

Unprecedented Cuts Seen For Medicare, Medicaid

BY JANE HIEBERT-WHITE

Government budgeteers have long debated the seemingly uncontrollable rise in spending on two public health insurance programs—Medicare and Medicaid. The debate reached new levels in Washington this spring and summer, however, as Republican lawmakers in the House and Senate proposed trimming these programs by nearly \$500 billion over seven years in an effort to balance the federal budget by 2002. Even though the proposed cuts are “only” decreases in the rate of spending increase for the two programs, they represent the largest cuts to date and have provider and patient groups crying foul.

BALANCING THE BUDGET

Medicare, the federal insurance program for 37 million elderly and disabled Americans, accounted for 10 percent of the federal budget in fiscal year 1994. Medicaid, the joint federal/state program for about 32 million of the nation's poor, accounted for 6 percent. When Republican lawmakers who had promised voters a balanced budget sat down to trim the fat out of the pie, the two health insurance programs proved tempting targets. For one thing, much of the rest of the budget is off-limits either practically or politically. Social Security claims the largest portion at 22 percent, followed by defense at 18 percent, and interest on the national debt at 15 percent. After these “untouchables” come Medicare and Medicaid. A scant 29 percent of the federal budget is then left for all other government activities.

The Medicare and Medicaid insurance programs were but one of several key factors fueling the recent explosion in the federal deficit—the others being the major tax cut of 1981, the sharp increase in military spending in the 1980s, and the savings and loan bailout. But, for Republican leaders, only the insurance programs present politically attractive targets for cuts.

Another reason the health insurance programs were targeted is their rapid growth rate. For instance, Medicaid spending more than doubled



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between 1988 and 1992, from \$51.3 billion to \$113.1 billion.¹ Spending in 1993 reached \$125.2 billion. Medicare spending is growing at a current annual rate of about 11 percent. The \$176 billion program (1995 estimate) is expected to nearly triple to \$460 billion by 2005. And that's *before* the more than 70 million Baby Boomers start turning 65 in 2010.

If lawmakers have any hope of balancing the federal budget, cutting spending is not enough; they must also control the growth of spending of the insurance programs. Thus, in May, the House voted to cut \$288 billion from Medicare and \$187 billion from Medicaid over seven years. The Senate voted cuts of \$256 billion from Medicare and \$175 billion from Medicaid.

Over the summer, the budget process will move through House and Senate conference committees toward agreement on the bills. Then the House and Senate must reconcile the approved spending levels with specific program cuts. The final budget package is not expected until at least October—and, given the sensitive politics of such deep budget cutting, the process may well last until December.

MEDICARE BANKRUPTCY

Cuts of the magnitude proposed by Congress are fraught with political minefields. For instance, a *Wall Street Journal*/NBC poll found that 62 percent of Americans would prefer keeping Medicare spending at its current level, rather than cutting it to reduce the deficit.² In addition, 42 percent said they would be less likely to vote for their member of Congress if that member voted for the Medicare cuts; only 15 percent said they would be more likely to vote for the member.

To provide some political cover on the issue of Medicare, the Republican leadership turned to the April 3 report of the Medicare trustees. This annual report usually receives little attention from Congress, but this year its timing and message were perfect. The report said that the Medicare Hospital Insurance (HI) Trust Fund (Part A) would go broke by 2002 at current spending levels.

According to *Wall Street Journal* columnist Gerald F. Seib, Republican Party Chairman Haley Barbour "seized upon the report, met quietly with Senate Majority Leader Robert Dole and House Speaker Newt Gingrich, and hatched a new strategy. Part one is to try to fundamentally change the debate, making it not about how to cut Medicare to balance the budget, but rather about the more noble goal of preserving the solvency of the system. Part two is to separate the Medicare debate from today's heated budget debate, a tactic that gives the GOP several more badly needed months to prepare the public for changes."³

However, past trustee reports have also predicted dire straits for Medicare. Last year's report also predicted insolvency in seven years (by 2001). In 1985 the projection was five years. And in 1970 it was two years. Each time, corrections were made to the program. As Eugene Lehrmann, president of the American Association of Retired Persons (AARP), told the Senate Finance Committee on May 17: "The HI Trustees Report is a valuable tool for examining the long-term stability of the Medicare program far enough in advance to make appropriate mid-course corrections. What the Trustees' projections should not be used as, however, is an excuse to make massive reductions in Medicare spending for deficit reduction in the guise of Trust Fund solvency."

Gail Wilensky, a leading Republican health policy adviser, a former administrator of the Medicare and Medicaid programs, and the new chairperson of the Physician Payment Review Commission, explained in a conversation some of the reasons why this year's trustees' report has taken on new urgency. "First, we already did the easy changes" to Medicare to save money or bring in new revenue. Second, we're approaching 1996, the "first year of deficit spending, where we're spending more than the taxes are bringing in." This deficit spending shift will be quickly exacerbated by the looming demographic changes.

GENERATIONAL INEQUITY

Today about four workers pay taxes into the trust fund for each Medicare beneficiary incurring healthcare expenses. After the nation's 77 million Baby Boomers retire, there will be only two workers per Medicare beneficiary. At that rate, taxes would have to be increased dramatically or benefits

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cut deeply to keep the insurance program afloat.

Consider the ratio of money paid into the system compared with the value of the benefits received by the average Medicare beneficiary. For the hospital portion of Medicare (Part A), this ratio was 5.19 for the average 65-year-old in 1994. In other words, for each dollar that a 65-year-old contributed in Medicare taxes, he or she will get \$5.19 in healthcare benefits.

This raises important intergenerational equity questions, according to Guy King, former chief actuary at the Health Care Financing Administration (HCFA) who is now at the accounting firm Ernst and Young in Washington, DC. "Medicare Part A, because it is financed by payroll taxes, represents in effect a compact among the generations. . . . The problem is that, because of the presence of the baby-boom generation in the work force, and the fact that health care costs today are much lower than they will be in the future, benefits paid today to today's retirees are disproportionately larger than the contributions they made and are much higher than what can be supported in the future."⁴

King estimated the impact of various Medicare reforms on intergenerational equity and concludes: "An immediate benefit reduction combined with indexed tax rates would produce the greatest intergenerational equity. Generally speaking, policy options that delay action or involve increasing taxes produce the least intergenerational equity."

Of the federal budget as a whole, more than one-third of spending goes to elderly Americans in the form of Social Security, Medicare, and Medicaid (primarily nursing home care for low-income elderly). Yet, according to the *Wall Street Journal*/NBC poll, only 9 percent of Americans believe the government is spending too much on the elderly, and 48 percent said it is spending too little.

MEDICAID REFORMS

Although Medicare has garnered the lion's share of recent press attention, the Medicaid program would also undergo dramatic changes under the House and Senate budget plans. As part of the broader goals of welfare reform and an increased role for the states, federal lawmakers are talking about turning Medicaid back to the states and providing each state with funding via block grants from the federal government.

Today the federal government pays states a per-

centage "matching" rate, ranging from 50 percent to 80 percent of the state's Medicaid spending. The federal government also currently sets a minimum standard for states, determining who is eligible for Medicaid and what benefits can be received by them. A program run solely by the states would undoubtedly change that base level of program standards.

"If it becomes a block grant with absolute state flexibility, it would be 'Taps' for Medicaid," predicted Catholic Health Association (CHA) lobbyist Jack Bresch in a recent conversation. "There is a potential for tremendous redistribution of federal money," he continued. "I wonder if the richer states understand that more money would probably go to poorer states" under such a plan, he asked.

IMPACT OF MEDICARE AND MEDICAID CUTS

Since one-third of current U.S. hospital revenues are derived from Medicare, the impact of the proposed deep budget cuts on them could be severe. To estimate just what a \$250 billion cut in Medicare would mean to hospitals, the American Hospital Association (AHA) commissioned Lewin-VHI, Fairfax, VA, to run some projections. The findings were released at a May 11 press conference.

According to Lewin-VHI, by the year 2000, overall Medicare inpatient operating margins could fall to negative 20.6 percent. Church-sponsored hospitals' margins would also fall to negative 20.6 percent. The average hospital would lose \$1,294 per Medicare patient; church-sponsored institutions would lose \$1,298 per patient. The Lewin-VHI numbers show that all types of hospitals would be affected—small, large, urban, rural, teaching, and nonteaching. Over seven years, these numbers could mean a reduction of \$94 billion in hospitals' reimbursements through the prospective payment system.

Moreover, "since the Omnibus Budget Reconciliation Act of 1987 was enacted, Medicare hospital spending reductions of at least \$48 billion have had a significant impact on hospitals and health systems," testified AHA president Richard Davidson on May 17 before the Senate Finance Committee. "In the past, hospitals have coped with Medicare spending reductions by shifting costs. . . . But those days are fast disappearing—and these reductions are unprecedented," continued Davidson.

"Without some federal supervision, some states might choose not to take care of the poorer members of their populations," Jack Bresch said.

To address some of the problems in Medicare, AHA wants to move the program toward its vision of "coordinated care." AHA is also calling for the creation of an independent citizen's commission on Medicare to "make the tough choices that will be needed to keep services and benefits in line with available money—and to keep Medicare from being a 'cash cow' that continually finances other policy initiatives and legislative agendas," said Davidson.

CHA is proposing that Medicare savings be achieved through use of community-oriented integrated delivery networks. After working with member institutions on this proposal, CHA plans to present it to Congress in September.

CHA is especially concerned about current proposals to effect Medicare savings by shifting more elderly into health maintenance organizations. "Many HMOs obtain savings through discounts and externally imposed utilization controls," said Bresch.

CHA is also concerned about "risk segmentation," Bresch added. "While CHA is not opposed to—and would support—using some marketplace incentives relative to the Medicare population, at the same time one needs to be aware of what is going on in the present market," he said. "For instance, the whole notion of managed care is to save money, but the elderly population requires more services and is sicker as a population. We're concerned that there'll be a lot of cherrypicking of the more healthy, youthful Medicare patients."

On Medicaid, CHA wants to see the government maintain federal minimum standards for both eligibility and services. If states were given complete flexibility, "how long would it take for Congress to look around the country and say we've got such a hodgepodge we need to establish some fundamental federal standards" for Medicaid? Bresch wondered. "There is an appropriate role for the federal government" in Medicaid, Bresch said. "Without some federal supervision, some states might choose not to take care of the poorer members of their populations."

A new study by the Urban Institute for the Kaiser Commission on the Future of Medicaid projects the impact of the House and Senate Medicaid budget cuts. The Urban Institute report finds that, in general, low-income states and those states whose Medicaid spending goes mostly to acute

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MUST READING FOR GUARDIANS OF THE NOT-FOR-PROFIT HEALTHCARE DELIVERY SYSTEM

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January 12, 1995

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HEALTH POLICY

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care would have the highest percentage reductions. West Virginia would fare the worst, with a more than 24 percent cut in spending.⁵

The impact on Medicaid beneficiaries would be devastating. If the growth in Medicaid spending were held to the inflation rate, the program would need to reduce the number of its recipients by 2.9 million to 4.6 million persons. In addition, Urban Institute economist John Holahan notes that the projected spending reductions for Medicaid would require more successful cost control than that seen in any similar effort, in either the private or public sector, in the past seven years.

With these unprecedented levels of budgetary savings proposed for both Medicare and Medicaid, we are in for a long summer of negotiation. However, even if some of the spending is restored, it appears that hospitals and healthcare providers should prepare for cuts larger than they have ever experienced before. As hospitals prepare for the future, "flexibility and ability to respond quickly is key to survival in the next decade," said Helen Smits, HCFA's deputy director. "If you're counting on Medicare staying stable, I wouldn't." □

NOTES

1. Kaiser Commission on the Future of Medicaid, *Health Needs and Medicaid Financing: State Facts*, Washington, DC, April 1995.
2. Hilary Stout and David Rogers, "GOP Plan to Cut the Deficit by Slashing Medicare Faces Political Risks as Most Voters Oppose Move," *Wall Street Journal*, April 27, 1995.
3. Gerald F. Seib, "How the GOP Seeks to Elude the Medicare Wreck," *Wall Street Journal*, May 3, 1995.
4. Guy King, "Health Care Reform and the Medicare Program," *Health Affairs*, Winter 1994, pp. 39-43.
5. Kaiser Commission on the Future of Medicaid, *Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures*, Washington, DC, May 1995.