

**IMPACT OF THE PRESIDENT'S 2004 BUDGET ON MEDICARE AND
MEDICAID**

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Chairman Nussle, Congressman Spratt and members of the Committee, I appreciate the opportunity to comment today on the Administration's 2004 Budget proposals regarding Medicare and Medicaid. The Administration describes its proposals as strengthening the ability of these vital programs to serve elderly, disabled and low income beneficiaries. In fact, however, the Administration proposals threaten rather than strengthen Medicare and Medicaid. Not only do these proposals offer too little fiscal support to meet program needs. They also make even this modest support contingent upon the abandonment of the federal fiscal guarantees that secure access to care for all eligible beneficiaries. Specifically, the Administration proposes to replace Medicare with private insurance and to replace Medicaid's guaranteed federal matching payments with capped federal funds. Such policies would severely weaken both programs and their ability to serve the people who count on them.

Let me explain—first for Medicare; then for Medicaid.

IMPACT OF ADMINISTRATION'S 2004 BUDGET ON MEDICARE

Although details are sketchy, it appears that the President's 2004 Budget proposes to make available (most of) \$400 billion over 10 years to support prescription drug coverage, but only for beneficiaries who leave the current Medicare program and enroll in private insurance plans for all of their health care. These plans would also offer enrollees a different cost-sharing structure for benefits than Medicare currently provides.

Rather than strengthening Medicare, this proposal provides too little benefit at too great a cost: First, it falls far short of the Administration's promise to assure all Medicare beneficiaries the protection against prescription drug costs they so sorely need. The proposed financing for prescription drug coverage does not come close to what is necessary to provide all beneficiaries adequate protection. At the same time, its thinly-veiled "bribe" to beneficiaries to leave Medicare for private insurance actually forces beneficiaries to choose between their need for a drug benefit and their need for Medicare's guarantee of dependable, affordable health insurance protection. Despite the urgency of beneficiaries' need for prescription drug protection, the Administration's price—structural reforms that would undermine Medicare's greatest strengths—are simply not worth it.

Inadequacy of the proposed benefit. Over the next 10 years, the Congressional Budget Office estimates that prescription drug costs for Medicare beneficiaries will cost \$1.8 trillion. The proposed \$400 billion finances only a slim portion of these costs—leaving beneficiaries to face substantial out-of-pocket expenses in terms of deductibles, co-insurance, and holes without any coverage at all. This benefit does not come close to the protection members of Congress (and I, as the wife of a federal retiree) have through the Federal Employees Health Benefit Plan (FEHBP). Indeed, estimates indicate that a comprehensive prescription drug benefit would cost about twice the Budget's \$400 billion allocation.

I know that this Committee is well aware of the fiscal challenges facing the nation. But providing adequate financing for prescription drugs is more a question of priorities than fiscal ability. For the Administration to propose such insufficient investment in prescription drug coverage alongside a proposal for a \$674 billion tax cut raises serious questions about their priorities.

Inadequacy of private insurance. The Administration's proposal to tie the availability of a prescription drug benefit, adequate or otherwise, to enrollment in private insurance plans forces beneficiaries to make an untenable choice: gain a drug benefit but lose Medicare's guaranteed access to care.

Longstanding experience with private insurance reveals that it does not offer the dependable protection that Medicare guarantees. Medicare is an enormously successful program because it brings together the healthy and the sick, the better off and the less well-off in a single insurance arrangement, pooling risks to insure that all beneficiaries—regardless of income or health status, are guaranteed financial protection against the costs of medical care. It is universal--covering virtually all people eligible--and enables beneficiaries to obtain services from the doctors, hospitals and other providers they choose.

Private insurance cannot compete with Medicare's performance. Over 30 years ago, Medicare was enacted because private insurance failed to reach nearly half the elderly population. Today, private insurance outside the workplace for the under age 65

population is plagued with “selection problems”—making affordable coverage available for people only when they are healthy and denying or restricting benefits to people when they are sick. And inside the workplace, the 1990s’ shift to manage care reveals that health plans have relied far more on barriers to access than on efficient care management to control their costs. Rather than offering beneficiaries a broader set of choices, health plans may limit the doctors or hospitals that plan members can use or require them to pay extra to use the providers they want. Indeed, Karen Davis and her colleagues at the Commonwealth Fund find that despite better health status and lower need for care among privately insured employees under age 65, they report less confidence in getting care when needed and higher incidence of access problem than do Medicare beneficiaries.

The Medicare program also has experience with reliance on private health insurance—through Medicare + Choice—that is decidedly disappointing. Plans that beneficiaries join in one year are out of business the next. Benefits that beneficiaries count on one year are reduced the next. And plans have never found it profitable to serve many parts of the country—especially rural areas. It appears that it is insurers who gain choice under these arrangements—not Medicare beneficiaries.

Nor is reliance on private insurance likely to save money. Medicare + Choice plans are asking for higher payments from Medicare, not costing Medicare less. Contrary to claims made by proponents of private insurance for Medicare, the current Medicare program is as good and often better than the private sector in controlling its costs. In the past 5 years, Medicare’s average growth in spending per beneficiary was lower than both

the private sector and FEHBP. And, according to Marilyn Moon of the Urban Institute, over the last 30 years, Medicare spending per beneficiary has grown at a rate of over one percentage point less than private health insurance—a cumulative savings of about 41 percent relative to what costs would have been through private insurance. The facts are that private insurers cannot best Medicare in terms of value for the dollar in the purchase of services.

The only way private insurance plans can likely spend less than Medicare is to provide less service. Indeed, previous proposals to rely on private insurers to provide prescription drug coverage to Medicare beneficiaries have sought savings precisely by allowing private insurers to limit beneficiaries' access to a full range of prescription drugs.

Reliance on private insurance plans for the full range of Medicare benefits—as the Administration proposes—would put affordable access to doctors and hospitals at similar risk. The risk to beneficiaries becomes even greater if the shift to private plans transforms Medicare from a program that guarantees the financing of service costs to a program that guarantees the financing of only a share of a private insurance premium. The latter would represent an explicit transfer of financial risk for overall health costs from the Medicare program to elderly and disabled beneficiaries.

Medicare's Future

The Administration's enthusiasm for shifting Medicare beneficiaries to private insurance is particularly suspect when it comes to Medicare's fiscal future. With the aging of the

baby boom generation, the proportion of the population served by Medicare will grow from 14 percent today to 22 percent in 2030. Along with likely continued increases in health care costs—not just for Medicare but for the nation as a whole—the demands on the program will be substantial. As just described, reliance on private insurance cannot finance increased demands through greater efficiency. Indeed, the only way that privatization can address Medicare’s future fiscal problems is if it shifts costs to beneficiaries, ending Medicare’s guarantee to assure affordable access to mainstream medical care.

Not only is the Administration promoting privatization as a false ‘solution’ to future fiscal problems; it is exaggerating their scope and squandering the resources needed to address them. The President’s Budget reports a \$13.3 trillion “shortfall” in Medicare over the next 75 years. However, that calculation assumes that only dedicated payroll taxes (which finance Medicare’s Hospital Insurance or Part A) and beneficiary-paid premiums (which finance 25 percent of Medicare’s Supplementary Medical Insurance or Part B) are available to finance the program. It ignores that by law and from Medicare’s inception, general revenues are used along with premiums to finance Medicare’s Part B expenses. Unless the Administration proposes to withdraw the statutory commitment to provide general revenue financing, the real “shortfall” is only one-third this amount. Further, the 75 year estimates involve long-term projections about which CBO and, in other places, the Administration have expressed accuracy concerns. CBO has said that health costs are among the top three reasons for miscalculations in its projections. Interestingly, at the

same time the Administration reports a 75-year Medicare projection, it is unwilling to project its own budget proposals beyond five years.

The right way to address the estimated and accurately calculated shortfall is to keep the nation's overall fiscal house in order. Between 2002 and 2011, Medicare's trustees estimate that payroll taxes will generate a surplus of over \$510 billion. These and other revenues from members of the baby boom generation, now in their prime earning years, can be used to minimize federal borrowing today, thereby strengthening the nation's capacity to meet future needs when they retire.

But the 2001 tax cut and the additional \$674 billion proposed in the President's 2004 budget move the nation in precisely the opposite direction. In part, they use the Medicare surplus to finance a tax cut. And, by increasing debt, they add dramatically to the burdens that will fall on future generations. To exaggerate Medicare's fiscal crisis, promote privatization, and cut taxes suggests that securing and strengthening the Medicare program, both now and in the future, is not the Administration's primary concern.

IMPACT OF ADMINISTRATION'S 2004 BUDGET ON MEDICAID

The Administration's 2004 Budget proposes to make available \$3.25 billion in 2004 and \$12.7 billion over seven years to share among states that agree to accept predetermined federal allocations or block grants to fund services to low income populations. States who accepted the additional funds would be expected to repay them in years eight, nine

and ten, regardless of program needs. The proposal is therefore budget neutral to the federal government over the ten year period.

This Medicaid proposal has much in common with the Administration's Medicare proposal. First, the fiscal relief offered by the proposal is insufficient to address state budget pressures that are endangering Medicaid. The early-year federal funds are tiny relative to state fiscal deficits estimated in the range of \$70 - \$85 billion in state fiscal year 2003. Second, the proposal offers states an untenable choice: gain even modest relief now but lose the current commitment to guaranteed federal matching payments, designed to flow with the number of people eligible and the actual costs of their care.

Inadequacy of the proposed federal support. Recessions place states between a rock and a hard place when it comes to Medicaid financing. At the same time recessions increase the number of low income people seeking Medicaid coverage, they reduce the availability of state revenues available to finance that coverage. Coupled with increases in health care costs--notably for prescription drugs--states find themselves with demands that exceed the revenues they have available. Without federal fiscal relief, states' likely response is to cut back the coverage that Medicaid provides. As of December 2002, proposed or implemented cutbacks were estimated to leave a million people without health care coverage.

What's needed to prevent these cutbacks is a significant increase in the federal government's share of Medicaid costs--a boost in the matching rate--in order to cushion

the recession's impact. Instead the Administration is proposing not only a small funding increase that states must repay but also caps on federal funds for Medicaid regardless of program needs. The proposal's repayment requirement would actually cut federal funds after seven years, regardless of the number of eligibles or costs of services at that point in time. The fact that the repayment cut would begin at precisely the point the baby boom population begins to turn 65, increasing the number of low income elderly people eligible for Medicaid, makes higher costs then almost a certainty.

Inadequacy of block grants. Whatever its form, capped rather than open-ended funding is not responsive to the needs of the Medicaid population, the providers who serve them, or the states who share responsibility for financing their care. Medicaid is now the nation's largest health insurance program, providing health insurance to low income families and people with disabilities, filling in Medicare's gaps for low income elderly, and providing virtually the only safety-net for people who need long-term care. To support these services, the federal government provides states open-ended matching funds: the more people who are eligible for service and the more services costs, the more states receive in federal matching funds; the fewer people eligible, the less states receive.

As explained by Andy Schneider in The Kaiser Family Foundation's **Medicaid Resource Book (July 2002)**, financing arrangements that guarantee states at least half the costs of services (up to 83 percent in the lowest income states) encourage states to extend coverage beyond levels their own resources would support and make funds automatically available when circumstances create a need. Recession is one such need. The Urban

Institute estimates that an increase in the unemployment rate from 4.5 percent to 5.5 percent produces an increase in Medicaid enrollment of 1.6 million--an increase that, under current law, is automatically supported by federal funds. Public health emergencies are another such need. Medicaid covers an estimated 55 percent of persons living with AIDS and 90 percent of all children living with AIDS. When the number of people affected increases or the costs of treatment rise, federal funds automatically increase to share the burden.

Predetermined federal allotments or block grants cannot achieve these goals. Block grants are distributed according to specific formulas, not according to the number of people served or the actual cost of services. Although the Administration has not spelled out its proposal in detail, replacing guaranteed matching payments with capped funding is inevitably less responsive to the needs of vulnerable people. As my Georgetown colleague Cindy Mann has explained, predetermined allotments, even with rates of increase (which the Administration has not specified), do not allow for variations in need across states (due to variation in health or economic circumstances) or for unanticipated changes in national circumstances. Had federal funding for Medicaid in 2002 been based on costs projected in 1998, for example, Mann estimates that financing would have been 12 percent below actual spending.

Reliance on uncertain projections to provide federal funding is particularly likely to jeopardize federal support for Medicaid services to low income elderly and disabled populations. Medicaid is now the only source of prescription drug protection for these

vulnerable populations (and the Administration's Medicare prescription drug proposal would not necessarily replace these Medicaid responsibilities). Medicaid is also the nation's long-term care safety net--financing almost half the nation's nursing home expenditures. Given the expected growth in the elderly and disabled population, capping federal funds is a strategy to shift responsibility for serving the baby boom population from the federal government to the states.

The Administration describes its proposal as providing states "flexibility" to use resources more creatively and presumably more efficiently to meet their needs. However, no creativity in delivery can offset likely increases in numbers of people in need and increases in the cost of services over which Medicaid has little if any control. With capped funds, states' ability to "flexibly" expand coverage--provide coverage to currently ineligible uninsured populations or continue to expand home and community-based long-term care services--will be hampered, not enhanced, given the need to cover the inevitably rising cost of existing obligations. Either that, or expansions will come at the expense of people already in need. The key to true expansion of protection is enhanced, guaranteed federal matching payments, not capped federal funds.

Indeed, with capped federal funds, "flexibility" is nothing more than a euphemism for cuts in protection that federal rules currently do not allow: creating waiting lists for enrollment, favoring some parts of states over others, charging even the poorest beneficiaries out-of-pocket payments for service, and limiting access to any and all services based on fiscal concerns. Although the Administration proposal may exempt

from some such restrictions Medicaid’s so-called “mandatory” population groups— primarily poor children, and elderly and disabled people eligible for Supplemental Security Income (SSI) (that is, with incomes below 74 percent of the federal poverty level), it is unclear whether these exemptions would apply to all the services these groups currently receive. New types of restriction may apply to optional services (for example, prescription drugs, dental services, physical therapy, and eyeglasses). For optional groups—which include elderly and disabled people with incomes above 74 percent of the federal poverty level, the majority of elderly Medicaid nursing home residents, pregnant women with incomes above 133 percent of the federal poverty level, near poor children and very poor parents—states would appear to have total discretion to limit the terms and scope of coverage. The same may be true for the State Children’s Health Insurance Program, funding for which is incorporated in the newly proposed state allotments.

In general, a cap on federal funds will constrain coverage for any and all groups and services subject to that cap. Similarly, elimination of an array of current federal Medicaid standards—like those related to nursing home quality, access to emergency rooms and other protections under managed care, and timely processing of applications—will affect any and all groups and services now benefiting from them.

Overall, the Administration's Medicaid proposal in no way secures Medicaid financing for vulnerable populations. Instead it takes advantage of states' current fiscal weakness to encourage states to take a bad risk: trading assured federal financing in the future for a bit of new revenue and authority to cut spending today.

CONCLUSION

In his most recent State of the Union Address, President Bush described Medicare as "the binding commitment of a caring nation." The same language applies to Medicaid. A strong Medicare prescription drug benefit along with fiscal prudence is needed to secure our binding commitment to Medicare. Enhanced and guaranteed federal matching payments are needed to secure our binding commitment to Medicaid. In his 2004 Budget, the President abandons rather than secures these commitments. A caring nation should reject these proposals.