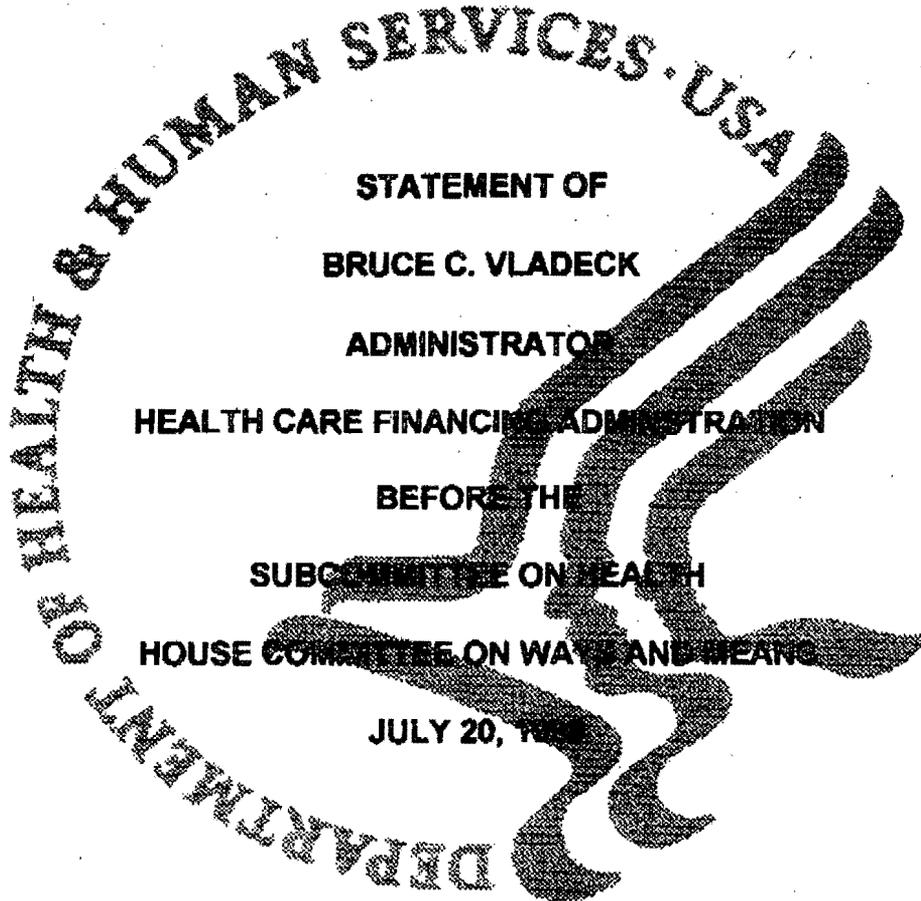


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**STATEMENT OF
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 ADMINISTRATOR
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 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 HOUSE COMMITTEE ON WAYS AND MEANS
 JULY 20, 1996**

INTRODUCTION

Thank you for the opportunity to testify today on approaches to restructuring Medicare. As the 30th anniversary of this enormously successful and enormously popular program approaches, we should approach any Medicare reform agenda with a healthy respect for the Medicare program's strengths and a determination to preserve the fundamental health security it offers Americans.

Medicare is universal. Because of the contract this nation made with its citizens in 1965, all Americans -- no matter how rich or poor, no matter how important or humble -- can count on health security in their retirement years or in the event of a severe disability.

Medicare is always available. Americans are not barred from Medicare due to preexisting conditions, nor are they charged more for Medicare because of their age or health status.

Medicare is portable. It costs beneficiaries the same amount and covers the same services, no matter where they live or how their personal circumstances might change.

And, Medicare provides choice. It is especially important to elderly and disabled beneficiaries, many of whom have multiple and complex health problems, to be able to select their own doctors.

This Administration is committed to preserving these essential strengths of the Medicare program, even while we pursue reforms to make the program even stronger and more beneficial to the 37 million Americans it serves today. In particular, I would like to testify today on our strategies for strengthening Medicare by expanding beneficiary choices, enhancing the quality of care and consumer information, and improving customer service.

In addition, I will testify on the Administration's strategy for containing Medicare costs, extending the life of the Medicare trust fund, and moving toward a balanced federal budget -- a strategy that is consistent with our goal of protecting beneficiaries and respecting Medicare's social contract.

Finally, I will distinguish our reform strategies from those of Congressional Republicans which we believe would fundamentally undermine Medicare's protections and harm its beneficiaries.

I. THE ADMINISTRATION'S STRATEGY FOR REFORM

Since we came into office 30 months ago, the Clinton Administration has pursued a multi-faceted approach to reforming Medicare in the context of our efforts toward broader health care reform. We are increasing the number of beneficiaries and plans participating in Medicare managed care and are testing new managed care options. To make possible well-informed decisions by our beneficiaries, we are developing improved consumer information and quality measures. Finally, we are continuing our efforts to improve customer service.

A. Giving Beneficiaries More Choices

Over the past two years, Medicare managed care enrollment has increased dramatically. In the first six months of 1995 we have already seen a nine percent increase in managed care enrollment, an acceleration over last year's annual rate of 16 percent growth. Currently, 9.5 percent of all Medicare beneficiaries -- over 3.5 million people -- have chosen to enroll in managed care plans. Seventy-four percent of Medicare beneficiaries have access to a managed care plan, and 57 percent have a choice between two or more plans.

More than 250 managed care organizations currently contract with the Health Care Financing Administration (HCFA) to serve Medicare beneficiaries, including 165 that do so on a risk basis. Interest in the Medicare managed care program continues to increase. In the last three weeks alone, we received 17 new applications. Much of the recent growth in new contracts has been in regions that have not had a strong Medicare managed care presence in the past.

As you know, however, most of the growth in managed care in the private sector in recent years has involved plans other than traditional closed HMOs. The centerpiece of our reform strategy is making such choices available to Medicare beneficiaries. We believe beneficiaries should have a wide range of choices and good information in a fair and non-coercive marketplace.

"Medicare Choices"

Just a few weeks ago, we announced "Medicare Choices," a demonstration program designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies. HCFA has invited a wide variety of managed care organizations to participate in this demonstration, including preferred provider organizations (PPOs), HMOs, and integrated delivery systems.

Nine geographic areas have been targeted for the demonstration: Jacksonville, Florida; Sacramento, California; Hartford, Connecticut; Philadelphia, Pennsylvania; Atlanta, Georgia; New Orleans, Louisiana; Columbus, Ohio; Louisville, Kentucky; and Houston, Texas. We chose these markets to build on the strong base of private sector plans currently available in these communities. We will, however, accept applications from innovative plans in other areas, and we are particularly interested in those that offer to extend coverage to rural areas and those that emphasize primary care case management.

Pre-application forms have already been distributed to over a thousand interested organizations. Based on the response to these initial forms, selected plans will be invited to submit more detailed final applications in the Fall, and we anticipate enrollments will begin early next year.

New Pricing Approaches

We are also exploring alternative payment methodologies and improvements to our current payment systems for managed care.

For example, we are planning to test competitive pricing as an alternative to the Adjusted Average Per Capita Cost (AAPCC) payment methodology, which is now used to establish Medicare's payment to entities that accept full risk for paying for patient care. The AAPCC payment methodology, required by statute, has long been a source of discontent. Plans have been concerned with the AAPCC's adequacy, stability, and equity. The best evidence available indicates that Medicare, using this methodology, has paid more than it would pay for comparable populations of beneficiaries who remain in the fee-for-service program.

We think that competitive pricing is a promising idea, and we would like to test variants of it in a number of geographic areas. We would be interested in working with the Subcommittee on the structure of a competitive pricing demonstration since specific legislation will be necessary to implement this demonstration.

HCFA has entered into discussions with Kaiser Permanente to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees.

For the past decade, HCFA has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should soon produce health status adjusters that can be used on a pilot or demonstration basis. HCFA has also undertaken a demonstration project in which we are

working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.

Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology. For example, the industry has expressed interest in using Metropolitan Statistical Areas (MSAs) rather than counties for geographically adjusting Medicare's payment rate to HMOs.

New Options

As I previously explained to the Subcommittee, we also want to make available to beneficiaries a PPO option. This option has proven to be very popular in the commercial market. Under the PPO option, beneficiaries would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the additional cost-sharing. Implementing such a change would require a change in statute.

HCFA is also currently developing guidelines, under existing statutory authority, for current risk contractors to offer a "point-of-service" (POS) option, with implementation anticipated for the 1996 contract year. The option would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace.

B. Quality Measures and Consumer Information

HCFA is committed to ensuring that beneficiaries -- whether they are served by traditional Medicare, HMOs, or one of the new managed care options described above -- receive high quality care. A major facet of our strategy for Medicare reform involves the development of quality measures and enhanced consumer information.

As I mentioned to this Subcommittee in March, HCFA has reinvented and modernized its Medicare fee-for-service quality assurance and improvement activities under our Health Care Quality Improvement Program (HCQIP). HCQIP gives providers the tools to achieve continuous quality improvement, allows for the external monitoring of how well providers are improving quality, and supports the development of quality improvement projects throughout the country.

We are equally interested in assuring that as Medicare managed care options evolve, we have adequate measures in place to assure quality of care. As Medicare beneficiaries' options expand, beneficiaries will require reliable information to make well-informed choices about their health care. We are working on a number of fronts simultaneously to achieve this goal.

For example, HCFA, together with the Department of Defense and the Federal Employees Health Benefits Program, has joined private sector health purchasers, including GTE, AT&T, and PepsiCo, to explore the formation of a new organization for quality improvement and managed care accountability. This group represents more than 80 million insured individuals. The group will leverage the collective buying power of the participating organizations to ensure that our beneficiaries' needs are met and to eliminate unnecessary duplication of individual quality improvement and accountability efforts. We expect our efforts to complement the initiatives of existing quality assurance and accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and have received their support.

HCFA also plans to collaborate with the NCQA, with the support of the Kaiser Family Foundation, to modify the Health Plan Employers Data and Information Set (HEDIS) to incorporate measures more germane to the Medicare population.

In May 1995, we launched a pilot test of the three core performance measures, developed by the Delmarva Foundation and Harvard University, to be used by Peer Review Organizations (PROs) in their external review of HMOs. The Delmarva contract was intended to help HCFA and the PROs shift from the current retrospective case review method of HMO oversight to one based on outcomes measurement and continuous quality improvement.

At this stage in the evolution of measures of plan quality, there is no single best approach. We intend to continue to work with a broad range of private sector organizations, as well as pursuing our own developmental work, to move forward as quickly as possible.

C. Improve Customer Service.

In everything HCFA does, we are focused on our strong commitment to improve customer service. To meet the President's call for increased customer satisfaction, we have set standards of service that meet or exceed the best practices in the public and private sectors. Today's HCFA is a significantly different organization from that of just two years ago. As we have embraced an ethic of customer service and beneficiary outreach, we have reinvented our agency to cultivate a consumer-focused workforce and partnership, responsive to the changing needs of our beneficiaries.

Under our consumer information strategy, we are improving opportunities to develop a dialogue with beneficiaries, to educate them about the programs and services available under Medicare, and to disseminate reliable data to foster informed

beneficiary choices about their health care needs and the providers who furnish care.

With the assistance of our contractors, we are redesigning our Explanation of Medicare Benefits (EOMB) form to consolidate Part A and Part B notices into a single, standardized, easy to understand benefits summary.

We have already totally revised the way in which we evaluate Medicare contractors to encourage better customer service, and we will also be proposing legislation to change the way we contract with fiscal intermediaries and carriers to make them more service oriented -- to both better adapt to changing program needs and improve the cost-effectiveness of the Medicare contractor budget.

We are also collaborating with contractors to fulfill our responsibility of fiscal stewardship. The Secretary has recently sent to Congress draft legislation to establish a Benefit Quality Assurance Program (BQAP) to ensure a stable level of funding for our critical payment safeguard activities. The legislation would enhance our ability: (1) to educate providers regarding payment integrity and benefit quality assurance; (2) to determine those situations in which Medicare should have been a secondary payer and recover payments that should not have been made; (3) to target our cost report auditing priorities toward focused field reviews which provide a high return on investment; and (4) to develop clear medical and utilization review policies and communicate those policies to providers.

Operation Restore Trust, the health care anti-fraud demonstration announced by the President in May, is a major effort to develop better methods to protect the fiscal integrity of the Medicare and Medicaid programs. An interdisciplinary team from HCFA, the Office of the Secretary, the HHS Inspector General, the Department of Justice, State governments, and the private sector will test the most effective approaches to combat fraud, waste, and abuse associated with certain Medicare and Medicaid providers and suppliers. The demonstration will target five States (New York, Florida, Illinois, Texas, and California) that account for more than a third of all Medicare beneficiaries in the country and nearly 40 percent of all Medicaid recipients.

II. THE ADMINISTRATION'S STRATEGY FOR COST CONTAINMENT

Many of the operational reforms I have described will produce significant long-term savings, but the President is also committed to reducing the growth of Medicare outlays in the shorter term as part of his plan to achieve a balanced federal budget. The Administration has offered a responsible deficit reduction plan that balances the budget and strengthens the Medicare trust fund while protecting beneficiaries.

The Administration has a three-pronged strategy for controlling costs in Medicare. First, we need to protect beneficiaries' access to affordable, quality health care. Second, necessary reductions in Medicare should serve to extend the solvency of the Hospital Insurance (HI) Trust Fund. Third, we want to take advantage of changes in the health care marketplace.

A. Protect Beneficiaries

Beneficiaries come first. We do not believe that Medicare beneficiaries, the majority of whom have incomes of \$25,000 or less, should be forced to pay thousands of dollars more to keep Medicare in order to finance the tax cuts for the wealthy.

Out-of-pocket costs are already too high for those aged 65 and older, currently accounting for 21 percent of their income. Massive reductions in Medicare spending of the magnitude in the Republican budget resolution achieved by shifting costs to beneficiaries would increase the financial burden on the nation's most vulnerable elderly. Furthermore, almost 60 percent of senior citizens rely on Social Security for 50 percent or more of their income. Shifting costs to these beneficiaries is the equivalent of reducing their Social Security checks.

Medicare has made significant contributions to improving the health status of the nation's elderly and disabled. Significant increases in beneficiaries' out-of-pocket costs could cause them to forgo needed health care services and might result in erasing some of the gains in health status that have been achieved since the implementation of Medicare.

B. Focus Deficit Reduction Efforts on Preserving Medicare

The President has proposed a plan to balance the Federal budget that presents a reasonable approach to ensure Medicare's financial solvency into the 21st century. The proposal includes \$124 billion in net spending reductions over the next seven years and extends the life of the HI trust fund through at least the year 2005.

The plan contains no new increases in out-of-pocket costs for beneficiaries, but does revise the Medicare benefit package by providing respite care for beneficiaries with Alzheimer's disease and by eliminating the copayment for mammography services.

C. Take Advantage of Private Sector Innovations

A major aspect of our cost-containment strategy will be to take advantage of some of the changes now occurring in the health care marketplace. Medicare has historically been a leader in

cost containment. The prospective payment system for hospitals and the physician fee schedule for physicians were groundbreaking payment systems that have become the basis for many payment systems in the private sector. However, the statutory constraints on Medicare's payment rates preclude us from taking advantage of changes in the market as rapidly as the private sector has done.

For example, competition for services has increased substantially in the private sector, with employers and insurance companies demanding large discounts on charges in return for an agreement to send patients to those providers. Given Medicare's large market share, we should be able to extract discounts, as the private sector does, in a wide variety of settings.

We also would like to work with the Subcommittees to establish competitive bidding for certain Part B services, such as clinical laboratory and certain types of durable medical equipment (DME). HCFA is now statutorily prohibited from engaging in such competition.

III. ALTERNATIVE PROPOSALS FOR MEDICARE REFORM

We believe our plan for Medicare represents the right way to balance beneficiary needs, program modernization and deficit reduction. In contrast, the Republican plan to cut \$270 billion from Medicare over the next seven years is the wrong way. It will do damage to beneficiaries and the entire health care system.

The \$270 billion in Medicare cuts that the Republicans have proposed is three times anything previously enacted. A quick review of the Republican Medicare reform working document suggests that Medicare beneficiaries would be required to pay substantially more just to keep their current coverage and access to their doctors. Specifically, preliminary HCFA estimates show that such beneficiaries would need to pay \$403 more in Part B premiums than they would under the President's plan in 2002. Additionally, they would face new coinsurance on home health and skilled nursing care that would cost the average person using these services in excess of \$1,000 for each benefit in 2002.

American Medical Association Proposal

Another wrong way to reduce Medicare spending is contained in the proposal by the American Medical Association (AMA) to end the current safeguards on beneficiary liability for charges for physician services. Extra billing limits give beneficiaries financial protection against unlimited charges by physicians. Under the AMA proposal, physicians would be allowed to charge beneficiaries an unlimited amount over and above what Medicare

pays for a service. A preliminary estimate is that removal of the extra billing limits could cost beneficiaries more than \$900 in out-of-pocket costs in the year 2002 alone.

Medicare has had limits on what physicians can charge since 1984. The current extra billing limits were an essential part of the physician payment reform package established in 1989, which consisted of (1) a fee schedule, (2) extra billing limits, and (3) the Medicare volume performance system. The AMA strongly supported the fee schedule, which was explicitly designed to rearrange Medicare physician payments across procedures and geographic areas while remaining budget neutral. The extra billing limits were an integral companion of the fee schedule, providing essential protection for beneficiaries in these circumstances -- otherwise any losing physician could simply shift the cost to the beneficiary.

We believe that the AMA's new proposal to repeal the limits on how much physicians can charge beneficiaries calls into question the entire political compromise represented by the Medicare physician payment reform and is nothing short of outrageous.

Voucher Proposals

Finally, I would like to comment specifically on the Republican proposals to convert Medicare into a "defined contribution" or "voucher" program. Instead of secure Medicare coverage for all medically necessary care from the provider of their choice, beneficiaries would be given a voucher to purchase medical insurance on the open market.

Advocates of voucher-like approaches frequently suggest that Medicare should emulate the private sector and therefore benefit from private-sector-like growth rates. CBO data indicate that the private sector per capita growth rate would be 7.1 percent from 1996-2002. However, the Republican Budget Resolution would require an incredibly tight 4.9 percent per capita growth rate for Medicare.

Constraining the costs of providing care for a much more vulnerable Medicare population to a rate of increase so much smaller than that of the private sector is, at best, unrealistic. The resulting impact would be that the value of the voucher would very quickly erode. Beneficiaries would be forced to pay a substantial new "premium" for exercising the choice to buy a policy that covers what Medicare covers today. Such an approach would put all the risk of increased medical care costs on the beneficiaries.

In view of the fact that 75 percent of Medicare beneficiaries have incomes below \$25,000, most seniors will find it extremely difficult to pay these additional amounts to keep their current Medicare benefits. The Republican voucher proposal would likely coerce many seniors into buying less coverage -- for example a medical savings account-like policy with a \$10,000 deductible that Republicans also are advocating.

If beneficiaries wanted not only to retain their current level of Medicare benefits, but also to remain in traditional fee-for-service Medicare so that they could continue to see their own doctors, their out-of-pocket costs could be much, much greater. Especially if adverse selection meant that sicker people were more likely to want fee-for-service coverage, the cost of traditional Medicare coverage could skyrocket.

In short, the choice beneficiaries would face under the Republican voucher plan would be to either pay significantly more or to get significantly less. We do not believe that this is the type of choice Medicare beneficiaries seek.

Even if the Republicans vouchers were adequately indexed, however, we have other concerns. First, for the Republican voucher system to work properly, there should be a wide range of plans available to Medicare beneficiaries, and beneficiaries would not be denied enrollment because of their medical conditions or subjected to pre-existing condition requirements. Our experience to date on how insurers behave vis-a-vis the Medicare population raises questions about how insurers might behave under a voucher system. Indeed, the Medicare program was created 30 years ago precisely because insurers did not make coverage available to the elderly except at prohibitively high premiums, and insured persons were at risk of losing their coverage after a serious illness.

The problems in the current "Medigap" market illustrate some of the problems that could be expected to arise if the health insurance market were not properly regulated. After the creation of Medicare, insurers began to offer Medigap policies to the elderly to fill in the "gaps" in Medicare. Medigap policies cover Medicare deductible and coinsurance costs, and some cover extra-billing by physicians and outpatient prescription drugs. The current market provides incentives to avoid risks by health screening or using medical underwriting criteria to offer coverage only at an unaffordable price. They also establish premiums that climb steadily as the beneficiary ages and becomes more likely to need expensive medical services, and hence to need Medigap insurance.

Of course, in principle, one could establish a set of market rules that would prevent such behavior. In fact, the Republican Medicare restructuring document seems to acknowledge this by

directing the Secretary to regulate this type of behavior in numerous instances throughout the document. This is ironic in light of the anti-regulatory agenda currently pursued by many in Congress.

Even more basically, there is a strong correlation among Medicare beneficiaries -- as in most populations -- between income and health status. Our poorest beneficiaries are also our sickest. A poorly designed voucher system could systematically disadvantage the most vulnerable.

IV. CONCLUSION

There is right way and a wrong way to reform Medicare. The right way is to protect beneficiaries' access to quality care and strengthen the HI Trust Fund while pursuing the broader goal of balancing the Federal budget in a reasonable time frame. The wrong way -- the way the Republican budget resolution has turned -- would demolish the basic protections embodied in Medicare in order to finance tax cuts for the wealthy. We believe that the right way is more consistent with rational health policy, fiscal prudence, and the overwhelming preferences of the American people.

Thank you for the opportunity to testify on this important subject. I would be happy to answer any questions you may have.

**MEDICARE RESTRUCTURING AND
FINANCIAL SECURITY FOR BENEFICIARIES**

Statement of

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Before

**U. S. House of Representatives
Commerce Committee
Hearing on Medicare
August 3, 1995**

MEDICARE RESTRUCTURING AND FINANCIAL SECURITY FOR BENEFICIARIES

Karen Davis

Thank you for this opportunity to testify on the importance of the Medicare program in protecting elderly and disabled beneficiaries from the financial hardship of health care bills. This year marks the 30th anniversary of the Medicare program. When it was enacted thirty years ago, most elderly people were uninsured. They lost their health insurance coverage when they retired. Medicare has brought health and economic security to some of the nation's most vulnerable citizens for three decades.

It is particularly fitting to take stock of Medicare's essential role as an insurer of elderly and disabled beneficiaries at this point in the program's history. Medicare is caught in a dilemma—brought on in part by its success. As the life expectancy of the elderly in the U.S. has increased to be among the best in the world and as modern technology has brought new ways of both extending and improving the quality of life, the cost of caring for older people has risen. Health care for the elderly and disabled is expensive for Medicare and it is expensive for beneficiaries. Understanding why this is the case is fundamental to any attempt to modify the program.

Who is Covered by Medicare?

It is particularly important to keep in mind an accurate picture of the people Medicare serves. Among the 37 million Medicare beneficiaries are those with limited financial resources, those with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace.

Despite popular views that older Americans enjoy high incomes and standard of living, most elderly Americans have modest incomes. Over three-fourths of Medicare beneficiaries have incomes below \$25,000. Fewer than 5 percent have incomes exceeding \$50,000. While poverty rates of older Americans are somewhat lower than for the non-elderly population, many elderly people have been lifted barely above the poverty level by Social Security benefits. For important subgroups, such as elderly people living alone poverty rates exceed 20 percent—comparable to poverty rates for children.

The high concentration of low-income elderly, and the fact that such elderly are more likely to be in poor health and need more health care services, means that Medicare outlays are concentrated on relatively low-income beneficiaries. Eighty-three percent of Medicare outlays go to beneficiaries with incomes of \$25,000 or less. Only 3 percent goes to elderly individuals or couples with incomes in excess of \$50,000 (see Chart 1).

Low-income elderly and disabled beneficiaries have increasingly relied on the

Medicaid program to supplement their Medicare benefits. The Qualified Medicare Beneficiary (QMB) program entitles all poor Medicare beneficiaries to supplemental Medicaid coverage for cost-sharing and subsidizes Medicare Part B premiums for beneficiaries with incomes up to 120 percent of the poverty level. Today, more than two-thirds of all Medicaid outlays are for the elderly and disabled.

Only about half of aged Medicare beneficiaries with incomes of under \$5,000 are enrolled in Medicaid (see Chart 2). A Commonwealth Fund study in the late 1980s found that the most common reasons why elderly poor are not covered by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible. Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

Medicaid and Medicare have also been important financers of long-term care for the frail elderly and those suffering from chronic and disabling physical and mental conditions. Together, the two programs account for half of long-term care expenditures; private health insurance coverage for long-term care is negligible. Medicaid is the only significant source of coverage for nursing home care or for personal care such as that provided by a home care aide, but to qualify an elderly person must become destitute. Medicare nursing home benefits are restricted to skilled nursing care, although Medicare does pay for about one-third of home health services for older Americans (see Chart 3).

Financial Burden of Health Costs on Medicare Beneficiaries

The financial burden of health care costs for Medicare beneficiaries is very unevenly distributed. Some elderly enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. Because Medicare beneficiaries have very different needs for health care, health expenditures are very skewed. In 1993, 10 percent of Medicare beneficiaries accounted for 70 percent of outlays (see Chart 4). One-fourth of beneficiaries accounted for 91 percent of outlays.

The average expenditure in 1993 for all Medicare beneficiaries was \$4,020 (see Chart 5). For the ten percent of Medicare beneficiaries with the highest outlays, the average expenditure was \$28,120. This is contrasted with \$1,340 for the 90 percent of Medicare beneficiaries with the lowest outlays.

Understanding this variation in outlays is particularly important in any discussion of expanding capitated managed care coverage under Medicare. If capitation payments are not appropriately adjusted for health status, over or underpayments can be quite serious. Plans can make considerable profit at a capitated rate of \$4,000 or even \$3,000 if they can avoid enrolling those beneficiaries likely to be in the most costly 10 percent. The incentives to enroll only healthier enrollees or encourage less healthy enrollees to disenroll are formidable.

Even though Medicare outlays are concentrated on the most vulnerable—the poor and those with serious medical problems—out-of-pocket costs to these groups can pose a serious

financial burden. About 12 percent of Medicare beneficiaries have no health insurance to supplement Medicare—either from Medicaid or from private coverage through a retiree health plan or through individually purchased Medi-Gap coverage. These beneficiaries are concentrated in incomes under \$10,000 (see Chart 2).

As shown in Chart 6, the hospital deductible under Medicare is \$716, the Part B deductible is \$100 per year, and the Part B premium is \$550 per year. The average Medi-Gap premium is now \$840. Given non-covered services such as prescription drugs, premiums and out-of-pocket costs for Medicare beneficiaries averages over \$2000 per year. For an elderly woman with an income of \$10,000, this is clearly an excessive and burdensome cost.

It is not well understood that the elderly pay far more for their own health care than the non-elderly—even with important coverage from Medicare. This happens because Medicare pays only 45 percent of the health care bills of the elderly. As shown in Chart 7, poor elderly households spend over a third of their incomes on health care. The average for non-elderly households is 3.7 percent of income.

Cost-sharing requirements by their very design mean that those who are ill and use services bear the burden. The chronically ill and other high utilizers of care are most likely to incur large individual liability for Medicare cost-sharing and uncovered services and charges. A Commonwealth Fund study, *Medicare's Poor*, found that thirty percent of Medicare beneficiaries rate their health as fair or poor. For those who are poor, members of minority groups, or over age 85 even higher numbers have poor health. For example, over 60 percent of poor elderly have arthritis. Half suffer from hypertension and need counseling about diet and exercise, and many require physician monitoring and prescription drugs to control their condition. Twelve percent of poor elderly people have diabetes and many require insulin treatment as well as medical care for the many conditions that arise as complications to diabetes.

For those elderly with long-term care needs, costs can be even higher. About 40 percent of all nursing home expenses are paid directly by patients and families. For those elderly with functional impairment living at home, costs can also be high. Over one-third of poor elderly people living at home report being restricted in one or more activities of daily living compared to 17 percent of those with moderate or high incomes.

Inadequate Medicare benefits not only mean financial burdens, but also barriers to needed care. The significant deductible and coinsurance provisions in Medicare deter some of the elderly poor and near poor from obtaining care. Low-income and minority elderly are less likely to get preventive services such as Pap smears and mammograms, in part because of the financial barrier posed by out-of-pocket costs. A recent study supported by The Commonwealth Fund found that elderly women without Medicaid or supplemental private health insurance were much less likely to get mammograms. The financial barriers posed by deductibles and copayments for cancer screening contribute to failure to detect cancer in an

early stage when recovery chances are higher. Rates of ambulatory sensitive hospital admission rates are particularly high for poor and minority elderly—indicating inadequate access to primary care.

In sum, poor and near-poor elderly are more likely to be experiencing health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes. For those who do get care large out-of-pocket medical expenses can lead to impoverishment.

Medicare's Record of Performance

Despite its limited benefits, Medicare has opened the door to health care and greater economic security for the nation's elderly and disabled populations for three decades. Particularly striking has been the program's success in improving access to care for low-income and minority elderly Americans. Racial disparities in care for elderly Americans have largely been eliminated, and Medicare has been instrumental in spurring desegregation of medical facilities for all minority Americans.

Medicare has also contributed to the development of research and innovation, through its funding of medical education and allowances for teaching hospitals. Technological innovation such as cataract surgery, joint replacements, and treatments for coronary artery disease, financed by Medicare, have improved the quality of life and functioning of millions of elderly people.

As the American population ages and lives longer, Medicare has financed the care of an ever older and frailer group of beneficiaries. At the same time Medicare leaves many elderly and disabled beneficiaries inadequately protected against high health care costs, the program's outlays have grown rapidly over time. Medicare outlays per enrollee exceed \$4000 per person. While Medicare outlays have grown at unacceptably high rates over the last decade and a half, there is some good news.

Most significantly, Medicare outlays per enrollee for a similar package of services have grown more slowly than private health insurance outlays for these services in the decade from 1984 to 1993 (see Chart 8). Spending on inpatient hospital and physician services have moderated considerably. Certainly the new methods of paying hospitals and physicians introduced in 1984 and 1992 respectively have had an impact. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches—particularly home health and skilled nursing facilities services. When long-term care services are excluded from the Medicare benefit package and prescription drugs are excluded from private insurance packages, even in the most recent 1991 to 1993 period Medicare expenditures per enrollee for a similar set of services have increased more slowly than private insurance.

Medicare has also had an excellent record of low administrative costs. Medicare's

administrative costs average 2 percent of program outlays, compared with 25 percent in small group market plans and 30-50 percent in individual insurance plans.

Why then is Medicare so costly? The simple answer is that Medicare is costly because it covers very sick people, and because health care costs for all Americans—whether privately insured or covered by Medicare or Medicaid—have risen rapidly over the last two decades. Until more effective approaches for containing health care costs in the health system as a whole are developed, the program is likely to be caught in the dilemma of high costs for both taxpayers and beneficiaries.

Medicare Restructuring: Putting Beneficiaries at Risk

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare on first examination has appeal as a policy option. Vouchers or giving beneficiaries the actuarial value of Medicare to invest in medical savings accounts and purchase private catastrophic coverage represent mechanisms for capping and limiting growth in budget outlays, shifting financial risks to beneficiaries, and creating incentives for individuals to control costs.

Vouchers would provide more choices for beneficiaries, including wider choices among benefit packages, but also shift more financial risk to individuals. Advocates of a private approach to financing health care for Medicare enrollees argue for a system of vouchers in which eligible persons would be allowed to choose their own health care plan from among an array of private options. For example, individuals might be able to opt for larger deductibles or coinsurance in return for coverage of other services such as drugs or long term care. Advocates of medical savings accounts, for example, would argue that such an option should be available to Medicare beneficiaries. In addition, since many Medicare enrollees now choose to supplement Medicare with private insurance, this approach would allow beneficiaries to combine the voucher with their own funds and buy one comprehensive plan. No longer would they have to worry about coordinating coverage between Medicare and their private supplemental plan. Moreover, persons with employer-provided supplemental coverage could remain in the health care plans they had as employees.

Competition among plans to attract enrollees might help to lower prices, but it also seems likely that there would be considerable non-price competition as well in the marketing strategies of various plans. As a consequence, the only certain way for Medicare to reduce costs under a voucher scheme would be to fix the payment level and its rate of growth over time (presumably with appropriate adjustments for risk factors).

To the government, this option would have the appeal of enabling a predictable rate of growth in the program. For example, the federal government could set the vouchers to grow at the same rate of growth as GDP or some other factor such as private sector health care costs. But most important, such options are usually developed to achieve major cost savings. The "price" of offering choice to enrollees might be a voucher set at 90 or 95

percent of the current level of government spending per enrollee. And even more important, by placing a cap on the rate of growth of the benefit, vouchers effectively shift the risk to the beneficiary if the cost of coverage exceeds the voucher amount.

If a plan is not successful in holding down health care costs and Medicare's contribution is fixed, the most likely response is to raise the supplemental contribution required of enrollees. This is effectively an indirect premium increase on beneficiaries. Advocates of vouchers argue that consumer opposition to paying higher prices would force insurers to hold down costs and that facing higher costs is thus a good thing and not a problem. Opponents claim that both consumers and insurers would lack the clout to achieve such cost controls.

How successful is the private sector likely to be in holding down costs as compared to the current Medicare program? First, private insurers will almost surely have higher administrative overhead costs than does Medicare. Medicare's administrative costs average less than 2 percent of outlays, while individual insurance administrative costs for the elderly often runs 30-50 percent. Insurers will need to advertise and promote their plans. They will face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. They will not have the advantage of Medicare's scale and governmental authority in imposing steep provider price discounts. For example, Medicare's physician payment rates are 68 percent of those of private insurers, and lower than managed care plans that use the Medicare system to pay physicians. These plans expect to return a profit to shareholders. All of these factors work against private companies performing better than Medicare. At least in the Medicare program, the government's track record at efficiently financing services is quite good, with overhead considerably below that in the private market.

Regulation would be needed to require insurers to take all comers and to guard against problems of adverse selection where one plan may be able to compete by choosing carefully what persons to cover. First, the program is most likely to be problematic if it is voluntary. Adverse selection is likely with sicker and poor beneficiaries remaining in Medicare and healthier, high income beneficiaries opting for vouchers. This could well cost the federal government money if vouchers are not adequately adjusted for health status—a major methodological problem with the current Medicare HMO option.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries—those in poor health and with modest incomes at particular risk. If vouchers or other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs due to the market segmentation. A two tier system of care could result in which modest income families are forced to choose less desirable plans.

On balance, vouchers offer little in the way of guarantees for continued protection under Medicare. They are most appealing as a way to cut substantially the federal government's contributions to the plan indirectly through erosion of the comprehensiveness of coverage that the private sector offers rather than as stated policy. The problems of making tough choices and the financial risks would be borne by beneficiaries. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those largely rejected by the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a universal benefit would be seriously undermined.

Medicare Restructuring: Managed Care

Medicare has been criticized for not promoting aggressively enough managed care alternatives for its beneficiaries. Yet, Medicare is itself similar to a preferred provider managed care plan. With the recent reforms in provider payment, Medicare sets prospective prices for hospitals and physicians at a substantial "discount" to usual charges. Medicare's physician payment fees, for example, average 68 percent of fees paid under private health insurance plans. All providers who are willing to participate at these rates are permitted to enroll. Physicians who agree to take "discounted" payments as payments in full become participating physicians and are listed in directories of preferred providers. This has worked remarkably well, to the extent that 92 percent of all Medicare physician services are now on assignment.

In addition Medicare makes HMO options available to beneficiaries. Three-fourths of beneficiaries live in areas where managed care plans are available. Seventy percent of HMOs now offer or plan to offer shortly a Medicare product marketed to Medicare beneficiaries. Despite the reluctance of many elderly to give up their personal physician to join an HMO, HMO enrollment has increased from 1 million in 1985 to 3 million in 1995—about 9 percent of all Medicare beneficiaries.

Even if enrollment were to expand more markedly, it is unlikely that there would be savings to the program, and in fact might cost the Medicare program. A recent study finds that the actual cost of serving Medicare beneficiaries who opt for HMO enrollment is 5.7 percent more than Medicare would have had paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage. Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.

Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries which they have very strong incentives to do, Medicare will be overpaying for those under managed care, and yet paying the full cost of the sickest

Medicare beneficiaries who are unattractive to managed care plans. Managed care plans have the option of switching to a fee-for-service method of payment from a capitated risk contract if they experience adverse selection and would receive higher payment under Medicare's fee-for-service provider payment rules. Monthly disenrollment by Medicare beneficiaries also means that managed care plans can encourage sicker patients to leave the plan and be cared for on a fee-for-service basis. In the case of network-model HMOs the same physician might even continue to care for the patient when he or she disenrolls.

The current method of paying managed care plans for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status seems years away.

The current method of Medicare HMO payment includes allowances for the direct and indirect costs of medical education even though managed care plans do not incur these costs; The payment rate also includes an allowance for disproportionate share payments even though managed care plans do not cover the uninsured, and in general are open only to those who can afford the premium or have employers or public programs that pay the premium on their behalf. These factors represent about a four percent overpayment to HMOs with Medicare risk contracts.

The extent of managed care abuses could be curbed by lowering capitation payment rates and imposing penalties on plans for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. Nor has the long-term success of managed care in controlling costs (aside from getting provider price discounts) yet been demonstrated.

Beneficiary Views of Medicare

Medicare enjoys a high degree of support from both the elderly and non-elderly. Medicare beneficiaries report high rates of satisfaction with the plan. The Medicare Current Beneficiary Survey finds that 89 percent are satisfied or very satisfied with the overall quality of medical care. A Kaiser-Commonwealth Fund 1993 health insurance survey found that 52 percent of Medicare beneficiaries are very satisfied with their Medicare insurance, compared with 44 percent of families covered by employer-provided private coverage, 39 percent of Medicaid beneficiaries, and 30 percent of those who purchase private health insurance individually (see Chart 9).

National opinion polls also show little support for cutting Medicare. A Kaiser Family Foundation/Harvard University voter exit survey in November 1994 found widespread support for Medicare. Only 8 percent of voters support decreased spending on Medicare for the elderly—even below the 17 percent who support decreased spending on Social Security. Some specific measures such as tighter provider payment rates or higher payments by very well off beneficiaries (the 5 percent with incomes over \$50,000) muster more support but these are unlikely to yield substantial savings.

Building on Medicare's Strengths

At present, too little attention is being focused on how to improve the functioning of the basic Medicare program, rather than departing radically from its basic structure. The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; capitated managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme.

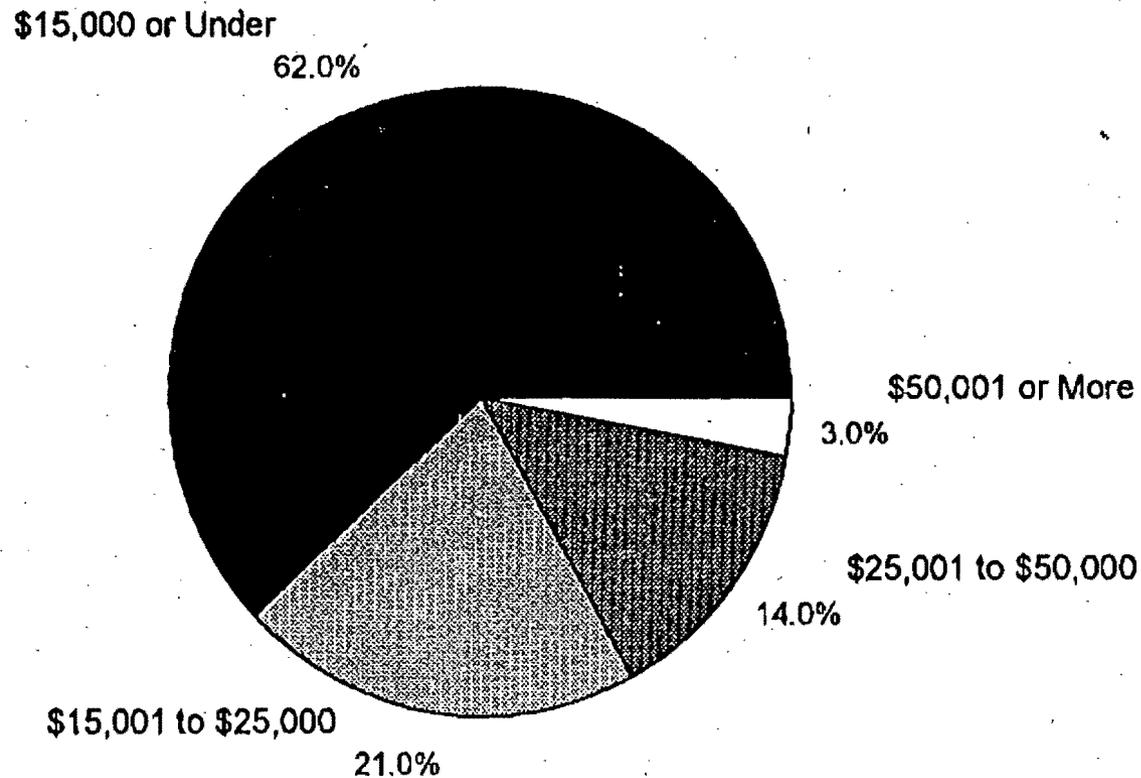
Major issues include: 1) how to improve the fee-for-service option within Medicare; 2) how to expand Medicare managed care choices while assuring quality standards; 3) how to minimize the difficulties posed by risk selection; and 4) what financial contribution Medicare beneficiaries and taxpayers can reasonably be expected to make (see Chart 10).

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should not be hastily jettisoned in an ill-conceived and short-sighted effort to obtain federal budgetary savings. Instead a full array of options needs to be carefully analyzed, critiqued, and debated.

Thank you.

MEDICARE EXPENDITURES BY BENEFICIARIES' INCOME, 1992

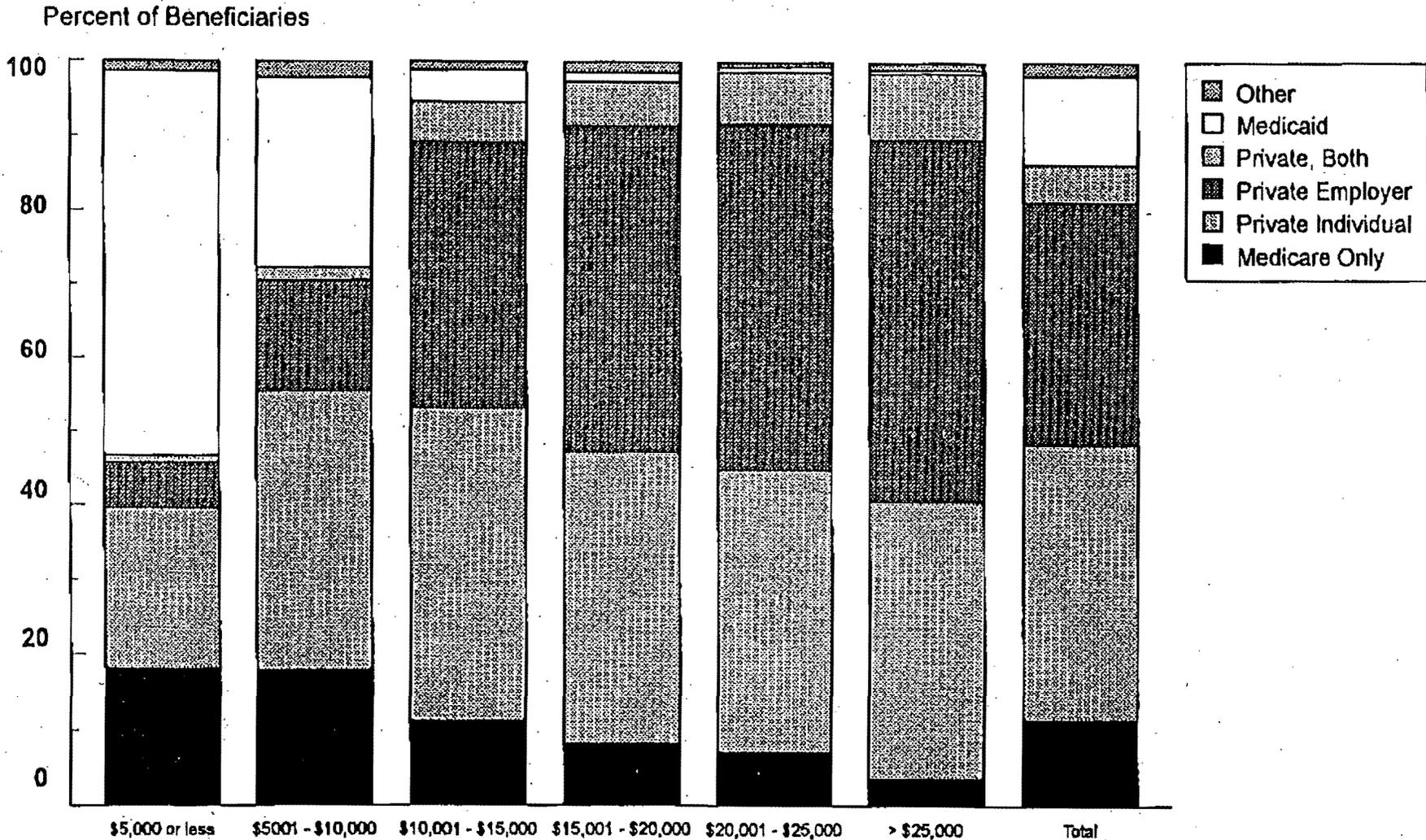
83% of Medicare Expenditures Are for Beneficiaries With Annual Incomes Under \$25,000



Note: Excludes 2.2% Not Reporting Income and HMO Enrollees (6%).
Source: Health Care Financing Administration, Office of the Actuary, 1995.

SUPPLEMENTAL INSURANCE COVERAGE OF ELDERLY MEDICARE BENEFICIARIES BY INCOME, 1991

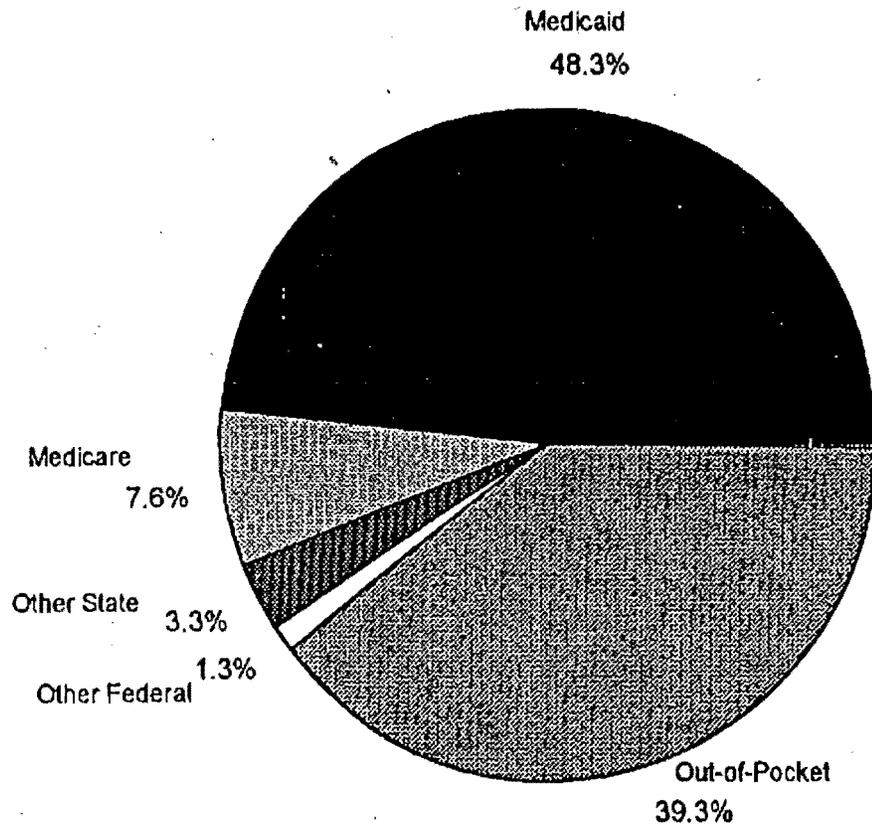
Medicaid Provides Supplemental Coverage for Many Low-Income Beneficiaries



Source: Chulls et al. *Journal of American Health Policy*, July/August 1993.

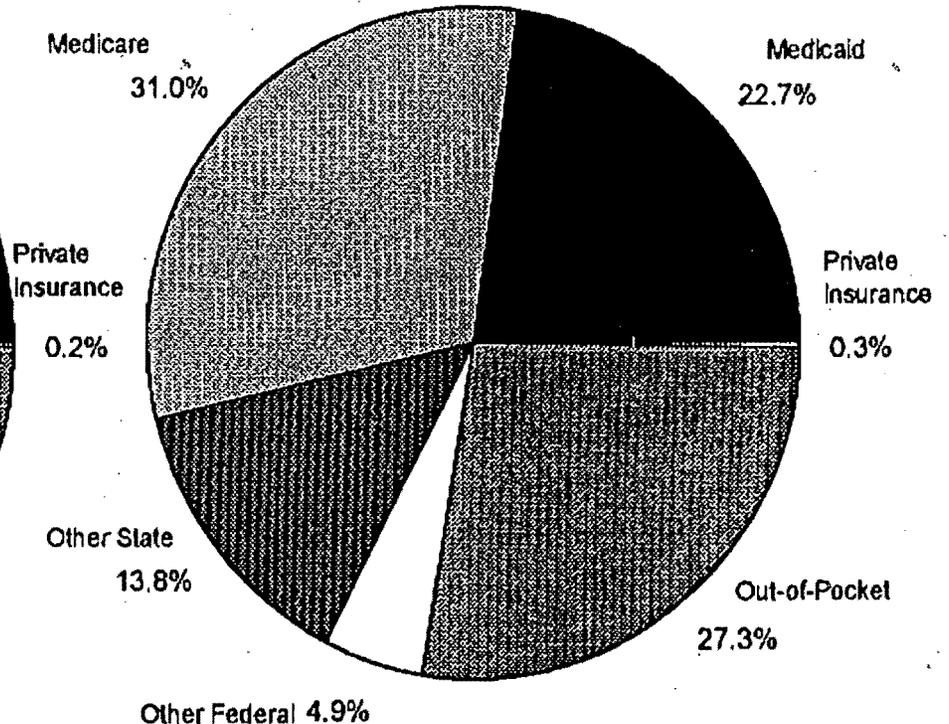
EXPENDITURES ON LONG-TERM CARE BY TYPE OF INSURANCE, 1993

Medicaid Biggest Payor of Nursing Home Care



Nursing Home Care

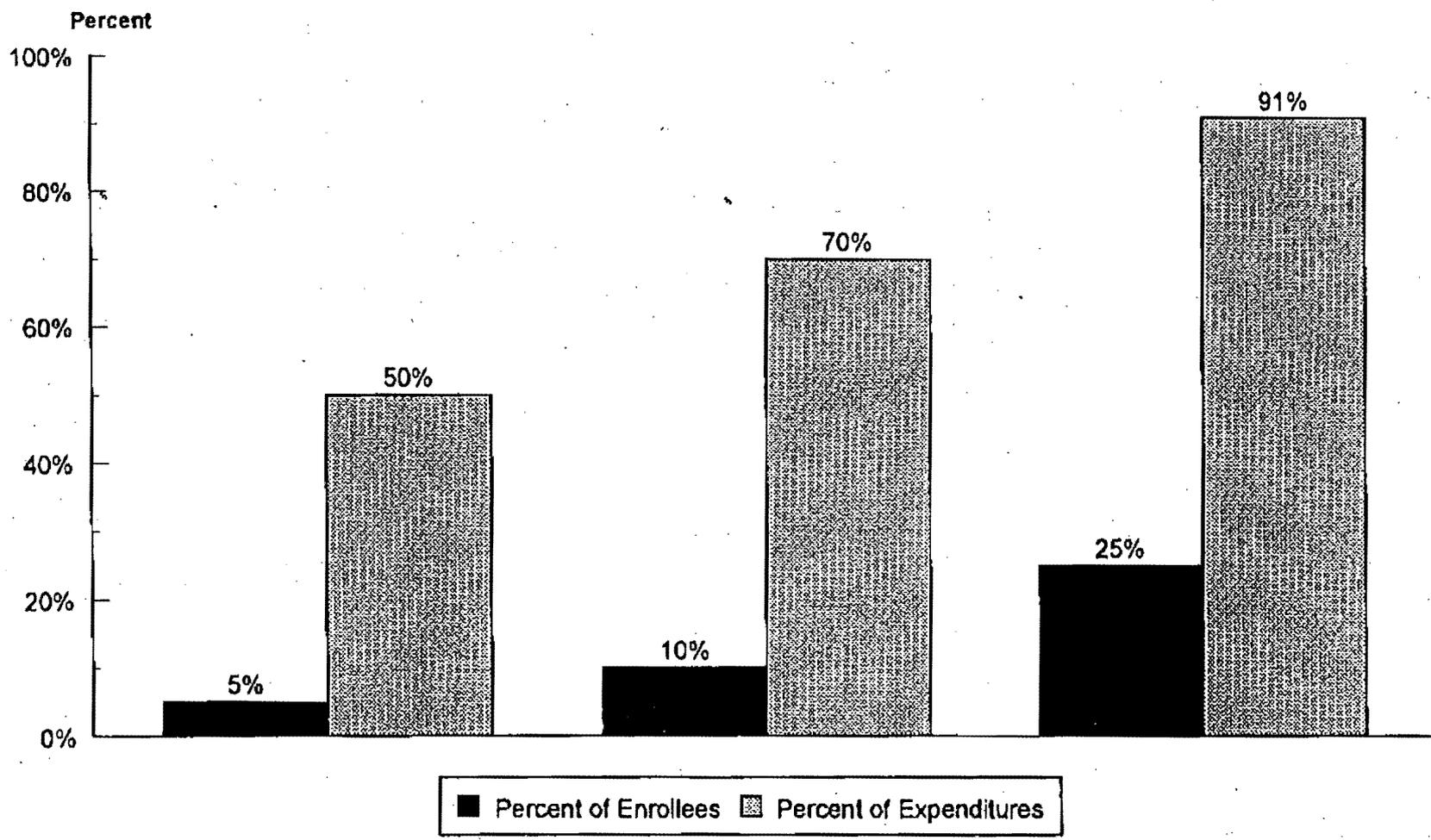
Total = \$75.2 Billion



Home Health Care

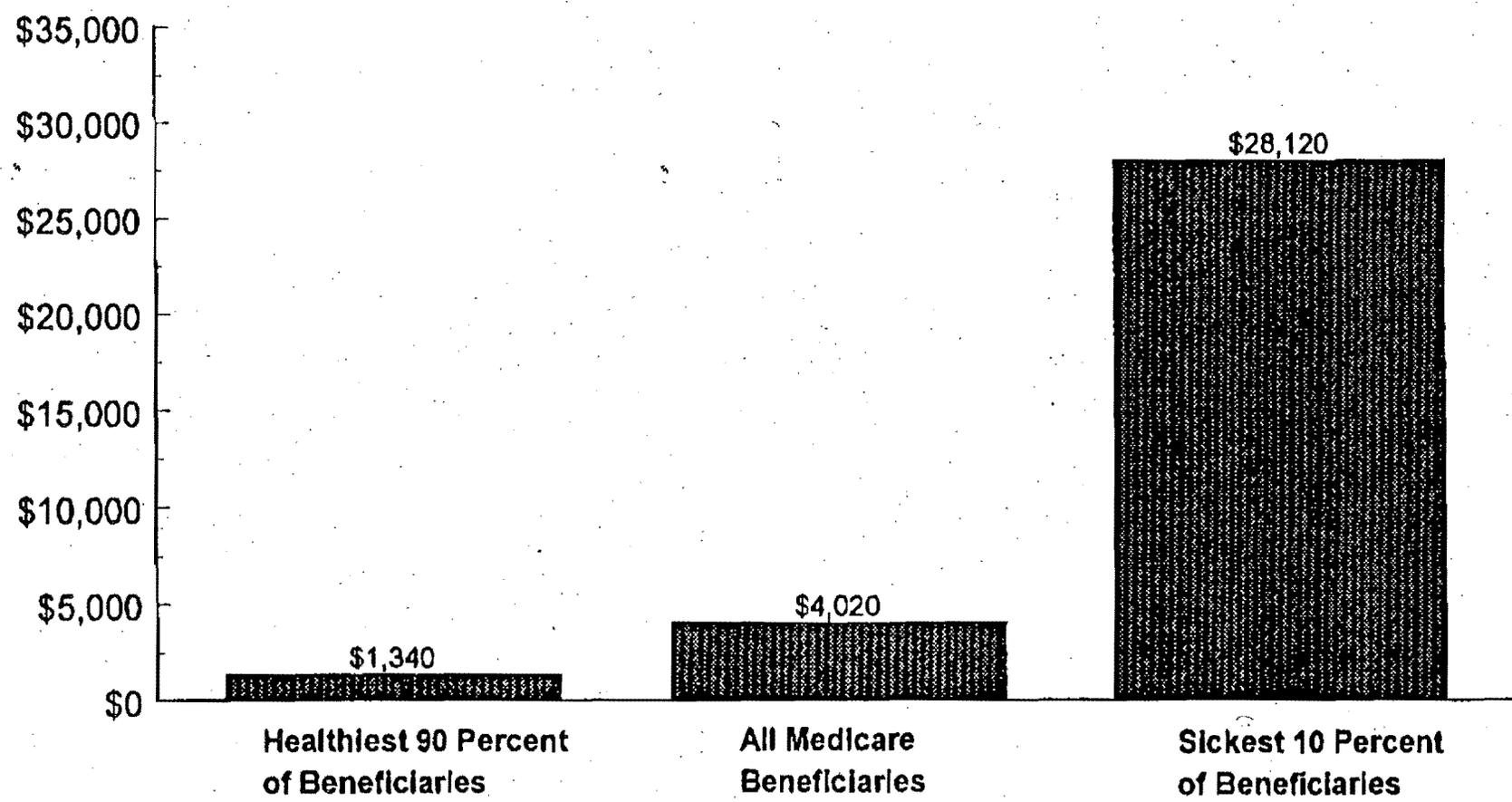
Total = \$32.6 Billion

DISTRIBUTION OF MEDICARE EXPENDITURES BY TOP PERCENTILES OF ENROLLEES, 1993



Source: HCFA/ Office of the Actuary, 1995.

AVERAGE MEDICARE OUTLAYS PER BENEFICIARY BY HEALTH STATUS, 1993



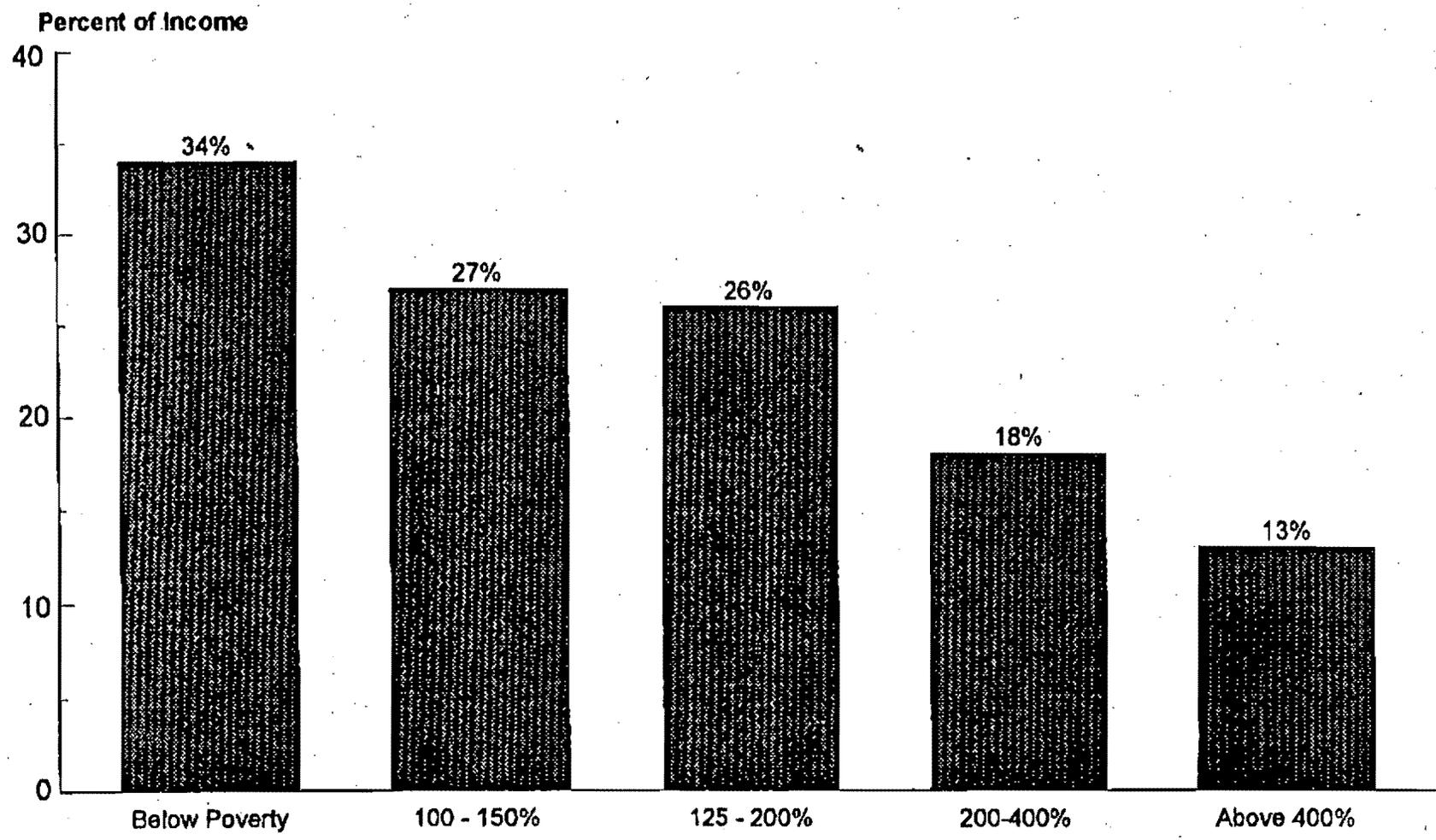
Source: Calculated by Karen Davis from HCFA's Medicare: A Profile, February 1995.

MEDICARE COST SHARING, 1995

- Inpatient Hospital Deductible = \$716 per benefit period
- Part B Deductible = \$100 per year
- Part B Premium = \$553 per year
- In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier, and hospital outpatient services.
- Average Medigap premium (1992) = \$840 per year

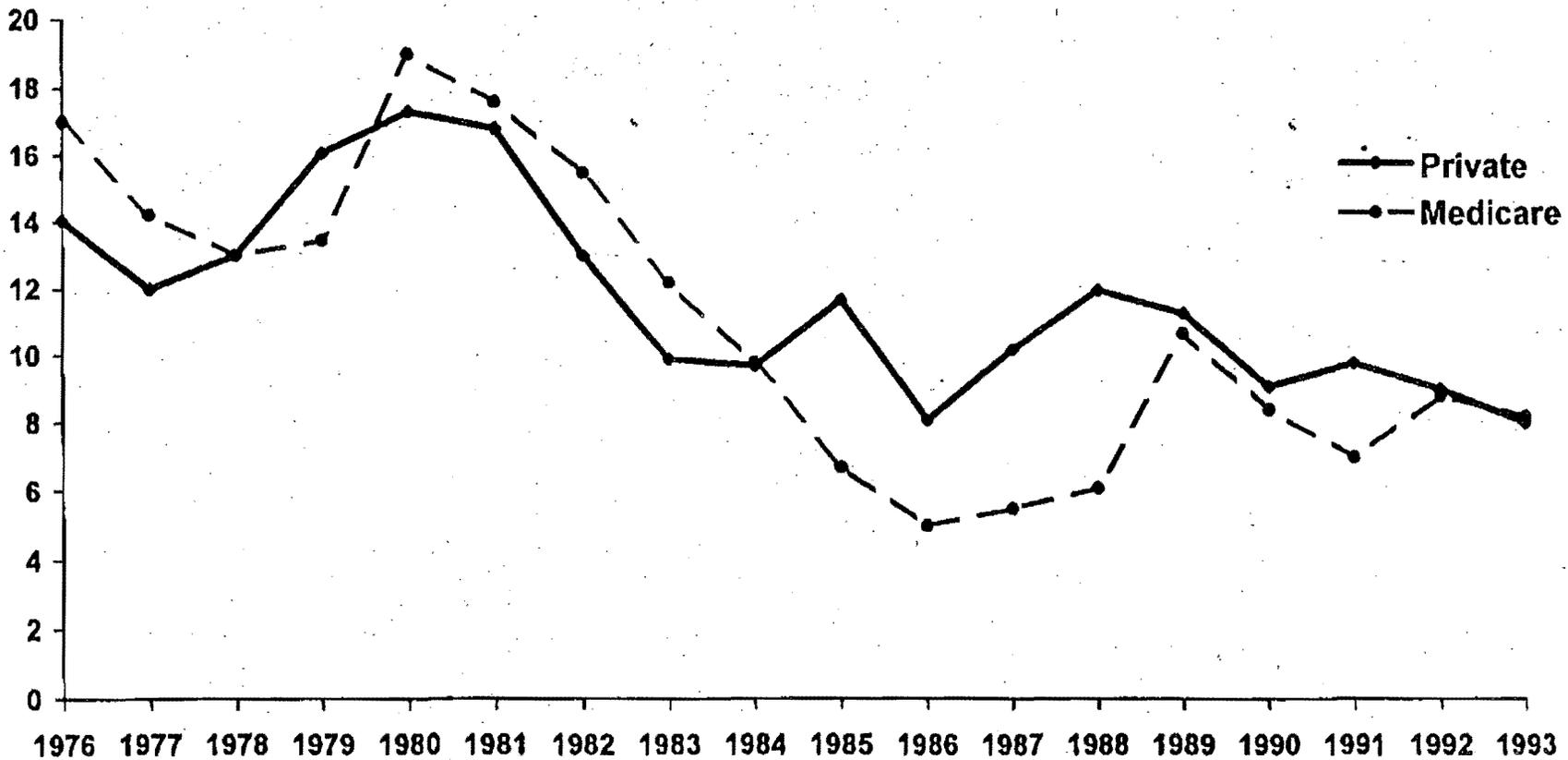
PERCENT OF INCOME SPENT ON OUT-OF-POCKET COSTS, ADULTS 65 AND OLDER, 1994

Poor and Near Poor Older Americans Spend High Percent of Income on Out-of-Pocket Costs



Source: American Association of Retired Persons and Urban Institute, February 1995.

Per Capita Outlay Growth Rates for Services Covered by Both Medicare and Private Insurance 1976-1993



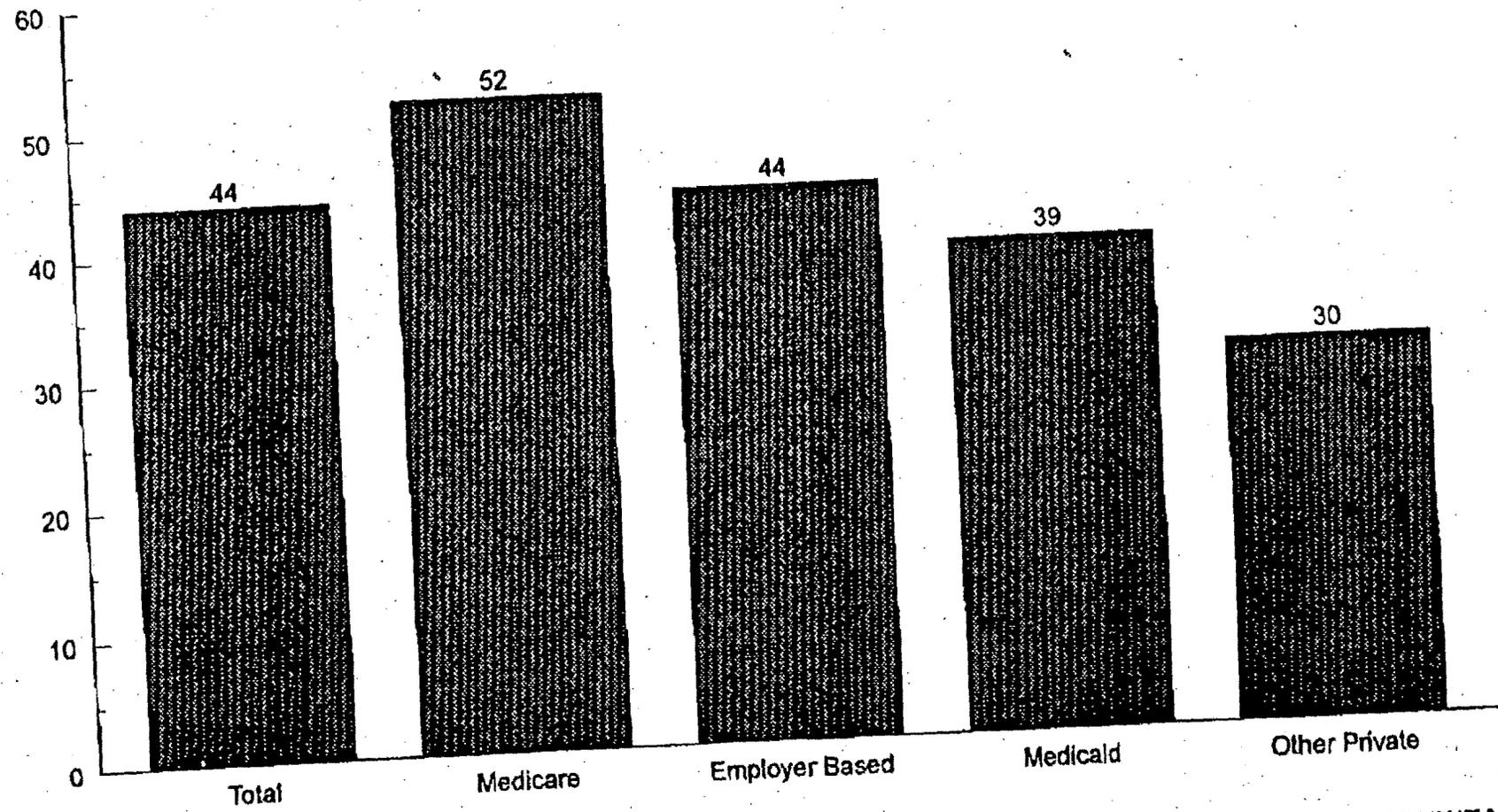
Source: M. Moon and S. Zuckerman, July, 1995
Are Private Insurers Really Controlling Spending Better Than Medicare?

THE COMMONWEALTH FUND

PERCENT OF POPULATION VERY SATISFIED WITH HEALTH INSURANCE, BY TYPE OF INSURANCE, 1993

Medicare Beneficiaries Most Satisfied With Coverage

Percent Reporting "Very Satisfied"



TOTAL P.10

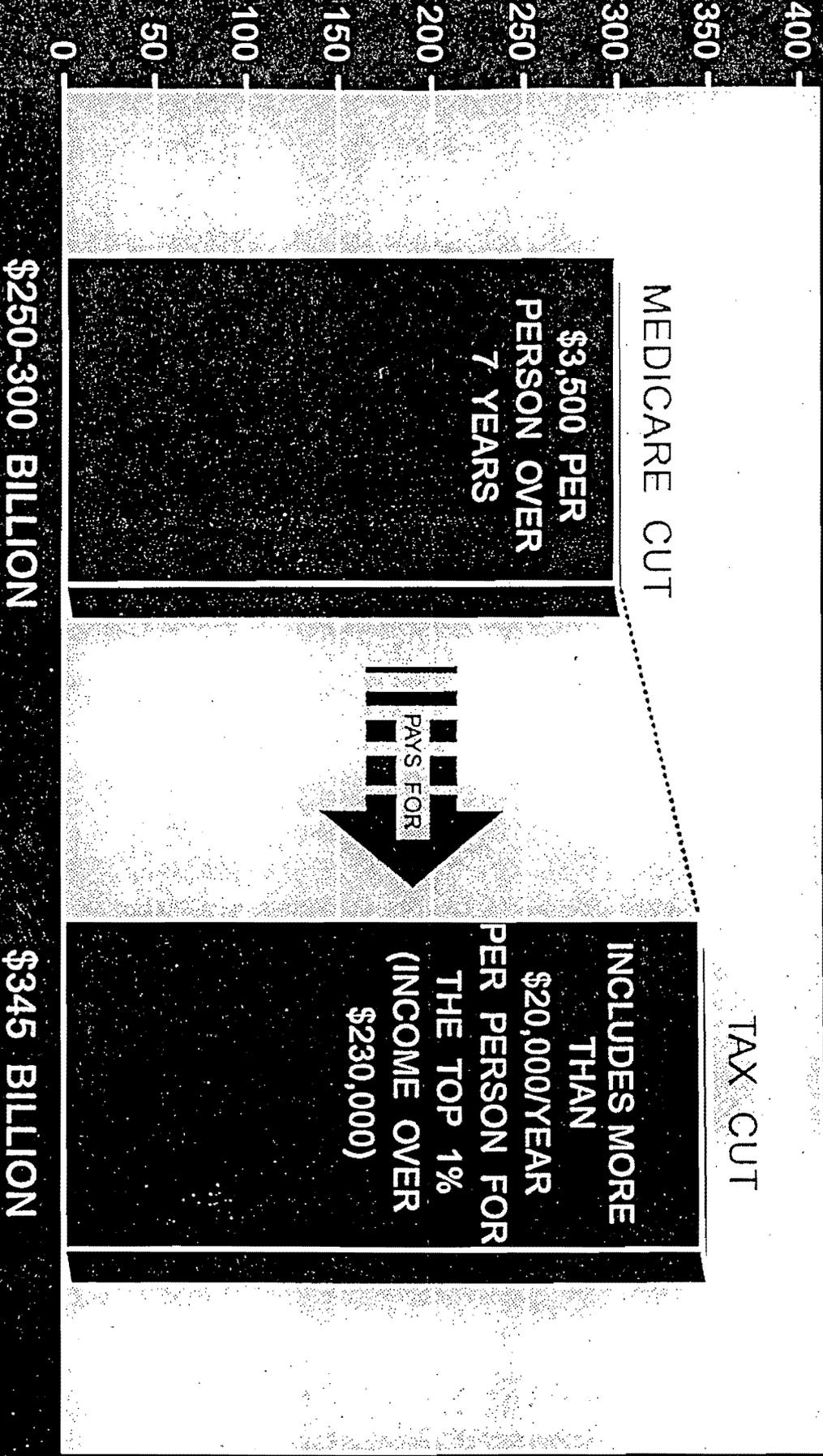
THE COMMONWEALTH FUND

Source: Kaiser Family Foundation/Commonwealth Fund Health Insurance Survey, 1993.

CUTTING MEDICARE TO PAY FOR TAX CUTS FOR THE WEALTHY

(FY 1996 - 2002)

DOLLARS IN BILLIONS



Medicare Poverty File

TO: Alan Cohen, John Hambor, Chris Jennings
cc: Judy Feder, Wendell Primus
RE: **CONCERNS WITH THE TREASURY ANALYSIS OF THE IMPACT OF THE REPUBLICAN CUTS ON THE ELDERLY**
FROM: Jeanne Lambrew
DATE: July 21, 1995

On Thursday, John Hambor dropped off an analysis that Treasury did on the number of elderly people who would be thrown into poverty as a result of Republican Medicare cuts (see attached). I think that their methodology is as follows:

- Take the 1993 poverty breaks for singles and couples. Project them to 2002 using the CPI.
- Look at the 1994 (or 1993?) CPS for the number of elderly singles and couples in poverty, and at 125% of poverty.
- Take the HHS estimated increase in out-of-pocket costs in \$625 (\$1,250 per couple) in 2002 relative to the President's budget. The \$625 per beneficiary is calculated by taking the estimated amount of the beneficiary hit (50% of the total cuts), dividing by the projected number of beneficiaries in 2002. Divide the increase into the difference between the projected 2002 poverty level and 125% of poverty. The difference between poverty and 125% of poverty in 2002 for singles is \$2,268.
- Apply this percent ($\$625/\$1,250$ divided by the nominal difference between 100% and 125% of poverty) to the number of persons between 100% and 125% of poverty. Use some kind of weighting to add the singles and couples affected [note: I could not follow the last step]

Technical issues:

There are three compelling reasons to do something more sophisticated than the Treasury analysis:

1. **Beneficiaries are not distributed evenly across income strata.** There is an odd distribution of beneficiaries by income strata (see attached).

This analysis assumes that beneficiaries between 100% and 125% of poverty are equally distributed. Given the large difference between these points (\$2,268 in 2002) and evidence from other data sets that show an uneven distribution of elderly by income, this is overly simplistic.

2. **Expenditures are not distributed evenly across beneficiaries or income strata.** As the attached chart shows, there is a considerable skew in the expenditures per beneficiary, with only about 5% of beneficiaries accounting for over 50% of Medicare expenditures. Additionally, the distribution of Medicare expenditures by income also is uneven.

This has implications for using the average effect on individuals in a narrow income band. Potentially a significant proportion of the Republican beneficiary increases will come from cost sharing, which is only applicable to users. High users will bear most of the burden of these effects. Thus, it is a stretch to apply the average hit to a small group of people and assume that the average still adequately reflects the experience of the group.

3. **Coverage of Medicare beneficiaries by other insurers:** In doing the national average impact, we did not take into account the fact that the large majority of Medicare beneficiaries have secondary coverage. In the context of "increase in out-of-pocket costs", it didn't seem critical. However, if we are now looking at individuals, not averages, and assuming that the increase is fully borne by the beneficiary in the form of reduced disposable income, this becomes an issue. While we can caveat this effect away, I think that more analysis is needed to make sure that we are not really off base.

Other Concerns:

- Projecting only the poverty level: Income and the number of beneficiaries are also changing over time, and at different rates. The income distribution of elderly in 2002 should take these effects into account, or the full analysis should be done in 1993 by deflating the out-of-pocket increase.
- Exclusion of persons with disabilities: Since these people would probably be disproportionately affected by cost sharing increases, and they are implicitly in
- Last step of the analysis: I cannot figure out how and why there is weighting going on.

CONCLUSION:

I think that this analyses oversimplifies the some of the characteristics of Medicare population, and I am not sure that it can be corrected using the CPS data. If this analysis is to be pursued, it should be done with potentially a different data set and possibly using a set of policies behind the assumption that 50% of Republican cuts affect beneficiaries. The policies that Republican chose will have an enormous impact of the effect across the income distribution. For instance, premium policies for the most part affect all beneficiaries, while home health and SNF coinsurance increases affect 10% and less than 5% of beneficiaries respectively.

However, before any work is done, I think that it is necessary to assess the credibility of the idea. There are serious questions as to whether people will believe these numbers when it requires an assumption that all of the increase comes out of disposable income. We are not subtracting out the out-of-pocket costs currently incurred by the elderly. Also, some may face no cost if they have retiree health coverage or Medicaid, or an additional premium if they have Medigap. While we can make assumptions to deal with these issues, these are important caveats to the numbers that probably won't always stick with the numbers.

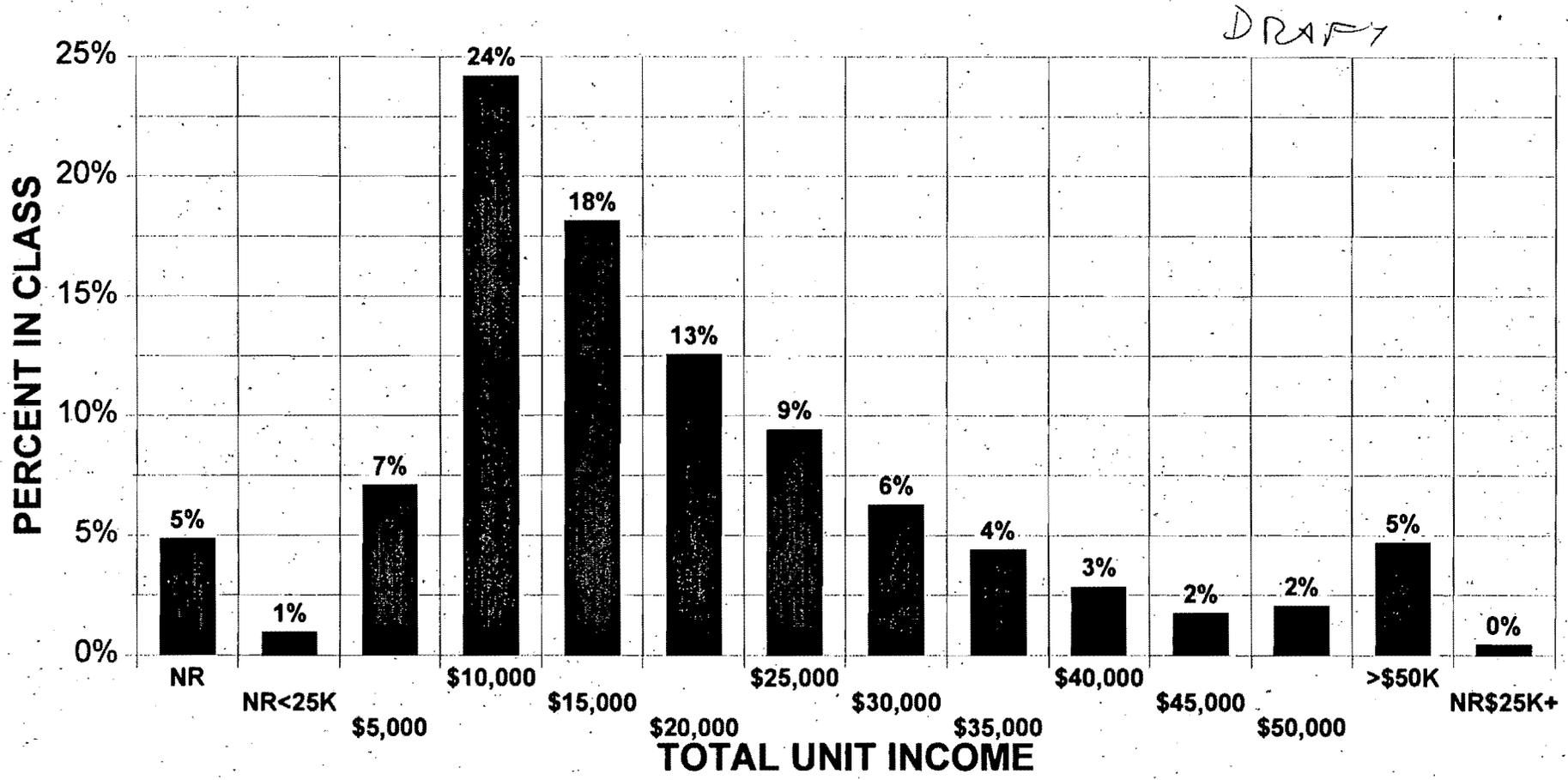
DISTCUTS

TREASURY
ANALYSIS:

7/20/95

	indiv 65+	cpls 65+
93 pov inc	6930	8734
02 pov inc	9085.9458	11451.176
cut%	0.0687878	0.1091591
# persons	9988	20791
# in pov	2412	1343
% in pov	0.2414898	0.0645953
# 1.25pov	3850	2227
% 1.25pov	0.3854626	0.1071137
	0.2751502	0.4366364
	0.0396141	0.0185651
	0.8812289	

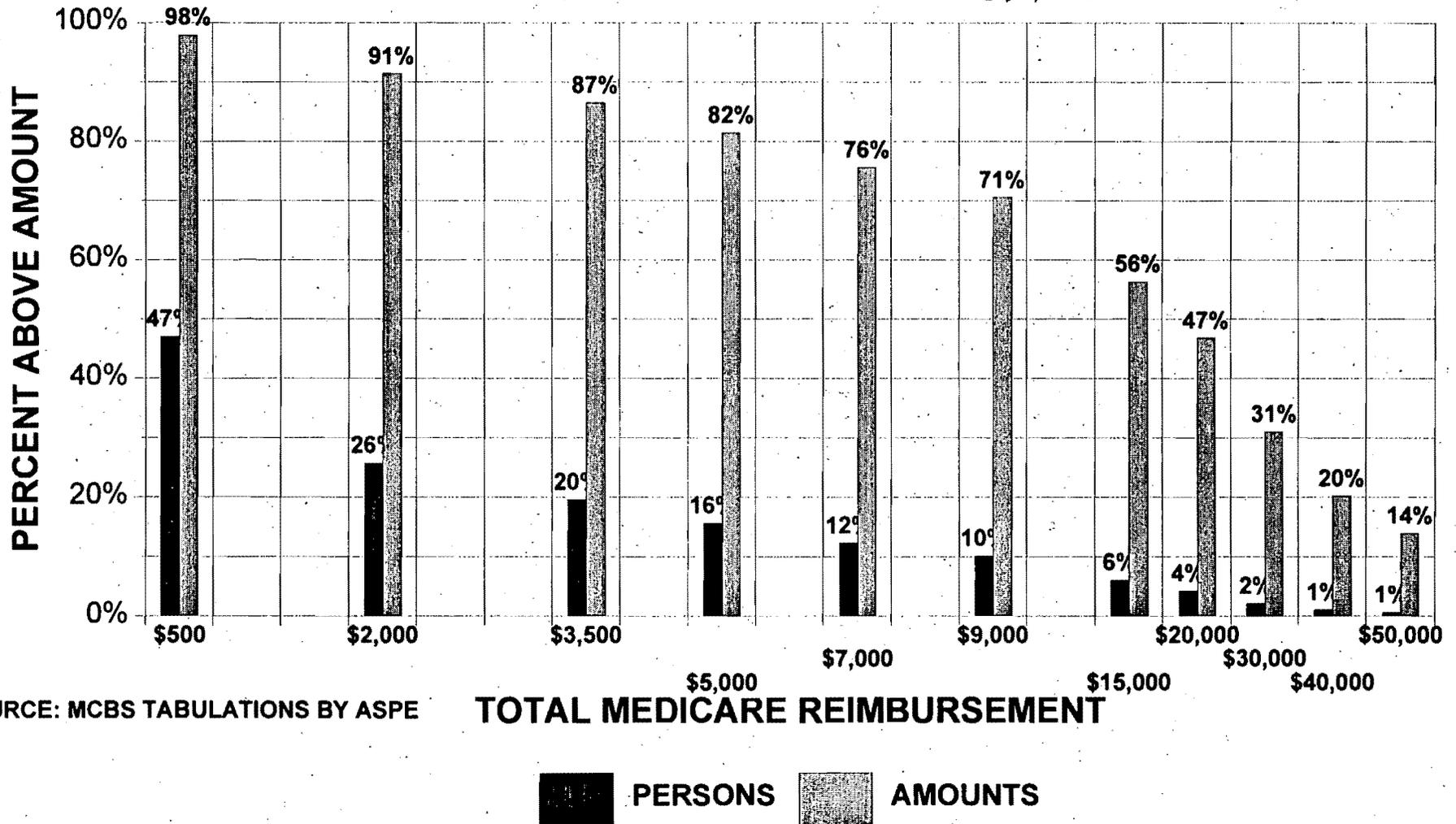
DISTRIBUTION OF MEDICARE BENEFICIARIES BY INCOME, 1993



SOURCE: MCBS TABULATIONS BY ASPE

DISTRIBUTION OF MEDICARE TOTAL REIMBURSEMENT AMOUNTS, 1993

DRAFT



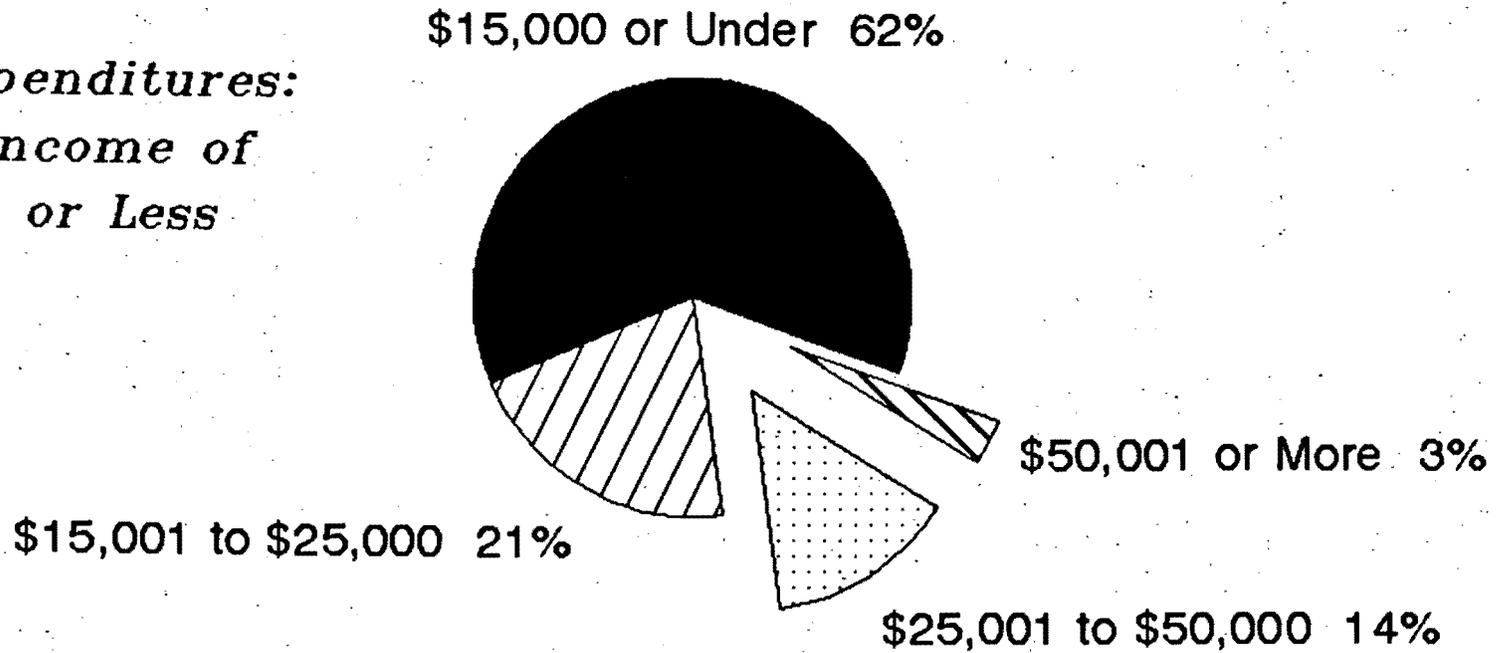
SOURCE: MCBS TABULATIONS BY ASPE

TOTAL MEDICARE REIMBURSEMENT

PERSONS
 AMOUNTS

Share of Program Expenditures by Income Of Medicare Individuals or Couples, 1992

*83% of Expenditures:
Annual Income of
\$25,000 or Less*

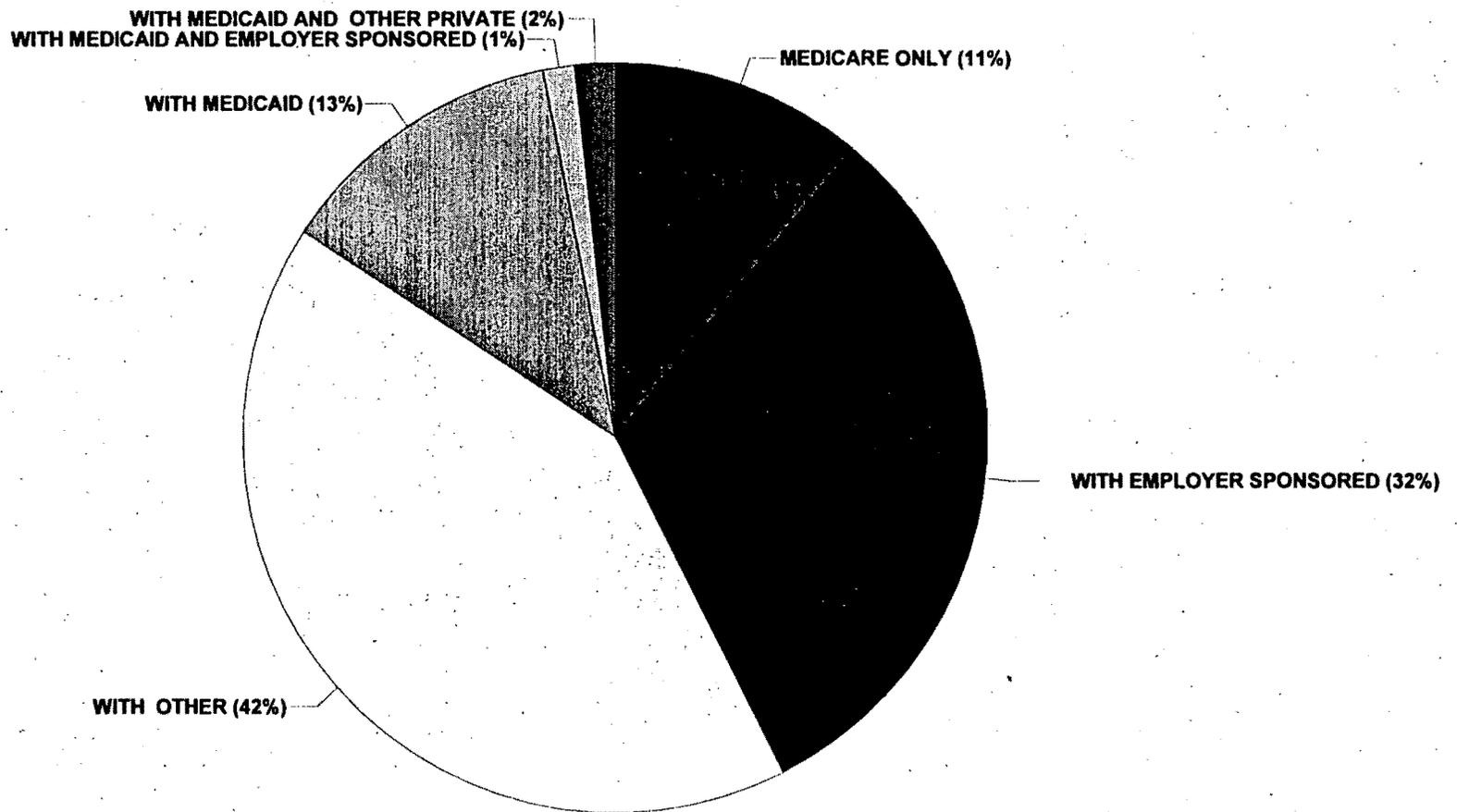


Excludes 2.2% not reporting income. Also excludes HMO enrollees (9%).

Source: HCFA/OACT

Chart PS-15

INSURANCE COVERAGE OF MEDICARE BENEFICIARIES, 1993



Melanne Verveer

Chris -

I've got news
from a M.C. It's
quite good. I mean
anything we can
do with it?



46-97-27

NET NET NAME

Medicare

90-046-97-27



THE MOUNT SINAI MEDICAL CENTER

The Mount Sinai Medical Center in New York City encompasses one of the country's oldest and largest voluntary hospitals and one of the nation's outstanding medical schools.

Since Mount Sinai's establishment, in 1852, its physicians have gained international recognition for some of the most important medical advances of the past century, including the development of the first safe method of blood transfusion and the first portable machine for kidney dialysis. Many illnesses and procedures bear the names of the Mount Sinai physicians who first identified them, including Crohn's, Buerger's and Tay Sachs disease, the Schick test for diphtheria, and the Master cardiac stress test.

THE MOUNT SINAI HOSPITAL

Today, Mount Sinai is a 1,172 bed, tertiary-care teaching hospital located on New York City's Upper East Side. Mount Sinai employs over 10,000 individuals, including 1,171 physicians, 879 residents and clinical fellows in training and 1,550 registered nurses. Each year nearly 44,000 people are treated at Mount Sinai on an inpatient basis, while its clinic and emergency room receive approximately outpatient visits annually.

The Hospital is a regional center for brain-injury rehabilitation, hemophilia, AIDs, neonatal special care services, and pediatric respiratory disease. It is also home to the nation's first hospital division of environmental and occupational medicine and the world's only center for the diagnosis and care of Jewish genetic diseases. Mount Sinai's obstetrics, gynecology and reproductive medicine services include the treatment of infertility and menopause, the first ovum donation program in New York City, and the care of high risk infants.

The Hospital has well-known services for the care of juvenile diabetes, inflammatory bowel disease, and other autoimmune diseases. Mount Sinai also is recognized for its care of large patient populations with Parkinson's disease and with relatively rare diseases including myasthenia gravis, amyotrophic lateral sclerosis (Lou Gehrig's Disease) and sarcoidosis.

In 1967, one of the first kidney transplantation programs in New York State was established at Mount Sinai, and in 1988, the first liver transplant in the State was performed here. Today, Mount Sinai provides a full-range of transplantation services including heart, lung, liver, kidney, bone marrow and heart/lung transplants. Mount Sinai's Children's Heart Center performs pediatric heart transplants and complex, life-saving cardiac surgery on infants and children.





The Mount Sinai Medical Center

One Gustave L. Levy Place
New York, NY 10029-6574

The Mount Sinai Hospital
Mount Sinai School of Medicine

MOUNT SINAI SCHOOL OF MEDICINE

The Mount Sinai School of Medicine of the City University of New York was established in 1963 and admitted its first students in 1968. Today the School enrolls nearly 700 MD and PHD students each year taught by a full and part-time faculty of 3,614. The School was the first in the nation to establish a Department of Geriatrics and Adult Development in 1982 and recently established The Morchand Center, one of this country's first centers for clinical competence aimed at improving doctor/patient relationships.

As an active center for research of international significance, Mount Sinai School of Medicine is engaged in more than 650 ongoing projects in fields ranging from microbiology and genetic engineering to the prevention and treatment of cancer and cardiovascular disease. Mount Sinai School of Medicine is a national center for research in Alzheimer's disease, schizophrenia, alcoholism, and environmental and occupational hazards and disease.

THE MOUNT SINAI HEALTH SYSTEM

The Mount Sinai Health System is a regional network encompassing twenty-one hospitals, eleven long-term care facilities, and associated medical staffs and practices throughout the Metropolitan Area.



THE MOUNT SINAI MEDICAL CENTER FACT SHEET

THE MOUNT SINAI HOSPITAL

FOUNDED:	1852
BEDS:	1,171
ATTENDING PHYSICIANS:	1,710
RESIDENTS:	664
FELLOWS:	215
NURSES (RN'S):	1,786
INPATIENT DAYS (EXCLUDING NEW BORN/TOTAL):	360,277/372,905
ADMISSIONS (EXCLUDING NEW BORN/TOTAL):	38,868/44,210
DISCHARGES (EXCLUDING NEW BORN/TOTAL):	39,340/44,198
NEWBORN DELIVERIES (LIVE BIRTHS)	5,342
OUTPATIENT VISITS:	284,796
EMERGENCY ROOM VISITS:	80,750

MOUNT SINAI SCHOOL OF MEDICINE

CHARTERED:	1963
STUDENTS:	
MD	518
MD/PHD	49
PHD	123

% OF PATIENT DAYS:
25% MEDICAID
35% MEDICARE



Bayside Senior Center
221-15 Horace Harding Expressway
Bayside, N.Y. 11364
(718) 225-1144

The Bayside Senior Center provides assistance to individuals from Queens County over the age of 60. Services include care assistance, congregate lunches, short term counseling by social workers, information referral assistance and education and recreational activities such as lectures, dancing and pool tables.

The Center also provides assistance with programs such as the Home Energy Assistance Program (HEAP), Real Property Tax Reduction (1/2 tax), Supplemental Security Income (SSI), Rent Increase Exemption (SCRIS), Section Eight Housing and Food Stamps.

In addition, Meals On Wheels and Transportation are supplied to certain areas of Queens.

*Medicare issues to be discussed by Rep. Gary Ackerman at this location include:

-The republican majority cutting more than \$450 billion in medicare and medicaid-the largest cuts in the history of the programs-in order to finance a tax cut that does nothing for the forgotten middle class.

-Seniors will pay more for health care and force many to give up their doctors.

-cuts will further squeeze state budgets resulting in possible job losses and higher taxes.

-Specific affects cuts will have on seniors in New York State

-Republicans only held one day of hearings.

The hours of the Bayside Senior Center are 8am-4pm, Monday-Friday. Services are sponsored by Builders for the Family and Youth (an affiliate of catholic charities Diocese of Brooklyn) and funded by the New York City Department for the Aging. Services are administered by the New York State office for the aging.

COBBLE HILL NURSING HOME

Cobble Hill Nursing Home is a not-for-profit 520 bed long term residential health care facility, located on Henry Street in the Cobble Hill section of Brooklyn. It is one of New York City's largest, voluntary residential health facilities.

Cobble Hill Nursing Home is dedicated to serving the community as well as providing comprehensive quality care to all residents. Our Comprehensive Nursing, Sub-Acute Care, Rehabilitation Programs and Hospice Care, are tailored to the individual needs of our residents, and provide services which include:

- ♦ 24 Hour Nursing Care
- ♦ Physical, Occupational and Recreational Therapy
- ♦ Psychiatric, psychological, and social services

Our Specialized *Alzheimer's Resource Center* has received national recognition for its multi-faceted programs. The Center integrates a unique residential setting with a wide variety of day and evening programs that are sensitive to the changing needs, interests, and abilities of people with dementia. Services include:

- ♦ Structured social and recreational activities geared to differing levels of functional abilities
- ♦ Late stage Alzheimer's Unit and Hospice Care
- ♦ Safe Areas for Wandering and a secure, home-like environment
- ♦ Comprehensive medical, nursing and rehabilitative services
- ♦ Psychological and social services for support and counseling
- ♦ Educational seminars and special events for family members and the community

We are currently renovating the facility to accommodate the new *Jacquelyn Hernandez Adult Day Health Center*, which is scheduled to open its doors in January 1996. The Center will operate Monday through Friday, and will provide compassionate, professional care for the frail elderly, Alzheimer's patients, and physically challenged adults. Services will include:

- ♦ Comprehensive Medical Care at 15 on-site Specialty Clinics
- ♦ Nursing, Comprehensive Physical, Occupational, and Speech Therapy
- ♦ Individual and Group Socialization, Recreational, and Cultural Activities
- ♦ Nutritious meals, and Dietary Counseling Supervised by Registered Dietitians
- ♦ Family Support and Counseling

Our wide range of services, coupled with the quality of care that we provide, have made us a valuable asset to the community. Our goal is to continue to provide high quality care for the elderly. However, if Congress makes drastic changes in Medicare and Medicaid funding to Nursing Homes such as ours, we will be forced to cut programs and services. Since ninety percent of our elderly rely on Medicaid dollars to provide for their care, the consequences for them will be detrimental. Current estimates of a Medicaid reduction of \$4 million will force us to lose 78 staff members. This must inevitably result in compromised quality of care.

Patient Profile

Patient Name: Medicare

Attending Physicians: Congressional Democrats

Chief Complaint: The patient has suffered severe life-threatening trauma, sustaining numerous lacerations that go through the fat into the muscle and bone.

Mechanism of Injury: The patient was the victim of vicious assault in the United States House of Representatives.

The patient was bound, gagged and robbed of \$270 billion by Republican assailants intent on funding a tax cut for the wealthiest of Americans.

Preliminary Assessment of Patient's Condition:

The patient is on life support systems.

The patient has sustained significant long-term damage which could lead to increased morbidity and mortality among beneficiaries.

The patient has been robbed of \$270 billion. Prior to the assault, the patient required minor corrective surgery to maintain its strength. The patient now needs major rehabilitative treatment to assure the health and safety of millions of beneficiaries.

The patient suffers from a severe case of **Chronic Republican Support Deficiency Syndrome.**

Prognosis and

Prescribed Treatment: Required treatment includes restoration of funding that the Republicans have cut to fund their tax cut.

The patient faces future complications as more than 1/4 of the slashed \$270 billion in cuts are unspecified and will be determined in the future.

Doctor's Notes:

[Medicare is] a program I would have no part of in a free world.

House Majority Leader Dick Armey (R-TX)

HISTORY OF
PRESENT ILLNESS

History of Present Illness

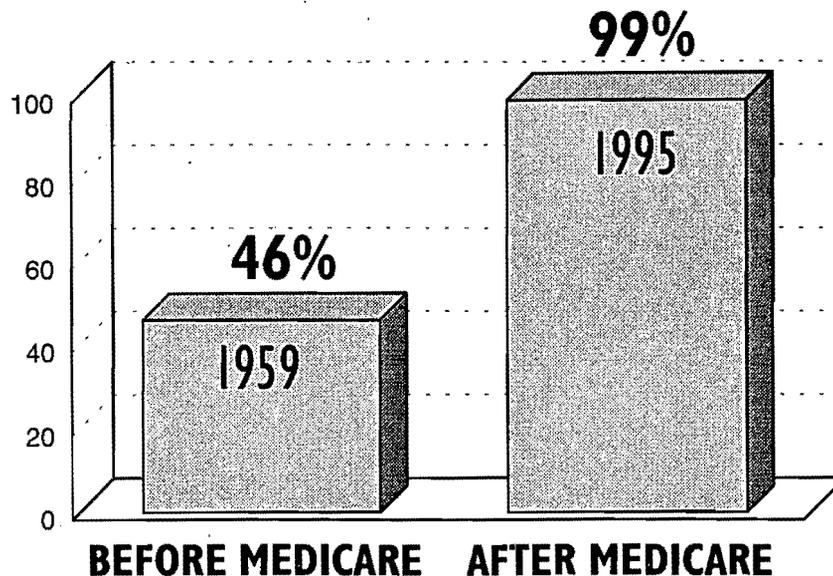
The patient was born in 1965. Prior to patient's birth, 30% of seniors lived in poverty. After its birth, that number decreased to 12%. Death due to stroke and heart disease has declined. Today, because of Medicare, seniors are living longer and with greater dignity.

Lab Report:

Medicare Means Access to Health Care Service

In 1959, only 46% of seniors had health coverage. Today, 99% of seniors have health coverage.

SENIORS WITH HEALTH COVERAGE



Source: CQ, 4/28/61, Social Security Administration
Prepared by the House Democratic Caucus and House Democratic Policy Committee, 7/95

Doctor's Notes:

Were not on board with the proposed budget reductions. Neither Medicare patients nor the health care delivery system can absorb budget cuts of the magnitude proposed."

Dr. Gerald E. Thompson, President, American College of Physicians. (NY Times, 10/6/95)

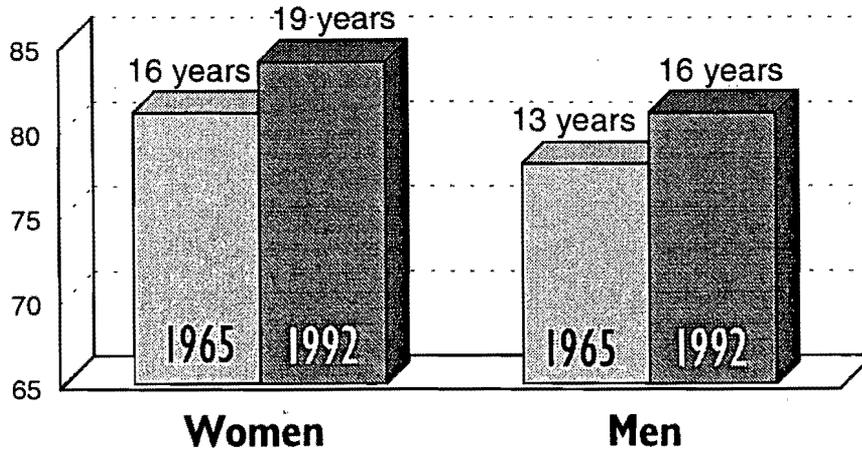
History of Present Illness

Lab Report:

Since Medicare, America's Seniors are Living Longer and Healthier Lives

Medicare has increased access to service for America's most vulnerable population: the elderly. Since its inception, Medicare has dramatically increased the length and quality of senior citizens' lives.

SINCE MEDICARE... AMERICA'S SENIORS ARE LIVING LONGER AND HEALTHIER LIVES



Source: Department of Health and Human Services

Doctor's Notes:

"I guarantee you that these reductions would be bad for quality health care... not just for our senior citizens but also for working families. If Medicare and Medicaid cuts are too deep, hospitals and doctors will shy away from serving the elderly and poor or will try to push costs to the non-elderly, which could further increase the number of uninsured. Or the quality of the whole health care system could decline."

Dr. Greg Ganske, M.D. (Des Moines Register, 10/3/95)

End Reports

**ANALYSIS OF PROPOSED MEDICAID AND MEDICARE FEDERAL BUDGET PROPOSALS ON
HOSPITALS, NURSING HOMES, HOME HEALTH AGENCIES, OTHER PROVIDERS & BENEFICIARIES**

New York State

Revision 10-9-95 Incorporates House Revisions, Latest CBO Estimates for House and Senate, and Revised Estimates of Outpatient Provisions	7 - YEAR IMPACT 1996 TO 2002 (LOSSES IN \$MILLIONS)	
	House	Senate
MEDICAID (FEDERAL FUNDS)		
HOSPITAL	\$9,426	\$9,766
NURSING HOME	5,484	4,240
HOME HEALTH	1,143	884
OTHER PROVIDERS AND BENEFICIARIES	11,246	9,311
TOTAL MEDICAID	\$27,300	\$24,200
MEDICARE	House	Senate
HOSPITALS		
- SPECIFIC PROVISIONS	\$10,630	\$10,167
- BUDGET CAP / LOOK-BACK	1,617 to 4,311	1,617 to 4,311
OTHER PROVIDERS		
- SPECIFIC PROVISIONS	4,246	4,279
- BUDGET CAP / LOOK-BACK	851 to 2,270	851 to 2,270
TOTAL PROVIDER IMPACTS	17,243 to 21,355	16,913 to 21,026
IMPACT ON BENEFICIARIES	3,872	5,143
TOTAL IMPACT ON PROVIDERS & BENEFICIARIES	\$21,115 to \$25,227	\$22,057 to \$26,170
TOTAL MEDICAID AND MEDICARE IMPACT ON PROVIDERS AND BENEFICIARIES	\$48,415 to \$52,527	\$46,257 to \$50,370
ADDITIONAL IMPACT FROM RESTRUCTURING MEDICARE	\$2,456	\$3,800

PROJECTED NEW YORK STATE JOB LOSS IN 2002:	256,600
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MEDICAID NOTES:

The provider specific impact is estimated by allocating the statewide loss to each provider sector based on its share of federal Medicaid funds. Under the Senate proposal, the disproportionate share and the non-disproportionate share funds are treated separately. The disproportionate share reductions is allocated to acute hospitals and state mental facilities based on its proportional share of disproportionate share payments. The non-disproportionate share Medicaid reduction is allocated to each provider sector based on its share of federal medicaid funds

MEDICARE NOTES:

The analysis of the House and Senate proposals includes estimates of the impacts on hospitals, nursing homes, home health agencies, physicians, durable medical equipment, and clinical laboratory services. The analysis also includes the impact on beneficiaries resulting from changes in part B premiums, increase in deductibles and means testing. The budget cap look-back is based on a 7 year \$30 to \$80 billion recovery requirement and allocated to New York State per its share of provider payments. This analysis does not include: (1) the impact of lower payments to providers resulting from lower utilization and negotiated rates associated with migration of beneficiaries to Medicare managed care, (2) the impact of any changes in the formulation of the AAPCC, including the Senate proposal to carve out GME and disproportionate share costs, and (3) any additional payments teaching hospitals might receive from the House proposal to establish a new trust fund for medical education.

JOB LOSSES:

Job losses are estimated based on the job multiplier developed by the U.S. Department of Commerce. A statewide job multiplier is used for all districts. The job loss estimates are for federal fiscal year (FFY) 2002. The job loss estimates are based on the average impact of Medicare and Medicaid provisions, with a Medicare look-back impact of \$30 billion nationwide.

PROVISIONS INCLUDED IN PROVIDER IMPACT ESTIMATES

Note: The provisions listed below are as of October 9, 1995. Changes are in bold type. The House and Senate are in the process of making amendments and these provisions, and the associated impacts on hospitals, nursing homes, and home health agencies may change.

	HOUSE	SENATE
MEDICAID		
Block Grants	Replaces current Medicaid program with a block grant to each state. Repeals all current eligibility requirements with some spending protection for targeted low-income families, low-income elderly, and low-income disabled persons.	Replaces current Medicaid program with a block grant to each state. Repeals most eligibility requirements with some spending protection for targeted low-income families, low-income elderly, low-income disabled persons, and limited protection to low-income children and pregnant women.
Spending Base	Federal fiscal year (FFY) 1994 total federal Medicaid payments by state.	Greater of the amount of Federal funds received in FFY 1994 or 1995. The DSH payment exceeding 3 percent of total program spending will be excluded from the spending base.
Growth Rate	<p>Nationally: 1994 to 1996: 14.8%</p> <p> 1996 to 1997: 6.8%</p> <p> 1997 to 2002: 4.0% each year</p> <p>Beginning in FFY 1997, payment to each state (which will have a maximum and a minimum) will be determined based on poverty population, case mix index, input cost index, national average spending per resident in poverty. According to this provision New York will only receive the minimum increase of 2 percent per year.</p>	<p>Nationally: 1995 to 1996: 7.25%</p> <p> 1996 to 1997: 6.75%</p> <p> 1997 to 2002: 4.424% each year</p> <p>Beginning in FFY 1997, payment to each state (which will have a maximum and a minimum) will be determined based on poverty population, case mix index, input cost index, national average spending per resident in poverty. According to this provision New York will only receive the minimum increase of 2 percent per year.</p>
Disproportionate Share Payment (DSH)	DSH is included in the base and its growth is limited to overall growth as stated above.	DSH is included in the base (at a maximum of 9 percent of total program spending) and its growth is limited to the overall growth as stated above. Each state must include in its state plan a description of how it will address the special needs of qualifying DSH hospitals.
Accountability Standards	Repeal of almost all accountability standards. In addition, the Boren amendment is repealed.	Repeal of almost all accountability standards. In addition, the Boren amendment is repealed.
Maintenance of Effort	The state must match federal funds using the lower of the state share calculated based on the current FMAP or the proposed new FMAP. This will decrease New York State's matching funds contribution from 50% to 40%.	State must match the federal Medicaid funds. State's matching requirement may be lowered to 40% from the current 50%.
MEDICARE		
HOSPITALS		
PPS Update Reductions	Marketbasket minus 2.5 for 1996, marketbasket minus 2.0 for 1997 - 2002; sole community hospitals: marketbasket minus 1 for 1996 - 2000.	Marketbasket minus 2.5 for 1996 - 2002.
PPS Disproportionate Share	17% reduction in DSH payments for FY1996 15% in FY1997, 20% in FY 1998-1999, 25% in FY2000, and 30% in FY2001 and beyond	5% reduction each year to 25% in 2000 and thereafter.
PPS Indirect Medical Education	Reduce factor to 6.0% for FY 1996 thru FY 2000, and to 5.6% for FY 2001 and beyond	Reduce factor to 6.7% in 1996, 5.6% in 1997, and 4.5% in 1998 and thereafter.

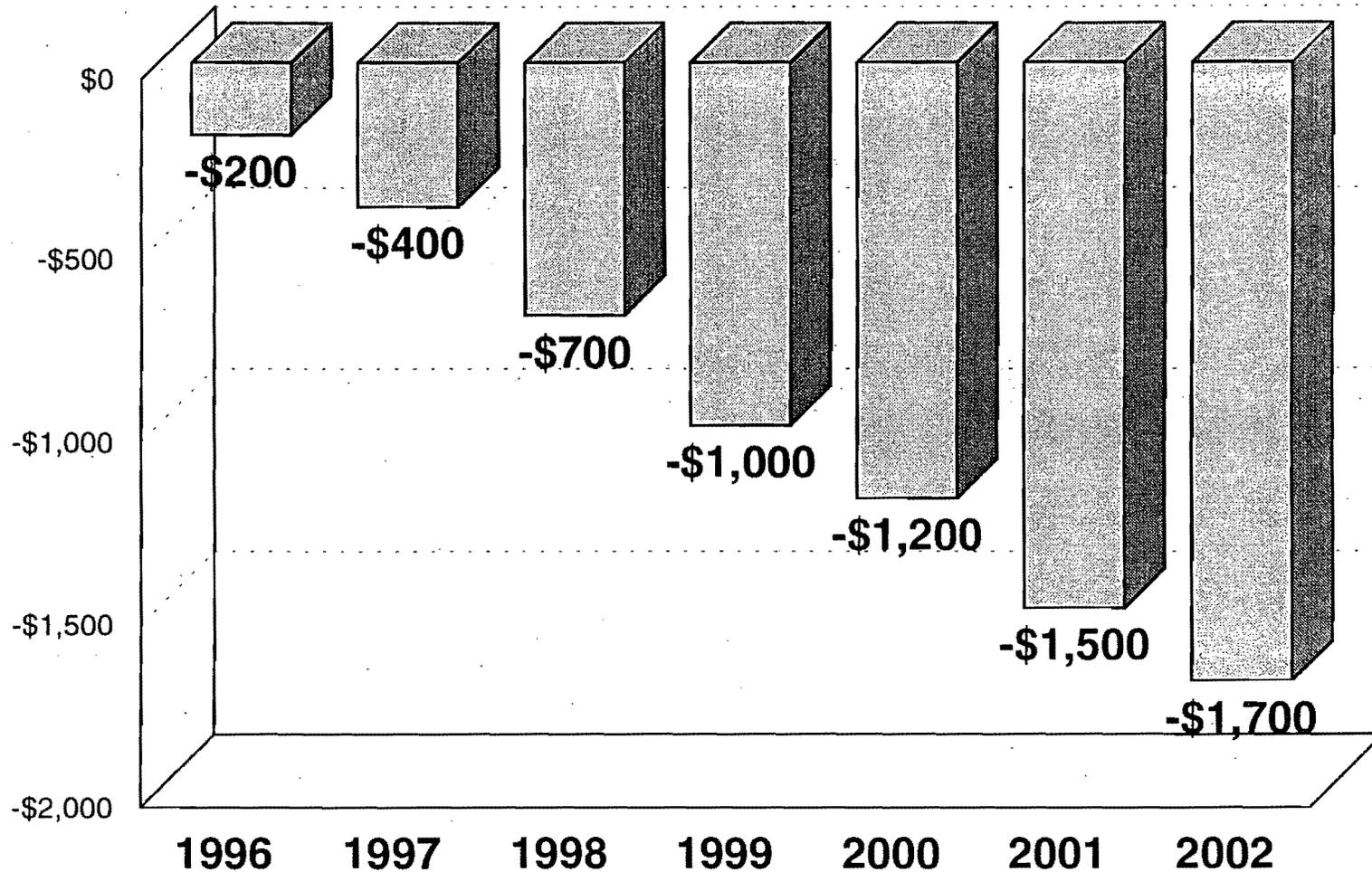
PROVISIONS INCLUDED IN PROVIDER IMPACT ESTIMATES

Note: The provisions listed below are as of October 9, 1995. Changes are in bold type. The House and Senate are in the process of making amendments and these provisions, and the associated impacts on hospitals, nursing homes, and home health agencies may change.

	HOUSE	SENATE
	MEDICARE continued	
HOSPITALS continued		
Direct Medical Education	Phase out payments for non-citizen residents over 4 years - 25% per year beginning in 1996. Exclusion of residents past their initial residency period.	No reductions.
PPS Hospital Capital	Limit payments to 85% of allowed costs.	Limit payments to 85% of allowed costs and reduce federal and hospital-specific rates.
PPS Exempt Hospitals	Extension of marketbasket minus 1%.	Marketbasket minus 2.5 for 1996 - 2002. Limit capital payments to 85% of allowed costs.
Bad Debt	Reduce payments for bad debt to 75% in 1996, 60% in 1997, and 50% in 1998 and thereafter.	No reductions.
Outpatient	Correct formula driven overpayment. Extend 10% capital reduction. Extend 5.8% reasonable cost reduction.	Correct formula driven overpayment. Increase capital reduction from 10% to 15% 1996 to 2002. Extend 5.8% reasonable cost reduction.
Budget Cap / Lookback	Establish targets for total mandatory Medicare outlays. If spending exceeds targets, reductions are made in subsequent year. Reductions are applied proportionately among all providers of the Medicare program. For purposes of this analysis, the lookback was estimated at \$30 to \$80 billion over the 7-year period.	Establish targets for total mandatory Medicare outlays. If spending exceeds targets, reductions are made in subsequent year. Reductions are applied proportionately among all providers of the Medicare program. For purposes of this analysis, the lookback was estimated at \$30 to \$80 billion over the 7-year period.
NURSING HOMES (Facility-specific estimates not included because of insufficient data to do projections.)		
Cost Limits	Extend OBRA 1993 cost limits through 2002. Include certain "routine ancillary" items and services in room rate; Payments for non-routine services based on lower of blended or facility specific amount.	Extend OBRA 1993 cost limit through 1996. Develop new routine cost limits; Payments for non-routine services based on lower of blended or facility specific amount.
Update Reductions	No reductions.	Update factor for SNF amounts equal to market-basket minus 2.5 percent for 1997 - 2002.
Capital	Nursing Home capital costs reduced by 15%.	Nursing Home capital costs reduced by 15%.
Part B	Reduce cost portion of Part B billings by 5.8% 1996 - 2002.	Reduce cost portion of Part B billings by 5.8% 1996 - 2002.
HOME HEALTH (Agency-specific estimates not included because of insufficient data to do projections.)		
Payments	Establish prospective payment system. Future payments to be based on current level by not allowing inflation that occurred during the freeze. (Extension of cost limits)	Establish prospective payment system. No reductions.

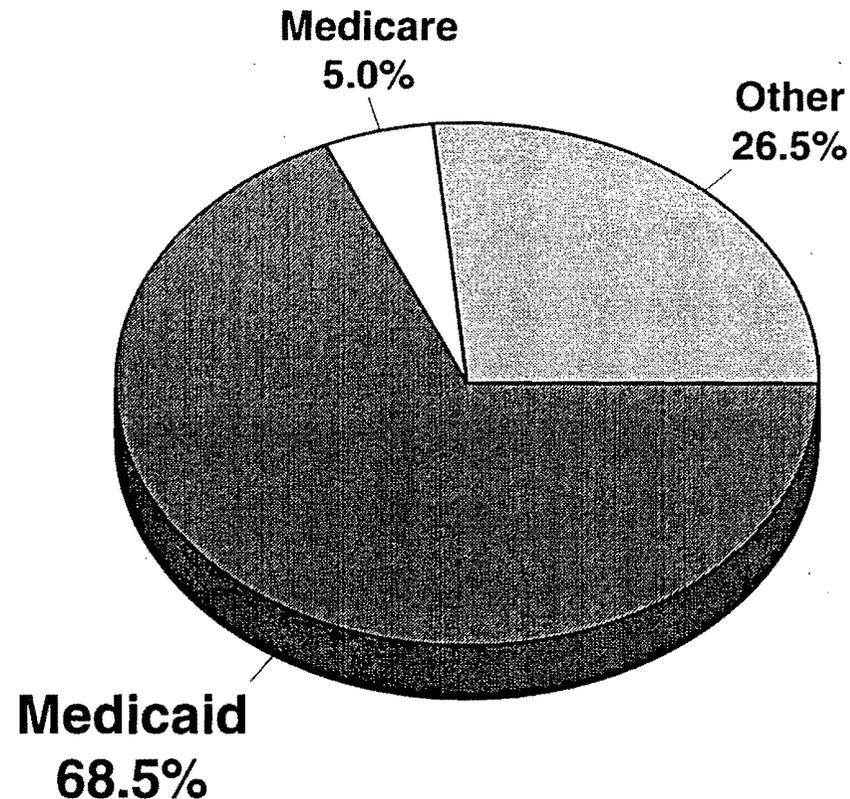
GOP PLAN MEANS \$1,700 LESS FOR SENIORS BY 2002

Reduction in Medicare Spending Per Beneficiary Under the House Capped Plan



Note: Total Medicare spending reductions divided by projected number of beneficiaries; fiscal years
Source: U.S. Department of Health and Human Services, Revised 10/10/95

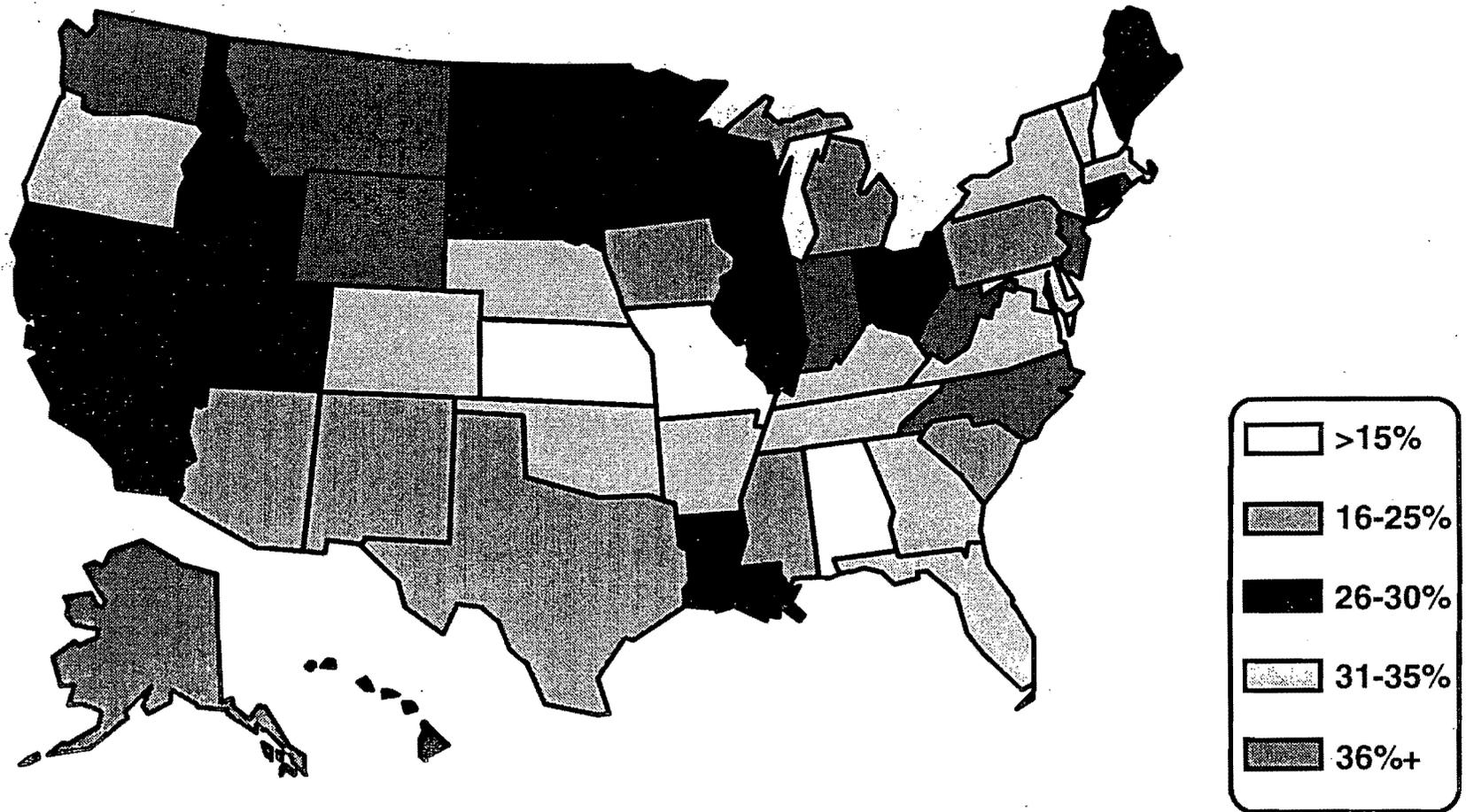
NEARLY 70% OF NURSING HOME RESIDENTS RELY ON MEDICAID TO PAY FOR THEIR CARE



Today, 40 percent of America's seniors will need nursing home care at some point in their lives.

STATES LOSE BIG UNDER REPUBLICAN MEDICAID PLAN

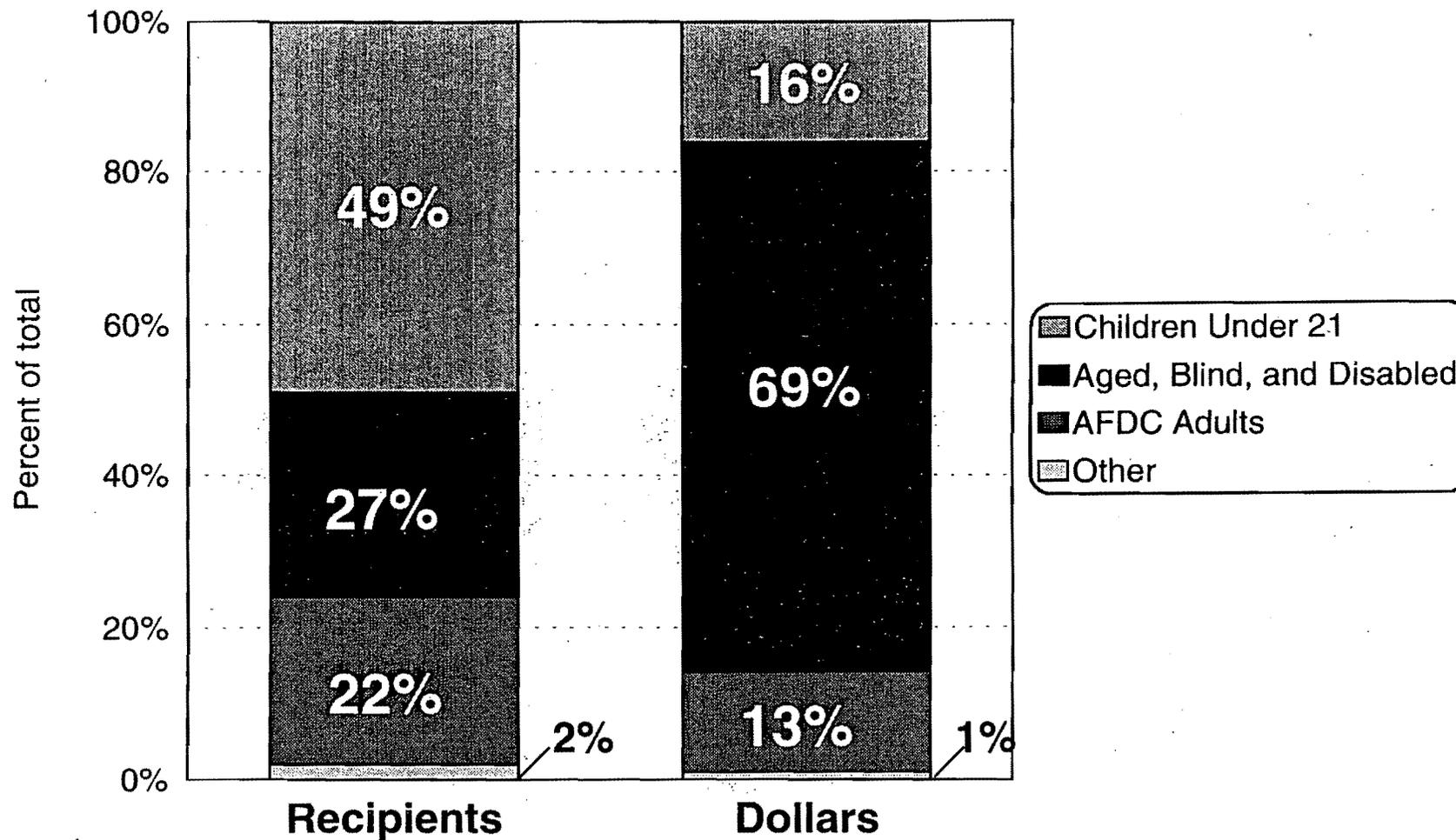
Expected Percentage Loss In Federal Medicaid Spending in 2002 Under House Plan



Source: U.S. Department of Health and Human Services, 10/95

MEDICAID POPULATION AND MEDICAID DOLLARS

Percent Distribution by Basis of Eligibility (Fiscal Year 1993)



Source: U.S. Department of Health and Human Services, 10/95

Medical Records



Department of
Health & Human
Services

FACTSHEET

Health Care
Financing
Administration

MEDICARE

January 1995

The Medicare program helps to pay for health care services furnished to people 65 and over and for persons receiving Social Security disability benefits after two years. Also served by Medicare are individuals of any age who have end-stage renal (kidney) disease (ESRD) and need dialysis or kidney transplants. Medicare currently covers more than 37 million people, of whom approximately four million are disabled under Social Security and approximately 230,000 are ESRD patients. The Medicare program has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

HOSPITAL INSURANCE (Part A)

What's Covered?

- o Inpatient hospital services, including room, meals, nursing care, operating room services, blood transfusions, special care units, drugs and medical supplies, laboratory tests, therapeutic rehabilitation services, and medical social services.
- o Skilled nursing facility care for continued treatment and/or rehabilitation following hospitalization.
- o Home health care services prescribed by a physician for treatment and/or rehabilitation of homebound patients, including part-time or intermittent nursing services.
- o Hospice care for the terminally ill.

What's not covered?

- o Long-term or custodial care.
- o Personal convenience services such as televisions and telephones, private-duty nurses or the extra costs of private rooms when not medically necessary.

Paying the Bills

- o For the first 60 days of inpatient hospital care in calendar year 1995, Medicare pays all approved charges except for a \$716 deductible for which the beneficiary is responsible.
- o For days 61 through 90, Medicare pays for all covered services except for \$179 per day coinsurance payments for which the patient is responsible.
- o From the 91st through the 150th day, the beneficiary coinsurance rate is \$358 a day, but coverage beyond 90 days in any benefit period is limited to the number of lifetime reserve days available.
- o Each beneficiary has 60 lifetime reserve days that can be used only once. If a beneficiary has been out of a hospital or skilled nursing facility for 60 consecutive days, but is then readmitted to a hospital, a new benefit period begins and the beneficiary is again responsible for a \$716 deductible for the first 60 days of inpatient care and coinsurance for days 60-90.
- o If services of a skilled nursing facility are needed for continued care of a patient after at least three consecutive days of hospital inpatient care, not including the day of discharge, Medicare will pay for all covered services for the first 20 days. From the 21st through the 100th day, the beneficiary is responsible for paying \$89.50 a day in 1994. Medicare does not pay for skilled nursing facility care beyond 100 days in each benefit period.
- o If a person is homebound and requires skilled care, Medicare can pay for medically necessary home health care, including part-time or intermittent nursing care, physical therapy, speech therapy, occupational therapy, medical social services, and medical supplies and equipment.
- o For terminally ill patients, Medicare will pay for care from a Medicare-certified hospice, where the specialized care includes pain relief, symptom management and supportive services in lieu of curative services.

Financing Hospital Insurance

The Hospital Insurance Trust Fund is financed mainly from a portion of the Social Security payroll tax (the FICA deduction). The Medicare part of the payroll tax is 1.45 percent from the employee and 1.45 percent from the employer.

MEDICAL INSURANCE (PART B)

Coverage

Medical Insurance helps to pay for physician services, outpatient hospital services (including emergency room visits when the patient is treated and released), outpatient surgery, diagnostic tests, clinical laboratory services, outpatient physical therapy and speech therapy services, medical equipment and supplies, rural health clinic services, renal dialysis and a variety of other health services and supplies.

- o **Generally, Medical Insurance does not cover routine physical examinations, preventive care, services not related to treatment of illness or injury, and outpatient prescription drugs to be self-administered.**
- o **Screening pap smear and mammography examinations are exceptions to the rule against Medicare coverage of routine physical examinations. Medicare covers screening pap smear tests at intervals of three years for detection of cervical cancer, or more frequently for women at high risk of developing cervical cancer. Medicare also covers screening mammography examinations every two years for women 65 and over; annually for women age 50 to 65; annually for women age 40 to 50 at high risk of developing breast cancer; every two years for women age 40 to 50 who are not at high risk; and one time for women 35 to 40.**

Paying the Bills

Medicare pays 80 percent of fee schedule amounts for most covered services after a beneficiary's payments for services have reached the annual deductible of \$100. After meeting the deductible, beneficiaries can limit their out-of-pocket costs to the 20 percent coinsurance amount by choosing physicians and suppliers who accept Medicare assignment, which means they accept Medicare fee schedule amounts as full payment for their services.

- o **"Participating" physicians and suppliers agree to accept Medicare assignment in all cases. Directories listing participating physicians and suppliers are available for examination in local Social Security offices, state and local offices on aging, and senior citizens organizations. Copies can be obtained from Medicare carriers.**
- o **Physicians who do not accept assignment can charge up to 15 percent above the Medicare fee schedule amounts, and beneficiaries are responsible for the difference. Physicians who overcharge beneficiaries can be required to make refunds.**

Funding Medical Insurance

Persons enrolled in Medicare Part B pay a monthly premium. The premium established by Congress for calendar year 1995 is \$46.10. The general tax revenues of the federal government support approximately 75 percent of the program costs.

MANAGED CARE

Medicare beneficiaries may have lower out-of-pocket costs and added coverage if they choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service arrangements. Most Medicare beneficiaries live in areas served by prepaid plans. Medicare contracts with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide care to Medicare beneficiaries. Medicare prepays a fixed amount per member, per month for all Medicare-covered benefits. Many organizations offer additional benefits not covered by Medicare.

ENROLLMENT AND CLAIMS

Enrollments in Medicare are handled by the Social Security Administration. Claims for payments for services to beneficiaries are processed by insurance companies under contract with HCFA.

Appeal procedures are available for persons whose claims have been denied or who are dissatisfied with the amount paid.

Contractors known as fiscal intermediaries make payments for services provided by hospitals, skilled nursing facilities, home health agencies and hospices. Generally, payments made for inpatient hospital stays are based on the diagnoses of patients' illnesses. Claims for the services of physicians, other medical professionals and suppliers are processed by contractors known as carriers.

QUALITY OF CARE

Surveys and Certification

The Health Care Financing Administration maintains an extensive survey and certification program to ensure that providers and suppliers serving Medicare and Medicaid beneficiaries are complying with federal standards for health, safety, and quality of care. HCFA oversees annual, unannounced inspections of approximately 16,500 nursing homes and 8,000 home health agencies. The agency's quality assurance activities also cover approximately 6,500 hospitals and 145,000 clinical laboratories. Providers and suppliers that are not in compliance and fail to correct deficiencies are dropped from the Medicare and Medicaid programs.

MEDICAID PRIMER

The Republican Budget Resolution calls for a cut of \$182 billion in Federal funding of Medicaid over the next 7 years. If enacted, this would be far and away the largest budget cut in the program's 30-year history.

In addition, the Republican Governors have proposed that Medicaid be converted from a program that guarantees basic health and long-term care coverage to low-income Americans into a block grant to the States. If enacted, this would be the most radical structural change in Medicaid in its 30-year history.

Medicaid is the Federal government's second largest health care program. This year, it will spend \$89 billion to help the States pay for hospital, physician, and nursing home care for over 36 million Americans.

The changes that the Republicans are proposing will, if enacted, have enormous implications not just for Medicaid's 36 million beneficiaries, but also for States, counties, and emergency care systems in every community, as well as individual hospitals, nursing homes, and clinics in both rural and urban communities.

Unfortunately, the Republicans have not yet made public their legislation to implement the \$182 billion in Federal Medicaid cuts, and no specific language is likely to be available until later this month, when House and Senate committees of jurisdiction (House Commerce, Senate Finance) are scheduled to take action.

Attached is some basic background material:

- A brief summary of Medicaid, who gets it, and what they get.
- A short explanation of why Medicaid costs are growing.
- A summary of the state-by-state impact of the Republican Medicaid budget cuts.

MEDICAID AT A GLANCE

- **Medicaid is America's 2nd largest health care program (after Medicare).**
 - This year, Medicaid will cover over 36 million low-income Americans, including over 18 million kids. (Medicare will cover 37 million elderly and disabled Americans).
 - This year, the Federal government will spend about \$89 billion on Medicaid, the States another \$67 billion. (The Federal government will spend \$181 billion on Medicare this year).

- **Three basic groups of people get Medicaid: the elderly, the disabled, and mothers and children.**
 - Over 4 million Americans age 65 and over are eligible for Medicaid this year.
 - About 6 million disabled Americans are eligible for Medicaid this year.
 - Over 18 million children and over 7 million women are eligible for Medicaid this year.

- **Most of Medicaid spending is for health and long-term care for the elderly and disabled.**
 - The elderly and disabled represent about 27 percent of the Medicaid population but account for about 67 percent of Medicaid spending.
 - Children account for about 50 percent of the Medicaid population but only about 18 percent of Medicaid spending.
 - This year, the Federal government will spend about \$800 per child, \$1300 per mother, \$4700 per disabled individual, and \$5600 per elderly American eligible for Medicaid.

- **Medicaid covers about one fourth of America's children.**
 - Of the 69 million children under 18 in America, about one fourth are currently covered by Medicaid.
 - By the year 2001, under current law, Medicaid will finish phasing in coverage of all children under 18 in families with incomes below poverty.

- **Medicaid is America's largest insurer of maternity care.**

- Medicaid pays for about 1/3 of the births in the country, including prenatal, delivery, and post-partum care.

- **Without Medicaid, millions more Americans would be uninsured.**

- For those eligible, Medicaid guarantees coverage for basic health care services, like hospital and physician care.

- There are now about 39 million uninsured Americans. Without the expansions in Medicaid coverage for pregnant women and children that occurred over the last decade, there would have been 9 million more uninsured Americans in 1994.

- **Medicaid is America's largest insurer of long-term care.**

- Medicaid pays for about half of all the nursing home care provided in this country (\$36 billion out of \$69 billion in 1993).

- Of the 1.3 million nursing home residents nationwide, about 900,000, or 69 percent, are covered by Medicaid.

- **People eligible for Medicaid get coverage for basic health and long-term care services.**

- All Americans who qualify for Medicaid coverage must have incomes and resources (i.e., savings and other assets) below certain levels. In general, these levels are specified by each State.

- All Medicaid eligibles are guaranteed coverage for the following basic services, when medically necessary: hospital care; physician services; laboratory and x-ray services; immunizations and other preventive screening, diagnostic, and treatment services for children; family planning services; health center services, and nursing home care.

- Many States have elected to cover additional services with help from Federal matching funds, including prescription drugs, institutional care for individuals with mental retardation, and home- and community-based care for the frail elderly.

- Of all the Medicaid dollars that States spend on benefits, only 38 percent are spent on required services for populations the States must cover; the remaining 62 percent are spent on services and populations that the States have chosen to cover with the help of Federal matching payments.

- **The number of Americans eligible for Medicaid is growing**

- The Congressional Budget Office projects that the number of Americans eligible for Medicaid will grow at about 3 percent per year over the next seven years, from 36.8 million in FY 1995 to 45.9 million in FY 2002.

- Among the groups eligible for Medicaid -- mothers and children, elderly, and the disabled -- the fastest growth is projected among the disabled.

- **Medicaid is a critical revenue source for teaching hospitals, public hospitals, children's hospitals, and community health centers**

- Over one fourth of all inpatients in the nation's teaching hospitals are covered by Medicaid

- Medicaid accounts for about 46 percent of the net revenues of the nation's public hospitals

- Medicaid represents about 42 percent of the gross revenues of the nation's children's hospitals

- About one third of all community and migrant health center revenues come from Medicaid patients

- **Medicaid is a joint venture between the Federal and State governments, with the Federal government picking up 57 percent of the cost overall.**

- Under current law, the Federal government shares in the State costs of health and long-term care for low-income residents according to a matching formula. The Federal share varies with State per capita income; the lower the State's per capita income, the higher the Federal share.

- All States get at least 50 percent of their costs covered by the Federal government; some States have as much as 80 percent of their costs covered. On average, the Federal government's share is 57 percent.

- **Medicaid is the largest source of Federal funds for the States and the second largest item in most State budgets**

- Federal Medicaid funds account for about 40 percent of all Federal dollars flowing to the States through grant-in-aid programs

- State spending on Medicaid accounted for about 13 percent of all State general revenue spending in 1993, second only to spending on elementary and secondary education (21 percent).

- **If you've seen one Medicaid program, you've seen one Medicaid program.**

-- There are certain minimum Federal standards, but States have broad discretion in how they administer the program. This means wide variation from State to State in who gets covered, what types of services are covered, how much providers are paid for those services, etc.

WHY ARE FEDERAL MEDICAID COSTS GROWING?

- **The Congressional Budget Office (CBO) estimates that Federal Medicaid spending will increase about 10 percent annually over the next 7 years .**
 - Federal Medicaid spending is expected to grow from \$89 billion in FY 1995 to \$178 billion in FY 2002.
 - State spending on Medicaid is expected to grow from \$67 billion in FY 1995 to \$134 billion in FY 2002.
- **According to CBO, most -- 70 percent -- of the growth in Federal Medicaid spending is caused by an increase in the number of Americans eligible for coverage and inflation in the price of the services that Medicaid buys.**
 - Increases in the number of Americans eligible for coverage account for about 40 percent of Medicaid spending growth.
 - Inflation in the price of the hospital, physician, nursing home, and other services that Medicaid covers accounts for about 30 percent.
 - Increases in payments to disproportionate share (DSH) hospitals that treat large numbers of Medicaid and low-income patients accounts for only 4 percent.
 - All other factors, including the rate at which beneficiaries use services and what optional care States cover, explain the remaining 25 percent of spending growth.
- **Cutting Federal Medicaid spending by \$182 billion over the next 7 years will force States to cut back on eligibility and services.**
 - According to preliminary CBO estimates, widespread use of managed care by the States will only save the Federal government about \$2.5 billion in Medicaid spending over the next 7 years, and repeal of the "Boren" requirements for "reasonable and adequate" payments to hospitals and nursing homes will only save the Federal government about \$2.4 billion over the next 7 years.
 - In short, program efficiencies will only bring about \$5 billion of the \$182 billion in Federal savings that the Republicans are trying to achieve in Medicaid. The rest will have to come from reducing Federal matching payments to the States.
 - The States will have only two options: increase their own spending to make up the shortfall in Federal funds, or cut back on eligibility and benefits.

Republican Medicaid Cut

(Federal Dollars in Billions)

Fiscal Year	Current Services Baseline	Republican Budget	Size of Cut	Percentage Cut
1996	\$99.3	\$95.7	\$3.6	3.6%
1997	\$110.0	\$102.1	\$7.9	7.2%
1998	\$122.1	\$106.2	\$15.9	13.0%
1999	\$134.8	\$110.5	\$24.3	18.0%
2000	\$148.1	\$114.9	\$33.2	22.4%
2001	\$162.6	\$119.5	\$43.1	26.5%
2002	\$177.8	\$124.3	\$53.5	30.1%

Table 3

Projected Changes in Federal Medicaid Expenditures, 1996-2002

Budget Resolution Block Grant Proposal

(millions of dollars)

	1996-2002				2002			
	Baseline	Expend.	New Change	%Change	Baseline	Expend.	New Change	%Change
Total	954,338	782,535	(171,803)	-18.0%	176,931	125,781	(51,150)	-28.9%
Alabama	13,823	12,090	(1,733)	-12.5%	2,485	1,943	(542)	-21.8%
Alaska	2,001	1,572	(429)	-21.4%	373	253	(121)	-32.3%
Arizona	12,903	10,231	(2,672)	-20.7%	2,436	1,644	(792)	-32.5%
Arkansas	11,081	8,636	(2,444)	-22.1%	2,084	1,388	(696)	-33.4%
California	95,663	77,631	(18,032)	-18.8%	17,955	12,478	(5,477)	-30.5%
Colorado	8,163	6,509	(1,654)	-20.3%	1,521	1,046	(475)	-31.2%
Connecticut	12,990	11,567	(1,423)	-11.0%	2,345	1,859	(486)	-20.7%
Delaware	1,728	1,397	(331)	-19.1%	323	225	(98)	-30.5%
District of Columbia	4,511	3,648	(863)	-19.1%	846	586	(259)	-30.7%
Florida	40,720	31,029	(9,691)	-23.8%	7,691	4,987	(2,704)	-35.2%
Georgia	26,050	19,957	(6,093)	-23.4%	4,900	3,208	(1,692)	-34.5%
Hawaii	2,732	2,160	(572)	-20.9%	508	347	(161)	-31.7%
Idaho	2,933	2,391	(542)	-18.5%	545	384	(160)	-29.4%
Illinois	33,242	27,123	(6,120)	-18.4%	6,207	4,360	(1,847)	-29.8%
Indiana	23,100	18,831	(4,269)	-18.5%	4,317	3,027	(1,290)	-29.9%
Iowa	7,807	6,572	(1,235)	-15.8%	1,440	1,056	(384)	-26.6%
Kansas	5,962	5,298	(663)	-11.1%	1,079	852	(226)	-21.1%
Kentucky	18,353	14,525	(3,828)	-20.9%	3,455	2,335	(1,121)	-32.4%
Louisiana	33,991	28,840	(5,151)	-15.2%	6,147	4,636	(1,511)	-24.6%
Maine	5,999	5,324	(675)	-11.3%	1,092	856	(236)	-21.6%
Maryland	13,478	10,776	(2,702)	-20.0%	2,532	1,732	(800)	-31.6%
Massachusetts	25,516	21,225	(4,291)	-16.8%	4,717	3,412	(1,305)	-27.7%
Michigan	32,153	26,218	(5,935)	-18.5%	5,992	4,214	(1,778)	-29.7%
Minnesota	14,665	12,531	(2,134)	-14.6%	2,701	2,014	(687)	-25.4%
Mississippi	12,640	10,183	(2,457)	-19.4%	2,342	1,637	(705)	-30.1%
Missouri	14,871	13,636	(1,235)	-8.3%	2,625	2,192	(433)	-16.5%
Montana	3,409	2,644	(766)	-22.5%	636	425	(211)	-33.2%
Nebraska	4,448	3,720	(728)	-16.4%	822	598	(224)	-27.3%
Nevada	2,899	2,383	(516)	-17.8%	540	383	(157)	-29.0%
New Hampshire	3,728	3,678	(51)	-1.4%	631	591	(40)	-6.3%
New Jersey	28,038	24,337	(3,701)	-13.2%	5,100	3,912	(1,188)	-23.3%
New Mexico	6,066	4,714	(1,352)	-22.3%	1,147	758	(389)	-33.9%
New York	119,527	100,604	(18,924)	-15.8%	22,034	16,171	(5,863)	-26.6%
North Carolina	29,014	22,250	(6,764)	-23.3%	5,406	3,576	(1,830)	-33.8%
North Dakota	2,491	2,109	(382)	-15.4%	457	339	(118)	-25.8%
Ohio	40,586	33,498	(7,088)	-17.5%	7,508	5,384	(2,124)	-28.3%
Oklahoma	11,074	8,824	(2,250)	-20.3%	2,060	1,418	(642)	-31.2%
Oregon	8,884	7,046	(1,838)	-20.7%	1,649	1,133	(516)	-31.3%
Pennsylvania	38,448	32,325	(6,123)	-15.9%	7,102	5,196	(1,906)	-26.8%
Rhode Island	5,465	4,604	(861)	-15.8%	1,004	740	(264)	-26.3%
South Carolina	15,252	12,971	(2,281)	-15.0%	2,756	2,085	(672)	-24.4%
South Dakota	2,380	1,985	(396)	-16.6%	442	319	(123)	-27.8%
Tennessee	24,576	19,487	(5,090)	-20.7%	4,587	3,132	(1,455)	-31.7%
Texas	61,167	50,032	(11,135)	-18.2%	11,358	8,042	(3,316)	-29.2%
Utah	5,128	4,093	(1,035)	-20.2%	960	658	(302)	-31.5%
Vermont	1,982	1,665	(318)	-16.0%	366	268	(99)	-27.0%
Virginia	13,022	10,179	(2,844)	-21.8%	2,434	1,636	(798)	-32.8%
Washington	18,203	14,484	(3,719)	-20.4%	3,381	2,328	(1,053)	-31.1%
West Virginia	13,723	10,403	(3,321)	-24.2%	2,591	1,672	(919)	-35.5%
Wisconsin	16,484	13,581	(2,903)	-17.6%	3,066	2,183	(883)	-28.8%
Wyoming	1,269	1,024	(245)	-19.3%	236	165	(72)	-30.3%

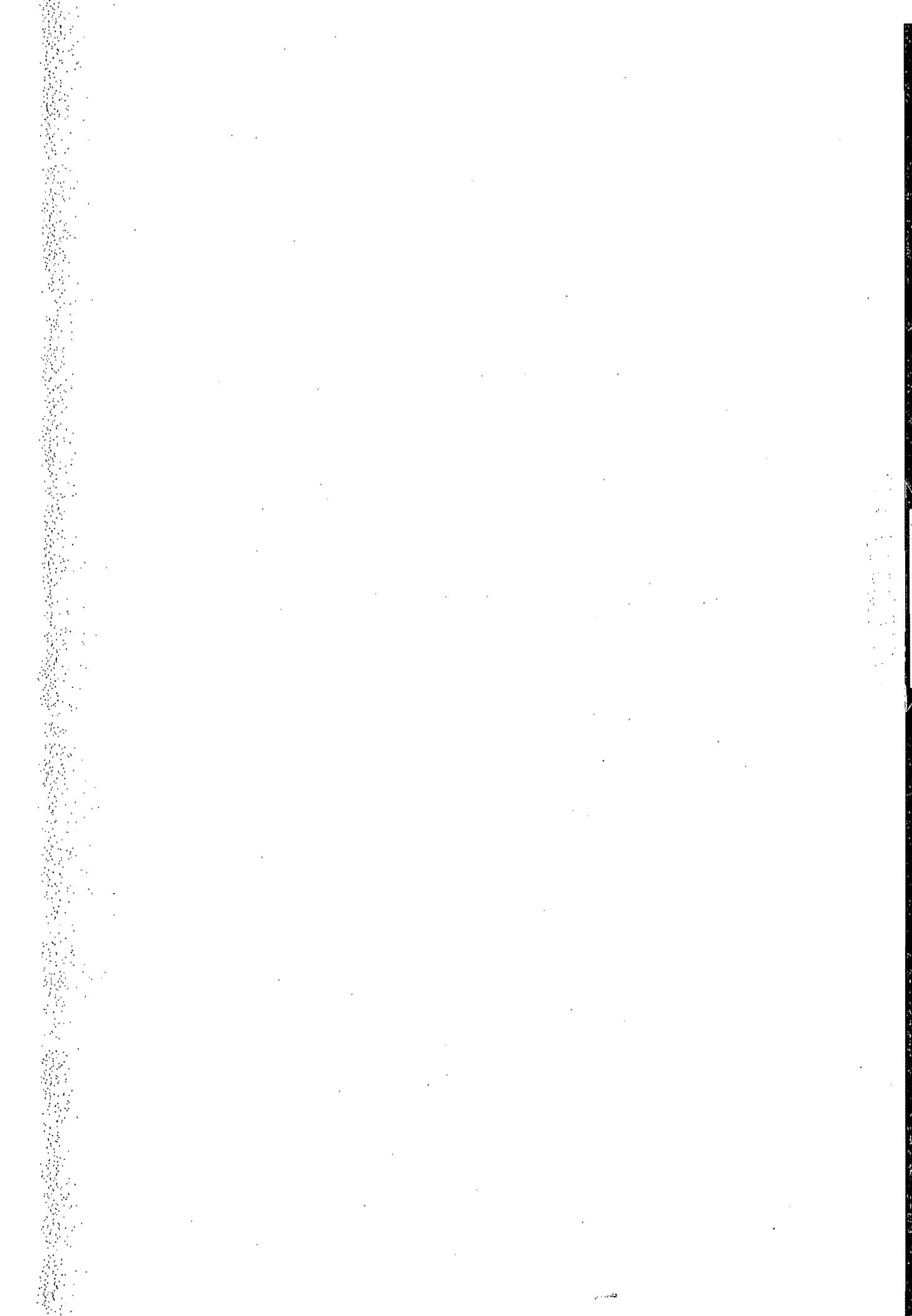
SOURCE: The Urban Institute Medicaid Expenditure Growth Model, 1995

Table 5
Projected Changes in Covered Medicaid Beneficiaries, 2002
Budget Resolution Block Grant Proposal
Expenditure per Beneficiary Growth Held to Inflation Beginning 1996

State	Baseline	With Cap	% Change	Reduction By Group			
				Aged	Disabled	Families	Total
Total	45,663,533	41,873,892	-8.3%	(407,965)	(599,850)	(2,733,904)	(3,789,641)
Alabama	737,918	722,368	-2.1%	(1,876)	(3,872)	(9,802)	(15,550)
Alaska	97,306	85,296	-12.3%	(622)	(1,037)	(10,350)	(12,010)
Arizona	568,256	520,334	-8.4%	n/a*	n/a*	n/a*	(47,922)
Arkansas	514,584	445,989	-13.3%	(9,075)	(16,367)	(43,153)	(68,595)
California	6,525,073	6,098,663	-6.5%	(34,962)	(53,660)	(337,788)	(426,410)
Colorado	422,676	369,576	-12.6%	(5,832)	(9,148)	(38,120)	(53,099)
Connecticut	453,199	430,937	-4.9%	(2,245)	(3,709)	(16,309)	(22,262)
Delaware	98,028	87,045	-11.2%	(741)	(1,634)	(8,607)	(10,982)
District of Columbia	142,580	138,969	-2.5%	(268)	(783)	(2,561)	(3,611)
Florida	2,796,542	2,375,959	-15.0%	(47,007)	(56,551)	(317,025)	(420,583)
Georgia	1,519,989	1,292,346	-15.0%	(24,480)	(38,012)	(165,151)	(227,643)
Hawaii	161,525	142,181	-12.0%	(1,807)	(2,952)	(14,585)	(19,344)
Idaho	150,705	132,501	-12.1%	(1,633)	(2,956)	(13,615)	(18,204)
Illinois	1,737,408	1,663,192	-4.3%	(5,964)	(15,128)	(53,124)	(74,216)
Indiana	704,941	673,416	-4.5%	(3,308)	(4,891)	(23,326)	(31,525)
Iowa	380,793	353,820	-7.1%	(3,371)	(4,528)	(19,074)	(26,973)
Kansas	315,649	313,413	-0.7%	(239)	(329)	(1,567)	(2,136)
Kentucky	856,134	778,103	-9.1%	(8,060)	(19,654)	(50,318)	(78,031)
Louisiana	1,081,591	1,053,725	-2.6%	(2,996)	(4,836)	(20,034)	(27,866)
Maine	227,286	219,113	-3.6%	(1,017)	(1,704)	(5,452)	(8,173)
Maryland	591,654	540,586	-8.6%	(4,660)	(9,789)	(36,619)	(51,068)
Massachusetts	1,054,057	959,326	-9.0%	(10,869)	(19,687)	(64,176)	(94,732)
Michigan	1,432,950	1,384,618	-3.4%	(3,432)	(9,549)	(35,350)	(48,332)
Minnesota	531,194	503,891	-5.1%	(3,525)	(3,776)	(20,002)	(27,303)
Mississippi	706,300	642,511	-9.0%	(8,223)	(13,545)	(42,021)	(63,789)
Missouri	822,420	822,420	0.0%	-	-	-	-
Montana	111,338	96,081	-13.7%	(1,693)	(3,172)	(10,391)	(15,256)
Nebraska	217,171	199,988	-7.9%	(1,946)	(2,293)	(12,945)	(17,183)
Nevada	132,513	121,115	-8.6%	(1,262)	(1,807)	(8,331)	(11,399)
New Hampshire	108,264	108,264	0.0%	-	-	-	-
New Jersey	1,082,880	1,042,153	-3.8%	(3,758)	(7,128)	(29,840)	(40,726)
New Mexico	355,684	312,840	-12.0%	(4,264)	(9,104)	(29,476)	(42,844)
New York	3,576,932	3,332,205	-6.8%	(25,190)	(38,085)	(181,452)	(244,727)
North Carolina	1,575,219	1,272,583	-19.2%	(52,660)	(42,493)	(207,484)	(302,636)
North Dakota	88,124	80,221	-9.0%	(1,197)	(1,040)	(5,666)	(7,903)
Ohio	1,854,988	1,776,238	-4.2%	(8,687)	(13,499)	(56,563)	(78,750)
Oklahoma	549,455	482,760	-12.1%	(7,512)	(8,770)	(50,413)	(66,695)
Oregon	497,541	430,931	-13.4%	(5,008)	(8,649)	(52,953)	(66,610)
Pennsylvania	1,612,660	1,482,438	-8.1%	(13,337)	(28,435)	(88,450)	(130,222)
Rhode Island	261,101	238,665	-8.6%	(3,445)	(4,899)	(14,092)	(22,436)
South Carolina	752,963	686,925	-8.8%	(9,456)	(10,988)	(45,594)	(66,038)
South Dakota	96,529	88,247	-8.6%	(988)	(1,463)	(5,831)	(8,282)
Tennessee	1,265,375	1,158,750	-8.4%	(12,053)	(26,449)	(68,122)	(106,625)
Texas	3,545,644	3,249,092	-8.4%	(28,828)	(29,566)	(238,158)	(296,552)
Utah	226,308	196,722	-13.1%	(1,786)	(3,474)	(24,325)	(29,586)
Vermont	107,648	99,514	-7.6%	(973)	(1,417)	(5,744)	(8,134)
Virginia	929,016	787,708	-15.2%	(19,395)	(21,806)	(100,107)	(141,308)
Washington	886,075	799,188	-9.8%	(6,146)	(14,001)	(66,740)	(86,887)
West Virginia	548,958	465,238	-15.3%	(7,933)	(15,661)	(60,124)	(83,719)
Wisconsin	582,023	554,842	-4.7%	(3,716)	(6,676)	(16,788)	(27,180)
Wyoming	68,467	60,884	-11.1%	(519)	(878)	(6,185)	(7,582)

*Arizona data not available by enrollment group.

SOURCE: The Urban Institute Medicaid Expenditure Growth Model, 1995



Commentary

PERSPECTIVE ON MEDICARE

Rehabilitation Needed, Not Surgery



The trust fund's crisis isn't new; the President offered a solution to insolvency.

By ROBERT E. RUBIN, DONNA E. SHALALA, ROBERT B. REICH and SHIRLEY S. CHATER

Our nation is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for \$270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and that all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund, which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an

examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure that the fund has adequate resources, the claim that it is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting President and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The President offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the President proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's trustees report that these members continually cite. The report found that predictions about the solvency of the fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by \$89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2006—11 years from now.

The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed \$270 billion in Medicare cuts

over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the President's plan. But a substantial part of the cuts the Republicans seek—at least \$100 billion—would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of \$1,650 per person or \$3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of \$2,825 per person or \$5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the health care burden on all older and disabled Americans and their families. The President's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren. The President's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term plan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

Robert E. Rubin is secretary of the Treasury. Donna E. Shalala is secretary of health and human services. Robert B. Reich is secretary of labor. Shirley S. Chater is commissioner of Social Security.

Pennsylvania Avenue

By Morton M. Kondracke

GOP Medicare Plan To 'Tax' Workers, New Study Shows

Republicans are claiming public relations successes on Medicare, but a new study indicates that their proposals contain what amounts to a hidden tax of \$1,000 over seven years on every worker with health insurance.

The study, conducted by the respected research firm Lewin-VHI, asserts that if Congress reduces government outlays for Medicare and Medicaid, health care providers will raise fees for private patients, increasing insurance premiums and causing employers to reduce wages.

On average, according to the study, such cost-shifting will reduce employees' anticipated wage increases by 2.7 percent. But low-wage workers are likely to be hit hardest, losing more than 10 percent of the wage hikes they might otherwise have received.

Conducted for the National Leadership Coalition on Health Care, a collection of unions and business groups, the study could provide new ammunition for Democrats to use in trying to prove that GOP Medicare cost reductions are unfair.

Both parties used Congress's August recess to wage war over Medicare, with Democrats arguing that the GOP wants to "cut" the program to finance tax reductions skewed to the wealthy and Republicans claiming that they are trying to "save" Medicare from bankruptcy by reducing its rate of growth.

As Congress returned from recess, Republican National Committee Chairman Haley Barbour claimed, "We are winning the public opinion battle" on Medicare, citing public and private poll results and some favorable press notices.

For example, an Aug. 30 Gallup poll for CNN/USA Today showed that by 61 percent to 34 percent, the public wants Congress to make "major changes in Medicare."

A private poll by Moore Information showed that by 64 to 18 percent, Americans agree that Medicare will go bankrupt in seven years unless "something is done soon to fix it." The poll showed that by 57 to 30 percent, the public trusts Congress to improve Medicare, rather than President Clinton.

According to a Luntz Research poll taken Aug. 24, only 42 percent of voters agree with the Democrats that Republicans want to cut

Medicare "to pay for their tax cut for the rich," while 52 percent disagree.

Republican efforts to control Medicare growth have won favorable comment — some of it grudging — from such disparate sources as the New York Times editorial page, pundits Michael Kinsley and Robert Samuelson, and Robert Reischauer, the former director of the Congressional Budget Office.

Despite the polls and praise, House GOP leaders reportedly anticipate that they will be unable to unveil their Medicare proposal prior to the original Sept. 22 deadline for measures to be included in the House budget reconciliation bill.

Health care lobbyists say they've been told by top GOP strategists that there's still no consensus on how to parcel out the pain of reducing Medicare outlays by \$280 billion over seven years and reducing the rate of Medicare growth from 10 percent per year to 5 percent, the rate of growth in the private sector.

GOP options include cutting payments to hospitals and doctors, increasing co-payments and premiums for recipients, means-testing benefits, capping per-patient outlays, and encouraging patients to join managed-care programs.

Lewin-VHI assumed that the Republicans would try to save \$50 billion over seven years by encouraging managed care, \$20 billion by

Health care lobbyists say they've been told there's still no GOP consensus on how to parcel out the pain of reducing Medicare outlays by \$280 billion over seven years.

making beneficiaries pay more, and \$210 billion by reducing payments to doctors and hospitals. It also assumed that the \$170 billion to be saved from Medicaid would mostly come from reduced payments to providers.

Previous studies have shown that when doctors and hospitals have been hit with government cutbacks in the past, they recovered about 40 percent of the loss by "cost-shifting" — i.e., raising fees for private patients.

If that holds true for the anticipated GOP reductions of \$450 billion, Lewin-VHI expects cost-shifting to come to at least \$91.6 billion and possibly \$99 billion if fewer individuals join managed-care plans than the GOP hopes.

"The increase in provider charges to private payers from the cost shift would be reflected in higher private insurance premiums," the study says. Employers would pay about \$75 billion more in premiums, employees would contribute \$6.4 billion more, and individuals who buy their own insurance would pay about \$10 billion more.

"Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages," the study said. "Lost wages and increased premium contributions... would equal about \$1,000 per covered worker over the 1996 through 2002 period."

Wage losses would be concentrated heaviest in service industries and would hit hardest those making less than \$6 per hour. Cost-shifting also would increase the number of persons without health insurance — currently, 41.2 million — by about 500,000, the study said.

Lewin-VHI does not refer to the cost-shifting attending Medicare and Medicaid reductions as a "tax," but that is what it amounts to, and Democrats would be foolish not to make Republicans pay a political price for proposing it.

GOP's rosy scenario a disaster

Medicare-Medicaid bill is unworkable

Republicans presume to cut Medicare by a rosy scenario. They presume to reform Medicaid by ditching the idea that the federal government should attach strings to the money it ships to states.

President Clinton says it's all quite scary. He's quite right.

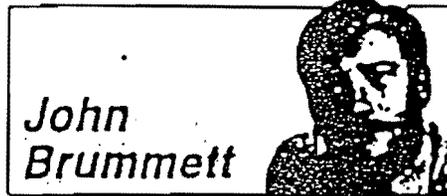
The peace of mind of poor elderly people nationwide may depend on the veto of a man who once in Arkansas vetoed a bill and then unvetoes it. Isn't it remarkable the challenge and opportunity that history can offer a mortal being who happens to cross its path?

The Republicans want to take \$270 billion from projected Medicare spending over the next seven years largely by assuming that 40 percent of old folks can be enticed into joining health maintenance organizations (HMOs). This would be purely voluntary, you understand.

It surely is the Grand Canyon of assumptions.

At the risk of stereotyping, may we stipulate that senior citizens tend to cling to familiarity and certainty in the one service most vital to them—health care—and to be set in their ways about the doctors they see and the procedures they are willing to endure to see those doctors?

Perhaps the wealthiest, healthiest, boldest and most progressive among those over 65 will embrace HMOs as cost-saving measures requiring a smaller contribution. But 40 percent? It'll be more like a handful, I'll wager. How strange that Republicans want to do to millions of old people what they claim to have saved all of us from last year in defeating the Clinton health care reform plan. By that I refer to alternative methods of health insurance that might limit the choice of a physician without a higher premium.



If the Republicans were determined to avail themselves of HMOs as budget-cutting measures, they might have considered them for Medicaid, the program for the poor, rather than for Medicare. Some states have had tentative success by moving Medicaid to managed care systems.

But, no, the Republicans propose to cut \$182 billion over seven years in Medicaid mainly by sending block grants to the states and telling the states to do with the money what they wish in the way of medical aid for the poor.

This Republican concoction that the states know best—that the real virtue lies in states having autonomy over the spending of federally collected money—is a most curious thing.

It assumes, for example, that the poor and the aged in Arkansas are better off if their lives are placed in the hands of the solons of the Arkansas Legislature than in the hands of Congress. I defy anyone to sit through a meeting of the Joint Budget Committee at the state Capitol and declare that view with a straight face.

Let us not forget that if we had left everything to the supposed virtue of the states, slavery might still be a supposedly virtuous practice in a couple of places. There's no need to name names, but the states of the Southeastern Conference somehow come to mind.

In his radio address Saturday, Clinton

transcended his usual moderation to wax positively frightful about all of this.

He explained that the House version contains no provision preserving the current protection against seizure of home, car and furniture from spouses of persons receiving Medicaid to stay in nursing homes. Whether to do that would be left to the virtues of Alabamans, Arkansans, Montanans, Californians and all the rest.

House Speaker Newt Gingrich says Democrats are morally bankrupt to fight budget cuts by scaring old people by raising such issues. As usual Newt's rhetoric is unacceptably overheated. Once again his view of morality is confused.

Budget cutting carries moral currency because it shows a responsibility to future generations. But suggesting that the federal government impose itself on the states to assure a safety net for old people in nursing homes is hardly the stuff of moral bankruptcy.

Memo to Newt: Caring for the sick has biblical precedent.

Gingrich seems to provide yet another example of the Republican preference for those unborn over those actually living and encountering inevitable misfortune.

If Gingrich means to say that Clinton and the Democrats are morally bankrupt to oppose budget cuts, I would cite the fact that Clinton and the Democrats already have cut nearly in half the federal budget deficit exceeding \$300 billion that they inherited.

Clinton vows a veto of the Medicare-Medicaid bill as written by the Republicans, largely in secret. If he's immoral, and I'm not passing any judgments, it would have to be on some other basis.

John Brummett's column appears every Tuesday, Thursday, Saturday and Sunday.

Retiree Group Plans Public Campaign In Opposition to GOP Cuts in Medicare

By CHRISTOPHER GEORGES

Staff Reporter of THE WALL STREET JOURNAL
WASHINGTON — In a sign of intensifying opposition to GOP health-care proposals, the American Association of Retired Persons is launching a public campaign this week to oppose cuts in the Medicare program.

"We're going public much more aggressively than we have been," said John Rother, the AARP's chief lobbyist. He declined to provide specific details of the campaign but said it will include advertisements and direct-mail messages to the group's members.

Until recently, the AARP and other groups affected by the proposed changes, including major doctor and hospital organizations, have been remarkably silent. That's partly because the Republican leadership has offered them "sweeteners"—legislative provisions they favor — if they remain silent and has threatened retribution if they go public with their opposition. It's also because, until recently, the groups haven't had a specific GOP proposal to attack.

Is Tide Turning?

But that may now be changing. Lawmakers have come under increasing pressure in recent weeks from hospitals and other health-care providers, staff members report. And recent public-opinion polls suggest the public, as well, may be souring some on the GOP Congress, in part because of its Medicare plans.

Neither the AARP nor the other groups involved expect to stop Medicare changes from being enacted. But they do hope to lessen the blow. The GOP plans call for cutting projected spending by \$270 billion over the next seven years. Several lobbyists involved in the discussion said Friday they now think that may be reduced to \$200 billion or less before the changes are enacted into law.

The Senate Finance Committee has already passed its Medicare-overhaul plan. In about two weeks, if all goes as planned, it will be bundled with other tax and spending proposals into a huge package, known as a reconciliation bill, for a vote by the full Senate. The House, slightly behind, will debate its Medicare plan at the committee level this week. House members, too, are hoping to finish their reconciliation package in about two weeks.

Reducing the size of the Medicare cuts will make it more difficult for the Republicans to reach their goal of eliminating the budget deficit by 2002. To make up the difference, some Republicans are considering reducing the \$245 billion in tax cuts now planned by the GOP.

But that won't be easy. House conservatives have strongly opposed lowering the overall size of the tax cuts. And in the Senate, Sen. Phil Gramm of Texas, who said he would oppose any tax cut below \$245 billion, was recently appointed to the Finance Committee, which has jurisdiction

over tax matters.

The Finance Committee this week is expected to offer its tax-cut plan with a vote scheduled for late in the week. If it passes, it also will be included in the reconciliation bill. The full House passed its tax-cut bill earlier this year.

Pressure on All Fronts

In addition to their internal squabbling, Republicans are facing sharper needling from President Clinton. On Saturday, he opened a new front saying the Republicans' budget package would add up to "\$148 billion worth of direct and indirect hidden taxes" on working Americans. Among the GOP proposals included in his calculation: \$42 billion in savings over seven years in the earned income tax credit, a tax refund for the working poor; \$4 billion in new fees for child support, and \$63 billion in new Medicare costs to beneficiaries, such as higher premiums.

The new line of attack puts Mr. Clinton in the unusual position of simultaneously criticizing Republicans for increasing taxes and cutting them. Democrats have for weeks been hammering at the GOP for what they describe as reduced spending on Medicare to pay for the tax cut.

The end game in the budget battle is fast approaching. After the scheduled tax cut and Medicare action this week, both Houses will move to vote on the megabills. At that point, the direction of events becomes much less predictable. If a compromise is to emerge between the White House and Congress, it could develop at the same time negotiators from the two houses sit down to work out differences in the reconciliation bills.

The White House is looking to lower the size of the budget reductions, in particular for Medicare, the health-care program for the elderly, and Medicaid, the health-care program for the poor. Republicans are equally adamant about passing a bill that balances the budget in seven years. Several scenarios are emerging that could allow both to happen.

One would be simply to stretch out the balanced-budget timetable over a longer period, say, 10 years instead of seven. In another, the two parties would agree to alter the calculation used to adjust government programs for inflation, either by altering the formula used to calculate the consumer price index or by adjusting benefits and tax brackets by less than the full increase in the CPI. This would lower Social Security payments and raise taxes for some, saving the government as much as \$280 billion over seven years.

Finally, both sides might agree to any of an array of other bookkeeping devices. Assuming faster economic growth, the Treasury could count on billions of dollars more in revenue. Or budget writers could assume that Medicare payments will grow at a slightly slower rate than currently assumed.

PERFORMANCE INFORMATION

SUMMARY OF LEWIN-VHI STUDY

STUDY DOCUMENTS THAT GOP MEDICARE/MEDICAID PLAN INCREASES HEALTH CARE COSTS OF AMERICAN WORKERS BY \$1,000 OVER NEXT SEVEN YEARS

The respected research firm Lewin-VHI study has issued a study that shows that the GOP Medicare/ Medicaid plan will result in increasing the health care costs borne by American workers by \$1,000 per worker over the next seven years. The study was prepared for the National Leadership Coalition on Health Care Reform.

The study documents that, in response to the drastic cuts in payments to hospitals and doctors under the GOP Medicare/Medicaid plan, these health care providers will raise fees for private patients -- increasing private insurance premiums and causing employers to reduce wages.

Lewin-VHI finds that, of the total \$450 BILLION in cuts in the Medicare and Medicaid programs included in the GOP plan, about \$92 BILLION would be shifted onto private payers in the form of higher charges.

The study finds that the GOP plan would increase the health care premiums paid by the nation's employers by a total of \$75.0 BILLION -- and that the employers would pass \$66.0 BILLION of these increased costs onto their workers in the form of reduced wages. In addition, the worker contributions for their health insurance would also increase by \$6.4 BILLION. These overall increased costs on workers of \$72.4 BILLION equal about \$1,000 per covered worker over the next seven years.

Following is a brief overview of the Lewin-VHI study.

The GOP Medicare/Medicaid Plan

The GOP budget plan calls for reducing funding for Medicare and Medicaid by a total of \$450 BILLION over the next seven years.

Since the details of how the GOP will achieve these \$450 BILLION in savings are still a secret, Lewin-VHI had to develop an illustrative scenario of how the GOP savings would be achieved.

For the Medicare plan, in developing its illustrative scenario, Lewin-VHI assumed that the GOP Medicare savings would include \$120 BILLION from cutting payments to hospitals, \$90 BILLION from cutting payments to doctors, \$50 BILLION from assuming savings for enrolling more seniors in managed care, and \$20 BILLION from increasing beneficiary costs.

For the Medicaid plan, in developing its illustrative scenario, Lewin-VHI assumed the GOP Medicaid savings would include \$63 BILLION from cutting payments to hospitals, \$24 BILLION from cutting payments to doctors, \$56 BILLION from cutting payments for long-term care, and \$27 BILLION from cutting payments for drugs and other personal care items.

Thus, of the total \$450 BILLION in Medicare and Medicaid savings in the GOP budget plan, Lewin-VHI estimated that \$297 BILLION included cuts in payments to hospitals and doctors -- \$210 BILLION in cuts in Medicare payments to hospitals and doctors and \$87 BILLION in cuts in Medicaid payments to hospitals and doctors.

What experience has shown is that some portion of the \$297 BILLION in cuts in payments to hospitals and doctors under Medicare and Medicaid is going to be passed on to privately insured persons in the form of higher charges through cost shifting.

Evidence on Cost Shifting

Cost shifting is the process whereby health care providers recover uncompensated care costs for the uninsured and payment shortfalls for Medicare and Medicaid enrollees in the form of higher charges to private payers. For example, hospital payment rates under public programs are on average about 10% below costs and the uninsured account for about \$12.3 BILLION in uncompensated hospital care. These shortfalls are recovered at least in part by increasing charges to private payers as much as 20% above costs.

Based on recent empirical studies, Lewin-VHI generally assumes that 40% of hospital payment shortfalls under the GOP plan would be passed onto private payers in the form of higher charges. Also based on recent empirical studies, Lewin-VHI generally assumes that 20% of doctor payment shortfalls under the GOP plan would be passed onto private payers in the form of higher charges. (Furthermore, Lewin-VHI assumes that, over the seven-year period, this cost-shifting will decline somewhat -- in response to increased selective contracting among hospitals and doctors.)

As was seen above, Lewin-VHI estimated that, of the total \$450 BILLION reduction in Medicare and Medicaid spending in the GOP plan, payments to hospitals and physicians would be reduced by \$297 BILLION. Lewin-VHI estimates that, in response to this, hospitals and doctors would shift about \$91.6 BILLION -- or 31% -- of the \$297 BILLION in payment reductions to those with private insurance.

Overall Effects of Cost Shifting

According to Lewin-VHI, the \$91.6 BILLION in cost-shifting would result in substantial increases in health insurance premiums over the seven-year period -- affecting all purchasers of private insurance, including employers and individuals.

Of this \$91.6 BILLION in cost shifting, Lewin-VHI finds that employers would pay \$75 BILLION more in premiums, employees would contribute \$6.4 BILLION more, and

individuals who buy their own insurance would pay \$10.2 BILLION more.

Impact on Workers of Cost Shifting

Empirical evidence indicates that employers are likely to pass on much of the increase in employer premium costs to employees in the form of reduced wages. Employers are typically limited in what they can charge in the marketplace, necessitating changes in other compensation costs as employer premiums increase. Based on a review of the literature, Lewin-VHI assumes that, on average, 88% of the change in employer costs under these reforms would be passed on to workers in the form of lost wage growth.

Under these assumptions, about \$66.0 BILLION of the \$75.0 BILLION increase in employer costs due to cost shifting would be passed on to workers in the form of lost wage growth. This wage loss is in addition to the \$6.4 BILLION increase in employee premium contributions resulting from higher private insurance premiums. Overall, the amount of the cost shift passed on to workers would be \$72.4 BILLION -- including lost wage growth and higher employee premium contributions.

The cost shift to workers would equal approximately \$1,000 per covered worker over the seven-year period.

On average, according to the study, such cost shifting will reduce employees' anticipated wage increases by 2.7%. But lower-wage workers are likely to be hit hardest -- losing more than 10% of the wage hikes they might otherwise have received.

Impact on Insurance Coverage

Furthermore, health care coverage is likely to decline among firms that see an increase in premiums as a result of this increased cost shifting. The number of people without insurance at any given point of time is currently estimated to be up to 41.2 million people. According to Lewin-VHI, once fully implemented, these budget cuts would increase the number of uninsured by about 523,000 persons in 2002. This includes about 278,000 workers whose employer would discontinue coverage and about 245,000 dependents of these workers.

Conclusion

Finally, Lewin-VHI concludes by noting that ultimately, American families will pay for this cost shift. First, providers will shift the payment shortfalls occurring under the GOP plan to their privately insured patients. Then, employers -- who pay the bulk of private insurance premiums -- will pass on the cost of their increased premiums to workers in the form of reduced wage growth and increased employee contributions. As noted above, Lewin-VHI estimates that the proposed Medicare and Medicaid budget cuts are expected to increase real health expenditures for workers by \$72.4 BILLION over the seven-year period.