care is improved.

Recent Policies

- There are still many outstanding issues in managed care, including challenges with state implementation, federal monitoring and oversight, and the movement of the disabled and chronic needs populations into Medicaid managed care. Finally, there is little conclusive evidence that savings due to Medicaid managed care are assured.

- The President's Medicaid reform plan makes it easier for states to pursue managed care for their Medicaid beneficiaries. The plan would no longer require States to seek a federal waiver to establish Medicaid managed care. The plan also proposes to modify managed care quality-of-care requirements by repealing certain procedural and contract requirements, replacing them with a provision requiring states to develop a quality improvement strategy, consistent with federal standards, to ensure that managed care providers maintain reasonable access and quality health care.

Medicaid Program Recent History & Trends, continued

Medicaid Section 1115 Demonstration Waivers

As Medicaid reform legislation has stalled, states are increasingly using the section 1115 Medicaid demonstration waiver authority to pursue major statewide health reform initiatives. In order to further control costs and expand eligibility beyond the upper limits in Medicaid law, states apply for these waivers of Medicaid law. OMB plays a major role in the negotiation of these waivers with HHS and the states, especially in the area of "budget neutrality."

History

- Since the original Medicaid legislation was passed in 1965, §1115 of the Social Security Act has given the Secretary of HHS the authority to waive certain requirements of the Medicaid program to support "an experimental, pilot or demonstration project."

- The §1115 authority allows the Secretary to waive more aspects of Medicaid law than the more limited §1915(b) waiver authority (known as a freedom of choice waiver) which states use even more frequently to move their eligible populations into managed care (as discussed above).

- This Administration has approved 12 statewide §1115 waivers and is in the process of evaluating 11 more. Prior to the Clinton Administration, only Arizona had received approval for a statewide §1115 waiver in 1984.

- States typically use the §1115 waiver process to:

  -- move their AFDC, and more recently their disabled populations, into managed care;

  -- obtain federal matching funds for costs that are not otherwise matchable under Title XIX (i.e. private health insurance premiums for the working poor);

  -- use the managed care savings and other waiver-related revenues to cover traditionally non-Medicaid populations;

  -- waive statutory enrollment requirements (e.g., the "75/25" rule that requires the enrollment of at least 25 percent privately insured patients in a managed care entity).

Budget Neutrality

- In 1993, the Administration recognized the desire and the need of states to have greater flexibility in reforming their Medicaid systems. At the same time, the Administration has also stated that the waivers must be budget neutral to the federal government. Although budget neutrality is not required by law, an agreement was reached on this issue with the National Governors Association that was published in the Federal Register.

- OMB plays a major role in the negotiations between the states and the federal government to assure budget neutrality.

- The budget neutrality discussions with the states generally focus on the development of an appropriate estimate of federal spending in a *base year* without the waiver, as well as appropriate *trend factors* over the five year life of the waiver. The federal without-waiver baseline is the limit of what the federal government will spend on the people and services under the waiver.

- In addition to agreeing on a base year and trend factor, other areas of discussion between the States and the Administration have been:

  -- will the baseline be increased to account for "hypothetical eligibles" -- people the State could have covered under the pre-waiver Medicaid program but chose not to cover;

  -- how will disallowed expenditures financed by impermissible provider tax revenues be accounted for in the base year spending;

  -- will the without-waiver baseline reflect reduced DSH spending due to the OBRA 93 limits on hospital-specific Medicaid reimbursements; and

  -- how will savings that have accrued from currently implemented §1915(b) managed care waivers be reflected in the base year expenditures.

- In two reports, the GAO has criticized the Administration for approving waivers GAO considers to be not budget neutral to the federal government. GAO concluded that budget neutrality calculations should rely on the use of the average of the 50 states' baseline rates of growth, instead of the more flexible approach based on individual state experience that has been taken by the Administration.

Medicaid Program Recent History & Trends, continued

The Challenge of Managing Long-Term Care Services

In the past, most of the movement to managed care has been in the area of acute care services for the non-aged, non-disabled population. As long-term care and chronic care for disabled people accounts for over two-thirds of Medicaid costs, states and the federal government have an incentive to begin managing care for these populations and these services.

Background

- National health expenditure data shows that Medicaid purchases slightly over half of all long-term care services in this country (51 percent in 1993).

- Unlike acute care services, private insurance plays a very small role in financing long-term care. It paid only 2.5 percent of nursing home costs in 1993. Other than Medicaid, long-term care is financed primarily through Medicare's home health benefit and private out-of-pocket expenditures.

- As the major purchaser of long-term care, Medicaid will be significantly affected by the demographic shift of aging baby boomers. In the next 25 years, the number of people aged 85 and over --- those who most need long-term care services --- could double or even triple.

- The Medicaid long-term care benefit serves people who have lived most of their lives as middle-income earners and have spent down their income and assets to become eligible for Medicaid nursing home care. Often the children of these Medicaid recipients are also middle-income and are recipients of assets their parents have transferred in order to qualify for Medicaid.

Recent Policies

- In anticipation of rising long-term care costs, states and the federal government have begun to explore ways to provide home and community-based services in place of nursing home care whenever possible.

- States and the federal government have also begun to explore ways to provide long-term care in a managed care setting.

Part IV: Medicaid Reform in the Balanced Budget Debate

Part IV of this document describes baseline projections of federal Medicaid spending by CBO and OMB, and describes the major Medicaid reform policies that have been proposed as part of the continuing balanced budget debate of 1995 and 1996, up to the latest Republican proposal, which was released on May 22, 1996.

Federal Medicaid Growth Projections, Fiscal Years 1996 - 2002

- The FY 1997 President's Budget baseline projects total federal Medicaid expenditures will grow at an average annual rate of 9 percent from FY 1996 - 2002. Recipients are projected to grow at an average annual rate of 2.5 percent over the same period. Federal spending per Medicaid recipient is projected to grow at an average annual rate of 6.4 percent.

- In its March 1996 baseline, CBO projects slightly higher Medicaid growth in every category. CBO projects that total federal Medicaid expenditures will grow at an average annual rate of 9.7 percent from FY 1996 - 2002. CBO projects that recipients will grow at an average annual rate of 2.7 percent over the same period. CBO projects that federal spending per Medicaid recipients will grow at an average annual rate of 6.8 percent.

- Although projections of Medicaid spending growth have continued to decline over the past few years, both the Administration and Congress continue to develop policies to control the growth in federal Medicaid costs.

The tables on the following pages summarize: 1) both the FY 1997 President's Budget and CBO March 1996 Baseline projections for Medicaid, and 2) a comparison of recent Medicaid savings proposals described in the text that follows the tables

Federal Medicaid Growth P[redacted]ions, Fiscal Years 1995-2002

OMB and CBO Baselines

(Expenditures in billions; recipients in millions)

OMB Baseline, FY 1997 President's Budget

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002
Expenditures:	89.0	94.9	102.3	112.0	121.8	133.2	145.6	159.4	
Growth:		*6.6%*	*7.8%*	*9.4%*	*8.7%*	*9.4%*	*9.3%*	*9.5%*	*9.0%*
Recipients:	36.2	37.5	38.7	39.8	40.8	41.8	42.7	43.5	
Growth:		*3.7%*	*3.1%*	*2.8%*	*2.7%*	*2.4%*	*2.2%*	*1.9%*	*2.5%*
Per Capita:	2,462	2,529	2,645	2,816	2,982	3,185	3,408	3,661	
Growth:		*2.8%*	*4.6%*	*6.4%*	*5.9%*	*6.8%*	*7.0%*	*7.4%*	*6.4%*

CBO March 1996 Baseline

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002
Expenditures:	89.1	95.7	104.9	115.5	126.5	138.3	151.6	166.6	
Growth:		*7.5%*	*9.5%*	*10.2%*	*9.5%*	*9.3%*	*9.7%*	*9.9%*	*9.7%*
Recipients:	36.0	36.8	38.1	39.1	40.1	41.1	42.1	43.1	
Growth:		*2.1%*	*3.7%*	*2.5%*	*2.5%*	*2.6%*	*2.5%*	*2.4%*	*2.7%*
Per Capita:	2,472	2,603	2,750	2,955	3,155	3,363	3,599	3,862	
Growth:		*5.3%*	*5.7%*	*7.5%*	*6.8%*	*6.6%*	*7.0%*	*7.3%*	*6.8%*

Source: HCFA Office of the Actuary & Congressional Budget Office

Comparison of Medicare Savings Proposals

Balanced Budget Act of 1995, FY 1997 President's Budget, & FY 1997 Budget Resolution

Fiscal Years 1996-2002

	Balanced Budget Act of 1995[a]	FY 1997 President's Budget[b]	FY 1997 Budget Resolution[b]
CBO Baseline Spending:	955	899	899
Growth Rate:	*10.2%*	*9.7%*	*9.7%*
CBO Baseline Recipient Growth Rate:	*3.0%*	*2.7%*	*2.7%*
Per Capita Growth Rate:	*7.0%*	*6.8%*	*6.8%*
Proposed Savings:	**-182**	**-54**	**-72**
Proposed Law Spending:	773	845	827
Growth Rate:	*4.5%*	*7.1%*	*6.5%*
Proposed Law Per Capita Growth Rate:	*1.4%*	*4.3%*	*3.7%*
Proposed Law Spending As Share of Current Law Spending:	81%	94%	92%

[a]Originally scored using CBO's March 1995 baseline.

[b]Scored using CBO's March 1996 baseline.

Medicaid Reform in the Balanced Budget Debate, continued

The President's "Per Capita Cap" Proposal

- As part of his balanced budget proposal, the President proposed a per capita cap for Medicaid.
  - -- CBO estimated that the President's plan would save $54 billion over seven years, off of their March baseline.
  - -- People currently eligible for Medicaid services would retain their federal guarantee of health care coverage. In addition, the plan would maintain the federal financial commitment to states in the event of an economic downturn that requires states to add beneficiaries.
  - -- To limit the growth in federal Medicaid expenditures, a per capita limit would be established to constrain the rate of increase in federal matching payments per beneficiary.
  - -- Federal payments to disproportionate share hospitals would also be gradually phased-out and replaced with a new program of payments to states for disproportionate share hospitals. In addition, the proposal would establish three new funding pools. The first pool makes supplemental funding available to states to help them during the transition to a per capita cap. The second pool would provide payments to the 15 states that have a disproportionate number of undocumented immigrants. The third pool would provide supplemental payments to Federally-qualified health centers and rural health clinics.
  - -- States would be given greater flexibility to change how they deliver and pay for services, so that they can reduce costs, not coverage. For example, the so-called Boren Amendment would be repealed. States would be permitted to require enrollment in certain types of managed care plans or provide home and community-based care at their option without a federal waiver.
  - -- Existing Federal standards for nursing homes would be maintained.
  - -- Protections against impoverishment for spouses of nursing home residents would be retained, as would the guarantee that Medicare premiums and cost-sharing be paid for by Medicaid.

- Critics of the President's plan claim that the plan results in an unfunded mandate on states. Critics assert that because states will continue to be governed by most of the current federal regulations for the Medicaid program, they may not be able to make their programs more efficient to be able to live within the federal funding constraints.

The Republican "MediGrant" Proposal

- The vetoed Congressional reconciliation bill proposed to replace the Medicaid program with a new MediGrant program -- a fixed-funding block grant to states to help pay for medical assistance furnished to low-income individuals.

  -- Under the reconciliation bill, federal Medicaid payments to states would be capped--or block granted--at an aggregate level, with each state's base year amount written in the statute. The base year is related to historical spending, but some states received enhancements. States would receive differential growth amounts each year in accordance with a formula written in the statute. The growth formula is unrelated to enrollment growth.

  -- CBO originally estimated that federal spending would be reduced by $182 billion over seven years as a result of this proposal.

  -- The block grant would maintain the federal/state matching requirements up to the cap, but would allow states to choose the most beneficial matching percentage and would increase the minimum federal contribution from 50 percent to 60 percent.

  -- The block grant would repeal prohibitions on provider taxes and donations and limitations on disproportionate share hospital payments.

  -- Federal enforcement of nursing home standards would be significantly weakened.

  -- The block grant would eliminate the individuals' federal entitlement to a defined set of benefits, but would require states to make certain levels of expenditures on behalf of certain population groups. The bill would also require that states make benefits available to certain populations, but does not define a minimum benefit package that states are required to offer.

  -- States would have broad flexibility to determine which groups of individuals would be entitled to benefits.

-- Other than childhood immunizations and family planning services, there would be no minimum benefit requirements.

-- States would have complete flexibility to determine provider payment levels, qualifications, and delivery systems.

- The Administration strongly opposed both the level of cuts in the Congressional bill and the repeal of the federal guarantee to health care coverage for low-income women and children, the elderly and disabled, as well as the repeal of current spousal impoverishment protections and federal nursing home standards.

- Supporters of a block grant argue that if states are allowed broad flexibility to run their Medicaid program, they will be able continue to provide comparable coverage to low-income beneficiaries while receiving less federal funding.

The National Governors' Association Proposal

- In February, the National Governors' Association reached bipartisan agreement on a set of policy specifications for Medicaid reform. No legislative language was drafted, nor was CBO able to estimate savings from the proposal.

- The Administration has voiced serious concerns about the NGA resolution. The Administration is concerned about the following issues:

  -- The NGA plan would raise the minimum federal matching percentage from 50 to 60 percent. The plan would also repeal the prohibitions on provider tax and donation programs.

  -- The NGA plan would guarantees coverage for a number of mandatory eligibility groups, but it would repeal the current law phase in of Medicaid coverage for children ages 13 - 18 in families with income below the federal poverty level.

  -- The NGA plan would repeal the federal standard for defining disability, replacing it with state definitions, making uncertain coverage and benefits for populations such as those with HIV.

  -- The NGA plan lists required benefits for the mandatory populations, but it would provide states with "complete" flexibility in defining the adequacy of those benefits.

Y 1997 Budget Resolution

- The recently-passed House Budget Resolution and the current Senate Budget Resolution reference the NGA agreement as a basis for reaching the $72 billion reduction in Medicaid spending over six years (FY 1997 - 2002).

- It appears as if the bipartisan support for the NGA agreement has eroded as Congress and the Governors debate the financing formula in more detail. Congressional Republicans already have indicated that they will not recommend the funding formula offered by the National Governors' Association.

- The Administration remains concerned about the policy issues raised in the NGA proposal (see above), but it also opposes the Senate and House Budget Resolutions for two other reasons:

  The level of Medicaid cuts is still too high. The Budget Resolutions call for Medicaid spending reductions of $72 billion over six years.

  Unlike the original NGA resolution, information from preliminary reports on the Medicaid policy in the Budget Resolutions indicate that federal funding may not automatically respond to unanticipated increases in enrollment, due to economic downturns.

- Republicans released legislative language for their latest Medicaid and welfare reform proposals on May 22, 1996, the first of three budget reconciliation packages Congress will take up after passing its FY 1997 Budget Resolution.

October 22, 1996

Health Division

Office of Management and Budget
Executive Office of the President

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Phone 202/395-4930
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Room: 7026

Subject: FY 1996 Medicaid Outlays

From: Nani Coloretti NC and Bonnie Washington BCW

Actual Federal Medicaid outlays for FY 1996 equaled $91.990 billion. This is $1.075 billion less than the estimate for FY 1996 outlays in the FY 1997 Mid-Session Review. **Total Federal Medicaid spending increased by only 3.3% over FY 1995**. This is the slowest growth in Medicaid since FY 1982, when Medicaid also grew by only 3.3% over FY 1981. Although no one can know with any certainty why Medicaid outlays grew so slowly, we can speculate on a number of factors which could have contributed to the lower spending:

- Medicaid spending in FY 1995 (especially the last six months) may have been unnaturally high, as states increased their spending on Medicaid in anticipation of a FY 1995 base year for a block grant or per capita cap.

- Also in anticipation of Medicaid reform, state legislatures may have enacted cost-cutting measures, the effects of which may be seen in the latter part of FY 1996. There have also been efforts to move more Medicaid beneficiaries into managed care contracts, which may be reducing spending.

- In addition, due to an improving economy and increased use of welfare waivers, there have been reductions in states' welfare caseloads, leading to lower Medicaid caseloads.

Federal Medicaid Outlays: FY 1996 Year-End Report

($ in millions)

FY 1996 Outlays Compared to Actual FY 1995 and FY 1994 Outlays:

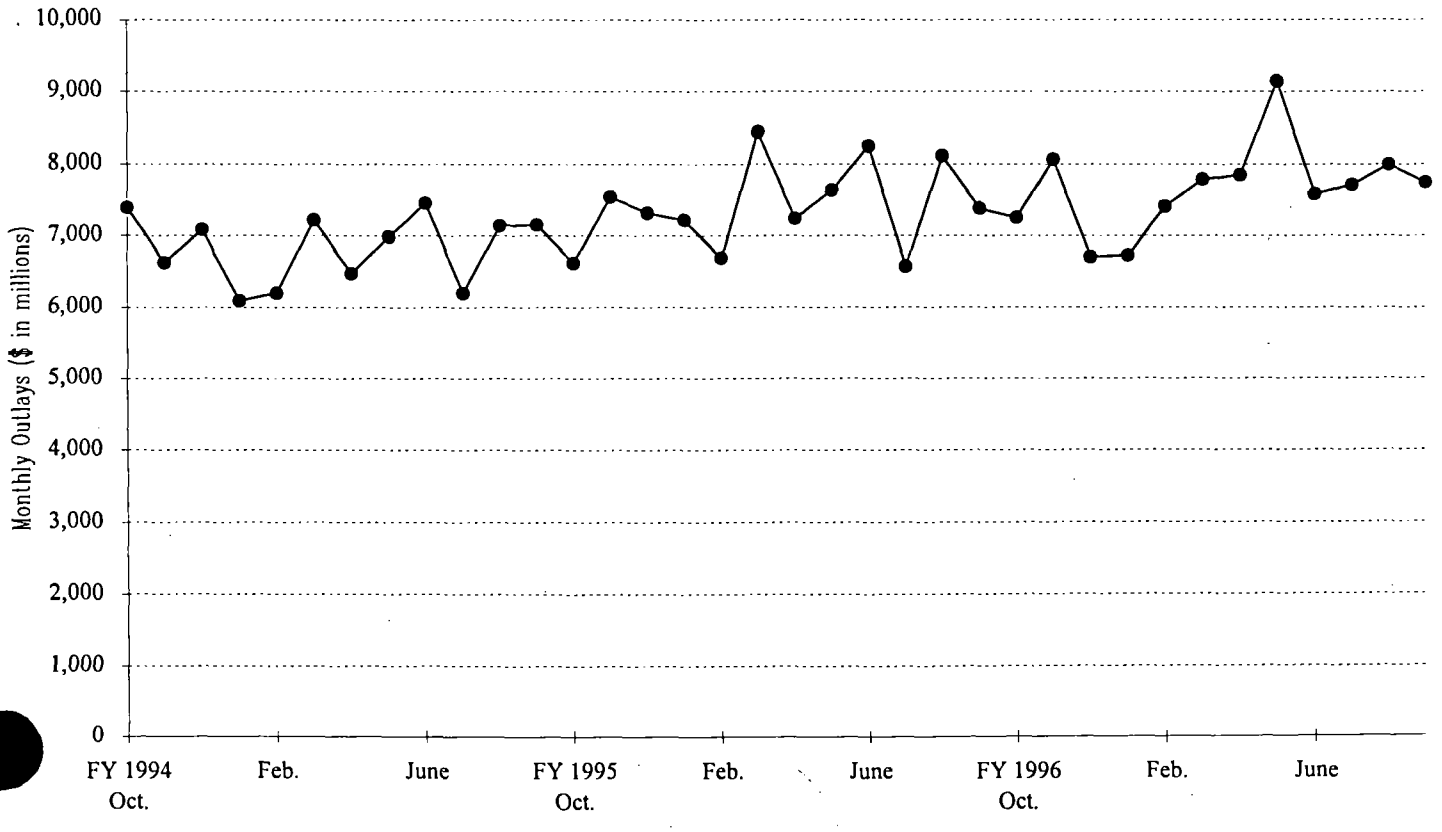
	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1996	7,252	8,070	6,702	6,730	7,411	7,787	7,853	9,144	7,582	7,714	7,998	7,747	91,990
FY 1995	6,622	7,545	7,320	7,216	6,694	8,448	7,239	7,638	8,250	6,573	8,117	7,381	89,043
FY 1994	7,394	6,626	7,088	6,097	6,202	7,220	6,475	6,982	7,456	6,204	7,138	7,153	82,035
FY 95 - 96 Cumulative Difference	630	1,155	537	51	768	107	721	2,227	1,559	2,700	2,581	2,947	2,947
Cumulative % Difference	9.5%	8.2%	2.5%	0.2%	2.2%	0.2%	1.4%	3.8%	2.3%	3.7%	3.2%	3.3%	3.3%

FY 1996 Medicaid Outlays: Comparison of FY 97 Mid-Session Review Estimate to Actuals

FY 1997 Mid-Session Review Estimate		93,065
	annual growth	4.5%
FY 1996 Actual Outlays		91,990
	annual growth	3.3%

Medicaid growth from FY 95 to 96 was only 3.3%

Federal Medicaid Outlays by Month: FY 1994 - FY 1996



WHITE HOUSE BRIEFING DOCUMENT ON MEDICARE AND MEDICAID KEY ISSUES

Medicare

1. Medicare Overview
2. Medicare Part A Trust Fund Solvency
3. Republican vs. President's Savings
4. Republican Spending Per Beneficiary
5. Why an Increase is Still a Cut
6. Impact on Medicare Premiums
7. Republican Plan Will Limit Choice
8. Cost Shifting to Those Private Insurance
9. Impact on the Poor Elderly (QMBs)
10. Impact on Hospital Closings
11. Medical Savings Accounts

Medicaid

1. Medicaid Overview
2. Republican vs. President's Savings
3. Republican Spending Per Beneficiary
4. Republicans End Guarantee to Medicaid
5. Republicans Put Families at Risk
6. Spousal Impoverishment Protections
7. Quality Standards
8. Impact on People with Disabilities
9. The President's Medicaid Plan

MEDICARE OVERVIEW

- Medicare provides health insurance for 37 million elderly and disabled Americans.

- Medicare has two parts:

  1. Medicare Part A (HI) covers hospital insurance.

     - Part A is funded by a Trust Fund which receives most of its income from the HI payroll tax.

     - The Part A Trust Fund is projected to be insolvent in 2002. On 9 separate occasions in the last 25 years, the Trust Fund has been projected to be insolvent in 7 years or less.

  2. Medicare Part B (SMI) covers physician services, outpatient hospital services, lab services, and durable medical equipment.

     - Part B is funded by general revenues and premiums paid by enrollees. It cannot become insolvent.

MEDICARE PART A TRUST FUND SOLVENCY: REPUBLICAN VS. THE PRESIDENT'S PLANS

- Neither the Republican or the President's plan solves the *long-term* insolvency crisis created by the aging of the baby boomers who will reach 65 in the year 2010.

- The President's Plan extends the Trust Fund through at least 2011.

  - Initially, it secured the Trust Fund for 10 years, through at least 2006. By shifting certain home health care costs not related to hospital stays from Part A to Part B, it now extends the Trust Fund through 2011.

  - Securing the trust fund through 2011 provides more than enough time to develop a bipartisan approach to address the long-term Trust Fund solvency issue.

- The Republican plan cuts Medicare more than twice as much as the President's plan yet extends the Trust Fund only slightly longer.

  - Medicare actuaries have not yet determined precisely how long the Republican proposal extends the Trust Fund.

REPUBLICAN VS. PRESIDENT'S MEDICARE SAVINGS

- Republicans cuts Medicare by $270 billion over 7 years. This cut is excessive, and will:

  - Raise costs to beneficiaries
  - Reduce quality by reducing spending below private sector rates
  - Increase costs for everyone with private insurance through massive cost shifting
  - Limit choice by leading doctors to drop out of traditional Medicare
  - Force many urban and rural hospitals to close

- The President's balanced budget calls for $124 billion in savings -- *less than half* the Republican level.

  - 20% of the savings are from extending current laws which both the President and Congress support.

  - All new savings are from providers.

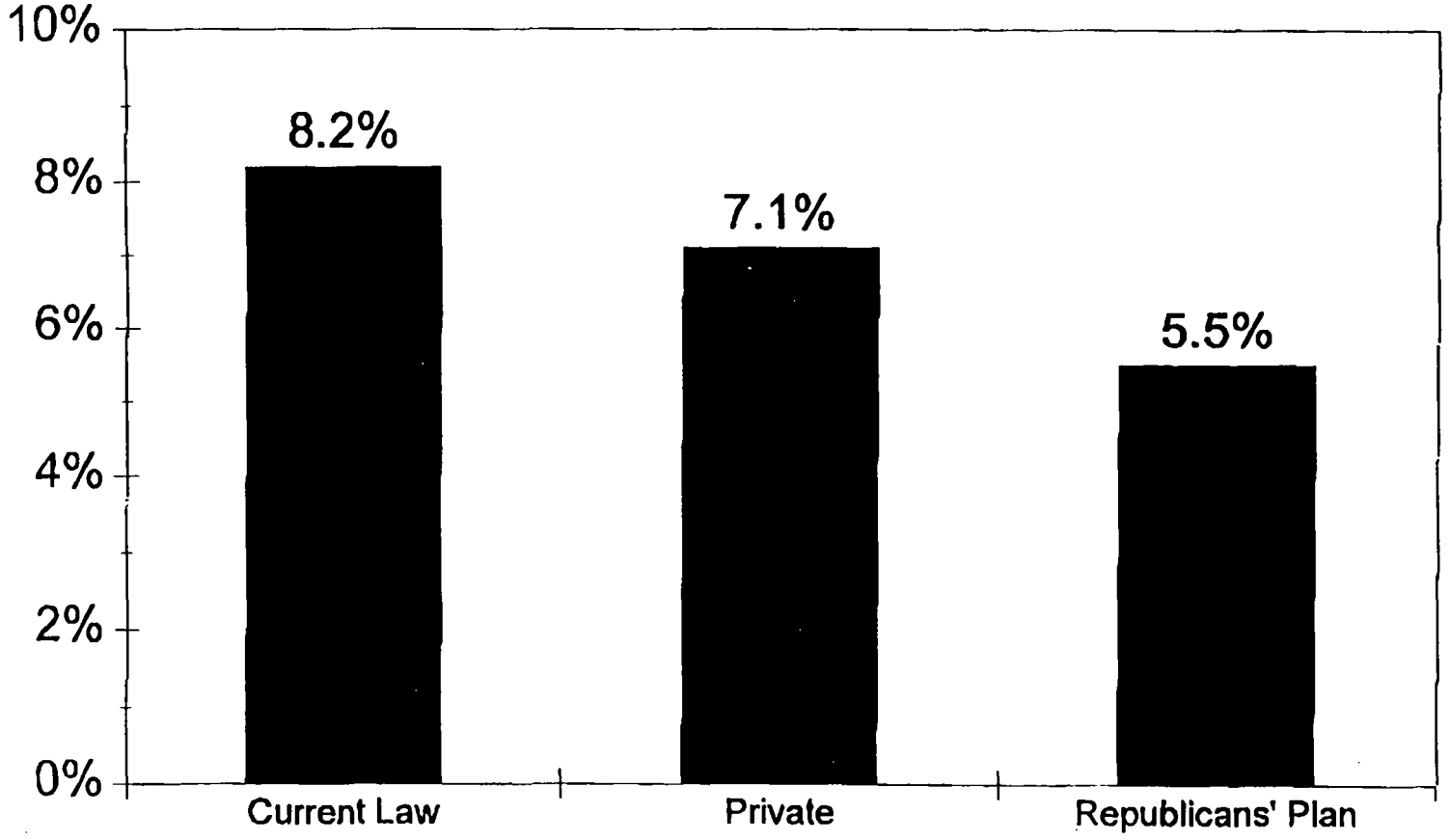
  - The President's plan saves about $124 billion off *any* baseline.

MEDICARE SPENDING PER BENEFICIARY

- Republicans claim they want the government to control health care spending as well as the private sector. But they propose to reduce spending *far below the private sector* per person growth rates.

  - The Republican $270 billion in Medicare cuts would constrain Medicare spending growth to 5.5% per beneficiary, over 20% *below* the projected private sector growth rate of 7.1%, based on CBO data.

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



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

WHY AN INCREASE IN SPENDING IS STILL A CUT

Republicans says they increase Medicare spending from $4,800 per beneficiary today to $7,000 in 2002.

This is a cut because:

- You cannot buy today's Medicare benefits with this amount of money in 2002. Beneficiaries will pay substantially more or get substantially fewer benefits. Spending would not keep up with the costs of prescription drugs, doctors, and hospitals.

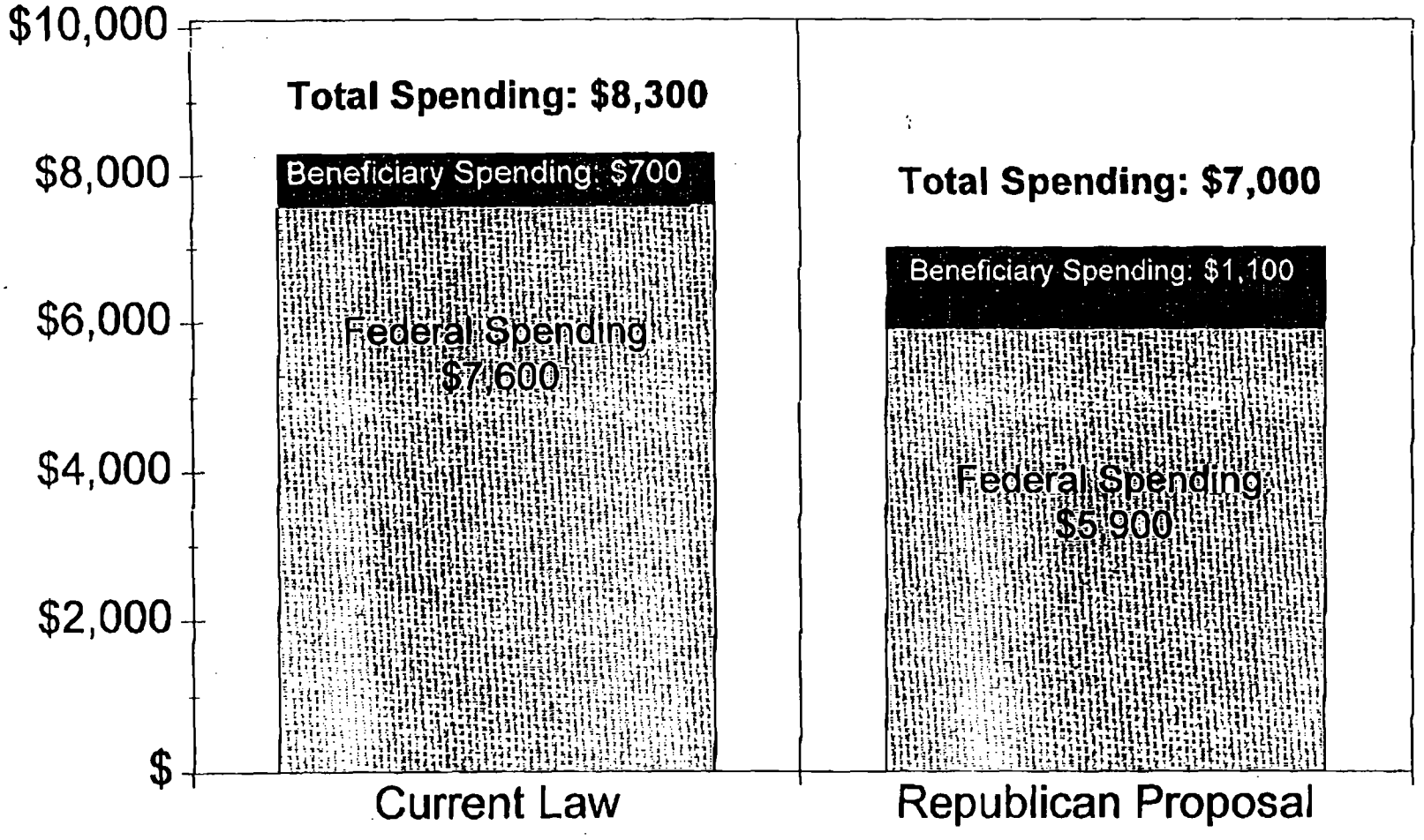
- Their $7,000 figure includes a $1,100 increase in premiums. *Federal* spending would increase to $5,900 per beneficiary.

- $5,900 is $1,700 less than would be spent under current law.

- $5,900 is about $1,000 [check] less than what would be spent per person if Medicare spending growth were constrained to the 7.1% per person growth rate in the private sector.

Republicans Cut Spending & Shift Costs

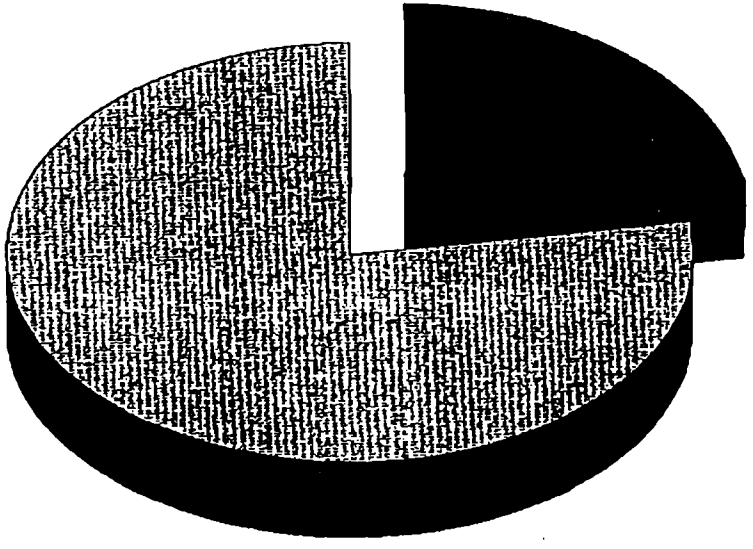
Medicare Spending per Beneficiary 2002



CBO baseline as of October 1995; CBO estimates of savings under the Conference Agreement, 11/16; Administration projections of beneficiares. Source: US DHHS

Republican Reduction in Medicare Spending Per Beneficiary, 2002

Republican Spending: $5,900



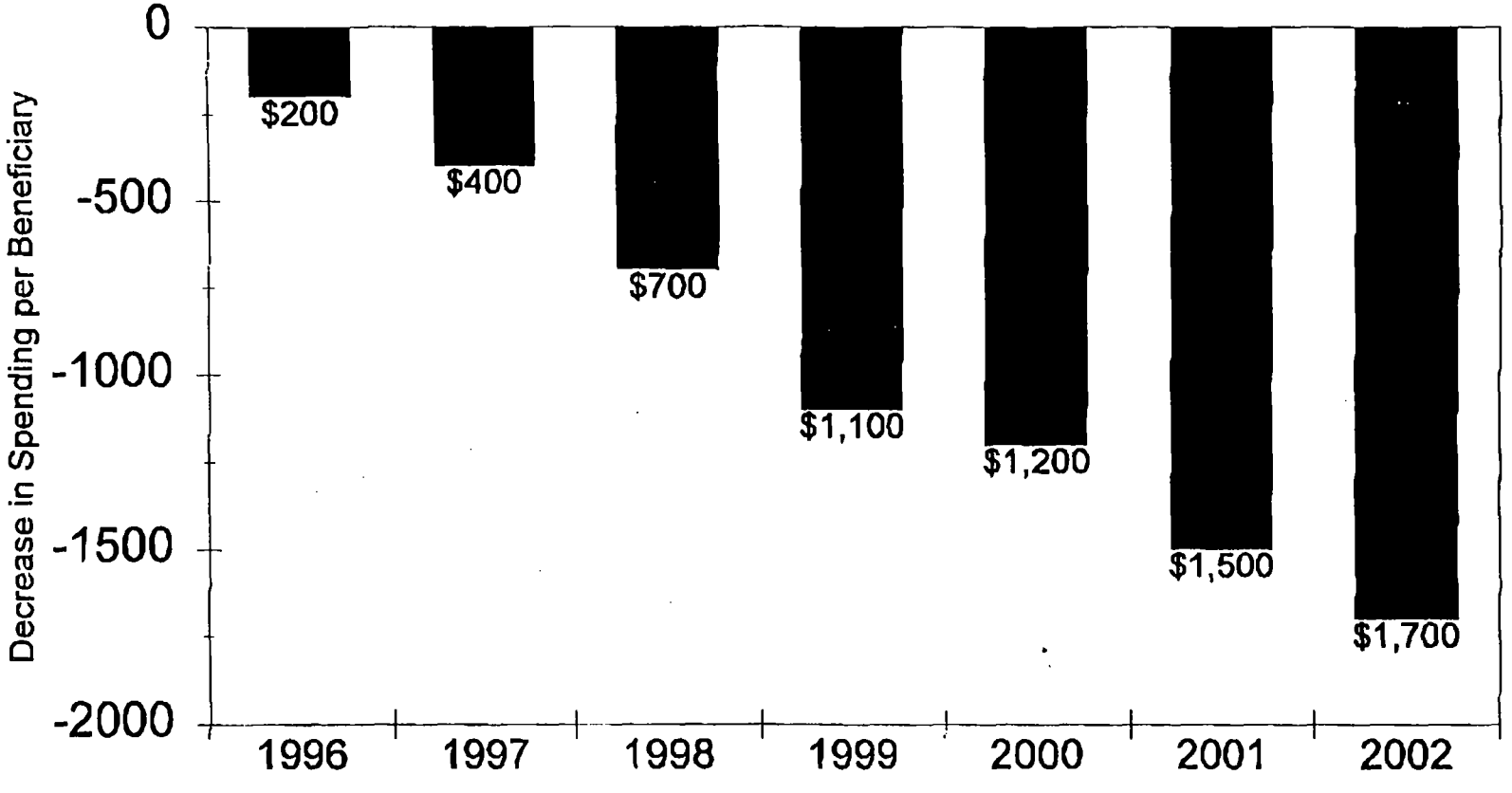
Republican Reduction: $1,700 (20%)

Current Law Federal Spending: $7,600

CBO baseline Medicare spending as of October 1995, divided by projected number of beneficiaries. DHHS estimates the President's proposed Federal spending to be $6,700 per beneficiary in fiscal year 2002. Source: U.S. Department of Health and Human Services.

Decreases in Federal Medicare Spending Per Beneficiary in the Republican Plan

Compared to Current Law



CBO estimates of the Conference Agreement, 11/16/95, using CBO baseline as of October 1995; Administration projections of beneficiaries. Source: US DHHS

IMPACT OF PROPOSALS ON MEDICARE PREMIUMS

- Since 1984, Medicare monthly premiums have been set at 25% of Medicare Part B program costs.

- In an effort to protect beneficiaries from excessive increases in Medicare premiums, premiums were set at specific dollar amounts, rather than at 25% of program costs, for 1991–1995.

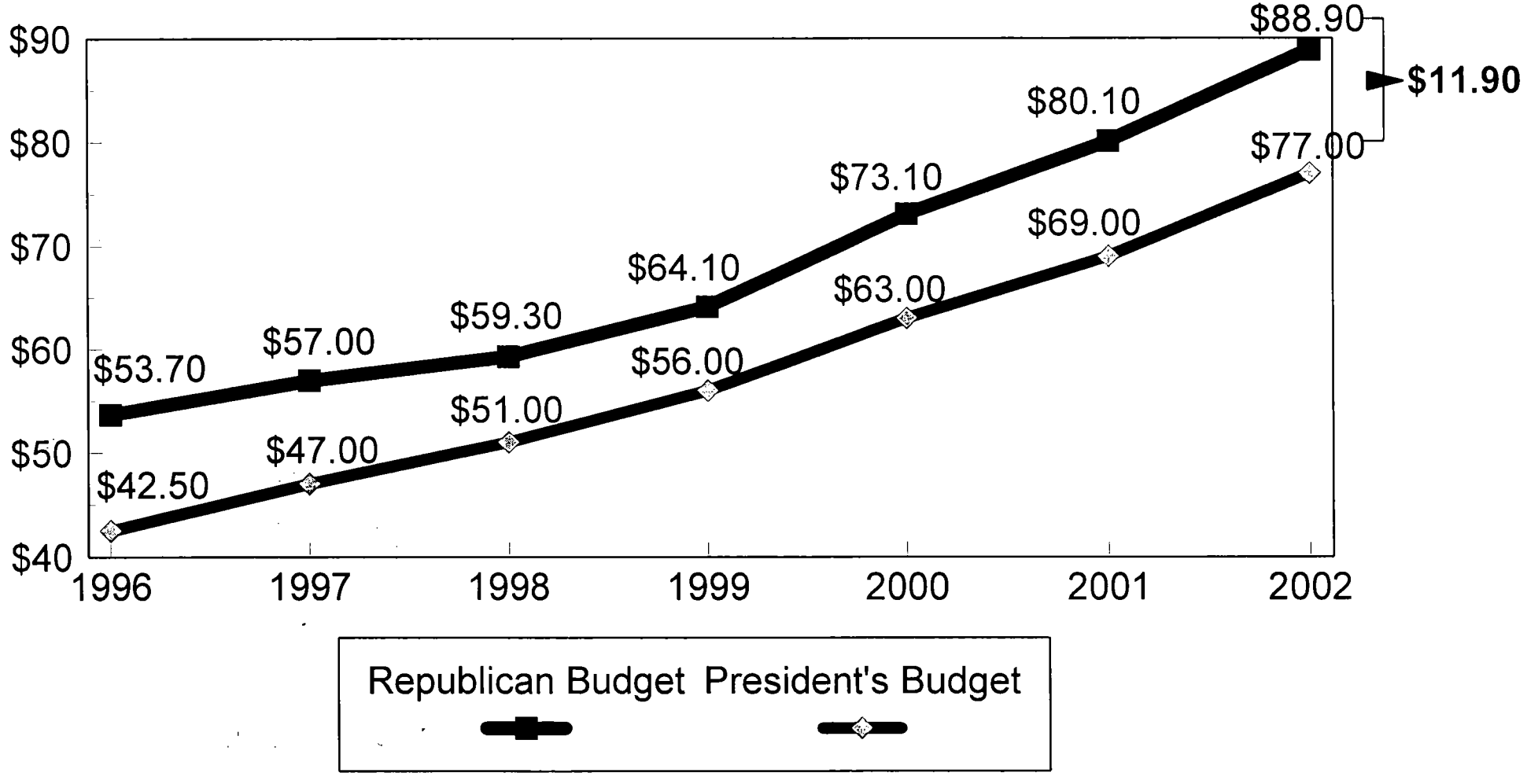
  - It turned out that the dollar amount set for 1995 amounted to 31.5% of programs costs, even though Congress *never intended to raise premiums above 25% of program costs.*

- Republicans would permanently set premiums at 31.5%. The President maintains them at 25% of program costs.

- Compared to the President's plan, the Republican increases monthly premiums by:

  - $12 a month per beneficiary in 2002
  - $143 a year per beneficiary and $246 per couple in 2002
  - $848 over per beneficiary and $1,696 per couple over 7 years

Medicare Monthly Premiums



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

REPUBLICAN PROPOSALS WILL LIMIT CHOICE

The Republican Medicare plan will limit patient choice by leading doctors to drop out of the traditional Medicare system. They will do so because:

1. Payments in the traditional Medicare system will not keep up

- Medicare payments per beneficiary in the traditional fee-for-service plans would increase far less than payments for beneficiaries in the new plans, creating strong and increasing incentives for doctors to leave traditional Medicare.

2. Doctors in the newly created plans could charge extra

- Under current law, Medicare limits the amount a doctor can charge a patient above the Medicare payment rate. This limit on "balance billing" protects beneficiaries from additional charges for services.

- The Republican plan does not extend balance billing protections to the new physician networks it creates outside the traditional fee-for-service system.

COST SHIFTING TO PEOPLE WITH PRIVATE INSURANCE

The Republican Medicare plan will not only increase costs for Medicare beneficiaries, but for everyone else as well. A study of the budget resolution by Lewin–VHI, an independent research firm, concluded that:

- The Republican's initial $452 billion cut in Medicare and Medicaid would lead doctors and hospitals to *raise their fees on private patients by at least $90 billion over 7 years.*
  - This cost shifting would cost employees almost $1,000 each.
- This cost shifting would increase the cost of private health insurance, which would effectively reduce wage increases by 2.7%, and as much as 10% for lower–wage workers
- This cost shifting would also force some firms to drop health insurance coverage for their employees, leaving hundreds of thousands more workers without insurance by 2002.
  - This loss of coverage is in addition to the nearly 8 million people who would be denied Medicaid coverage in 2002, based on HHS estimates.

IMPACT OF REPUBLICAN PLAN ON POOR ELDERLY

- Medicaid covers Medicare premiums, deductibles, and copayments for people with incomes below 100% of poverty (known as "Qualified Medicare Beneficiaries") and Medicare premiums for people with incomes between 100% and 120% of poverty.

  - 5.4 million very low-income elderly and disabled people had their Medicare premiums, deductibles, and copayments covered by Medicaid in 1995.

- The Republican Medicaid plan would no longer guarantee coverage of Medicare premiums, deductibles, and copayments for low-income Medicare beneficiaries.

  - They set aside *less than half* of the funding needed to cover premiums for low-income Medicare beneficiaries in 2002, and do not set aside *any* funding for deductibles and copayments.

- Thus, Republicans significantly increase costs for poor elderly by slashing funds covering their Medicare premiums and allowing some doctors to overcharge at the same time that they increase premiums.

IMPACT ON HOSPITALS

According the American Hospital Association, the Republican Medicare would:

- Reduce payments to hospitals by about $96 billion -- $78 billion in "traditional" reductions and $18 billion from the "failsafe" provision.
  - Hospitals would be paid $1,025 less per admission on average over 7 years compared with current law -- a 13% reduction.
- With cuts of this magnitude, payments will not even keep up with general inflation, much less medical inflation.
  - According to a study by Lewin-VHI, with a $100 billion reduction in payments to hospitals, payments will rise only 2.4% per beneficiary per year -- almost a full percentage point below general inflation.
  - These cuts will adversely affect the quality and availability of care, as payments fail to keep up with the cost of drugs, equipment, and salaries.

IMPACT ON HOSPITALS

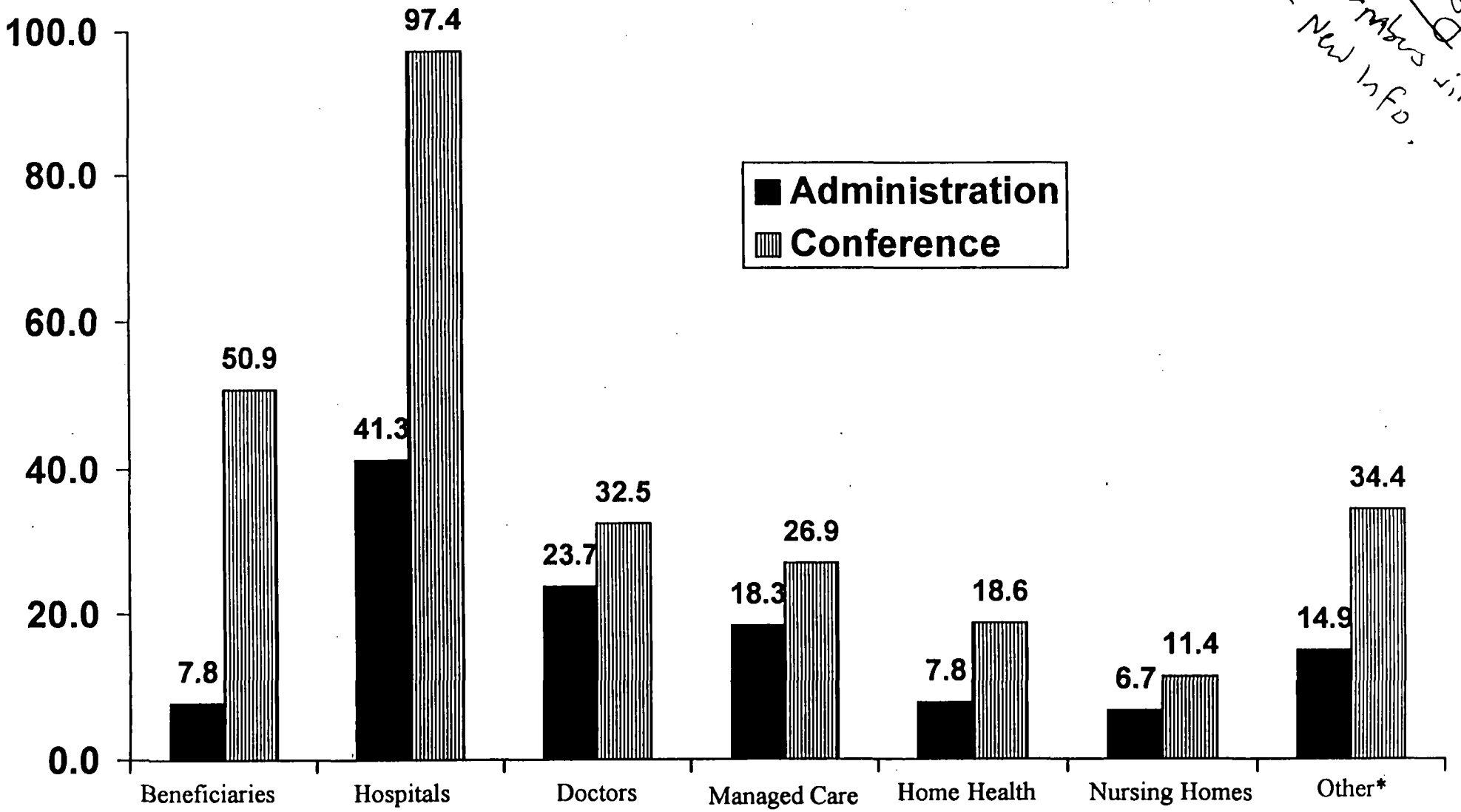
The massive Republican cuts in Medicaid and in Medicare payments to hospitals will force many hospitals to close and jeopardize quality and availability of care at all hospitals:

- According to the American Hospital Association, almost 700 hospitals derive *two-thirds or more* of their net patient revenues from Medicare and Medicaid. About 300 hospitals derive *three-quarters or more* of their net patient revenues from them.

  - Over half of these 700 highly vulnerable hospitals are rural
  - 20% are inner-city hospitals

- The Americans Hospital Association, the Catholic Health Association, the National Association of Public Hospitals, and over 40 State Hospital Associations stated on November 17 that the Republican cuts would "jeopardize the ability of hospitals and health systems to deliver quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

Medicare Savings by Category
President's Plan vs. Republican Conference Agreement
(Estimated CBO Scoring, Dollars in billions, 7-yr Totals)



* Other includes fraud and abuse, interactions, Medicare secondary payer, lab services, durable medical equipment, ambulatory surgical centers, and centers of excellence. Administration managed care savings include both direct managed care payment reductions and the indirect effect of fee for service cuts on managed care. All Conference Agreement managed care savings are direct cuts in payments to plans because the link between fee for service expenditures and managed care payments is severed.

MEDICAL SAVINGS ACCOUNTS

- The Republican Medicare plan allows beneficiaries to withdraw a set amount of money from the Medicare program to buy health insurance with a high deductible. Individuals may deposit any money left over after the purchase into a tax-preferred medical savings account (MSA).

- MSAs tend to attract only the healthiest individuals, who expect few medical expenses in the coming year and who typically cost the Medicare program little.

- To the extent that MSA vouchers are set at a level that exceeds the cost of these healthy beneficiaries under the current Medicare system, MSAs will increase spending on healthy beneficiaries.

  - In fact, CBO estimates that MSAs will raise Medicare costs by $2.3 billion over 7 years [CHECK]. Lewin-VHI concluded that MSAs will cost the Medicare system $15-$20 billion over 7 years.

- Since the Republican plan caps Medicare spending, MSA costs would have to be offset by further cuts in services for the less healthy beneficiaries remaining in the traditional fee-for-service plans.

MEDICAID OVERVIEW

- Medicaid covers over 36 million Americans, including
- Medicaid provides three types of critical health protection:
  - Health insurance for people with disabilities and low-income families
  - Long-term care for older Americans and people with disabilities
  - Medigap coverage that helps low-income elderly with their Medicare costs and fills in the gaps in their Medicare benefits

REPUBLICAN VS. PRESIDENT'S MEDICAID SAVINGS

- Republicans end the Medicaid program and replace it with an underfunded block grant.

  - Their plan cuts federal funding by $163 billion over 7 years.

  - The total Medicaid cuts could ultimately exceed $400 billion. A new analysis by the Center on Budget and Policy Priorities shows that if states provide only the funding required to receive their full block grant allocation and provide no additional funding, the total reduction in federal and state Medicaid funds would *exceed $400 billion over seven years,* compared with current law.

- The President's balanced budget plan maintains the Medicaid program and includes savings of $54 billion over seven years -- less than one-third of the Republican $163 billion cut.

REPUBLICAN SPENDING PER BENEFICIARY

- Total Medicaid spending has grown rapidly, in part because of enrollment growth.

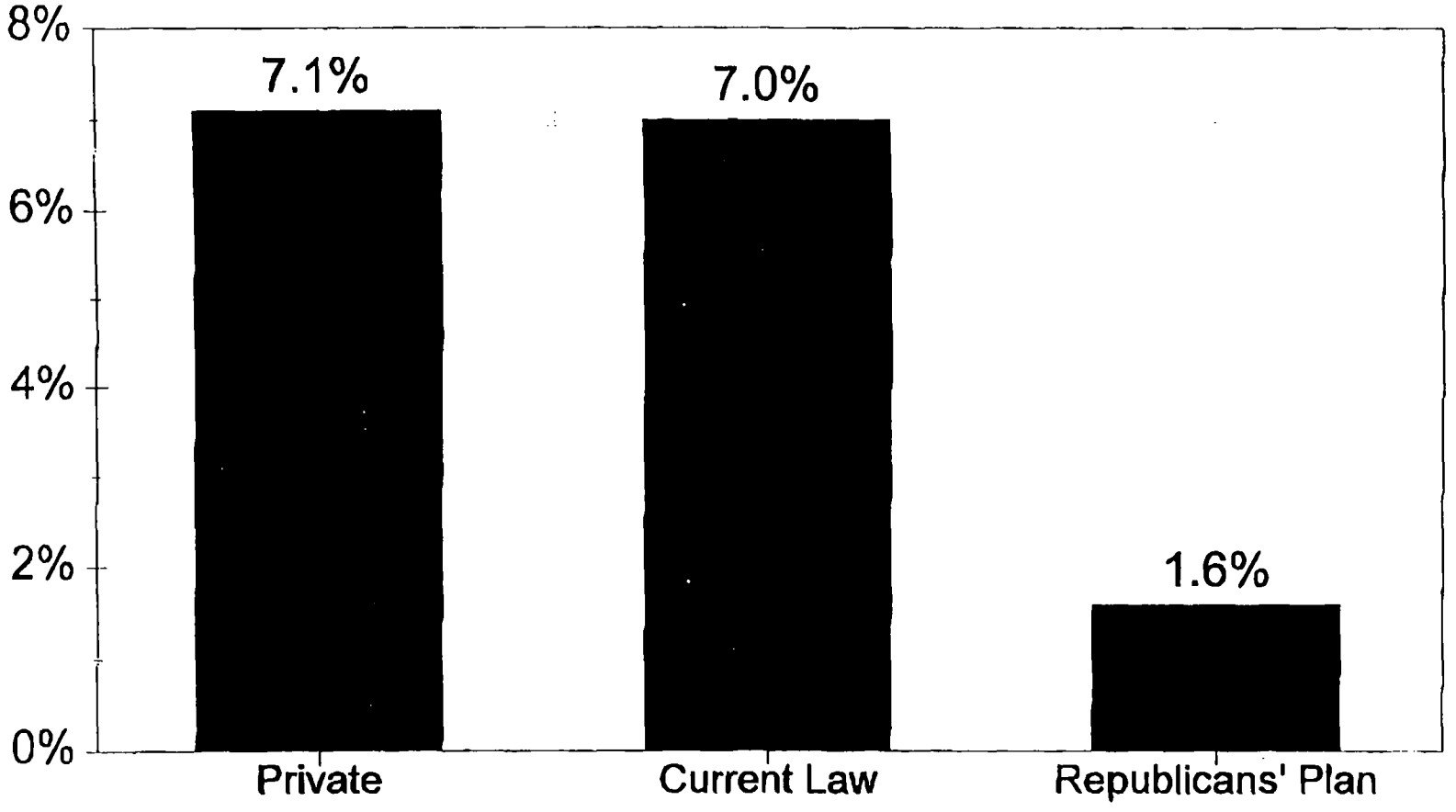
- Medicaid spending *per beneficiary* is projected to increase 7.0% per year over the next seven years under current law.

  - This is slightly *below* the private sector per person rate of 7.1%, using CBO data.

- The Republican $163 billion cut in Medicaid would constrain spending growth per beneficiary to 1.6% per year. This is:

  - 77% below the projected private sector growth rate (7.1%)
  - 70% below medical inflation (5.3%)
  - 50% below general inflation (3.3%) [check]

Comparison of Growth in Total Medicaid Spending Per Beneficiary: 1996-2002



CBO baseline; CBO estimates of savings under the Conference Agreement; Administration estimates of private health spending growth per insured person, using CBO data; DHHS estimates that the President's proposal would produce Federal spending growth per beneficiary of more than 6% over the period. US DHHS

REPUBLICANS END THE GUARANTEE TO MEDICAID

- Republicans end the guarantee to coverage for the disabled, poor families, and sick older Americans needing nursing home care.

  - They require states to cover poor pregnant women and children under age 13 and poor disabled people, *but allow states to define eligible disabilities and the level of services provided.*

  - Because the block grant constrains spending growth per beneficiary to 1.6% per year, providing 28% less funding than under current law by 2002, states will be forced to reduce significantly Medicaid eligibility and benefits.

  - There will be no guaranteed of even the minimum set of services now covered by all states, such as doctor and hospital care.

- Their underfunded block grant will force states to deny coverage for nearly 8 million people in 2002, including:

  - 3.8 million children
  - 1.3 million people with disabilities
  - 850,000 older Americans

REPUBLICANS PUT MIDDLE CLASS FAMILIES AT RISK

- Republicans repeal the guarantee of nursing home coverage.
  - Medicaid is now the largest insurer of long-term care. Medicaid covers 68% of nursing home residents and over 50% of nursing home costs.
  - Nursing home care costs an average of $38,000 per year.
- Without Medicaid, middle class families may have to choose between nursing home care for their parents and education for their children.

REPUBLICANS PUT MIDDLE CLASS FAMILIES AT RISK

- Republicans repeal all federal laws protecting a minimum level of income and assets, such as the family home or farm, for Medicaid eligibility. States could eliminate or substantially weaken current protections.

  - *This means the sick could be forced to sell their homes, family farm, car, and all their savings in order to qualify for Medicaid.*

- They repeal all protections from liens, allowing states to impose liens on the homes and family farms of Medicaid recipients and their families.

- They would allow beneficiaries and their families to be charged large up-front payments as the price of admission, and would allow nursing homes to charge unlimited additional fees.

- They would allow nursing homes to deny admission to those with limited resources, who could become eligible for Medicaid.

SPOUSAL IMPOVERISHMENT PROTECTIONS

- Medicaid protects spouses of nursing home residents from having to become impoverished in order for their spouse to qualify for Medicaid. States must let spouses keep income equal to 150% of the national poverty level -- about $15,000 per year. States must also allow spouses to keep a minimum amount of the couple's assets -- ranging from $15,000 to $75,000 -- in addition to their house and car.

- Since this law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of the spouses are women.

SPOUSAL IMPOVERISHMENT PROTECTIONS

- Initially, Republicans repealed the current protections from spousal impoverishment. In response to criticism that spouses could be forced to use all their income and assets to pay for nursing home care, Republicans modified their plans. But the protections in their reconciliation bill are hollow:

  - They repeal the guarantee to nursing home coverage, effectively repealing the guarantee to protection from spousal impoverishment.

  - They repeal all current protections from liens, allowing states to impose liens on the homes and family farms of Medicaid recipients and their spouses.

  - They make it more difficult for the federal government to ensure that states protect spouses.

  - They repeal the right of individuals to sue states to enforce spousal protections. Thus, the protections are unenforceable.

QUALITY STANDARDS

- To be reimbursed by Medicaid, nursing homes must comply with strict federal quality standards. These standards -- signed into law by President Reagan -- require facilities to provide all needed services, limit the use of physical and chemical restraints, and ensure that nurse aides are trained and qualified.

  - Since these standards have been in place, there has been a:

    - 50% reduction in dehydration among residents,
    - 31% reduction in hospitalization rates, and
    - 25% reduction in the use of physical restraints.
      [Sources: Research Triangle Institute and HCFA.]

- Since 1971, to be reimbursed by Medicaid, institutions caring for the mentally retarded have had to comply with federal Medicaid quality standards. Because of these standards, people with mental retardation can live in safe, healthy institutions rather than in the deplorable conditions of the past.

REPUBLICAN BUDGET AND QUALITY STANDARDS

The Republican reconciliation bill:

- **Repeals federal enforcement of nursing home quality standards.**

  - States would define and enforce nursing home standards.
  - The federal government would have no way to ensure that states enforce these standards.
  - States could even turn over their standard setting and enforcement responsibilities to private organizations, with no federal review.
  - Deep Medicaid funding cuts, combined with the elimination of federal standards and monitoring, could threaten quality of care.

- **Repeals entirely federal standards for institutions caring for people with mental retardation and developmental disabilities.**

  - In alsò does not require states to assure even the most basic rights, such as protection from abuse and neglect. States do not have quality standards for these institutions in place today.

MEDICAID AND PEOPLE WITH DISABILITIES

- Medicaid serves more than 6 million people with disabilities, including nearly 1 million children.

- Medicaid provides hospital and physician services, nursing home services, and institutional care. At a state's option, it also covers prescription drugs, rehabilitation services, assistive devices and equipment such as wheelchairs, and home and community-based care.

- Medicaid is the primary insurer of people with disabilities because private insurance is either not available or not affordable for people with pre-existing conditions or severe disabilities.

- Medicaid payments for people with disabilities account for *over one third* of all Medicaid spending, or $53 billion in 1995.

IMPACT OF THE REPUBLICAN MEDICAID PLAN ON PEOPLE WITH DISABILITIES

Under the Republican Medicaid block grant:

- 1.3 million people with disabilities could be denied coverage in 2002.
- Coverage for the disabled is *not* guaranteed, despite claims by some Republicans.
  - States would be required to cover [POOR??] people with disabilities, but each state would define eligible disabilities and the level of services provided.
  - The deep federal cuts could force states to reduce significantly Medicaid eligibility and benefits for disabled individuals.

THE PRESIDENT'S MEDICAID PLAN

- The President's Medicaid plan includes savings of $54 billion over seven years -- less than one-third of the Republican $163 billion cut.

- The President's plan limits the growth in federal Medicaid payments to States on a per person basis, so that states do not need to reduce coverage to achieve savings.

- The President's plan guarantees coverage to people currently eligible for Medicaid. Under the Republican plan, nearly 8 million people would be denied coverage in 2002 alone.

- The President's plan also maintains the core set of services for people on Medicaid. The Republican plan would leave states free to decide not to cover any service.

- The President's plan protects quality of care in nursing homes and other facilities, and ensures that spouses and families of nursing home residents are not driven into poverty by the costs of nursing home care.

October 29, 1996

Health Division

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Please route to:
Mark Miller
Barry Clendenin
Nancy-Ann Min
Andy Schoenbach

ACTION REQUESTED:
_____ *Decision or Approval*
_____ *Please sign*
_____ *Per your request*
X *Please comment*
_____ *For your information*

TIME SENSITIVITY:
_____ *Urgent*
X *ASAP*
*Time Action Requested by*_____
*Not Time-Sensitive*_____

TYPE OF DELIVERY:
HOTBOX X *OVERNIGHT*____ *Attached cc: Sarah* Bianchi__

With informational copies for:

Subject: BRD Request for Medicaid & Medicare FY 1997 Budget Policy Spending Levels

From: Health Financing Branch

Phone: 202/395-4930
Fax: 202/395-3910
Room: NEOB #7001

BRD Request. Attachment A responds to BRD's request this morning for FY 1997 Budget policy spending levels. BRD is preparing charts for the Director's briefing on the "Step One/Step Two" balanced budget exercise. The draft charts we received from BRD are also attached.

"Step One" spending levels include the savings from $124 and $59 billion over seven years, and "Step Two" includes $124 and $59 billion over five years.

HD Response. We had two options for responding:

- present the spending levels from the FY 1997 Budget document, which reflect $124 and $59 billion in savings over FY 1997-2002 (i.e., assume the policies had been enacted last year); or
- present the estimated spending levels from delaying the FY 1997 Budget policies by one year, which would reflect $83 and $30 billion in savings over FY 1998-2002.

We chose the second option because we believe this is more consistent with Nancy-Ann's guidance when we were preparing the Medicare and Medicaid papers for the Director's briefing book.

Medicaid "Step Two" Savings Issue. We also recommend that BRD change the "Step Two" savings estimates they are using to reflect the savings estimates that we included in the Medicaid five-year balanced budget paper we turned in on Friday. The stream BRD is using includes new spending in FY 1997, which would not be possible because the policies cannot be implemented before FY 1998. The stream presented in our paper assumes the policy would begin in FY 1998. A copy of this paper is attached and the recommended stream of savings is indicated.

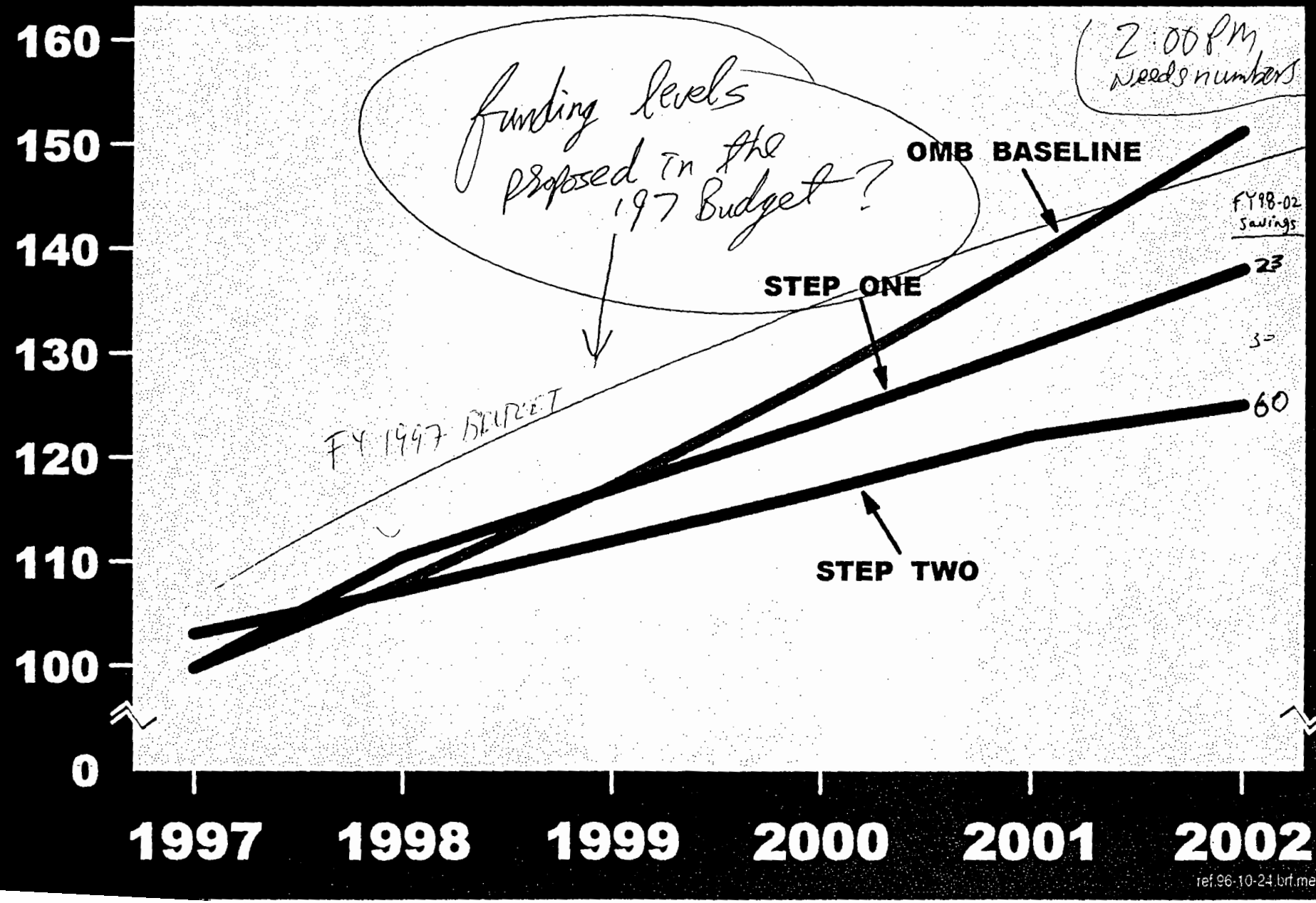
10/29/96

ATTACHMENT A

(Fiscal years, billions of dollars)	1997	1998	1999	2000	2001	2002	Total, 1998-2002
Medicare							
Baseline Spending	194.3	212.4	231.5	252.5	274.7	299.0	
Estimated Savings from FY 97 Budget Policies, Delayed 1 Year	0.0	-5.5	-9.3	-15.1	-23.4	-29.4	-82.7
FY 97 Budget Policy Spending, with Policies Delayed 1 Year	194.3	206.9	222.2	237.4	251.3	269.6	
Medicaid							
Baseline Spending	99.7	107.9	117.2	127.6	139.0	151.2	
Estimated Savings from FY 97 Budget Policies, Delayed 1 Year	0.0	3.3	-0.4	-5.2	-10.8	-17.0	-30.1
FY 97 Budget Policy Spending, with Policies Delayed 1 Year	99.7	111.2	116.8	122.4	128.2	134.2	

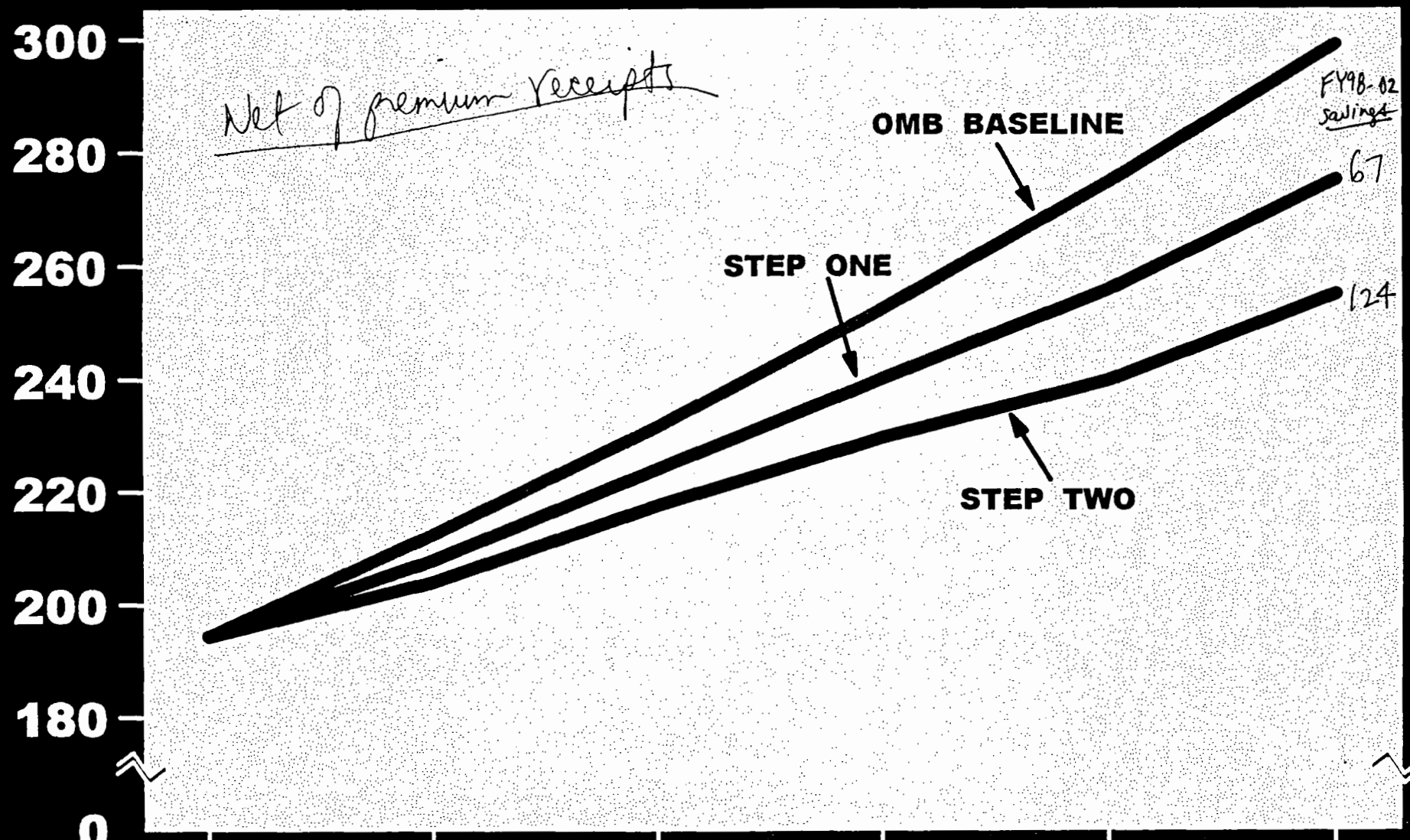
MEDICAID FUNDING LEVELS

OUTLAYS IN BILLIONS



MEDICARE FU..DING LEVELS

OUTLAYS IN BILLIONS



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BRD should use this savings stream

"STEP TWO"

October 25, 1995

Medicaid: Achieving $59 Billion in Savings Over the Five-Year Budget Window

Change in Medicaid Outlays, fiscal years, dollars in millions.

	1997	1998	1999	2000	2001	2002	1998 - 2002
FY 1997 Budget Savings*	+3,300	-646	-5,563	-11,264	-17,589	-26,961	-62,023
FY 1997 Budget Policies Delayed 1 Year		+3,300	-400	-5,200	-10,800	-17,000	-30,100
FY 1997 Savings over 5 Years[1]		+1,300	-5,800	-12,300	-17,500	-26,000	-59,900

*The FY 97 Budget had 1997 costs of $3 billion, resulting in 1997 - 2002 savings of $59 billion.

Any comparison of potential Medicaid savings options to the policy in the FY 1997 Budget should be made with caution. The level of Medicaid savings produced by the policies and the resulting growth rates largely depend on the baseline projections of Medicaid spending. We expect the Medicaid baseline to decrease, perhaps significantly, from the FY 1997 Mid-Session Review. Therefore, it may be more difficult to achieve $59 billion in savings off of the new baseline than the FY 1997 Budget baseline.

Difference: Order of Magnitude. In the FY 1997 Budget, there was about $27 billion in Medicaid savings in 2002. If you assume that the Medicaid baseline remains the same, one can achieve $59 billion in savings in the five year budget window with roughly the same total cuts in 2002. However, this option requires a different policy than the policy in the FY 1997 Budget.

Per Capita Growth Rates:	1996 - 2002	1998 - 2002
FY 1997 Budget Policy	3%	2%
$59 Billion in Savings over 5 Years	n/a	2%

[1]This stream does not match the BRD stream. The BRD stream included new spending in FY 1997, which would not be possible, as the policies cannot be implemented before FY 1998. The stream in this table assumes that the policy would begin in FY 1998.