



DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

DWP

FAX TRANSMITTAL SHEET

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

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TO: CHRIS JENKINS

ADDRESSEE'S FAX #: 456-7431

ADDRESSEE'S CONFIRMATION #: \_\_\_\_\_

FROM: Alan Cohen

SENDER'S FAX #: 202-622-0073

SENDER'S CONFIRMATION #: 202-622-1700

SPECIAL INSTRUCTIONS/COMMENTS:

## NUMBER OF ELDERLY PUSHED INTO POVERTY BY MEDICARE CUTS IN REPUBLICAN BUDGET RESOLUTION

State	Number of Additional Poor Elderly
Alabama	15,100
Alaska	150
Arizona	4,500
Arkansas	9,650
California	28,200
Colorado	5,000
Connecticut	2,450
Delaware	1,000
District of Columbia	1,700
Florida	35,500
Georgia	15,750
Hawaii	1,850
Idaho	1,300
Illinois	19,300
Indiana	9,900
Iowa	6,600
Kansas	5,250
Kentucky	10,650
Louisiana	10,550
Maine	2,400
Maryland	9,150
Massachusetts	11,150
Michigan	14,800
Minnesota	7,350
Mississippi	10,950
Missouri	14,900
Montana	1,750

State	Number of Additional Poor Elderly
Nebraska	2,650
Nevada	2,400
New Hampshire	1,150
New Jersey	10,500
New Mexico	3,100
New York	46,500
North Carolina	23,750
North Dakota	1,650
Ohio	18,750
Oklahoma	7,200
Oregon	2,350
Pennsylvania	22,850
Rhode Island	1,300
South Carolina	8,900
South Dakota	2,450
Tennessee	14,800
Texas	35,050
Utah	1,650
Vermont	800
Virginia	8,750
Washington	11,550
West Virginia	5,300
Wisconsin	8,850
Wyoming	950
<b>TOTAL</b>	<b>500,000*</b>

\* Numbers may not add due to rounding.

**NUMBER OF ELDERLY PUSHED INTO POVERTY BY MEDICARE CUTS  
IN REPUBLICAN BUDGET RESOLUTION**

State	Number of Additional Poor Elderly
Alabama	15,100
Alaska	150
Arizona	4,500
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Colorado	5,000
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Delaware	1,000
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Hawaii	1,850
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Indiana	9,900
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Louisiana	10,550
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Oregon	2,350
Pennsylvania	22,850
Rhode Island	1,300
South Carolina	8,900
South Dakota	2,450
Tennessee	14,800
Texas	35,050
Utah	1,650
Vermont	800
Virginia	8,750
Washington	11,550
West Virginia	5,300
Wisconsin	8,850
Wyoming	950
<b>TOTAL</b>	<b>500,000*</b>

\* Numbers may not add due to rounding.

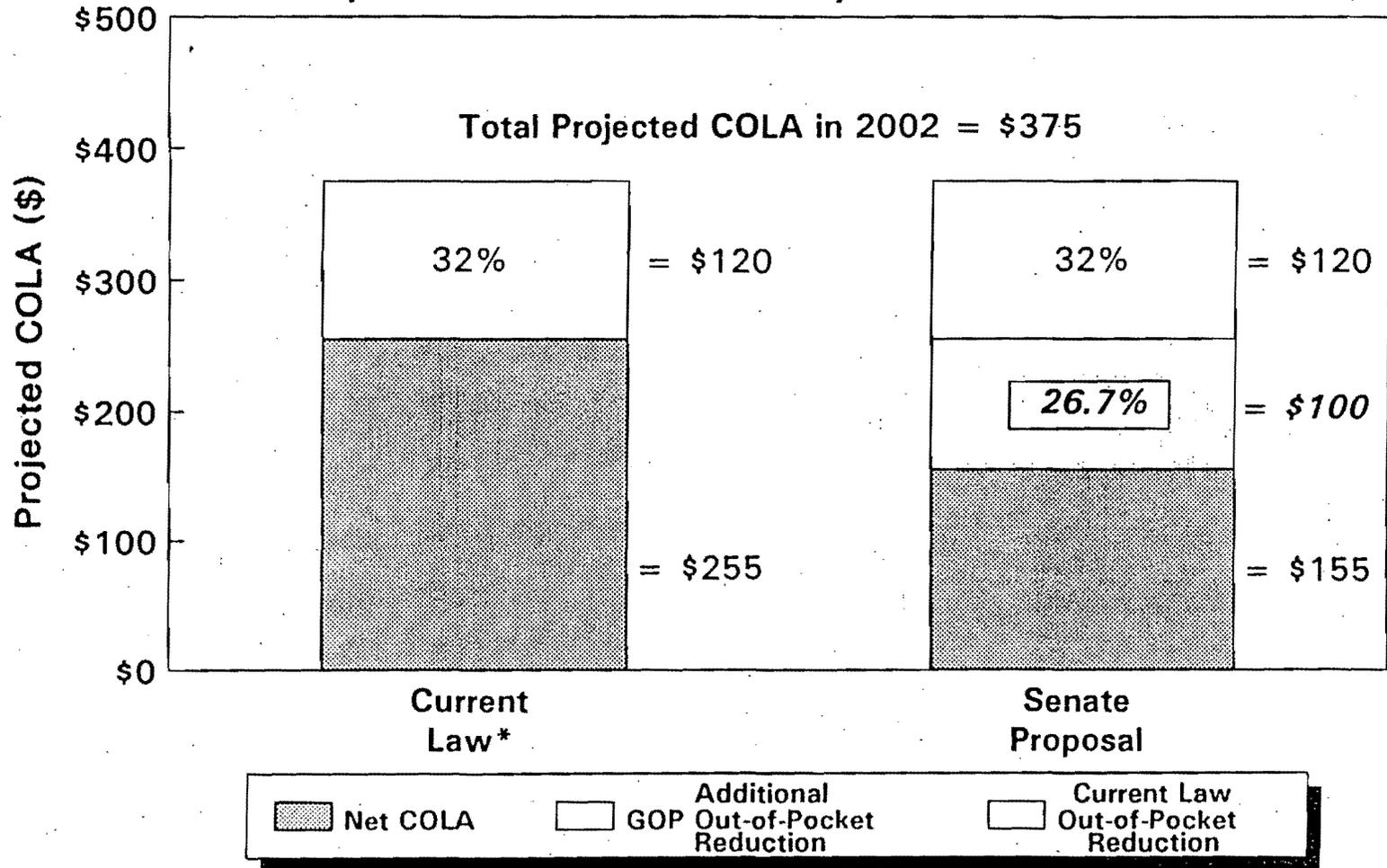
**Effects of the Domenici Medicare Proposal on States  
Losses by State Under the Proposal  
(Fiscal years)**

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

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

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

## Senate Medicare Out-of-Pocket Proposals Would Effectively Consume Over 25% of a Social Security Beneficiary's Expected COLA Increase by the Year 2002



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

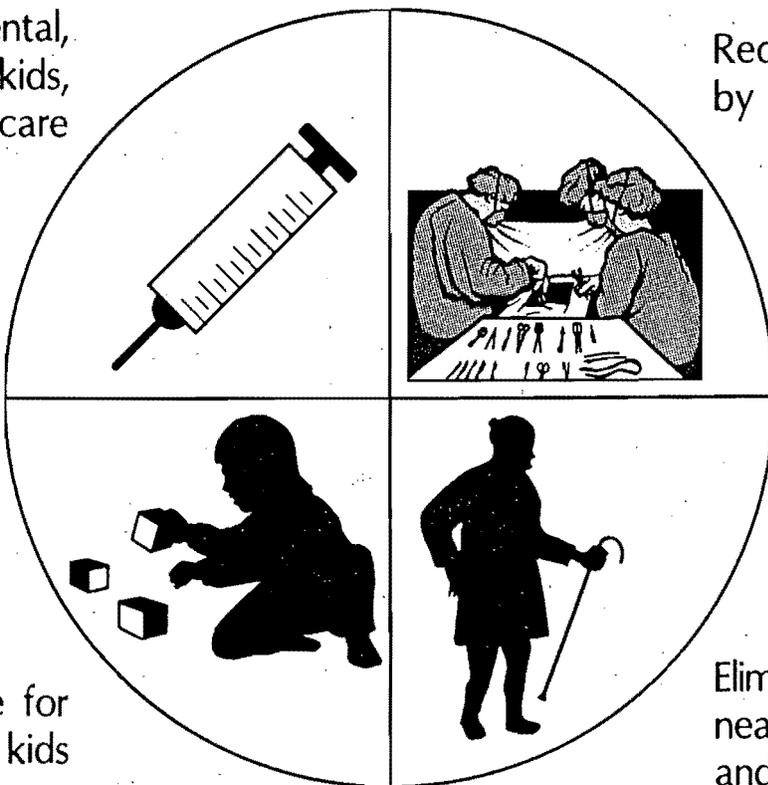
Source: DHHS Estimates

Note: Assumes \$256 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries.

# Medicaid Cuts That States Would Be Forced to Make

2002

Eliminate coverage for dental,  
screening services for kids,  
and hospice and home care



Reduce provider payments  
by almost \$13 billion

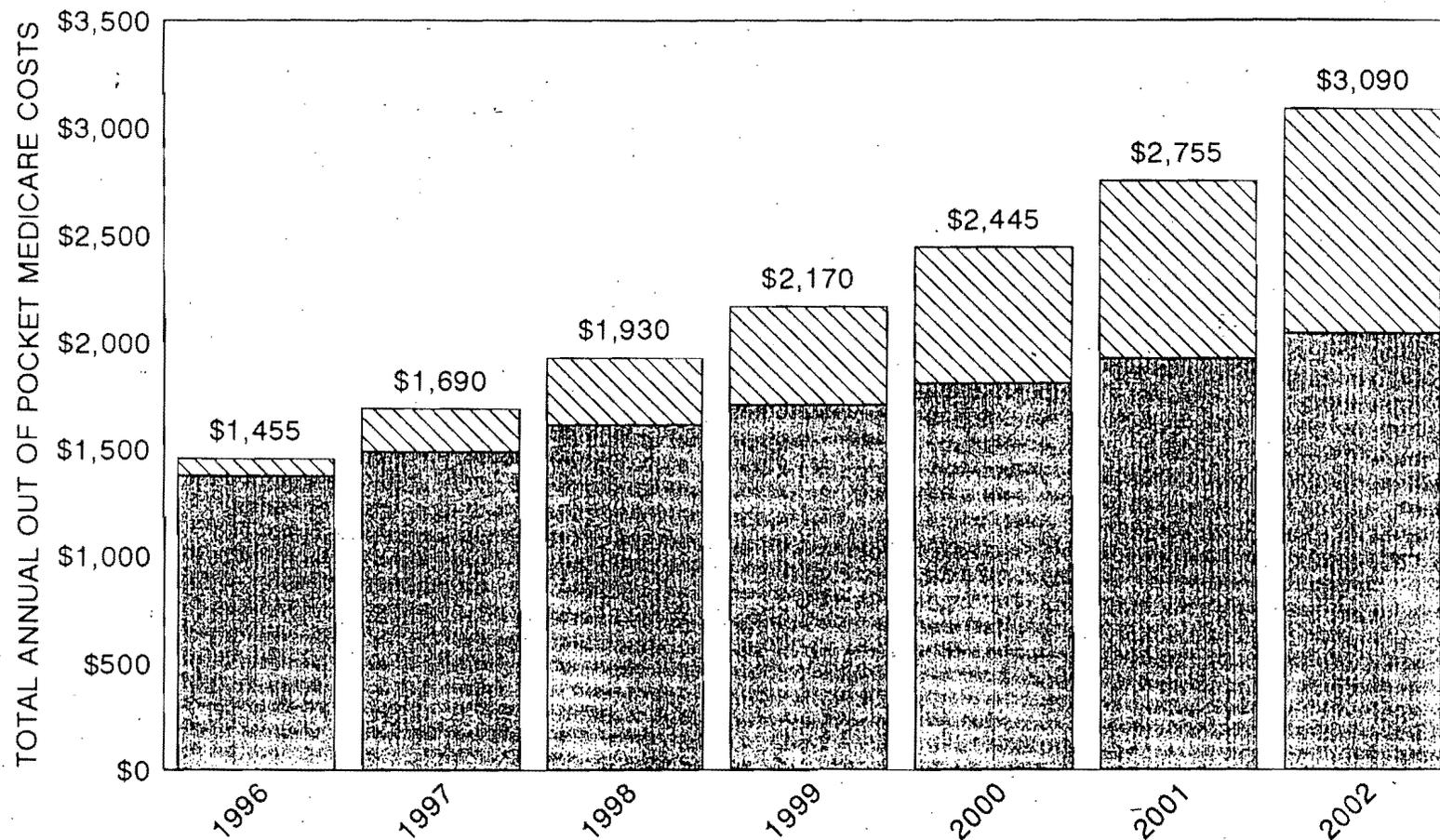
Eliminate coverage for  
7 million kids

Eliminate coverage for  
nearly one million elderly  
and persons with disabilities

*NOTE: Assuming 25% cut in each of these categories.*

# HOUSE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS

## SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3500



Proposed Increase	\$80	\$200	\$315	\$460	\$635	\$830	\$1,045
Current Law Costs	\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

FISCAL YEAR

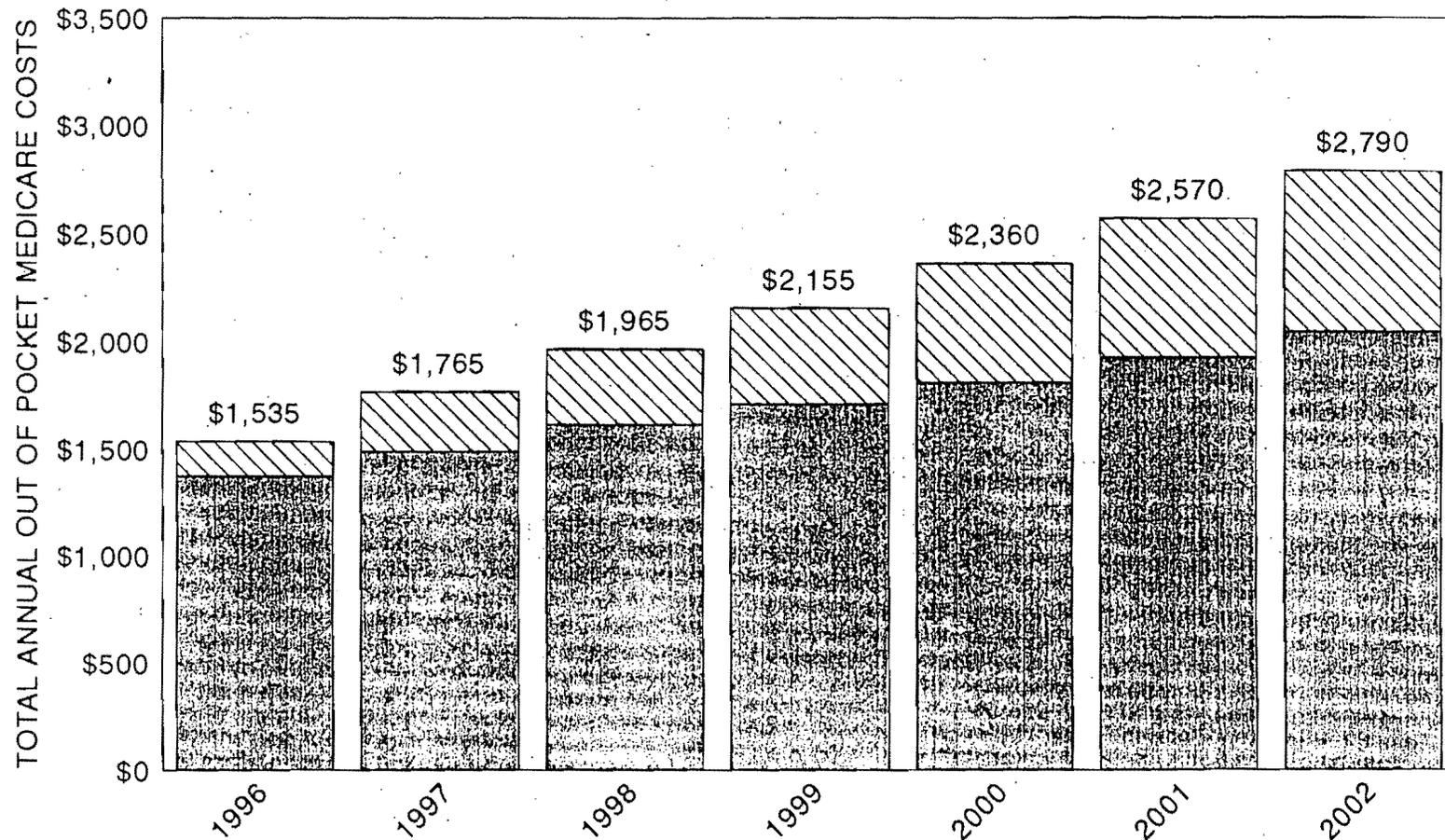
Assumes \$288 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.

Source: Health Care Financing Administration

# SENATE REPUBLICANS' PROPOSED MEDICARE CUTS HURT AMERICA'S SENIORS

## SENIORS' ANNUAL OUT-OF-POCKET MEDICARE COSTS WOULD INCREASE MORE THAN \$3,100



Proposed Increase	\$160	\$275	\$350	\$445	\$550	\$645	\$745
Current Law Costs	\$1,375	\$1,490	\$1,615	\$1,710	\$1,810	\$1,925	\$2,045

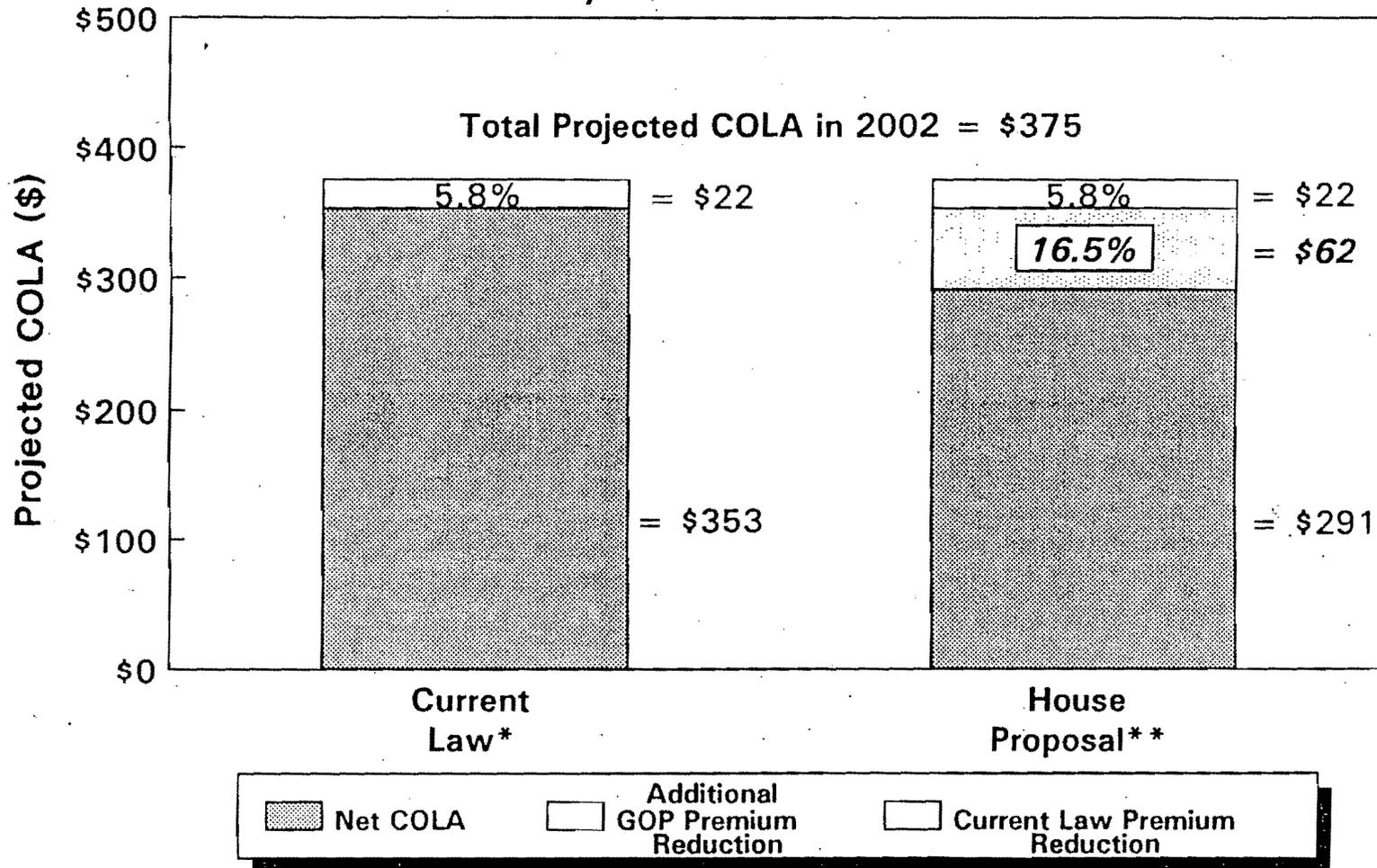
FISCAL YEAR

Assumes \$256 billion total savings over 7 years, with 50% of cuts affecting out-of-pocket costs.

Out-of-pocket costs include: Part A and B copayments and deductibles, and Part B premiums.

Source: Health Care Financing Administration

## House Medicare Premium Proposals Would Consume Over 15% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002



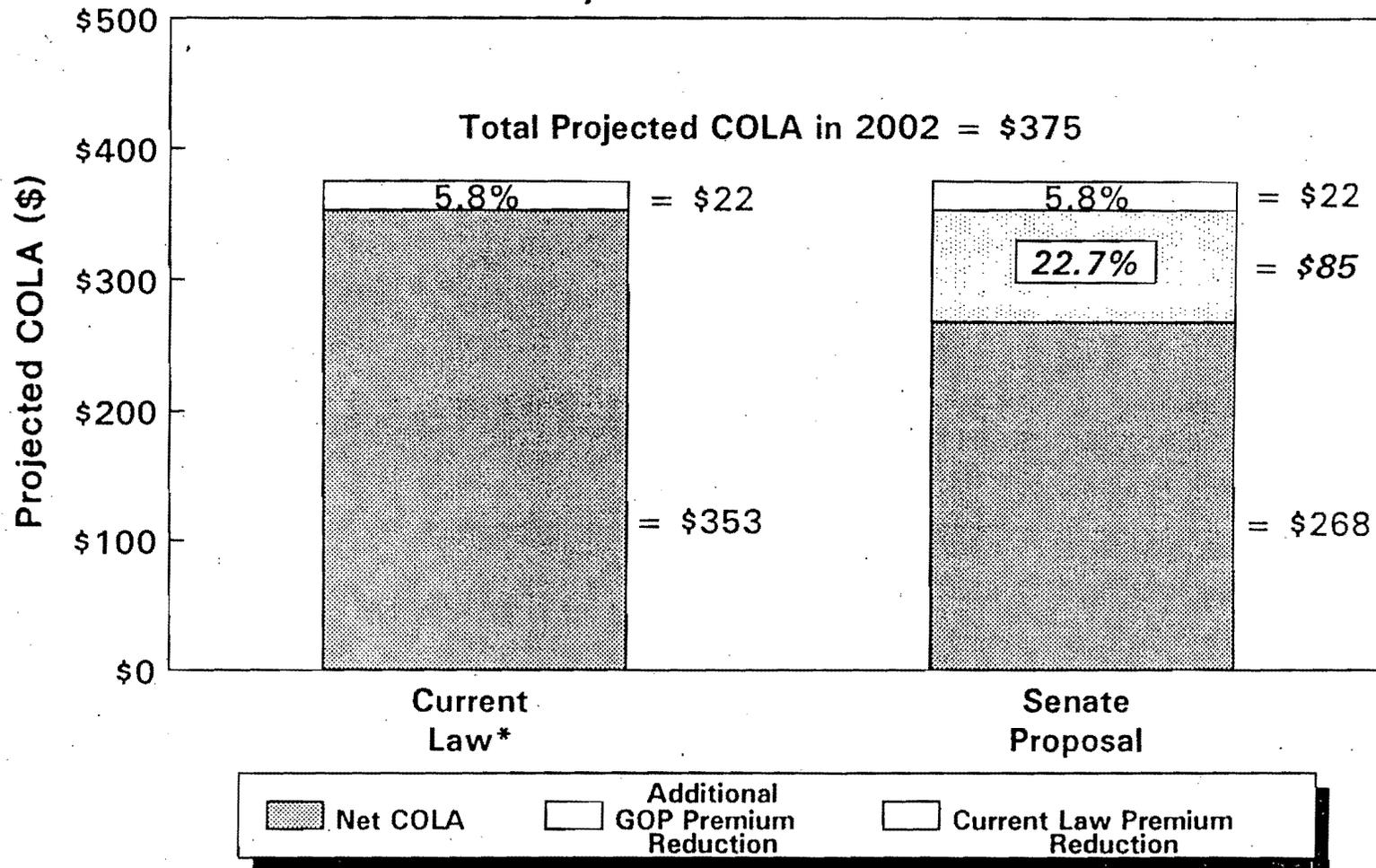
\* Does NOT Include PB 25% Premium Extension Proposal

\*\* Does NOT Include Effect of Proposal to Means Test Premium

Source: DHHS Estimates

Note: Assumes \$288 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total that is Slightly Different.

## Senate Medicare Premium Proposals Would Consume Over 20% of Social Security Beneficiaries' Expected COLA Increase By the Year 2002

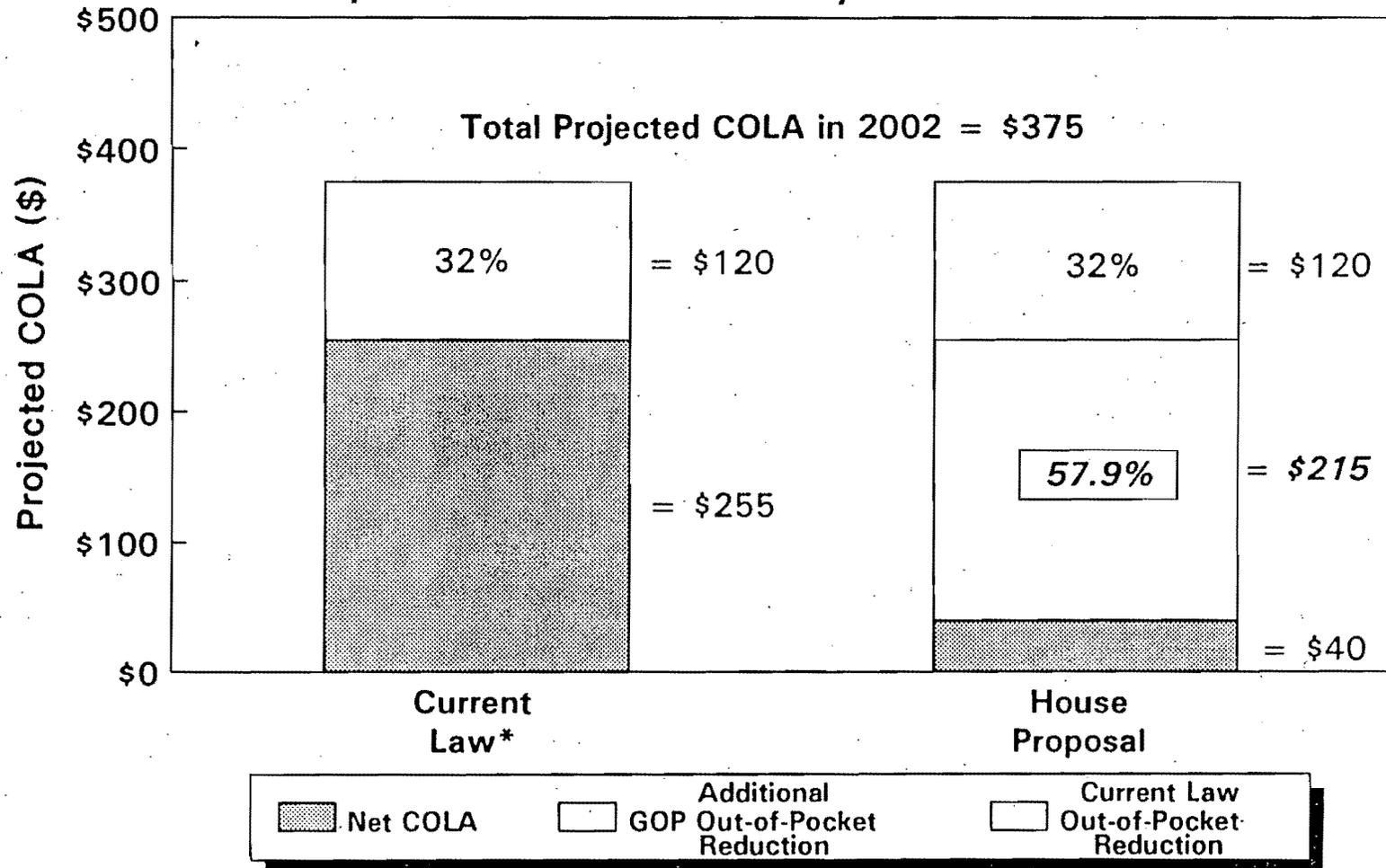


\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Source: DHHS Estimates

Note: Assumes \$256 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries.

## House Medicare Out-of-Pocket Proposals Would Effectively Consume Nearly 60% of a Social Security Beneficiary's Expected COLA Increase by the Year 2002



\* Does NOT include President's Budget Proposal to Maintain Part B Premium at 25% of Program Costs

Source: DHHS Estimates

Note: Assumes \$288 Billion in Total Savings Over 7 Years, with 50% of Cuts Affecting Beneficiaries. Technical Reestimates May Result in a 7-Year Total that is Slightly Different.

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

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

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences,

(2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

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

Projected Medicare Beneficiaries by State

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

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

\* Totals may not add due to rounding

## Talking Points

### on Republican Budget Proposals:

#### "A Broken Contract with American Families and Their Parents"

May 10, 1995

#### INTRODUCTION

- As you all know, Republicans made a big promise:

They promised to balance the budget without hurting anyone and without raising taxes -- while giving a huge tax cut to the wealthy.

- Guess what? They broke their promise.

-- In terms of cuts that will hurt people:

- The strongest evidence of the severe pain they would impose are their deep cuts in Medicare and Medicaid.

- They would cut discretionary programs -- from education to science and technology -- an average 30 percent across the board. They also have announced proposals to terminate specific programs, such as Americorps, that are important investments in the future.

- To find the remaining savings, Republicans also plan to make deep cuts in such other entitlements as veterans' and farm programs.

-- In terms of tax increases.

- Republicans are proposing to raise taxes on millions of working families.

- Why are they doing all this?

-- They want to finance a tax cut for the wealthy at the expense of average families.

- House Republicans have adopted a huge tax cut as part of their budget program.
- House Speaker Newt Gingrich has called the tax cut "the crown jewel of the Republican contract."

- Senate Republican leaders -- Bob Dole, Trent Lott, and others -- and Sen. Phil Gramm are committed to a tax cut and say they will push for one on the Senate floor.

- We believe that there is a right way, and a wrong way, to do deficit reduction.

-- In 1993, on our own, we did it the right way:

- We reduced the deficit by cutting unnecessary programs, but also invested in programs that will help working families build a more prosperous future.

-- Now, they want to do it the wrong way:

- They want to cut programs for working families and their parents, in order to fund a tax cut for the wealthy.

## Medicare and the Budget

- House Speaker Newt Gingrich wants to treat Medicare apart from the budget, but that statement is meaningless and the promise is a lie.

- Late last month, he said,

"What we want to do is create an environment over the next three or four months where, standing by itself, there is a bill to save Medicare. That bill moves focused on Medicare. It has Medicare-related ideas. It's not tied up in the budget. It's not tied into getting to balance by 2002."

- Medicare is a federal program just like any other.

- And Republican plans rely heavily on it to get to balance.

- Domenici's Medicare cut is the largest single cut in any one program.

- Republicans need to cut Medicare to pay for their tax cut for the wealthy.

- And more than half of the savings that Domenici claims comes from cutting Medicare and Medicaid.

## Limits to Medicare/Medicaid Growth Rates

- Republicans imply that Medicare and Medicaid are growing out of control, but in fact they are growing at the same per-person rate as private health plans.

- Republicans are proposing to force Medicare spending down, but to ignore health reform in general.

- In effect, they are proposing to make Medicare a "second class" health care system -- it would provide low-quality care and restricted access.

- These are cuts that will affect your own parents and grandparents, whether they now get Medicare or they eventually need the long-term care provided by Medicaid.

- Specifically, Medicare and Medicaid spending are rising 9-10 percent a year because of increases in the numbers of beneficiaries and the costs of medical services, including improvements in technology and care.

-- While that may seem high, on a per-person basis, Medicare spending is projected to grow at about the same rate as private health insurance costs.

• Thus, limiting the rate of growth of total (not per-person) Medicare and Medicaid spending to 7.1 percent, as Sen. Domenici proposes, is a real cut with real consequences.

-- It could mean limits on the numbers of elderly or low-income individuals served.

-- It could mean limits on the quality and quantity of services that the programs provide.

-- It could mean that the elderly and low-income have to pay more, themselves, for some of the services that they now receive.

-- These "savings" could be passed on to businesses and individuals who buy health insurance and health care services.

• In short, reducing Medicare's rate of growth would hold it below the growth in the private sector -- creating a growing "quality gap" between care for seniors and health services for others.

## Medicare/Medicaid cuts

### Medicare Cuts:

- If distributed evenly between providers and beneficiaries, the Republican Medicare cuts could force beneficiaries to pay:

- between \$745 and \$1,030 more in out-of-pocket costs in 2002; and

- between \$3,175 and \$3,445 more in out-of-pocket costs over 7 years.

- Republican Medicare cuts, in effect, amount to cuts in Social Security:

- By 2002, the typical Medicare beneficiary would see 40-50 percent of his or her Social Security COLA eaten up by increases in Medicare cost sharing and premiums.

- About 2 million beneficiaries would have 100 percent or more of the COLAs eaten up by increases in cost sharing and premiums.

### Medicaid Cuts:

- Cuts in Medicaid are especially outrageous:

- Medicaid provides health insurance for the most vulnerable Americans.

- 2/3 of Medicaid costs go to the indigent elderly and disabled, who have no other available resources.

- Medicaid is also a vital protection for middle-income Americans.

- Working families with a parent who needs long-term care would face nursing home bills of an average of \$38,000 a year without Medicaid.

- Working couples who may need long-term care after retirement rely on Medicaid to get such care.

- If distributed evenly between eliminating eligibility for the elderly and disabled, eliminating eligibility for children, cutting services, and cutting provider payments, Republican cuts in 2002 alone would mean:

- 7 million children would lose coverage;
- 1 million elderly and disabled would lose coverage; and
- Tens of millions of Americans would lose important benefits, such as home care, hospice, and preventive screening services for children.
- Provider payments would be reduced by almost \$13 billion.

### Managed Care and Savings

- Republicans claim that they can produce significant savings by giving beneficiaries more managed care choices simply are not true.

-- As CBO reported recently, achieving savings in Medicare without financial coercion would actually reduce managed care enrollment.

-- So, to get both more beneficiaries in managed care and large savings for Medicare, some form of coercion -- such as making it more expensive for beneficiaries to stay in Medicare fee-for-service -- would be needed.

### Impact on Providers

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals.
  - For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. According to the 1994 Special Report of the National Association of Public Hospitals, while Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.
- Large reductions in Medicare payments could also endanger rural hospitals.
  - Nearly 10 million Medicare beneficiaries (25 percent of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to serve primarily Medicare patients.
  - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

## The Earned Income Tax Credit (EITC) and the Economic Implications of Republican Budget Plans

### EITC:

- While Republicans cut Medicare and Medicaid to finance their tax cut for the wealthy, they also plan a tax increase on low-income, working families.

- Republican tax proposals reveal the sharpest possible distinction between the President's vision for America and that of Republicans.

- The President wants to provide targeted tax relief for middle-income Americans who may not have shared in the economic recovery.

- He wants to help them raise their children, educate and train themselves and their children, and save for the future.

- Republicans want to cut taxes for the wealthy, and actually increase taxes on the very people who need and deserve it most.

- Republicans plan to raise \$13 billion over five years by rolling back part of the President's 1993 expansion of the EITC, which would ensure that working Americans do not have to raise their families in poverty.

- Most EITC recipients are doing the hardest job in America -- playing by the rules, working at modest wages to support their children.

- The 1993 law was designed to help those who are not benefiting from the current economic expansion.

- The cut eliminates the EITC entirely to families without children.

- Freezing the proposed EITC expansions could cost millions of moderate-income families with children up to \$350 a year in added taxes.

### Economic Implications of Republican Budget Plans:

(to be provided by Laura Tyson)

UNITED STATE SENATE  
COMMITTEE ON THE BUDGET  
DEMOCRATIC STAFF

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**DRAFT**

**MEDICARE:  
FINANCIAL SECURITY FOR BENEFICIARIES AND THE PROGRAM**

**Statement of**

**Karen Davis**

**President**

**The Commonwealth Fund  
One East 75th Street  
New York, New York 10021**

**Before**

**U. S. Senate Budget Committee  
Hearing on Medicare Solvency  
May 3, 1995**

**MEDICARE:  
FINANCIAL SECURITY FOR BENEFICIARIES AND THE PROGRAM**

**Karen Davis**

Thank you for this opportunity to testify on the importance of assuring the fiscal solvency of the Medicare program while achieving its goal of 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. Even with Medicare and Medicaid which supplements Medicare for the poor, many aged and disabled persons face serious financial hardship and forego needed care because they cannot afford it.

Despite popular views that older Americans enjoy high incomes and standard of living, most elderly Americans have modest incomes. As shown in Chart 1, 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.

Poor Medicare beneficiaries are eligible for Medicaid to help pay Medicare premiums and cost-sharing, as well as for other services such as prescription drugs. However, 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.

### **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 3). One-fourth of beneficiaries accounted for 91 percent of outlays.

The average expenditure in 1993 for all Medicare beneficiaries was \$4,020 (see Chart 4). 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 5, the hospital deductible under Medicare is \$716, the Part B deductible is \$100 per year, and the Part B premium is \$550 per year. Given non-covered services such as prescription drugs, out-of-pocket costs for Medicare beneficiaries who rely only on Medicare can easily exceed \$2000 per year. For an elderly woman with an income of \$10,000, this is clearly an excessive and burdensome cost. Even for those with Medi-Gap private coverage, costs can be high. The average Medi-Gap premium is now \$840, which in

combination with the Part B premium and even modest outlays for non-covered services, can run over \$1500 a year.

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 6, on average elderly households spend 12 percent of their incomes directly out-of-pocket for health care, compared with 3.7 percent for nonelderly households.

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. Medicare pays only 2 percent of all nursing home expenses; about half 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 Expenditures**

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 for hospital and physician services per enrollee have grown more slowly than private health insurance outlays for these services in the decade from 1984 to 1993 (see Chart 7). After two decades of increasing more rapidly than the private sector, Medicare's more recent performance is considerably better than that of the private sector. Spending on inpatient hospital and physician services have moderated considerably. In 1993, hospital inpatient outlays grew at 8.3 percent, and physician outlays at 4.5 percent, down from double-digit rates of growth in the 1980s (see Chart 8). 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.

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 5.5 percent in large group market 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 and 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.

## **Medicare Solvency**

The recent Medicare trustees report has focused attention on the exhaustion of the Part A trust fund by the year 2002. The looming fiscal crisis in Medicare is not new news. A decade ago trustees reports predicted the trust fund would be insolvent by now. The success of Medicare hospital payment reform in slowing Medicare hospital spending has been one major factor in postponing the projected date.

What this history demonstrates is that the Medicare projections are highly sensitive to changes in economic conditions and to trends in the health care industry. For example, if Medicare hospital outlays were to grow at a one percentage point slower rate than currently projected, the date when the Part A Trust Fund would be exhausted would move back by three years.

The current baseline projections are highly uncertain given the changes that are occurring in the health care industry. Advances in technology are shifting care from the hospital inpatient setting to ambulatory care. Hospitals are under pressure to contain costs. Physicians are bombarded with the pervasive view that it is important to practice conservatively and not hospitalize patients who could be cared for on an outpatient basis. As these shifts occur, they will reduce the pressure on the Part A Trust Fund and could substantially alter future projections.

Even if the current baseline projections hold, modest policy changes could assure the Part A Trust Fund solvency for the next 10 to 15 years. For example, simply moving the home health benefit from Part A to Part B would move the date back by approximately five years.

There is no doubt that as the baby boom population begins to reach eligibility for Social Security and Medicare around 2010, major action will be required to assure the fiscal solvency of Medicare. What is clear is that such action needs to be designed carefully and deliberately, and with a clear mandate to assure the adequacy of Medicare for beneficiaries into the 21st century.

If the primary concern is with federal budget deficit reduction in the short-term, there are in fact few attractive alternatives for reducing Medicare outlays. Cuts in benefits would add to the financial hardship on beneficiaries. This is particularly true of increases in deductibles or copayments on services such as hospital care or home health that are used by the sickest beneficiaries. Provider payment rates could be tightened further, but they are already considerably lower than private payers. Severe cuts would jeopardize the financial stability of hospitals serving older and seriously ill patients—such as rural hospitals and teaching hospitals. Some modest savings might be achieved through practices such as high cost case management and selective contracting for specialized services.

Proposals to save Medicare money through vouchers or increased incentives to enroll

in managed care raise several concerns. Medicare has low administrative costs. Managed care plans average 20-25 percent "overhead"—the difference between actual outlays for medical expenses and capitation payment rates. Individual private health insurance plans often have 30 to 50 percent "overhead" rates. Vouchers to buy individual private health insurance plans or enroll in managed care plans raise additional issues of marketing practices, confusion and possible exploitation of frail older people, as well as high administrative costs for advertising, sales commissions, and other administrative overhead. Adverse risk selection—as a result of practices of health plans to enroll and retain relatively healthier patients—could well undermine the community rated nature of Medicare, as plans compete for Medicare beneficiaries not on the basis of the quality of care they offer, but on their ability to screen out those who have had a stroke, advanced heart or pulmonary disease, or a bout with cancer.

Any changes to Medicare will need to be designed with care to avoid unintended consequences that are harmful either to vulnerable beneficiaries or to the health system that provides accessible, high quality care.

### **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 (see Chart 9). 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 10).

National opinion polls also show little support for cutting Medicare. As shown in Chart 11, 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.

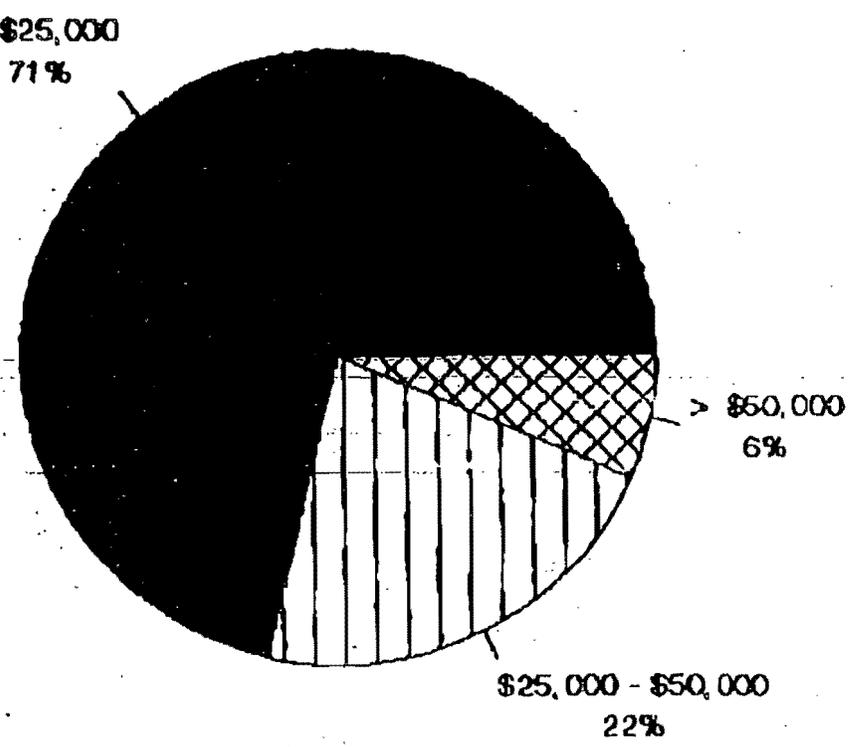
Medicare is an effective and popular program. But more importantly it is a program on which 37 million of the nation's sickest and most vulnerable Americans rely. Medicare was established in 1965 because private insurance was not accessible to older Americans. They were dropped as they reached retirement because they were bad risks. We should not risk reversing the important gain in health and economic security that Medicare has achieved as we look to assuring its fiscal solvency for future generations.

Thank you.

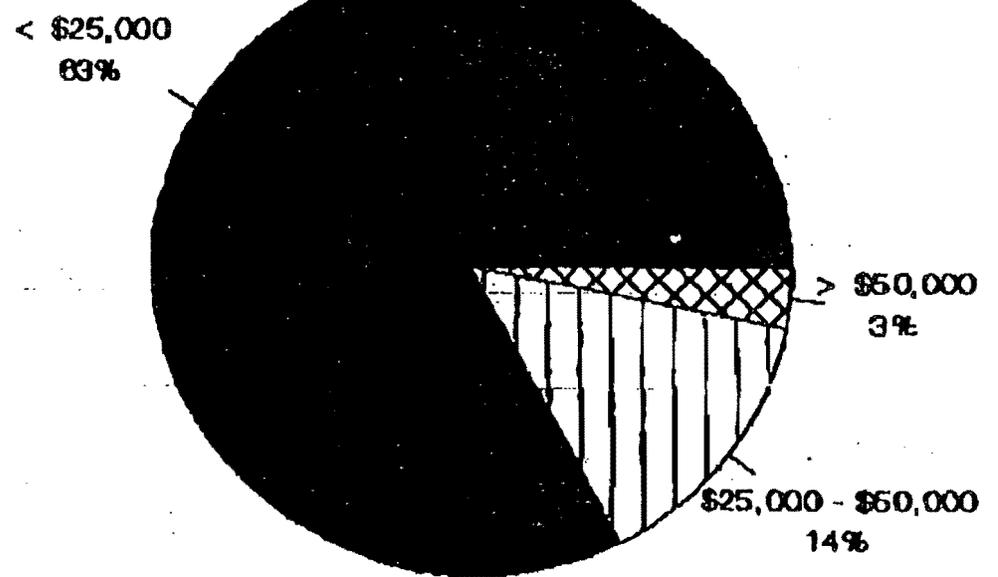
# Income Distribution of Medicare Beneficiaries by Gender, 1992

05-02-95 01:19 PM FROM S B C MAJORITY  
 03/01/95 16:28 FAX 212 806 3876

COMMONWEALTH FD



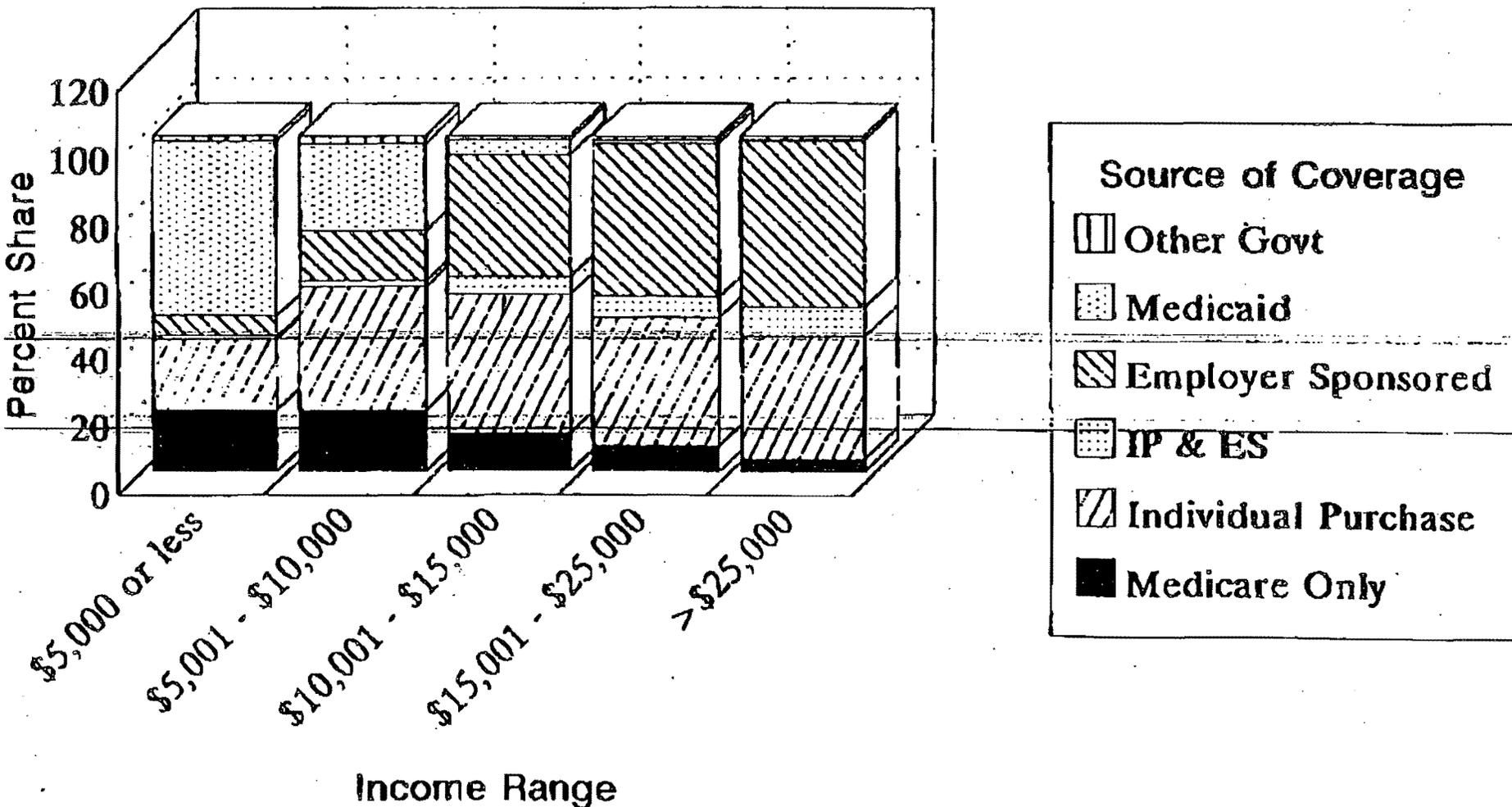
Males



Females

# Insurance Holdings of Aged Medicare Beneficiaries

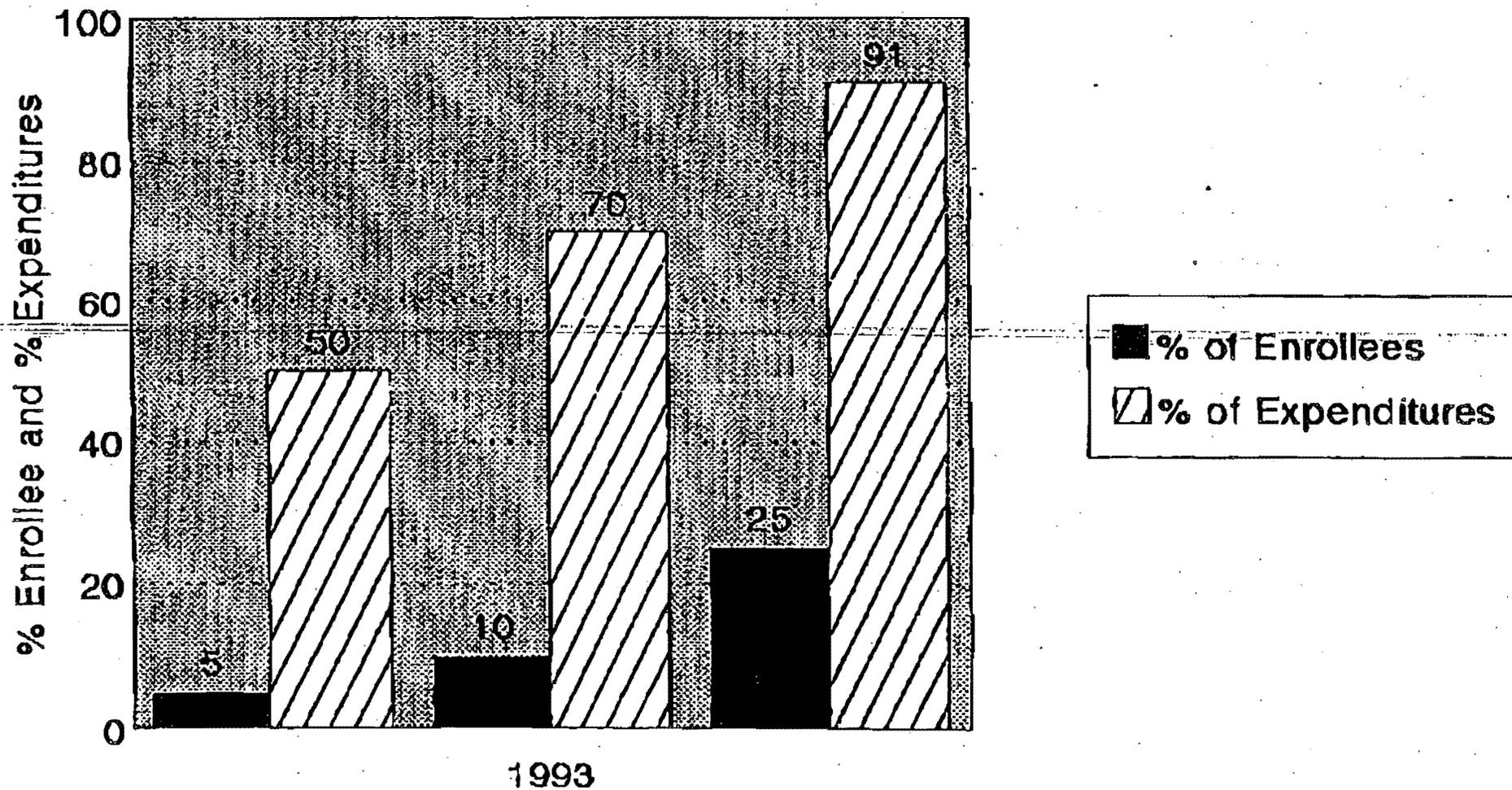
## Percent Share By Income



"Why More Cost-Sharing Won't Slow Medicare Spending"  
of American Health Policy, July/August 1993

Chart 2

# Distribution of Medicare Expenditures by Top Percentiles of Enrollees



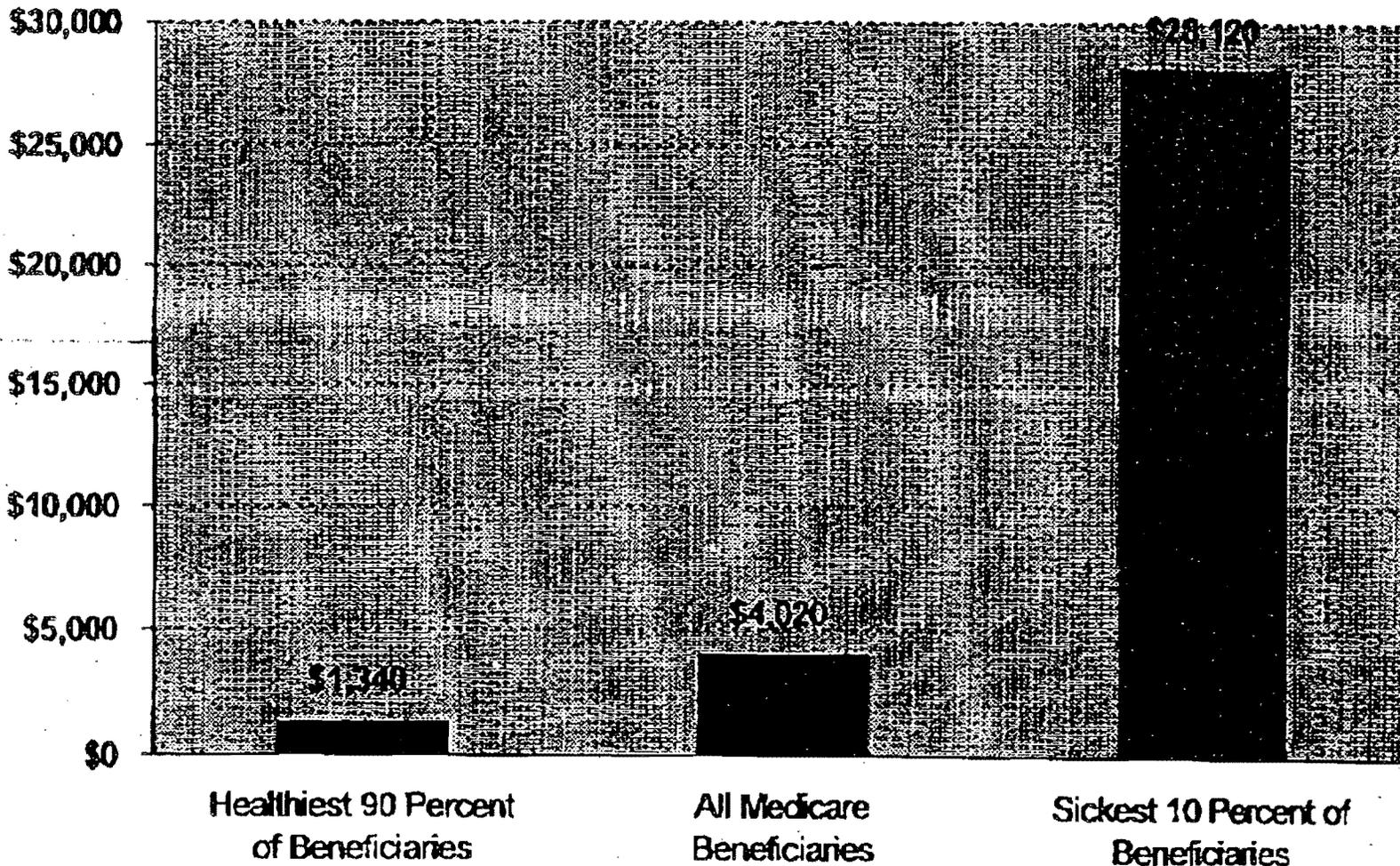
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012

Chart 3

# Average Medicare Outlays per Beneficiary by Health Status, 1993



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

Chart 4

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## Medicare Cost Sharing 1995

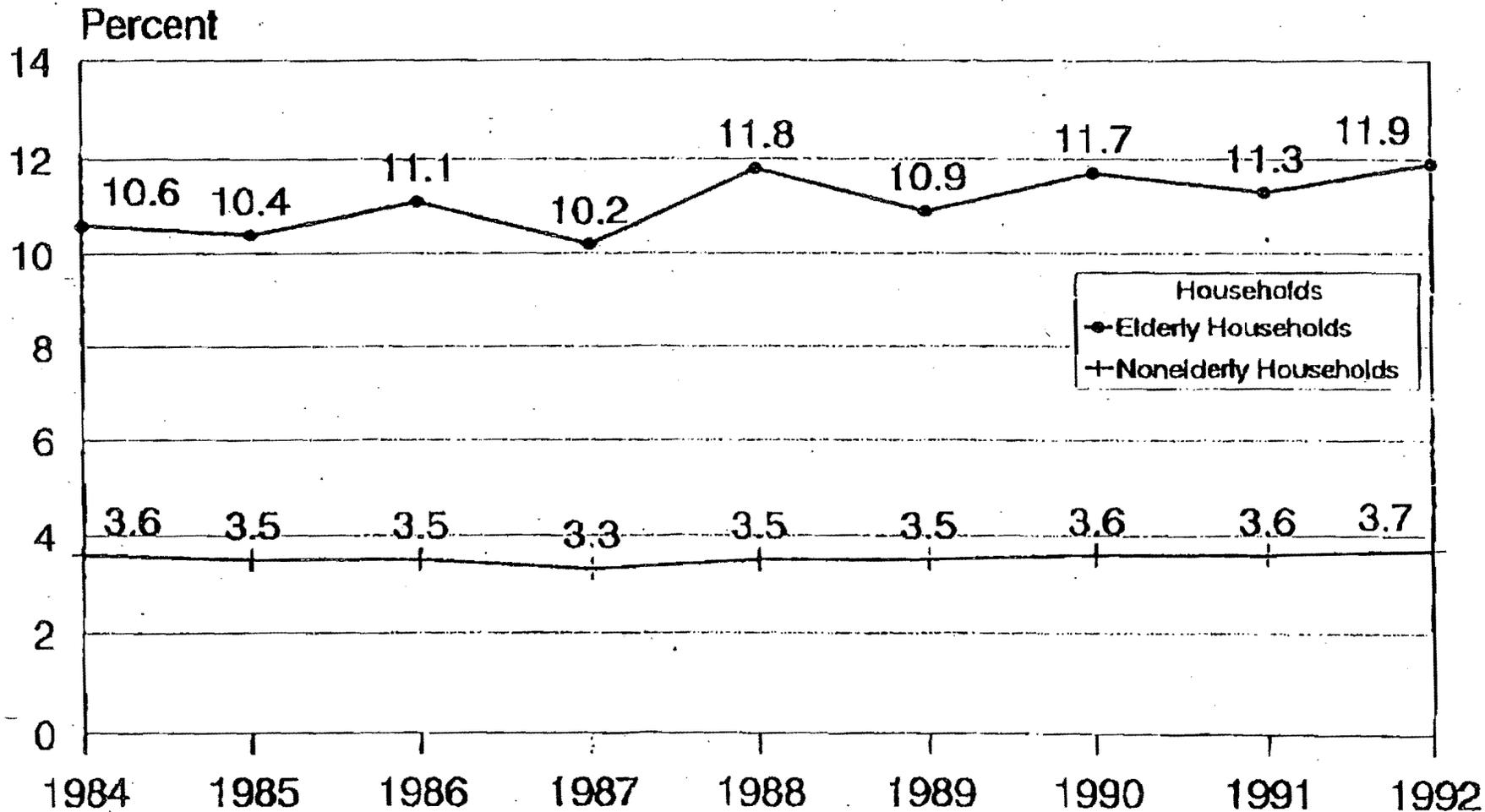
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- ▶ Inpatient Hospital Deductible = \$716 per benefit period
- ▶ Part B Deductible = \$100 per year
- ▶ Part B Premium = \$46.10 per month
- ▶ In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier and hospital outpatient services.

# Direct Household Spending for Health Care as Percentage of Household Income, 1984-1992

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 05/01/95 18:33 FAX 212 606 3876

COMMONWEALTH FD



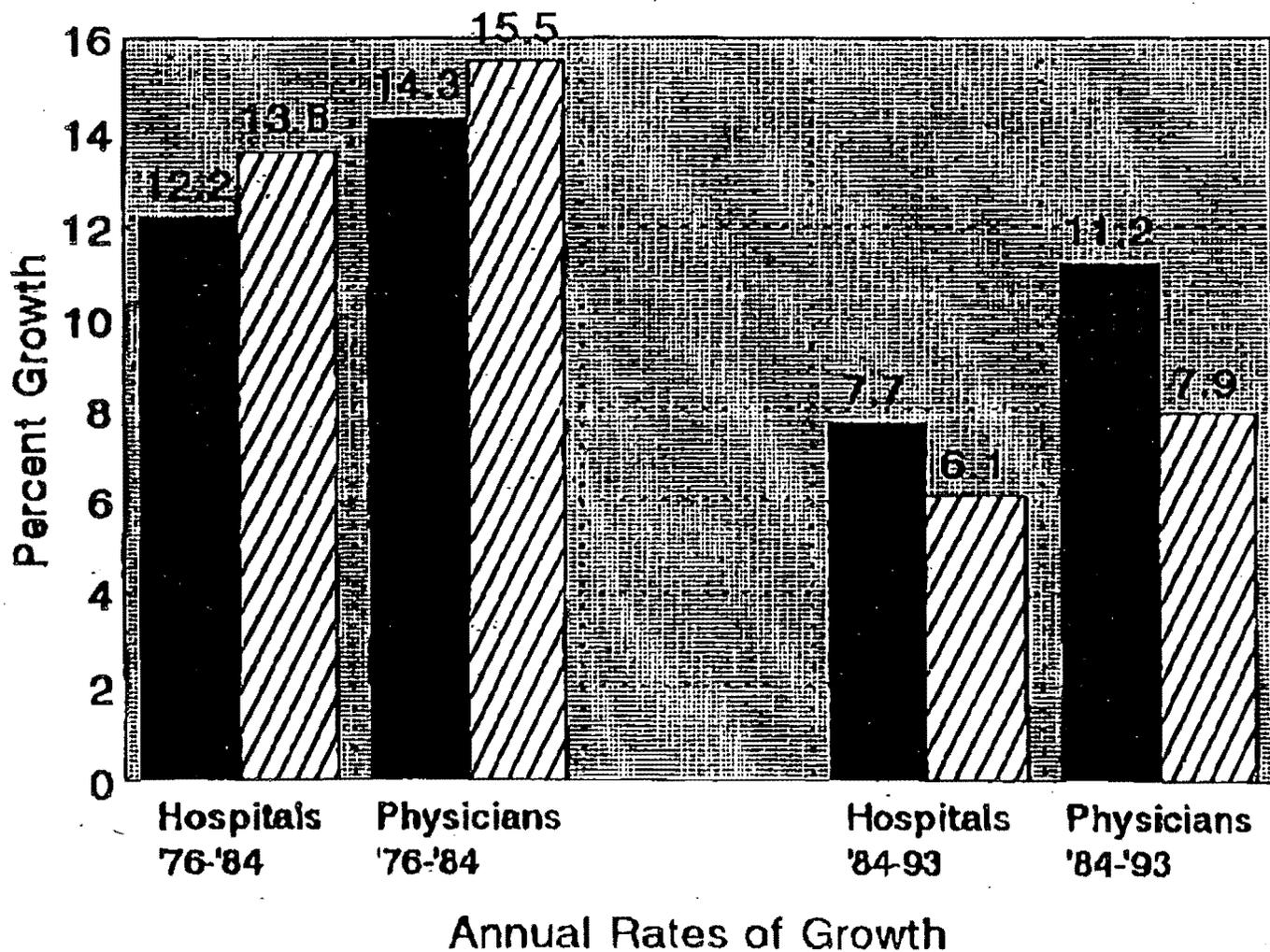
Congressional Budget Office calculations based on data from the  
 per Expenditure Surveys of the Bureau of Labor Statistics, 1984-1992.

THE COMMONWEALTH FUND

Chart 6

# Comparison of Growth in Hospital and Physician Expenditures Per Enrollee

## Private Health Insurance vs. Medicare



Private  
 Medicare

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05/01/95 16:33 FAX 212 608 3578

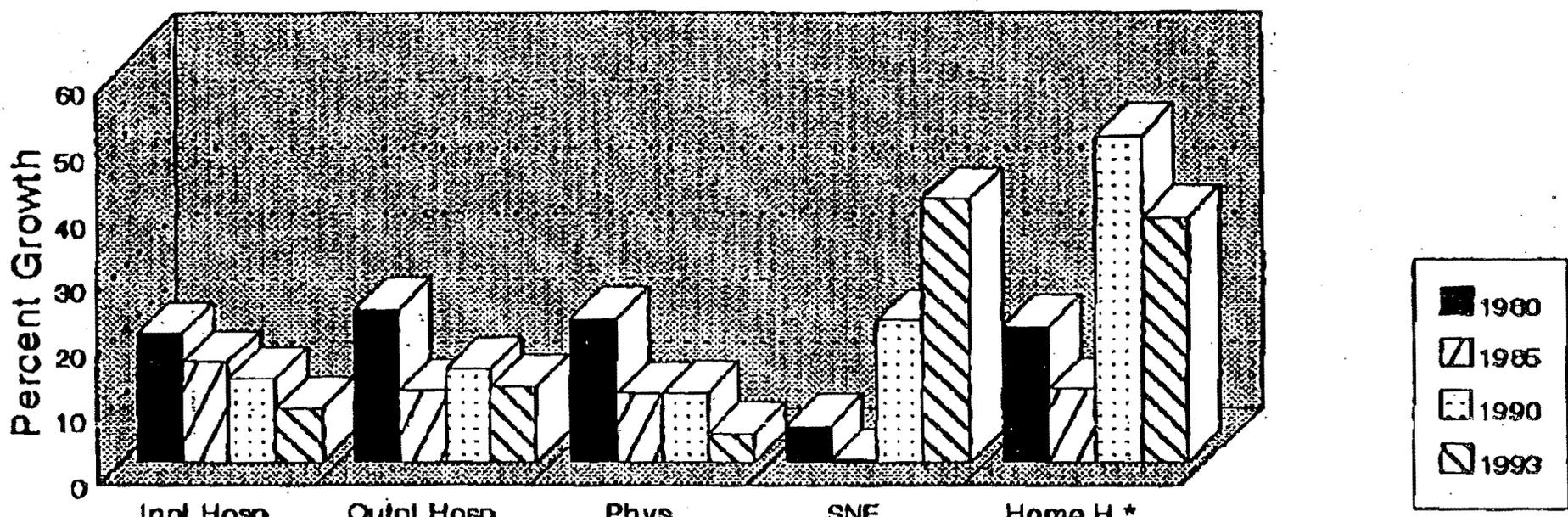
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Chart 7

# Annual Growth in Medicare Outlays

## Select Years

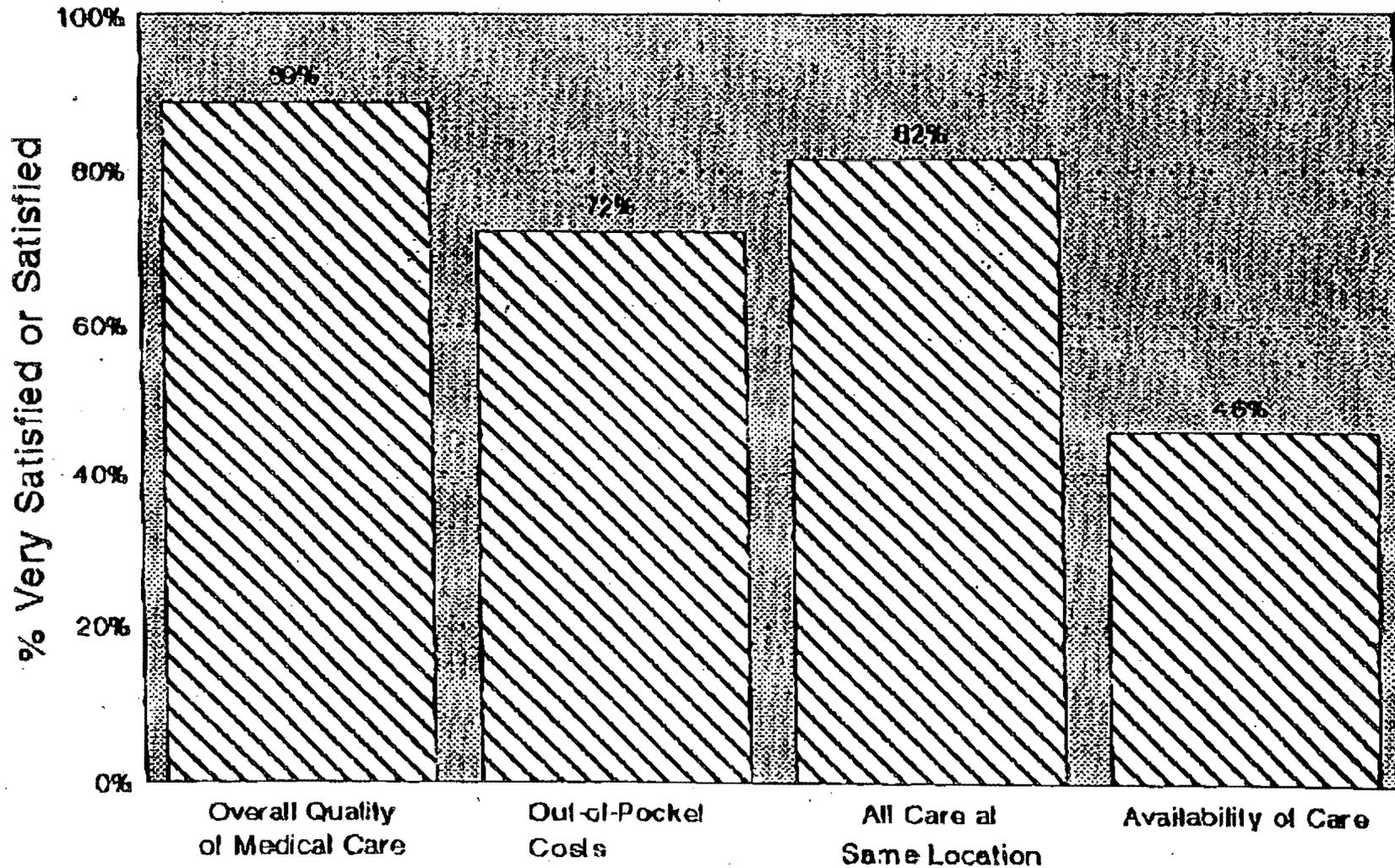


	Inpt Hosp	Outpl Hosp	Phys	SNF	Home H.*
1980	19.9	23.7	22.2	5.7	21
1985	15.4	11	10.5	0.4	11.2
1990	12.9	14.3	10.6	21.9	50.1
1993	8.3	11.6	4.5	40.6	37.8

Health includes Part A only  
 HCFA/Division of Budget

Chart 8

# Beneficiary Satisfaction



in the community.

: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

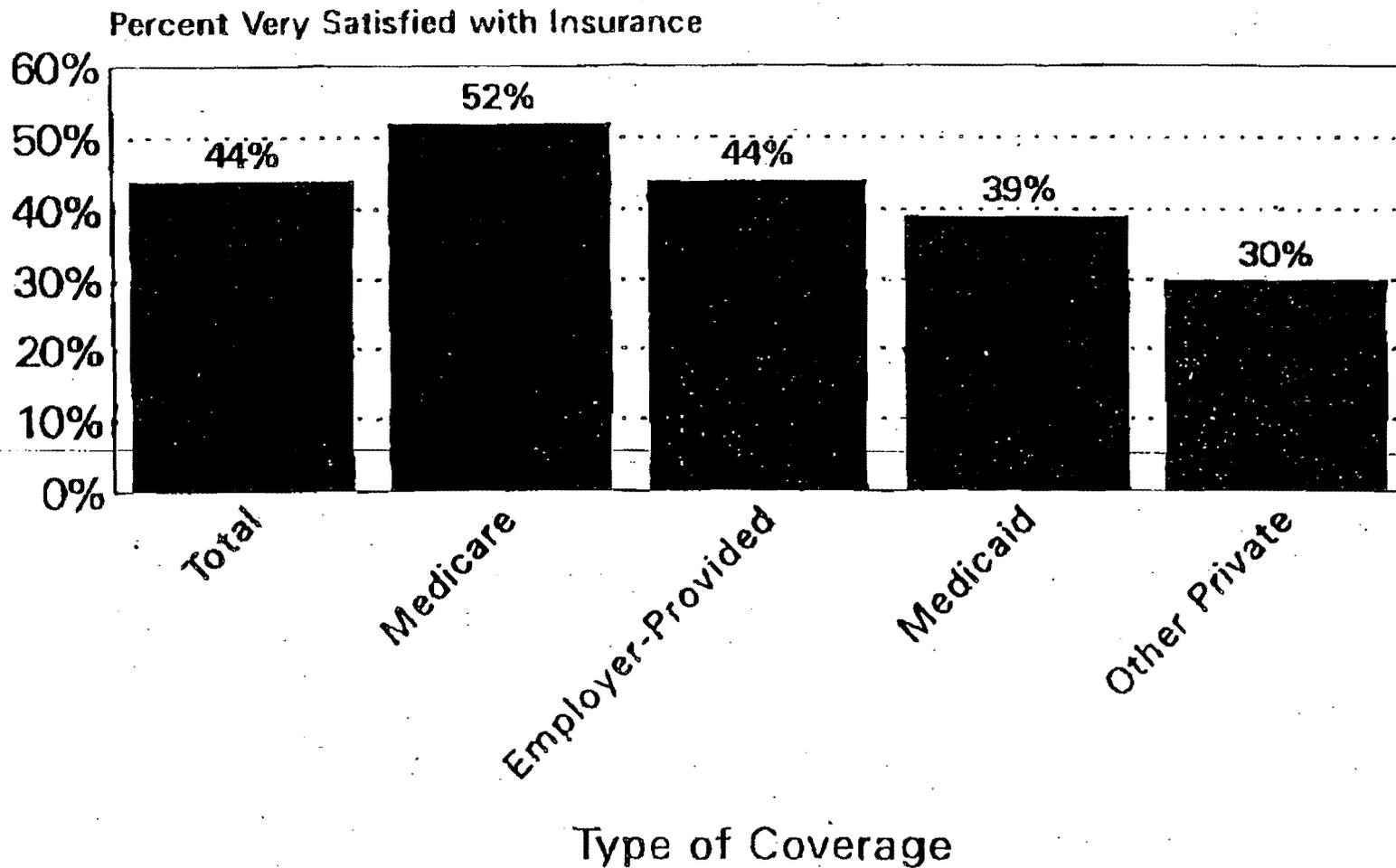
Chart 9

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# Satisfaction with Health Insurance

## Medicare Recipients Most Satisfied



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05/01/95 16:35 FAX 212 606 3876

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**VOTER SUPPORT FOR 25 SELECTED POLICIES  
 TO REDUCE THE FEDERAL DEFICIT**

% of voters who favor the proposal

	Total Voters	Voted for Republican in House	Voted for Democrat in House
<b>STRONG TO MODERATE SUPPORT</b>			
Having people over age 65 who earn more than \$50,000 a year pay more for Medicare than other seniors	71%	69%	73%
Decrease spending on food stamps	55%	60%	54%
Decrease agricultural price supports	53%	50%	56%
Decrease defense spending	53%	40%	64%
<b>MODERATE OPPOSITION</b>			
Paying doctors and hospitals less for the care they provide to seniors under Medicare	48%	44%	55%
Decrease spending on public housing	45%	50%	43%
Decrease spending on unemployment compensation	43%	44%	42%
Increase the proportion of Social Security benefits subject to federal income taxes	42%	40%	47%
Decrease federal aid to cities	39%	47%	33%
Decrease spending on AFDC	39%	49%	27%
Increase the retirement age for Social Security from 65 to 67	39%	44%	28%
Increase Social Security or employer taxes	35%	27%	44%
Limiting the tax deduction for employers' contributions to their employees' health insurance	32%	38%	27%
Requiring people to pay a larger share of nursing home costs before federal assistance begins	32%	38%	24%

(continued)

Source: Kaiser/Harvard Survey 1994

**VOTER SUPPORT FOR 25 SELECTED POLICIES  
 TO REDUCE THE FEDERAL DEFICIT (continued)**

**% of voters who favor the proposal**

	<b>Total Voters</b>	<b>Voted for Republican in House</b>	<b>Voted for Democrat in House</b>
<b>STRONG OPPOSITION</b>			
Decrease or eliminate tax deduction for charitable giving.	29%	29%	29%
Decrease or eliminate tax deduction for home mortgages	27%	32%	24%
Reduce the annual cost of living increase in Social Security	26%	34%	18%
Decrease federal aid for college student loans	24%	26%	21%
Increase the federal income tax	23%	20%	31%
Increase taxes on gasoline and heating oil	20%	15%	25%
Decrease federal aid to education	19%	18%	21%
Decrease spending on Social Security	17%	21%	13%
Decrease spending on Medicaid for the poor	17%	17%	15%
Decrease spending on Medicare for the elderly	8%	5%	10%
Decrease veterans' benefits	7%	8%	8%

Source: Kaiser/Harvard Survey 1994

**MEDICARE CUTS: OUT-OF-POCKET SPENDING TALKING POINTS**

↑ by X%  
\$

Older Americans already spend 21% of their incomes on out-of-pocket health care, not even including nursing home care. This is almost three times on average what families under 65 years old spend.

- Older Americans currently spend an average of \$2,500 on health care out-of-pocket. The Republican cuts that total \$250 billion between 1996 and 2002 would amount to \$1,630 per beneficiary in the year 2002.
- The Republicans say that they are not cutting Social Security. However, the effect of a Medicare cut is a back-door reduction in the Social Security benefits. Whereas the estimate increase in the median Social Security check will be \$400 in 2002, the Republican cuts would average \$1,600 per beneficiary in that year.

Bruce Vladeck  
2:30 pm

ARRP  
Lewin

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## MEDICAID LONG TERM CARE TALKING POINTS

- Long term care accounts for more than one-third of all Medicaid spending. Given the magnitude of the cuts proposed by the Republicans, states could not possibly respond without making deep reductions in eligibility for long term care, benefits, or payments to nursing homes and community-based providers.
- In 1993, 2.9 million people relied on Medicaid for nursing home or community-based long term care. According to an analysis by Lewin-VHI, cuts of the magnitude proposed by Republicans could reduce federal long term care spending by over \$37 billion from 1996 to 2000. They predict that over 1.7 million long-term care beneficiaries would lose services or be unable to secure services by 2000.
- Cuts in Medicaid long term care coverage would hurt middle class people, not just the poor. Medicaid pays for 41% of all formal long term care, and for over half of all nursing home care.

Elderly and disabled people are already paying too much out-of-pocket for nursing home care -- \$23 billion in 1993, almost three times what they spent in 1980. Without Medicaid, the 13 million Americans with an elderly parent or spouse who is disabled would face nursing home bills that average \$38,000 a year.

### Comparison of Social Security COLAs and illustrative increases in out-of-pocket expenses under proposals to reduce Medicare costs

Item	Calendar year							
	1995	1996	1997	1998	1999	2000	2001	2002
Social Security COLA (effective for December of year shown).....	3.0%	3.2%	3.3%	3.4%	3.6%	3.7%	3.9%	4.0%
Annual Social Security benefit for retired worker beneficiaries in following percentile:								
10%.....	\$ 4,213	\$ 4,940	\$ 4,479	\$ 4,626	\$ 4,783	\$ 4,956	\$ 5,139	\$ 5,340
25%.....	5,679	6,650	6,037	6,236	6,449	6,681	6,928	7,199
50%.....	8,445	8,899	8,978	9,278	9,591	9,937	10,305	10,707
75%.....	10,568	10,907	11,267	11,625	12,025	12,458	12,920	13,425
90%.....	12,630	13,010	13,428	13,872	14,345	14,852	15,414	16,016
Annual amount of COLA for retired worker beneficiaries in following percentile:								
10%.....	—	\$ 127	\$ 139	\$ 147	\$ 157	\$ 173	\$ 184	\$ 200
25%.....	—	171	187	199	213	232	248	270
50%.....	—	254	279	297	317	345	369	402
75%.....	—	318	350	372	397	433	462	504
90%.....	—	380	417	444	473	518	552	602
Illustrative increase* in out-of-pocket expenses for individual Medicare beneficiaries with covered services, under proposals that would increase aggregate cost sharing over the next 7 years								
\$50 billion		\$95	144	164	186	199	217	242
\$100 billion		128	214	277	348	417	500	597
\$150 billion		161	286	391	511	635	779	946
\$200 billion		196	360	509	678	857	1,062	1,296
\$250 billion		232	434	627	843	1,074	1,336	1,634
\$300 billion		270	513	750	1,014	1,297	1,615	1,975

\* The actual increase in out-of-pocket expenditures for individual Medicare beneficiaries would depend critically on (i) the specific provisions of the legislation, and (ii) the specific medical services used by the beneficiary. The increases shown here represent the average amount for all Medicare beneficiaries who would incur reimbursable charges under present law. Amounts for specific individuals could be substantially different.

Note: See accompanying memorandum concerning interpretation of these figures and their limitations.

Office of the Actuary  
Health Care Financing Admin.  
April 28, 1995

Prescription drug expenditures and  
 out-of-pocket expenditures for drugs per  
 non-institutionalized Medicare enrollee, by  
 income stratum, 1992

Income as % of poverty	Distrib. by stratum	Total spending	Out-of-pocket spending	Percent out-of-pocket
Total	100.0%	\$493	\$278	56.3%
Unknown	3.1%	\$263	\$175	66.6%
100 or under	26.3%	\$509	\$242	47.5%
101 - 120	7.9%	\$508	\$311	61.2%
121 - 150	11.9%	\$509	\$324	63.7%
151 - 200	14.1%	\$496	\$304	61.3%
201 - 300	17.0%	\$494	\$286	57.9%
300 or more	19.8%	\$492	\$275	55.9%

**MEDICARE**  
**Potential cuts to be Considered by the 104th Congress**

<u>Description</u>	<u>Five-Year Savings</u>
<u>Part A - Hospitals</u>	
Reduce inpatient PPS updates (savings reflect 1% reduction from market basket)	\$25 - \$30 billion
Capital Reductions—For discharges beginning in FY 1996, reduce the unadjusted federal capital payment rate by 7.31% and the unadjusted hospital-specific payment rate by 10.41%. FY1996 through 2000—reduce capital update by 4.9%. FY 1996 through 2003—reduce inpatient capital payments to exempt hospitals by 15%.	\$10 - \$15 billion
Disproportionate share hospital reductions (estimate reflects cutting DSH payments by half)	\$20 - \$25 billion
Moratorium on new long term care hospitals	\$0.5 - \$1.5 billion
Reduce indirect medical education adjustment (estimate reflects reducing IME adjustment to 3.0% in 1st year)	\$17 - \$23 billion
Reduce direct medical education payments	\$1.0 - \$2 billion
Eliminate Medicare's Additional Payments to Sole Community Hospitals	\$1.5 - \$2 billion
Continue Medicare's transition to prospective payment for facility costs in hospital outpatient departments	\$0.5 - \$1.0 billion
Eliminate Medicare payments to hospitals for beneficiaries' bad debts	\$2 - \$2.5 billion
<u>Part A - Skilled Nursing Facilities</u>	
Reduce or eliminate catch-up after freeze on SNF cost limits expires 10/1/95	\$1 - \$1.5 billion

Part B - Hospitals

Eliminate the "formula-driven overpayment" \$10 - \$15 billion

Part B - Physicians

Base Medicare Volume Performance Standards on real GDP per capita growth \$7 - \$9 billion

Establish cumulative growth targets for physician services \$6 - \$8 billion

Reduce Medicare fee schedule conversion factor one time, except for primary care physicians (estimate reflects a 3% reductions) \$3 - \$5 billion

Limit payments to high cost medical staffs (RAPs) \$3 - \$5 billion

Part B - Clinical Laboratories

Competitively contract for all Part B laboratory services \$1.5 - \$2 billion

Part B - Beneficiaries

Competitively contract for other Part B services and supplies \$1.5 - \$2 billion

Income-relate Part B premium—increase premium on sliding scale basis to 75% of part B program costs \$5 - \$7 billion

Increase to \$150 and index Medicare's deductible for physicians' services \$10 - \$12 billion

Increase SMI coinsurance rate to 25 percent \$17.5 - \$22.5 billion

Re-establish 20% coinsurance for laboratory services \$8 - \$10 billion

Establish 20 percent coinsurance for all home health and SNF services \$20 - \$25 billion

Parts A & B Hospitals/Physicians

Expand Centers of Excellence for coronary artery bypass graft surgery \$0.6 - \$1 billion

Parts A & B - Home Health

Eliminate catch-up after home health freeze expires on 7/1/96 \$2.5 - \$3.5 billion

Lower home health limits to 100% of median \$0.75 - \$1 billion

Parts A & B - Beneficiaries

Require a 10% copayment on all home health visits for visits other than those occurring 30 days after discharge \$10 - \$12 billion

Parts A & B - Medicare Secondary Payer (MSP)

Extend MSP data match with SSA and IRS \$0.6 - \$1 billion

Establish a threshold of 20 employees for MSP for the disabled \$0.7 - \$1 billion

Extend MSP for disabled provision in OBRA 1993 \$2.5 - \$3 billion

Extend MSP for end-stage renal disease patients provision \$0.2 - \$0.3 billion

Other

HMO payment reform \$1.5 - \$2 billion

## EFFECTS OF REPUBLICAN MEDICARE CUTS

- Republicans have proposed to cut Medicare funding by \$300 billion between now and 2002 -- a 24% cut in 2002 alone.
- Medicare managed care cannot produce the magnitude of savings being proposed by the Republicans. For example, Senator Gregg predicts that managed care could save \$35-45 billion between 1996 and 2000, although there is no evidence that managed care can produce Medicare savings of this magnitude. But even this overly optimistic projection produces less than one-third of the cuts being proposed by Republicans.
  - ▶ Claims that substantial savings can be achieved through Medicare managed care actually rely on capping federal contributions or on charging beneficiaries more to stay in fee-for-service Medicare.
  - ▶ CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the necessary changes to the existing payment system would be "difficult to specify."
  - ▶ Even with an improved payment methodology, the savings to Medicare would be only a small percentage of cuts being proposed by Republicans.
- Even if the level of savings suggested by Senator Gregg (extended through 2002) for Medicare managed care could be realized, the proposed cuts would have serious impacts on beneficiaries and providers. If the remaining cuts were allocated so that beneficiaries bore 50% of the burden and health care providers bore the remaining 50%:
  - ▶ Elderly and disabled beneficiaries who were enrolled in Medicare between 1996 and 2002 would have to pay about \$2,980 more for Medicare. In 2002 alone, they would be required to pay about \$775 more.
  - ▶ In 2002 alone, a 9.3% cut in Medicare payments to hospitals, physicians and other health care providers would be needed.
- Cuts of this magnitude would cause serious financial distress to the nation's medical system. Hospitals and other providers would still bear the growing burden of uncompensated care.
  - ▶ There are now 40 million uninsured Americans, and this number will continue to grow.
- Huge Medicare cuts, combined with the growing uncompensated care burden, will force providers to shift costs to business. And because their disadvantage in the insurance market, small business will bear the brunt of this cost shift.

- Reducing Medicare payments would disproportionately harm rural hospitals.
- Small rural hospitals -- often the only hospital in their county -- depend heavily on Medicare as a source of revenue. Many of these hospitals already are in financial difficulty and cannot absorb large Medicare payment reductions.
- In the last Congress, bills sponsored by both Republicans and Democrats contained large Medicare cuts. However, unlike current Republican proposals, the bills last year reinvested their savings into the health care system through subsidies to expand insurance coverage. Reinvesting the savings would have reduced the uncompensated care burden on provider and business and mitigated many of the adverse effects of Medicare cuts.
- Despite the current rhetoric, Medicare growth is comparable to the growth in private health insurance.
  - ▶ Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is growing only about 1% faster than private health insurance.
  - ▶ So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

## EFFECTS OF CAPPING MEDICAID

### IMPACT OF CUTS

- Medicaid is a safety net for over 35 million mothers and children, the elderly, and people with disabilities.
  - ▶ About 60% of Medicaid spending services are for the elderly and disabled. (This includes acute care services, such as hospitals, physicians, and prescription drug coverage.)
  - ▶ About 35% of Medicaid spending is for long-term care.
- Republicans have proposed (through the use of a block grant with a 5% cap on growth) to cut federal Medicaid funding by more than \$190 billion between now and 2002 -- a 30% cut in 2002 alone.
- Though the Republicans claim that all they are doing is providing added flexibility to states, what they are really doing is cutting \$190 billion in critical health care services.
- Managed care savings cannot offset even a small portion of these cuts. Even under optimistic assumptions, managed care could produce only about \$10 billion in savings between now and 2002. The remaining \$180 billion in cuts proposed by the Republicans would have to come from deep cuts in payments to health care providers, benefits and eligibility.

If the \$180 billion were divided equally among cuts in health care provider payments, benefits and eligibility:

- ▶ Total payments to hospitals, physicians and other health care providers would be cut by \$60 billion between now and 2002. The cut in 2002 alone would be about \$17 billion.
  - ▶ Cuts of this magnitude would place a heavy strain on public and inner-city hospitals and other providers -- who depend on Medicaid to keep their doors open. This would further erode access to services for Medicaid beneficiaries.
  - ▶ Eliminating outpatient prescription drugs for the tens of millions of Medicaid beneficiaries would roughly offset one-third of the cuts in 2002, a particularly burdensome cut for the vulnerable and elderly.
  - ▶ And, in 2002, eliminating coverage for roughly 2.5 million mothers and children and over three-quarters of a million elderly and disabled together would offset the remainder of the cuts.
- Even these dramatic figures probably understate the true level of cuts under the Republican proposals, since states, like the federal government, are looking to spend less on Medicaid, not more. Under Republican block grant proposals, states could save money only if they cut more than \$190 billion out of Medicaid.

### VARIATION ACROSS STATES

- An across-the-board 5% cap on Medicaid spending does not recognize significant differences across states, leaving some states even harder hit than these numbers suggest.

- ▶ Growth rates vary significantly across states and over time in a given state. Across states, variation results from differences in population, regional medical costs, enrollment patterns, and service mix. Over time, a state's growth rate can change because of recession or other economic factors.
  - ▶ When a recession occurs in a state, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. With a cap on Medicaid, states would bear this burden.
  - ▶ Ironically, states with the most efficient programs are most penalized by a 5% cap -- because it is hardest for them to find additional savings.
  - ▶ Retirement states with large numbers of elderly residents would bear a disproportionate burden as the population ages.
- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission of the Future of Medicaid finds that a 5% cap on the growth of federal Medicaid payments would cost states over \$167 billion between 1996 and 2002. [Note: This estimate is less than the CBO baseline estimate].
    - ▶ New York, California, Texas, Florida and Ohio would lose the largest amounts. New York would lose \$18.5 billion, California over \$14 billion, Texas almost \$11 billion, Florida \$9.5 billion, and Ohio over \$7 billion.
    - ▶ States in the South and Mountain regions would have the biggest percentage reductions in federal payments. Reductions during the period would average over 20% in states such as Florida, Georgia, Arkansas, Colorado, Montana, West Virginia and North Carolina.

## **NO EVIDENCE THAT THIS LEVEL OF GROWTH IS ACHIEVABLE WITHOUT SEVERE CUTS**

- Republicans claim that managed care can generate enormous savings.
  - ▶ But, there is no evidence that managed care alone can achieve the level of cuts they are proposing.
  - ▶ States already are aggressively pursuing managed care, but the populations for whom care can readily be managed -- children and AFDC adults -- account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.
  - ▶ Applying managed care techniques to the services typically used by the elderly and disabled (such as long-term care) is largely untried, making the potential for savings hard to predict.
- The potential for managed care savings also varies tremendously across states. States that have already applied managed care broadly will be less able to achieve additional savings. In rural states, where HMO coverage is not readily available even in the private sector, efficient managed care also is not a real option.
- Some may point to low Medicaid growth rates in certain states as evidence that a 5% cap on growth is achievable.

- ▶ While a few states may be able to hold growth down to 5% for a few years, no state has demonstrated the ability to sustain such a low growth rate for any significant period of time.
- ▶ Since 1992, 19 states have applied for state-wide health reform demonstration waivers from the Department of Health and Human Services. Under these waivers, states are able to change their Medicaid programs to increase efficiency and expand coverage. No state has projected an annual growth rate over the period at or below 5%.
- Republicans justify these cuts by claiming that Medicaid spending is out of control, but the facts show otherwise. The truth is that both the Congressional Budget Office and the Administration project that Medicaid spending per person will grow no faster than health insurance spending in the private sector.