# AGENDA

**March 10, 1995**

I. Introduction/Purpose of Meeting, Carol Rasco and Laura Tyson

II. Review of Health Care Calendar, Chris Jennings

III. Impact of Republican Medicare/Medicaid Cut Proposals, Bruce Vladeck Presenting

IV. Review of Draft Talking Points about Cuts

V. Discussion about Republican Health "Reform" Bills and If/How/When We Respond

## MEDICAID BLOCK GRANT PROPOSAL

- Republicans are proposing to cap federal payments to states under the Medicaid program as part of their effort to balance the federal budget.

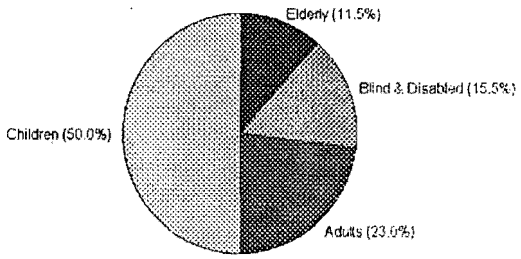
- House leaders have discussed a target of $180 - 190 billion in reduced federal contributions for Medicaid between 1996 and 2002. This is approximately equivalent to capping annual growth in federal Medicaid payments at 5% beginning in 1996.

  Senate leaders have discussed a target of about $75 billion in reduced federal Medicaid contributions between 1996 and 2000 (which would correspond approximately to a 6.5% cap).

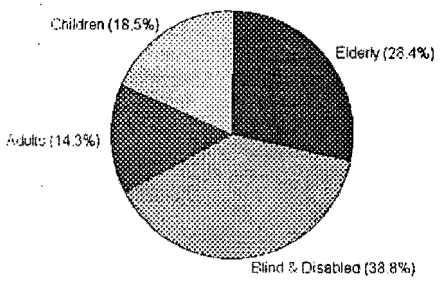
- While there are no specific Congressional block grant proposals for Medicaid, the presumption is that states would be given broad flexibility to determine eligibility, benefits, and provider payment levels.

# CURRENT MEDICAID PROGRAM

## Medicaid Beneficiaries and Expenditures: 1993




**Beneficiaries: 32.1 million**

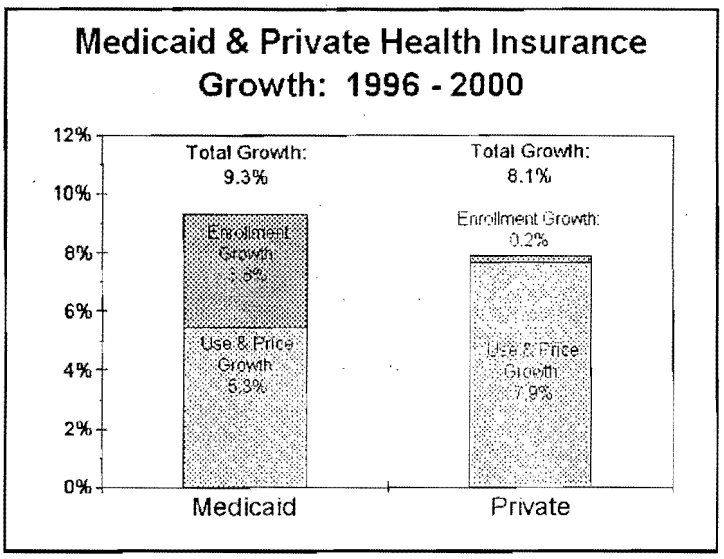



**Non-DSH Expenditures: $108 billion**

Note: Does not include Arizona or U.S. Territories
Source: The Urban Institute, 1994, Prepared for the Kaiser Commission on the Future of Medicaid

- Children and adults (non-elderly, non-disabled) comprise about three quarters of enrollment, but account for only one-third of spending (DSH excluded). Adults alone account for only about 14% of spending.
- The elderly and people with disabilities comprise only 27% of enrollment, but account for 67% of the spending.
- Long-term care services account for 35% of total Medicaid spending.

## GROWTH IN MEDICAID ENROLLMENT




- Medicaid enrollment increases are responsible for the relatively high rates in Medicaid expenditure growth.

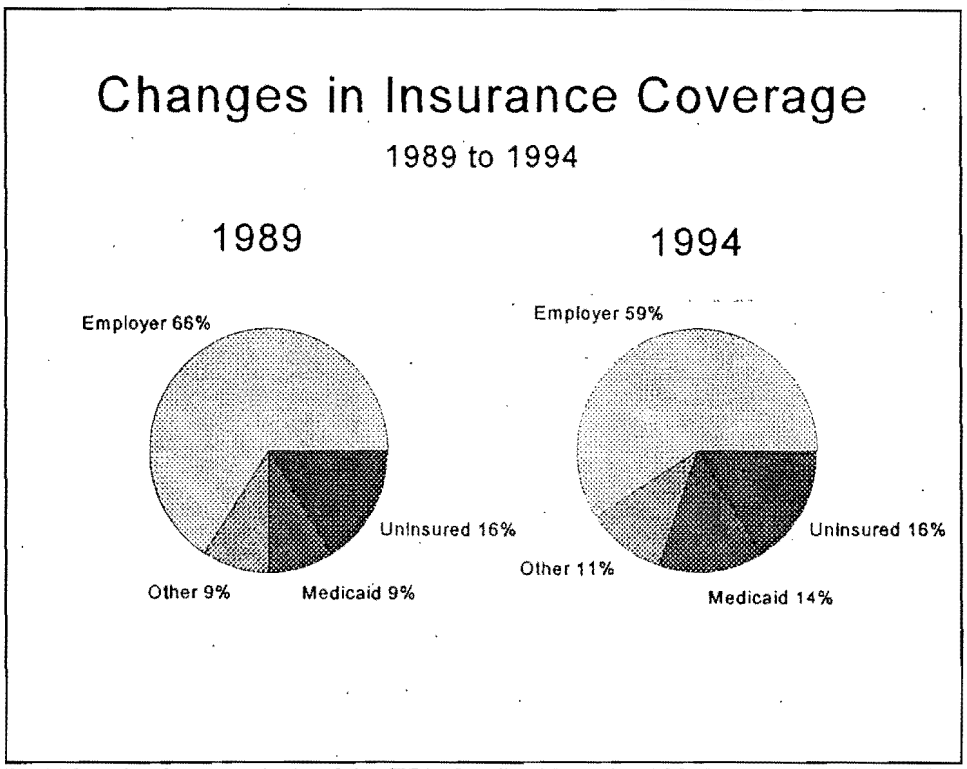
- On a per person basis, Medicaid actually is projected to grow at a slower rate than private health spending — about 5.3% annually per recipient as compared to about 7.9% annually per insured person.

- Medicaid is projected to cover an additional 10 million people by 2002 (for a total of 47 million people).

  - Between 1996 and 2000, the number of AFDC recipients covered by Medicaid is projected to grow 2.3% annually

  - The number of aged and disabled recipients is projected to grow by 4.7% annually during the period.

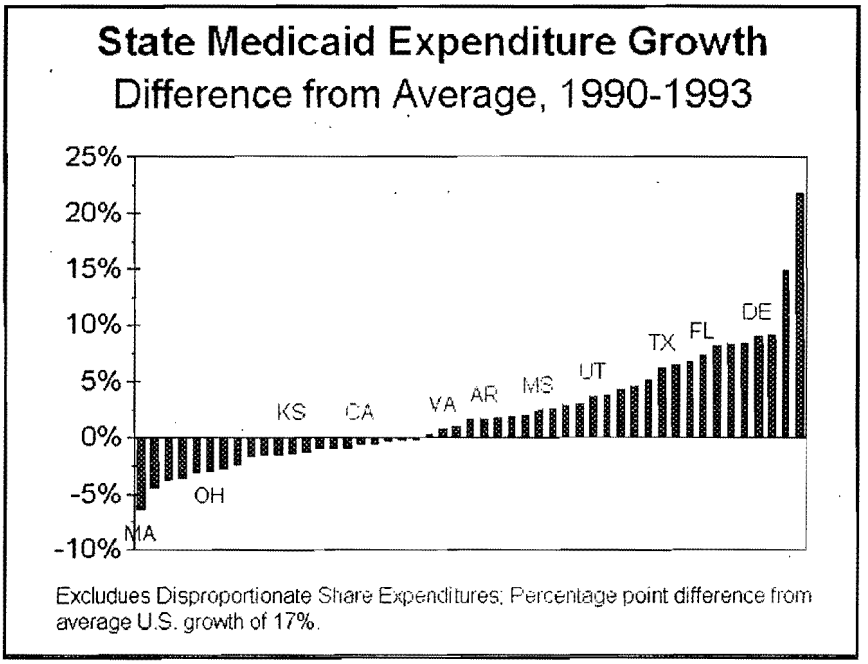
## CHANGES IN MEDICAID ENROLLMENT




SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

- Medicaid has been a significant and growing source of health insurance for many people.
  - Between 1989 and 1994, the percentage of the population covered by Medicaid grew from 9% to over 14%, while the percentage covered by private health insurance fell from about 66% to about 59%.
  - Without this growth in Medicaid, the number of uninsured would likely have increased significantly.
- This trend could be partially reversed by Republican welfare reform proposals, which could eliminate Medicaid eligibility for up to 2 million people (over 6 million if all AFDC adults lose eligibility for Medicaid).
- Additional Republican proposals to significantly cut federal Medicaid payments through a block grant would likely exacerbate the loss of Medicaid coverage. The magnitude of the suggested cuts would leave states with little choice but to reduce eligibility and benefits.

## STATE VARIATIONS IN GROWTH RATES




- The rate of growth in Medicaid spending varies significantly from state to state. Growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns, or service mix.

## EFFECT OF A BLOCK GRANT

As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the number of people eligible in a state.

- **Block Grants Do Not Recognize Differences Among State Programs.**

  - State growth rates can vary significantly across states (e.g., for differences in population, regional medical costs, enrollment patterns, or service mix) and over time in a given state.

  - States also have very different opportunities to achieve savings through managed care. For example, some states already have achieved savings, rural states have less capacity to implement capitated payment arrangements, and some states have a larger proportion of elderly and disabled recipients (for whom managed care is largely untested).

- **States At Risk from Inflation and Recession.** When a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, federal payments to the state would rise, but under a block grant with a fixed growth rate they would not.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services for an increasing number of elderly people.

## CAPPING MEDICAID SPENDING

### Reduction of Federal Spending Under a 5% Growth Cap (Billions of Dollars, Fiscal Years)

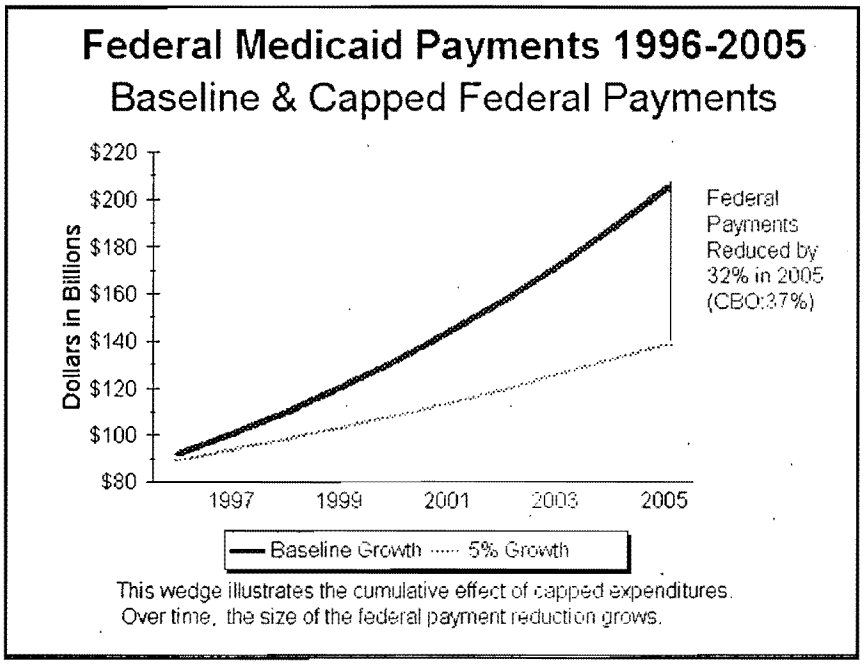
| | 1996-2000 | 1996-2002 | 1996-2005 |
|---|---|---|---|
| **CBO** | | | |
| Baseline | $614 | $955 | $1,593 |
| 5% Growth | $518 | $763 | $1,178 |
| **Fed. Reduction** | **$97** | **$192** | **$415** |
| **Administration** | | | |
| Baseline | $576 | $890 | $1,477 |
| 5% Growth | $513 | $756 | $1,168 |
| **Fed. Reduction** | **$63** | **$134** | **$309** |

- Under the President's baseline, Medicaid is projected to grow at 9.3% through 2002. This is a dramatic reduction from the over 20% annual average growth rate during the Bush Administration.

- Under the CBO baseline, Medicaid is projected to grow at 10.2% through 2002.

- Due to the cumulative effect of the annual reductions under a 5% rate of growth cap, the reduction in federal payments to states doubles (from $97 billion to $192 billion under the CBO baseline) between FY2000 and FY2002.

## CAPPING MEDICAID SPENDING




- Over five years (1996 to 2000), federal payments to states would be 11% below the baseline projection (16% under the CBO baseline).

- Over ten years (1996 to 2005), the cumulative reduction in federal payments is 21% (26% under CBO baseline).

- In FY 2005 alone, federal payments to states would be 32% below the baseline projections (37% under the CBO baseline).

## STATE-BY-STATE EFFECTS OF CAPPING FEDERAL MEDICAID PAYMENTS

- The state-by-state effects of capping federal Medicaid payments have been analyzed two ways.
  - The first method estimates the reduction in federal payments for each state assuming that federal payments to each state under the status quo would grow at the national rate of growth in Medicaid spending projected by CBO.
  - The second method estimates the reduction in federal payments for each state assuming that federal payments to each state grow between 1996 and 2002 at the same annual rate that the state is projecting for the period 1993 to 1996.
  - Note: The total reductions differ between the two methods because the second method is based entirely on state data (and is not controlled to Administration or CBO baselines).
- Assuming that all states grow at the projected national annual growth rate, a block grant with 5% growth would reduce federal payments in every state.
- Assuming state-specific growth rates, changing federal Medicaid payments into a block grant with 5% growth would disproprotionately harm states with high growth rates and benefit states with lower rates of growth.
  - For example, Texas, which has a high rate of growth, would lose almost $21 billion between 1996 and 2002 under a 5% cap. (Their loss would be about $13 billion if payments grew at the national average rate of growth).
  - Some states with low growth rates would actually benefit from a block grant. For example, Colorado would gain over $700 million between 1996 and 2002 under a block grant with a 5% cap if it could sustain its recent growth rates..

**Illustrative Effect of a Medicaid Block Grant**
**Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002**
(Dollars in millions, fiscal years)

| | State Baseline Growth at National Rates | State Baseline Growth at State Projected Rates |
|---|---|---|
| **US** | **(192,119)** | **(172,965)** |
| Alabama | (2,772) | (709) |
| Alaska | (368) | 217 |
| Arizona | (2,531) | (3,364) |
| Arkansas | (1,839) | (156) |
| California | (21,125) | (5,075) |
| Colorado | (1,701) | 714 |
| Connecticut | (2,742) | (3,342) |
| Delaware | (377) | (261) |
| District of Columbia | (896) | (1,484) |
| Florida | (7,645) | (13,483) |
| Georgia | (4,766) | (6,231) |
| Hawaii | (584) | (864) |
| Idaho | (529) | (439) |
| Illinois | (6,476) | (3,477) |
| Indiana | (3,936) | 1,979 |
| Iowa | (1,594) | (1,138) |
| Kansas | (1,238) | 1,093 |
| Kentucky | (2,901) | 50 |
| Louisiana | (6,295) | 373 |
| Maine | (1,299) | (299) |
| Maryland | (2,944) | (4,932) |
| Massachusetts | (5,052) | (2,655) |
| Michigan | (6,549) | (4,829) |
| Minnesota | (3,236) | (4,071) |
| Mississippi | (2,396) | (1,695) |
| Missouri | (3,469) | (1,706) |
| Montana | (538) | (163) |
| Nebraska | (903) | (1,014) |
| Nevada | (470) | 110 |
| New Hampshire | (740) | (879) |
| New Jersey | (5,313) | 1,941 |
| New Mexico | (1,173) | (1,888) |
| New York | (27,160) | (65,988) |
| North Carolina | (5,062) | (8,653) |
| North Dakota | (425) | 27 |
| Ohio | (7,988) | (7,167) |
| Oklahoma | (1,691) | 271 |
| Oregon | (1,861) | (4,940) |
| Pennsylvania | (8,875) | 1,437 |
| Rhode Island | (1,006) | 549 |
| South Carolina | (3,176) | 289 |
| South Dakota | (481) | (541) |
| Tennessee | (5,019) | (2,459) |
| Texas | (12,688) | (20,865) |
| Utah | (914) | (862) |
| Vermont | (413) | (183) |
| Virginia | (2,263) | (1,158) |
| Washington | (3,368) | (3,576) |
| West Virginia | (1,979) | (284) |
| Wisconsin | (3,120) | (942) |
| Wyoming | (237) | (246) |

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.

Assumes that Federal payments to states grow at the CBO projected national average growth rates (column 1) or each state's average compound growth rate between FY 1993 (actual data) and states' projected expenditures for FY 1996 (column 2). The states submitted these projected expenditures in November, 1994.

## POTENTIAL STATE RESPONSES TO OFFSET FEDERAL PAYMENT REDUCTIONS

- Medicaid Managed Care
- Reduction in Payments to Providers
- Reduction in Benefits
- Reduction in Eligibility/Recipients
- Increase or Decrease in State Medicaid Spending

## MEDICAID MANAGED CARE

- While many point to managed care as a source of significant savings under Medicaid, studies (including one by CBO) have generally found that it produces a one-time savings of about 5 to 15% over baseline costs without slowing the rate of growth.

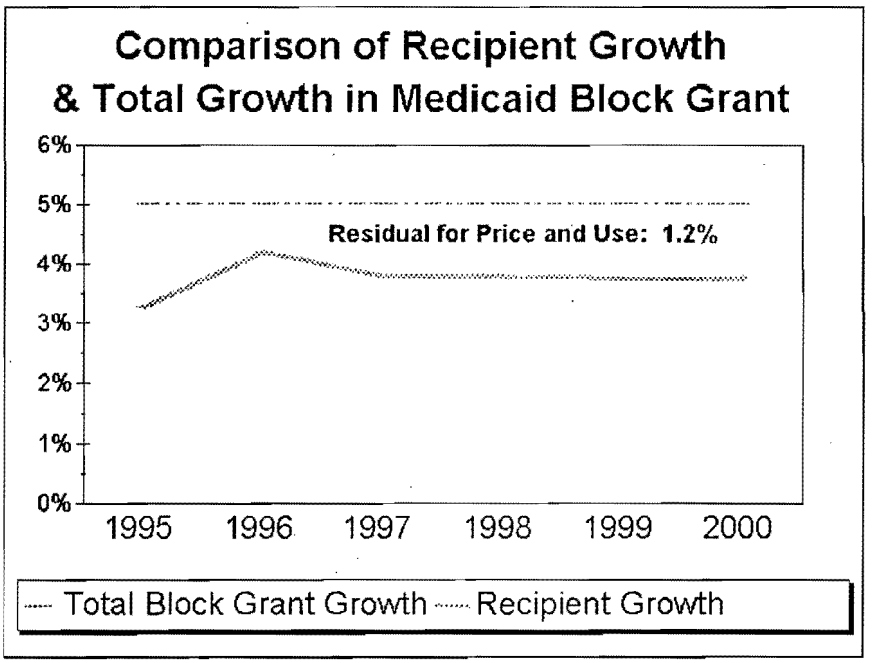
- States have applied managed care primarily to children and AFDC adults, who account for less than one-third of Medicaid spending. Applying managed care techniques to the services typically used by the elderly and disabled (such as long term care) is largely untried and difficult, making the potential for achieving savings hard to predict.

- Baseline projections already assume that a substantial proportion of Medicaid recipients will be in managed care arrangements (33% of AFDC and non-cash children currently, growing to over 50% by the end of the decade).

- Therefore, the percentage of Medicaid spending for which there is some evidence that managed care could produce saving is relatively small, and varies significantly by state (e.g., the percentage of state Medicaid enrollees that are aged or disabled ranges from 15% to 40%).

- Preliminary estimates show that if **all** AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be less than $4 billion, a very small proportion of the $309 billion (under Administration baseline) needed to offset the reduction in federal payments over this period.

## BASELINE ENROLLMENT GROWTH




- The number of people covered by Medicaid is projected to grow by an average of 3.8% a year from 1996 to 2000.

- If states did not reduce coverage under Medicaid, a block grant growing at 5% per year would allow only 1.2% growth in federal Medicaid payments per person. This is far less than the 5.3% projected annual growth in medical inflation.

## REDUCTIONS IN PROVIDERS PAYMENTS, BENEFITS AND ELIGIBILITY

Because managed care cannot produce anywhere near the level of necessary savings, states would be forced to respond by reducing payments to providers, cutting benefits or cutting eligibility. The following **illustrates** the magnitude of the cuts necessary to offset the reduction in federal payments.

- If states chose to respond by cutting provider payments only:
  - In 1997, a 4% reduction in provider payments would be needed.
  - In 2002, a 14% reduction would be needed.
  - In 2005, a 19% reduction would be needed.

- If states chose to respond by reducing benefits only:
  - In 1997, eliminating home health, hospice, and assistance for Medicare premiums and cost sharing would offset the reduction.
  - In 2002, however, eliminating these benefits would achieve only about one-third of the necessary savings.
  - Eliminating home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services would offset the federal reduction in payments.

- If states chose to respond by cutting back on eligibility only:
  - In 1997, eliminating eligibility for non-cash children (the OBRA expansions) would almost achieve the savings necessary.
  - In 2002, however, eliminating eligibility for this population would offset less than one-third of the reduction in federal payments, and eliminate coverage for over 6 million children.
  - Eliminating eligibility for both non-cash kids and AFDC adults would offset about 80% of the reduction in federal payments and would eliminate 11 million people from Medicaid.

## COMBINATION OF MEDICAID SERVICE, PROVIDER, AND RECIPIENT CUTS

- A state could react to the reduced federal Medicaid payments by combining Medicaid managed care, benefits reductions, provider payment reductions and recipient cuts.

- The following scenario illustrates one way that states could offset the federal Medicaid cut in payments of **$39.4 billion** in 2002.

  - Enrolling all adults and children through Medicaid managed care would reduce costs by about $1 billion.

  - Eliminating home health, personal care services and premium and cost-sharing support for Medicare dual eligibles would reduce costs by $17.4 billion.

  - A 5% across-the-board reduction in provider payments would reduce costs by $11.5 billion.

  - Cutting eligibility for a little over 4 million non-disabled adults and children would reduce costs by $9.5 billion.

## CAPPING MEDICARE SPENDING

- Republican efforts to balance the federal budget may also lead to proposals to cap federal spending for the Medicare program. For example, Senator Dole has suggested a reduction in Medicare spending of about $150 billion between 1996 and 2000. This is approximately equivalent to capping annual growth in Medicare spending at about 5% beginning in 1996.

- Medicare is currently projected to grow at an average annual rate of 9.3% between fiscal years 1996 and 2002 (9.8% under CBO baseline).

  On a per person basis, Medicare actually is projected to grow at about the same rate (about 7.6% as compared to 7.8%) as private health spending for people with insurance. (Under CBO projections, per capita Medicare expenditures may be growing at a slightly faster rate than private health spending).

- Using CBO budget estimates, a 5% growth cap would reduce federal Medicare spending below baseline projections by almost $328 billion from fiscal years 1996 to 2002, and by $720 billion from 1996 to 2005.

- The following table shows the potential effects of a 5% growth cap on a state-by-state basis. This analysis assumes that Medicare spending in each state under the status quo would grow at same rate as CBO projects overall Medicare spending to grow.

**Illustrative Effect of Medicare Capped Expenditures**
**Reduction in Federal Payments Assuming 5% Growth Cap**
(Dollars in millions, fiscal years)

| | 1996 - 2002 |
|---|---|
| **US*** | **(328,328)** |
| Alabama | (5,647) |
| Alaska | (223) |
| Arizona | (4,999) |
| Arkansas | (2,997) |
| California | (37,838) |
| Colorado | (3,281) |
| Connecticut | (4,711) |
| Delaware | (822) |
| District of Columbia | (2,552) |
| Florida | (26,901) |
| Georgia | (7,577) |
| Hawaii | (1,085) |
| Idaho | (784) |
| Illinois | (14,083) |
| Indiana | (6,599) |
| Iowa | (2,996) |
| Kansas | (3,099) |
| Kentucky | (4,495) |
| Louisiana | (5,983) |
| Maine | (1,289) |
| Maryland | (5,668) |
| Massachusetts | (10,298) |
| Michigan | (11,868) |
| Minnesota | (4,834) |
| Mississippi | (3,047) |
| Missouri | (7,165) |
| Montana | (848) |
| Nebraska | (1,582) |
| Nevada | (1,523) |
| New Hampshire | (1,061) |
| New Jersey | (10,899) |
| New Mexico | (1,277) |
| New York | (26,272) |
| North Carolina | (7,441) |
| North Dakota | (797) |
| Ohio | (13,967) |
| Oklahoma | (3,549) |
| Oregon | (3,313) |
| Pennsylvania | (21,276) |
| Rhode Island | (1,443) |
| South Carolina | (3,305) |
| South Dakota | (761) |
| Tennessee | (7,462) |
| Texas | (18,376) |
| Utah | (1,356) |
| Vermont | (523) |
| Virginia | (5,554) |
| Washington | (4,972) |
| West Virginia | (2,334) |
| Wisconsin | (5,290) |
| Wyoming | (318) |

Federal payment reductions are allocated across states in proportion to the states' FY 1993 share of Medicare spending.

* States' losses do not sum to U.S. losses due to the exclusion of territories.

## POTENTIAL RESPONSES TO ACCOMPLISH REDUCED MEDICARE SPENDING GROWTH

- Medicare Managed Care
- Reduction in Medicare Payments to Providers
- Reduction in Medicare Benefits
- Increases in Medicare Premiums

## MEDICARE MANAGED CARE

The potential for achieving scorable savings in Medicare through managed care is uncertain.

- Currently, 74 % of Medicare beneficiaries have access to a managed care option and 9% of Medicare beneficiaries have chosen to enroll in a managed care plan. Of this 9%, two-thirds are enrolled in an HMO. By the year 2000, we project that about 16% of beneficiaries will be enrolled in HMOs.

- Managed care currently costs the Medicare program rather than achieving savings. Evaluations have determined that due to favorable selection, Medicare pays 5.7% more for every enrollee in risk-based managed care than would have been paid if the beneficiary had stayed in fee-for-service.

- CBO has testified that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

- The Department has a number of efforts underway to improve and expand the managed care choices available to beneficiaries, including developing a PPO option and evaluating methods to improve the current payment methodology for Medicare managed care plans.

## COMBINATION OF REDUCED PAYMENTS TO PROVIDERS AND BENEFICIARY PREMIUM INCREASES

- Under the Mainstream Coalition bill, Medicare cuts were distributed across providers and beneficiaries so that providers bore about three-quarters of the reductions and beneficiaries bore about one-quarter. Using this same distribution, the following would be necessary to offset the effects of a 5% cap on Medicare.

- **Provider Cuts**: If cuts were distributed proportionately across providers:

| | |
|---|---|
| Hospitals: | 9% reduction in 1997;<br>26% reduction in 2002; and<br>39% reduction in 2005. |
| Physicians: | 8% reduction in 1997;<br>22% reduction in 2002; and<br>28% reduction in 2005. |
| Other Providers: | 6% reduction in 1997;<br>13% reduction in 2002; and<br>16% reduction in 2005. |

  - A relatively large percentage of rural hospitals are heavily dependent on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals.

- **Increases in Medicare Premiums**: If these savings were achieved by increasing Medicare premiums, the premiums would increase by:

  $142 per year in 1997;
  $533 per year in 2002; and
  $898 per year in 2005.

  - Medicare beneficiaries already spend almost 12% of their household incomes on health care, as compared to less than 4% for nonelderly families.

## EFFECTS ON ACCESS AND PRIVATE PAYERS

- Between 1996 and 2002, 5% caps on the growth in Medicaid and Medicare would reduce federal health payments by over $500 billion.

- Reductions of this magnitude raises questions about how providers would respond. With the number of uninsured projected to rise over the decade, hospitals and other providers will be face the strain of provider more uncompensated care with fewer resources. Cuts in Medicaid enrollment would exacerbate the strain.

- Recently, it appears that private payers — particularly large employers — have intensified their cost containment efforts. These efforts have forced hospitals and other providers to reduce expenses, further diminishing their capacity to absorb reductions in Medicare and Medicaid payments and increases in uncompensated care.

- Given the magnitude of the proposed cuts, providers may not be able to respond to the reductions in payments entirely through increased efficiency.

  - Access to care for Medicare beneficiaries and uninsured patients may be jeopardized. Understandably, providers may be less willing to see these patients as their sources of payment shrink.

  - Private payers may also bear a portion of this burden through cost shifting. Small employers and individual purchasers, who have less leverage in the marketplace, may be particularly vulnerable to cost shifting.

**Illustrative Effect of a Medicaid Block Grant & Medicare Capped Expenditures Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002**
(Dollars in millions, fiscal years)

| | State Baseline Growth at National Rates | State Baseline Growth at State Projected Rates |
|---|---|---|
| **US** | **(520,447)** | **(501,293)** |
| Alabama | (8,419) | (6,356) |
| Alaska | (591) | (6) |
| Arizona | (7,530) | (8,363) |
| Arkansas | (4,836) | (3,154) |
| California | (58,963) | (42,913) |
| Colorado | (4,981) | (2,567) |
| Connecticut | (7,452) | (8,053) |
| Delaware | (1,199) | (1,084) |
| District of Columbia | (3,447) | (4,036) |
| Florida | (34,546) | (40,384) |
| Georgia | (12,343) | (13,808) |
| Hawaii | (1,669) | (1,948) |
| Idaho | (1,313) | (1,223) |
| Illinois | (20,559) | (17,560) |
| Indiana | (10,536) | (4,620) |
| Iowa | (4,590) | (4,133) |
| Kansas | (4,336) | (2,005) |
| Kentucky | (7,396) | (4,446) |
| Louisiana | (12,278) | (5,610) |
| Maine | (2,588) | (1,588) |
| Maryland | (8,611) | (10,600) |
| Massachusetts | (15,349) | (12,952) |
| Michigan | (18,417) | (16,697) |
| Minnesota | (8,069) | (8,905) |
| Mississippi | (5,444) | (4,743) |
| Missouri | (10,634) | (8,871) |
| Montana | (1,386) | (1,011) |
| Nebraska | (2,486) | (2,596) |
| Nevada | (1,993) | (1,413) |
| New Hampshire | (1,801) | (1,940) |
| New Jersey | (16,213) | (8,958) |
| New Mexico | (2,450) | (3,166) |
| New York | (53,432) | (92,260) |
| North Carolina | (12,503) | (16,093) |
| North Dakota | (1,221) | (770) |
| Ohio | (21,955) | (21,134) |
| Oklahoma | (5,240) | (3,278) |
| Oregon | (5,174) | (8,253) |
| Pennsylvania | (30,151) | (19,839) |
| Rhode Island | (2,449) | (894) |
| South Carolina | (6,482) | (3,016) |
| South Dakota | (1,242) | (1,301) |
| Tennessee | (12,481) | (9,921) |
| Texas | (31,063) | (39,241) |
| Utah | (2,270) | (2,218) |
| Vermont | (936) | (706) |
| Virginia | (7,817) | (6,712) |
| Washington | (8,340) | (8,548) |
| West Virginia | (4,313) | (2,618) |
| Wisconsin | (8,410) | (6,232) |
| Wyoming | (555) | (564) |

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.
Assumes that Federal Medicare and Medicaid payments grow at the CBO projected national average growth rates (column 1) or the Medicaid average compound growth rates between FY 1993 (actual data) and states' projected expenditures for each state for FY 1996 (column 2).

## SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICARE

- Medicare is the primary health care program for 32 million elderly and 4 million disabled Americans.

- Republicans have proposed to cut Medicare funding by at least $150 billion between now and 2000 -- a **20% cut** in 2000 alone.

- Medicare spending per person is already projected to grow at roughly the same rate as private sector health spending. So with a cut this large, both beneficiaries and providers will be forced to shoulder huge burdens.

  - Medicare managed care is unlikely to provide significant savings in the near future. CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

  - If cuts were allocated as under the Mainstream Coalition health reform bill, providers would bear about three-quarters of the reductions and beneficiaries would bear about one-quarter:

    - In 2002 alone, a 23% cut in Medicare payments to providers would be needed.

    - Elderly and disabled beneficiaries would have to pay $533 more for Medicare, a 42% increase over the premiums they pay today.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system, which would still bear the growing burden of uncompensated care. This is likely to shift costs to small businesses.

- Reducing Medicare payments also would disproportionately harm rural hospitals. Rural hospitals are more likely than other hospitals to depend heavily on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals, which makes them less able to absorb large Medicare payment reductions.

- In the last Congress, bills proposed by Senator Dole and the Mainstream Coalition also proposed large Medicare cuts. However, unlike current Republican proposals, the Dole and the Mainstream Coalition proposals reinvested their savings into the health care system through subsidies to expand insurance coverage. By reinvesting their savings, they would have reduced the uncompensated care burden on provider and business and mitigated many of the adverse effects from Medicare cuts.

## SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICAID

- Medicaid is a safety net for over 35 million mothers and children, the elderly and people with disabilities. By the year 2002, Medicaid will cover roughly 46 million people.

- Republicans have proposed (through the use of a block grant with 5% growth) to cut federal Medicaid funding by at least $180 to $190 billion between now and 2002 -- a **24% cut** in 2002 alone.

- There is no evidence that manage care alone can achieve this level of savings.

  - States already are aggressively pursuing managed care, but the populations that can readily be managed -- children and AFDC adults -- account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

  - As a result, the potential savings from expanding managed care actually is less than five percent of the needed savings.

- Contrary to Republican claims, Medicaid spending per person is already projected to grow at a slower rate than private health spending. So, with a cut this large, health care coverage for vulnerable Americans is at severe risk.

  - To protect mothers and children, states could:

    - Drop coverage for as many as **3 million elderly and people with disabilities,** or

    - Eliminate benefits disproportionately used by the elderly and people with disabilities like home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services --- and, by 2005, begin to limit nursing home services.

  - Alternatively, to protect the elderly and people with disabilities, states could:

    - Drop coverage for as many as **16 million mothers and children**, or

    - Eliminate all inpatient hospital, outpatient, and physician services for mothers and children -- and still not have enough savings to offset the loss of federal funds.

- States could decide to increase their spending by over $180 billion. But that would mean a 33% increase in state Medicaid spending in 2002 alone. States would be forced to raise taxes or slash spending for services like education and public safety.

**DRAFT** March 10, 1995

## FAWELL (HR 995 AND HR 996)

Strengths

- Provides access to health coverage for those who lack access today because they are sick.
  - Eliminates pre-existing condition exclusions for those changing coverage (e.g., when changing jobs), and limits exclusions for those newly purchasing insurance. These rules would apply to all plans, including self-insured plans. Due to ERISA, states have only been able to limit exclusions for insured plans (generally offered by smaller employers).
  - Requires health plans to guarantee access to and renewal of coverage. This provision applies both to small businesses (those with 50 or fewer employees) and individuals.
- Preempts state anti-managed care laws.

Weaknesses

- Preempts all state health insurance laws that are inconsistent with the bill.
  - States that have gone further in guaranteeing access to coverage or moving towards community rating would have to scale back reform. States could choose to continue to enforce insurance laws, but would have no discretion over the content of the laws.
  - Preempts state mandated benefits laws without establishing a national minimum or standardized benefits package.
- Continues to permit wide variations in premiums across small businesses and individuals.
  - Small business premiums could vary due to age by a factor of 4 to 1 (potentially phased down in the future to three to one). Variations due to age for individual purchasers (e.g., the self-employed) would be unlimited.
  - Small business premiums could vary due to claims experience by a factor or 1.5 to 1 (potentially phased down in the future). Premiums for individual purchasers could vary due to claims experience by a factor of 2 to 1. All of the major Republican bills last Congress prohibited experience rating.

- Health plans could vary premiums by size of business for differences in administrative costs (up to 15% higher for the smallest businesses).

- Insurers could establish separate classes of business (based, for example, on how coverage is marketed), and charge different premiums across these classes.

- These provisions are similar to the rating reforms that most states have already implemented, based on a model law prepared by the National Association of Insurance Commissioners (NAIC). However, in its updated model law, the NAIC has gone further, suggesting the elimination experience rating altogether.

♦ Permits associations of small employers and individuals to obtain coverage through self-insured or insured arrangements outside of the community risk pool.

- This provision would preempt state efforts to restrict or regulate these arrangements.

- The bill establishes reserve requirements for self-insured associations, but these requirements are inadequate. Multiple employer associations sell coverage to employers, much like an insurance company. However, the bill requires reserves much smaller than what insurance companies are required to hold. This would put these arrangements at high risk of insolvency, leaving consumers at risk for unpaid medical bills.

♦ Establishes medical savings accounts, which could further segment healthy and sick individuals into separate risk pools. (Note that the tax treatment of medical savings accounts is under the jurisdiction of the Ways and Means Committee.)

**DRAFT** March 10, 1995

# THOMAS (HR 1234)

## Strengths

- Provides access to health coverage for those who lack access today because they are sick.
  - Eliminates pre-existing condition exclusions for those changing coverage (e.g., when changing jobs), and limits exclusions for those newly purchasing insurance. These rules would apply to all plans, including self-insured plans. Due to ERISA, states have only been able to limit exclusions for insured plans (generally offered by smaller employers).
  - Requires health plans to guarantee access to and renewal of coverage. This provision applies both to small businesses (those with 50 or fewer employees) and individuals.
  - Most states have already implemented similar access reforms.
- Insurance rating reforms go beyond what most states have done. In particular, experience rating would be eliminated (at least for small businesses). However, some weaknesses still remain, including:
  - Small business premiums could vary due to age by a factor of 4 to 1 (phasing down in the future to 3 to 1). Though in a voluntary market some variations for age are necessary to prevent younger people from dropping coverage, most Democratic bills last Congress limited the variation to no more than 2 to 1.
  - Health plans could vary premiums by size of business for differences in administrative costs (up to 20% higher for the smallest businesses).
- Insurance access and rating reforms are applied to individual purchasers (e.g., the self-employed) as well as small employers, which few states have done.

  However, the bill maintains separate risk pools (leading to different premium levels) for individual purchasers and small businesses. Applying insurance reforms to individual purchasers without spreading their cost across a broader population is likely to lead to unaffordably high premiums in that market.
- Requires the establishment of a risk adjustment mechanism so that health plans that attract a disproportionate share of high-cost or high-risk individuals would be compensated.

- Preempts state anti-managed care laws.

- Prohibits self-insurance by individual small employers (those with 50 employees or fewer employees), preventing employers with healthy employees from leaving the community risk pool.

- Facilitates the establishment of state-chartered purchasing cooperatives ("Health Plan Choice Organizations") for small businesses and individual purchasers.

Weaknesses

- Preempts all state health insurance laws that are inconsistent with the bill.

  - States that have gone further in guaranteeing access to coverage or moving towards community rating would have to scale back reform. States could choose to continue to enforce insurance laws, but would have no discretion over the content of the laws.

  - Preempts state mandated benefits laws without establishing a national minimum or standardized benefits package.

- The bill does not prohibit self-insurance by associations of small employers, but it is unclear to what extent it would preempt state efforts to restrict or regulate these arrangements. Self-insured association plans would be required to meet state-established solvency standards.

- Establishes medical savings accounts, which could further segment healthy and sick individuals into separate risk pools.

- The bill contains a number of malpractice provisions that would preempt less restrictive state laws, including:

  - Requires initial resolution through an alternative dispute resolution (ADR) process before a claim can be brought to court. The party that contests an ADR ruling in court is required to pay the attorney costs for the opposing party if the court ruling is less favorable than the original ADR ruling.

  - Permits states to establish practice guidelines that form a rebuttable presumption in malpractice cases.

  - Caps non-economic damages at $250,000.

  - Eliminates joint liability for non-economic damages and allocates liability to multiple defendants based on the percentage of responsibility.

## OTHER PROVISIONS

- Establishes standards for managed care arrangements, including: prompt access to care (including specialty care), the ability to choose a personal physician, due process standards for selecting providers, and standards for utilization review procedures. The standards would not likely require significant changes in current managed care practices, though could prevent some future abuses.

- The bill contains standards for the electronic transmission of health information intended to encourage the development of a health information network. [Note: Further work is required to assess the desirability of these provisions.]

- Requires the Attorney General to exempt from antitrust laws any health care collaborative where the benefits (e.g., increasing access, maintaining or increasing quality, preserving health facilities in underserved areas, and reducing duplication of resources) outweigh any reduction in competition.

# ALTERNATIVE MEDICAID CAPS

## Reductions in Federal Spending Under Alternative Growth Caps

**(Fiscal Years; Dollars in Billions)**

| Alternative Growth Caps | 1996 - 2002 | 1996 - 2005 |
|---|---|---|
| **Total Program Block Grant** | | |
| 5% cap (Admin / CBO) | $134 / $192 | $309 / $415 |
| 7% cap (Admin / CBO) | $71 / $129 | $170 / $275 |
| Enrollment + CPI cap (Admin / CBO) | $66 / $136 | $160 / $313 |
| Enrollment + MCPI cap (Admin / CBO) | ($10)** / $62 | ($14)* / $146 |
| **Acute Care Block Grant (Admin)** | | |
| 5% cap (Admin / CBO) | $95 / $124 | $218 / $266 |
| 7% cap (Admin / CBO) | $62 / $92 | $145 / $195 |
| Enrollment + CPI cap (Admin / CBO) | $59 / $96 | $140 / $214 |
| Enrollment + MCPI cap (Admin / CBO) | $20 / $58 | $49 / $129 |

* Cap at enrollment + MCPI would increase the deficit over the periods under Administration baseline.

- None of the alternative growth caps achieve the level federal payment reductions discussed by House Leaders.
  - A 5% acute care cap achieves about one-half the federal reduction discussed by House leaders. Even though acute care is more amendable to managed care savings, such a cap would only permit a per capita rate of growth of just over 1%, much lower than growth in private per capita health spending.
- A per capita growth cap (e.g., enrollment + CPI) addresses some, but not all, of the problems associated with a Medicaid block grant.
  - A per capita cap accommodates changes in enrollment due to recessions, but does not address many other reasons for variations in state program growth such as differences in regional medical costs, enrollment patterns, or service mix.

- A per capita cap does not recognize the different capacities of states to achieve savings through expanded managed care.

# AGENDA

**March 10, 1995**

I. Introduction/Purpose of Meeting, Carol Rasco and Laura Tyson

II. Review of Health Care Calendar, Chris Jennings

III. Impact of Republican Medicare/Medicaid Cut Proposals, Bruce Vladeck Presenting

IV. Review of Draft Talking Points about Cuts

V. Discussion about Republican Health "Reform" Bills and If/How/When We Respond

# HEALTH CARE MARCH 1995

| | | | Wed. Mar. 1, 1995 | Thu. Mar. 2, 1995 | Fri. Mar. 3, 1995 | Sat. Mar. 4, 1995 |
|---|---|---|---|---|---|---|
| | | | - House Govt. Operations Subcommittee/REGO/ Secretary Shalala testifies<br>- Senate Approps Subcommittee(AG)/ Dr. Kessler testifies | - Rescission Bill considered by full House Approps<br>- Balanced Budget vote defeated 65-35 | | |
| **Sun. Mar. 5, 1995** | **Mon. Mar. 6, 1995** | **Tue. Mar. 7, 1995** | **Wed. Mar. 8, 1995** | **Thu. Mar. 9, 1995** | **Fri. Mar. 10, 1995** | **Sat. Mar. 11, 1995** |
| | - GOP ATTACKING DEMS FOR NO HEALTH ENTITLEMENT CUTS TO REDUCE DEFICIT | | - Budget/House Approps Subcommittee /Secretary Shalala testifies<br>- House Approps Subcommittee/Dr. Lee testifies<br>- Health Professions Senate Labor/HR/Dr. Lee testifies<br>- 'Ways&M'ans H.R.483 mark up/Medica' Select&Medicare Extenders for tax package | - Budget/Senate Approps Subcommittee/Secretary Shalala testifies<br>- House Approps Subcommittees/Dr. Chavez, SAMHSA testifies<br>- House Approps Subcommittee/Dr. Sumaya, HRSA testifies<br>- House Approps Subcommittee/Dr. Graus, AHCPR testifies | - House Labor Committee hearing on Fawell bill | |
| **Sun. Mar. 12, 1995** | **Mon. Mar. 13, 1995** | **Tue. Mar. 14, 1995** | **Wed. Mar. 15, 1995** | **Thu. Mar. 16, 1995** | **Fri. Mar. 17, 1995** | **Sat. Mar. 18, 1995** |
| | - GOP ATTACKING DEMS FOR NO HEALTH ENTITLEMENT CUTS TO REDUCE DEFICIT | 'Kassebaum Seante Labor Committee hearings on health reform: the problem | - 'Kassebaum Seante Labor Committee hearings on health reform: the solution<br>- Possible POTUS release of FDA Regulatory Reforms?<br>- House Approps Subcommittee(AG)/ Dr. Kessler, FDA testifies | - Possible POTUS release of FDA Regulatory Reforms? | | |
| **Sun. Mar. 19, 1995** | **Mon. Mar. 20, 1995** | **Tue. Mar. 21, 1995** | **Wed. Mar. 22, 1995** | **Thu. Mar. 23, 1995** | **Fri. Mar. 24, 1995** | **Sat. Mar. 25, 1995** |
| | - GOP ATTACKING DEMS FOR NO HEALTH ENTITLEMENT CUTS TO REDUCE DEFICIT | | - Secretary Shalala testifies to House Budget Committee re: FY'96 Budget | | | |
| **Sun. Mar. 26, 1995** | **Mon. Mar. 27, 1995** | **Tue. Mar. 28, 1995** | **Wed. Mar. 29, 1995** | **Thu. Mar. 30, 1995** | **Fri. Mar. 31, 1995** | |
| | - GOP ATTACKING DEMS FOR NO HEALTH ENTITLEMENT CUTS TO REDUCE DEFICIT | | | | - Prep for upcoming Budget Resolution mark ups which will likely include ranking Democrats proposing Medicare cuts | |

## MEDICAID BLOCK GRANT PROPOSAL

- Republicans are proposing to cap federal payments to states under the Medicaid program as part of their effort to balance the federal budget.

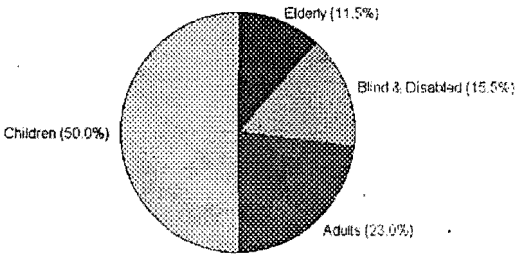
- House leaders have discussed a target of $180 - 190 billion in reduced federal contributions for Medicaid between 1996 and 2002. This is approximately equivalent to capping annual growth in federal Medicaid payments at 5% beginning in 1996.

  Senate leaders have discussed a target of about $75 billion in reduced federal Medicaid contributions between 1996 and 2000 (which would correspond approximately to a 6.5% cap).

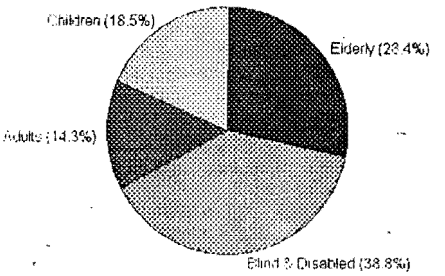
- While there are no specific Congressional block grant proposals for Medicaid, the presumption is that states would be given broad flexibility to determine eligibility, benefits, and provider payment levels.

# CURRENT MEDICAID PROGRAM

## Medicaid Beneficiaries and Expenditures: 1993




**Beneficiaries: 32.1 million**




**Non-DSH Expenditures: $108 billion**

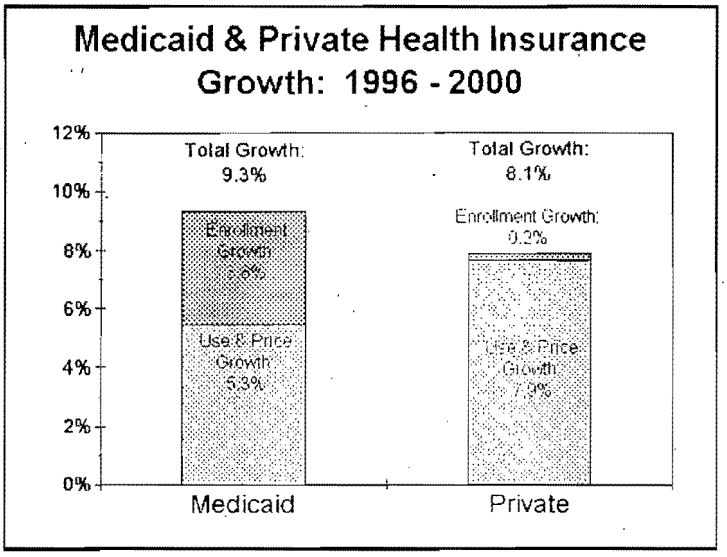
Note: Does not include Arizona or U.S. Territories
Source: The Urban Institute, 1994, Prepared for the Kaiser Commission on the Future of Medicaid

- Children and adults (non-elderly, non-disabled) comprise about three quarters of enrollment, but account for only one-third of spending (DSH excluded). Adults alone account for only about 14% of spending.

- The elderly and people with disabilities comprise only 27% of enrollment, but account for 67% of the spending.

- Long-term care services account for 35% of total Medicaid spending.

## GROWTH IN MEDICAID ENROLLMENT




- Medicaid enrollment increases are responsible for the relatively high rates in Medicaid expenditure growth.

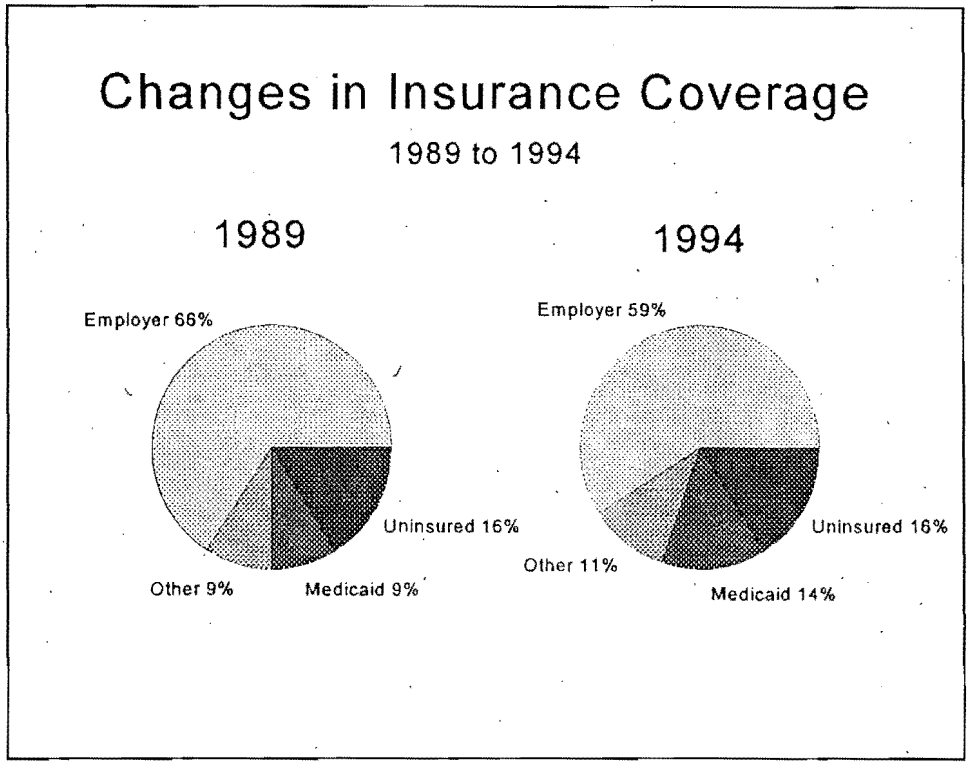
- On a per person basis, Medicaid actually is projected to grow at a slower rate than private health spending — about 5.3% annually per recipient as compared to about 7.9% annually per insured person.

- Medicaid is projected to cover an additional 10 million people by 2002 (for a total of 47 million people).

  - Between 1996 and 2000, the number of AFDC recipients covered by Medicaid is projected to grow 2.3% annually

  - The number of aged and disabled recipients is projected to grow by 4.7% annually during the period.

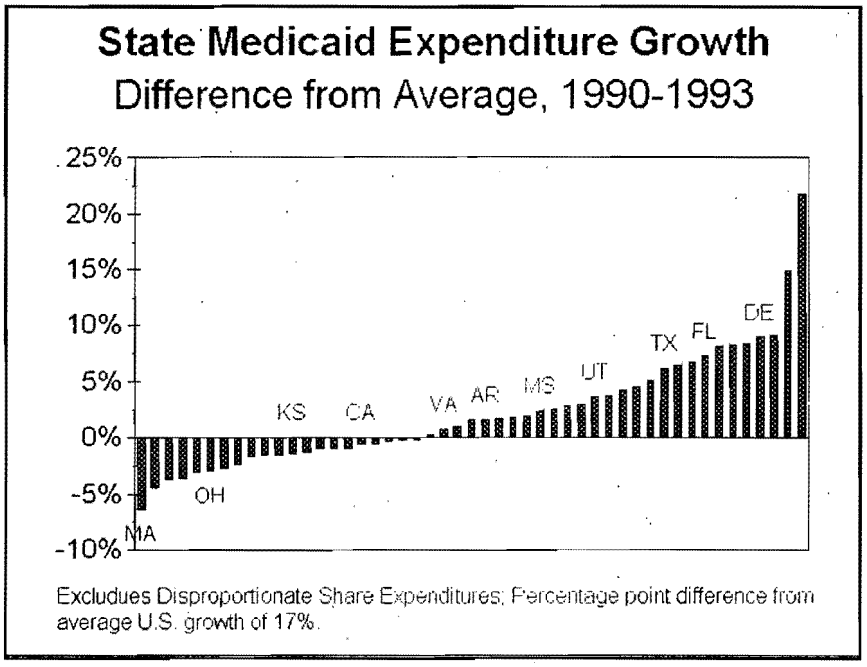
## CHANGES IN MEDICAID ENROLLMENT




SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

- Medicaid has been a significant and growing source of health insurance for many people.
  - Between 1989 and 1994, the percentage of the population covered by Medicaid grew from 9% to over 14%, while the percentage covered by private health insurance fell from about 66% to about 59%.
  - Without this growth in Medicaid; the number of uninsured would likely have increased significantly.
- This trend could be partially reversed by Republican welfare reform proposals, which could eliminate Medicaid eligibility for up to 2 million people (over 6 million if all AFDC adults lose eligibility for Medicaid).
- Additional Republican proposals to significantly cut federal Medicaid payments through a block grant would likely exacerbate the loss of Medicaid coverage. The magnitude of the suggested cuts would leave states with little choice but to reduce eligibility and benefits.

## STATE VARIATIONS IN GROWTH RATES




- The rate of growth in Medicaid spending varies significantly from state to state. Growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns, or service mix.

## EFFECT OF A BLOCK GRANT

As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the number of people eligible in a state.

- **Block Grants Do Not Recognize Differences Among State Programs.**
  - State growth rates can vary significantly across states (e.g., for differences in population, regional medical costs, enrollment patterns, or service mix) and over time in a given state.
  - States also have very different opportunities to achieve savings through managed care. For example, some states already have achieved savings, rural states have less capacity to implement capitated payment arrangements, and some states have a larger proportion of elderly and disabled recipients (for whom managed care is largely untested).
- **States At Risk from Inflation and Recession.** When a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, federal payments to the state would rise, but under a block grant with a fixed growth rate they would not.
- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services for an increasing number of elderly people.

## CAPPING MEDICAID SPENDING

### Reduction of Federal Spending Under a 5% Growth Cap (Billions of Dollars, Fiscal Years)

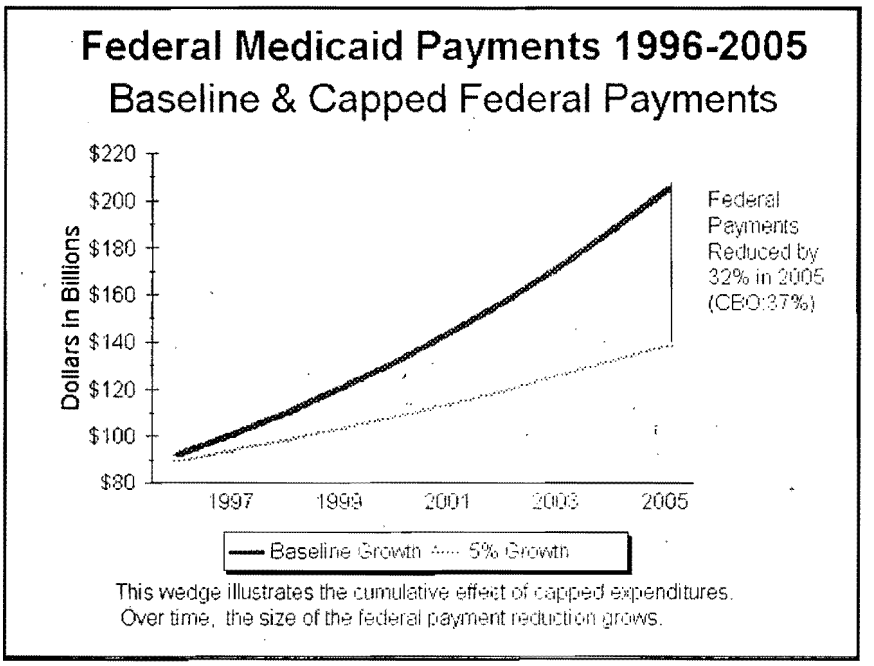
| | 1996-2000 | 1996-2002 | 1996-2005 |
|---|---|---|---|
| **CBO** | | | |
| Baseline | $614 | $955 | $1,593 |
| 5% Growth | $518 | $763 | $1,178 |
| **Fed. Reduction** | **$97** | **$192** | **$415** |
| **Administration** | | | |
| Baseline | $576 | $890 | $1,477 |
| 5% Growth | $513 | $756 | $1,168 |
| **Fed. Reduction** | **$63** | **$134** | **$309** |

- Under the President's baseline, Medicaid is projected to grow at 9.3% through 2002. This is a dramatic reduction from the over 20% annual average growth rate during the Bush Administration.

- Under the CBO baseline, Medicaid is projected to grow at 10.2% through 2002.

- Due to the cumulative effect of the annual reductions under a 5% rate of growth cap, the reduction in federal payments to states doubles (from $97 billion to $192 billion under the CBO baseline) between FY2000 and FY2002.

## CAPPING MEDICAID SPENDING




- Over five years (1996 to 2000), federal payments to states would be 11% below the baseline projection (16% under the CBO baseline).

- Over ten years (1996 to 2005), the cumulative reduction in federal payments is 21% (26% under CBO baseline).

- In FY 2005 alone, federal payments to states would be 32% below the baseline projections (37% under the CBO baseline).

## STATE-BY-STATE EFFECTS OF CAPPING FEDERAL MEDICAID PAYMENTS

- The state-by-state effects of capping federal Medicaid payments have been analyzed two ways.
  - The first method estimates the reduction in federal payments for each state assuming that federal payments to each state under the status quo would grow at the national rate of growth in Medicaid spending projected by CBO.
  - The second method estimates the reduction in federal payments for each state assuming that federal payments to each state grow between 1996 and 2002 at the same annual rate that the state is projecting for the period 1993 to 1996.
  - Note: The total reductions differ between the two methods because the second method is based entirely on state data (and is not controlled to Administration or CBO baselines).
- Assuming that all states grow at the projected national annual growth rate, a block grant with 5% growth would reduce federal payments in every state.
- Assuming state-specific growth rates, changing federal Medicaid payments into a block grant with 5% growth would disproprotionately harm states with high growth rates and benefit states with lower rates of growth.
  - For example, Texas, which has a high rate of growth, would lose almost $21 billion between 1996 and 2002 under a 5% cap. (Their loss would be about $13 billion if payments grew at the national average rate of growth).
  - Some states with low growth rates would actually benefit from a block grant. For example, Colorado would gain over $700 million between 1996 and 2002 under a block grant with a 5% cap if it could sustain its recent growth rates..

**Illustrative Effect of a Medicaid Block Grant**
**Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002**
(Dollars in millions, fiscal years)

| | State Baseline Growth at National Rates | State Baseline Growth at State Projected Rates |
|---|---|---|
| **US** | **(192,119)** | **(172,965)** |
| Alabama | (2,772) | (709) |
| Alaska | (368) | 217 |
| Arizona | (2,531) | (3,364) |
| Arkansas | (1,839) | (156) |
| California | (21,125) | (5,075) |
| Colorado | (1,701) | 714 |
| Connecticut | (2,742) | (3,342) |
| Delaware | (377) | (261) |
| District of Columbia | (896) | (1,484) |
| Florida | (7,645) | (13,483) |
| Georgia | (4,766) | (6,231) |
| Hawaii | (584) | (864) |
| Idaho | (529) | (439) |
| Illinois | (6,476) | (3,477) |
| Indiana | (3,936) | 1,979 |
| Iowa | (1,594) | (1,138) |
| Kansas | (1,238) | 1,093 |
| Kentucky | (2,901) | 50 |
| Louisiana | (6,295) | 373 |
| Maine | (1,299) | (299) |
| Maryland | (2,944) | (4,932) |
| Massachusetts | (5,052) | (2,655) |
| Michigan | (6,549) | (4,829) |
| Minnesota | (3,236) | (4,071) |
| Mississippi | (2,396) | (1,695) |
| Missouri | (3,469) | (1,706) |
| Montana | (538) | (163) |
| Nebraska | (903) | (1,014) |
| Nevada | (470) | 110 |
| New Hampshire | (740) | (879) |
| New Jersey | (5,313) | 1,941 |
| New Mexico | (1,173) | (1,888) |
| New York | (27,160) | (65,988) |
| North Carolina | (5,062) | (8,653) |
| North Dakota | (425) | 27 |
| Ohio | (7,988) | (7,167) |
| Oklahoma | (1,691) | 271 |
| Oregon | (1,861) | (4,940) |
| Pennsylvania | (8,875) | 1,437 |
| Rhode Island | (1,006) | 549 |
| South Carolina | (3,176) | 289 |
| South Dakota | (481) | (541) |
| Tennessee | (5,019) | (2,459) |
| Texas | (12,688) | (20,865) |
| Utah | (914) | (862) |
| Vermont | (413) | (183) |
| Virginia | (2,263) | (1,158) |
| Washington | (3,368) | (3,576) |
| West Virginia | (1,979) | (284) |
| Wisconsin | (3,120) | (942) |
| Wyoming | (237) | (246) |

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.

Assumes that Federal payments to states grow at the CBO projected national average growth rates (column 1) or each state's average compound growth rate between FY 1993 (actual data) and states' projected expenditures for FY 1996 (column 2). The states submitted these projected expenditures in November, 1994.

## POTENTIAL STATE RESPONSES TO OFFSET FEDERAL PAYMENT REDUCTIONS

- Medicaid Managed Care
- Reduction in Payments to Providers
- Reduction in Benefits
- Reduction in Eligibility/Recipients
- Increase or Decrease in State Medicaid Spending

## MEDICAID MANAGED CARE

- While many point to managed care as a source of significant savings under Medicaid, studies (including one by CBO) have generally found that it produces a one-time savings of about 5 to 15% over baseline costs without slowing the rate of growth.

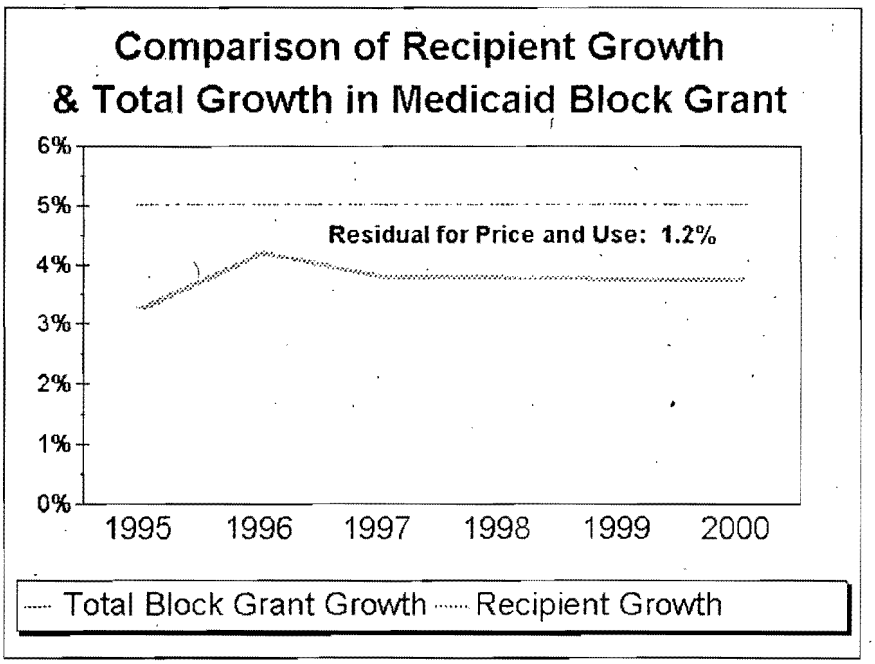
- States have applied managed care primarily to children and AFDC adults, who account for less than one-third of Medicaid spending. Applying managed care techniques to the services typically used by the elderly and disabled (such as long term care) is largely untried and difficult, making the potential for achieving savings hard to predict.

- Baseline projections already assume that a substantial proportion of Medicaid recipients will be in managed care arrangements (33% of AFDC and non-cash children currently, growing to over 50% by the end of the decade).

- Therefore, the percentage of Medicaid spending for which there is some evidence that managed care could produce saving is relatively small, and varies significantly by state (e.g., the percentage of state Medicaid enrollees that are aged or disabled ranges from 15% to 40%).

- Preliminary estimates show that if **all** AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be less than $4 billion, a very small proportion of the $309 billion (under Administration baseline) needed to offset the reduction in federal payments over this period.

## BASELINE ENROLLMENT GROWTH




- The number of people covered by Medicaid is projected to grow by an average of 3.8% a year from 1996 to 2000.

- If states did not reduce coverage under Medicaid, a block grant growing at 5% per year would allow only 1.2% growth in federal Medicaid payments per person. This is far less than the 5.3% projected annual growth in medical inflation.

## REDUCTIONS IN PROVIDERS PAYMENTS, BENEFITS AND ELIGIBILITY

Because managed care cannot produce anywhere near the level of necessary savings, states would be forced to respond by reducing payments to providers, cutting benefits or cutting eligibility. The following **illustrates** the magnitude of the cuts necessary to offset the reduction in federal payments.

- If states chose to respond by cutting provider payments only:
  - In 1997, a 4% reduction in provider payments would be needed.
  - In 2002, a 14% reduction would be needed.
  - In 2005, a 19% reduction would be needed.

- If states chose to respond by reducing benefits only:
  - In 1997, eliminating home health, hospice, and assistance for Medicare premiums and cost sharing would offset the reduction.
  - In 2002, however, eliminating these benefits would achieve only about one-third of the necessary savings.
  - Eliminating home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services would offset the federal reduction in payments.

- If states chose to respond by cutting back on eligibility only:
  - In 1997, eliminating eligibility for non-cash children (the OBRA expansions) would almost achieve the savings necessary.
  - In 2002, however, eliminating eligibility for this population would offset less than one-third of the reduction in federal payments, and eliminate coverage for over 6 million children.
  - Eliminating eligibility for both non-cash kids and AFDC adults would offset about 80% of the reduction in federal payments and would eliminate 11 million people from Medicaid.

## COMBINATION OF MEDICAID SERVICE, PROVIDER, AND RECIPIENT CUTS

- A state could react to the reduced federal Medicaid payments by combining Medicaid managed care, benefits reductions, provider payment reductions and recipient cuts.

- The following scenario illustrates one way that states could offset the federal Medicaid cut in payments of **$39.4 billion** in 2002.

  - Enrolling all adults and children through Medicaid managed care would reduce costs by about $1 billion.

  - Eliminating home health, personal care services and premium and cost-sharing support for Medicare dual eligibles would reduce costs by $17.4 billion.

  - A 5% across-the-board reduction in provider payments would reduce costs by $11.5 billion.

  - Cutting eligibility for a little over 4 million non-disabled adults and children would reduce costs by $9.5 billion.

## CAPPING MEDICARE SPENDING

- Republican efforts to balance the federal budget may also lead to proposals to cap federal spending for the Medicare program. For example, Senator Dole has suggested a reduction in Medicare spending of about $150 billion between 1996 and 2000. This is approximately equivalent to capping annual growth in Medicare spending at about 5% beginning in 1996.

- Medicare is currently projected to grow at an average annual rate of 9.3% between fiscal years 1996 and 2002 (9.8% under CBO baseline).

  On a per person basis, Medicare actually is projected to grow at about the same rate (about 7.6% as compared to 7.8%) as private health spending for people with insurance. (Under CBO projections, per capita Medicare expenditures may be growing at a slightly faster rate than private health spending).

- Using CBO budget estimates, a 5% growth cap would reduce federal Medicare spending below baseline projections by almost $328 billion from fiscal years 1996 to 2002, and by $720 billion from 1996 to 2005.

- The following table shows the potential effects of a 5% growth cap on a state-by-state basis. This analysis assumes that Medicare spending in each state under the status quo would grow at same rate as CBO projects overall Medicare spending to grow.

**Illustrative Effect of Medicare Capped Expenditures**
**Reduction in Federal Payments Assuming 5% Growth Cap**
(Dollars in millions, fiscal years)

| | 1996 - 2002 |
|---|---|
| **US*** | **(328,328)** |
| Alabama | (5,647) |
| Alaska | (223) |
| Arizona | (4,999) |
| Arkansas | (2,997) |
| California | (37,838) |
| Colorado | (3,281) |
| Connecticut | (4,711) |
| Delaware | (822) |
| District of Columbia | (2,552) |
| Florida | (26,901) |
| Georgia | (7,577) |
| Hawaii | (1,085) |
| Idaho | (784) |
| Illinois | (14,083) |
| Indiana | (6,599) |
| Iowa | (2,996) |
| Kansas | (3,099) |
| Kentucky | (4,495) |
| Louisiana | (5,983) |
| Maine | (1,289) |
| Maryland | (5,668) |
| Massachusetts | (10,298) |
| Michigan | (11,868) |
| Minnesota | (4,834) |
| Mississippi | (3,047) |
| Missouri | (7,165) |
| Montana | (848) |
| Nebraska | (1,582) |
| Nevada | (1,523) |
| New Hampshire | (1,061) |
| New Jersey | (10,899) |
| New Mexico | (1,277) |
| New York | (26,272) |
| North Carolina | (7,441) |
| North Dakota | (797) |
| Ohio | (13,967) |
| Oklahoma | (3,549) |
| Oregon | (3,313) |
| Pennsylvania | (21,276) |
| Rhode Island | (1,443) |
| South Carolina | (3,305) |
| South Dakota | (761) |
| Tennessee | (7,462) |
| Texas | (18,376) |
| Utah | (1,356) |
| Vermont | (523) |
| Virginia | (5,554) |
| Washington | (4,972) |
| West Virginia | (2,334) |
| Wisconsin | (5,290) |
| Wyoming | (318) |

Federal payment reductions are allocated across states in proportion to the states' FY 1993 share of Medicare spending.

* States' losses do not sum to U.S. losses due to the exclusion of territories.

## POTENTIAL RESPONSES TO ACCOMPLISH REDUCED MEDICARE SPENDING GROWTH

- Medicare Managed Care
- Reduction in Medicare Payments to Providers
- Reduction in Medicare Benefits
- Increases in Medicare Premiums

## MEDICARE MANAGED CARE

The potential for achieving scorable savings in Medicare through managed care is uncertain.

- Currently, 74 % of Medicare beneficiaries have access to a managed care option and 9% of Medicare beneficiaries have chosen to enroll in a managed care plan. Of this 9%, two-thirds are enrolled in an HMO. By the year 2000, we project that about 16% of beneficiaries will be enrolled in HMOs.

- Managed care currently costs the Medicare program rather than achieving savings. Evaluations have determined that due to favorable selection, Medicare pays 5.7% more for every enrollee in risk-based managed care than would have been paid if the beneficiary had stayed in fee-for-service.

- CBO has testified that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

- The Department has a number of efforts underway to improve and expand the managed care choices available to beneficiaries, including developing a PPO option and evaluating methods to improve the current payment methodology for Medicare managed care plans.

## COMBINATION OF REDUCED PAYMENTS TO PROVIDERS AND BENEFICIARY PREMIUM INCREASES

- Under the Mainstream Coalition bill, Medicare cuts were distributed across providers and beneficiaries so that providers bore about three-quarters of the reductions and beneficiaries bore about one-quarter. Using this same distribution, the following would be necessary to offset the effects of a 5% cap on Medicare.

- **Provider Cuts**: If cuts were distributed proportionately across providers:

| | |
|---|---|
| Hospitals: | 9% reduction in 1997;<br>26% reduction in 2002; and<br>39% reduction in 2005. |
| Physicians: | 8% reduction in 1997;<br>22% reduction in 2002; and<br>28% reduction in 2005. |
| Other Providers: | 6% reduction in 1997;<br>13% reduction in 2002; and<br>16% reduction in 2005. |

  - A relatively large percentage of rural hospitals are heavily dependent on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals.

- **Increases in Medicare Premiums**: If these savings were achieved by increasing Medicare premiums, the premiums would increase by:

  $142 per year in 1997;
  $533 per year in 2002; and
  $898 per year in 2005.

  - Medicare beneficiaries already spend almost 12% of their household incomes on health care, as compared to less than 4% for nonelderly families.

## EFFECTS ON ACCESS AND PRIVATE PAYERS

- Between 1996 and 2002, 5% caps on the growth in Medicaid and Medicare would reduce federal health payments by over $500 billion.

- Reductions of this magnitude raises questions about how providers would respond. With the number of uninsured projected to rise over the decade, hospitals and other providers will be face the strain of provider more uncompensated care with fewer resources. Cuts in Medicaid enrollment would exacerbate the strain.

- Recently, it appears that private payers — particularly large employers — have intensified their cost containment efforts. These efforts have forced hospitals and other providers to reduce expenses, further diminishing their capacity to absorb reductions in Medicare and Medicaid payments and increases in uncompensated care.

- Given the magnitude of the proposed cuts, providers may not be able to respond to the reductions in payments entirely through increased efficiency.

    - Access to care for Medicare beneficiaries and uninsured patients may be jeopardized. Understandably, providers may be less willing to see these patients as their sources of payment shrink.

    - Private payers may also bear a portion of this burden through cost shifting. Small employers and individual purchasers, who have less leverage in the marketplace, may be particularly vulnerable to cost shifting.

**Illustrative Effect of a Medicaid Block Grant & Medicare Capped Expenditures Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002**
(Dollars in millions, fiscal years)

| | State Baseline Growth at National Rates | State Baseline Growth at State Projected Rates |
|---|---|---|
| **US** | **(520,447)** | **(501,293)** |
| Alabama | (8,419) | (6,356) |
| Alaska | (591) | (6) |
| Arizona | (7,530) | (8,363) |
| Arkansas | (4,836) | (3,154) |
| California | (58,963) | (42,913) |
| Colorado | (4,981) | (2,567) |
| Connecticut | (7,452) | (8,053) |
| Delaware | (1,199) | (1,084) |
| District of Columbia | (3,447) | (4,036) |
| Florida | (34,546) | (40,384) |
| Georgia | (12,343) | (13,808) |
| Hawaii | (1,669) | (1,948) |
| Idaho | (1,313) | (1,223) |
| Illinois | (20,559) | (17,560) |
| Indiana | (10,536) | (4,620) |
| Iowa | (4,590) | (4,133) |
| Kansas | (4,336) | (2,005) |
| Kentucky | (7,396) | (4,446) |
| Louisiana | (12,278) | (5,610) |
| Maine | (2,588) | (1,588) |
| Maryland | (8,611) | (10,600) |
| Massachusetts | (15,349) | (12,952) |
| Michigan | (18,417) | (16,697) |
| Minnesota | (8,069) | (8,905) |
| Mississippi | (5,444) | (4,743) |
| Missouri | (10,634) | (8,871) |
| Montana | (1,386) | (1,011) |
| Nebraska | (2,486) | (2,596) |
| Nevada | (1,993) | (1,413) |
| New Hampshire | (1,801) | (1,940) |
| New Jersey | (16,213) | (8,958) |
| New Mexico | (2,450) | (3,166) |
| New York | (53,432) | (92,260) |
| North Carolina | (12,503) | (16,093) |
| North Dakota | (1,221) | (770) |
| Ohio | (21,955) | (21,134) |
| Oklahoma | (5,240) | (3,278) |
| Oregon | (5,174) | (8,253) |
| Pennsylvania | (30,151) | (19,839) |
| Rhode Island | (2,449) | (894) |
| South Carolina | (6,482) | (3,016) |
| South Dakota | (1,242) | (1,301) |
| Tennessee | (12,481) | (9,921) |
| Texas | (31,063) | (39,241) |
| Utah | (2,270) | (2,218) |
| Vermont | (936) | (706) |
| Virginia | (7,817) | (6,712) |
| Washington | (8,340) | (8,548) |
| West Virginia | (4,313) | (2,618) |
| Wisconsin | (8,410) | (6,232) |
| Wyoming | (555) | (564) |

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.
Assumes that Federal Medicare and Medicaid payments grow at the CBO projected national average growth rates (column 1) or the Medicaid average compound growth rates between FY 1993 (actual data) and states' projected expenditures for each state for FY 1996 (column 2).

## SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICARE

- Medicare is the primary health care program for 32 million elderly and 4 million disabled Americans.

- Republicans have proposed to cut Medicare funding by at least $150 billion between now and 2000 -- a **20% cut** in 2000 alone.

- Medicare spending per person is already projected to grow at roughly the same rate as private sector health spending. So with a cut this large, both beneficiaries and providers will be forced to shoulder huge burdens.

  - Medicare managed care is unlikely to provide significant savings in the near future. CBO testified in January that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

  - If cuts were allocated as under the Mainstream Coalition health reform bill, providers would bear about three-quarters of the reductions and beneficiaries would bear about one-quarter:

    - In 2002 alone, a 23% cut in Medicare payments to providers would be needed.

    - Elderly and disabled beneficiaries would have to pay $533 more for Medicare, a 42% increase over the premiums they pay today.

- Cuts of this magnitude would cause serious financial distress to the nation's medical system, which would still bear the growing burden of uncompensated care. This is likely to shift costs to small businesses.

- Reducing Medicare payments also would disproportionately harm rural hospitals. Rural hospitals are more likely than other hospitals to depend heavily on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals, which makes them less able to absorb large Medicare payment reductions.

- In the last Congress, bills proposed by Senator Dole and the Mainstream Coalition also proposed large Medicare cuts. However, unlike current Republican proposals, the Dole and the Mainstream Coalition proposals reinvested their savings into the health care system through subsidies to expand insurance coverage. By reinvesting their savings, they would have reduced the uncompensated care burden on provider and business and mitigated many of the adverse effects from Medicare cuts.

## SMOKE-OUT TALKING POINTS: EFFECTS OF CAPPING MEDICAID

- Medicaid is a safety net for over 35 million mothers and children, the elderly and people with disabilities. By the year 2002, Medicaid will cover roughly 46 million people.

- Republicans have proposed (through the use of a block grant with 5% growth) to cut federal Medicaid funding by at least $180 to $190 billion between now and 2002 -- a **24% cut** in 2002 alone.

- There is no evidence that manage care alone can achieve this level of savings.

  - States already are aggressively pursuing managed care, but the populations that can readily be managed – children and AFDC adults – account for less than one-third of total Medicaid spending. And, over one-third of these recipients already are in managed care.

  - As a result, the potential savings from expanding managed care actually is less than five percent of the needed savings.

- Contrary to Republican claims, Medicaid spending per person is already projected to grow at a slower rate than private health spending. So, with a cut this large, health care coverage for vulnerable Americans is at severe risk.

  - To protect mothers and children, states could:

    - Drop coverage for as many as **3 million elderly and people with disabilities**, or

    - Eliminate benefits disproportionately used by the elderly and people with disabilities like home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services --- and, by 2005, begin to limit nursing home services.

  - Alternatively, to protect the elderly and people with disabilities, states could:

    - Drop coverage for as many as **16 million mothers and children**, or

    - Eliminate all inpatient hospital, outpatient, and physician services for mothers and children -- and still not have enough savings to offset the loss of federal funds.

- States could decide to increase their spending by over $180 billion. But that would mean a 33% increase in state Medicaid spending in 2002 alone. States would be forced to raise taxes or slash spending for services like education and public safety.

**DRAFT** March 10, 1995

## THOMAS (HR 1234)

**Strengths**

- Provides access to health coverage for those who lack access today because they are sick.
  - Eliminates pre-existing condition exclusions for those changing coverage (e.g., when changing jobs), and limits exclusions for those newly purchasing insurance. These rules would apply to all plans, including self-insured plans. Due to ERISA, states have only been able to limit exclusions for insured plans (generally offered by smaller employers).
  - Requires health plans to guarantee access to and renewal of coverage. This provision applies both to small businesses (those with 50 or fewer employees) and individuals.
  - Most states have already implemented similar access reforms.
- Insurance rating reforms go beyond what most states have done. In particular, experience rating would be eliminated (at least for small businesses). However, some weaknesses still remain, including:
  - Small business premiums could vary due to age by a factor of 4 to 1 (phasing down in the future to 3 to 1). Though in a voluntary market some variations for age are necessary to prevent younger people from dropping coverage, most Democratic bills last Congress limited the variation to no more than 2 to 1.
  - Health plans could vary premiums by size of business for differences in administrative costs (up to 20% higher for the smallest businesses).
- Insurance access and rating reforms are applied to individual purchasers (e.g., the self-employed) as well as small employers, which few states have done.

  However, the bill maintains separate risk pools (leading to different premium levels) for individual purchasers and small businesses. Applying insurance reforms to individual purchasers without spreading their cost across a broader population is likely to lead to unaffordably high premiums in that market.
- Requires the establishment of a risk adjustment mechanism so that health plans that attract a disproportionate share of high-cost or high-risk individuals would be compensated.

- Preempts state anti-managed care laws.

- Prohibits self-insurance by individual small employers (those with 50 employees or fewer employees), preventing employers with healthy employees from leaving the community risk pool.

- Facilitates the establishment of state-chartered purchasing cooperatives ("Health Plan Choice Organizations") for small businesses and individual purchasers.

Weaknesses

- Preempts all state health insurance laws that are inconsistent with the bill.

  - States that have gone further in guaranteeing access to coverage or moving towards community rating would have to scale back reform. States could choose to continue to enforce insurance laws, but would have no discretion over the content of the laws.

  - Preempts state mandated benefits laws without establishing a national minimum or standardized benefits package.

- The bill does not prohibit self-insurance by associations of small employers, but it is unclear to what extent it would preempt state efforts to restrict or regulate these arrangements. Self-insured association plans would be required to meet state-established solvency standards.

- Establishes medical savings accounts, which could further segment healthy and sick individuals into separate risk pools.

- The bill contains a number of malpractice provisions that would preempt less restrictive state laws, including:

  - Requires initial resolution through an alternative dispute resolution (ADR) process before a claim can be brought to court. The party that contests an ADR ruling in court is required to pay the attorney costs for the opposing party if the court ruling is less favorable than the original ADR ruling.

  - Permits states to establish practice guidelines that form a rebuttable presumption in malpractice cases.

  - Caps non-economic damages at $250,000.

  - Eliminates joint liability for non-economic damages and allocates liability to multiple defendants based on the percentage of responsibility.

## OTHER PROVISIONS

- Establishes standards for managed care arrangements, including: prompt access to care (including specialty care), the ability to choose a personal physician, due process standards for selecting providers, and standards for utilization review procedures. The standards would not likely require significant changes in current managed care practices, though could prevent some future abuses.

- The bill contains standards for the electronic transmission of health information intended to encourage the development of a health information network. [Note: Further work is required to assess the desirability of these provisions.]

- Requires the Attorney General to exempt from antitrust laws any health care collaborative where the benefits (e.g., increasing access, maintaining or increasing quality, preserving health facilities in underserved areas, and reducing duplication of resources) outweigh any reduction in competition.

**DRAFT** March 10, 1995

## FAWELL (HR 995 AND HR 996)

### Strengths

- Provides access to health coverage for those who lack access today because they are sick.
  - Eliminates pre-existing condition exclusions for those changing coverage (e.g., when changing jobs), and limits exclusions for those newly purchasing insurance. These rules would apply to all plans, including self-insured plans. Due to ERISA, states have only been able to limit exclusions for insured plans (generally offered by smaller employers).
  - Requires health plans to guarantee access to and renewal of coverage. This provision applies both to small businesses (those with 50 or fewer employees) and individuals.
- Preempts state anti-managed care laws.

### Weaknesses

- Preempts all state health insurance laws that are inconsistent with the bill.
  - States that have gone further in guaranteeing access to coverage or moving towards community rating would have to scale back reform. States could choose to continue to enforce insurance laws, but would have no discretion over the content of the laws.
  - Preempts state mandated benefits laws without establishing a national minimum or standardized benefits package.
- Continues to permit wide variations in premiums across small businesses and individuals.
  - Small business premiums could vary due to age by a factor of 4 to 1 (potentially phased down in the future to three to one). Variations due to age for individual purchasers (e.g., the self-employed) would be unlimited.
  - Small business premiums could vary due to claims experience by a factor or 1.5 to 1 (potentially phased down in the future). Premiums for individual purchasers could vary due to claims experience by a factor of 2 to 1. All of the major Republican bills last Congress prohibited experience rating.

- Health plans could vary premiums by size of business for differences in administrative costs (up to 15% higher for the smallest businesses).

- Insurers could establish separate classes of business (based, for example, on how coverage is marketed), and charge different premiums across these classes.

- These provisions are similar to the rating reforms that most states have already implemented, based on a model law prepared by the National Association of Insurance Commissioners (NAIC). However, in its updated model law, the NAIC has gone further, suggesting the elimination experience rating altogether.

♦ Permits associations of small employers and individuals to obtain coverage through self-insured or insured arrangements outside of the community risk pool.

- This provision would preempt state efforts to restrict or regulate these arrangements.

- The bill establishes reserve requirements for self-insured associations, but these requirements are inadequate. Multiple employer associations sell coverage to employers, much like an insurance company. However, the bill requires reserves much smaller than what insurance companies are required to hold. This would put these arrangements at high risk of insolvency, leaving consumers at risk for unpaid medical bills.

♦ Establishes medical savings accounts, which could further segment healthy and sick individuals into separate risk pools. (Note that the tax treatment of medical savings accounts is under the jurisdiction of the Ways and Means Committee.)