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EFFECTS ON CITIES

MEDICARE

Proposed Congressional reductions below the President's plan for Medicare would have an enormous effect on cities. For Medicare, the proposed Congressional cuts nationwide are \$8 billion in 1996, \$71 billion in 2002, and \$270 billion for the seven-year period (1996-2002). About 70 percent of Medicare beneficiaries, or 26 million beneficiaries, are in cities. Assuming 70 percent of the \$270 billion Medicare cut is in cities, Medicare spending would be cut by \$189 billion in cities.

MEDICAID

Proposed Congressional reductions below the President's plan for Medicaid would have an enormous effect on cities. For Medicaid, the proposed Congressional cuts nationwide are \$4 billion in 1996, \$54 billion in 2002, and \$182 billion for the seven-year period (1996-2002). About 75 percent of Medicaid recipients, or 26 million recipients, are in cities. Assuming 75 percent of the \$182 billion Medicaid cut is in cities, Medicaid spending would be cut by \$137 billion in cities.

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Relative to President's Budget:

Proposed Congressional reductions below the President's plan for Medicare would have an enormous effect on cities. For Medicare, the proposed Congressional cuts nationwide are \$4 billion below the President's plan for 1996, \$32 billion in 2002, and \$146 billion for the seven-year period (1996 - 2002). About 70 percent of Medicare beneficiaries, or 26 million beneficiaries, are in cities, and would experience an average increase in out-of-pocket health care costs of \$2,825 over the seven-year period.

MEDICAID

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Relative to President's Budget:

Proposed Congressional reductions below the President's plan for Medicaid would have an enormous effect on cities. For Medicaid, the proposed Congressional cuts nationwide are about the same as the President's plan for 1996, but \$41 billion below the President's plan in 2002, and \$128 billion for the seven-year period (1996 - 2002). About 75 percent of Medicaid recipients, or 26 million recipients, are in cities, and up to 8.8 million recipients could lose coverage in 2002 under this proposal.

AFDC

Proposed Congressional reductions below the President's plan for Aid to Families with Dependent Children (AFDC) would have an enormous effect on cities. For AFDC, the proposed Congressional cuts nationwide are \$1.1 billion in 1996, \$1.9 billion in 2002, and \$22.9 billion for the seven-year period (1996 - 2002).

FOOD STAMPS

Proposed Congressional reductions below the President's plan for Food Stamps would have an enormous effect on cities. For Food Stamps, the proposed Congressional cuts under the Lugar bill are \$2.3 billion in 1996, \$4.0 billion in 2002, and \$23.7 billion for the seven-year period (1996 - 2002).

THE MEDICARE PRESERVATION ACT OF 1995

A bill to preserve, protect and strengthen Medicare

An outline released by the House Republican Leadership

INTRODUCTION

According to the Medicare Board of Trustees, which includes three Clinton Administration cabinet secretaries, Medicare Part A next year begins spending out more than it takes in for the first time in the program's 30 year history. By 2002, the Trust Fund will be bankrupt.

If the program is insolvent, the Treasury can not issue checks to pay hospital bills. If nothing is done, the health care of millions of current beneficiaries and millions more nearing retirement who have paid into the system all their working lives will be threatened. Bankrupting Medicare is unacceptable public policy.

Republicans propose to preserve, protect and strengthen Medicare with the Medicare Preservation Act of 1995. Legislative language and budgetary scoring are not presently available, but the following outline covers the policy options contained in the bill.

THE MEDICARE PRESERVATION ACT OF 1995

The Medicare Preservation Act of 1995 (MPA) will preserve the system for current beneficiaries, protect it for future beneficiaries, and strengthen it through reforms that have worked in the private sector.

Legislation to save Medicare from bankruptcy revolves around six key components:

1. Keeping our government's commitment to traditional Medicare.
2. Allowing seniors the same health care choices available to other Americans.
3. Rooting out rampant waste, fraud and abuse.
4. Maximizing the taxpayer's health care dollar.
5. Affluence testing for taxpayer subsidized premiums.
6. Guaranteeing solvency through a budgetary "fail safe" provision.

[Policy proposals are in italics].

1. TRADITIONAL MEDICARE: KEEPING OUR COMMITMENT

Just as Republicans promised throughout the summer, traditional Medicare will continue to be an option for all current and future beneficiaries, with four important aspects:

- ▶ *Average per beneficiary spending will rise from \$4,800 in 1996 to \$6,700 in 2002.*
- ▶ *No change in copayments.*
- ▶ *No change in deductibles.*
- ▶ *No change in the current rate for premiums.*

Today, premiums are 31.5 percent of Part B costs. Premiums will continue to be calculated that way, so that they will increase slightly every year, just as they have done since the inception of the program.

The bill exposes the shameless fear tactics of the past few months and the lie that premium would rise by \$2,000 per year. According to the Congressional Budget Office, the difference between President Clinton's proposal to drop the current 31.5% rate to 25% at current spending levels and maintaining the current rate at lower levels of increased spending amounts to only \$700 per month, per beneficiary. And beneficiaries will not face any increase in deductibles and payments, in contrast to the months of demagoguery.

For Medicare beneficiaries who want to remain in the existing system, keeping it is as simple as checking a box every year. Indeed, it's as simple as not checking a box every year, since failure to do so results in a beneficiary's automatic enrollment in traditional Medicare.

THE BETTER MEDICARE: GIVING SENIORS MORE CHOICES

The MPA would root out waste and bring private sector efficiency to the system. First, the bill lets Medicare beneficiaries choose between traditional Medicare and several private sector options in a new Medicare Plus plan. Every year, beneficiaries will receive a booklet describing the approved plans available in their area. Any private insurer who at least covers the Medicare benefits meets consumer protection standards can submit an application for the Medicare Plus booklet. Beneficiaries will simply check off the plan of their choice. If a beneficiary makes no choice, he is automatically enrolled in fee-for-service Medicare.

The Medicare Plus program will offer a wide range of choices to seniors.

Coordinated Care. Coordinated care companies are likely to offer several options for seniors. In choosing a coordinated care plan, a senior might agree to a limited choice of physicians or other providers in return for more benefits than Medicare now offers. Such benefits could include less out-of-pocket expenses for coinsurance and deductibles, and/or added benefits like outpatient prescription drugs, preventive care, eyeglasses and hearing aids.

All coordinated care plans must meet solvency requirements, and offer a minimum benefit package equal to that of Medicare.

Medical Savings Accounts. The Medicare Plus program will also offer a Medical Savings Accounts (Medisave) option to all seniors. A senior choosing Medisave would get a high-deductible insurance policy along with a cash deposit in a Medical Savings Account that would cover a significant portion of the deductible. The high-deductible policy would have no copayments, so that seniors would be assured a limit on their out-of-pocket costs—a quality many are likely to find attractive.

Seniors choosing this option would have complete control over the dollars they spend on routine medical care. They could make important medical decisions with their doctors, without worrying about an insurer's or Medicare's payment policies. They can spend their funds for whatever medical needs they have or use them to purchase long-term care insurance.

A beneficiary could take funds out of her Medisave account for non-health related purposes as long as she maintains a minimum balance of 60 percent of her catastrophic insurance deductible. If the funds are used for non-health care expenses, they are taxed as income. All interest earnings would be considered taxable income.

The maximum deductible would be capped to insure consumer protection.

Provider Service Networks. *Doctors and hospitals will be allowed to form provider service networks to cover Medicare benefits, without the insurance company or managed care company as intermediary. A group of doctors or hospitals that forms a network would be required to meet solvency and marketing requirements.*

Per beneficiary contributions will be adjusted for age and other factors, so that Medicare is providing funds according to need. Each year, the per beneficiary contribution will increase according to specified growth rates, established to ensure that Medicare remains solvent. Every plan participating in Medicare must agree to take all applicants and allow everyone to stay in the plan as long as they want — no one will be shut out due to an illness or a pre-existing condition.

3. ROOTING OUT WASTE, FRAUD AND ABUSE.

Ask just about any senior who has used the Medicare system and they can tell you why Medicare spending is out of control. The system is riddled with waste, abuse and outright fraud. In hundreds of town hall meetings and tens of thousands of letters from angry seniors, Republicans listened this spring and summer to story after story of a Medicare system that needs greater scrutiny. Whether it was the story of a woman who went into the hospital for eye surgery and was charged for an autopsy, or the gentleman who was charged \$14,000 for a three and a half hour hospital stay, the message from seniors all over American is the same: Get rid of the fraud and abuse.

The General Accounting Office notes "Since Medicare was enacted in 1965, the delivery of health care services has become more complex, but Medicare's fraud and abuse controls have not kept pace." In other words, like much of the Medicare program, the enforcement component has not adapted to the new realities of the health care market.

Market incentives and private sector competition as described above are not enough to clean up fraud and abuse. The Medicare Preservation Act will enhance the enforcement system and give patients incentives to scrub their bills for mistakes. *The Medicare Preservation Act provides the Department of Health and Human Services the authority to reward beneficiaries who report incidences of waste, fraud and abuse.*

The bill would require skilled nursing facilities and home health agencies to provide cost estimates up front to any patient, because making pricing publicly available guards against later bill-padding. The plan also imposes significant penalties on anyone who defrauds Medicare.

The Medicare Preservation Act Myths, Facts, Questions and Answers

THE PROCESS

MYTH: You're ramming this bill through without any real hearings.

- Since the Trustees' report came out in April, we've had dozens of hearings and heard thousands of pages of testimony. Outside Washington, Representatives have been talking to seniors, providers, hospitals and insurance companies, explaining the problem and looking for advice and solutions.
- This has been an open process, and will continue to be as we work through the bill in committee, on the floor, and with the Senate.

Q. President Clinton is going to veto this bill. Why go through all this?

- President Clinton admitted Medicare is going broke and it must be changed if it's to be around for our seniors. I truly hope he doesn't choose politics over securing Medicare's future solvency.

Q. What's wrong with Ross Perot's idea to try some of these reforms as "pilot projects?"

- Medicare is in critical condition. And unless we enact these reforms, Medicare will be bankrupt.
- We aren't forcing new ideas on anyone -- instead of bureaucrats deciding what's best, we're letting 37 million seniors and disabled Americans make their own choices. And for those who don't want to change, traditional Medicare will remain as an option and seniors will always be able to switch back to it.

HOW SENIORS WILL BE AFFECTED

MYTH: You are forcing people into HMOs.

- Seniors will have the option to stay in the current program, move into a private fee-for-service or managed care plan, or purchase a MediSave Account. No one will be financially pushed into any plan -- it's up to each senior to decide what's best for him or her.

MYTH: If premiums increase, the practical effect will be to force people into managed care, whatever their choice.

- In 7 years, seniors will pay between \$7 and \$10 a month more than they would under the President's budget. We believe this is a reasonable and practical cost to ask from seniors to save the program from bankruptcy.

Q. Will seniors get a better benefit package than they have right now?

- Seniors will be guaranteed the same benefits they have now, no matter what plan they choose. But they will have the option to choose a plan that may offer, for example, prescription drugs or eyeglasses, or preventative care or better hospital coverage in addition to traditional Medicare benefits. Or, they may choose a MediSave account with a

catastrophic policy that will allow them total control over their health care dollars. It's up to seniors to decide what's best for them.

MYTH: Managed care doesn't work in areas like rural America.

- That's why seniors will have choices of many types of plans. We know that what works in Los Angeles won't work in rural South Dakota.
- We're also going to make it easier for doctors and hospitals to network together, to provide health care at a better value.

MYTH: The poorest and most vulnerable seniors won't be assured Medicaid will cover their nursing care.

- Rather than relying on Medicare and Medicaid interacting properly, we are streamlining the programs so Medicare provides direct relief to low-income seniors.

MYTH: Seniors' out-of-pocket costs are going to skyrocket.

- Because Medicare is a top-down, government-designed program, seniors are getting a raw deal. For example, their hospital -- Part A -- deductible is more than \$700, and after 2 months, it's about \$180 a day. That's far higher than private insurance. And too many things aren't covered, like prescription drugs and hearing aids, meaning 70% of seniors have to purchase Medigap insurance, at about \$1,200 a year.
- We're offering choices so seniors can choose a plan that offers low copayments and deductibles. And we're not increasing co-payments and deductibles for those who wish to remain in traditional Medicare.

Q. Will seniors be guaranteed they can keep their own doctor?

- A senior choosing traditional Medicare will continue to have complete choice over what doctors they see. If their physician is affiliated with a plan they like, they can choose that plan. If a senior opts for a MediSave account, he or she can continue to see whatever doctor he wants.

MYTH: President Clinton's plan doesn't affect seniors, and it makes Medicare solvent. Why do seniors have to pay for the government's screw-ups?

- President Clinton has never submitted a Medicare reform plan. His original budget simply let it go broke. We don't know what he plans to do -- he talks a good game, but we've never seen any bill.
- And President Clinton has used some funny math. If he used the same figures we do, which are more conservative about growth rates and inflation rates, his savings work out to be \$192 billion -- not the \$128 billion he claims. In seven years, that means the difference between his plan and ours is about a dime on the dollar.

Q. How will Seniors sign up for these new plans?

- Every year, the government will send seniors a brochure that outlines the different options available. This is how federal employees make insurance choices each year. Beneficiaries who do nothing will automatically be enrolled in traditional Medicare. If they want to choose one of the new private plans, they just fill out a form in the booklet and mail it in.
- After you're enrolled in the new plan, you have a short time frame to change your mind. And then every year after that, you have the option to switch to whatever plan you choose.

Q. What if the voucher isn't enough to buy any plan?

- This is not a voucher program. The federal government is not simply going to give each elderly a coupon and tell them to find their own insurance. Every plan that participates in Medicare will have a contract with the federal government, assuring they meet consumer protection standards. Every participating plan must agree to take all applicants. They can't differentiate between older and younger seniors, or between healthy or ill seniors.

- Right now, Medicare spends about \$4,800 per beneficiary. In seven years under our plan, Medicare will spend about \$6,700. We've worked with providers and doctors, and they assure us that's plenty of money for high-quality health care.

Q. Will you increase co-payments?

- No.

Q. Will you increase deductibles?

- No.

Q. Seniors like the convenience of Medicare -- there's no need to deal with insurance agents. Now they'll have to buy a plan, file claims forms with insurance companies, and deal with all that hassle, won't they?

- Seniors don't have to choose a private plan if they wish to stay in traditional Medicare.
- But anyone who has ever filed a claim with Medicare knows it's not exactly user-friendly. And if you have Medicare, you have to deal with two bureaucracies instead of one. Many of the private plans eliminate a lot of the paperwork for seniors.

MYTH: Fly-by-night crooks will set up scams to rip off seniors, taking their vouchers & running off with the money, leaving them without health coverage.

- Seniors will never receive a check from the government with which they have to buy insurance. They'll get a booklet, make their choice, and mail in a form. Medicare will directly reimburse health plans. And Medicare will only allow plans to participate in Medicare if they meet strict consumer protection and other standards. That will prevent seniors and taxpayers from getting ripped off.

HOW OUR PLAN SOLVES THE PROBLEM

Q. What does this mean for Medicare's bankruptcy?

- Our plan makes Medicare solvent until 2014, just before the baby-boomers retire. We're ensuring that Medicare is there for today's current and future seniors. We will also appoint a commission to look beyond 2014, and recommend policies to address the huge demographic shift coming then.

Q. What about waste, fraud, and abuse?

- Everywhere every Congressman went over the summer, he or she heard horror stories about waste, fraud, and abuse. They heard about government bureaucrats who simply didn't care about their complaints, they heard about hospitals that didn't worry about correcting mistakes because "seniors aren't paying for it anyway."
- They told us about unnecessary tests and procedures because unscrupulous providers are trying to make a quick buck. They told us about receiving medical devices they don't need because someone got a hold of their Medicare number. We'll fix that by giving beneficiaries who stay in traditional Medicare a reward for reporting fraud. We'll also require all private Medicare plans to maintain a 1-800 number to receive billing complaints.
- And most importantly, we're bringing this system into the 21st century. By introducing competition and making providers and insurers compete for seniors' business, seniors will be assured the best bang for their buck. And that means providers and insurers will lose business if they continue to waste money -- they won't be able to afford to tolerate waste and fraud.

Q. Experts believe that options like coordinated care and Medisave will attract only the healthiest seniors, leaving a sicker and sicker population in traditional Medicare. How will that solve the bankruptcy issue?

- They're wrong. Those seniors with higher health costs will find several attractive private sector options. The fact is, Medicare leaves seniors exposed to far more out-of-pocket risk than the average private insurance plan. Beneficiaries with major illnesses, who are those generally on fixed incomes, face the prospect at the beginning of each year of a \$718 Part A deductible, a \$100 Part B deductible, and 20 percent copayments on most additional medical services, along with no coverage for prescription drugs.
- The only way to avoid these possibly unlimited costs right now is to spend \$800 to \$1,400 on Medigap insurance. Our Medicare Plus options likely will, as is the practice in private insurance for those under age 65, offer explicit limits on out-of-pocket liability. That will be very appealing to a senior on a fixed income who is worried about incurring large medical bills during the year.

Q. HCFA right now claims that the Medicare risk contract program actually costs more than traditional Medicare. How will managed care solve the bankruptcy problem?

- Other studies have shown that Medicare risk contracts save money. But it's available in only certain areas, not across the country and with major restrictions, so we simply can't compare today's limited program to the new Medicare Plus system.

HOW DOCTORS & HOSPITALS WILL BE AFFECTED

MYTH: Cutting doctors' fees means they won't want to see seniors -- that will ration care.

- Doctors and hospitals must contribute to saving Medicare. But under a more efficient Medicare system, Medicare dollars will go a lot farther than they have in the past.
- If the system goes bankrupt, the government can't pay bills. That's what will ration care, and we won't let that happen.

Q. Doesn't cutting doctor and hospital fees for Medicare mean they'll just pass on those costs to the rest of us? It sounds like a hidden tax increase.

- We are making the system more efficient and giving doctors and hospitals more flexibility so they can better treat patients at reasonable costs.

Q. Are you doing anything about malpractice reform?

- We've already passed a limit on non-economic damages in our Contract legal reform bill.

Q. Won't these cuts mean some rural hospitals will have to close?

- Hospitals are going to have to change, to become more efficient. That's happening all around the country, because Medical technology has changed. Surgeries that once required four and five days in the hospital are now outpatient procedures. We think rural hospitals are as able to achieve efficiencies as urban ones.

Q. Are you cutting funding for graduate medical education?

- We are making modest reductions in funding and at the same time improving the targeting of medical education funds toward their best use -- training primary care physicians rather than highly specialized doctors who treat fewer patients.

Q. Will the fail safe mechanisms mean hospitals and doctors won't see me if Medicare runs over budget?

- No. The fail safe is designed to make minor adjustments in payments for medical services. In fact, if providers don't overspend, the fail safe won't even be triggered.

GENERAL QUESTIONS

Q. It's only Part A that's going bankrupt. Why do you have to increase Part B premiums and make reforms to that program?

- Part A pays hospital bills. Part B pays doctor bills. But it's doctors who put people into hospitals -- you can't separate the two. And the same report that warned us about Part A's bankruptcy also said that Part B was growing at unsustainable levels -- 12.1% a year for the rest of the decade, while private insurance costs actually dropped last year.

MYTH: Right now, the government spends only pennies on three dollar for administering Medicare. Private insurers spend far more money -- meaning seniors will get less bang for the buck, and pay more in paperwork costs.

- Today, we spend billions to contract out administering Medicare, and it's impossible to know exactly how much Medicare spends on paperwork and bureaucracy.
- Seniors will get a better value by opening up Medicare to competition. Insurers will have real incentives to keep their overhead down, and that translates into more money being spent on health care, and less on paperwork. Any plan that cannot keep its costs down simply will not be able to compete for seniors' business.
- Seniors will compare plans and see which plan is spending more on paperwork and overhead, and which one is spending more on health care.

Q. I've heard horror stories about insurers canceling policies if someone gets very sick. They also deny or limit coverage if someone is already sick and wants to purchase coverage. Will that happen to seniors who choose to buy from private insurers?

- No. If a senior chooses to purchase a private plan, they will be guaranteed coverage and renewability of their policies each year. No Medicare Plus participating insurer can deny any senior a plan.

Q. Is this like what the Clintons tried to do last year?

- The Clinton health care plan proposed to take everyone's private health insurance and turn it over to the government. We're going to take a government insurance program and apply the lessons of the private sector.
- We're increasing choices for Medicare beneficiaries, they proposed to decrease choices for everyone, and their plan would have let Medicare go bankrupt.

MYTH: Your plan is going to chase doctors out of traditional Medicare.

- Doctors today are turning away new Medicare patients, because the bureaucracy is so overbearing. HCFA employees with no medical training regularly overrule doctors' judgments, and declare billed services medically unnecessary. That means the doctors and patients get stuck with bills Medicare won't pay. Our plan will give doctors the flexibility to work with beneficiaries to determine the best treatment for given circumstances, without a government bureaucrat looking over his shoulder.
- Doctors can choose to participate in Medicare Plus plans, so they have the freedom to put a patient's needs first.

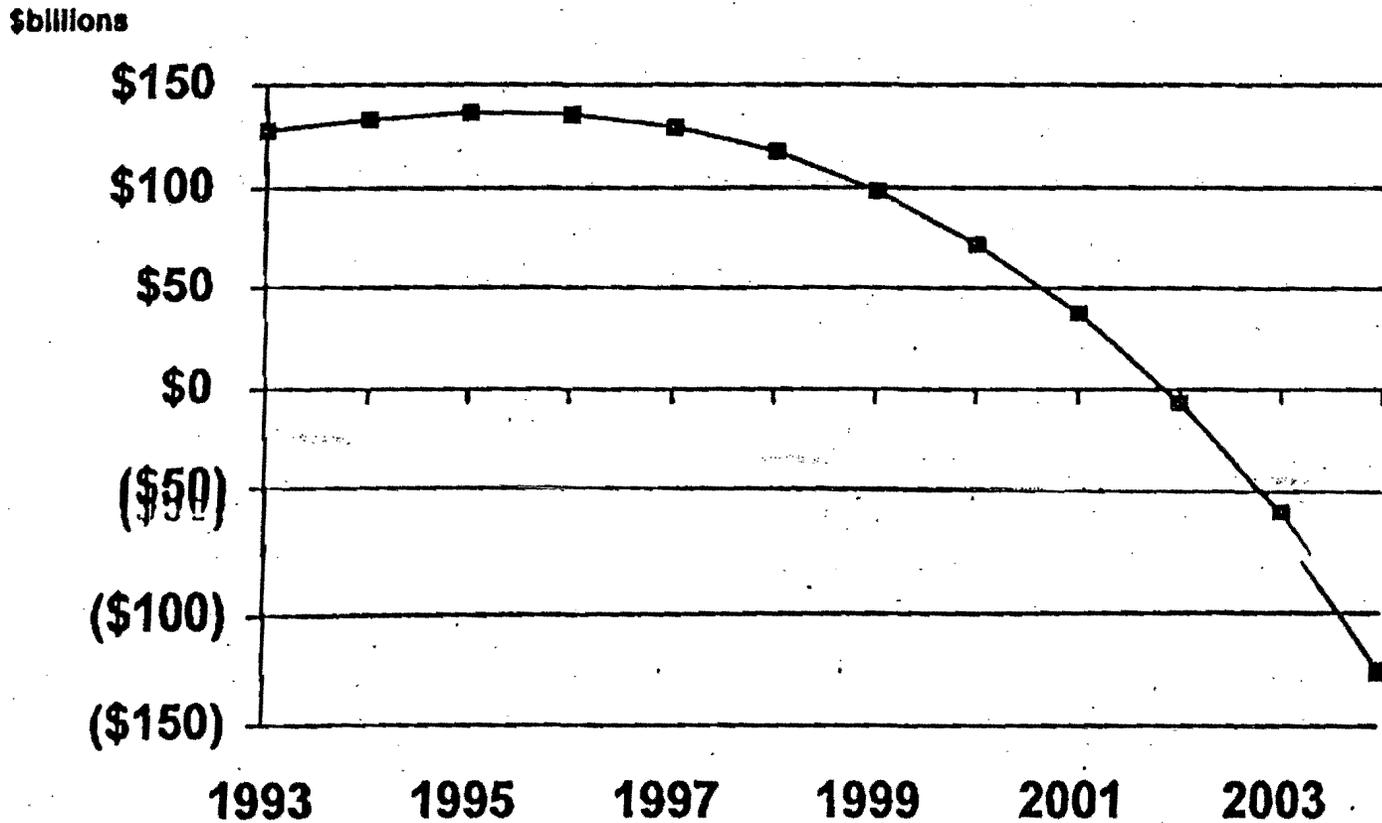
What the Clinton Trustees Said This Year About Medicare's Hospital Program:

- *“Under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins.” (page 3)*
- *“The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI trust fund's financial imbalance.” (page 13)*

Source: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Program,
signed by Secretaries Rubin, Shalala and Reich

MEDICARE HOSPITAL TRUST FUND EMPTY IN SEVEN YEARS

(Trust Fund Reserves)

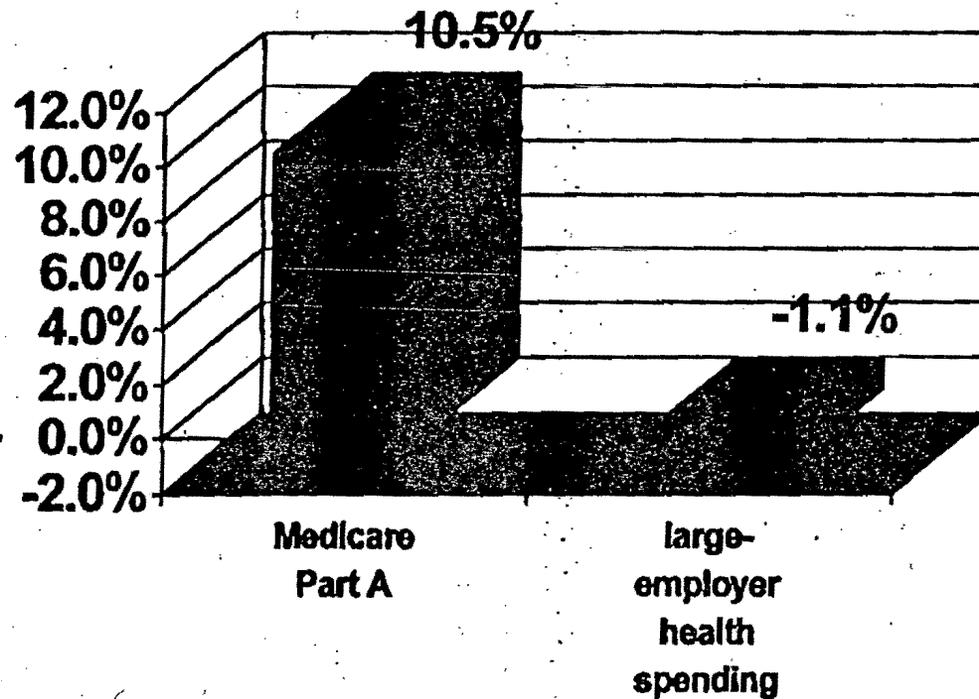


Source: 1995 Annual Report of the HI Trustees, April 1995, p. 13

If We Don't Reform Medicare,
Payroll Taxes Will Have to
Double by 2020
to Avoid Bankruptcy

Source: 1995 Annual Report of HI Trustees, page 20

Private Sector Has Made Improvements that Can Help Medicare (1994 Spending Growth)



Sources: 1995 Annual Report of HI Trustees and HCFA actuaries

Traditional Medicare

Keeping the Commitment

Copayments: No Change

Deductibles: No Change

Premiums: Current 31.5% Rate

In 2002, the premium for an average retiree will be \$7 more than under President Clinton's proposal.

CHOICE IN MEDICARE

Fee-For-Service

MedicarePlus

Current System

HMO
PPO

Choices

FFS
POS

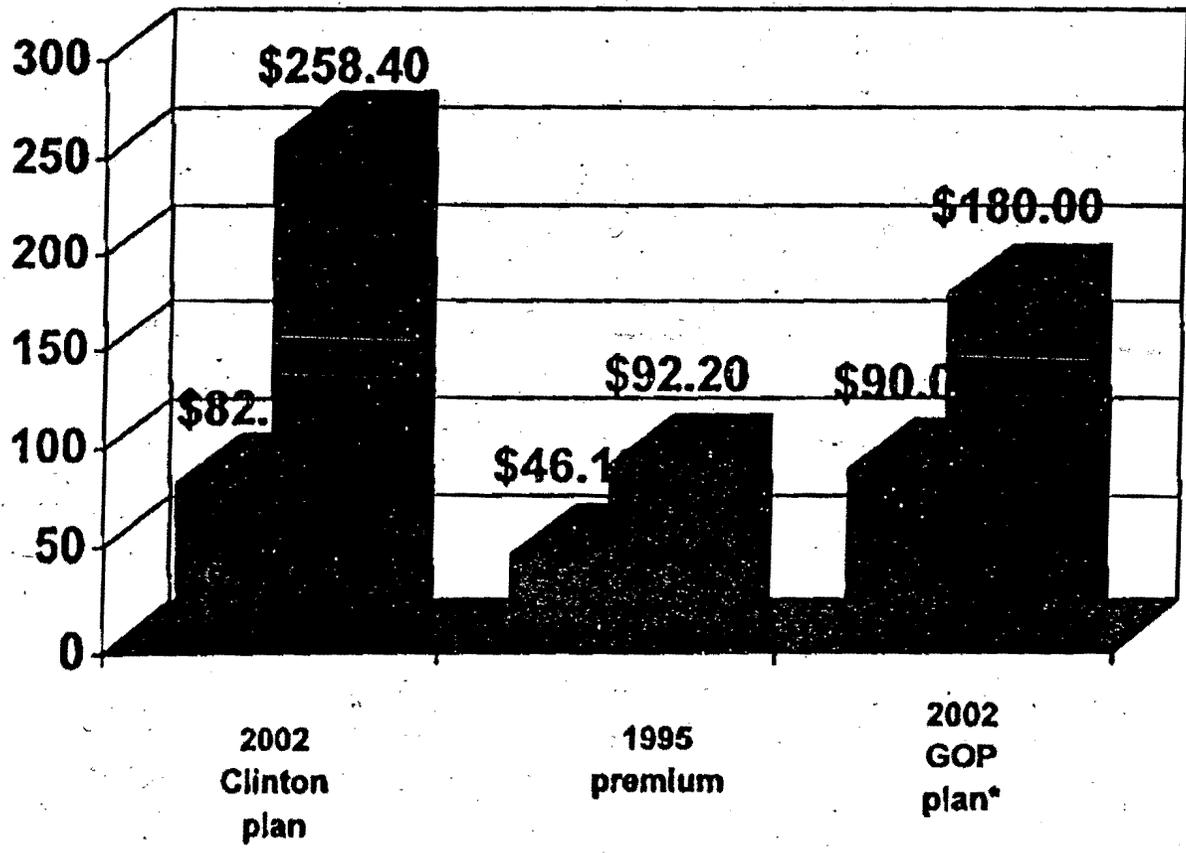
Provider Service
Networks

Private Sector
Insurance Policies

Medical Savings
Accounts

Monthly Part B Premium: Beneficiary Cost vs Taxpayer Cost

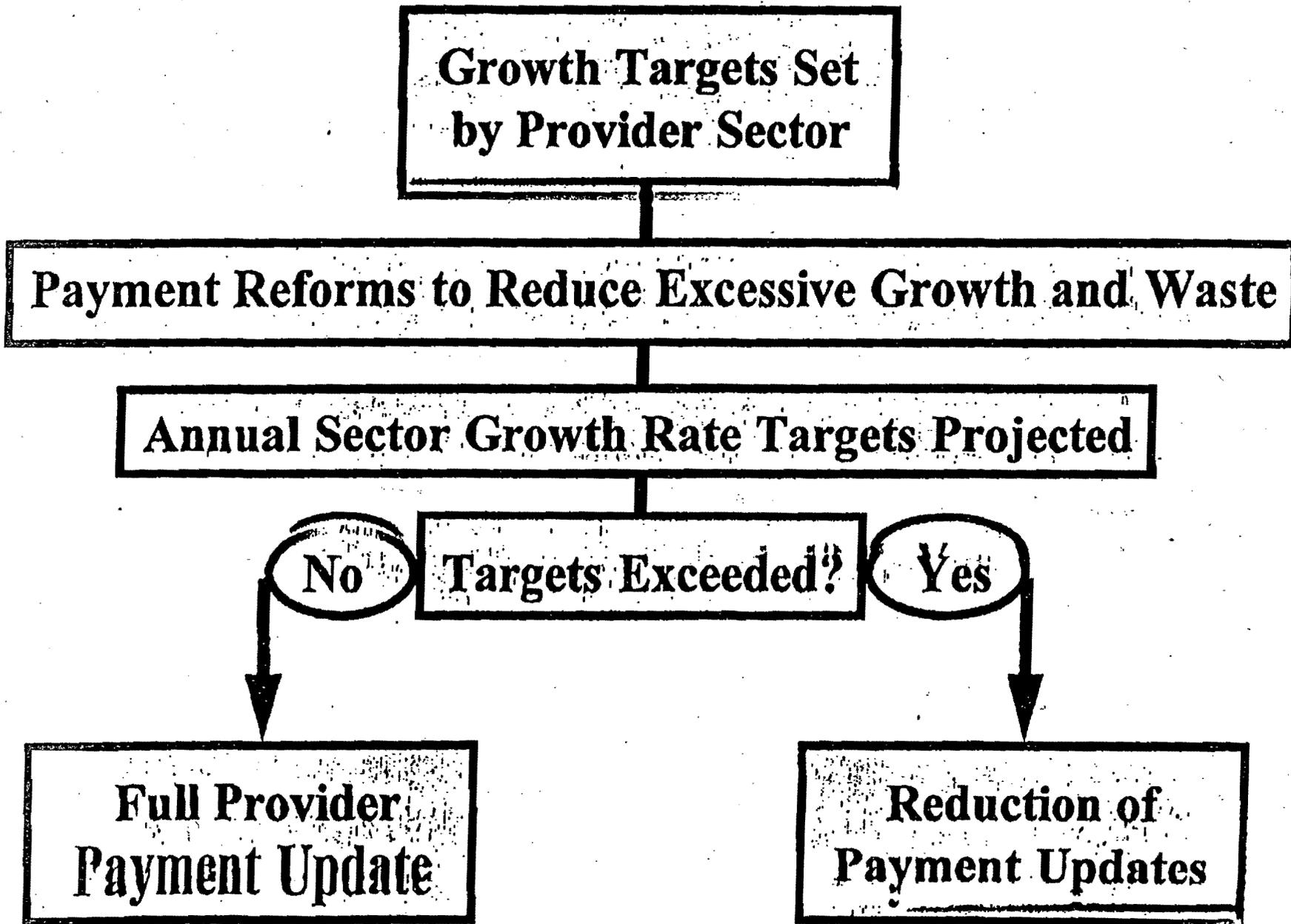
(portion of premium paid by beneficiary vs. portion of premium paid from general revenues)



*estimate

page 7

Fail-Safe Mechanism



EXAMPLE:

75-year old, average income senior

Costs:

- no additional deductible or copayment
- continued 31.5 percent premium rate

Options:

- can stay in traditional Medicare
- can choose a managed care option with drug coverage
- can choose a Medisave plan, limiting out-of-pocket costs

Hospitals Will Be More Efficient

The Medicare Preservation Act:

- allows creation of provider sponsored networks
- repeals Stark I and II excessive regulations
- establishes an advisory commission on Medicare
- establishes a commission to recommend Medicare policy changes to prepare for retirement of the baby boom generation

Doctors Can Put Their Patients First

The Medicare Preservation Act:

- includes a Medisave option
- allows creation of provider sponsored networks
- emphasizes previously passed malpractice reform
- repeals Stark I and II excessive regulations

REPUBLICAN PLAN ENDS MEDICAID: PUTS MIDDLE-CLASS FAMILIES AT RISK

- 1. The Republican Medicaid Plan Will Force States to Eliminate Coverage for Millions of Americans, including:**
 - 4.4 million children,**
 - More than 900,000 elderly, and**
 - 1.4 million people with disabilities.**
- 2. The Republican Plan Will Force Families to Choose Between Nursing Home Care for Their Parents and Education for Their Children.**
- 3. The Republican Plan May Force Elderly Spouses Into Poverty.**
- 4. The Republican Plan Will Wipe Out Quality Standards for Nursing Homes and Institutions Caring for the Mentally Retarded.**

REPUBLICAN PLAN ENDS MEDICAID: PUTS MIDDLE-CLASS FAMILIES AT RISK

Republican Plan Will Force States to Eliminate Coverage for Millions of Americans. Medicaid currently covers 36 million Americans and provides middle-class families with protection from the high costs of nursing home care for their parents. In order to pay for their huge tax cut for the wealthy, Republicans propose slashing Medicaid by an unprecedented \$182 billion -- cutting funding to states by 30% in 2002.

States will be forced to raise taxes, reduce Medicaid coverage, and cut services. According to data from the non-partisan Urban Institute, the GOP cuts will force states to eliminate Medicaid coverage for as many as 8.8 million Americans in 2002, including:

- 4.4 million children
- more than 900,000 seniors
- 1.4 million people with disabilities

Republican Plan Will Force Families to Choose Between Nursing Home Care for Their Parents and Education for Their Children. Medicaid currently is the largest insurer of long-term care, covering *over two-thirds* of all nursing home residents. Without the guarantee of Medicaid, families of elderly and disabled individuals needing long-term care could be stuck with nursing home bills, currently averaging \$38,000 a year. This extra charge to middle-class families may force them to choose between nursing home care for their parents and education for their children. That's a false choice for millions of hard working families. And that's the wrong way to balance the budget.

Republican Plan May Force Elderly Spouses Into Poverty. Republicans are turning their backs on the common ground protection that President Reagan signed into law to ensure that seniors do not have to give up everything they own -- their car, their home, and all their savings -- in order to pay for nursing home care for their sick spouse. The GOP plan repeals this protection, putting seniors at risk of *losing their homes and being driven into poverty* by the cost of their spouse's nursing home care. The GOP plan also means that parents of mentally retarded children may be forced into poverty to pay for their children's care in an institution or at home.

Republican Plan Will Wipe Out Quality Standards for Nursing Homes and Institutions Caring for the Mentally Retarded. The Republican plan throws away a decade of progress by repealing another common ground law signed by President Reagan that established quality standards for nursing homes and institutions for the mentally retarded. These standards restrict the use of drugs and restraints and require that nurses' aides are properly trained. Under the guise of reform, Republicans would repeal this law and throw away these fundamental protections -- just to pay for their tax cut.

HOUSE REPUBLICAN MEDICARE PLAN: FALSE CHOICES AND PROMISES**"MEDICAREPLUS," BY ANY OTHER NAME, IS STILL A VOUCHER**

- Republican plan creates new MedicarePlus, under which seniors will have a choice of many new kinds of health plans. However, MedicarePlus guarantees beneficiaries nothing more than a defined contribution, or voucher, to purchase coverage under these new plans.
- The value of this voucher will decline over time. The voucher amounts are indexed to Republican's arbitrary budget targets (on average, 4.9% annual growth rate), not to the rising cost of health care coverage (on average, 7.1% annual growth rate).
- As a result, beneficiaries will have to spend more and more out of their own pocket just to buy basic Medicare benefits in MedicarePlus.
 - ♦ Seniors already spend ..% of their income on Medigap insurance, prescription drugs, long term care services, and other health care needs not included in Medicare. They can ill afford to shoulder an additional and increasing financial burden just to purchase their basic Medicare

BALANCE BILLING IN MEDICAREPLUS PLANS SHIFTS COSTS TO SENIORS

- It appears that under MedicarePlus plans, doctors and hospitals can charge seniors any amount they want for Medicare services.
- By contrast, in traditional Medicare, seniors are protected from balance billing.
 - ♦ Medicare says hospitals may not charge beneficiaries one penny more than Medicare will pay
 - ♦ Medicare says doctors may not charge beneficiaries more than 15% above what Medicare will pay
- Without balance billing limits, MedicarePlus providers will be able to shift costs to the elderly in order to maintain their own incomes. Given the tight budget caps Republicans are imposing on Medicare, the elderly will be particularly vulnerable to balance billing.

- This hidden tax on seniors (75% of whom have incomes below \$25,000) is a direct transfer to physicians (whose average income is \$...,000) and to other providers.

"FAILSAFE" THREATENS FUTURE OF FEE-FOR-SERVICE MEDICARE

- Under Republican "failsafe," lookback budget cuts apply only to provider payments in fee-for-service Medicare.
- Republican plan requires that Medicare payments to doctors and hospitals be cut low enough to satisfy tight budget targets, and then be cut 1/3 more! (The Secretary is required to cut payments by 133.33 percent of the amount necessary to reach budget targets)
- Because healthier people are more likely to go into managed care plans, while less healthy people are more likely to remain in fee-for-service, Medicare's average per person cost is likely to rise. Therefore, the failsafe cuts on fee-for-service Medicare will have to be even deeper.
- As provider payments in fee-for-service Medicare decline, providers may be more inclined to move into MedicarePlus plans, where they have an opportunity to make up their losses through higher premiums and balance billing.
- Over time, fee-for-service Medicare could become seriously underfinanced and unattractive to both providers and beneficiaries

REPUBLICAN PLAN OFFERS SENIORS COERCION, NOT CHOICE

- Budget failsafe (see above) is designed to make traditional Medicare less attractive. If hospitals and doctors migrate out of traditional Medicare and into their own plans, seniors will have no choice but to leave Medicare for new plans with less protection.
- According to CBO, Republican curtailment of Medicaid subsidies for low income seniors' Medicare cost sharing will force more of these individuals into HMOs.
- As seniors leave Medicare, they will also leave the protection of a powerful, nationwide health care program with the market clout to demand fair and affordable treatment on their behalf. By contrast, in MedicarePlus, seniors will be individual purchasers with a limited voucher

in a market where insurance companies and powerful provider conglomerates call the shots.

- Very quickly, the choice facing seniors will be to pay more or get less.

MEDICAL SAVINGS ACCOUNTS WILL HELP BREAK UP MEDICARE

- Republicans propose to experiment with new, untested Medical Savings Accounts (MSAs), using Medicare beneficiaries as their guinea pigs.
- Under MSAs, the MedicarePlus voucher could be used to buy a catastrophic health insurance policy (with a deductible as high as \$10,000).
 - ◆ Any difference between the cost of that policy and the voucher amount would be placed in a tax-favored medical savings account.
- Only the healthiest and wealthiest seniors could afford to gamble with such a high deductible policy. As these individuals buy MSAs, the average cost of those remaining in Medicare would increase.
- CBO has estimated that MSAs will, in fact, cost Medicare over \$2 billion.
- It is ironic that Republicans, who profess concern for the Trust Fund solvency, nevertheless include in their Medicare bill a costly provision that will benefit only the most fortunate.

REPUBLICAN ANTI-FRAUD PROGRAM IS A FRAUD

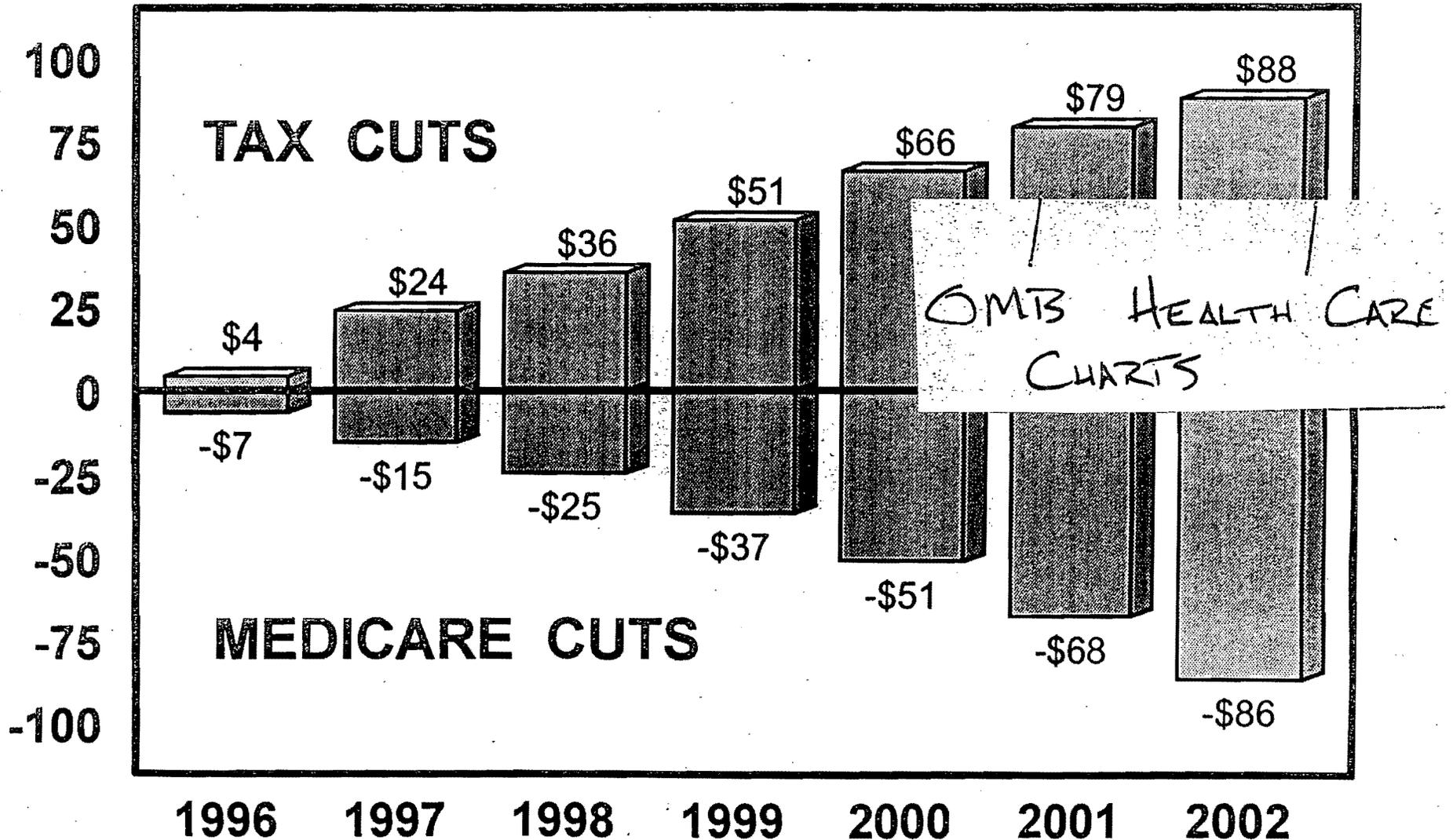
- The Inspector General has severely criticized the Republican anti-fraud program.
 - ◆ The IG says, "if enacted, major provisions...would cripple the efforts of law enforcement agencies to control health care fraud... and to bring wrongdoers to justice."
- Republicans relieve providers of the duty to use "reasonable diligence" to ensure that their Medicare claims are true and accurate.
- Republicans weaken the anti-kickback laws.
- Republicans fail to make additional resources available to law enforcement agencies to fight health care fraud and abuse.

REPUBLICANS REFORM MEDICARE BY CONVERTING IT TO A PIGGYBANK

- Republican plans for Medicare clearly are not reform. They take away seniors true choice, strip away consumer protections and increase the cost of health care for Medicare beneficiaries.
- Protection of the Medicare Part A Trust Fund clearly is not the true agenda underlying Republican proposals
 - ◆ The majority of Republican Medicare cuts (\$137 billion of \$270 billion) come from Part B. Not one penny of these cuts go into the Part A trust fund.
 - ◆ Almost \$54 billion of Part B cuts come directly from beneficiaries in the form of higher premiums -- hikes the elderly on limited incomes can ill afford to pay.
 - ◆ Introduction of untested MSA plans will cost Medicare billions, according to CBO, making the trust fund problems worse.
 - ◆ Easing up on health care fraud is the wrong way to go when finances are tight and taxpayers and beneficiaries are demanding greater vigilance.
 - ◆ Republicans break up Medicare by enticing out the healthiest and wealthiest, forcing out the poorest, and encouraging providers to leave fee-for-service. This transforms beneficiaries -- now a powerful group with market clout -- into 37 million individuals armed only with a limited voucher in an expensive health care market place.
- The Republican agenda for Medicare is clear: transform the program into a piggybank they can use to buy a tax break for the wealthy and other financial goodies for their powerful provider friends.

REPUBLICAN TAX CUTS REQUIRE DEEP MEDICARE CUTS

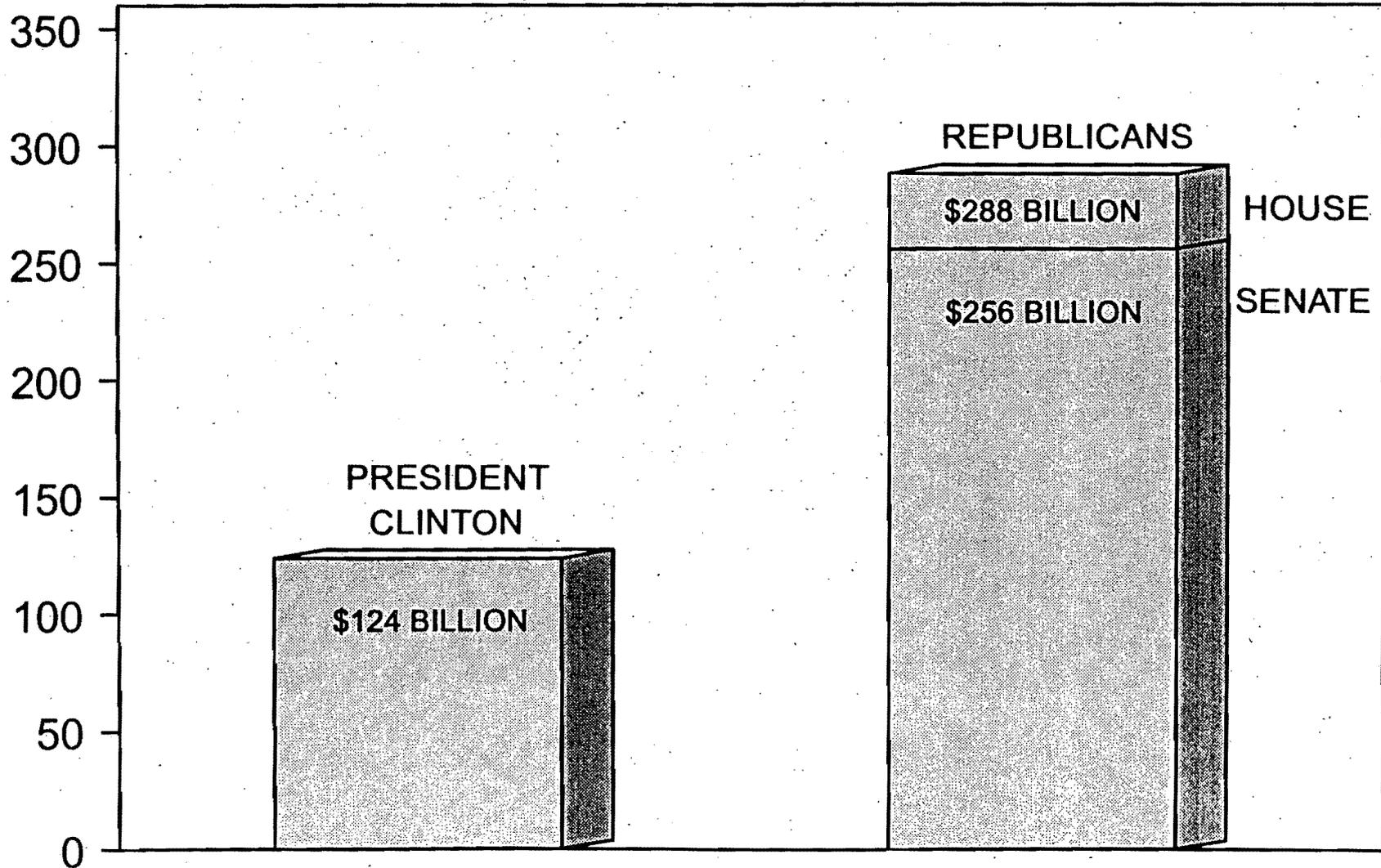
DOLLARS IN BILLIONS



NOTE: House Budget Resolution numbers.

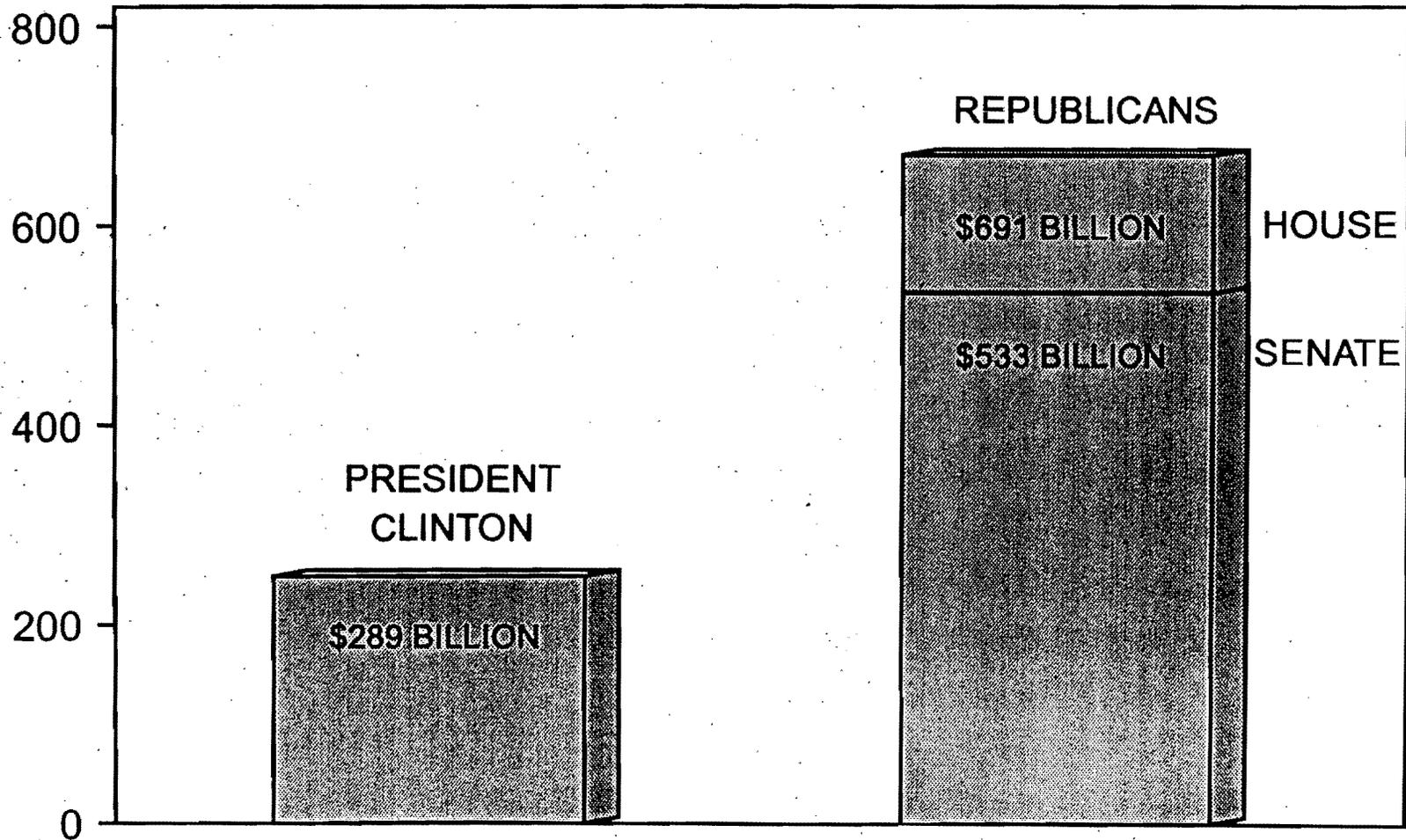
MEDICARE SAVINGS SEVEN YEARS

DOLLARS IN BILLIONS



MEDICARE SAVINGS TEN YEARS

DOLLARS IN BILLIONS



MEDICARE REFORM

IMPACT ON BENEFICIARIES IN 2002

Republican Proposals

▪ **\$1,700 CUT PER COUPLE**

- **Additional Costs**
 - Higher Co-Payments
 - Higher Premiums
 - Coercive Plan
 - 2nd Class Health Care System for Seniors

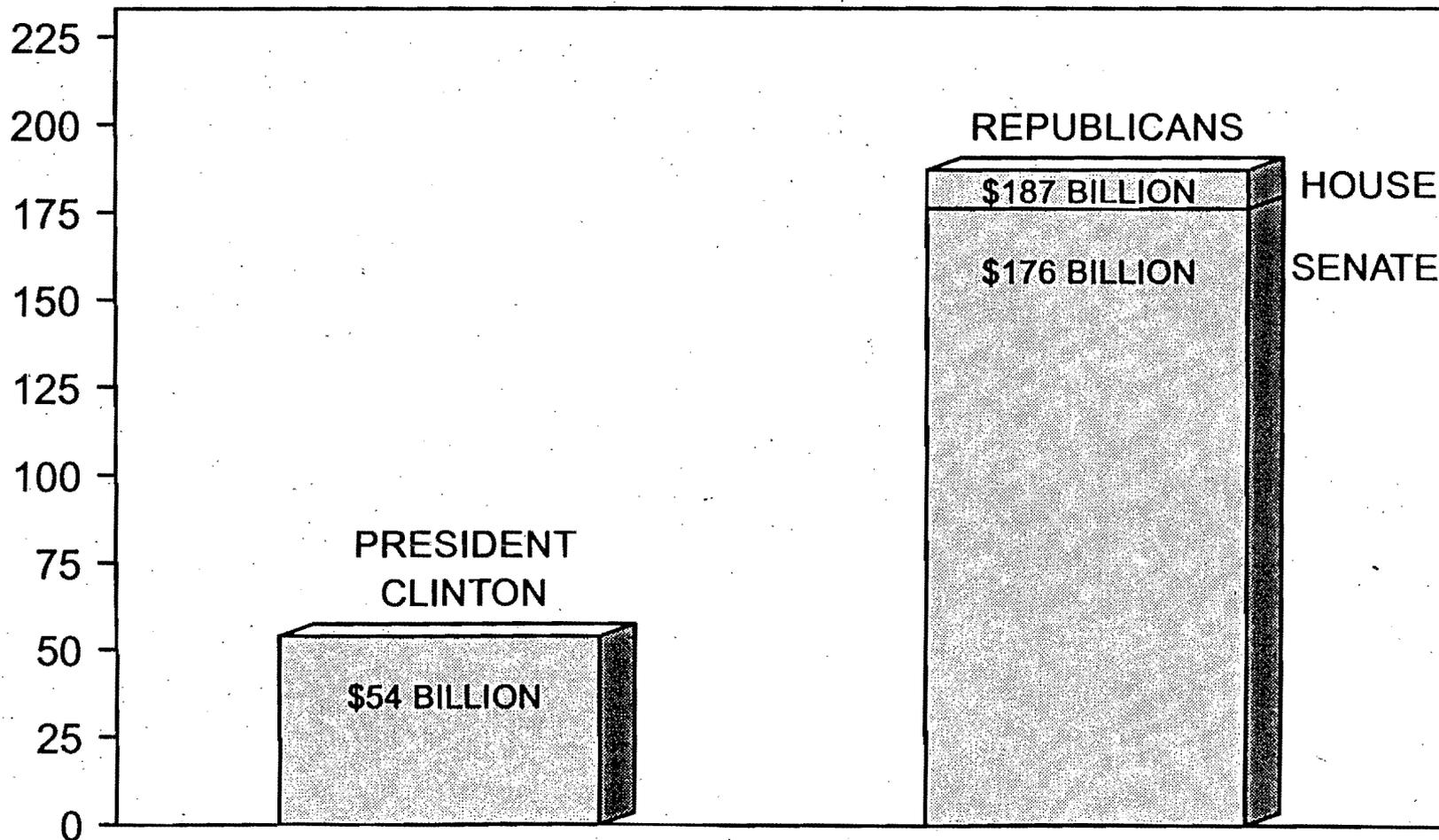
President's Proposal

▪ **NO NEW BENEFIT CUTS**

- **Additional Benefits**
 - Home- and Community-Based Care Grants
 - Respite Benefits for Alzheimer's Caretakers
 - Preventive Health Benefits: No Mammography Co-Payment

MEDICAID SAVINGS SEVEN YEARS

DOLLARS IN BILLIONS



THE REPUBLICAN BUDGET TARGETS RURAL AMERICA AND HITS IT HARD

October 11, 1995

THE REPUBLICAN BUDGET TARGETS RURAL MEDICARE BENEFICIARIES AND HOSPITALS:

- **Cuts Medicare for rural Americans by \$58 billion -- a 20% cut in 2002 -- just to pay for a huge tax cut for the wealthy:**
- **Higher out-of-pocket costs and a second class Medicare program for the 9.6 million older and disabled Americans in rural areas.**
- **Many rural hospitals will be forced to close -- sometimes the only hospital for miles, leaving rural Americans with nowhere to turn for the health care they need.**

THE REPUBLICAN BUDGET TARGETS RURAL MEDICAID:

- **Eliminates coverage for as many as 2.2 million rural Americans including:**
 - Over 1 million children
 - 230,000 older Americans
 - 350,000 people with disabilities
- **77,000 rural older and disabled Americans could be denied nursing home coverage.**
- **55,000 rural older and disabled Americans could be denied home care benefits.**
- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.**

THE REPUBLICAN BUDGET TARGETS FARMERS:

- **25% bite out of farm programs -- jeopardizing the rural way of life in America.**
- **Cuts come right out of the pockets of farmers -- net farm income for target price crops and soybeans is expected to decline by \$9 billion over seven years.**

THE REPUBLICAN BUDGET RAISES TAXES ON RURAL WORKING FAMILIES:

- **Raises taxes on 4 million rural working families by an average of \$352.**

THE REPUBLICAN BUDGET TARGETS RURAL EDUCATION:

- **Cuts will deny 113,000 rural children basic and advanced skills education -- at a time when many small-town and rural schools are already having trouble making ends meet.**

IMPACT OF REPUBLICAN BUDGET CUTS ON RURAL AMERICA

October 11, 1995

HEALTH CARE IN RURAL AMERICA

The Republican MEDICARE Cuts Will Force 9.6 Million Older And Disabled Americans In Rural America To Pay Higher Premiums and Higher Deductibles For A Weakened Second Class Medicare Program.

Medicare Spending For People In Rural Areas Of America Will Be Cut By \$58 billion Over Seven Years -- A 20% Percent Cut In 2002 Alone.

- **The Republican Cuts Will Increase The Severe Financial Pressure On Rural Hospitals In America And Force Some Rural Hospitals To Close.** Today, rural hospitals lose money on Medicare patients while urban hospitals make a small profit. Medicare accounts for almost 40% of net patient revenue in the average rural hospital, and as much as 80% in some rural hospitals.
- **According to the American Hospital Association, under the Republican cuts, the typical rural hospital will lose \$5 million in Medicare funding over seven years.**
- **Rural Medicare Recipients Would Lose Much-Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

The Republican MEDICAID Cuts Will Further Hurt Rural Hospitals And Eliminate Coverage For Millions Of Rural Americans.

- **Rural Hospitals Will Suffer Additional Revenue Losses From The \$45 Billion Republican Medicaid Cuts.** In addition to the average of \$5 million rural hospitals will lose from Medicare cuts, rural hospitals will also face revenue shortages due to the severe Republican Medicaid cut.
- **As Many As 2.2 Million Rural Americans Will Be Denied Medicaid Coverage, Including:**
 - 1 Million Children
 - 230,000 Older Americans
 - 350,000 People With Disabilities
- **Over 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage in 2002.** Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, approximately 77,000 rural nursing home residents (22%) could be denied coverage.
- **Over 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits in 2002.** Most of the 365,600 poor elderly in rural America who need home care are covered by Medicaid. Under the Republican Medicaid plan, approximately 55,000 (17%) rural poor elderly who need home care will lose coverage.

FARMING IN RURAL AMERICA

The Republican Budget Slashes Farm Spending By 25% over seven years. Farm spending in America will be reduced by \$13 billion -- drastically reducing support for commodity programs.

The Republican Budget Will Reduce Farm Income Nationwide. As a result of the Republican cuts, net farm income for target price crops and soybeans is expected to decline by \$9 billion over seven years -- a 4% reduction in earnings.

TAXES ON WORKING FAMILIES IN RURAL AMERICA

The Republican Budget Raises Taxes On 4 Million Working Families In Rural America By An Average Of \$352 in 2002. Republican cuts to the Earned Income Tax Credit will impose a \$59.2 million tax increase on working families and their children in rural America.

EDUCATION IN RURAL AMERICA

The Republican Education Cuts Will Deny 113,000 Children Basic And Advanced Skills In Rural America in 1996. Title I funds in rural areas will be cut by \$113 million -- more than 17% -- denying crucial assistance at a time when many small-town and rural schools are already having trouble making ends meet.

PUBLIC HEALTH AND THE ENVIRONMENT IN RURAL AMERICA

The Republican Budget Will Reduce The Amount Of Money That States Can Spend To Keep Water Clean In Small Communities And Rural Areas By 20% Compared To The President's Balanced Budget. These cuts will derail initiatives that are working to fight water pollution and protect public health.

The Republican Budget Proposal Will Stop Or Slow The Clean-up Of At Least 115 Toxic Waste Sites In Rural America. Nationwide, the Republican Budget reduces spending on toxic waste cleanups by 36% -- or \$560 million -- below the President's balanced budget. These cuts will restrict or stop clean-ups of sites nationwide that pose a threat to public health and the environment.

TRANSPORTATION IN RURAL AMERICA

The Republican Budget Will Cut Transportation Grants For Rural Areas By 20%. Republican proposals cut \$57.4 million for rural transportation in America. These funds are essential for giving residents access to medical services, supermarkets and grocery stores, and job training.

NUTRITION IN RURAL AMERICA

Republican Cuts Will Slash Up To 15% From Food Assistance To Rural America.

Republican budget cuts will fall particularly hard on the rural poor, cutting as much as \$11 billion in food assistance from rural areas over seven years.

Republican Nutrition Cuts Will Eliminate Jobs In America. These cuts will reduce farm prices and incomes, and result in the loss of as many as 328,900 jobs nationwide -- including up to 57,800 rural jobs.

HOUSING IN RURAL AMERICA

The Republican Housing Cuts Will Reduce Spending On Public Housing Capital In Rural America 46% Below The President's Request in 1996. Cuts to public housing capital assistance in rural areas will total \$460 million in 1996, severely hindering efforts by rural housing agencies to rehabilitate run down public housing projects and provide much needed security and anti-crime programs.

The Republican Budget Will Cut 40% From Assistance To Homeless Persons in Rural Areas in 1996. The Republican plan will cut \$108 million in homeless assistance to rural areas. The reduction will mean 4.9 million fewer nights of shelter for America's rural homeless.

REPEALING PROTECTIONS FOR LOW-INCOME MEDICARE BENEFICIARIES

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

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

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

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

Background and Legislative History

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

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

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

ENDING MEDICAID PROTECTIONS AGAINST SPOUSAL IMPOVERISHMENT

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

Current Law Protects Spouses and Their Families from Poverty

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

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

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

Background and Legislative History

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

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

Republican Medicaid Block Grant Ends Spousal Impoverishment Protection

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

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

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

ENDING MEDICAID NURSING HOME QUALITY STANDARDS

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

Background and Legislative History

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

Current Federal Quality Standards

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

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

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

Republican Medicaid Block Grant Repeals These Fundamental Protections

Under the guise of reform, Republicans propose to repeal the federal Medicaid quality standards, as well as the requirement that Medicaid cover nursing home care at all. Medicaid is now the largest payor of long-term care, covering *over two-thirds* of all nursing home residents. As many as 350,000 elderly and disabled Americans would lose nursing home coverage in 2002, and nursing home residents would be vulnerable to abuse and neglect, to being inappropriately restrained and drugged, and dumped onto the streets when they run out of money.

BUDGET CUTS TARGET RURAL HEALTH CARE AND HOSPITALS

October 12, 1995

RURAL HOSPITALS ARE ALREADY IN A PRECARIOUS FINANCIAL POSITION:

- The number of rural hospitals dropped 17% between 1983 and 1993, while the number of urban hospitals dropped 2%.
- 25% of rural hospitals operate at a loss.
- Rural hospitals lose money on Medicare patients; urban hospitals make a small profit.

RURAL HOSPITALS DEPEND ON MEDICARE AND MEDICAID:

- Medicare alone accounts for almost 40% of the average rural hospital's net patient revenue. For some rural hospitals, Medicare accounts for as much as 80%.
- About 60% of the people discharged from rural hospitals are Medicare or Medicaid beneficiaries -- 25% higher than the share for urban hospitals.
- Rural Americans depend more on Medicaid and Medicare because their incomes are 33% lower than the average urban American. And a 60% higher share of elderly live in poverty in rural areas than in urban areas.

THE REPUBLICAN BUDGET TARGETS RURAL AMERICANS' HEALTH CARE AND RURAL HOSPITALS:

- Cuts Medicare for rural Americans by \$58 billion -- a 20% cut in 2002 -- just to pay for a huge tax cut for the wealthy.
- Cuts will cost the typical rural hospital \$5 million over seven years. This is a huge hit since the typical rural hospital has annual expenses of less than \$15 million.
- Higher out-of-pocket costs and a second class Medicare program for the 9.6 million older and disabled Medicare recipients in rural areas.
- Cuts Medicaid for rural Americans by \$45 billion, denying coverage for as many as 2.2 million rural Americans, including:
 - Over 1 million children
 - 230,000 older Americans
 - 350,000 people with disabilities
- 77,000 rural older and disabled Americans could be denied nursing home coverage.
- 55,000 rural older and disabled Americans could be denied home care benefits.
- Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.

FACTS ON THE IMPACT OF BUDGET CUTS ON RURAL RESIDENTS AND RURAL HOSPITALS

Rural residents and hospitals are uniquely vulnerable to cuts in Medicare and Medicaid. Both are disproportionately dependant on these programs and both typically face significant financial pressures. The Republican budget cuts, as a result, will threaten coverage for many rural residents and pose a unique danger to the many rural hospitals operating on the edge of financial survival.

I. IMPACT OF REPUBLICAN CUTS ON RURAL HOSPITALS

RURAL HOSPITALS REMAIN IN A UNIQUELY PRECARIOUS FINANCIAL POSITION.

- **Rural Hospitals Have Been Closing At A Disproportionate Rate:** The number of rural hospitals in America fell by 17% between 1983 and 1993 (compared to a decrease of 1.9% for urban hospitals). [American Hospital Association, Hospital Statistics, 1994]
- **Rural Hospitals Face Uniquely Severe Financial Pressures**
 - **Higher cost per patient.** The low volume of patients means that many rural hospitals face higher costs per patient than large urban hospitals. [Rural Policy Research Institute (RUPRI), 1995]
 - **Lower Medicare payments.** Making matters worse is the fact that Medicare payments are roughly 20% less per beneficiary in rural areas than in urban ones. [RUPRI, 1995]
 - **Net loss on every beneficiary.** Higher costs and lower payments mean that rural hospitals lose roughly 2% on Medicare patients. Urban hospitals, in contrast, run a slight profit (.6% on Medicare patients). [Prospective Payment Assessment Commission (PPRC), 1995]
 - **Some states may have even larger losses.** According to the *Kansas City Star*, "it is not a question of whether Indiana hospitals will close. It is a question of when Indiana hospitals already lose about 12 to 14 cents of every dollar they spend on Medicare patients." [*Kansas City Star*, 7/30/95]
- **One out of four Rural Hospitals Operate At A Loss:** *Twenty-five percent* of rural hospitals had a negative total operating margin in 1993. [PPRC, 1995]

RURAL HOSPITALS WILL BE HIT UNUSUALLY HARD BECAUSE THEY SERVE A DISPROPORTIONATE NUMBER OF MEDICARE BENEFICIARIES.

- **The Vast Majority Of Rural Patients Are Medicare Or Medicaid Beneficiaries.** About 60% of the discharges in rural hospitals are Medicare or Medicaid beneficiaries -- 25% higher than the proportion in urban hospitals. [American Hospital Association, Annual Survey of Hospitals, 1993]
- **Medicare Alone Accounts For Almost 40% Of Net Patient Revenue In The Average Rural Hospital.** [Frenzen, 1995] In some rural areas, Medicare represents as much as 80% of revenues.
- **Rural Indiana:** "On average, Indiana hospitals get about 40 percent to 45 percent of their income from Medicare.... [A]t smaller hospitals in rural Indiana, however, Medicare and...Medicaid can account for 60 to 80 cents of every dollar they collect." [*The Indianapolis-Star*, 10/8/95, citing Bob Morr, Vice President of the Indiana Hospital Association]
- **Rural Minnesota:** Swift County-Benson Hospital, out in the prairie of Benson, Minnesota, gets an overwhelming 85% of its revenue from Medicare and Medicaid. [*Star Tribune*, 10/2/95]
- **Rural Nebraska:** In a recent article, the *New York Times* profiled a rural hospital in Nebraska -- the Saunders County Health Services -- which "ministers to a population that is largely elderly and exceedingly dependant on Medicare." The *Times* reports that the elderly actually account for 80% of the hospital's revenue. The precarious financial straits of the hospital are typical of many rural centers. Saunders "lost money last year, hopes to break even this year and has been struggling since the mid-1980s." Its manager worries that the new spending controls on Medicare would have a significant impact on his 30-bed hospital. As the *Times* notes, "the Medicare policies being created in Washington instill anxiety and frustration." [*New York Times*, 5/21/95]

GIVEN THEIR PRECARIOUS FINANCIAL SITUATION AND THEIR SIGNIFICANT RELIANCE ON MEDICARE AND MEDICAID, PROPOSED BUDGET CUTS WILL LIKELY FORCE THE CLOSING OF MANY RURAL HOSPITALS ACROSS THE NATION.

- **Budget Cuts Will Cost The Typical Rural Hospital \$5 Million Over Seven Years,** according to the American Hospital Association. [American Hospital Association, 10/6/95]. To put that figure in context, the typical rural community hospital has total expenses of less than \$15 million every year. [American Hospital Association, Annual Survey of Hospitals, 1993]
- **Example: Nebraska:** The Nebraska Association of Hospitals and Health Systems released a study on September 8, 1995, reporting that the Republican cuts will cost a small rural Nebraska hospital (less than 49 beds) \$3.3 million, a mid-size hospital (49-100 beds) \$11 million, and a typical larger size rural hospital (100-200 beds) \$33 million. [Press Release, 9/8/95]
- **Cuts ask Hospitals to Provide 19 Months of Free Care:** "The proposed \$270 billion reduction in Medicare spending is asking hospitals to provide 19 months of free care to Medicare recipients over the next seven years. . . . Clearly, it's a lose-lose situation, not only for hospitals, but for the public who depend on these hospitals," says Harlan Heald, President of The Nebraska Association of Hospitals and Health System [Press Release, 9/8/95]

Recent Press Reports Warn Of Hospital Closings Under Republican Budget Cuts.

- **The *Kansas City Star*** reports: "If Congress cuts Medicare spending by \$270 billion, rural health care will be one of its biggest victims, hospital operators, researchers and others predict. Such reductions will force the closing of some rural hospitals, curb such basic services as emergency rooms and community health clinics, and worsen an already serious shortage of doctors and other health care workers." [*Kansas City Star*, 7/30/95]
- **The *Wall Street Journal*** reports: "hospitals are closing anyway at a rate of 50 or so each year. But that number could double, or even triple due to stepped-up financial pressures from the government and private payers, analysts say." [*Wall Street Journal*, 10/2/95]
- **The *Billings Gazette***: "In rural areas, the percentage of Medicare [patients] is probably higher so the effect would be more pronounced. Overall, it's going to be devastating." Jim Ahrens, President of the Montana Hospital Association [*Billings Gazette*, 5/29/95]
- **The *Fort Lauderdale Sun-Sentinel*** reports that the budget cut "means higher health care premiums, higher deductibles, and more restrictive employer-provided health care plans . . . or an awful lot of rural medical facilities are going to go belly up and a lot of the nation's great teaching hospitals are going to become shells of their former excellence. It's probably both." [*Sun-Sentinel*, 10/3/95]
- ***Baton Rouge Advocate***: "We're facing an enormous crisis in rural hospitals if something is not done about these cuts in Medicare and Medicaid," warned Joe Soileau, chairman of the Louisiana Rural Hospital Coalition. [*Baton Rouge Advocate*, 9/23/95]
- ***Minneapolis Star Tribune***: "The small hospital out on the prairie in Benson, Minnesota has a message for the members of Congress who are trying to shake up the Medicare-Medicaid system: 'If some things don't happen to help us, our life as we know it today will be over in 12 to 18 months,' said John Stidt, Chief Executive Officer of Swift County-Benson Hospital. 'We will have to close our doors.'" [*Star Tribune*, 10/2/95]
- ***Arkansas Democrat-Gazette***: One hospital near Prescott, Arkansas, may soon close its doors. The hospital, according to an administrator, relied on Medicare and Medicaid for 72% of its payments. If it closes, "the nearest hospital will be in Hope, about 15 miles to the southwest." A spokesman for the Arkansas Hospital Association "said that rural hospitals suffer disproportionately because of their heavy reliance on Medicare and Medicaid payments." [*Arkansas Democrat-Gazette*, 7/19/95]

II. IMPACT OF HEALTH CARE CUTS ON RURAL RESIDENTS

MEDICARE CUTS IN RURAL AMERICA WILL AMOUNT TO \$58 BILLION OVER SEVEN YEARS. A 20% CUT IN 2002. THESE CUTS WILL SEVERELY DISRUPT THE PROVISION OF MEDICAL SERVICES TO MANY RURAL RESIDENTS.

- **Approximately 9.6 Million Older And Disabled Residents In Rural America Depend On Medicare For Their Health Care.** [Department of Health and Human Services (HHS)]
- **Because Of The Migration Of Young To Urban Centers, A Higher Proportion of Rural Residents Are Older Than Urban Dwellers And Depend Heavily On Medicare.**
 - **Far higher enrollment rates.** The Medicare enrollment rate is 28% higher in rural than in urban areas (16.0% vs. 12.5%), making Medicare a critical source of revenue for the rural health care system. [Frenzen. 1995]
 - **Medicare is particularly vital in farming communities.** 22% of farm operators were 65 or older in 1990, compared to only 3% of the U.S. workforce as a whole. [Council of Economic Advisers]
 - **Example: Nebraska.** In Nebraska, "it is the rural health-care system that is most 'fragile,' as Dr. Mark Horton, the state director of health, put it. Eighteen percent of Nebraska's rural population is over 65; many of the hospitals in rural areas, and many of the primary care physicians there, are exceedingly reliant on the Medicare program." [*Sunday Gazette Mail*, 5/21/95]
- **Rural Communities Are Less Able To Bear The Burden Of Medicare Cuts,** since their residents have less income on average than urban residents and their economies depend more heavily on Medicare payments.
 - **Rural residents have lower incomes:** Rural residents had an average per capita income in 1993 of \$16,028, compared to \$23,843 for urban residents. [Bureau of Economic Analysis, Regional Economic Information System, 1993.] The incidence of poverty among the non-metropolitan elderly is approximately 60% higher than among metropolitan elderly (16.7% vs. 10.5%). Thus, an across the board increase in premiums will represent a far larger tax in percentage terms on the rural elderly than on the urban elderly. [HHS, RUPRI, 1995]
 - **Rural economies depend more heavily on Medicare payments than urban economies.** Medicare comprises a far greater percentage of total personal income in rural areas than urban areas -- 41% more. [RUPRI, 1995]
 - **"A Financial Shock" to rural America.** "Clearly, a uniform percentage cut in Medicare would give rural America a financial shock," said Glenn Nelson, a researcher for the Rural Policy Research Institute. [*Kansas City Star*, 7/30/95]

MEDICAID SPENDING WILL FALL BY \$45 BILLION IN RURAL AMERICA, FORCING MANY TO LOSE CRITICAL HEALTH CARE COVERAGE FOR NEEDED SERVICES.

- **Spending Cuts Could Deny Medicaid Coverage To As Many As 2.2 Million Rural Americans,** according to the Department of Health and Human Services, including:
 - 1 Million Children
 - 230,000 Older Americans
 - 350,000 People With Disabilities
- **As Many As 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage** in 2002. Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, as many as 77,000 rural nursing home residents (22%) could be denied coverage. [HHS]
- **As Many As 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits** in 2002. About 333,000 poor elderly in rural America need home care. Under the Republican Medicaid plan, as many as 55,000 (17%) rural poor elderly who need home care will lose coverage. [HHS]

III. RURAL HEALTH CARE AND ACCESS TO DOCTORS

BECAUSE RURAL DOCTORS RELY DISPROPORTIONATELY ON MEDICARE AND MEDICAID, REPUBLICAN PROPOSALS WILL MEAN THE LOSS OF MUCH NEEDED DOCTORS.

- **Rural Medicare Recipients Could Have Less Choice of their Own Doctor Under Republican Medicare Plans:** Only 44% of physicians in rural areas are members of HMO or PPO plans, compared to 81% for physicians in urban areas. [American Medical Association, 1993].
- **Rural Physicians Rely More on Medicare and Medicaid Than Urban Physicians.**
 - Medicare and Medicaid accounts for 53% of the practice of non-metropolitan primary care physicians, but only 41% of the practice of physicians in large metropolitan areas. [Report of the Council on Medicaid Services, 1995].
- **Republican Budget Cuts Will Make Medical Practice in Rural Communities Less Desirable and Will Cause Medicare Recipients To Lose Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. [Mueller, 1995]. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [New York Times, October 10, 1995.]

MEMORANDUM

To: Distribution
From: Chris Jennings
Date: May 12, 1995
Re: Medicare State by State Information

Attached, for your information, are the back-up tables for the Medicare portion of the state by state analysis being released today. You will find two pages of information: the first is a beneficiary breakout by state, and the second is the state by state analysis of the Kasich proposal.

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

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

Projected Medicare Beneficiaries by State

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

NOTES: Based on historical state share of Medicare enrollees, trended forward with growth in the states' share of enrollees.

* Totals may not add due to rounding

Effects of the Kasich Medicare Proposal By State
 Losses by State Under the Proposal
 (Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect (\$ / benef.)	
	2002	1996-2002	2002	1996-2002
US	84,900	279,200	1,028	3,447
Alabama	1,986	6,146	1,412	4,450
Alaska	50	171	502	1,889
Arizona	1,491	4,799	1,002	3,389
Arkansas	627	2,165	696	2,435
California	11,830	37,780	1,466	4,783
Colorado	1,147	3,579	1,116	3,630
Connecticut	1,247	4,103	1,167	3,885
Delaware	281	899	1,215	4,002
District of Columbia	1,431	4,001	NA	NA
Florida	9,314	29,258	1,578	5,082
Georgia	2,077	6,754	1,090	3,649
Hawaii	432	1,311	1,173	3,710
Idaho	149	532	436	1,603
Illinois	2,652	9,301	784	2,770
Indiana	1,569	5,253	881	2,994
Iowa	495	1,786	510	1,845
Kansas	834	2,741	1,048	3,464
Kentucky	968	3,318	760	2,652
Louisiana	1,590	5,235	1,254	4,201
Maine	231	825	521	1,900
Maryland	1,066	3,752	787	2,843
Massachusetts	3,072	9,828	1,542	4,989
Michigan	2,185	7,717	737	2,657
Minnesota	1,512	4,725	1,126	3,557
Mississippi	674	2,297	799	2,758
Missouri	1,531	5,219	873	3,004
Montana	157	551	553	1,986
Nebraska	338	1,158	659	2,266
Nevada	638	1,946	1,080	3,620
New Hampshire	292	956	816	2,755
New Jersey	2,320	7,945	932	3,229
New Mexico	249	866	484	1,761
New York	5,359	18,539	986	3,423
North Carolina	2,165	6,998	900	3,012
North Dakota	159	551	750	2,604
Ohio	2,584	9,083	718	2,562
Oklahoma	757	2,625	729	2,560
Oregon	1,010	3,213	963	3,135
Pennsylvania	4,526	15,479	1,034	3,570
Rhode Island	482	1,511	1,375	4,336
South Carolina	1,103	3,495	929	3,043
South Dakota	153	530	628	2,186
Tennessee	2,378	7,537	1,393	4,509
Texas	5,428	17,608	1,122	3,757
Utah	331	1,096	727	2,511
Vermont	105	365	573	2,034
Virginia	1,052	3,711	561	2,044
Washington	978	3,377	633	2,246
West Virginia	471	1,628	676	2,362
Wisconsin	914	3,254	569	2,044
Wyoming	49	182	337	1,313
Puerto Rico	457	1,488	433	1,440
All Other Areas	3	14	4	20

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

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

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

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

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

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