WR Medicaid

MEDICARE COMPROMISE

MEDICAL SAVINGS ACCOUNTS (MSAs) AND OTHER PLAN OPTIONS

- A 2-year national demonstration MSA program with enrollment capped at 3% of Medicare beneficiaries. A joint Congressional/Presidential Commission to study and make recommendations as to whether option should be continued/expanded. Open enrollment; health screening prohibited.

- 4-year demonstration of private fee-for-service plans in 10 states. Current-law rules for balance billing; premiums for basic Medicare benefit package cannot exceed actuarial equivalent of Medicare deductible; coinsurance uniform for all beneficiaries. Open enrollment; health screening prohibited.

NO "FAILSAFE" OR "LOOKBACK" CAPS ON FEE-FOR-SERVICE

BALANCE BILLING

- No balance billing permitted for authorized services received out-of-plan.

- Balance billing permitted for private fee-for-service demonstration (see above), but limited to current-law effective rate for fee-for-service.

PREMIUMS ABOVE MEDICARE CAPITATED PAYMENT

- Plans may charge up to their adjusted community rate for basic Medicare benefits, but may not exceed Medicare payment amount.

- No limits on premiums for supplemental benefits if full disclosure made.

MEDIGAP PROTECTION

- Require Medigap plans to accept all beneficiaries who elect coverage during annual open enrollment period to protect those who choose one of the new managed care plans but then want to turn to traditional fee-for-service Medicare.

- Allow Medigap plans to charge higher premiums to those who elect Medigap after managed care plans, but plans would be required to charge the same average premium charged by that plan to beneficiaries with comparable demographics (e.g., age).

ENROLLMENT

- Require initial contacts with beneficiaries and enrollment to be conducted by third party (i.e., not by health plans) for transition period. Secretary would contract with third party to provide information about all plans in area.

- After transition period, plans could contact and enroll beneficiaries directly. Health screening prohibited.

SAVINGS PROPOSALS

- Increase overall Medicare savings to $140 billion.

- Proposal would charge higher-income beneficiaries a Part B premium up to 75% of program costs, beginning at modified adjusted gross incomes of $100,000 for singles (phasing up to 75% at $125,000) and $125,000 for couples (phasing up to 75% at $150,000). This proposal could be expected to save in the neighborhood of $10 billion over 7 years.

MEDICAID COMPROMISE

NEW GENERAL FLEXIBILITY PROVISIONS FOR STATES, including:

- Eliminate federal waiver process for mandatory enrollment in managed care.
- Eliminate federal waiver process for home and community-based care options.
- Repeal the Boren Amendment.
- Repeal the cost-based reimbursement requirement for health centers/clinics.
- Repeal requirements for federal review of managed care contracts exceeding $100,000.

FINANCING

- Accept and work off the NGA financing formula to achieve CBO scorable savings, (which has no cap and ensures that federal support increases with enrollment), but retain current law with regard to state matching and provider tax rules.

ELIGIBILITY

- Accept NGA definition of eligibility with the exception of two modifications to the kids and disability definitions.
  - — Retain current law that phases in kids ages 13-18, but repeal requirement that makes it impossible for states to "roll-back" optional coverage of kids and pregnant women to the mandatory poverty/coverage levels.
  - — Retain federal disability designation authority, but restrict it to the definition agreed to in the welfare bill, (which excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids from mandatory coverage).
- Empower states to use any Medicaid savings to provide coverage of anyone under 150 percent of poverty WITHOUT any federal waiver.

BENEFITS

- Accept the NGA benefits definition, but retain appropriate federal standards to ensure that the benefits are meaningful.
  - -- Retain current law's flexibility in defining benefits' "amount, duration, and scope" as long as it is "reasonable to achieve its purpose," is available statewide, and meets the current law's comparability requirements.
  - -- Authorize the Secretary to narrow the definition of "treatment" that states must provide for children under the EPSDT benefit.
- Allow states to require nominal copayments for Medicaid HMO coverage.

ENFORCEMENT

- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.
- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.
- Preserve individual federal right of action (through the federal courts) for eligibility disputes, but limit access to federal courts (and substitute state court jurisdiction) over most benefit disputes.

STRUCTURE/SECOND TIER ISSUES

- Repeal outdated managed care quality standards, i.e., the private/public-75/25 enrollment rule, and substitute outcomes oriented quality rules.
- Retain federal nursing home standards and enforcement, but eliminate duplicative nursing home resident reviews and allow for nurse-aide training to take place in rural nursing homes.
- Retain current federal family financial protections, like spousal impoverishment and protections against liens on family property.
- Preserve current law protections by drafting reforms off of Title XIX.

Possible Seven-Year Deficit Reduction Plan

Discretionary:	$298
Mandatory:	
Medicare	$140
Medicaid	$62
Welfare	$40
EITC	$8
Other Mandatory	$67
	$317
Tax Cuts	- $140
Corporate Loophole Closers	$35
CPI baseline adjustment	$38
Debt Service	$62
	$610

More Troubles for Teamsters President

Mentor Faces Corruption Charges, and Election Rules Are Rejected

By STEVEN GREENHOUSE

James P. Hoffa, the Teamsters president, has suffered two recent setbacks that are likely to make it harder to achieve his goal of ending federal supervision of the union.

In one, a federal judge, using extraordinarily harsh language, rejected the rules that the union and the Justice Department had developed to run next year's Teamsters election.

In the other setback, a federal oversight board filed charges this month that could lead to the expulsion of the head of the Teamsters in Michigan, Lawrence Brennan, a mentor to Mr. Hoffa who played a major role in his ascent to the union's presidency.

The two developments come at a time when Mr. Hoffa has vowed to improve the image of a union that was long known for corruption. And they come as Mr. Hoffa, who took the union's helm 16 months ago, has made a concerted effort to persuade the Justice Department to end its intensive and invasive decade-long supervision of the International Brotherhood of Teamsters.

"It's been a bit of a pipe dream that federal supervision will end any time soon, but these developments will certainly make it harder," said Michael Belzer, a trucking industry expert at the University of Michigan.

Last Friday, Judge David N. Edelstein of Federal District Court in Manhattan issued a decision denouncing the rules that the union and government had proposed for next year's Teamsters election.

"The submissions are a farrago of ill advice and misguided, inept, controversial and confused argots," he wrote. "Their program has the potential of bringing grief, strife, controversy and corruption."

But union and government officials professed some bewilderment at the decision of Judge Edelstein, who oversees the federal supervision of the union, because he never spelled out what specifically he objected to.

Potentially more damaging to Mr. Hoffa were charges that the oversight board, the Independent Review Board, brought against Mr. Brennan. The board charged him with masterminding a scheme in which the executive board of a Teamsters local in Detroit doubled the board members' traditional Christmas bonus. Then the board members contributed the additional bonus to Mr. Brennan's campaign.

The oversight board maintained that the doubled bonus was a pretext to siphon about $30,000 in members' dues to finance Mr. Brennan's reelection. The board charged Mr. Brennan with embezzlement and violation of his fiduciary duties.

Before Mr. Hoffa was elected Teamsters president in December 1998, he was Mr. Brennan's administrative assistant. Mr. Brennan is president of Teamsters Local 337 in Detroit and of Teamsters Joint Council 43, which oversees all of Michigan's locals.

An even rockier road to ending federal oversight of a union.

When federal officials ruled a decade ago that Mr. Hoffa could not run for the union's presidency in 1991 because he had not worked as a Teamster, Mr. Brennan helped Mr. Hoffa meet that qualification by hiring him as an assistant.

The oversight board has forwarded its charges to the Teamsters executive board to investigate. Union officials said Mr. Hoffa has recused himself because he knows Mr. Brennan and the five other Michigan Teamster officials charged. They can face fines, suspension or even expulsion.

In a statement, Mr. Brennan said that he was innocent. His defenders say the charges were based on the testimony of just one official, while several other Teamster officials have testified to the contrary.

"This is going to be a test for Hoffa," said Ken Paff, national coordinator of Teamsters for a Democratic Union, a faction that has repeatedly clashed with Mr. Hoffa. "His mentor, his benefactor, the man who created a position for him to become eligible for president, has been charged with embezzling a lot of money. Hoffa says he's going to establish ethics in the Teamsters. We're going to see if he has the will to follow through here."

The oversight board did not bring charges against Carlow Scalf, a former Brennan assistant who is now one of Mr. Hoffa's top aides. In its written charges, the oversight board assailed Mr. Scalf's testimony as misleading and faulted his role in moving all the Christmas bonus money to Mr. Brennan's campaign.

"The fact is Carlow participated fully in the investigation and was not named as a defendant," said Bret Caldwell, a Teamsters spokesman.

Regarding the election rules, Judge Edelstein said the union should institute and rely on rules similar to those used in the 1991, 1996 and 1998 elections. Federal monitors ordered a rerun election in 1998 after finding that aides to Ron Carey, who narrowly beat Mr. Hoffa in 1996, had siphoned union money into the Carey campaign.

But Teamster officials said they had based their proposed election rules largely on those of past years.

Herb Haddad, a spokesman for the United States Attorney's office in New York, said, "The government and the Teamsters are working together to attempt to meet the court's concerns."

Patrick J. Szymanski, the Teamsters general counsel, wrote to the Justice Department yesterday, saying that the union was moving ahead with its plans to conduct the election and hoped the ruling would not delay the election. He said the union would consult with the department about what steps were appropriate in light of Judge Edelstein's ruling.

Tom Leedham, an Oregon Teamster leader who plans to run against Mr. Hoffa next year, said the judge must have found the proposed rules objectionable because they allow for little input in shaping the rules from forces other than Mr. Hoffa's.

The New York Times

TUESDAY, JUNE 20, 2000

A Million Parents Lost Medicaid, Study Says

By ROBERT PEAR

WASHINGTON, June 19 — Nearly a million low-income parents have lost Medicaid coverage and have probably become uninsured since Congress and the states began overhauling the nation's welfare programs in 1996, a consumer group said in a new study today.

The group, Families USA, said the number of low-income parents enrolled in Medicaid in 15 states had declined by 945,880, or 27 percent — to 2,557,673 in December 1999, from 3,503,553 in January 1996.

Those states are home to 70 percent of the uninsured adults who are under the age of 65 and have incomes less than twice the poverty level, or under $28,300 for a family of three.

When it passed a landmark welfare law in 1996, Congress tried to guarantee continuation of Medicaid coverage for people losing cash assistance. But many states did not carry out the requirements of the law, and until recently federal officials said they were unaware of any serious problems.

Under federal law, people leaving welfare are automatically entitled to health insurance under Medicaid for six months to a year, but states have not always provided this coverage.

Families USA did not trace individual families who left welfare, but other studies have found that adults in such families typically take low-paying jobs that do not offer health benefits. Even if parents are offered insurance by employers, they are often unable to pay the premiums.

Ronald F. Pollack, executive director of Families USA, said: "Our study shows that hundreds of thousands of low-wage working parents were cast adrift without health insurance when they did the right thing and found jobs. Most parents moving from welfare to work are in jobs that provide no health coverage, but they are losing their Medicaid lifeline."

The study said that Medicaid enrollment of parents had dropped by 155,846, or 19 percent, in California; by 123,630, or 25 percent, in New York; by 95,854, or 42 percent, in Ohio; and by 106,012, or 46 percent, in Texas.

Mr. Pollack said that New York and Ohio had liberalized eligibility standards for Medicaid in the last year so more parents would qualify.

Economists said the number of people on welfare and Medicaid might be expected to decline in a booming economy, which has reduced the unemployment rate to the lowest level in three decades.

But in an interview, Mr. Pollack said: "If Medicaid enrollment declines while the number of uninsured grows, there is obviously a problem.

UPDATE

Losing Welfare, Losing Medicaid

A new study finds that since the overhaul of welfare in 1996, the number of parents receiving Medicaid has dropped sharply in the 15 states with the highest number of low-income adults. Hundreds of thousands of children also lost Medicaid when their families lost welfare benefits, but this loss of coverage has been partly offset by new federal and state health programs for children.

RANK OF STATE BY NUMBER OF LOW-INCOME ADULTS		PARENTS ON MEDICAID, JAN. 1996-DEC. 1999: PERCENTAGE CHANGE (-50% -40 -30 -20 -10 0)	NUMBER
6	Georgia	-50	- 64,931
2	Texas	-46	- 106,012
8	Ohio*	-42	- 95,854
4	Florida	-37	- 82,682
13	Virginia	-34	- 20,000
14	Louisiana*	-31	- 19,088
12	New Jersey*	-30	- 38,092
10	North Carolina	-30	- 32,549
11	Michigan	-25	- 51,258
3	New York	-25	- 123,630
9	Pennsylvania	-23	- 75,975
7	Arizona	-20	- 12,202
1	California	-19	- 155,846
5	Illinois	-19	- 55,459
15	Tennessee	-11	- 12,302
	TOTAL, 15 STATES	-27	**- 945,880**

*State did not provide Dec. 1999 data; for Louisiana, most recent figure is for July 1999; for New Jersey and Ohio, figure is for October 1999.

Source: Families USA, from state Medicaid agency data

The New York Times

Leaving welfare for low-wage jobs, often without health insurance.

Reductions in Medicaid enrollment are, in fact, fueling an increase in the number of people who are uninsured."

Melissa T. Skolfield, a spokeswoman for the Department of Health and Human Services, said: "The report by Families USA shows that there is a lot of state-to-state variation. States can and should do more to expand Medicaid coverage for people leaving welfare."

Until recently, federal officials did not acknowledge that the 1996 welfare law was contributing to an increase in the uninsured. In May 1999, Ms. Skolfield said it was "too early to know for sure if there is a cause-and-effect relationship."

Researchers say hundreds of thousands of children also lost Medicaid when their families lost welfare benefits. But the decline in children's insurance coverage has been offset, to some extent, by the creation of federal and state health programs specifically for children.

Mr. Pollack said most states imposed strict limits on the income that a parent could earn and still qualify for Medicaid. In 32 states, he said, parents who work full time at the minimum wage of $5.15 an hour are considered to have too much income to qualify for Medicaid.

"In Louisiana, Virginia and Texas," Mr. Pollack said, "parents working at the minimum wage are disqualified from Medicaid if they work more than 12, 17 and 18 hours a week, respectively."

In April, the Clinton administration ordered states to restore Medicaid benefits to families who had been improperly deprived of such coverage. State officials say they have begun to comply.

The New York Times

TUESDAY, JUNE 20, 2000

WR-
Medicaid

EXECUTIVE OFFICE OF THE PRESIDENT

Office of Management and Budget
Program Associate Director for Human Resources
260 Old Executive Office Building
Washington, DC 20503
Fax #: 395-5730 **Phone #: 395-4844**

FACSIMILE COVER SHEET

DATE: 3-7-96

TO: Keith Fontenot, Rick Raphan, Mary Jo Bane, Bruce Reed

Fax Number: _____ **Voice Number:** _____

Number of pages (including cover sheet): 5

FROM: Ken Apfel

REMARKS:

Is there really a fairly easy fix to this problem?

FAX TRANSMISSION

CENTER ON BUDGET AND POLICY PRIORITIES
777 N. CAPITOL ST., NE SUITE 705
WASHINGTON, DC 20002
202-408-1080
FAX: 202-408-1056

To Ruth
Rick T
Mary Jo
Bruce

Is this really a fairly easy fix to this problem?
— Ken A

To: Ken Apfel
395-5730

Date: March 5, 1996

Pages: 4, including this cover sheet.

From: Cindy Mann

Subject: Medicaid coverage for AFDC families

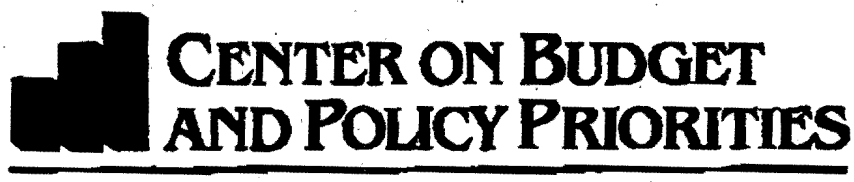
COMMENTS:

As per your conversation with Bob, we are hoping that the Administration will revisit the question of whether the NGA Medicaid proposal for AFDC older children and parents is the best possible option. It seems that it would *not* be very difficult for states to be required to follow option one of their proposal – to cover children and parents whose income meets state AFDC standards, particularly if you translate those standards to a percent of the poverty level. Thus, in any given state, children children over age 12 would have to be covered if their income were x percent of poverty (with "x" determined by measuring the state's current standard against the current poverty level). Medicaid asset rules would apply.

The only wrinkle is whether "deprivation" rules for children over twelve and parents would be retained. We have proposed that states be allowed to drop deprivation rules as a state option. It may have a price tag (hence it should be an option rather than a mandate), but given the very low levels of income that would be applied to this group of older children and parents it is not clear that the cost would be very high. The option allows states to completely get away from using AFDC rules for Medicaid purposes in the event that AFDC is repealed.

Our point (as noted in the attached memo) is that the governors' proposal will leave out large numbers of kids and parents now covered under the program and that there is a solution that would not carry with it all of the AFDC program rules. The governors' seized on the right approach in their option 1, but then undercut that approach by allowing the other options.

The attached memo spells out our concerns and describes the approach we think is much better.



MEMO

To: Interested Parties
From: Cindy Mann
Subject: Medicaid eligibility for AFDC recipients
Date: March 5, 1996

Since the beginning of the Medicaid program, eligibility for cash assistance and eligibility for Medicaid have been linked. Linkage made sense: AFDC was intended to aid the poorest children and their parents, and it followed that the same group of people ought to qualify for Medicaid as well. Over time, Medicaid eligibility rules have been expanded to assure coverage of some groups of poor children and pregnant women without regard to receipt of cash aid. The eligibility link between AFDC and Medicaid was retained, however, because linkage continued to be a simple, direct means for assuring that the poorest of the poor had health care coverage.

In light of proposed changes in the welfare system, however, linkage with cash assistance is no longer an effective means for assuring that poor children and parents receive coverage under Medicaid. The governors' welfare plan would repeal the AFDC program along with the federal rules that determine the categories of people who shall receive welfare payments; the design of the welfare program or programs that would replace AFDC would be left almost entirely to the states. The question of how to assure Medicaid eligibility for the children and parents who no longer would be guaranteed coverage through linkage with AFDC is a critical one. *Approximately 1.5 million children over age 12 and four million parents currently receive Medicaid based on their eligibility for AFDC.*

While there is strong support for proposals that would afford states much greater flexibility to design welfare programs and to experiment with new approaches to reduce the welfare rolls, even the most ardent supporters of radical welfare reform do not suggest that reform is promoted by leaving millions of very poor children and parents without access to health care. Throughout much of the welfare debate in Congress, Republican leaders have taken the position that changes in cash assistance should not affect Medicaid eligibility. For example, the House and the Senate welfare bills sought to assure continued Medicaid coverage for poor children and their parents by requiring states to cover under Medicaid persons who would have qualified for AFDC under rules in effect as of March, 1995.

However, because of the close relationship between AFDC and Medicaid under current law, the task of assuring that families that currently receive Medicaid through the AFDC linkage would remain eligible for Medicaid if AFDC is repealed is complex. The governors' plan tackles the issue, but its approach has serious flaws.

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056

Under the plan, states could cover parents and children who meet the state's current AFDC income and asset standards. But states also would have two other options that could result in millions of very poor children and parents losing Medicaid coverage. The plan would allow states with above-average AFDC income standards to lower their standards to the national average and thereby to cut Medicaid eligibility significantly. The national average income limit is only $399 a month — less than $4,800 a year for a family of three and only 38 percent of the federal poverty line. About 53 percent of the children over age 12 who receive Medicaid based on their receipt of AFDC live in states with AFDC income standards above the national average. While there is no data showing how many of these children have income above the $399 monthly average AFDC income standard, it is likely that a significant portion of these children could lose Medicaid coverage under the governors' plan.

In addition, the governors' proposal would allow states the option of limiting coverage to persons who qualify for aid under whatever new welfare program the state may create under its welfare block grant. States that restrict the scope of their welfare program through time limits even much shorter than five years, family caps, and other rules could similarly restrict coverage under Medicaid.[1] Thus, under this option, a parent and child who had reached their time limit in a state that limited welfare to two years would lose eligibility to Medicaid as well as cash assistance even if the parent had no job, and the family had no source of income or health insurance coverage.[2]

In short, neither of these options achieves the objective of assuring that very low-income children and parents do not lose Medicaid coverage as a result of welfare changes.

The following proposal attempts to meet this objective, building on the approach adopted by the governors:

(1) States would be required to cover parents and children over age 12 not yet covered by the poverty-level phase-in if their resources are below the AFDC asset limit and their income is below the state's current AFDC payment standard, measured as a percent of the poverty line. For example, Illinois' AFDC payment level for a family of three equals 36 percent of the poverty line. Under this

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[1] Under the welfare block grant proposals, states could even eliminate cash assistance altogether. For example, a state could use all of its welfare block grant funds to provide child care, transportation assistance and clothing vouchers instead of cash aid. It is not clear under the governors' plan whether states that took the option to link Medicaid with their new welfare plan would be required to cover persons receiving noncash as well as cash assistance funded under the block grant.

[2] The governors may be proposing an additional provision not included in their February 6th resolution that would retain the current law provision granting one-year of transitional Medicaid coverage for families who leave welfare for employment. While this would be an important improvement, it would *not* resolve the problems with the option to link Medicaid coverage with eligibility for welfare. Families that reach time limits, for example, and who remain unemployed would not be helped by transitional Medicaid coverage.

option, Illinois would be required to cover parents and older children whose income was below 36 percent of the poverty level. AFDC "deprivation" rules (ie., the rules that limit AFDC coverage to families with children deprived of parental support) would continue to apply, but states could be given the option to expand coverage by eliminating these nonfinancial eligibility rules.[3]

(2) States could be allowed the option of establishing an automatic eligibility link between Medicaid and their new welfare program (assuming AFDC is repealed and replaced with a block grant), but this would be an additional, alternate route to Medicaid eligibility; it would not replace the income-based rules established in (1).

This approach has the following advantages:

- It assures continued Medicaid eligibility to the poorest children and parents without expanding mandatory coverage beyond current law.
- It makes Medicaid eligibility rules internally consistent. All protected groups of people (ie., children, parents, pregnant women, elderly and disabled people) would qualify for Medicaid based on their income.
- By delinking Medicaid eligibility from receipt of welfare, states can experiment with welfare reform. States are free to use their welfare block grant funds in innovative ways, since a dollar of welfare benefits would no longer carry with it the obligation to provide the full range of Medicaid benefits. A state could use welfare block grants to provide modest transportation assistance or a state earned income credit to working families significantly above the poverty line without worrying about having to provide Medicaid coverage for all such people.

While there is no perfect approach for assuring that families who now receive Medicaid through the AFDC linkage will remain eligible for Medicaid if AFDC is repealed, it no longer makes sense to rely on the link between welfare and Medicaid as the principal means to assure that poor children and parents have access to Medicaid coverage. The approach suggested here substitutes an income-based rule for the cash assistance linkage, consistent with the approach adopted by the governors with respect to other categories of protected groups of beneficiaries, without disturbing current differences among states in terms of the specific income limits that would be used in the Medicaid program.

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[3] Over time, if the poverty-level phase-in is maintained, all children under 18 with income below the poverty line would be covered without regard to "deprivation" rules. Thus, these coverage rules, as they pertain to children as opposed to parents, would be transitional, assuring that very poor children over age 12 are covered under Medicaid until the phase-in assures coverage of all children with incomes below the poverty line.

WR Medicaid

SUSPENSION

(Policy Position offered by Governor Thompson and Governor Bob Miller)

RESTRUCTURING MEDICAID

PREAMBLE

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics.

Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the elderly. This year, states and the federal government combined will spend more than $140 billion in this program providing care to more than 28 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained and those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

THE NEW PROGRAM

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the nation's Governors proposal that blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens.

Program Goals. *The program is guided by four primary goals.*

1. *The basic health care needs of the nation's most vulnerable populations must be guaranteed.*
2. *The growth in health care expenditures must be brought under control.*

3. *States must have maximum flexibility in the design and implementation of cost-effective systems of care.*
4. *States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.*

Eligibility. *Coverage remains guaranteed for:*

- *Pregnant women to 133 percent of poverty.*
- *Children to age 6 to 133 percent of poverty.*
- *Children age 6 through 12 to 100 percent of poverty.*
- *The elderly who meet SSI income and resource standards.*
- *Persons with disabilities as defined by the state in their state plan. States will have a funds set-aside requirement equal to 90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities.*
- *Medicare cost sharing for Qualified Medicare Beneficiaries.*
- *Either:*
  - *Individuals or families who meet current AFDC income and resource standards (states with income standards higher than the national average may lower those standards to the national average); or*
  - *States can run a single eligibility system for individuals who are eligible for a new welfare program as defined by the state.*

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act.

Coverage remains optional for:

- *All other optional groups in the current Medicaid program.*
- *Other individuals or families as defined by the state but below 275 percent of poverty.*

Benefits

- *The following benefits remain guaranteed for the guaranteed populations only.*
  - *Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The*

"T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

- *At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.*
- *States have complete flexibility in defining amount, duration, and scope of services.*

Private Right of Action

- *The following are the only rights of action for individuals or classes for eligibility.*
  - *Before taking action in the state courts, the individual must follow a state administrative appeals process.*
  - *States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.*
  - *Following action in the state courts, an individual or class could appeal directly to the U.S. Supreme Court.*
  - *Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.*
- *There should be no private right of action for providers or health plans.*

Service Delivery

- *States must be able to use all available health care delivery systems for these populations without any special permission from the federal government.*
- *States must not have federally imposed limits on the number of beneficiaries who may be enrolled in any network.*

Provider Standards and Reimbursements

- *States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.*
- *The Boren amendment and other Boren-like statutory provisions must be repealed.*
- *"One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics.*

- *States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.*
- *For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.*

Nursing Home Reforms

- *States will abide by the OBRA '87 standards for nursing homes.*
- *States will have the flexibility to determine enforcement strategies for nursing home standards and will include them in their state plan.*

Plan Administration

- *States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration.*
- *The plan and plan amendment process must be streamlined to remove HCFA micromanagement of state programs.*
- *Oversight of state activities by the Secretary must be streamlined to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan.*
- *HCFA can only impose disallowances that are commensurate with the size of the violation.*
- *This program should be written under a new title of the Social Security Act.*

Provider Taxes and Donations

- *Current provider tax and donation restrictions in federal statutes would be repealed.*
- *Current and pending state disputes with HHS over provider taxes would be discontinued.*

Financing. *Each state will have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation is available only if the state puts up a matching percentage (methodology to be defined). The allocation is the sum of four factors: base allocation, growth, special grants (special grants have no state matching requirement) and an insurance umbrella, described as follows:*

1. *Base. In determining base expenditures, a state may choose from the following—1993 expenditures, 1994 expenditures, or 1995 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.*
2. *Growth. This is a formula that accounts for estimated changes in the state's caseload (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the best available data.*
3. *Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirement to gain access to these federal funds.*
4. *The Insurance Umbrella. This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.*

   Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups—persons with disabilities and the elderly.

   Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

   1. *States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.*
   2. *Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.*
5. *Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.*
6. *Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for*

low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

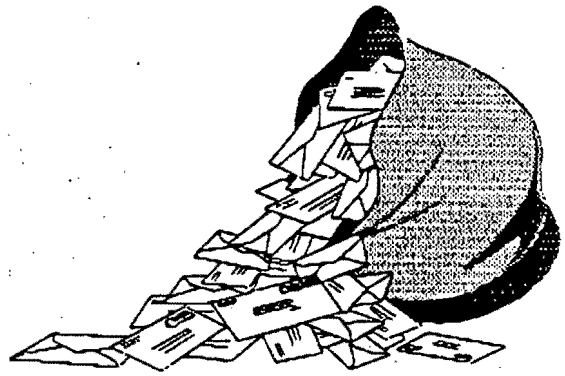
Provision for Territories. *The National Governors' Association strongly encourages Congress to work with the Governors of Puerto Rico, Guam, and other territories towards allocating equitable federal funding for their medical assistance programs.*

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

URGENT



URGENT

WR Medicaid

FROM: Melinda Haskins **395-3923**

DATE: 6/10/96 **TIME:** 11:35 AM

Pages sent (including transmittal sheet): 25

COMMENTS: See. Shalala is scheduled to give testimony before H. Commerce tomorrow on Medicaid reform. HHS has added a new TP to this testimony that I'd like you to review (see p.2).

TO: Ken Apfel
Bruce Reed.

Please provide any comments by 1:30 PM TODAY.

Sorry for the short turnaround,

MH

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

REVISED 11 a.m
Mon - June 10
~~Thursday, June 6, 5:00~~

SECRETARY'S MEDICAID TESTIMONY

HOUSE COMMERCE COMMITTEE

Mr. Chairman, Congressman Dingell and members of the Committee: thank you for inviting me to testify today about the most recent Medicaid proposal introduced by last month.

As this Committee and the Congress continue to consider options to reform the Medicaid program and pursue a balanced budget, we appreciate the opportunity to state clearly the President's vision for reform in this area.

The Clinton Administration believes that we must balance the budget by the year 2002 and give more responsibility to the states and local communities. But we must do it in a way that is consistent with the values of our nations.

As the President has said time and time again: We can balance the budget and find common ground -- without turning our backs on our values, our families, and our future.

In Medicaid, we believe we can give the states the flexibility they need, while maintaining a strong federal-state partnership built on a foundation of shared resources, accountability to the taxpayers, and national protections for the most vulnerable Americans.

That is why the President has proposed a common sense plan that balances the budget, gives unprecedented flexibility to the states, and reforms Medicaid without breaking our promises to our citizens -- from seniors living in nursing homes to families struggling to work their way out of poverty. And that is why he has refused to sign legislation which breaks these promises.

The President has also made clear that the current strategy of the majority in Congress to link welfare reform to unacceptable changes in Medicaid will leave him no choice but to veto the entire package. We call on Congressional leaders to abandon the "poison pill" strategy that is designed to provoke this veto, and join in the bipartisan efforts of the governors and moderate bipartisan groups in both Houses of Congess to enact sensible reforms for both Medicaid and Welfare.

Medicaid provides vitally important health and long-term care coverage for approximately 36 million Americans and their families:

- It provides primary and preventive care for 18 million low-income

children;

- It covers 6 million individuals with disabilities -- providing the health, rehabilitation, and long-term care services that would otherwise be unaffordable for these individuals and their families;

- It covers 4 million senior citizens -- including long-term care benefits that provide financial protection for beneficiaries, spouses, and the adult children of those requiring nursing home care.

- Finally, it pays the Medicare premium and cost sharing for low income seniors, thus putting the benefits of Medicare within reach.

The Clinton Administration is dedicated to strengthening and improving Medicaid, so that it can continue to fulfill the promise of our nation to millions of children, elderly, and disabled Americans and their families. To achieve this goal, this Administration has worked vigorously in partnership with the states to test innovative new approaches to delivering and financing care for Medicaid patients. During our first 3 years in office, this Administration approved 91 major Freedom of Choice waivers, and 163 new and renewed Home and Community-Based Services waivers. In addition, since January 1993 we have approved 12 statewide Medicaid demonstrations, 8 of which are currently operational. This compares to a

total of one such demonstration approved under all previous administrations. In addition, we are currently reviewing proposals submitted by 10 other states. Some statewide demonstrations expand access to the uninsured, others test new methods for delivering mental health services, and still others implement simplified eligibility requirements.

The flexibility provided by these waivers has allowed states to improve the efficiency with which they provide care. States have used th resulting savings to cover additional populations with unmet health care needs. When all of the currently approved demonstrations are implemented, nearly 2.2 million individuals who did not receive Medicaid coverage will be eligible for services.

As part of his balanced budget plan, the President has proposed a carefully designed and balanced approach to Medicaid reform which builds on this experience. His plan preserves the essential elements of Medicaid (title XIX of the Social Security Act) while making important changes that will give states unprecedented flexibility to meet the needs of the people they serve. The President's plan:

- o preserves Medicaid protection for all currently eligible groups;

The President's Medicaid Proposal: Flexibility for States

Promote Managed Care	✓ Permits enrollment in managed care without waivers ✓ Eliminates certain Federal contracting rules – Eliminates 75/25 rule – Eliminates Federal review of contracts over $100,000
Increase Flexibility in Eligibility/Benefits	✓ Permits home and community-based care programs without waivers ✓ Allows eligibility simplification
Eliminate Federal Provider Payment Rules	✓ Repeals Boren Amendment ✓ Replaces cost-based payment with federal grants to health centers (FQHCs/RHCs) ✓ Eliminates qualification requirements for certain physicians (Ob/Peds)
Streamline Administration	✓ Eliminates annual state reporting requirements for certain providers ✓ Simplifies computer system requirements ✓ Eliminates personnel requirements ✓ Eliminates cooperative agreement requirements ✓ Eliminates duplicative nursing home reviews

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- maintains our shared financial partnership with the states as they provide health coverage to needy individuals;

- preserves the Federal guarantee of a congressionally-defined benefit package for Medicaid beneficiaries;

- contributes Federal savings to the balanced budget plan through reductions in disproportionate share hospital payments and the use of a per capita cap on Federal matching that adjusts automatically to changes in state Medicaid enrollment and changes in the economy.

- provides states far greater flexibility to better manage their programs, pay providers of care, and operate managed care and other arrangements with reasonable Federal requirements to maintain programmatic and fiscal accountability (Chart A)

I have brought a chart that details the broad new flexibility states would have under the President's proposal.

As you know, the President strongly opposed the Medicaid proposals passed by Congress last year because they failed to meet these principles. The Congress repealed the Medicaid program and replaced it with a new "Medigrant" program

that did not provide meaningful guarantees of eligibility or benefits. The Congress also put forward a "block-grant" funding mechanism that breached the 30 year Federal commitment with the states to share in changes in state Medicaid spending and left states with the full financial responsibility for providing health care to individuals who qualifiy for services in the future..

Last February, the National Governors' Association approved the outlines of a bipartisan Medicaid reform plan. As I testified before this Committee in March, we believed the governors' plan -- produced through a bipartisan process-- held some promise and we were hopeful that, once more details were known, there would be a real basis for Medicaid reform. The governors clearly worked very hard to move the debate forward. At the same time, however, I discussed the Administration's concerns with some elements of the governors' plan.

Last month, the Republican majority in both Houses of Congress introduced a revised version of their Medicaid bill, which I will discuss today. This bill moves us further away from the bipartisan reform envisioned by the governors, and much closer to the Republican legislation that the President vetoed last year. Our view is shared by the Democratic governors who were instrumental in crafting the NGA agreement. In a May 29 letter to Senator Roth, four Democratic governors stated that:

"[The Republicans'] Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year and rejected by the Governors at our winter meeting..."

Let me be clear: the new Republican bill, like its predecessor, fails to meet the President's basic principles for Medicaid reform. If this bill is sent to the President, he will veto it.

I discussed the President's basic principles for Medicaid reform when I testified before this committee last fall and this spring. As shown on the next chart, they are: (1) the need for a real, enforceable Federal guarantee of coverage to a congressionally-defined benefit package; (2) appropriate Federal and state financing; and (3) quality standards, beneficiary protections, and accountability. I will now discuss why the new Republican Medicaid plan fails to meet each of these three principles.

The Federal Guarantee of Coverage and Benefits

The Federal "guarantee" of coverage and benefits is at the core of the Medicaid program. Unfortunately, the term "guarantee" has been assigned very different meanings in the context of the current Medicaid debate. When we use the term guarantee in the context of a Federal statute like Medicaid, we mean a

Principles of Medicaid Reform

- Enforceable Federal Guarantee of Coverage and Benefits:
  - Guaranteed eligibility
  - Meaningful benefits
  - Federal enforcement
- Shared Financial Partnership with States
  - Federal dollars follow the people
  - Federal savings to help balance the budget
- Protections for Beneficiaries, Families, and Taxpayers
  - Limit out-of-pocket costs
  - Assure quality of care
  - Maintain fiscal accountability

real guarantee, composed of three interrelated components: definitions of 1) eligibility; 2) benefits, and 3) enforcement.

Eligibility

Let's begin with eligibility. The new Republican bill would deny millions of Americans the guarantee of Medicaid eligibility that they now have under current law. The bill repeals the phase-in of Medicaid coverage for children ages 13 to 18 in families with income below the Federal poverty level -- a bipartisan coverage expansion signed into law by President Bush.

In addition, the new Republican bill repeals the Federal standard for defining disability and replaces it with language that could mean 50 separate state definitions. This has the affect of making Medicaid coverage and benefits for those with disabilities uncertain and variable across the nation. For example, some states could use restricted definitions of disability that result in very limited coverage for those whose needs are pronounced and among the most costly. In fact, States might be forced to narrow their definitions of disability in order to cope with lower Federal funding levels. In such situations, narrow state definitions of disability could preclude individuals with HIV, certain physical disabilities, or mental illness from receiving critically needed services under Medicaid. We should not turn back the clock on those with disabilities by permitting 50 different state

definitions for purposes of Medicaid coverage.

The new Republican bill also eliminates the current law requirement that Medicaid be provided for one year to persons who leave welfare in order to join the workforce. By eliminating this guarantee, the Republican proposal will discourage individuals from leaving welfare and set back our efforts to reform the welfare system.

Finally, the new Republican bill gives states the authority to impose additional eligibility limits based on age, residence, employment or immigration status, or more restrictive definitions of assets and income. This provision will enable states, if financially necessary, to restrict eligibility even among those people who supposedly are "guaranteed" coverage.

Benefits

Eligibility is only one component of the guarantee. The next question is "eligibility for what?", which brings us to benefits. The new Republican bill "guarantees" some benefits for those populations who are "guaranteed" eligibility. But this guarantee is hollow. Many loopholes make it essentially meaningless.

One giant loophole relates to the adequacy of the benefits. Current

Medicaid law and regulations already give states substantial flexibility in defining the amount, duration, and scope of benefits, and states have used this flexibility to tailor Medicaid packages to their unique circumstances. This latitude is tempered by a very reasonable constraint -- benefits must be "sufficient to reasonably achieve their purpose." The Republican bill removes this sensible provision, giving states complete flexibility on amount, duration, and scope. Thus, states could "guarantee" coverage for hospital and physician services, but -- if forced to do so -- could limit this coverage to unreasonably low levels such as 3 days of hospital care and one physician visit per year. This type of guarantee is meaningless for persons who truly need medical care.

Another loophole in this "guarantee" is the new elimination of current law standards of comparability and "statewideness" of services. Without these standards, some states could offer different coverage and benefit packages in different parts of the state, or to different groups based on their age or diagnosis. Eliminating requirements for comparability and statewideness leaves states free to discriminate against persons who live in certain areas, who have specific diseases (such as AIDS), or who lack political clout (such as children).

The new Republican bill also severely curtails the treatment services which must be provided under the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. Under the Republican bill, children must be screened for a range of health problems, but treatment is only required for dental, hearing,

and vision problems. If a child is diagnosed with any other medical problem, they are not guaranteed treatment. Therefore, an asthmatic child would not be guaranteed coverage for treatment, such as asthma-controlling drugs or inhalers. Diagnosis without treatment is bad medical care and a wasteful use of taxpayers' dollars.

Enforcement

The third essential component of the Federal guarantee is enforcement. Implicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism. A Federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights <u>everywhere in the United States</u>. The new Republican bill requires states to provide a state right of action, but eliminates any Federal right of action for individuals and providers who assert that a state is violating Federal Medicaid laws. The only access to Federal court for such claims would be the opportunity to petition the U.S. Supreme Court for review of a decision of a state's highest court.

By denying beneficiaries access to the Federal courts, the Republican bill eliminates individuals' guarantee to enforceable Federal benefits. Thus, Medicaid would confer a Federal right to benefits but completely lack a Federal enforcement mechanism - a virtually unprecedented situation. In addition, eliminating the

Federal right of action promotes inconsistent interpretations of the Medicaid statute across the country. Common sense tells us that those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. When the same question arises across multiple jurisdictions, decision-making in the Federal court system maximizes equity and predictability. This is particularly true when Medicaid interacts, as is often the case, with other Federal statutes, such as Medicare, Social Security, Supplemental Security Income, and Aid to Families with Dependent Children. Federal courts are more experienced in analyzing these Federal programs and are better able to understand and decide cases involving relationships among them. We should not construct a system that will encourage different outcomes in different states.

Provider suits against states have caused the greatest problem to the states. Under the Administration's plan, the Boren Amendment and related provider payment provisions would be repealed, thereby eliminating these causes of action by providers. Thus, the Administration's plan resolves states' major concern about their exposure to providers' suits in Federal court, and does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits.

On balance, when we assess the three components required to make any guarantee real -- the definitions of eligibility, benefits, and enforcement -- we find that the so-called "guarantee" of Medicaid coverage and benefits contained in the

new Republican bill is neither real nor enforceable for beneficairies. This is not about whether the governors can be trusted. They can be trusted, which is why our proposal offers states unprecedented flexibility in program management and why we have worked with so many states on their innovative demonstrations. The issue is whether an individual, regardless of where he or she lives, is guaranteed meaningful coverage.

Financing

The President's second principle for Medicaid reform is an appropriate financing structure -- namely, one that maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Under this partnership, Federal dollars follow the people, meaning that the Federal government shares responsibility with the states for increased costs associated with increases in enrollment. As with the Federal guarantee of coverage and benefits, the new Republican bill falls far short of meeting this principle.

I have reviewed the components of the new Republican financing arrangement before -- and it was not in the governors' agreement. This newest financing structure is simply the Medi Grant II block grant formula, dressed up with a tiny embellishment to pay lip service to the governors' principles that funding must automatically adjust for enrollment.

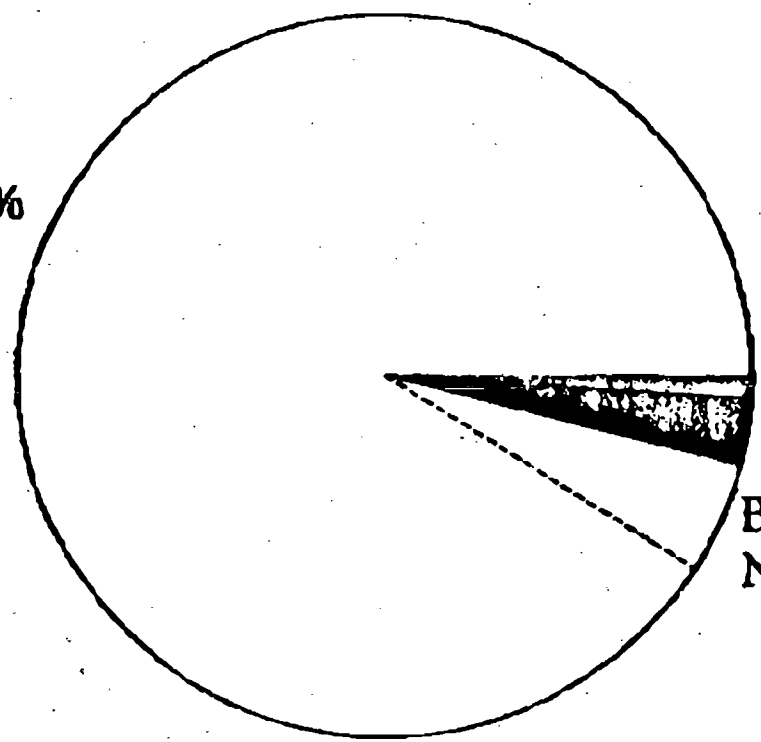
To demonstrate this point, I will walk through each component of the financing structure of the new Republican bill, and I will use this next chart to illustrate my points.

Base Allotment

The first component of the Republican funding system is called the base allotment. These allotments, which account for an average of 96 percent of total Federal spending over the 6 year period (as shown on the chart) are distributed to states based on a formula that includes factors such as "needs-based amounts" and "program need". Given this structure, at first it might appear that each state's base allotment is determined based on its actual need, including enrollment growth and caseload changes.

However, the base allotment is not what it seems. After careful analysis, my staff has concluded that only 5 percent of this 96 percent of funding is actually distributed based on need. The remaining 91 percent is distributed to states based on what is essentially a block grant system. Under this system, states' allotments are determined through the use of "floors" and "ceilings", rather than by the results of the needs-based formula. Each year, between 44 and 49 states' allotments are determined through a floor or ceiling. For these states, the new Republican bill is a block grant, with a new name.

Republican Medicaid Bill: Funding Not Based on Need



Source: DHHS analysis based on legislative provisions of the 5/21 Republican Medicaid Bill.

Furthermore, even the 5 percent "needs-based" funding does not truly reflect the financial need of states in their Medicaid programs. This is because it is determined by the number of poor people in a state rather than Medicaid enrollment growth. As a result, if the number of Medicaid recipients in a state increases but the number of poor people does not, the state's base allotment would not increase.

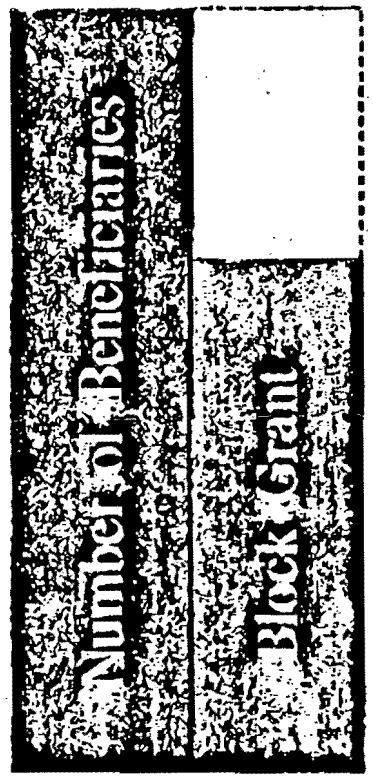
Umbrella Fund

The second component of the financing structure is called the "umbrella fund", and it consists of supplemental Federal money that is to be distributed to states with high enrollment growth. But if the Republican umbrella is the states' only protection against the costs of high enrollment growth, the states are going to get drenched. The entire umbrella fund accounts for only 3 percent of all Federal Medicaid spending; thus, it could provide only a fraction of what states would need in times of recession or natural disaster. In addition, it covers enrollment increases only for the year of the increase -- not for any later years during which the new enrollees continue to receive Medicaid. Thus, if a state suffered a three-year recession that caused its Medicaid enrollment to rise, it could get umbrella funds for new enrollees for their first year, but could be forced to bear the entire cost of these enrollees for any later years during which they remained on Medicaid.

Republican Medicaid Bill: Dollars Do Not Follow People!

Year 1

Year 2



Year 3

This is shown on my next chart. Assume that the recession begins in year 2. As you can see, this recession causes a dramatic increase in the state's enrollment, which triggers an umbrella payment to assist the state in covering the costs of these new enrollees. In year three, however, the state's enrollment remains at the same level as in year two, but this time there is no umbrella payment, because these payments are based only on changes in enrollment, not total enrollment. Thus, the state is forced to bear the cost of the much higher enrollment with the same amount of Federal assistance as it received in year one.

Pools for Undocumented Aliens and Indians

The final component of the financing structure is $4.3 billion to assist states in providing care for undocumented aliens and Native Americans. The first pool is allocated across the 15 states with the highest numbers of undocumented aliens. The second pool is allocated among all states that have Indian-funded health facilities or programs.

Changes in FMAP and Taxes and Donations Laws

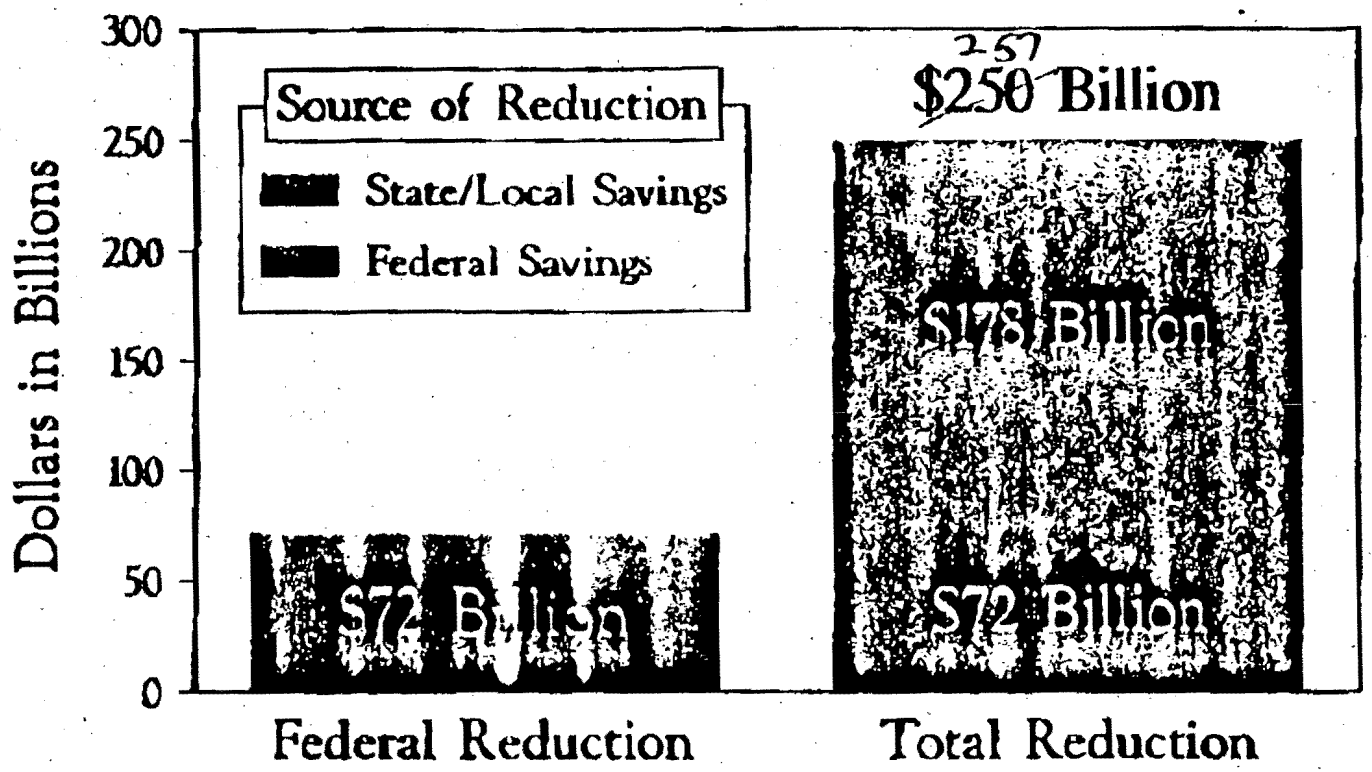
In addition to replacing the current financing partnership with a block grant to states, the new Republican bill also includes two changes in the way states finance their share of Medicaid costs. It increases the rate of Federal contribution

to Medicaid (known as the FMAP) for many states, thereby reducing the amount of funds necessary to collect Federal matching funds. It also repeals the restrictions on states' use of provider tax and donation financing mechanisms.

While these proposals are appealing to many states, they raise significant concerns. Specifically, the proposed changes to the FMAP will raise the Federal share of national Medicaid spending from 57 percent to 63 percent. In addition, the FMAP changes could encourage states to reduce their contributions to the program, resulting in even deeper reductions in total Medicaid spending than this bill suggests. As shown in the left bar of the next chart, the new Republican bill will reduce total Federal spending on Medicaid by $72 billion over 6 years. But total reductions in Medicaid spending could be far greater. The Center for Budget and Policy Priorities estimates that states could reduce their own spending on Medicaid by about $185 billion over 6 years without decreasing the amount of Federal funds for which they are eligible. Thus, as shown in the right-hand bar on the chart, the new Republican bill could lead to a total reduction of approximately $257 billion in Medicaid spending over the next 6 years.

Defining and revising the appropriate Federal and state contributions and spending levels always will be one of the most difficult issues to settle in any Medicaid reform plan. There is no question that these matters merit careful attention in the long-term. However, given the enormous fiscal implications, the

Republican Medicaid Bill: Funding Reductions*



* *Assumes minimum State expenditure for maximum Federal matching payment*

Source: ~~*HHS analysis based on the May 1996 Republican Medicaid Plan*~~

Based on analysis by the Center for Budget and Policy Priorities

President's plan proposes to gain advice from an intergovernmental advisory commission on the appropriate relationship between Federal and state funding before the Congress proceeds to change the current distribution.

The new Republican bill also would permit unconstrained use of provider tax and donation financing approaches for the "state" share of Medicaid. These are the exact mechanisms that the Congress, in a bipartisan fashion, recently limited -- in the case of taxes -- or outlawed completely -- in the case of donations. During the late 1980s and early 1990s, many states took advantage of these funding mechanisms, costing the Federal government billions of dollars and helping to drive annual Medicaid spending growth rates to well over 20 percent. Now the Republican bill seeks to remove the restrictions that were passed with overwhelming bipartisan support just a few years ago. Without these restrictions, states would be free to finance significant portions of the state share without contributing any real state dollars, leading to substantially lower support overall for the Medicaid program.

In summary, the new Republican bill fails to meet the President's second principle for Medicaid reform -- a financing structure that maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Neither does it meet the principles agreed to on a bipartisan basis by the

Governors. The Governors' proposal reflected a willingness to assume a greater responsibility for the management of the Medicaid program, but only if they had a strong financial partner to help meet the costs. The NGA proposal was carefully designed to provide this Federal-state partnership, and was based on a funding mechanism that clearly protected states from the full costs associated with actual changes in enrollment. The money was supposed to follow the people, in order to protect states from unexpected, uncontrollable enrollment increases. When the latest Republican proposal was released, it did not take the Governors long to realize that the centerpiece of their deal was no longer part of the mix.

Protecting beneficiaries, families, and taxpayers

This brings me to the President's third principle for Medicaid reform: protections for beneficiaries, families, and taxpayers. Once again, the new Republican bill fails to meet to President's principle.

The new Republican bill would repeal title XIX and create a new title for the Medicaid program. This has the effect of seriously compromising the framework for quality standards, beneficiary and family financial protections that limit families' out-of-pocket costs, and program accountability.

Out-of-Pocket Costs

This bill reduces or eliminates many long-standing family and beneficiary protections. For example, it would permit states to require adult children of Medicaid beneficiaries to contribute to the cost of their care, except for long-term care. In addition, the bill grants states broad discretion to impose cost-sharing requirements on Medicaid beneficiaries. It imposes minimal cost-sharing limits only for certain services to children and pregnant women below poverty, leaving other women, children, and most disabled and elderly fully exposed to potentially serious financial consequences. This lack of limits on cost-sharing is another factor which effectively undermines these persons' "guarantee" of eligibility and benefits.

[illegible] while the bill retains current law provisions designed to protect spouses and other relatives of nursing home patients from excessive liability for the cost of care, repeal of the more general cost sharing protections significantly minimize these protections. For example, nursing home residents who have spent down their incomes to become eligible for Medicaid could be charged any level of cost-sharing. In addition, services included in the nursing home benefit could be [illegible] the spouses or children of nursing home residents to bear the full cost of these services. Furthermore, states could charge elderly or disabled persons any [illegible] which could be set so high as to effectively exclude them from the program.

Quality Assurance Requirements for Managed Care

In addition, the new Republican bill makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care. This is a serious concern since Medicaid managed care enrollment is increasing so dramatically. About one-third of beneficiaries now are in managed care, a 140 percent increase in enrollment over the past three years. The President's plan recognizes the need for updating managed care quality standards. It replaces some outdated approaches with a quality improvement program that must include appropriate standards for Medicaid-contracting health plans and data analysis that tracks utilization and outcomes.

Fiscal Accountability

Finally, we recognize that the Federal government finances well over half of Medicaid spending nationwide, at a cost to Federal taxpayers of more than $100 billion a year. The Federal government has a responsibility to those taxpayers to ensure that these funds are spent efficiently and appropriately.

Fulfilling this responsibility requires imposing a minimal amount of reporting and monitoring requirements on states. There are ways, similar to the approach taken in the President's plan, that would provide states with expanded flexibility in

management and operation of their Medicaid programs, while ensuring accountability for funds at the same time. Unfortunately, the new Republican bill includes no quality assurance requirements or monitoring responsibilities for Medicaid managed care, and it contains no mechanism to ensure that changes in benefits and cost-sharing do not jeopardize the sufficiency of coverage. Thus, under the Republican bill, the Federal government will finance a greater percentage of the Medicaid program, but taxpayers will have fewer assurances that their money is being well spent.

In summary, like its predecessor last fall, the new Republican bill fails to meet the President's third principle -- protecting beneficiaries, families, and taxpayers.

CONCLUSION

Let me conclude by focusing on one fundamental structural issue -- whether we approach the task of Medicaid reform by making changes in the current title XIX of the Social Security Act, or by repealing that program and replacing it with a new title. We support reform, not repeal, of title XIX. The potential unintended consequences of repealing and replacing this program are staggering -- for states, beneficiaries, providers, and the Federal government, especially when you consider

that it would reopen thirty years of settled litigation. The Congress can address many of the most pressing concerns about any Medicaid reform plan by amending the current law.

We in the Administration believe that Medicaid must be financed through a Federal-state partnership that ensures Federal funding and provides a real, enforceable guarantee of coverage for a defined package of health and long-term care benefits. The President's plan proposes unprecedented flexibility for the states to operate their programs, pay providers, and use managed care and other delivery arrangements, while retaining and revising key standards related to quality and other beneficiary protections. The President's proposal would achieve those objectives in a way that would also help to balance the budget by 2002.

[illegible] committee, I was encouraged that the bipartisan efforts appeared to be moving us toward a solution that could meet all of the President's principles. Since that time Moderate Republicans and Democrats in the Senate and more recently in the House have worked hard to build on the balanced approach envisioned in the NGA agreements. I am disappointed that the bill before this Committee today is extremely similar to the one that the President vetoed last fall and that departs dramatically from the bipartisan agreements reached by the Governors just a few months ago. While we cannot support this bill, I can assure you that we stand ready to work with the

members of this committee and the entire Congress to design a reformed Medicaid program that will meet the needs of beneficiaries, states and taxpayers.

Mr. Chairman, thank you again for the opportunity to testify today and I look forward to answering your questions.

Attn: Chris Jennings
from: Hilary Stout

① WR - Repubs
② WR - Medicaid

chris: here's what i want to use. thanks, hilary — 662-9233

"We're very close on a welfare deal and we strongly feel you shouldn't hold welfare hostage to disagreements over Medicaid."

or

"Our strong message is let's move forward on welfare, let's get ~~this thing~~ done, let's not hold welfare hostage to Medicaid and political games."

WR is part of their Contract and ours.
~~but should not~~ ~~the~~ Repubs leaders shouldn't hold

→ ~~The~~ Republican Leaders have to decide whether they want to play politics or get the job done.

~~Clearly~~ We could ~~come~~ run a signature agenda tomorrow on welfare reform.

Repub leadership shouldn't try to poison ~~that~~ the prospects ~~with~~ that ~~Medicaid plan that the Repubs can't support~~, or real reform ~~Democrats and many Repubs~~ extremist

We'd still like to see a balanced budget ~~deal~~ agmt. ~~that reforms welfare entitlements~~

But We certainly shouldn't hold bipartisan WR hostage to Wash. ~~partisan~~ political games.

by holding welfare hostage to an extremist ~~plan to get~~ Medicaid

SPECIAL

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001
6/12/96
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 4717
FILE NO: 2362
Total Page(s): 5

TO: Legislative Liaison Officer - See Distribution below:

FROM: Janet FORSGREN Janet Forsgren (for) Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI 395-4871 Legislative Assistant's Line: 395-7362
C=US, A=TELEMAIL, P=GOV+EOP, O=OMB, OU1=LRD, S=PELLICCI, G=ROBERT, I=J
pellicci_r@a1.eop.gov

SUBJECT: HHS Fact Sheet RE: HR3507, Personal Responsibility and Work Opportunity Act of 1996 and the Medicaid Restructuring Act of 1996

DEADLINE: NOON Thursday, June 13,1996

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

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RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: **4717**
FILE NO: **2362**

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.
If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.
You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Fact Sheet RE: HR3507, Personal Responsibility and Work Opportunity Act of 1996 and the Medicaid Restructuring Act of 1996

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

WR-Medicaid

LOSS OF MEDICAID ASSURANCE UNDER H.R. 3507

The House Republican proposal (H.R. 3507) to reform welfare effectively loosens the link between welfare receipt and eligibility for Medicaid. Under the Medicaid reform proposal many more people will lose their assurance of medical coverage. For poor AFDC recipients the loss of cash assistance and health coverage would be devastating.

The House Republican plan keeps as a mandatory group for Medicaid coverage recipients of cash assistance. Yet the details of the proposal would place many recipients at-risk for the loss of coverage. The proposal clearly states that 'certain low income families' namely individuals and members of families who meet current AFDC eligibility criteria related to income and resources would retain Medicaid eligibility. But the proposal goes on to offer states two options to redefine this group:

1. States with high income and resource criteria under current law could lower them to the national average; thus in those states cash assistance recipients would be denied Medicaid coverage.

2. States could link Medicaid eligibility and eligibility for cash assistance under a newly defined State plan under Part A or E (cash assistance block grant or foster care). This provision effectively changes the eligibility criteria from current law to whatever new criteria a state includes in the new state plan. Under this option states could change not only the definition of income and resources but also household filing unit, budgeting and reporting periods, and other non-financial eligibility criteria. This second option allows states to expand or contract the eligible population but any expansions would not incur any additional federal financial participation.

Under the House Republican proposals adult AFDC recipients (except poor, pregnant women) as well as all children aged 13 and older could lose the guarantee if the State opts to either lower Medicaid eligibility criteria to the national average or restrict eligibility for its cash assistance program. In addition, poor families that leave welfare for work or because of increased child support payments will lose the guarantee of transitional Medicaid benefits (the Archer welfare markup document may seek to restore the transitional benefit). Finally, even if the Congress restored the current eligibility rules many members of families subjected to the Federally mandated five year time limit as well as the optional State imposed shorter time limits would lose the Medicaid guarantee.

The numbers presented in the attached table indicate the number of adults and children who will be either placed at-risk to lose their guarantee of Medicaid or lose that coverage under the proposal. These estimates are based upon the current law projections of the size of the AFDC caseload and the characteristics of the recipients in 1994.

Draft: aspe/dto June 11, 1996

In FY 1997 almost 44 percent of all recipients of AFDC will be placed at-risk; only children less than 13 years of age and pregnant women would be certain of continued eligibility. Of the 5.9 million at-risk recipients just less than two million are child recipients aged 13 and over. The remaining 3.9 million at-risk recipients are adults.

The loss of the Transitional Medicaid guarantee would eliminate the guarantee for recipients who leave welfare to work or through increased child support payments. Under current law those who leave for work (adults and their children) and have income below the poverty line are eligible for one year of transitional coverage.

It is estimated that almost 2.2 million recipients would leave welfare for work and be in their first 12 months after exit in the average month in FY 1997. Of these 1.7 million would be eligible for transitional coverage because their incomes are below the poverty line. Under the proposal only the poor children under 13 and pregnant women who be eligible for coverage (note: this eligibility has nothing to do with transitioning off welfare -- these are mandatory groups under the proposal). Thus in FY 1997 780 thousand former recipients would be ineligible for coverage. Of these recipients 25 percent would be poor children aged 13 and over; in 1997 this would mean the loss the Medicaid guarantee for almost 200 thousand children. The total average monthly number of losers would be expected to grow to 830 thousand by the year 2002.. In addition, an unknown number of recipients who leave welfare because of increased child support would lose the Medicaid transitional benefits. In 1994 the Office of Child Support Enforcement reported close to 300 thousand case closures due to increased child support collections. States could, at their option, continue to provide this coverage to those families who leave welfare for work or due to increased child support under the terms of the proposal.

Restoring the link between current AFDC eligibility rules and Medicaid would still leave many families who would be subjected to a time limit of 5 years or less, at State option, with a loss of the Medicaid guarantee. In fiscal year 2002, some 3.2 million recipients could be dropped from the AFDC program if all States imposed a two-year time limit and provided a full 20 percent exemption. Of these recipients 1.2 million would be children aged 13 and older. When the full impact of the federally mandated 5 year limit is felt (assuming states fully utilize the 20% exemption) about 1.7 million recipients, including 700,000 children aged 13 and older, would lose the guarantee to Medicaid coverage.

6/11/96

INDIVIDUALS WHO ARE PUT AT RISK OF MEDICAID LOSS UNDER NEW GOP BILL
(numbers in 1000s)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
TOTAL RECIPIENTS AND WORK LEAVERS	15,584	15,803	16,028	16,224	16,421	16,617	16,817	17,020	17,223	17,426
TOTAL RECIPIENTS AND WORK LEAVERS WHO ARE PUT AT RISK	**6,638**	**6,731**	**6,827**	**6,919**	**6,994**	**7,078**	**7,163**	**7,249**	**7,335**	**7,422**
Adults	4,488	4,552	4,616	4,673	4,730	4,786	4,844	4,902	4,960	5,019
Children	2,149	2,180	2,210	2,238	2,265	2,292	2,319	2,347	2,375	2,403
TOTAL AFDC RECIPIENTS	13,414	13,603	13,795	13,964	14,133	14,302	14,474	14,649	14,824	14,998
TOTAL RECIPIENTS PUT AT RISK	**5,857**	**5,940**	**6,023**	**6,097**	**6,171**	**6,246**	**6,320**	**6,396**	**6,472**	**6,548**
Adult Recipients	3,905	3,960	4,016	4,065	4,114	4,164	4,214	4,264	4,315	4,366
Men	545	553	561	568	575	581	588	595	603	610
Nonpregnant Women	3,360	3,407	3,455	3,498	3,540	3,582	3,625	3,669	3,713	3,757
nonpregnant teen moms < 18 yrs	38	39	39	40	40	41	41	42	42	43
Child recipients (> 13 yrs)	1,952	1,979	2,007	2,032	2,056	2,081	2,106	2,131	2,157	2,182
nonpregnant teen moms < 18 yrs	29	30	30	30	31	31	31	32	32	33
LOSE GUARANTEE DUE TO 5 YEAR TIME LIMIT (20% EXEMPT)*	0	0	0	0	0	0	484	1,444	1,652	1,709
Adult Recipients	0	0	0	0	0	0	268	799	914	945
Men	0	0	0	0	0	0	37	112	128	132
Nonpregnant Women	0	0	0	0	0	0	231	687	786	814
Child recipients (> 13 yrs)	0	0	0	0	0	0	216	645	738	763
LOSE GUARANTEE DUE TO 2 YEAR TIME LIMIT (20% EXEMPT)*	0	0	0	1,268	2,857	3,205	3,307	3,359	3,402	3,443
Adult Recipients	0	0	0	803	1,809	2,030	2,094	2,127	2,154	2,180
Men	0	0	0	112	253	283	292	297	301	304
Nonpregnant Women	0	0	0	691	1,556	1,747	1,802	1,830	1,854	1,876
Child recipients (> 13 yrs)	0	0	0	465	1,048	1,176	1,213	1,232	1,248	1,263
TOTAL LEAVERS FOR WORK (1ST 12 MONTHS)	2,169	2,200	2,233	2,260	2,288	2,315	2,343	2,371	2,399	2,427
LEAVERS FOR WORK WHO LOSE GUARANTEE	**781**	**792**	**804**	**813**	**823**	**833**	**843**	**853**	**863**	**874**
adults	583	592	600	608	615	623	630	638	645	653
children	197	200	203	206	208	211	213	216	218	221

Source: ASPE projections
Note: This does not include families who lose their guarantee because they left welfare due to increased child support.
* States have the option of choosing a time limit shorter than 5 years.

CJ/DA/PP

This does need to be discussed.
I want to hear Jack's view.
We may need a small meeting with us, Jack + Larry's First
GS 6/13

THE WHITE HOUSE
WASHINGTON

June 11, 1998

Bruce/Gene -
Please, in particular, read the "Our thoughts" section. Has much broader implications than just this "100 hour rule" issue. We may want to ask Jack Lew for a principals meeting. Thanks
Chris

TO: Bruce R., Gene S.

FROM: Chris J., Diana F., Jeanne L.

RE: **Resolving the Medicaid "100-Hour Rule" issue**

cc. Elena K., Sally K.

This is an update on an important Medicaid coverage issue that we would like to resolve as soon as possible, but that may be at an impasse. HHS has proposed a regulatory change to the definition of an unemployed parent for Medicaid purposes (i.e., allow alternatives to defining "unemployed" as working less than 100 hours per month). This change gives states the option of allowing two-parent families meeting the other eligibility criteria to qualify for Medicaid. States with pre-welfare reform waivers of this provision say it's important both in their welfare to work efforts and in encouraging two-parent families. However, the Actuaries have estimated that, for the 17 or so states without a pre-welfare reform waiver of this rule, this reg will cost about $850 million over 5 years. OMB, HHS and White House staff all support the policy, and it is an important reg to the Governors. However, OMB is currently insisting that HHS find an offset for its cost since they are uncomfortable with its size. HHS has refused to do so because it is: (1) virtually impossible for OMB and HHS to find this amount in Medicaid (particularly in a way that the States will support), (2) against HHS policy and politically unviable to use Medicare savings to offset Medicaid costs, and (3) an OMB policy that has not been used in other health reg during this Administration.

We would like to get a decision on this issue, one way or the other, for two reasons. First, states and advocates continue to ask for this reg and wonder why it is delayed; and, second, if we decide to go forward with this reg, we would like to announce it at the Family Conference on June 22. We think that OMB and HHS may be trying to work out this issue tomorrow, but think that we ought to weigh in as well, especially if it does not get resolved.

BACKGROUND

"100-hour rule." The proposed regulation would allow states to cover two-parent families that meet other state Medicaid eligibility rules. It would do so by changing an old AFDC "deprivation" requirement that restricted AFDC / Medicaid eligibility to families that include a child who was deprived of parental support or care by reason of death, absence (single parents), incapacity, or unemployment of the parent. The old AFDC regs defined ~~"unemployment" as~~ working less than 100 hours per month. Before welfare reform, 31 states received statewide and another 6 states received substate 1115 waivers of this rule because they thought it overly strict and anti-family. However, because welfare reform locked in place the rules in effect in 1996, states without those waivers want this change in regulation.

Post-welfare reform history. This reg was one of several that were contemplated immediately after welfare reform. In fact, had it been drafted in 1996, its costs probably would have been included in the Medicaid baseline released in January 1997. However, because of the huge regulatory schedule that resulted from welfare reform, this reg was put off. The final rule with comment was signed by Shalala and submitted to OMB on January 30, 1998.

On substantive health and welfare reform grounds, OMB, HHS and White House staff all support this policy. It not only allows states to align their TANF and Medicaid eligibility, but could serve as a way for states to cover low-income parents, should they choose to do so. This could be especially helpful in the tobacco debate.

OMB concerns. Since its submission, OMB expressed concern about the cost of this reg and recommended that HHS use a Medicare offset for this provision. Specifically, they worry about:

- **Spending the surplus**: Since this reg's costs were not included in the post-welfare reform baseline, they would represent an increase to the baseline / decrease in the surplus if not accompanied by an offset. This goes against both the BBA and the President's "Social Security First" pledge.

- **Bad precedent**. This reg's cost are high. Allowing it to be published without an offset could encourage agencies to ignore the cost implications of administrative changes, and could make OMB vulnerable on the Hill, which has become aware of this issue.

HHS reaction. HHS disagrees with OMB for two main reasons.

- **Not a new precedent**. HHS points to the fact that several regs (e.g., change in the timing of SSI payments $10 million, SSI "bucket" reg $1.4 billion over 5 years) that did or could have had cost implications were not required to have offsets.

- **Even if they concede the cost issue, no acceptable options**. HHS thinks that it would be nearly impossible to find a Medicaid administrative offset of this size, and have policy concerns about using non-Medicaid savings -- in particular, Medicare savings. Although HHS support reducing Medicare spending, they are concerned about both enacting them because of the regulation and the political challenge of explaining why a Medicare change is needed for a Medicaid regulation.

As much as they want the reg, they are not willing to come up with an offset for it.

Our thoughts. We believe that this reg is important and should be published one way or another. It would be particularly appropriate for the Family Conference, because it would give the President an opportunity to talk about how he has changed Medicaid from being a program for single mothers to families. It also can help us fight off States desire to use CHIP for adults.

However, we think that there is a bigger issue here. While OMB is right that such a reg could decrease the surplus, the decision to hold regulatory actions to the same budget rules as legislative actions has important ramifications. First, it may result in delays in publishing regs, since agencies may start holding regs with savings so that they can be published at the same time as with regs with cost. Forcing a coupling of regs with savings and costs could cause political as well as policy problems. Second, we are already uncomfortable with the extent to which often extremely uncertain cost estimates influence policy decisions. Given that reg effects are typically smaller and probably more difficult to estimate, we don't think making cost estimates the central concern in whether to publish a reg is good policy. Third, it is only a small step from requiring an offset for a regulation to requiring an offset for other administrative actions (e.g., executive orders, Secretarial initiatives). Should the offset requirement be broadly applied, we are, in essence, placing a new, important restriction on executive authority. And, lastly, at a time when the Congress is rushing to spend the budget surplus, a legitimate question needs to be raised about the advisability of restricting our ability to address priorities administratively, consistent with our legal authority, even if there are cost implications.

We have had preliminary conversations with OMB, and they may eventually give on this reg if HHS promises to find offsets for all future regs. We are hoping to have some news tomorrow and will keep you informed.

BACKGROUND ON THE MEDICAID "100-HOUR RULE"

OVERVIEW. The new "100-hour rule" regulation gives states increased flexibility to offer Medicaid to low-income, working parents. Under previous welfare and Medicaid rules, a two-parent family could only be eligible for assistance if the primary wage earner was unemployed, defined in regulation as working less than 100 hours per month. Because this tended to discourage parents from working and was not applied to single-parent families, a number of states received a waiver of this "100-hour rule" prior to welfare reform. However, states that did not receive such a waiver cannot do so now because welfare reform locked in place the states' eligibility rules as of 1996.

The revision of the regulation allows all states, including those without waivers, to change the 100-hour rule, thus allowing them to cover two-parent, working families. As such, it eliminates a vestige of the old welfare system that provided disincentives against marriage and full time work. Combined with flexibility in setting income eligibility, this provision also enables all states to cover many low-income, two-parent families under Medicaid.

PROBLEM. Historically, Medicaid was an add-on to welfare, so that, in general, only people receiving welfare were eligible for Medicaid. Welfare (prior to reform in 1996) was limited to certain types of families — in particular, single-parent families or two-parent families where the primary wager earner is unemployed. These "deprivation rules" date back to the creation of the Aid to Families with Dependent Children (AFDC) program, which was targeted toward "broken" rather than poor families.

Since President Clinton took office, the inequities of limiting cash assistance and Medicaid to only a narrow group of two-parent families led to changes designed to encourage work and marriage. Rather than using the regulatory definition of "unemployed" under the old welfare law -- working less than 100 hours per month -- many states received waivers to encourage work by considering parents working more than 100 hours a week as "unemployed." As of 1996, 32 states had received such waivers.

Welfare reform in 1996 limited other states from changing the 100-hour rule to allow them to cover two-parent, working families under Medicaid. It replaced it with a rule that states must, at a minimum, offer Medicaid to people who would have been eligible for welfare prior to the law. States could cover additional groups of people, but only if their income or resources were higher -- not if they worked more hours. While states that received waivers of the 100-hour rule prior to 1996 could continue those waivers, the remaining 18 states plus the District of Columbia were locked into their pre-1996 rules.

REVISED REGULATION. To allow all states the flexibility previously offered under welfare waivers, the Secretary of Health and Human Services is revising the regulations at 45 CFR 233.101(a)(1) to permit states to extend Medicaid eligibility to families whose parents would not have met the 100-hour rule contained in the existing definition. This is a final regulation with a 60-day comment period.

Bruce — revised

EFFECTS OF THE CHANGE

The following 18 states (plus District of Columbia) did not, at the time of welfare reform, have statewide waivers of the 100-hour rule:

Alabama	New Hampshire
Alaska	New Jersey
Arkansas	New York
Colorado	North Dakota
Florida	Oklahoma
Kentucky	Pennsylvania
Louisiana	South Dakota
Maine	Virginia
Nevada	Wyoming

States with waivers for only subsets of families (e.g., certain counties; only parents under the age of 21) also can broaden eligibility through this revised regulation.

There are two main benefits of this change. First, it eliminates an anti-work and anti-family vestige of the old welfare system. Instead of rewarding work, the 100-hour rule took away health care from two-parent families who increased their hours at work. And instead of rewarding marriage, it punished single mothers who married and gave preference to single over two-parent families.

Second, the revision allows all states the important option of covering low-income parents. While Medicaid coverage of children has expanded, most states have not been able to extend coverage to their parents because of this rule. This change gives all states the flexibility to give the whole family, and not a fraction of it, health coverage. With this flexibility, approximately 135,000 people could gain Medicaid coverage.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
Medicaid Bureau

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

OCT - 4 1996

WR-Medicaid

Dear State Medicaid Director:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. In order to address implementation issues carefully, we have been working very closely with the joint Federal/State Eligibility Technical Advisory Group (E-TAG). That process is continuing, and will culminate in the issuance of a State Medicaid Manual issuance in December which will address many of the eligibility issues.

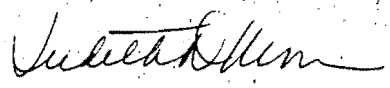
In the meantime, we understand that some States are moving ahead to submit Temporary Assistance to Needy Families (TANF) plans. In such cases, we will presume that you will continue to provide Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants. For administrative purposes, we request that you notify us to that effect. If you are going to make any change to Medicaid coverage of eligibility groups, please submit a State Plan Amendment to do so. Plan Amendments may be submitted to us using whatever format you think appropriate, but providing as much information as necessary to describe the eligibility options you are electing for Medicaid. We are happy to work with you on the details of plan amendments as you proceed with implementation.

Please recognize that many legal immigrants (who might otherwise qualify for Medicaid) entering the country on or after August 22, 1996, are not eligible for Medicaid for five (5) years. However, under Section 402 of P. L. 104-193, States must continue to provide Medicaid eligibility, until at least January 1, 1997, to any qualified immigrant receiving Medicaid on August 22, 1996. States should be aware that Section 402 also permits states to continue coverage for most legal immigrants and to receive Federal matching funds for coverage of these individuals. In any event, States must continue to cover immigrants enrolled in Medicaid prior to August 22, 1996 until the State submits a State Plan Amendment to the contrary.

To sum up, in the absence of submitting a State Plan Amendment, you are expected to continue providing Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants.

We will keep you informed as we develop Federal policy to implement this Act and will issue further policy guidance as soon as possible. Thank you for your cooperation in implementing this program.

Sincerely,



Judith D. Moore
Acting Director
Medicaid Bureau

cc:
All Regional Administrators
All Associate Administrators for Medicaid
Lloyd Bishop, OLIGA
Jennifer Baxendall, NGA
Lee Partridge, APWA
Joy Wilson, NCSL

FACT SHEET #1

LINK BETWEEN MEDICAID AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Prior to enactment of P.L 104-193, the Personal Responsibility and Work Opportunities Act of 1996:

- Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid. (Section 1902(a)(10)(A)(i)(I) of the Social Security Act)

- Families who lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for transitional Medicaid assistance for an additional period of time. (Sections 1902(a)(10)(A)(i)(I) and 1925 of the Social Security Act)

- Various rules of the AFDC program were used to establish Medicaid eligibility for other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.) (Section 1902 of the Social Security Act)

The new welfare reform law eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF) (Section 103 of the new law). However, families who meet the AFDC eligibility criteria prior to welfare reform will be eligible for Medicaid. States are not required to make a complete eligibility determination using all the pre-reform AFDC program rules. This determination is replaced by two basic eligibility requirements:

- The family income and resources must meet the pre-reform AFDC standards (Section 1931(b)(1)(I) of the Social Security Act).

- The pre-reform AFDC deprivation requirement must be met. (i.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.) (Section 1931(b)(1)(A)(ii) of the Social Security Act)

As under pre-reform law, if a family loses Medicaid eligibility because of employment or receipt of support payments or employment and received Medicaid in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits. (Sections 408(a)(11) and 1931(c) of the Social Security Act)

States are permitted to deny Medicaid benefits to adults and heads of household who lose TANF benefits because of refusal to work. However, welfare reform law specifically exempts poverty-related pregnant

women and children from this provision and mandates their continued Medicaid eligibility. (Section 1931(b)(3) of the Social Security Act)

Because the AFDC cash assistance program is eliminated, welfare reform provides that any reference in Title XIX to an AFDC provision or an AFDC State Plan will be considered a reference to the AFDC provision or plan in effect for the State on July 16, 1996, i.e. "pre-reform" AFDC. This effectively freezes the pre-reform AFDC program for all Medicaid eligibility purposes, except that welfare reform also permits States to retain flexibility to change the applicable income and resource methodologies, as follows:

- A State may lower its income standards, but not below the standards it applied on May 1, 1988. (Section 1931(b)(2)(A) of the Social Security Act)

- A State may increase its income and resource standards up to the percentage increase in the CPI subsequent to July 16, 1996. (Section 1931(b)(2)(B) of the Social Security Act)

- A State may also use less restrictive income and resource methodologies than those in effect on July 16, 1996. (Section 1931(b)(2)(C) of the Social Security Act)

Related Fact Sheets:

Link Between Medicaid and SSI Coverage of Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations under Welfare Reform

FACT SHEET #2

LINK BETWEEN MEDICAID AND SSI COVERAGE OF CHILDREN UNDER WELFARE REFORM

Under the new law, the definition of childhood disability is no longer linked to the definition of disability for adults. The reference to "comparable severity" in the old law has been deleted.

The new definition says: (1) an individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months; and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must: (1) discontinue the individualized functional assessment (IFA) for children; and (2) eliminate maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. These changes will result in some children losing SSI, and therefore Medicaid eligibility. However, many of the children affected could still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that determination affects the individual's Medicaid eligibility.

Section 204(a) of the new law provides that SSI payments, for all beneficiaries, including children, may only begin as of the first day of the month following: (1) the date the application is filed or, if later, (2) the date the person first meets all eligibility factors. This is a delay in SSI eligibility in comparison with the old law.

Under Section 211 of the new law, SSA is required to redetermine the eligibility of recipients under age 18 by August 22, 1997. No SSI-eligible child may lose benefits by reason of a redetermination of disability using the new definition earlier than July 1, 1997.

Also under Section 211, SSA is required to send notices to the representative payees of all affected recipients no later than January 1, 1997.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations Under Welfare Reform

FACT SHEET #3

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of Legal Immigrants

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) identifies two categories of legal immigrants: "qualified aliens" and others.

"Qualified Alien" Defined: *A "qualified alien" is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act (INA) including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, an individual who has had his/her deportation withheld, and who has been granted conditional entry. This definition also includes battered immigrants, and/or immigrants who would be indigent without assistance, because their sponsors are not providing adequate support.*

States have the following options to cover legal immigrants, as long as these individuals meet the financial and other eligibility requirements of the program.

Immigrants Residing in the U.S.

States are not required to end Medicaid coverage or eligibility for any "qualified aliens" residing in the U.S. before August 22, 1996. If the State Plan already provides such coverage and eligibility, HCFA will presume the State will continue to provide Medicaid to these individuals, until a State Plan Amendment is submitted to the contrary.

- For immigrants who are "qualified aliens" receiving Medicaid benefits (were enrolled in the State's Medicaid program) on August 22, 1996, States must continue Medicaid coverage until at least January 1, 1997. After that date, HCFA will assume that States are continuing to cover these individuals, unless the State amends its State Plan to discontinue coverage of these individuals.

- For immigrants who are "qualified aliens" residing in the United States before August 22, 1996, but were not enrolled on that date, whether eligible or not, States have the option not to provide Medicaid beginning on August 22, 1996. To do so, the State must amend its State Plan.

- For other immigrants who are not "qualified aliens," Medicaid eligibility was terminated on August 22, 1996 under P.L. 104-193, except for those receiving SSI. For these immigrants, Medicaid eligibility continues until SSA redetermines eligibility (see page 4).

Excepted Groups of Immigrants

There is an excepted group of immigrants to whom the State ***must*** provide Medicaid coverage, provided the individuals are otherwise eligible. The following groups of immigrants are considered part of the excepted group:

- Refugees -- For the first 5 years after entry to U.S. in that status
- Asylees -- For the first 5 years after granted asylum
- Individuals whose deportation is being withheld by the INS -- For the first 5 years after grant of deportation withholding
- Lawful Permanent Residents -- After they have been credited with 40 quarters of coverage under Social Security (based upon their own work and/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited). Members of this group are not excepted if the immigrant arrives in the U.S. after August 22, 1996.
- Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- At any time.

Immigrants Admitted to the U.S. On or After August 22, 1996

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens" newly admitted to the U.S. on or after August 22, 1996. The ban is in effect for the first five years they are in the U.S. in that status, unless the individual is a member of one of the excepted groups. After the five-year ban expires, an immigrant's access to Medicaid is at State option (for those otherwise eligible). For those who have individual sponsors who sign new, legally binding affidavits of support (required elsewhere in welfare reform, beginning no later than February 1997), States must deem the income and resources of the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when determining the immigrant's eligibility for Medicaid. For most immigrants, deeming will not take effect for five years.

Individuals who have been credited with 40 quarters of work without receiving assistance are not considered an excepted group under these provisions.

Sponsor to "Qualified Alien" Deeming of Income and Resources

There is no deeming of sponsors' income and resources for individuals who entered the U.S. under the old affidavits of support. The new deeming requirements apply to Medicaid in the following situations:

- Deeming applies only to sponsors signing new, legally binding affidavits of support.
- The sponsor's and sponsor spouse's income and resources will be counted when determining the income and resources available to the immigrant they sponsor.
- Deeming applies only to immigrants who are sponsored by individuals.
- Under the omnibus appropriations amendments, deeming does not apply to battered immigrants or to those who would be indigent, defined as unable to obtain food and shelter without assistance, because their sponsors are not providing adequate support.
- Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
- Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Provided they meet the financial and categorical eligibility requirements, both qualified aliens and non-qualified aliens continue to be eligible for emergency services under Medicaid.

SSI/ Medicaid Connection for "Qualified Aliens"

Other provisions of welfare reform ban receipt of SSI cash benefits for both current and new otherwise eligible " qualified aliens," unless they are a member of one of the excepted groups listed above.

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. The Social Security Administration must redetermine the SSI eligibility of all immigrants within one year of enactment. Upon redetermination, the immigrant may lose cash assistance if he/she is not a member of one of the above excepted groups.

States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that termination affects the indvidual's eligibility for Medicaid. Those losing or barred in the future from receiving SSI cash benefits will find their Medicaid benefits affected in the following ways:

- A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would automatically continue Medicaid for "qualified aliens" who fit into those groups.

- A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to provide coverage for non-cash SSI-related groups. HCFA is exploring options to permit States to do this as simply as possible.

In addition, a State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.).

An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and has found that the individual does not qualify for Medicaid by any other means.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and Coverage of SSI Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

FACT SHEET #4

INCREASED FEDERAL MATCHING RATES FOR EXTRA ADMINISTRATIVE COSTS OF ELIGIBILITY DETERMINATION UNDER WELFARE REFORM

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. Section 114 of the law (Section 1931(h) of the Social Security Act) provides a special fund of $500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

The normal FFP rate for States' administrative costs for eligibility determinations in the Medicaid program is 50 percent. However, under this new law, the Secretary is given discretion to increase the FFP rate above 50 percent, up to a fixed national cap of $500 million for this enhanced funding. This enhanced funding is for extra administrative costs applicable to the increased cost of eligibility determinations due to welfare reform.

National Limitation on Total Funding

The total Federal funds available for enhanced match are limited to $500 million.

Time Limitations

The $500 million is available nationally for expenditures during the Fiscal Years 1997 through 2000. For each state, however, the enhanced funding is available for only the first 12 calendar quarters in which a State's Temporary Assistance to Needy Families (TANF) program is in effect after August 21, 1996.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and Coverage of SSI Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996