# *TOO MUCH, TOO FAST*

The Impact on Older Americans of Medicare and Medicaid Reductions in the FY'96 Budget Resolution

Prepared by the
American Association of Retired Persons
June 29, 1995

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# Introduction

Older Americans support deficit reduction and they want a strong economy for their children and grandchildren. But they also understand that financial security — for themselves and their families — is dependent upon adequate and affordable health care coverage.

AARP believes that deficit reduction should be fair and balanced. We should strive to keep our economy on a steady path of deficit reduction, but we should not jeopardize the Medicare and Medicaid programs and the financial security they provide in the process.

**The Fiscal Year 1996 (FY96) Budget Resolution proposes to take nearly half of the deficit reduction of the next 7 years out of Medicare and Medicaid.** In both programs these are the largest cuts ever proposed, and in Medicare the proposed cuts are far more than what is needed to keep the programs solvent for the next decade.

As Congress struggles to meet its arbitrary deficit reduction deadlines and targets, hasty and ill-considered policy decisions are almost inevitable. Medicare and Medicaid beneficiaries will end up paying out-of-pocket what the programs will no longer pay.

The Medicare and Medicaid programs are not perfect. Changes are appropriate. Indeed, they must begin this year. A better approach recognizes that the Medicare and Medicaid programs will need to adapt to changing needs and budgetary constraints. But these changes should be carefully thought out, with considerable input from beneficiaries who understand fully what these changes will mean for them and for their children and grandchildren.

# CONGRESSIONAL BUDGET RESOLUTION COULD DEVASTATE MEDICARE BENEFICIARIES

Congress has proposed unprecedented reductions in Medicare spending as part of the FY96 Budget Resolution. The proposal would reduce Medicare by $270 billion over the next seven years. These reductions are nearly three times as large as the reduction enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA93).(1)

This document describes illustrative increases in beneficiary out-of-pocket costs under the resolution and the impact these cuts would likely have on the average older American.

## How Much More Will Beneficiaries Pay?

- AARP estimates that these proposals to reduce Medicare spending would mean that the average Medicare beneficiary would pay approximately **$3,400 more out-of-pocket** over the next seven years (see Chart 1).(2) Estimates are based on the assumption that one-half of proposed Medicare spending reductions come from beneficiaries.

## What Are Beneficiaries Paying Already?

- In 1995, the average older beneficiary will spend about $2,750 out-of-pocket to cover the cost of Medicare premiums, deductibles, coinsurance and the cost of services not covered by Medicare — like prescription drugs and preventive care. This does not include the enormous cost of nursing home care, which is nearly $40,000 a year. Even without any changes in Medicare, these older beneficiaries are already projected to spend more than $25,500 out-of-pocket for health care costs over the next 7 years.(3) **Under the Budget Resolution, an average beneficiary would end up spending a total of about $29,000 over seven years — an increase of about $3,400.**

## How Will Beneficiaries Be Affected?

- To achieve the Medicare spending reductions in these proposals, costs that are currently paid by the Medicare program would probably be shifted to Medicare beneficiaries in the form of higher premiums, deductibles and coinsurance.

These could include:

- **a higher Medicare Part B premium;**
- **an increase in the annual Part B deductible to $150, indexed to program growth;**
- **a new 20 percent home health coinsurance;**
- **a new 20 percent coinsurance for skilled nursing facility care;**
- **a new 20 percent lab coinsurance;**
- **a new income-related premium for higher-income beneficiaries**

All of these options have been under review in the Congress this year.

## What Will These Additional Out-of-Pocket Costs Mean to Beneficiaries?

### 1) *A Higher Medicare Part B Premium*

Currently, the Part B premium is intended to approximate 25 percent of Part B costs. In 1995, the premium is $46.10 per month, $553.20 annually. It is estimated to grow to $60.80 per month, $729.60 annually, by 2002. The premium is deducted from most beneficiaries' Social Security checks. The remaining 75 percent of Part B costs are paid from general revenues.

When Medicare was enacted in 1965, the Part B premium was set at 50 percent of program costs. In 1973, in an effort to keep health care costs from consuming more and more of beneficiaries' income, Congress limited the percentage growth in the Part B premium to the annual increase in the Social Security COLA; the share of costs paid by premiums declined thereafter until it reached roughly 23 percent in 1982. Since 1982, Congress has set the Part B premium to equal or approximate 25 percent of program costs.

- The Budget Resolution could substantially increase the Part B premium paid by Medicare beneficiaries thereby shifting higher health care costs to Medicare beneficiaries. Under the proposal, the premium is estimated to jump to $97.70 per month, or $1172.40 annually by 2002. That is $442.80 more than the beneficiary would pay under current law. Over the next 7 years, most Medicare beneficiaries would pay an estimated additional $1,590 for the Part B premium alone.

### 2) *An Increase in the Medicare Part B Deductible to $150 — Indexed to Part B Program Costs*

Each year, all Part B enrollees pay the first $100 in approved charges for Part B services. This annual Part B deductible is not indexed. Roughly 80 percent of Part B enrollees meet the Part B deductible.

- Increasing the Part B deductible from $100 to $150 would present a significant barrier to access for lower income beneficiaries. Moreover, anticipated reductions and changes to the Medicaid program make it increasingly unlikely that Medicaid would pay the additional costs for low-income individuals.

- Indexing the deductible would increase out-of-pocket costs for the average Medicare beneficiary for each succeeding year. Under the Budget Resolution, the deductible could grow from $100 today to $270 by 2002 . For beneficiaries, the total out-of-pocket increase for the deductible over the 7 year period would be $384 per beneficiary. Even those beneficiaries with Medigap plans covering the Part B deductible would not be immune to the increased out-of-pocket costs, since Medigap premiums would likely increase to cover the cost of the higher deductible.

### 3) *A New 20 Percent Medicare Home Health Coinsurance*

For a beneficiary to qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time skilled care (skilled nursing or therapy). In 1996, about 3.8 million Medicare beneficiaries will use home health benefits. Approximately two-thirds of Medicare home health users are women; almost two-thirds are over age 75. Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services.

- **A new 20 percent coinsurance would require the average home health user to pay an additional $900 in 1996 and almost $1,200 out-of-pocket in 2002.** The very frail individuals who need and use home health care the most, over 700,000 Medicare beneficiaries in 2002, would pay an annual coinsurance of over $3,800 in that year.

- Imposing a new out-of-pocket payment would be a "**sick tax**" on the most frail and vulnerable elderly and disabled Americans — those who can **least afford it.** Almost 80 percent of all Medicare home health users have annual incomes of less than $15,000 (see Chart 2). Approximately 24 percent have incomes between 100 percent and 150 percentof the federal poverty line (almost one million beneficiaries in 2002) — too high to qualify for current low-income protection under the Qualified Medicare Beneficiary (QMB) program, and too low to be able to afford a Medigap policy to cover these new out-of-pocket costs. As a result, many would lose access to these necessary services.

Under the current QMB program, individuals with incomes below 100 percent of the

Federal poverty line ($7,360 for singles and $9,840 for couples in 1994) would be eligible to have Medicaid pay the new 20 percent coinsurance. Unfortunately, the QMB program provides inadequate protection even for those who are eligible, primarily as a result of inadequate outreach. In addition, anticipated reductions and changes in the Medicaid program make it increasingly unlikely that Medicaid will continue to pay for qualified Medicare beneficiaries (QMBs) in many states.

- Since physicians are responsible for determining eligibility for Medicare home health coverage, a new beneficiary coinsurance is not an effective method for controlling potential inappropriate utilization.

- The 20 percent coinsurance proposal is "penny wise and pound foolish" because many beneficiaries who could not afford the coinsurance and, as a result, failed to receive needed services would be forced into nursing homes or hospitals. Those who could afford the new coinsurance would also spend down to Medicaid eligibility levels more quickly. As a result, states and the federal government could end up having to spend more than they would without the new coinsurance.

- There appears to be significant fraud and abuse in the Medicare home health program. Before making older Americans pay more, this fraud and abuse must be significantly reduced. It is not fair to force beneficiaries to make percentage payments based on artificially inflated costs that may have been fraudulently incurred.

**CASE STUDY**

**Imposing a New 20 Percent Medicare Home Health Coinsurance. . . .**

The typical Medicare beneficiary who needs home health care is a lower income woman over age 75. To illustrate the impact of a 20 percent home health coinsurance, let us take the hypothetical example of Mrs. Jones, who is an 80-year-old widow and has an annual income of $10,000 (approximately the median income level for home health users). Mrs. Jones currently spends about $3,000 per year out-of-pocket on her health needs (a typical amount for an 80-year old). She has too much income to qualify for QMB protection, but not enough to be able to buy a Medigap policy. If Mrs. Jones were forced to pay an additional 20 percent home health coinsurance, **her out-of-pocket health costs in 1996 would increase from $3,000 to $3,900**. This would leave her with about $6,100, or approximately $500 per month to pay for her basic needs for food, clothing and shelter.

### 4) *A New 20 Percent Coinsurance for Medicare Skilled Nursing Facility (SNF) Care*

Under current law, beneficiaries are eligible to receive up to 100 days of Medicare-covered skilled nursing facility (SNF) services following at least three consecutive days in a hospital. Beneficiaries must need "medically necessary skilled services" to receive coverage. No coinsurance is imposed for the first 20 days of covered care. For days

21-100, beneficiaries must pay $89.50 per day (one-eighth of the Part A Hospital deductible). On average, Medicare beneficiaries who need SNF care receive about 30 days of coverage. Typical diagnoses for SNF users are hip fracture and stroke.

- Imposing a 20 percent coinsurance amount for all covered days means that the vast majority of SNF users will have to pay more out-of-pocket to receive needed care. This is because the average length of coverage is about 30 days, and under current law, no coinsurance is imposed for the first 20 days.

- A major concern is that lower income beneficiaries will not be able to afford the coinsurance and may be denied access to needed rehabilitative services in a SNF. This is particularly true if the proposal to cap and block grant the Medicaid program is enacted, because it would seriously jeopardize the only low-income protection available under current law — the Qualified Medicare Beneficiary (QMB) program (see Medicaid section). Without this help in paying for SNF coinsurance, many low-income stroke and hip fracture victims would not be able to get the rehabilitation they need, and could end up spending additional days in the hospital or needing to be readmitted to the hospital.

### 5) *A New 20 Percent Coinsurance for Medicare Laboratory Services*

Currently, Medicare beneficiaries do not pay a coinsurance for laboratory services. Labs are paid on the basis of a fee schedule and are required to accept Medicare payments as full payment.

- Since physicians order laboratory tests — not beneficiaries — a 20 percent coinsurance could present a shift in costs for services over which beneficiaries have no control.

- Many lab tests are low cost — under $15.00 or $20.00. In some cases it probably will not be cost effective to collect a coinsurance.

### 6) *A New Income-Related Premium for Higher Income Medicare Beneficiaries*

Currently the Part B premium is intended to approximate 25 percent of Part B costs, and it is not based on beneficiaries' income.

- As a result of the Budget Resolution, Congress could impose a new, income-related premium for beneficiaries with incomes above $125,000 (singles) or $150,000 (couples). Some propose setting these threshholds as low as $55,000 for a single.

- At the highest income categories, beneficiaries would pay triple the amount they now pay for the Part B premium. If the income thresholds for the proposed high-income premium are not indexed, each year a greater percentage of Medicare beneficiaries would be required to pay the new, higher premium. In the future, Congress could simply choose to lower the income threshold, thereby increasing revenues.

- At the same time that an income-related premium would be imposed on Medicare beneficiaries, federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies come in the form of the tax deduction for employer-provided health insurance. As a result of the savings target under the Budget Resolution, Congress could impose higher health costs on higher-income older Americans but would continue federal subsidies for corporate executives, middle-aged millionaires, and Members of Congress. A May, 1994 Price Waterhouse analysis estimated that reducing federal subsidies for higher-income individuals under age 65 in the same manner as for Medicare beneficiaries would result in federal budget savings that are four times as large as the Medicare income-related premium savings.

### 7) *Beneficiary Access to Care could be Jeopardized*

Medicare beneficiaries' access to needed health care could be seriously hurt by the unprecedented reductions in Medicare spending included in the FY 96 Budget Resolution. For the average older American, the $270 billion in Medicare spending reductions will mean:

- **Increased Out-of-Pocket Costs That Could Limit *Access to Services*:** For the average beneficiary, the proposal to reduce Medicare spending could cost about $3,400 more out-of-pocket over the next seven years in the form of higher premiums, coinsurance and deductibles. For many beneficiaries — particularly those with low incomes — the additional costs are on top of the $2,750 they already pay out-of-pocket for health care in 1995. Older Americans spend roughly 20 percent of their income on health care — nearly three times as much as those under age 65. Increasing out-of-pocket costs could mean that fewer beneficiaries would be able to afford the care they need and many would be forced to wait until a condition worsens and care is even more expensive.

- **Spending Cuts That Could Limit *Access to Providers*:** As physician payments are reduced, many doctors will try to shift more costs onto Medicare beneficiaries. One likely way for this to happen is through the elimination of the Medicare balance billing limits. This change would allow doctors to charge beneficiaries significantly more than what Medicare approves. If this happens, many older Americans would no longer be able to afford to see their doctors. In other

cases, physicians may find that it is no longer profitable to treat Medicare patients, leaving beneficiaries without access to a doctor. Still other beneficiaries may have to travel long distances for hospital care since many hospitals across the country — particularly in rural areas — would be forced to close.

- **Spending Cuts That Could Limit *Access to Health Plans***: The level of spending reductions included in the Budget Resolution could result in substantially higher premiums for beneficiaries who choose to remain in traditional fee-for-service Medicare. Some beneficiaries might no longer be able to afford to stay in fee-for-service and would be forced into managed care.

8) ***Medicare Caps could be Imposed***

- **Structure**

  Members of Congress are considering a Medicare spending "cap" as one method for achieving budget savings. Under this approach, yearly spending limits or targets would be established for the Medicare program. This cap could take one of several forms: a total spending limit for the program, a limit on the annual growth rate in the program; or a per capita spending limit. The cap could be fixed in law or determined on a yearly basis.

  Annual Medicare spending would then be measured against the cap. Under one approach, known as a "look-back," actual Medicare spending would be compared with the target at the end of each year. If actual spending exceeded the target, then Medicare spending for the following year would be reduced by the amount exceeding the target.

- **Impact on Beneficiaries**

  A Medicare cap would have a direct bearing on Medicare beneficiaries. If Medicare spending exceeds the yearly cap, automatic cuts in Medicare spending would likely translate into higher out-of-pocket costs for Medicare beneficiaries — in the form of higher premiums, coinsurance or deductibles — as well as reductions in payments to hospitals and doctors which would affect beneficiary access to services.

  Advocates of a Medicare cap claim that this kind of target is necessary to keep program spending in check. However, for the average beneficiary — who has little control over Medicare program spending — this would mean an even greater out-of-pocket burden for Medicare services.

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(1) This analysis is based on the June 22, 1995 Budget Resolution Conference Agreement.

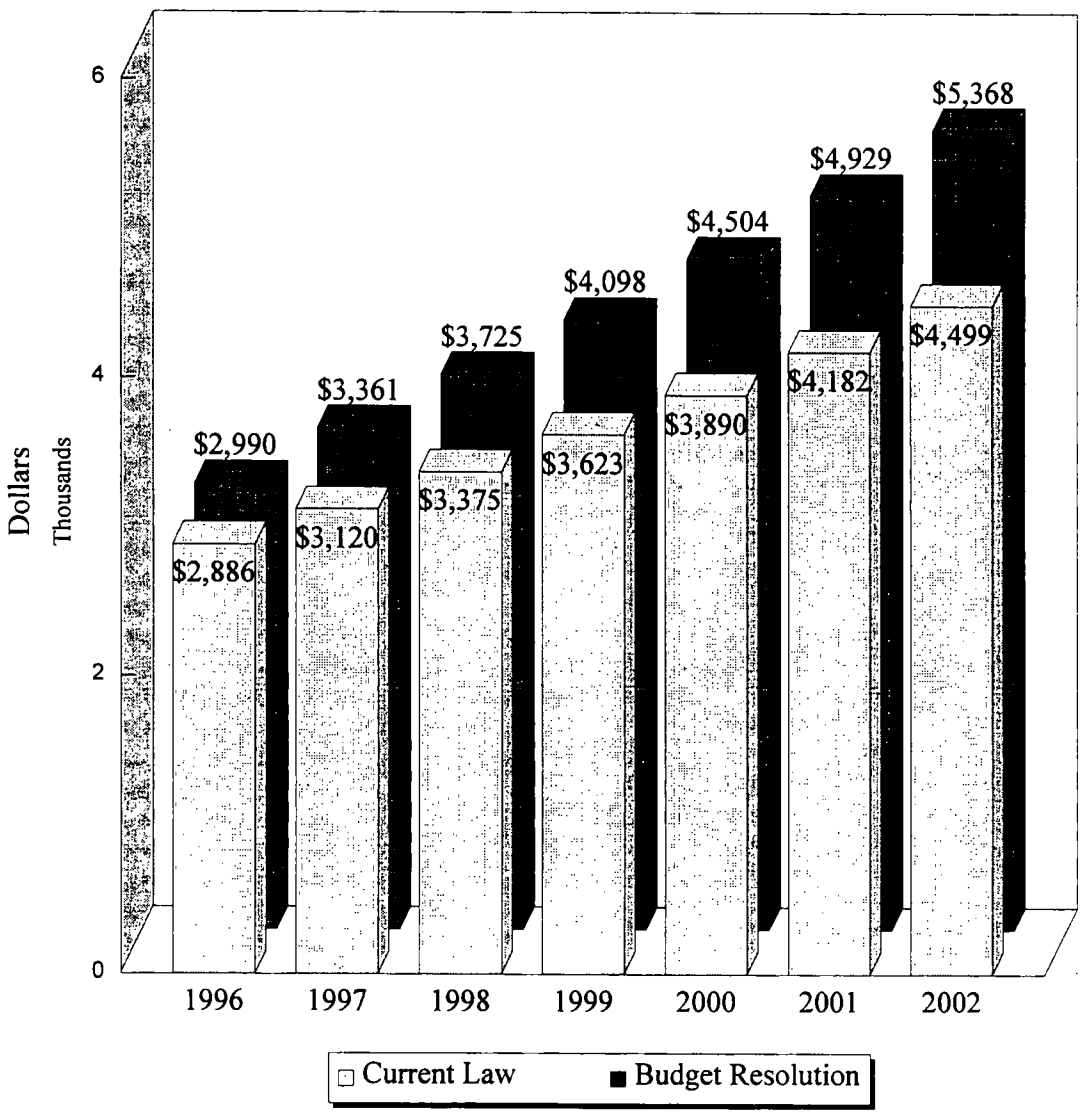
(2) Increased out-of-pocket costs are averaged across all Medicare beneficiaries.

(3) Out-of-pocket health costs include all health care expenses of non-institutionalized older individuals except those paid by Medicare. Medicare and private premiums, and prescriptions drugs, for example, are considered out-of-pocket costs. Data are based on December, 1993 CBO projections of population subgroups and National Health Accounts data by type of service and payer.

Chart 1

# Comparison of Illustrative Increases in Average Beneficiary Out-of-Pocket Costs under the Congressional Budget Resolution

Over the seven year period, 1996-2002, average costs would increase by $3,400 per beneficiary.

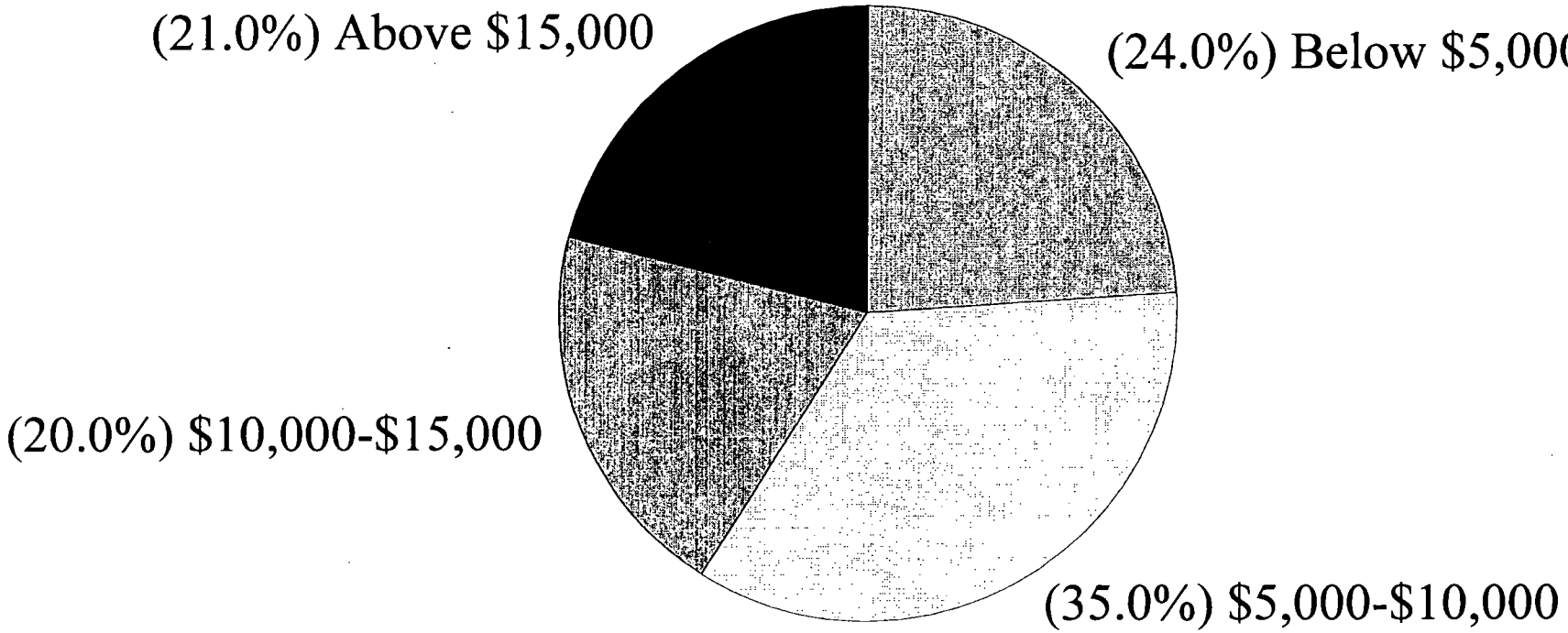



**Sources:**

a. "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans." Prepared by AARP/Public Policy Institute, April 1994; Updated February 1995.

b. Prepared by AARP/Federal Affairs based on information from "Reducing the Deficit: Spending and Revenue Options," Congressional Budget Office, February 1995.

# 1992 Income* of Medicare Home Health Users




* Self-reported by income categories, including spouses' income.

Source: 1992 HCFA Current Beneficiary Survey, AARP Federal Affairs

August 18, 1995

TO: Molly Brostrom
FROM: Katie Smeltz
RE: Summary of "Too Much, Too Fast: The Impact on Older Americans of Medicare and Medicaid Reductions in the FY'96 Budget Resolution"

Additional Cuts Would Cause:

- a higher Medicare Part B premium;
- an increase in the annual Part B deductible to $150, indexed to program growth;
- a new 20 percent home health coinsurance;
- a new 20 percent lab coinsurance;
- a new income-related premium for higher-income beneficiaries
- a new 20 percent coinsurance for skilled nursing facility care;

Unprecedented Medicaid Reductions Could Eliminate Health Insurance Coverage For Many Vulnerable Americans

*The number of families without basic health insurance would likely increase dramatically.

*Many older Americans would likely lose coverage for long-term care.

In the year 2002, over 2 million Americans could lose their Medicaid coverage for long-term care as a result of the proposed reductions.

AARP *JUST THE FACTS. . . .*

## Medicaid Block Grants Would Threaten Essential Protections For Older Americans

The budget proposal to block grant Medicaid **jeopardizes important federal consumer protections** designed to help older Americans. These protections were enacted, in large part, because states were not doing enough voluntarily. Absent federal requirements, there is little reason to be confident that all states will continue to provide protections like spousal impoverishment and nursing home quality programs. States could reduce or eliminate some or all of these essential programs for vulnerable older Americans.

- **Low-Income Protections for Qualified Medicare Beneficiaries (QMBs)** — A block grant could allow states to eliminate the QMB program entirely, leaving vulnerable, low-income seniors without the ability to afford even the most basic Medicare services. Under current federal law, Medicaid pays the Medicare deductibles and coinsurance for beneficiaries with incomes below the federal poverty line (about $7,500 for singles and $10,000 for couples) and premiums for qualified Medicare beneficiaries (QMBs) with incomes under 120% of poverty. The governors have strongly supported federal takeover of this program, a position that suggests that they would be unlikely to dedicate adequate state funds to maintain it. Medicare and Medicaid reductions, combined with a block grant, create the very real possibility that the state and federal governments will **abandon low-income Medicare beneficiaries entirely**.

- **Nursing Home Spousal Impoverishment Protections** — A block grant could allow states to eliminate current spousal impoverishment protections. Financial protections for spouses of nursing home residents were enacted in 1988 because spouses who remained in the community were often left without income and savings to survive on as their wives or husbands entered a nursing home and spent-down to Medicaid. In some cases, the situation was causing couples married for 50 years to sue each other or get divorced to ensure that the spouse living in the community had the financial resources needed to live. Repealing this protection could lead to **bankrupting spouses who remain in the community** when their husband or wife has to go into a nursing home and spend down to Medicaid.

- **Nursing Home Quality Protections** — A block grant could eliminate successful federal nursing home quality standards and procedures, making nursing homes truly dangerous places in which to live. A 1986 study by the widely respected, independent National Academy of Sciences Institute of Medicine concluded: "A stronger federal leadership role is essential for improving nursing home regulations because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government." Landmark federal nursing home quality improvements were enacted in the following year. Repealing these quality protections would be a drastic step backward, and could **place millions of frail nursing home residents in jeopardy.**

AARP *JUST THE FACTS. . . .*

## Unprecedented Medicaid Reductions Could Eliminate Health Insurance Coverage For Many Vulnerable Americans

The FY 96 Budget Resolution includes the **largest Medicaid reductions in the history of the program — $182 billion** in savings over the next 7 years. In the year 2002 alone, the budget proposal would reduce projected federal Medicaid spending by $54 billion, a reduction of about 30% below what the government estimates it will cost to run the program delivering the same services and benefits that it does today. The annual Medicaid growth rate would be capped, gradually reduced to a 4 percent rate of growth — less than half of the current 10 percent growth rate. In addition, the Budget Resolution anticipates that the entire Medicaid program would be turned into a "block grant" to the states.

Medicaid is the health and long-term care safety net for vulnerable children, older and disabled Americans. **More than 4 million older Americans depend on Medicaid** for coverage of preventive care, prescription drugs, nursing home and home and community-based long-term care. Medicaid also assists **over 2 million low-income qualified Medicare** beneficiaries (QMBs) by paying their Medicare premiums (if income is below 120 percent of poverty), deductibles and coinsurance (if income is below 100 percent of poverty). In addition, **more than 15 million low-income children are covered by Medicaid,** most of whom live in families where at least one adult is employed.

Budget reductions of this size will have enormous consequences for these vulnerable Americans:

- **The number of families without basic health insurance would likely increase dramatically.** How individual states would respond to the proposed cuts would vary by state, but some things are clear. It is unlikely that states will raise taxes or shift money from education or prisons to make up for the federal reductions. Some states are likely to respond by cutting their own Medicaid spending as well. According to estimates by the Urban Institute, in the year 2002, more than **8 million Americans could lose their Medicaid coverage** as a result of these proposed reductions.

- **Many older Americans would likely lose coverage for long-term care.** Medicaid is most Americans' sole protection against the high costs of long-term care. About 35 percent of Medicaid spending goes for long-term care and Medicaid pays for more than half of the nation's nursing home costs. Many who need long-

term care start off as taxpaying, middle class Americans. When chronic illness strikes, they must "spend down" their life savings until they are eligible for the Medicaid long-term care "safety net." According to estimates by Lewin-VHI, in the year 2002, **over 2 million Americans could lose their Medicaid coverage for long-term care** as a result of the proposed reductions.

Some greater state flexibility could help Medicaid — but **block grants, like the proposed reductions, go too far.** There remain substantial opportunities for simplifying the program and making coverage more rational. AARP would support greater state flexibility when it would expand coverage, improve services, or contain costs without jeopardizing access or quality. Repealing essential federal consumer protections, however, could result in great harm to older Americans.

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# NINE DIFFERENT WAYS:

## How the Budget Hurts Older Americans

**Report of the**

LEADERSHIP COUNCIL OF  AGING ORGANIZATIONS



**Tuesday, November 28, 1995**

# NINE DIFFERENT WAYS:

## HOW THE BUDGET HURTS OLDER AMERICANS

### REPORT OF THE FOLLOWING
### LEADERSHIP COUNCIL OF AGING ORGANIZATIONS:

Alliance for Aging Research, Alzheimer's Association, American Association for International Aging, American Association of Homes and Services for the Aging, American Association of Retired Persons, AFSCME Retiree Program, American Foundation for the Blind, American Geriatrics Society, American Society on Aging, Asociacion Nacional pro Personas Mayores, Association for Gerontology in Higher Education, Association for Gerontology and Human Development in Historically Black Colleges and Universities, B'nai B'rith Center for Senior Housing and Services, Eldercare America, Families USA, The Gerontological Society of America, Gray Panthers, National Asian Pacific Center on Aging, National Association for Home Care, National Association of Area Agencies on Aging, National Association of Foster Grandparent Program Directors, National Association of Meal Programs, National Association of Nutrition and Aging Services Programs, National Association of Retired and Senior Volunteer Program Directors, National Association of Senior Companion Project Directors, National Association of State Units on Aging, National Caucus and Center on Black Aged, Inc., National Committee to Preserve Social Security and Medicare, National Council of Senior Citizens, National Council on the Aging, National Hispanic Council on Aging, National Osteoporosis Foundation, National Senior Citizens Law Center, North American Association of Jewish Homes and Housing for the Aging, Older Women's League

## EXECUTIVE SUMMARY

# NINE DIFFERENT WAYS:

## HOW THE BUDGET HURTS OLDER AMERICANS

Report of the Leadership Council of Aging Organizations

The news media have reported on massive cuts in programs vital to older Americans; but they have not yet focused on the cumulative impact of those cuts. As Congress embarks on the most drastic changes in the social safety net in history, these multiple cuts will do far more damage than has been reported. The nine points below are not in order of importance; all are equally important to the LCAO.

1. Congress Cuts Medicare $270 Billion Part B premiums rise from $46.10 to almost $90 a month by 2002. Beneficiaries needing certain hospital outpatient services would pay even more than the 50% coinsurance they now pay and many would lose extended home care coverage.

2. Congress Cuts Medicaid Long Term Care Medicaid spending would be cut by $164 billion over seven years. Federal standards for eligibility, services, payment, and quality would be seriously weakened.

3. Congress Cuts Medicaid Acute Care Current federal requirements to pay Medicare deductibles and coinsurance for low-income Medicare beneficiaries would be ended. The conference report allocates some money to assist states in helping beneficiaries pay Part B premiums, but projections are that the amount will be insuffient to cover all those with incomes below poverty level who are eligible.

4. Human Services – Older Americans Act, Legal Services, Aging Research, Training, Senior Volunteers Cuts will mean 6.2 million fewer meals at senior centers and 5.6 million fewer to homebound elders. Research on aging issues, funded under Older Americans Act Title 4, has been severely cut or eliminated. Elderly and disabled transportation program is cut $7.5 million. Legal Services Corp. and legal assistance under Older Americans Act are severely cut.

5. Welfare Reform and Grandparents During the last decade the number of grandparents raising grandchildren climbed 40%. Most have household incomes under $20,000 per year. Reforms will make it more difficult to obtain aid for their grandchildren.

6. Food Stamps Block grants offer no assurance that even minimal protections for older people would be retained by states, making access to benefits still more difficult.

7. Supplemental Security Income Individual states may slash or eliminate SSI supplementary benefits. Cash benefits for institutionalized children covered by Medicare or private insurance would be capped at $30 a month.

8. Housing Assistance Older people make up approximately one-third of all public housing residents. Operating subsidies and modernization funds for public housing would be cut by 3.5 and 33 percent respectively from 1995 levels. Rents will be raised for residents of privately owned section 8 subsidized units; 46 percent are elderly.

9. Low Income Home Energy Assistance Program The Senate recommendation is for a 32 percent cut. Nearly 2 million households could lose their energy assistance.

# WHAT CONGRESS IS DOING TO WIDOW JONES, AGE 73

Mrs. Jones, a 73 year old widow who lives alone, has a total cash income of $458 per month ($5,496 per year) from Social Security and Supplemental Security Income. In addition, she receives assistance from Medicaid, food stamps, the Low-Income Home Energy Assistance Program and the Older Americans Act. Mrs. Jones is eligible for both Medicare and Medicaid (as an SSI beneficiary). Medicare and Medicaid pay most of Mrs. Jones' doctor bills and occasional hospital visits, including her prescription drugs for diabetes, arthritis, and glaucoma and pay for her eyeglasses. Medicaid also pays her Medicare premiums, deductibles, and coinsurance, but were she not dually eligible, her low income would still qualify her for Medicaid payment of Medicare premiums, coinsurance, and deductibles under the Qualified Medicare Beneficiary program. Mrs. Jones receives a hot home-delivered meal five days a week, receives a one-time $160 payment through the Low-Income Home Energy Assistance Program and receives $63 per month in food stamps.

The chart below illustrates the disastrous cumulative impact of budget cuts to elderly health and welfare programs. If Medicaid and food stamps are block-granted, Mrs. Jones could lose her eligibility for both. She could also lose her yearly $160 help with heating bills and services under the Older Americans Act such as meals-on-wheels and help with legal matters. She would have to pay for Medicare coverage as well as some medical costs, including some medicines, that are now paid by Medicaid.

Widow Jones' total income is $5,496. To make up for the impact of congressional budget cuts, her 1996 out-of-pocket costs would exceed her total income by $379. And she still would need to find money for the basics: housing, utilities, telephone, and transportation. She may not be able to get medical care. She may not be able to purchase needed medications. Or, if she pays for medical care, she may become homeless. Note that her out-of-pocket costs go up every year through 2002.

**Estimated Benefit Cuts/Cost Increases for Hypothetical Example of Mrs. Jones***

| Benefit Cut/Cost Increase | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 1996-2002 |
|---|---|---|---|---|---|---|---|---|
| Medicare Part B premium | $60 | $40 | $28 | $58 | $84 | $84 | $96 | $450 |
| Medicare Part B deductible | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 700 |
| Drugs ($270 average) | 2880 | 3168 | 3485 | 3833 | 4217 | 4638 | 5102 | 27323 |
| Coinsurance ($487 average) | 1387 | 1484 | 1588 | 1699 | 1818 | 1945 | 2082 | 12003 |
| Food Stamps | 756 | 781 | 808 | 835 | 863 | 893 | 923 | 5859 |
| LIHEAP | 160 | 165 | 171 | 176 | 182 | 189 | 195 | 1238 |
| Meals | 520 | 537 | 555 | 574 | 594 | 614 | 635 | 4029 |
| Total | $5,863 | $6,275 | $6,735 | $7,275 | $7,858 | $8,463 | $9,133 | $51,602 |

*The figures in the table represent the estimated dollar value of the reductions in benefits that would occur as a result of proposed budget cuts. They do not represent losses of income, but rather losses of benefits. In fact, it would be impossible for Mrs. Jones to purchase all of these services and products were she to lose eligibility for Medicaid, food stamps, etc. because her income simply would be insufficient to pay for them. The figures above are based on the following assumptions: 1) Mrs. Jones is no longer eligible for Medicaid, food stamps, LIHEAP, or meals; 2) she now must have her Medicare Part B premium subtracted from her Social Security COLA, thereby eliminating part or all of her annual COLA increase (her monthly Social Security benefit level is assumed to be $200 in 1995, which provides a COLA of just over $6.00 per month in future years, so Mrs. Jones cannot pay the full Part B premium increase); 3) she must pay for the entire cost of drugs out-of-pocket now because she no longer has Medicaid coverage, and these costs are not covered by Medicare; 4) the Part B premium under current law would revert to 25 percent of Part B costs, but it is assumed here to remain at its current level of 31.5 percent of Part B costs; 5) estimated monthly costs of drugs for diabetes are estimated at $125, for glaucoma at $65, and for arthritis at $50; 6) estimated costs of coinsurance are based on average costs for poor Medicaid beneficiaries for hospital and physician services covered by Medicaid less the Part B premium, Part B deductible, and drug coinsurance; and 7) drugs and coinsurance are inflated at 7 percent per year; food stamps, LIHEAP, and meals are inflated at the rate of the CPI.

# NINE DIFFERENT WAYS:

## How the Budget Hurts Older Americans

### Report of the Leadership Council of Aging Organizations

The news media have reported on the massive cuts in programs vital to older Americans but they have not yet focused on the cumulative impact of those cuts. For many vulnerable elderly, these multiple cuts, piled one on top of the other, will do far more damage than has been reported.

Congress is embarking on the most drastic changes in the social safety net in the history of our nation. Congressional proposals would cut Medicare by $270 billion over seven years, end any entitlement to public assistance and Medicaid and turn them into block grants to the states, limit or eliminate Supplemental Security Income benefits for certain aged, disabled or noncitizen beneficiaries, and make major cuts in food stamps, housing support programs, home heating, nutrition, and a variety of other programs. All this comes at the expense of the nation's most vulnerable populations.

## 1 Congress Cuts Medicare $270 Billion

In 1995, the average Medicare beneficiary pays $2,750 in out-of-pocket health care costs. The conference report on the budget reconciliation bill will increase that amount.

The plan nearly doubles the Part B premium from $46.10 a month in 1995 to almost $90 a month by 2002. While the current limit on physician balance billing in the traditional Medicare fee for service program would remain in place, limits would not apply to the new coverage options outlined in the plan except for in-network physicians and certain emergency care. Beneficiaries in the traditional program who need certain hospital outpatient services would pay even more than the 50 percent coinsurance they are paying today.

***The plan nearly doubles the Part B premium from $46.10 in 1995 to almost $90 a month by 2002.***

Most of the proposed cuts in Medicare spending—approximately $150 billion—come from lowering fees to doctors, hospitals and other providers. Medicare already pays physicians and hospitals only about two-thirds as much as private insurers. Payments to doctors, hospitals and other providers in fee-for-service would be further reduced if total fee-for-service costs are projected to exceed a cap, known as a "fail-safe" mechanism. These additional cuts could create serious disincentives for doctors to treat Medicare fee-for-service patients, or could reduce the quality of care.

Under the reconciliation package, current federal law requiring Medicaid to pay Medicare deductibles and coinsurance for low-income Medicare beneficiaries would

be ended. The budget proposal allocates some money to assist states in helping beneficiaries pay Part B premiums, but projections are that the amount allocated will be insufficient to cover all those eligible with incomes below poverty level.

Proposed changes in the ways home health care agencies are paid could reduce access to home health services for patients who need care for more than 120 days. These changes could mean that nearly 1 million of the sickest, frailest seniors would be in at risk of being denied vitally needed services. In addition, Congress has proposed shifting the home care reimbursement from Part A to Part B after 165 days. This shift alone could jeopardize access to home care for 1.8 million seniors who have Part A but not Part B.

The proposal would also make unprecedented changes in the way many Medicare beneficiaries receive care. Beneficiaries would be permitted to stay in the traditional fee-for- service program, but could also choose new coverage options, including new managed care plans, medical savings accounts, private fee-for-service, and provider-sponsored networks. If healthier beneficiaries choose the new options, leaving sicker beneficiaries in the traditional program, costs in the traditional program would rise. Another risk is that Medicare payments will not keep pace with the actual costs of coverage, so that purchasing power is eroded and seniors will have to pay higher premiums or receive reduced coverage.

## 2 Congress Cuts Medicaid Long Term Care

Almost two-thirds of nursing home residents currently receive assistance from Medicaid. Most are elderly women. Medicaid pays more than half the nation's nursing home bill, including care for thousands of middle class older Americans who have spent nearly all their assets paying the average $38,000 annual nursing home fee.

Although Congressional proponents of Medicaid reductions say their plan does not cut Medicaid, but rather only limits the rate of growth, projected Medicaid spending would be cut by $164 billion over seven years. Growth in Medicaid costs would be held to an average of approximately five percent a year compared to a current projected annual growth rate of about 10 percent. Federal Medicaid dollars to the states would be capped regardless of changes in inflation or need, and federal standards for eligibility, services, payment, and quality would be seriously weakened.

***Medicaid pays more than half the nation's nursing home bill...***

The program would be turned into a block grant to the states. Under the block grant, states could decide to eliminate coverage for high cost services such as home care or institutional long term care. Or if states chose to continue covering institutional care, they might severely cut coverage of home and community services—the settings preferred by the vast majority of people with disabilities.

States could force adult children of those needing nursing home care to pay for that care before Medicaid does if the children's income exceeds the state's median. And states could force spouses, disabled children, or brothers and sisters formerly living in the same home as the nursing home resident to sell their home to

pay for nursing home care.

Major improvements in nursing home quality standards were enacted in 1987, after an Institute of Medicine report documented problems in care for the elderly. Currently, every nursing home in the nation is inspected annually on the basis of strong uniform standards of care. Under the budget reconciliation proposal, the federal government would make states responsible for enforcement of nursing home standards. Given the unevenness in the application of quality standards prior to OBRA 87, valuable protections for nursing home residents, in such areas as inspections, nurse aide training, admission criteria, enforcement actions, etc. would be compromised.

## 3 Congress Cuts Medicaid Acute Care

Beyond long term-care expenses, vulnerable older Americans currently get assistance from Medicaid in a number of ways. For elderly people living in poverty, Medicaid pays their Medicare premiums, deductibles, and coinsurance requirements (these beneficiaries are termed Qualified Medicare Beneficiaries or QMBs). For low-income Medicare beneficiaries (income between 100 and 120 percent of poverty), Medicaid pays only their Medicare premium. For the poorest elderly, those meeting the Supplemental Security Income eligibility criteria (income below 75% of poverty), Medicaid covers services that Medicare does not cover such as prescription drugs, hearing aids, and eye glasses. Medicaid also pays their Medicare premium, deductible, and coinsurance. Under the budget reconciliation proposal, current federal requirements to pay Medicare deductibles and coinsurance for low-income Medicare beneficiaries would be eliminated. Although there will be minimal requirements for states to pay Medicare premiums, an additional 4.8 million people could be left without assistance to pay for Medicare out of pocket costs and without access to extended home health care benefits. Such assistance would be left to the states to cover at their option. The same would be true of coverage of Medicaid services for the poorest elderly, including important services not covered by Medicare. The reconciliation bill eliminates the individual entitlement to Medicaid for Supplemental Security Income recipients, leaving states to determine eligibility for Medicaid services for the elderly and disabled.

***...current federal requirements to pay Medicare deductibles and coinsurance for low-income Medicare beneficiaries would be eliminated.***

Although it is unlikely states will abandon all coverage of elderly individuals, the magnitude of the cuts—28 percent by 2002—makes it unlikely that states can continue their current commitment to the elderly. Medicaid eligibility for the elderly is likely to be reduced and many low-income elderly would also be at risk of losing their Medicare coverage. Today, 68 percent of all elderly living in poverty rely on either Medicare alone (40%) or Medicaid and Medicare (28%) for their health care coverage. Without assistance from Medicaid, many low-income elderly would not be able to afford their Medicare Part B premium, let alone private supplemental coverage for services Medicare does not cover. If they cannot afford the Medicare Part A deductible and coinsurance, they might also lose access to

Part A services. Low-income elderly individuals would be forced to choose between paying their Medicare out-of-pocket expenses or paying rent and other basic needs.

## 4 Human Services — The Older Americans Act, Legal Services, Aging Research, Training, Senior Volunteers

Reductions in human services programs will further jeopardize the ability of older people to remain independent in their own communities. Of paramount importance in providing human service programs to the elderly is the Older Americans Act.

For the past thirty years, the Older Americans Act has served the best interests of the elderly and their caregivers by funding a variety of services, supporting research and training in the aging field, and providing job training programs for low-income older individuals. Since 1980, funding for the Older Americans Act has declined in real terms by over 30 percent. Funding plans passed by the House would cut the program by $145 million, an 11 percent reduction from current levels. Critical services in local communities including meals, in-home services, elder abuse prevention, nursing home ombudsman, senior centers, senior employment, aging research and training, and other important areas that serve older Americans will be cut back or eliminated. Grants for Native American elders programs will suffer greatly, given the traditionally low funding levels which support the provision of all services to North American Indian and Native Hawaiian elders.

***As a result of these cuts, 6.2 million fewer meals would be served in congregate sites and 5.6 million fewer meals would be delivered to homebound elders...***

As a result of cuts, 6.2 million fewer meals would be served in congregate sites and 5.6 million fewer meals would be delivered to homebound elders; 14,000 older workers would be terminated from the Senior Community Services Employment Program; and 165 local ombudsman programs would be eliminated, reducing services to 52,000 nursing home residents.

The current $24 million for Title IV aging research has been severely cut by Congress. Its funding for training, research, demonstrations, and education, was eliminated by the House and cut by $21 million in the Senate. The Health Care Financing Administration's research and demonstration funding was cut by $94 million in the House. The Health Resources and Services Research funds would be cut by $102 million. All of these research funds have assisted in demonstrating new programs and streamlining public programs for the elderly. Demand for these programs will continue to rise as the population of our nation continues to age.

Transportation programs for the aged and people with disabilities are also in danger. House and Senate conferees have proposed cutting the Federal Transit Act's Section 16 program for the elderly and disabled by $7.5 million over last year's conference report. Compounded by the proposed cuts in Medicaid, the Older Americans Act, and mass transit appropriations, transportation services for

the elderly will be seriously impacted.

Congress is sharply cutting the Legal Services Corporation as well as legal assistance provided for under the Older Americans Act. Appropriations have been drastically cut and restrictions have been placed on what attorneys will be able to do in representing their clients. The specialty backup centers have lost all support from the Legal Services Corporation. Local programs will no longer be able to conduct class action suits, provide representation before legislative bodies, challenge the legality of welfare reform statutes, or provide numerous other types of representation. Also disturbing are the new restrictions on the kinds of matters that can be handled by LSC funded programs.

The funding for the National Senior Service Corps (the Foster Grandparent Program, the Senior Companion Program and the Retired and Senior Volunteer Program) has been cut by $7.423 million from its FY 95 appropriation levels. In real terms, this means 1,959 Foster Grandparent service years and 28 local projects will be eliminated. In the Retired and Senior Volunteer Program, the reduction will eliminate approximately 55 projects serving over 4,400 local agencies and organizations in approximately 100 counties in all states which today provide opportunities for 33,000 older volunteers. This cut represents a retrenchment from program growth which has brought needed service to communities across America and hundreds of thousands of service opportunities to older Americans.

## Welfare Reform and Grandparents

Much of the current welfare reform debate has centered on developing policies for children being raised in poverty by single mothers. While there are many children who fit this description, a growing number of children are in the care of someone other than a parent, and in many cases, that someone is a grandparent. During the last decade, the number of grandparents raising grandchildren has increased by 40 percent.

***...Congress will make it more difficult for grandparents to obtain aid on behalf of grandchildren in their care.***

Many grandparents raise their grandchildren not out of choice but out of necessity, and at great cost to themselves. Fifty-six percent of grandparent caregiver households have incomes of less than $20,000 per year. Twenty-seven percent live at or below the poverty level, which was $10,030 for a family of two in 1995. Because their own incomes are so modest, many of these grandparents depend on Aid to Families With Dependent Children to meet the needs of their grandchildren. Current reforms pending in Congress will make it more difficult for grandparents to obtain aid on behalf of grandchildren in their care.

Among numerous other changes to AFDC, Congress intends to consolidate cash grant programs and related social service programs into block grants, to eliminate the entitlement to AFDC, and to limit the time that states can provide benefits to any individual. States would have no obligation to maintain their current level of state spending. As a consequence, some states may reduce benefit levels and tighten eligibility requirements. As a result of ending the entitlement to AFDC,

Congress would force states to establish waiting lists, limit eligibility, or reduce benefits. This would be a hardship for grandparents who cannot afford to take care of their grandchildren without benefits, and for grandchildren who cannot afford to wait for benefits. And the time limits on benefits could create hardships for those entrusted with the care of young children. Absent a hardship waiver, a 64-year-old grandfather who assumes care of his 6-year-old grandson because of his mother's death would at most receive aid until the child reached age 11.

## Food Stamps

Sweeping changes to the Food Stamp Program would end the federal framework for distribution of benefits, reduce benefits, and complicate the program's administration. If these reforms are adopted, the health of many low-income elders—a population with little opportunity to improve its economic status—may be jeopardized. Block grants offer no assurance that even minimal protections for older people would be retained by states, making access to benefits still more difficult.

***...no assurance that even minimal protections for older people would be retained...***

The Food Stamp Program is needs-based. Applicants must prove that their household income is below the maximum income allowed, based on family size. In general, a household must have gross income below 130 percent of the poverty level. In 1995 that was $809 per month for a household of one. In addition to having a low income, a Food Stamp household cannot have resources exceeding $2,000 in countable assets ($3,000 if the household includes a person aged 60 or older).

The budget reconciliation conference bill would allow states to receive food stamp funds in a block grant if they have electronic benefit transfer systems in place or have quality control error rates below six percent. Block grants do not allow flexibility to respond to economic downturns that might cause increases in food stamp participation. States that opt for block grants could set up their own food assistance programs using different eligibility standards and different nutrition benefits.

The legislation cuts benefit levels across the board from 103 percent to 100 percent of the Thrifty Food Plan. Since benefits are already insufficient to meet needs throughout the month, recipients will likely turn to already overburdened soup kitchens and food pantries. Separate legislation is expected to cap the authorization levels of the Food Stamp Program, limiting the ability to respond immediately to increased need in periods of recession or natural disasters. The reconciliation conference bill cuts the Food Stamp Program by more than $34 billion over seven years. This will create hardships for well over a million older persons needing food assistance.

# 7 Supplemental Security Income

The maximum monthly federal Supplemental Security Income benefit for an individual living independently is $458 in 1995, well under the poverty line. Most recipients do not receive the maximum however. The average benefit for an individual over 65 in 1995 is $143.62 per month. The average benefit for an individual with a disability is $383.11, and for a blind person it is $363.94.

As the states are required to take on more financial responsibility, individual states may drastically reduce or eliminate the supplementary benefits they provide for specific populations of SSI beneficiaries. Additionally, SSI cash benefits for institutionalized individuals who are covered by Medicare or private insurance will be capped at $30 per month.

*As the states are required to take on more financial responsibility, individual states may drastically reduce or eliminate the supplementary benefits they provide for specific populations of SSI beneficiaries.*

The reconciliation bill eliminates benefits to those for whom drug addiction and alcoholism are a contributing factor in their disability determination. SSI recipients who are primarily disabled because of drug and alcohol abuse will have their benefits eliminated. (They may reapply based on another impairment.)

The reconciliation bill severely limits the access of noncitizens to SSI. It prohibits SSI eligibility to all noncitizen except: refugees, persons who have been granted aylum, and persons granted withholding of deportation (all up to five years) and residents who have at least 40 quarters of Social Security coverage or who are veterans. The bill also requires the income of the sponsors to apply to new immigrant applicants until they become citizens.

# 8 Housing Assistance

Proposed spending reductions in federal housing programs, particularly public and Section 8 housing, would have a severe impact on older residents of federally assisted housing and those older householders who need but currently do not receive housing assistance. Over 500,000 older people live in public housing, making up approximately one-third of all public housing residents. Under the conference agreement for the appropriations bill, operating subsidies and modernization funds for public housing would be cut by 3.5 and 33 percent respectively ($100 million and $1.2 billion) from 1995 levels that were already low. These cuts will force the deferral of routine maintenance and repairs, the loss of key personnel such as service coordinators, and the cancellation of major renovations, such as congregate facilities, designed to serve an increasingly elderly resident population.

*...spending reductions in federal housing programs... would have a severe impact on older residents...*

The appropriation bill will also increase rents for residents of privately owned Section 8 subsidized units of whom 46 percent (546,000) are

elderly. Poor tenants who now pay little or nothing in rent because of very low incomes will be required to pay a minimum rent of $25 per month or an additional $300 per year. In addition, rent contributions for all residents will be increased from 30 to 32 percent of income, an additional $140 a year for the average resident. Finally, the bill eliminates funding for new housing certificates and vouchers, eliminates funding for the Congregate Housing Services Program and eliminates separate funding for service coordinators, and reduces funding available for housing assistance for older persons under the section 202 program. HUD reports that almost one million older households having "worst case needs" do not receive any housing assistance.

## 9 Low Income Home Energy Assistance Program

In FY 1995 the Low-Income Home Energy Assistance Program block grant was funded at a level of $1.319 billion dollars. States have estimated that they will spend more than $915 million of FY 95 funds for heating assistance alone. This assistance will go to more than five million households (over one-third are headed by older persons), including over one million in New York, 350,000 in California and 200,000 in Illinois.

The current Senate recommendation is for an appropriation in FY '96 of $900 million, representing a 32 percent cut. Under the Senate recommendation, it is estimated that nearly two million households could lose their energy assistance. This assistance includes emergency cooling assistance as well as heating assistance. Experts estimate that to continue functioning in any meaningful way, the program requires a minimum $1 billion federal contribution.

***...nearly 2 million households could lose their energy assistance.***

In FY 95, 44 states and 25 Indian tribes received additional funds ("leveraged incentive awards") as a result of committing non-federal funds for home energy assistance. A one-third reduction of federal funding could discourage states from attempting to continue their current contribution.

# NINE DIFFERENT WAYS:

## How the Budget Hurts Older Americans

**Report of the**

**LEADERSHIP COUNCIL OF AGING ORGANIZATIONS**

final rpt

# NINE DIFFERENT WAYS:

## HOW THE BUDGET HURTS OLDER AMERICANS

### REPORT OF THE
### LEADERSHIP COUNCIL OF AGING ORGANIZATIONS:

Alliance for Aging Research, Alzheimer's Association, American Association for International Aging, American Association of Homes and Services for the Aging, American Association of Retired Persons (AARP), AFL-CIO Department of Employee Benefits, AFSCME Retiree Program, American Foundation for the Blind, American Geriatrics Society, American Society on Aging, Asociacion Nacional pro Personas Mayores, Association for Gerontology in Higher Education, Association for Gerontology and Human Development in Historically Black Colleges and Universities, B'nai B'rith Center for Senior Housing and Services, Catholic Golden Age, Eldercare America, Inc., Families USA, The Gerontological Society of America, Gray Panthers, Green Thumb, Inc., National Asian Pacific Center on Aging, National Association for Home Care, National Association of Area Agencies on Aging, National Association of Foster Grandparent Program Directors, National Association of Meal Programs, National Association of Nutrition and Aging Services Programs, National Association of Retired and Senior Volunteer Program Directors, Inc., National Association of Retired Federal Employees (NARFE), National Association of Senior Companion Project Directors, National Association of State Units on Aging, National Caucus and Center on Black Aged, Inc., National Committee to Preserve Social Security and Medicare, National Council of Senior Citizens (NCSC), National Council on the Aging, Inc., National Hispanic Council on Aging, National Osteoporosis Foundation, National Senior Citizens Law Center, National Senior Service Corps Directors Associations, North American Association of Jewish Homes and Housing for the Aging, Older Women's League, United Auto Workers Retired Members Department

# EXECUTIVE SUMMARY
# NINE DIFFERENT WAYS:
# HOW THE BUDGET HURTS OLDER AMERICANS
## Report of the Leadership Council of Aging Organizations

The news media have reported on massive cuts in programs vital to older Americans; but they have not yet focused on the cumulative impact of those cuts. As Congress embarks on the most drastic changes in the social safety net in history, these multiple cuts will do far more damage than has been reported.

**1. Congress Cuts Medicare $270 Billion** Part B premiums rise from $46.10 to almost $90 a month by 2002. Senate plan doubles Part B deductibles from $100 a year to $210 by 2002. Beneficiaries needing certain hospital outpatient services would pay even more than the 50% coinsurance they now pay.

**2. Congress Cuts Medicaid Long Term Care** Medicaid spending would be cut by $170 billion over seven years. Federal standards for eligibility, services, payment, and quality would be seriously weakened. The House would allow states to force people to sell the family home to qualify for long term care and end federal protection from nursing home abuse.

**3. Congress Cuts Medicaid Acute Care** Under the House proposal, current federal requirements to pay Medicare deductibles and coinsurance for low-income Medicare beneficiaries would be ended. The Senate would eliminate current federal requirements to pay Medicare premiums, deductibles, and coinsurance for low-income beneficiaries.

**4. Welfare Reform and Grandparents** During the last decade the number of grandparents raising grandchildren climbed 40%. Most have household incomes under $20,000 per year. Reforms will make it more difficult to obtain aid for their grandchildren.

**5. Food Stamps** Block grants offer no assurance that even minimal protections for older people would be retained by states, making access to benefits still more difficult.

**6. Supplemental Security Income** Individual states may slash or eliminate SSI supplementary benefits. Cash benefits for institutionalized elderly covered by Medicare or private insurance would be capped at $30 a month.

**7. Housing Assistance** Older people make up approximately one-third of all public housing residents. Operating subsidies and modernization funds for public housing would be cut by 14 and 33 percent respectively from 1995 levels. Rents will be raised for residents of privately owned section 8 subsidized units; 46 percent are elderly.

**8. Low Income Home Energy Assistance Program** The Senate recommendation is for a 32 percent cut. Nearly 2 million households could lose their energy assistance.

**9. Older Americans Act – Human Services, Legal Services, Aging Research, Training** Cuts will mean 6.2 million fewer meals at senior centers and 5.6 million fewer to homebound elders. Research on aging issues, funded under Older Americans Act Title 4, has been severely cut or eliminated. Senate cuts funds 80%. House bill eliminates funding. Elderly and disabled transportation program cut $7.5 million. Legal Services Corp. and legal assistance under Older Americans Act severely cut.

# NINE DIFFERENT WAYS:

## How the Budget Hurts Older Americans

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Congress is embarking on the most drastic changes in the social safety net in the history of our nation. The budget reconciliation bills would cut Medicare by $270 billion over seven years, end any entitlement to public assistance and Medicaid and turn them into block grants to the states. The bills will limit or eliminate SSI benefits for certain aged, disabled or non-citizen beneficiaries and make major cuts in food stamp, housing support programs, home heating, nutrition, and a variety of other programs. All this comes at the expense of the nation's most vulnerable populations. At the same time Congress is cutting taxes by $245 billion, including massive tax reductions for big corporations and wealthy individuals.

## 1 Congress Cuts Medicare $270 Billion

In 1995, the average Medicare beneficiary pays $2,750 in out-of-pocket health care costs. The House and Senate proposals to increase premiums and deductibles will increase that amount significantly.

The House and Senate plans double Part B premiums from $46.10 in 1995 to almost $90 a month by 2002. The Senate plan doubles Part B deductibles, currently $100 per year, to $210 by the year 2002. While the current limit on physician balance billing in the traditional Medicare fee for service program would remain in place, limits would likely not apply to the new coverage options outlined in the plan. Beneficiaries in the traditional program who need certain hospital outpatient services would pay even more than the 50% coinsurance they are paying today.

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Most of the proposed cuts in Medicare spending—approximately $150 billion— come from lowering fees to doctors, hospitals and other providers. Medicare already pays physicians and hospitals only about two-thirds as much as private insurers. These additional cuts could create serious disincentives for doctors to treat Medicare fee-for-service patients, or could reduce the quality of care.

Payments to doctors, hospitals and other providers would be further reduced under the House bill, if total fee-for-service costs are projected to exceed a cap, known as a "fail-safe" mechanism. Proposed changes in the ways home health agencies are paid, included in both the House and Senate plans, could reduce ac-

cess to home health services by persons who need care for an extended period (over 120 days).

The proposals would also make unprecedented changes in the way many Medicare beneficiaries receive care. Beneficiaries would be permitted to stay in the traditional fee for service program, but could also choose new coverage options, including new managed care plans, medical savings accounts, and provider-sponsored networks. If healthier beneficiaries choose the new options, leaving sicker beneficiaries in the traditional program, costs in the traditional program would rise. Another risk is that Medicare payments will not keep pace with the actual costs of coverage, so that purchasing power is eroded and seniors will have to pay higher premiums or receive reduced coverage.

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Although Congressional proponents of Medicaid reductions say their plan does not cut Medicaid, it only limits the rate of growth, projected Medicaid spending would be cut by $170 billion over seven years. Growth in Medicaid costs would be held to an average of approximately four percent a year compared to a projected annual growth rate of about 10 percent. Federal Medicaid dollars to the states would be capped regardless of changes in inflation or need and federal standards for eligibility, services, payment, and quality would be seriously weakened, especially in the House bill.

***States would have to choose between paying for enforcement of tough standards themselves, or once again leaving nursing homes without consistent standards.***

The program would be turned into a block grant to the states. Under the block grant, states could decide to eliminate coverage for high cost services such as institutional long term care. Or if states chose to continue covering institutional care, they might severely cut coverage of home and community services—the settings preferred by the vast majority of people with disabilities.

The House proposal would allow states to force individuals to sell the family home in order to qualify for Medicaid long term care.

Major improvements in nursing home quality standards were enacted in 1987, after an Institute of Medicine report documented the problems in care for the elderly. Currently, every nursing home in the nation is inspected annually. Under the House proposal, the federal government would make states responsible for monitoring nursing homes. States would have to choose between paying for the enforcement of tough standards themselves, or once again leaving nursing homes without consistent standards.

# 3 Congress Cuts Medicaid Acute Care

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# 4 Welfare Reform and Grandparents

Much of the current welfare reform debate has centered on developing policies for children being raised in poverty by single mothers. While there are many children who fit this description, a growing number of children are in the care of someone other than a parent, and in many cases, that someone is a grandparent. During the last decade the number of grandparents raising grandchildren has increased by 40 percent.

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cessity, and at great cost to themselves. Fifty-six percent of grandparent caregiver households have incomes of less than $20,000 per year. Twenty-seven percent live at or below the poverty level, which was $10,030 for a family of two in 1995. Because their own incomes are so modest, many of these grandparents depend on Aid to Families With Dependent Children (AFDC) to meet the needs of their grandchildren. Current reforms pending in Congress will make it more difficult for grandparents to obtain aid on behalf of grandchildren in their care.

***...Congress will make it more difficult for grandparents to obtain aid on behalf of grandchildren in their care.***

Among numerous other changes to AFDC, Congress intends to consolidate cash grant programs and related social service programs into block grants, to eliminate the entitlement to AFDC, and to limit the time that states can provide benefits to any individual. States would have no obligation to maintain their current level of state spending. As a consequence, some states may reduce benefit levels and tighten eligibility requirements. As a result of ending the entitlement to AFDC, Congress would force states to establish waiting lists, limit eligibility, or reduce benefits. This would be a hardship for grandparents who cannot afford to take care of their grandchildren without benefits, and for grandchildren who cannot afford to wait for benefits. And the time limits on benefits could create hardships for those entrusted with the care of young children. Absent a hardship waiver, a 64-year-old grandfather who assumes care of his 6-year-old grandson because of his mother's death would at most receive aid until the child reached age 11.

## 5 Food Stamps

Sweeping changes to the Food Stamp Program would end the federal framework for distribution of benefits, reduce benefits, and complicate the program's administration. If these reforms are adopted, the health of many low income elders—a population with little opportunity to improve its economic status—may be jeopardized. Block grants offer no assurance that even minimal protections for older people would be retained by states, making access to benefits still more difficult.

The Food Stamp Program is needs-based. Applicants must prove that their household income is below the maximum income allowed, based on family size. In general, a household must have gross income below 130 percent of the poverty level. In 1995 that was $809 per month for a household of one. In addition to having a low income, a Food Stamp household cannot have resources exceeding $2,000 in countable assets ($3,000 if the household includes a person aged 60 or older).

***...no assurance that even minimal protections for older people would be retained...***

The new legislation would allow states to design their own eligibility and benefit standards. As a consequence, there could be 50 different programs, using 50 different eligibility standards, and offering 50 different nutrition benefits. The House version would create a capped entitlement with almost no flexibility to respond to economic downturns that might cause increases in food stamp participation.. It would cap annual increases in allotment levels at 2 percent, regardless of

food price inflation, thus eliminating the critical link to basic nutrition standards.

The Senate version would reauthorize the program through FY 2002 with no cap. Both House and Senate versions would disqualify any childless adults who do not work or participate in workfare programs 20 hours per week. There is no requirement that states provide jobs, training, or workfare slots.

## 6 Supplemental Security Income

The maximum monthly federal SSI benefit for an individual living independently is $458 in 1995. Most recipients do not receive the maximum, however. The average benefit for an individual over 65 in 1995 is $143.62 per month, about one-quarter of the federal poverty line. The average benefit for an individual with a disability is $383.11, and for a blind person it is $363.94—both well below the poverty line.

***Those who need SSI benefits because they are old and poor will have to wait longer...***

As the states are required to take on more financial responsibility, individual states may drastically reduce or eliminate the supplementary benefits they provide for specific populations of SSI beneficiaries. Additionally, SSI cash benefits for institutionalized individuals who are covered by Medicare or private insurance will be capped at $30 per month. Those who need SSI benefits because they are old and poor will have to wait longer, if the House bill becomes law. The eligibility age for the SSI aged category increases from 65 to 67 in 2003.

The House bill eliminates benefits to those for whom drug addiction and alcoholism are a contributing factor in their disability. SSI recipients who are disabled solely because of drug and alcohol abuse will receive no help from SSI.

The House bill severely limits the access of non-citizens to SSI. It prohibits SSI eligibility for all non-citizens except: Refugees who have been in the US less than five years; lawful permanent residents over age 75 who have been in the US at least 5 years (not eligible in Senate bill); lawful permanent residents who cannot take the naturalization exam because of physical or mental impairment (not eligible in Senate bill); and residents who have enough quarters of coverage to receive Social Security (not eligible in House bill). The House bill also requires the income of sponsors to apply to new immigrant applicants.

## 7 Housing Assistance

Proposed spending reductions in federal housing programs, particularly public and Section 8 housing, would have a severe impact on older residents of federally assisted housing and those older householders who need but currently do not receive housing assistance. Over 500,000 older people live in public housing and they make up approximately one-third of all public housing residents. Under the House-passed appropriations bill, operating subsidies and modernization funds for public housing would be cut by 14 and 33 percent respectively ($400 million and $1.2 billion) from 1995 levels. These cuts will force the deferral of routine

maintenance and repairs, the loss of key personnel such as service coordinators, and the cancellation of major renovations, such as congregate facilities, designed to serve an increasingly elderly resident population.

The appropriation bill will also increase rents for residents of privately owned section 8 subsidized units of whom 46 percent (546,000) are elderly. Poor tenants who now pay little or nothing in rent because of very low incomes will be required to pay a minimum rent of $50 per month or an additional $600 per year. In addition, rent contributions for all residents will be increased from 30 to 32 percent of income, an additional $140 a year. Finally, the bill eliminates funding for new housing certificates and vouchers, and reduces funding available for construction of special units for older persons under the section 202 program. HUD reports that almost one million older households having "worst case needs" do not receive any housing assistance.

***...older people...make up approximately one-third of all public housing residents.***

## 8 Low Income Home Energy Assistance Program

In 1995, the appropriation for the Low-Income Home Energy Assistance Program (LIHEAP) block grant was funded at a level of $1.319 billion dollars. States have estimated that they will obligate more than $915 million of FY 95 funds for heating assistance alone. This assistance will go to more than five million households (half are headed by older persons), including over one million in New York, 350,000 in California and 200,000 in Illinois.

The current Senate recommendation is for an appropriation of $900 million, representing a 32 percent cut. Under the Senate recommendation, it is estimated nearly 2 million households could lose their energy assistance. This assistance includes emergency cooling assistance as well as heating assistance. Experts have estimated that to continue to function in any meaningful way a minimum $1 billion federal contribution is essential.

***...nearly 2 million households could lose their energy assistance.***

In FY 95, 44 states and 25 Indian tribes received additional funds ("leveraged incentive awards") as a result of committing non-federal funds for home energy assistance. A one-third reduction of federal funding could discourage states from attempting to continue their current contribution.

## 9 The Older Americans Act — Human Services, Legal Services, Aging Research, Training

Reductions in human services programs will further jeopardize the ability of older people to remain independent in their own communities. Of paramount importance in providing human service programs to the elderly is the Older American Act.

For the past thirty years, the Older American Act (OAA) has served the best interests of the elderly and their caregivers by funding a variety of services, supporting research and training in the aging field, and providing job training programs for low income older individuals. Since 1980, funding for OAA has declined in real terms by over 30 percent. Funding plans passed by the House would cut the program by $145 million, an 11 percent reduction from current levels. Critical services in local communities including meals, in-home services, elder abuse prevention, nursing home ombudsman, senior centers, senior employment, aging research and training, and other important areas that serve older Americans will be cut back or eliminated. Grants for Native American seniors program will suffer greatly given the traditionally low funding levels which support the provision of all services to American Indian and Native Hawaiian elders.

***As a result of these cuts, 6.2 million fewer meals would be served in congregate sites and 5.6 million fewer meals would be delivered to homebound elders...***

As a result of cuts, 6.2 million fewer meals would be served to in congregate sits and 5.6 million fewer meals would be delivered to homebound elders; 14,000 older workers would be terminated from the Senior Community Services Employment Program; and 165 local ombudsman programs would be eliminated, reducing services to 52,000 nursing home residents.

Money for aging research has been severely cut by Congress. Title IV of the Older Americans Act, which supports training, research, demonstrations and education, was zeroed out by the House and cut by $21 million in the Senate. The Health Care Financing Administration's research and demonstration funding was cut by $94 million in the House. The Health Resources and Services Research funds would be cut by $102 million. All of these research funds have assisted in demonstrating new programs and streamlining public programs for the elderly. Demand for these programs will continue to rise as the population of our nation continues to age.

Transportation programs for the aged and people with disabilities are also in danger. House and Senate conferees have proposed cutting the Federal Transit Act's Section 16 program for the Elderly and Disabled by $7.5 million over last year's conference report. Compounded by the proposed cuts in Medicaid, the Older Americans Act, and mass transit appropriations, transportation services for the elderly will be seriously impacted.

Congress is sharply cutting the Legal Services Corporation (LSC) as well as legal assistance provided for under the Older Americans Act. Appropriations have been drastically cut and restrictions have been placed on what attorneys will by able to do in representing their clients. The substantive backup centers have lost all support from LSC. Local programs will no longer be able to do class action suits, representation before legislative bodies, file suits against states that challenge the legality of the welfare reform, and numerous other types of representation. Also disturbing is the new funding sources restricted by LDC limitations.

Special projects, such as the White House Conference on Aging, have also been defunded.

# WHAT CONGRESS IS DOING TO WIDOW JONES, AGE 73

Mrs. Jones, a 73 year old widow who lives alone, has a total cash income of $458 per month ($5,496 per year) from Social Security and SSI. In addition, she receives assistance from Medicaid, food stamps, the Low-Income Home Energy Assistance Program (LIHEAP) and OAA. Mrs. Jones is eligible for both Medicare and Medicaid (as an SSI beneficiary). Medicare and Medicaid pay for most of Mrs. Jones's doctor bills and occasional hospital visits, including her prescription drugs for diabetes, arthritis, and glaucoma and pays for her eyeglasses. Medicaid also pays for her Medicare premiums, deductibles, and coinsurance, but were she not dually eligible, her low income would still qualify her for Medicaid payment of Medicare premiums, coinsurance, and deductibles under the Qualified Medicare Beneficiary (QMB) program. Mrs. Jones receives a hot home-delivered meal five days a week, receives a one-time $160 payment through the Low-Income Home Energy Assistance Program (LIHEAP) and $63 per month in food stamps.

The chart bellow illustrates the disastrous cumulative impact of Budget cuts to elderly health and welfare programs. If Medicaid and food stamps are block-granted, Mrs. Jones could lose her eligibility for both. She could also lose her yearly $160 help with heating bills and services under the Older Americans Act such as meals on wheels and help with legal matters. She would have to pay for Medicare coverage as well as some medical costs, including some medicines, that are now paid by Medicaid.

Widow Jones total income is $5,496. To make up for the impact of Congressional Budget cuts, her 1996 out-of-pockets would exceed her total income by $188. And she still would need to find money for the basics: housing, utilities, telephone, and transportation. She may not be able to get medical care. She may not be able to purchase needed medications. Or, if she pays for medical care, she may become homeless. Note that her out-of-pocket costs go up every year through 2002.

**Estimated Benefit Cuts/Cost Increases for Hypothetical Example of Mrs. Jones***

| | Fiscal Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Benefit Cut/Cost Increase | 1996 | 1997 | 1998 | 1999 | 2002 | 2001 | 2002 | 1996-2002 |
| Part B premium | $72 | $48 | $48 | $60 | $84 | $72 | $84 | $468 |
| Part B deductible | 150 | 160 | 170 | 180 | 190 | 200 | 210 | 1260 |
| Drugs | 2880 | 3168 | 3485 | 3833 | 4217 | 4638 | 5102 | 27323 |
| Coinsurance | 1387 | 1484 | 1588 | 1699 | 1818 | 1945 | 2082 | 12003 |
| Food Stamps | 756 | 781 | 808 | 835 | 863 | 893 | 923 | 5859 |
| LIHEAP | 160 | 165 | 171 | 176 | 182 | 189 | 195 | 1238 |
| Meals | 320 | 537 | 555 | 574 | 594 | 614 | 635 | 4029 |
| Total | $5,925 | $6,343 | $6,825 | $7,357 | $7,948 | $8,551 | $9,231 | $52,180 |

*The figures in the table represent the estimated dollar value of the reductions in benefits that would occur as a result of proposed budget cuts. They do not represent losses of income, but rather losses of benefits. In fact, it would be impossible for Mrs. Jones to purchase all of these services and products were she to lose eligibility for Medicaid, food stamps, etc. because her income simply would be insufficient to pay for them. The figures above are based on the following assumptions: 1) Mrs. Jones is no longer eligible for Medicaid, food stamps, LIHEAP, or meals; 2) she now must have her Medicare Part B premium subtracted from her Social Security COLA, thereby eliminating her annual COLA increase (her monthly Social Security benefit level is assumed to be $200 in 1995, which provides a COLA of just over $6.00 per month, so Mrs. Jones cannot pay the full Part B premium increase); 3) she must pay her Part B deductible out-of-pocket, and she must pay for the entire cost of drugs and personal care out-of-pocket now because she no longer has Medicaid coverage, and these costs are not covered by Medicare; 4) the Part B premium under current law would revert to 25 percent of Part B costs, but it is assumed here to remain at its current level of 31.5 percent of Part B costs; 5) the Part B deductible is assumed to increase to $150 in 1996 and rise to $210 by 2002; 6) estimated monthly costs of drugs for diabetes are estimated at $125, for glaucoma at $65, and for arthritis at $50; 7) estimated costs of coinsurance are based on average costs for poor Medicaid beneficiaries for hospital and physician services covered by Medicaid less the Part B premium, Part B deductible, and drug coinsurance; and 8) drugs and coinsurance are inflated at 7 percent per year; food stamps, LIHEAP, and meals are inflated at the rate of the CPI.

**FY'96 Appropriations for Elderly Programs (in thousands)**

| | FY'95 Actual | FY'96 House | FY'96 Senate | FY'96 Final |
|---|---|---|---|---|
| ***Administration on Aging*** (total) | $876,007 | $801,232 | $831,027 | $829,393 |
| Supportive services and centers | 306,711 | 291,375 | 291,375 | *300,556 |
| Ombudsman services | 4,449 | 0 | 4,449 | 0 |
| Elder abuse prevention | 4,732 | 0 | 4,732 | 0 |
| Pension counseling | 1,976 | 0 | 0 | 0 |
| Preventive health | 16,982 | 0 | 15,623 | 15,623 |
| Congregate meals | 375,809 | 364,535 | 364,535 | 364,535 |
| Home-delivered meals | 94,065 | 105,339 | 105,339 | 105,339 |
| In-home services/frail | 9,263 | 9,263 | 9,263 | 9,263 |
| Native Americans | 16,902 | 15,550 | 15,550 | 16,057 |
| Research, training, special proj. | 25,630 | 0 | 4,991 | 2,850 |
| Federal Council on Aging | 176 | 0 | 0 | 0 |
| White House Conference on Aging | 3,000 | 0 | 0 | 0 |
| Program administration | 16,312 | 15,170 | 15,170 | 15,170 |
| ***Department of Labor*** | | | | |
| Adult training | 996,813 | 745,700 | 900,000 | 850,000 |
| Senior community service | 396,060 | 350,000 | 350,000 | **373,000 |
| Dislocated worker assistance | 1,228,550 | 867,000 | 1,200,000 | 1,097,500 |
| ***Health Care Financing Administration*** | | | | |
| Medicare contractor payments | 1,604,171 | 1,604,171 | 1,584,767 | 1,604,171 |
| Medicare state survey and certification | 145,800 | 147,625 | 147,625 | 147,625 |
| Medicaid current law benefits | 84,835,700 | 92,235,200 | 92,235,200 | 92,235,200 |
| Medicaid state/local administration | 3,602,660 | 3,742,000 | 3,742,000 | 3,742,000 |
| Program management | 2,178,024 | 2,130,810 | 2,111,406 | 2,130,810 |
| Insurance counseling | 4,536 | 0 | 0 | 0 |
| Research, demo., evaluation | 45,146 | 40,000 | 40,000 | 40,000 |
| ***Housing and Urban Development/Agriculture*** | | | | |
| Assisted housing | 11,083,000 | 10,155,795 | 10,086,795 | 9,818,795 |
| Section 202 elderly housing | 610,575 | 780,000 | 780,000 | 780,240 |
| Section 8 renewals | 2,536,000 | 0 | 0 | 0 |
| Congregate services | 25,000 | 0 | 0 | 0 |
| HOME | 1,400,000 | 1,400,000 | 1,400,000 | 1,400,000 |
| Homeless assistance grants | 1,120,000 | 823,000 | 823,000 | 823,000 |
| Very low-income housing repair (USDA) | 1,100 | 1,100 | 1,100 | 1,100 |
| ***National Senior Volunteer Corps*** | 135,764 | 128,341 | 128,341 | 128,341 |
| Foster Grandparents Program | 67,812 | 62,237 | 62,237 | 62,237 |
| Senior Companions Program | 31,244 | 31,155 | 31,155 | 31,155 |
| Retired Senior Volunteers | 35,708 | 34,949 | 34,949 | 34,949 |
| Senior demo. | 1,000 | 0 | 0 | 0 |
| ***Miscellaneous programs*** | | | | |
| Alzheimer's demonstration grants | 4,959 | 4,000 | 4,000 | 4,000 |
| Breast/cervical cancer screening | 100,000 | 125,000 | 125,000 | 125,000 |
| Community Services Block Grant | 389,600 | 389,600 | 389,600 | 389,600 |
| Community Food & Nutrition | 8,676 | 4,000 | 4,000 | 4,000 |
| Geriatric education & training | 8,273 | consolidated | 6,618 | 7,942 |
| Legal Services Corp. | 400,000 | 278,000 | 300,000 | 278,000 |
| Low Income Home Energy Asst. | 1,319,202 | 900,000 | 900,000 | 900,000 |
| National Institute on Aging (non-AIDS) | 432,164 | 453,917 | 453,917 | 453,917 |
| Services for Older Blind Individuals/DOE | 8,952 | 8,952 | 8,952 | 8,952 |
| Social Services Block Grant | 2,800,000 | 2,520,000 | 2,310,000 | 2,381,000 |
| Veterans medical care | 16,214,684 | 16,564,000 | 16,564,000 | 16,564,000 |

*Includes $4.5 million for ombudsman, $4.7 million for abuse prevention.

**Earmarks 22% for states and 78% for national contractors as proposed by Senate.