal	Republican Proposal
Plan Standards	All private plans must meet standards established and enforced by Secretary.	All private plans must meet standards established and enforced by Secretary (Senate). All private plans (with exception of Taft-Hartly, association and PSOs) must meet standards established and enforced by States. Taft-Hartly, association and PSOs must meet standards established and enforced by Secretary (House).
Medigap	30 day annual open enrollment and phased-in community rating	Not addressed
Income Testing Benefits	None	Part B benefits subject to income testing.
Anti-trust Changes	None	Exempts provider service networks, which unlike PSOs would not be required to be at financial risk, from per se rule against price-fixing (House).



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAY 6

TO: Mark Miller

FROM: Christy Schmidt *CS*

Subject: Draft Analysis of the House Budget Committee Medicare Reductions

Attached is the Department's analysis of the effects on providers and beneficiaries of the Medicare reductions contained in the options paper released by members of the House Budget committee (Shays, Hobson, Miller, Largent). The options paper and the budget mark assume cuts in Medicare of \$288 billion over seven years.

The following analysis focuses mainly on the provider effects of the proposals and specifically the effects on hospitals. We are working on a more detailed beneficiary impact analysis and will forward that to you under separate cover when it is completed.

If you have any questions or would like some further analysis of the plan, please give me a call so I can help coordinate your requests across the HCFA, ASPE, ASL and ASMB team working on this.

House Republican's Medicare Proposals

"PLAN A" - Incentive Base Medicare Reform

- Plan A is a combination of program cuts and changes to the Medicare managed care program.
- The managed care proposals include informing beneficiaries about managed care options, allowing HMO plans to offer cash rebates to beneficiaries, lifting the requirement that at least 50% of enrollees in HMOs that contract with Medicare be privately insured, and eliminating the Part B premium for beneficiaries in HMOs.
- The program cuts, when added with interactions, total \$288 billion over 7 years, the amount the committee now says it needs to achieve their mark.
- The division of beneficiary cuts to provider cuts is about 25% to 75%.

"PLAN B" - Defined Medicare Contribution

- Plan B introduces a voucher plan where beneficiaries would choose their plan and Medicare would make a capped contribution to that plan. If the plan was more expensive than the Medicare payment, the beneficiary would be required to pay the difference. The value of the voucher would be increased each year by the allowed per capita growth rate in the Medicare program, 3.7%.
- Unlike Plan A which distributes the cuts between providers and beneficiaries, this proposal places all of the financial burden for the cuts on the beneficiary. If the beneficiary is unable to find a plan that will accept the voucher amount, the beneficiary must pay a higher premium to get services.

"PLAN C" - Incentive Based Medicare Reform with Look Back Sequester

- Plan C is a combination of "first level" cuts, which includes implementing some of the proposals from Plan A, and savings from increased enrollment in private managed care plans. It also includes a sequester if spending targets are not met. The first level savings would achieve about \$145 billion over 7 years. The remaining \$143 billion in cuts needed to reach their targets would be achieved through increased enrollment in managed care or through a sequester if the savings from managed care enrollment did not reach the savings target. The amount of beneficiary cuts in the sequester cannot exceed 50% of the total cuts needed to reach the target.

Effects of the House Republicans' Medicare Proposals
On Providers and Beneficiaries

House "Plan A": Incentive Based Medicare Reform

- o Overall about one-third of the savings in House Plan A are from beneficiary proposals, and two-thirds are from proposals affecting providers and others.
- o Nearly half of all savings are from hospital proposals. The changes to the PPS system alone will reduce the growth over the period in hospital payments per case to less than one-half the rate of inflation (CPI).
- o Eight percent of all savings is from physician proposals and eight percent is from SNF/HH proposals.
- o While it has been argued that extending Part A Trust Fund solvency is the reason the cuts are needed, only about 55 percent of the cuts are from Part A.

House "Plan A" Hospital Proposals

- o Hospital payments would be severely reduced under the proposed plan.
 - + The effect of three proposals alone, reducing hospital updates, indirect medical education payments, and disproportionate share payments, would reduce PPS payments per case by 13 percent on average from FY 1996 to FY 2002, and 17 percent in FY 2002 alone.
 - + Several other policy changes, including eliminating payments for bad debts, reductions in capital and graduate medical education payments, creating a PPO option and reducing outpatient payments, would decrease hospital payments even more.
- o Large urban hospitals, and especially teaching and DSH hospitals, would see the largest reductions.
 - + Teaching hospitals with 100 or more residents would see a 23 percent reduction in payments per case over the period FY 1996 to FY 2002, and a 28 percent reduction in FY 2002 alone.
 - + Large DSH hospital (100+ beds) payments per case would be reduced by 18 percent on average over the period, and 23 percent in FY 2002 alone.
 - + For these teaching and DSH hospitals, these cuts will result in lower payments per case in FY 2002 than current law for FY 1996.

Page 2:

House "Plan B": Defined Medicare Contribution

- o This plan would transform Medicare into a defined contribution program for all beneficiaries.
- o It appears that there are not specific provider cuts in this plan.

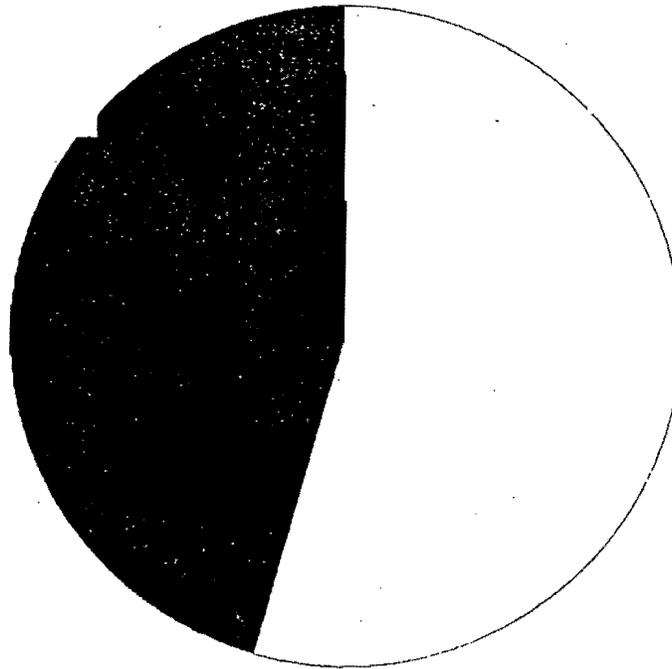
House "Plan C": Incentive Based Medicare Reform with Look Back Sequester

- o Of the first level (i.e., immediate) savings from Plan C, about one-half of the savings are from beneficiary proposals and one-half are from proposals affecting providers and others.
- o Hospital proposal savings account for 22 percent of the total, physicians 6 percent and SNFs/HH 15 percent.
- o While it has been argued that extending Part A Trust Fund solvency is the reason the cuts are needed, only about 55 percent of the cuts are from Part A.
- o An additional \$143 billion savings is assumed to be achieved through increased private plan enrollment and success of these private plans in reducing health care expenditure growth.
 - + If expenditures increase more than a specified target, then a look-back sequester would be implemented.
- o The sequester could result in additional beneficiary and provider cuts.
 - + The first order proposals in the sequester would be reductions in provider payment updates. Second order proposals would be reductions in add-on payments and cost limit changes. Third order proposals would be cost-sharing in high growth services.
 - + Beneficiaries could be responsible for up to 50 percent of the savings from the look back sequester.
 - + HI payroll tax increases and increases in the general revenue percentage for SMI would be prohibited.

House Republican "Plan A" Cuts Effects on Medicare Parts A & B

Part B
(Supplemental Medical
Insurance)
45% of Cuts

Part A
(Hospital Insurance)
55% of Cuts

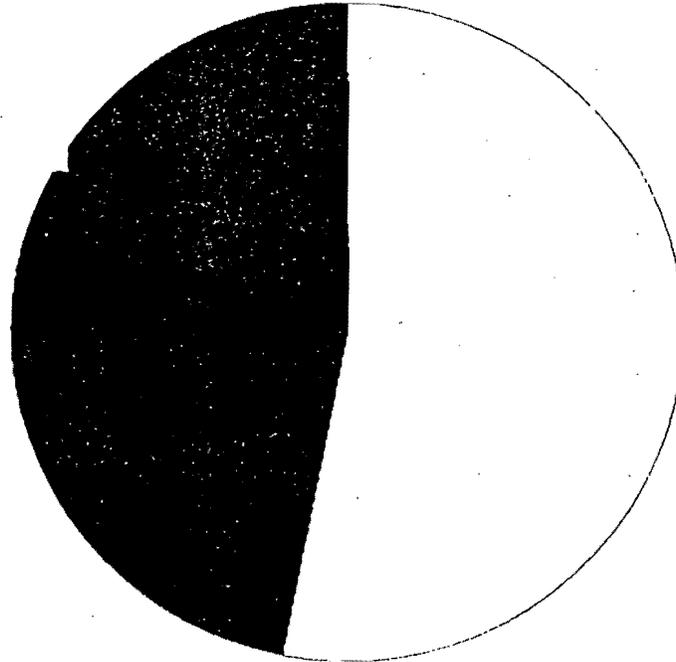


1996 - 2002: Total of \$288 billion

House Republican "Plan C" Cuts Effects on Medicare Parts A & B

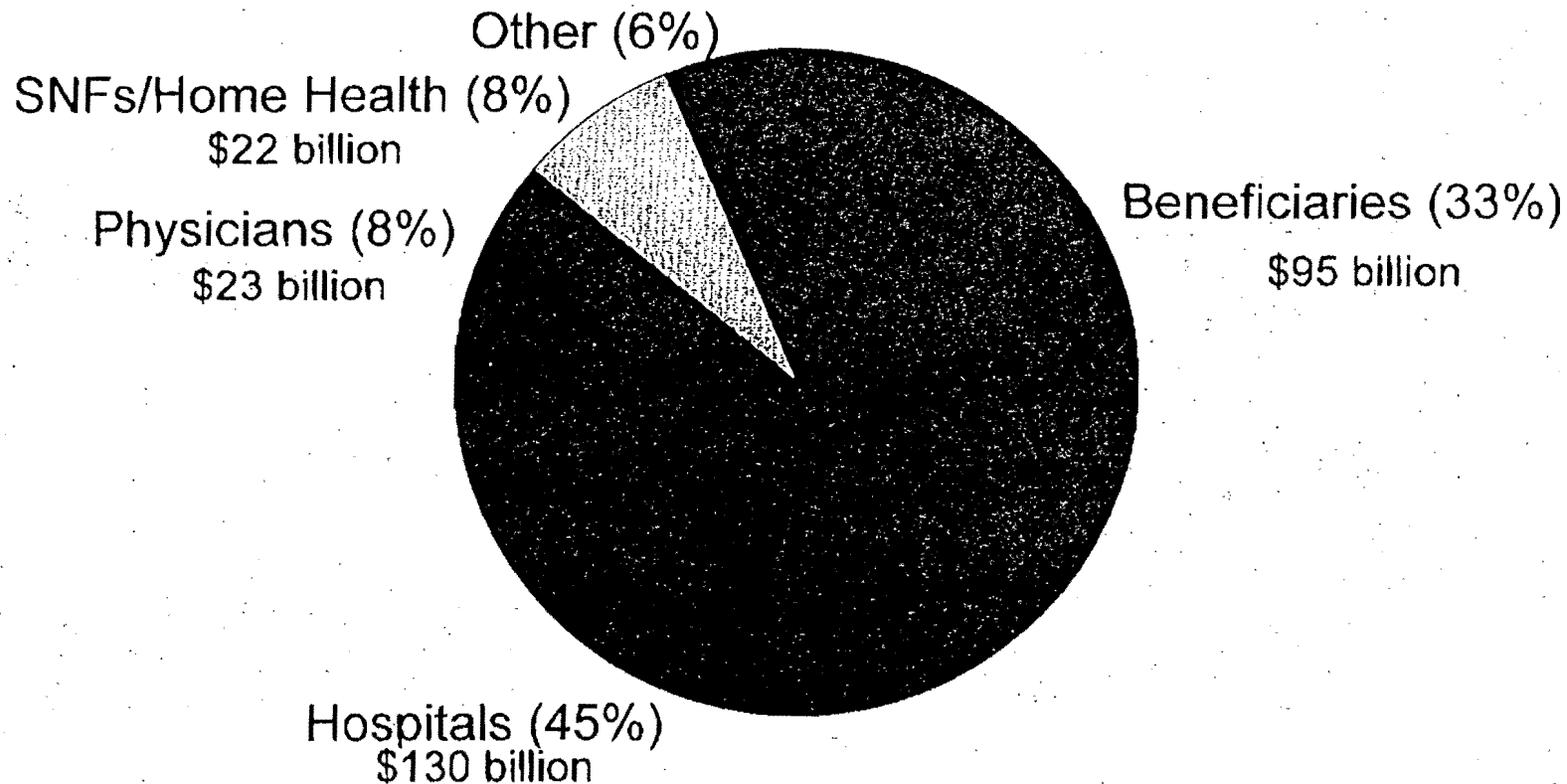
Part B
(Supplemental Medical
Insurance)
47% of Cuts

Part A
(Hospital Insurance)
53% of Cuts



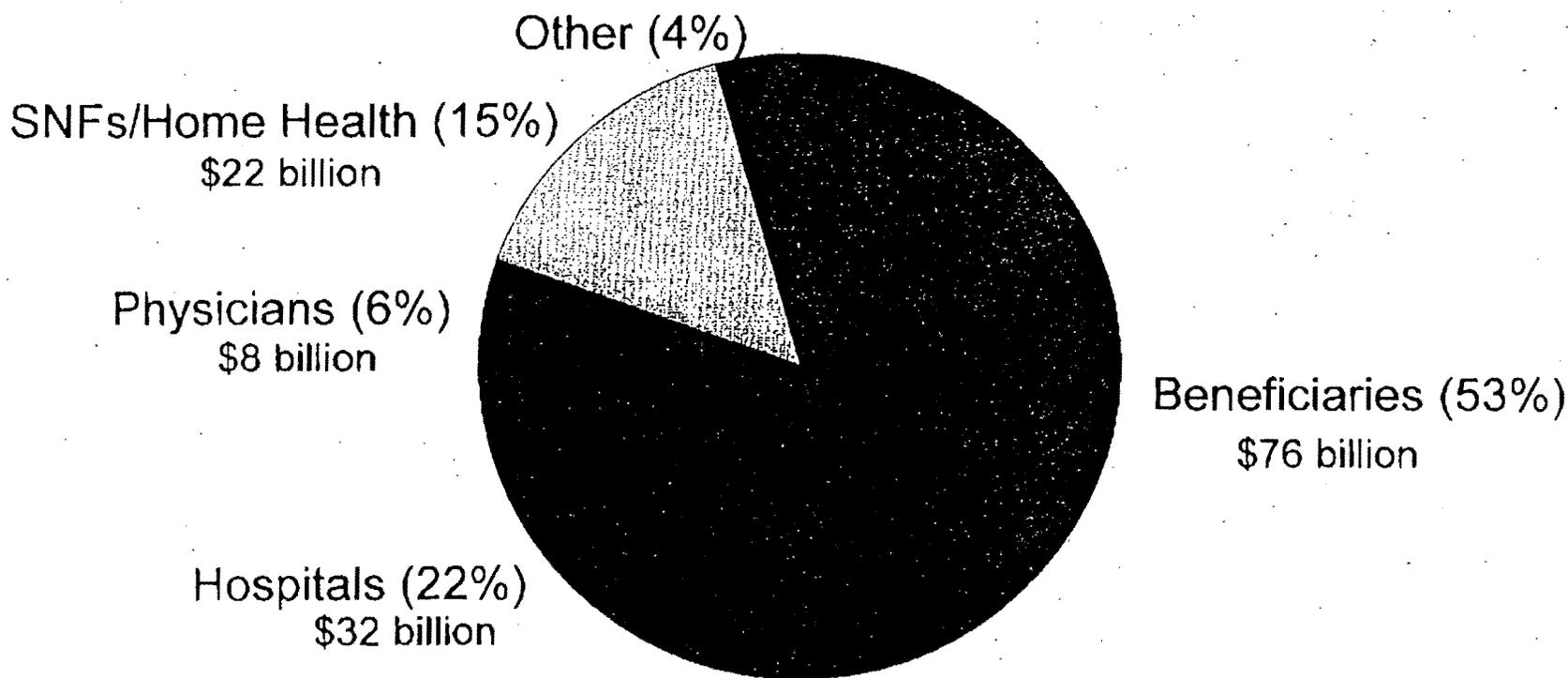
1996 - 2002: Total of \$145 billion in
"First Level: Immediate Solvency Measures"

House Republican "Plan A" Cuts Impact on Providers & Beneficiaries



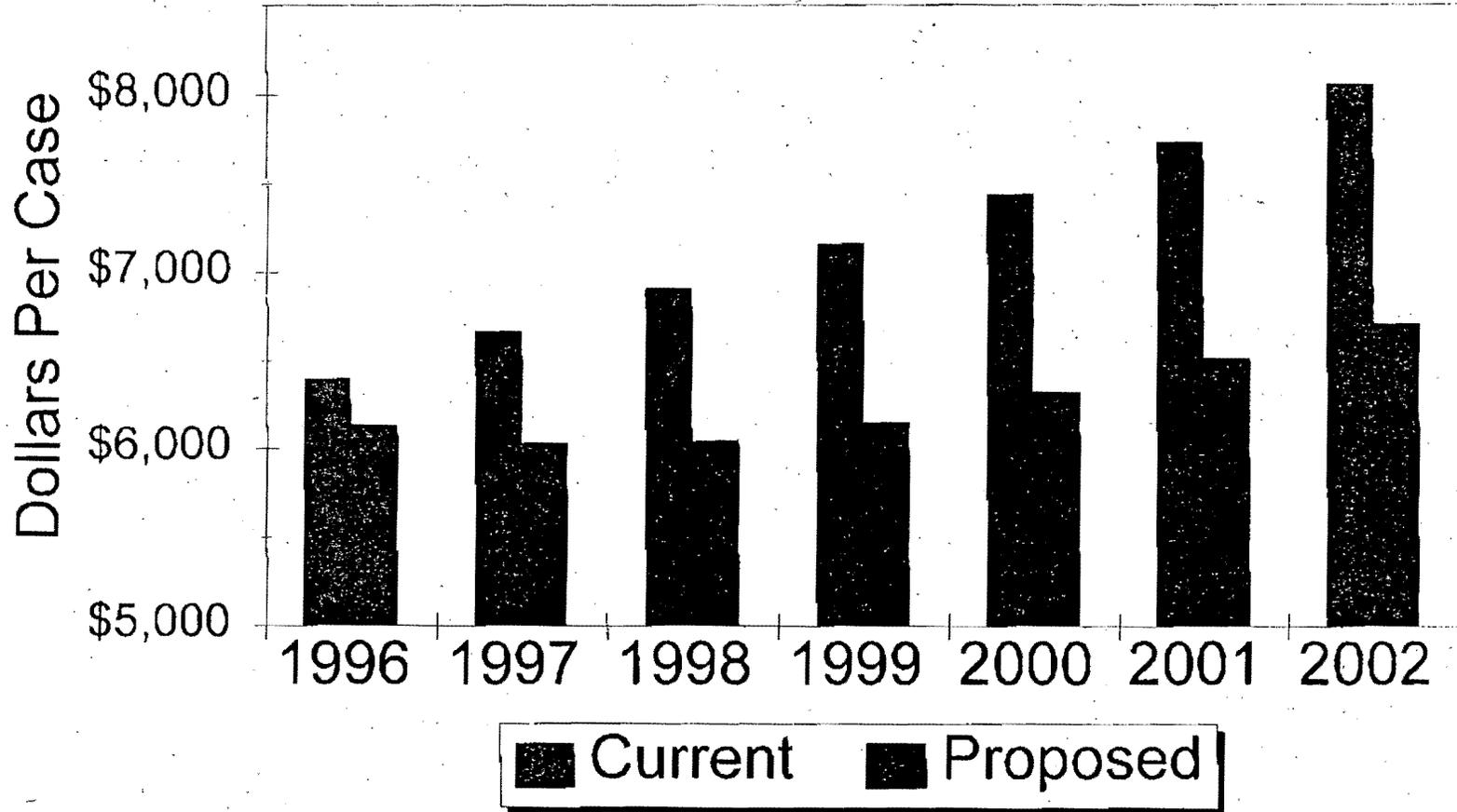
1996 - 2002: Total of \$288 billion

House Republican "Plan C" Cuts Impact on Providers & Beneficiaries



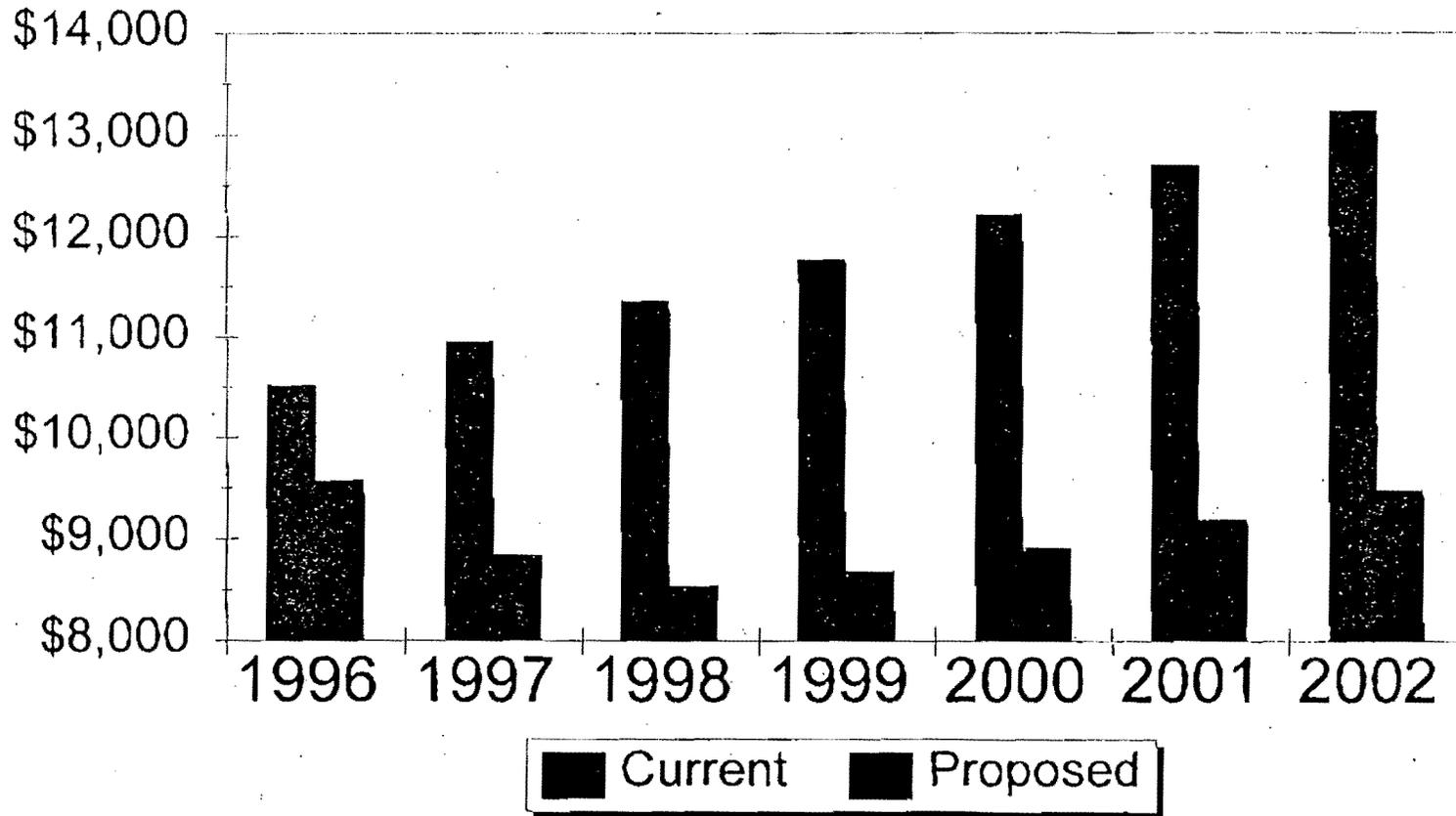
1996 - 2002: Total of \$145 billion in
"First Level: Immediate Solvency Measures"

House Republican "Plan A" Cuts Hospital Payments Per Case



Includes cuts in IME, DSH & Hospital Updates only

House Republican "Plan A" Cuts Teaching Hospital Payments Per Case



For Teaching Hospitals with 100 or more residents
Includes cuts in IME, DSH & Hospital Updates only

U.S. HOUSE OF REPRESENTATIVES
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HEALTH CARE WORKFORCE DEVELOPMENT
HEALTH CARE WORKFORCE ENHANCEMENT
HEALTH CARE WORKFORCE OPTIMIZATION
HEALTH CARE WORKFORCE TRANSFORMATION
HEALTH CARE WORKFORCE REVOLUTION

DRAFT

REPUBLICAN MEDICARE AND MEDICAID BUDGET CUTS

After spending seven months in hiding, Republicans have released the first details of their proposals to reduce Medicare and Medicaid spending by \$452 billion over the next seven years. Before the Congress rushes to enact this plan, the American public deserves to know the truth behind these proposals.

MEDICARE

The Republican Medicare plan makes deep and unprecedented reductions in Medicare spending.

The Republicans claim this plan increases Medicare spending. Yet they also claim the GOP plan is cutting \$270 billion from Medicare for deficit reduction. The GOP can't have it both ways. A cut is a cut is a cut.

The truth is the Republican Medicare plan would reduce Medicare spending below the CBO baseline by an average of 14 percent over the next seven years and almost 20 percent in 2002 alone.

As a result of the Republican cuts, per capita Medicare spending would be forced to grow at a rate about one-third less than the growth in private-sector health spending (4.9 percent Medicare growth versus 7.1 percent private sector growth). This will create a growing gap between payments for senior citizens on Medicare and working Americans with private insurance -- despite the fact that the elderly and disabled often have much greater health needs and costs.

To achieve those savings, the Republican plan ratchets down Medicare spending per beneficiary below the CBO baseline levels. The Republican plan reduces per beneficiary spending by a total of \$6,700 over the next seven years.

With each new Republican plan, beneficiaries are asked to foot more and more of the bill for a tax cut for the wealthy that isn't needed and isn't even wanted by most Americans.

The Republicans first talked about just a small premium increase for beneficiaries. But House Republicans have proposed doubling premiums for all beneficiaries and quadrupling premiums for upper-income beneficiaries.

Now, the Senate Republicans propose both of those premium increases, and impose two more expenses on the frail elderly. The Part B deductible would be more than doubled over the seven year period, from \$100 per year to \$210 per year in 2002. And, the Senate Republicans would phase-in a cut off of all benefits to Americans between the ages of 65 and 67 beginning in 2003.

The bottom line is that both Republican proposals take more than one-quarter of their savings from Medicare beneficiaries, regardless of their health status.

DRAFT

The traditional Medicare program is threatened further by deep provider payment cuts; backed up by a phony gimmick to make the numbers add up.

The Republican plan lays out the deepest cuts in the history of Medicare in payments to hospitals, physicians, and other health care providers. AND, the so-called "lookback mechanism" could nearly double those cuts without new legislation.

House Republicans, in particular, rely on a highly-regulatory "gimmick" to achieve nearly one-third of their savings. The "lookback" mechanism relies on HHS to impose arbitrary retroactive cuts in payments to health care providers, regardless of their efficiency.

The Republican Medicare plan would unwisely experiment with the health plans of the elderly.

In the name of "choice," the Republican plan opens the Medicare program to untested, untried, and potentially unsafe health care approaches that could endanger the financial health of beneficiaries and the program itself. Medical Savings Accounts (MSAs) are barely in their infancy among working Americans and there is virtually no experience with them among the elderly. Yet the GOP plan would test them out on beneficiaries.

The Republican Medicare plan imposes heavy new costs on States and others.

The Senate Republican plan imposes costs on State and Local governments by extending the Medicare Hospital Insurance tax to state employees hired before April 1, 1986. This is a clear violation of the recently enacted law barring imposition of "unfunded mandates" on States.

Increased Medicare premiums and deductibles will also create a drain on State Medicaid programs, which pick up the cost of Medicare cost-sharing for the elderly who live in poverty.

The Senate's proposed delay in Medicare eligibility would impose a heavy burden on private employers, already struggling with the cost of health insurance for retired workers.

MEDICAID

The Republican proposals to cut \$182 billion from the Federal share of Medicaid represent unprecedented reductions in a program serving 37 million low-income women and children, frail elderly in nursing homes, and disabled at home and in institutions.

These cuts put States in an untenable situation. States will be forced to either raise taxes, reduce Medicaid coverage or cut services. Any downturn in the economy would magnify the problem.

More than 8 million pregnant women, children, disabled, and elderly Americans could be cut from Medicaid by 2002.

The Republican proposals completely eliminate all current requirements for coverage for the frail elderly, disabled children and adults, pregnant women, and young children -- no matter how poor they are or how serious their health needs. Further, it eliminates all current requirements for services, such as prenatal care for pregnant women.

The Republican Medicaid plan places the elderly and their families at particular risk

Medicaid currently pays for an estimated 50 percent of all nursing home care in this country. The Republican proposal to repeal Medicaid could leave poor and near-poor senior citizens no longer able to afford basic health services. The Republican plans eliminate the requirement that States pay Medicare premiums and deductibles for seniors living in poverty. They eliminate the requirement that at-home spouses of nursing home residents be protected from impoverishment. They allow States to place liens on the homes of adult children of nursing home residents.

Quality of nursing home care could be compromised

In 1987, President Reagan signed bipartisan legislation protecting nursing home residents against poor-quality care. That law has already reduced the use of restraints and drugs to sedate residents and keep them in their beds. The Republican proposal to repeal Medicaid would wipe those laws off of the books, leaving the frail elderly subject to a new wave of abuses.