

MEMORANDUM

February 18, 1997

TO: Gene Sperling
FR: Chris Jennings and Jeanne Lambrew
RE: Background on the Workers' Between Jobs Initiative

Attached are our summary documents on the Workers' Between Jobs Initiative that you may find useful for your meeting with Union leaders tomorrow. They include: (1) a two-page summary of our initiative; (2) talking points on the initiative and who will be helped by it; (3) q&a's that were originally written to answer criticisms from Senator Domenici; and (4) a more detailed analysis of the problems that dislocated workers and their families have with regard to health care coverage.

There are a number of policy issues that have not yet been fully resolved. We hope to get closure on these outstanding issues in the next week. However, we believe that you will find more than enough information on this initiative in these documents.

We hope you find this information useful. Please feel free to call Chris at 6-5560 with any questions.

HIGHLIGHTS OF THE PRESIDENT'S INITIATIVES TO MAINTAIN AND EXPAND WORKERS' COVERAGE

Because most Americans have employment-based health insurance, health care coverage is often jeopardized for workers who change jobs. In fact, over 50 percent of the uninsured lost their health insurance due to a job change. Many of these uninsured Americans are the spouses and children of workers. The President's initiative will provide temporary premium assistance to families with workers who are in-between jobs. For millions of these workers and their families this assistance could make it possible for them to maintain their health care coverage while looking for another job. This initiative is fully paid for within the President's FY 1998 balanced budget plan. In addition, to assist small businesses - which often have more difficulty providing and maintaining health care coverage for their workers -- the President has proposed to help States create voluntary purchasing cooperatives.

Funding

Invests \$9.8 billion over the budget window and is paid for in the President's FY1998 balanced budget.

Eligibility

Helps an estimated 3.3 million Americans in 1998, including about 700,000 children.

- A full subsidy would be provided up to 100% of the poverty level for and would be phased out at 240% of the poverty level.
- To assure that limited federal dollars are cost-effectively targeted, individuals who are eligible for Medicare, Medicaid or who have an employed spouse with coverage, are not eligible for this program.
- While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$30,000, for a family of four.

Coverage for Families of Workers Who Are In-Between Jobs

Helps to assure that Kassebaum-Kennedy protections against pre-existing conditions are not placed at risk because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose much of their income.

Gives States the flexibility to provide coverage in ways that best meets the needs of their populations. States would have flexibility to administer their own programs, (e.g., COBRA, a private insurance product, Medicaid, or an alternative means of coverage).

Voluntary Purchasing Cooperatives

Small businesses have more difficulty providing health care coverage for their workers because they have higher per capita costs due to increased risk and because of extraordinarily high administrative costs.

The President's budget will make it easier for small businesses to provide health care coverage for their employees, by allowing them to band together to reduce their risks, lower administrative costs, and improve their purchasing power with insurance companies.

His budget proposes to empower small businesses to access and purchase more affordable health insurance through the use of voluntary health purchasing cooperatives. This will be accomplished by providing \$25 million a year in grants that States can use for technical assistance, by setting up voluntary purchasing cooperatives, and by allowing these purchasing cooperatives to access to Federal Employees Health Benefit Plans.

HEALTH CARE COVERAGE FOR FAMILIES WITH WORKERS WHO ARE IN-BETWEEN JOBS

This initiative for families with workers who are in-between jobs is a carefully constructed, targeted and paid for program that builds on the Kassebaum-Kennedy law (The Health Insurance Portability and Accountability Act of 1996). It would provide temporary health insurance premium assistance for workers who are in-between jobs and their families and would help an estimated 3.3 million Americans in 1998, including 700,000 children.

Health Insurance is Often Jeopardized When Workers Change Jobs.

- **Most Americans have employment-based health insurance.** Nearly 148 million Americans (64% of the non-elderly civilian population) receive their health insurance from an employment-based plan.
- **Workers with job changes are more likely to be uninsured.**
 - Over 50% of the uninsured lost insurance due to a job change. Many of these are the spouses and children of the worker.
 - Over one-third of workers who left an insured job, became unemployed, and received unemployment insurance, were uninsured.
 - Workers with job changes are more than three times as likely to have gaps in insurance than continuous workers.
- **These workers often cannot afford health care coverage.**
 - For most workers in-between jobs, health insurance is accessible (through COBRA Continuous Coverage). However, the costs of health insurance coverage presents a significant barrier for many Americans who are in-between jobs.

The President's Initiative for Families of Workers Who Are In-Between Jobs

- **Provides temporary premium assistance for up to six months for unemployed workers who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own.**
- **Assures that Kassebaum-Kennedy protections against pre-existing conditions are not placed at risk** because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose much of their income.

- **Gives states the flexibility to provide coverage in the way that best meets the needs of their populations.** While states have the flexibility to design their own programs, this initiative is targeted only to those who would not otherwise have health care coverage.
- **Costs approximately \$2 billion a year and is paid for in the President's balanced budget.**

Who This Initiative Helps

- **Helps an estimated 3.3 million Americans in 1998, including about 700,000 children.**
- **Strengthens the safety net for middle-income, working Americans** in an increasingly mobile workforce.
 - While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$30,000, for a family of four.
 - To assure that limited federal dollars are cost-effectively targeted to those most in need, only families up to 240% of poverty are eligible for this population.

WORKERS' TRANSITION HEALTH CARE INITIATIVE

The Workers' Transition Health Care Initiative is a carefully constructed, targeted and paid for program that builds on the Kennedy-Kassebaum law (The Health Insurance Portability and Accountability Act of 1996). It would provide health insurance premium assistance for an estimated 3 million Americans, including 700,000 children. According to the September 1996 Lewin Group study, the cost of health insurance coverage presents a significant barrier for many people who are in between jobs. In fact, less than 20 percent of workers elect to use COBRA, which allows the unemployed to keep their old insurance policy while looking for another job. The Workers' Transition Health Care Initiative:

- Provides temporary premium assistance for up to six months for those who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own.
- Assures that the Kennedy-Kassebaum protection against pre-existing conditions are not placed at risk because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose all or much of their income.
- Strengthens the safety net for middle-income, working Americans in an increasingly mobile workforce. While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$31,200, for a family of four. However, the 240% of poverty cap on assistance assures that limited federal dollars are cost-effectively targeted to those most in need.
- Gives states the flexibility to provide coverage in the way that best meets the needs of their populations. While states have the flexibility to design their own programs, this initiative is targeted only to those who would not otherwise have health care coverage. For example, individuals who are in between jobs that have access to insurance through a spouse whose employer contributes at least 50% of the cost of the premium are not eligible.
- Costs approximately \$2 billion a year and is paid for in the President's balanced budget.

QUESTIONS AND ANSWERS

Question: Isn't this just another open-ended entitlement that will be much more expensive than you assume?

Answer: The Workers' Transition Health Care Initiative is a capped entitlement to states, meaning that the federal costs can never exceed the amount specified in the legislation. Also, our analysts developed cost estimates for this program using conservative assumptions about the number of people who will participate in the program and how much health care coverage would cost per beneficiary.

Question: Aren't your estimates a bit unrealistic given the fact that this new generous benefit will cause more people to stay unemployed for the six month duration they are eligible for this subsidy?

Answer: The likelihood of people turning down a job simply so that they can keep a modest, time-limited health insurance subsidy are almost none. The vast majority of people would rather start a new job as soon as possible, even if it means giving up premium assistance for their health insurance. Our current unemployed insurance program (UI) provides evidence that most Americans, when given the option, choose work over a modest government benefit. Although UI coverage is available for 24 weeks, most leave the program after less than 17 weeks. Because the health insurance premium benefit is only \$240 a month, it would be even less likely for people to give up a job for this more modest benefit. However, extremely conservative estimates were used, including the unlikely assumption that some people would unwisely delay re-employment for a period of time.

Question: What happens if there is a recession?

Answer: This program gives states the flexibility to allow for changes in the unemployment rate. States are allowed to retain funds in low unemployment years to offset increased costs in higher unemployment years. States are given the flexibility to design a program that meets the needs of a changing economy. This proposal would also use a small portion of appropriations to establish a Federal loan fund that states could access in times of need.

Question: What are the income limits for this health insurance premium support?

Answer: Families with incomes below poverty (\$15,600 for a family of four) would get full assistance covering their premiums. The premium assistance would be phased out up to 240% of poverty, or a \$37,440 family income, for a family of four. However, since eligibility is determined on current monthly income, many families who previously had higher incomes and have little to none because of unemployment would be eligible.

Question: Why are you proposing a program that helps people who were previously insured but ignores the millions of Americans who still lack health insurance?

Answer: This program will help millions of Americans keep their health insurance. According to the Lewin Group study, the cost of coverage is a significant barrier for workers who are in between jobs. And while workers who are eligible for COBRA often cannot afford the cost of keeping their coverage, workers who were employed in firms with under 20 people are not even eligible for COBRA, so they must try and enter the difficult and expensive individual market. The Workers' Transition Health Care Initiative will give these workers access to insurance and the means to pay for it while they look for their next job.

This initiative, of course, does not resolve all of the problems in our current health care system. It will, however, provide health insurance for 3 million Americans, including 700,000 children each year. And it builds on the step-by-step approach the President is committed to pursuing.

Question: Is this another big government health care proposal?

Answer: No. This initiative is a limited demonstration that is phased out after four years. At that time, the Congress and the President can decide if it is an effective way to help Americans who are in between jobs keep their health insurance. This proposal is also already paid for in the President's balanced budget. Furthermore, this idea also has enjoyed longstanding bipartisan support. As *The Washington Times*, reported on September 6, the Dole Campaign has made clear that Senator Dole proposed a similar idea ten years ago as Senate Minority Leader.

Question: The Republicans on the Senate Budget Committee estimate that subsidizing health insurance for the full six months would cost taxpayers between \$15 and \$22 billion over six years. How do you justify your own estimates?

Answer: In their estimate, the Republican Budget Committee assumes that every individual who participates in this program will receive benefits for the entire six months of eligibility. It is ridiculous to expect that all of these workers would pass up a job simply to get this benefit for the maximum amount of time. This has never been the case with unemployment insurance and there is no reason to expect that people would remain unemployed for this even more modest benefit. Their analysis really has no bearing on this policy.

Question: The proposal mysteriously terminates in the year 2002, presumably because extending beyond 2002 would push the President's budget plan even farther out of balance."

Answer: The President's *demonstration* program is intended to determine if providing assistance to workers between jobs is a cost-effective method to assuring that individuals and their families do not lose insurance coverage while they are in between jobs. Like all other demonstration programs, the program is intentionally designed to end at a specified date. At that time, if the program is successful, Congress and the President are free to extend the demonstration or continue it as a permanent program. Ironically, this is the same mechanism that Senator Domenici himself used in the mental health parity initiative that the President supported.

Question: The Republican Budget Committee cites a provision in COBRA 1985 called 'continuation coverage' that allows the unemployed to buy into their former employer's health plan for up to 18 months while looking for another job. They then conclude that the problem, [for the unemployed], is "not a loss of health insurance, but a loss of income."

Answer: For most workers, a loss of income means a loss of health insurance. According to the Lewin Group study, less than 20 percent of eligible workers elect to use COBRA, and the cost of health insurance coverage is often a formidable barrier for those who do not. The Workers' Transition Health Care Initiative is designed to provide premium assistance to workers in between jobs, so that they do not have to forgo their health insurance while they are searching for a new job. It is important to note that firms with fewer than 20 workers do not have to provide COBRA to their former workers. For these workers, without some type of assistance, they will undoubtedly lose their health coverage.

Question: The Republican Budget Committee has asked why we don't just give the unemployed cash? They state that 'if health insurance is needed, the cash can be used to pay for COBRA continuation coverage. If health insurance is available (maybe through a spouse), the cash could be used to pay for food, housing, education, or job training.' What is wrong with this idea?

Answer: The President's proposal gives states the flexibility to provide coverage through COBRA or other private insurance. If a state shows they can provide cash to participants and still assure that participants have health coverage, then the Secretary of Health and Human Services can approve the state's program. However, States must ensure that they are providing this benefit to those individuals who would not otherwise have access to health insurance. For example, if an individual can receive health care coverage through their spouse, then they are not eligible to receive benefits from this program. States must demonstrate that the money they spend is targeted to meet the goals of this program: to help provide health care coverage for those who would otherwise lose their insurance.

Question: The Republican Budget Committee claims that the Administration is proposing to tax workers (or increase deficits) to subsidize non-workers. Is that true?

Answer: Absolutely not. The President's proposal is a part of his balanced budget proposal. As such, the costs are offset by savings in other programs. The Administration has not proposed to tax workers nor increase the deficit to pay for this program.

Question: It also states that while the President's rhetoric may lead people to believe that he is promising they will have health insurance for six months if they lose their job. In reality, he says 'up to six months'

Answer: Under the President's plan, individuals will be eligible to receive benefits for six months, if necessary. The vast majority of the people who participate in this program will not need to receive the benefit for the entire six months, as they will find a new job before they reach the six month limit.

Uninsured, Unemployed Workers and their Families: The Problem and Policy Options

Overview

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These families pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years' worth of premium payments is lost. They have to cover their health care costs alone at a time when they no longer have a major source of income. Worse, for families with an ill child or a worker with a chronic condition, the loss of health insurance while between jobs can make it financially impossible to regain coverage. This paper outlines the scope of this problem and policy options that help reduce it.

More People Experience Job Transitions

In today's economy, an increasing number of Americans will at some point lose their jobs. While the unemployment rate remains low and job creation remains high, the fast-moving economy has resulted in rapid job turnover and job elimination. In a *New York Times* article on the topic, economist Paul Krugman wrote, "What economists call 'labor market flexibility' is a euphemism for a certain amount of brutality. But it seems an unfortunate price we have to pay for having as dynamic an economy as we do." (Lohr, 1996).

About 9.4 million Americans (8% of all workers) lost their jobs due to plant or company closure, insufficient work, or elimination of their positions between January 1993 and December 1995. This number is about the same as in the early 1990s, when there was a recession, and is an increase from 5.9 million displaced workers between 1989 and 1991. Increasingly, these are white collar workers. While about 7 in 10 of the displaced workers were reemployed, more than half did not receive written advance notice of their job termination and probably spent time unemployed between jobs. Less than half of displaced workers were reemployed in full-time jobs with earnings the same or higher (USDL, 10/25/96).

Job loss and transitions do not affect a small subset of the population. In 1995, over 15 million American workers received unemployment compensation at some point (USDL, 12/17/96). An estimated one out of every four workers will make an unemployment claim once over a four year period. (Myer & Rosenberg, 1996). These workers' unemployment affects a larger number of people, including spouses and children. In a recent poll, one in two people were somewhat or very concerned that someone in their household would be laid off in the next two or three years (Lohr, 1996).

Changing Jobs Leads to Changing Insurance

In the United States, health insurance is usually linked to employment. Nearly 148 million (64% of the nonelderly, civilian population) receive health insurance through an employment-based plan (EBRI, 1996). About half of this number (76 million) are the workers themselves; the other half includes spouses and children gaining coverage through the worker's plan.

Since health insurance is often employment based, change in employment is a major reason why people lose health insurance. About 42% of workers with one or more job interruptions experienced at least a month without health insurance between 1992 and 1995. This compares to only 13% of full-time workers without job interruptions (Bennefield, 1996). According to one study, 58% of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage (Sheils & Alecxih, 1996). This affects family as well as workers: nearly 45% of children who lose their health insurance do so due to a change in their parent's employment status (Sheils & Alecxih, 1996).

The Unemployed are Often Uninsured

In 1995, about 16 million of the 40 million uninsured were nonworkers (8.7 million), part-year workers and their dependents (3.0 million) and full year workers and dependents with some unemployment (4.4 million) (EBRI, 1996). This includes people who are out of the labor force, do not receive unemployment compensation, and/or did not receive insurance on their last job. This number is a point-in-time estimate; since unemployed workers usually spend only part of the year between jobs, this snapshot only captures some of the temporarily unemployed and uninsured.

While only a minority of the total uninsured, the unemployed are more likely to be uninsured than the rest of the population. Three times as many uninsured were unemployed, compared to the proportion of all adults who were unemployed and looking for work (Klerman, 1995). Over one-third of workers who left an insured job, became unemployed, and received unemployment compensation also became uninsured (Klerman, 1995). This is twice the proportion of uninsured in the general population.

Policies and Proposals for Uninsured, Unemployed Families

Three sets of policies exist today that assist uninsured, unemployed families. Additionally, several have been proposed to address the gaps left by these policies.

COBRA. The 1986 Consolidated Omnibus Reconciliation Act (COBRA) allows most employees to purchase health coverage from their former employer for up to 18 months

after their employment ends.¹ The employee must pay the full premium for this coverage (up to 102% of the group rate). Given the high premiums in the individual market and the possibility of denied coverage for pre-existing conditions, these premiums are probably the lowest that most unemployed, uninsured workers and their families can find.

Most researchers agree that COBRA has improved health coverage among the unemployed. About 20 to 30% of all eligible take the option (Flynn, 1992; Klerman, 1995; Berger, Black & Scott, 1996). In part, these rates underestimate COBRA's assistance since many of the unemployed join the health plans of spouses with employer-based insurance. When looking only at the unemployed with no access to spousal coverage, the rate of COBRA coverage increases to over 40%. Additionally, when only the unemployed who receive unemployment compensation are examined, 43% appear to have taken COBRA coverage (Klerman, 1995). On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods (Gruber and Madrian, 1994; Klerman, 1995; Berger, Black & Scott, 1996).

One concern about the policy, however, is its use by low-income unemployed. The difference in take-up rates for low-income people is significant: only 15% of eligible unemployed with income below \$25,000 participated in COBRA and over two-thirds remained uninsured. This compares to a participation rate of 33% for unemployed with higher income, and an uninsured rate of 33% (Berger, Black & Scott, 1996).

Medicaid. Three Medicaid eligibility provisions help unemployed, uninsured families. In the 1988 Family Support Act, states were required to extend eligibility to two-parent families whose principal wage earner is unemployed (the Aid to Families with Dependent Children Unemployed Parent program (AFDC-UP)). To qualify, the worker must have worked a certain number of quarters or be eligible to receive unemployment compensation. In OBRA 1990, Medicaid eligibility was broadened to cover all poor children and pregnant women. To the extent that the unemployed, uninsured are poor, their children may be covered by Medicaid. Additionally, states have the option to pay for COBRA coverage for poor workers whose firm had 75 or more employees; few states have taken this option (Congressional Research Service, 1993). It is not known how many people have been covered through the AFDC-UP and COBRA coverage options.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the

¹Employees of firms with fewer than 20 workers or who were terminated from their jobs under certain circumstances are not eligible for COBRA.

Kassebaum-Kennedy bill), makes it easier for workers and their families to maintain health insurance coverage. Under HIPAA, health plans are prohibited from imposing new pre-existing condition exclusions for enrollees with more than 12 months of previous continuous coverage.² Preexisting conditions are limited to 12 months and can be imposed only for conditions diagnosed or treated within the 6 months prior to enrollment.

However, HIPAA only helps those who maintain their health care coverage between jobs. If a worker loses coverage for more than sixty-three days while unemployed, these protections are no longer available. Since the Act's provisions begin in 1997, its implications for the unemployed and uninsured have yet to be determined. However, it is clear that it is extremely important that Americans are able to maintain their health care coverage while they are looking for a new job to benefit the guarantees in HIPAA.

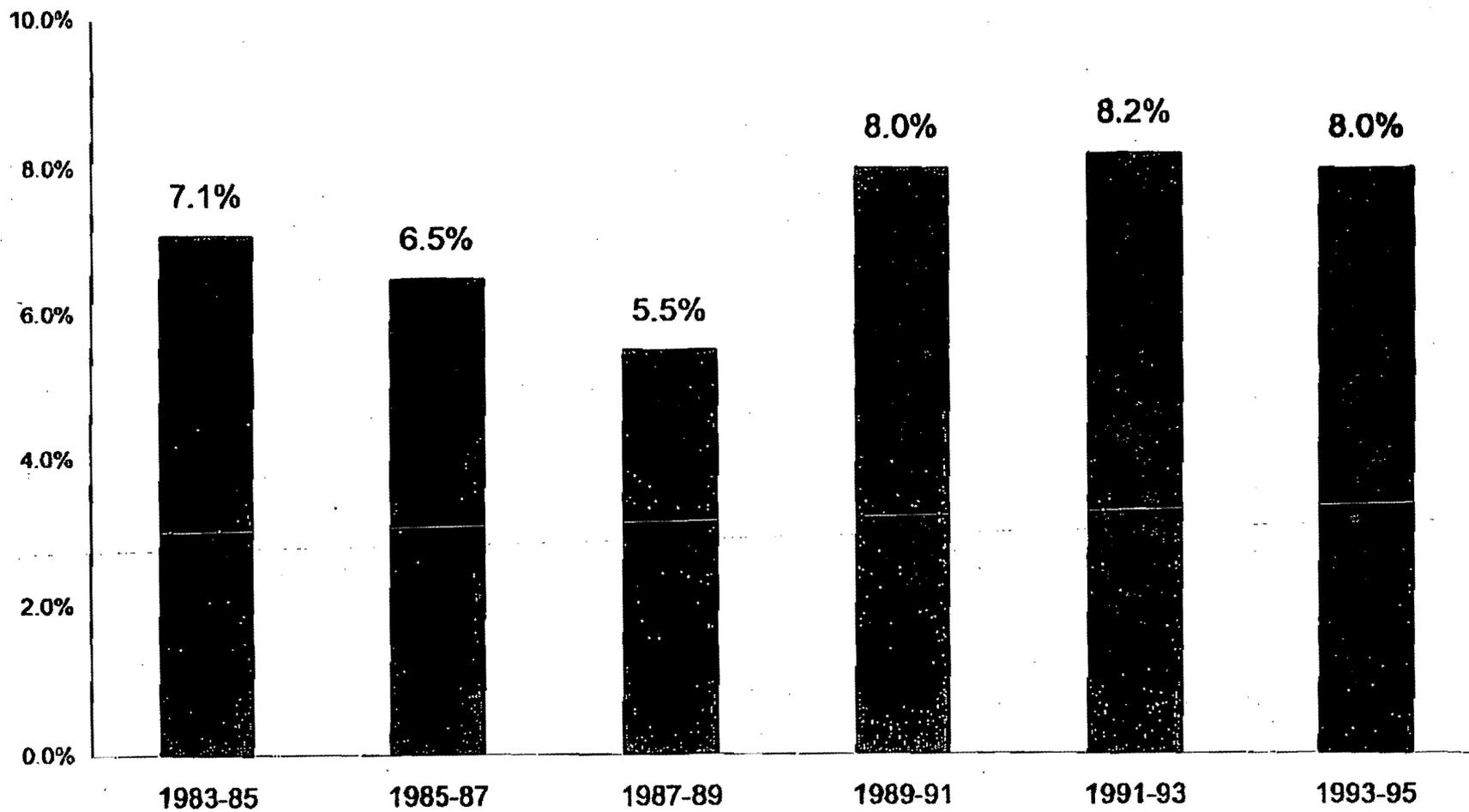
Administration's Proposal. While COBRA, Medicaid, and HIPAA offer access to insurance for uninsured, unemployed families, the question of affordability remains largely unaddressed. Workers who are temporarily unemployed often are not qualified for Medicaid and cannot afford to buy into COBRA. At a time when they have lost a major source of income, they have to pay their health care costs alone. They (and their family) have no protection against the costs of a catastrophic illness, and they are unlikely to receive important preventive services which help avoid costlier services later.

Consequently, the Administration has put forth a new proposal to help workers who are between jobs. This program would provide temporary premium assistance for people who previously had health insurance through their employer, are in between jobs, and cannot afford COBRA or other coverage on their own. Families with income below poverty are eligible for a full subsidy, while families with income up to 240 percent of poverty can receive a partial subsidy for a basic benefits package. Only workers and dependents who receive unemployment compensation, do not have access to health insurance through a spouse, and are not eligible for Medicaid qualify for assistance. The program would be run as a capped entitlement to states, who would design the operation of the program. The Office of Management and Budget (OMB) estimates that this initiative will cost about \$2 billion a year [pending final budget decisions].

According to Administration analysis, over 3 million people, including 700,000 children, would participate in this program in 1997 (if it were fully implemented in that year). About 85% of these participants would be middle class (defined as being in the second through fourth income quintile).

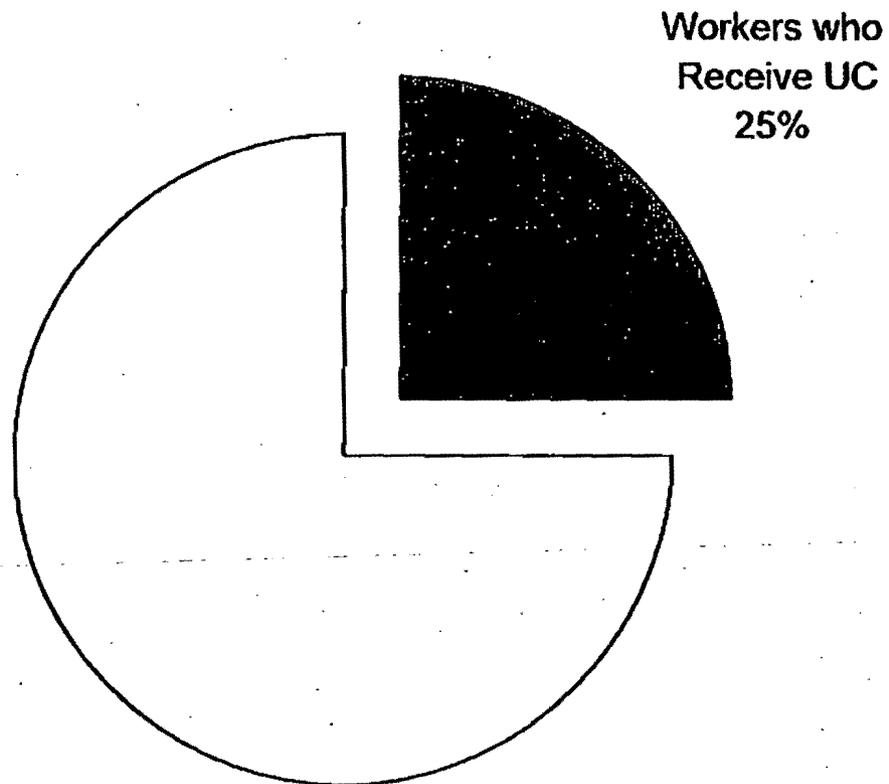
²Enrollees who have up to twelve months of health care coverage are subject to pre-existing conditions for 12 months minus the number of months they have previously been insured.

Percent of Workforce with Permanent Job Loss Remains High



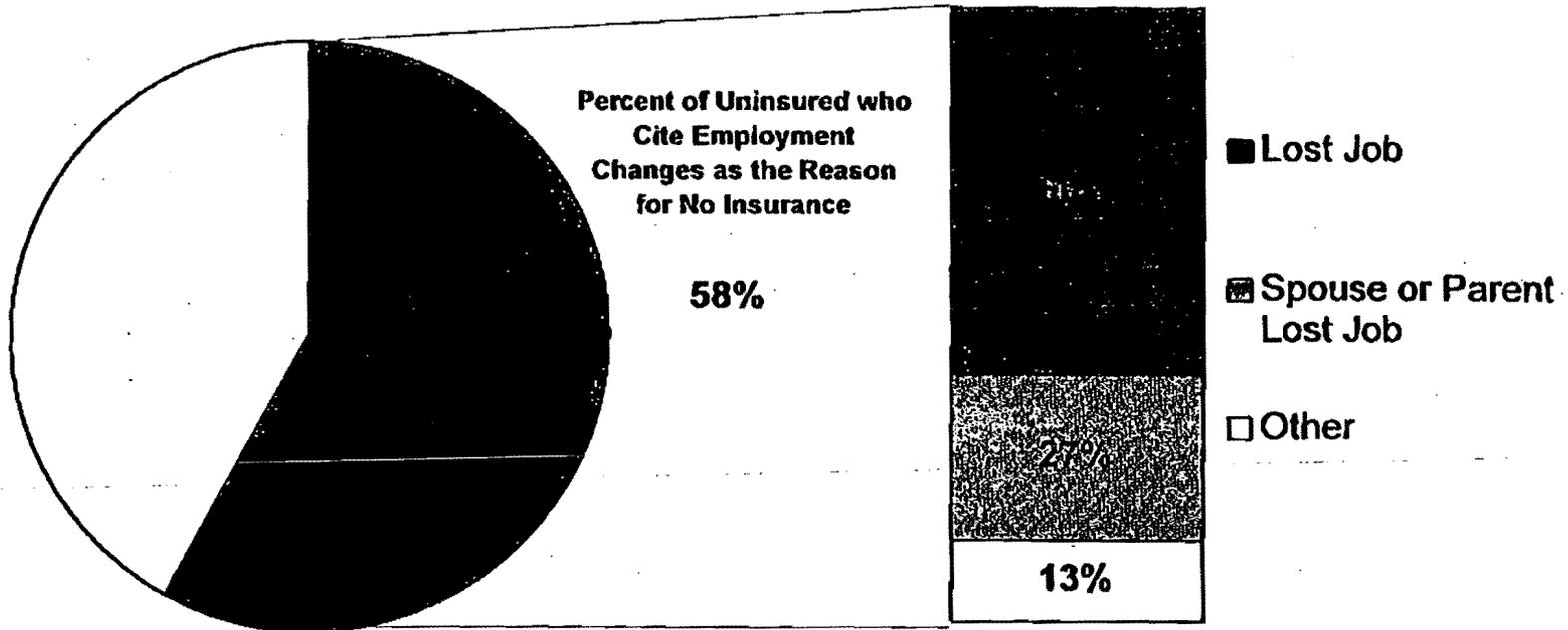
Source: U.S. Department of Labor, Bureau of Labor Statistics (1996).

Nearly One in Four Workers Receives Unemployment Compensation over a 4-Year Period



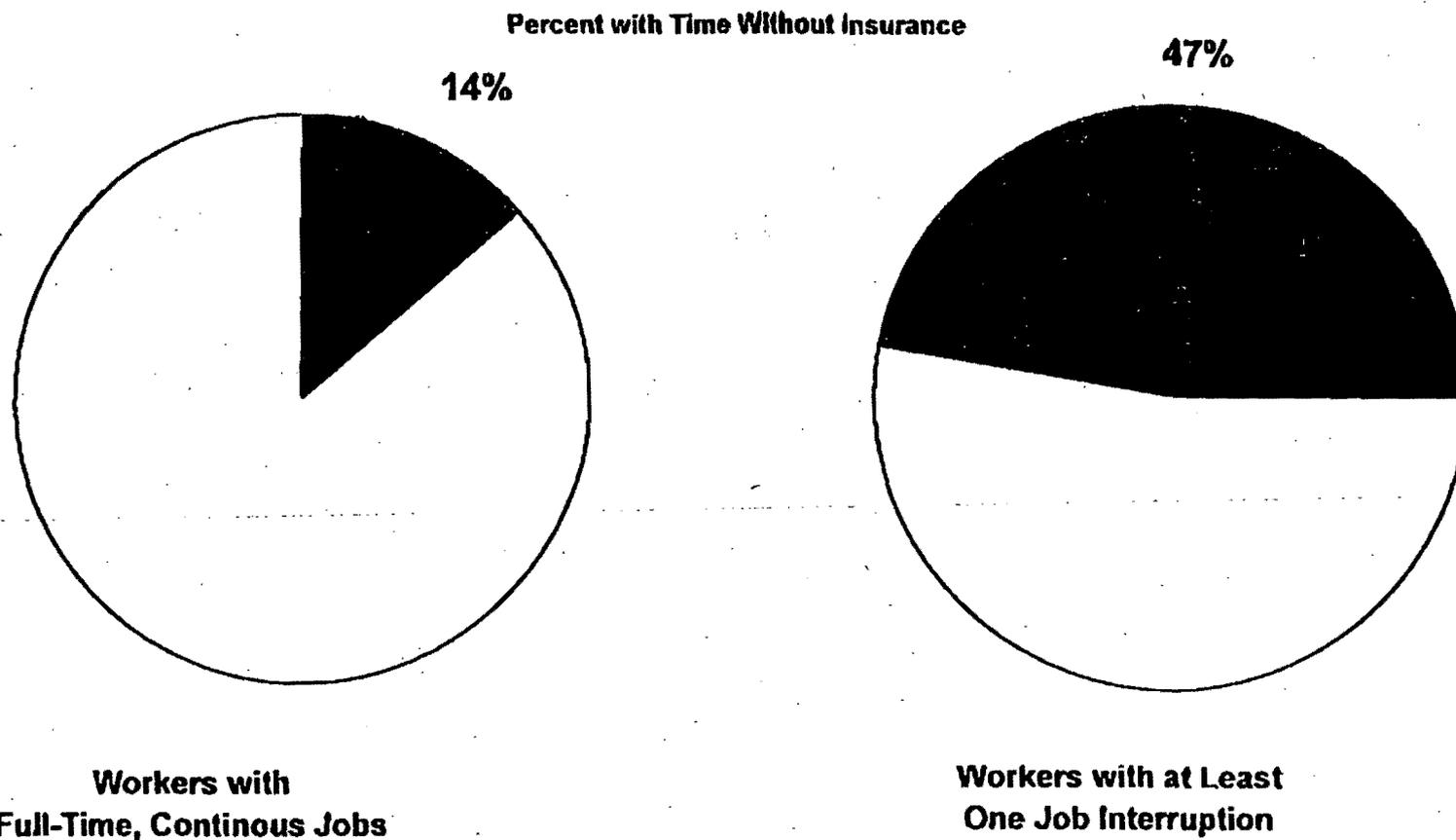
Source: Myer & Rosenberg (1996). Repeat Use of Unemployment Insurance.

Changes in Employment Cause Most Loses of Employer-Based Health Insurance



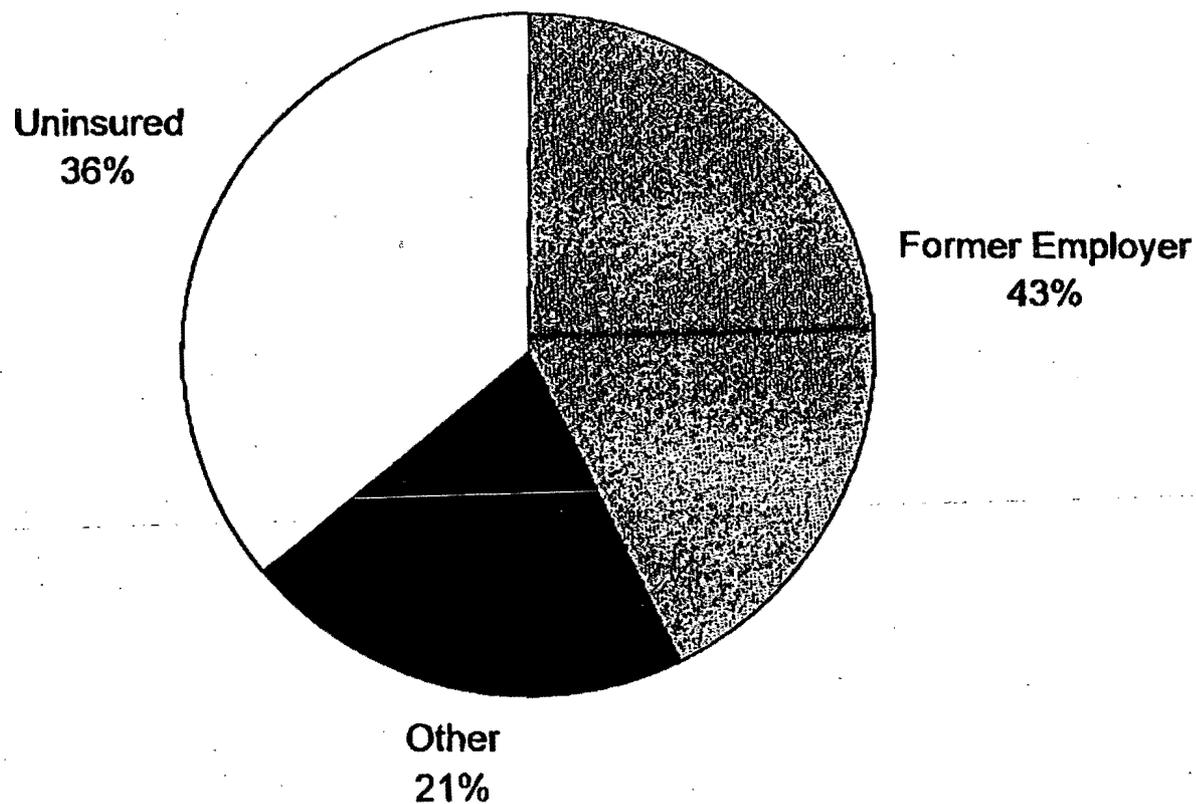
Source: Sheils & Alexih (1996). Recent Trends in Employer Health Insurance Coverage and Benefits.

Workers With Job Transitions Are More Likely to Experience Gaps in Health Insurance



Source: Bennefield, 1996: Who Loses Coverage and for How Long? US Dept. of Commerce.

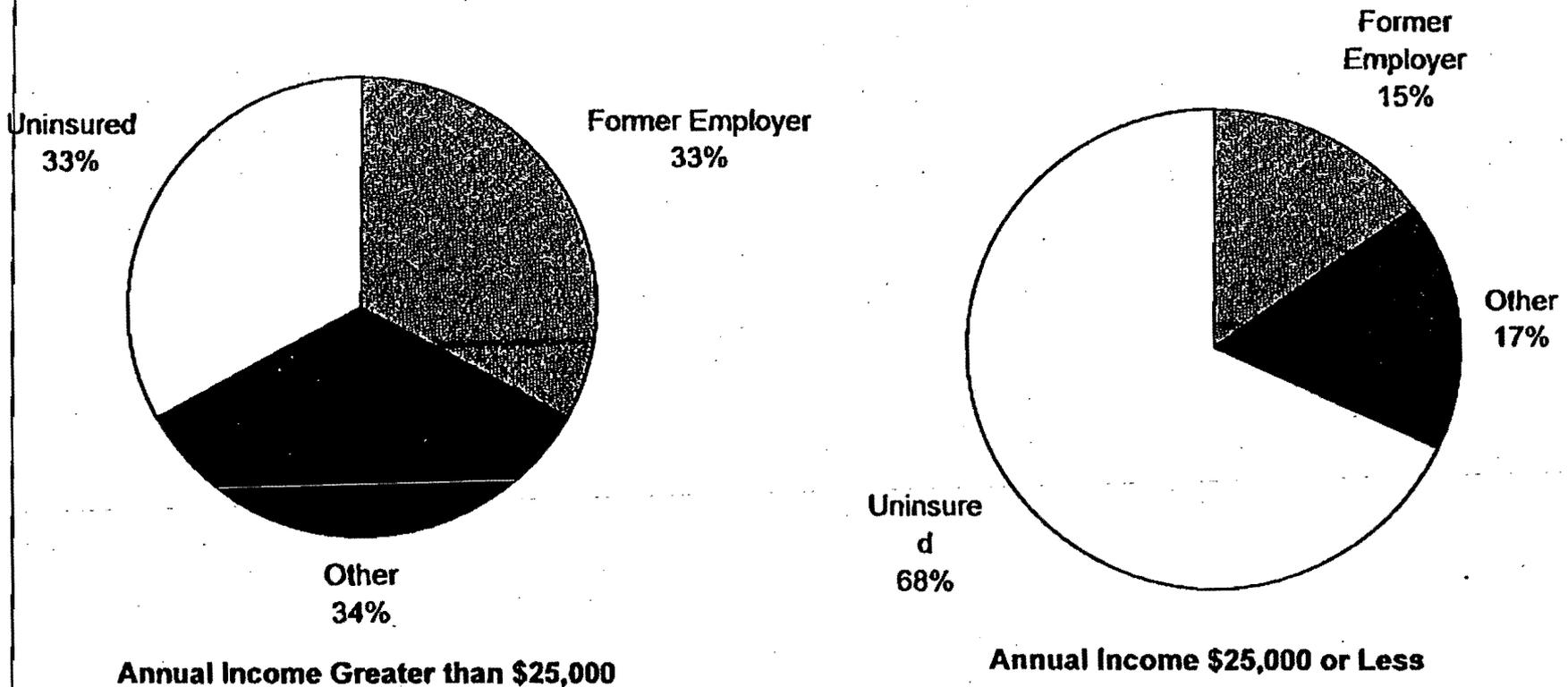
Health Coverage of Workers who Leave an Insured Job, Become Unemployed, & Receive Unemployment Compensation



Note: Former employer usually means the person participated in COBRA
Source: Klerman (1995). Health Insurance for the Unemployed: An Options Paper.

Low-Income Unemployed are Less Likely to Be Insured

Health Insurance Coverage of COBRA-Eligible Unemployed



Note: Former employer usually means the person participated in COBRA
Source: Berger, Black & Scott (1996). Health Insurance Coverage of the Unemployed.

Medicaid
(outlay savings in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	5-Year Savings	10-Year Savings
Medicaid savings	--	-0.3	-2.5	-5.1	-7.1	-9.1	-11.4	-13.7	-16.5	-20.0	-23.8	-24.1	-109.5
Medicaid investments	--	0.0	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	1.1	3.0
Medicaid, net	--	-0.3	-2.3	-4.8	-6.8	-8.8	-11.1	-13.3	-16.1	-19.6	-23.4	-23.0	-106.5

(Numbers may not add due to rounding)

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Description

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• Include ~~\$24.1~~ ^{XXS.C.} billion in gross Medicaid savings over five years (net of Part B premium interaction), linked to (but not including the costs of) the children's health and welfare reform proposals

• Gross savings derived from per capita cap and reduced disproportionate share payments ^{and new enhanced flexibility} ~~(was open to other different~~ approaches to budgeting ~~as well as to differential growth rates.~~

• Gross savings offset by \$1.1 billion in additional Medicaid spending in Puerto Rico and the District of Columbia (and other technical changes), for net savings of \$23.0 billion (excluding children's health and welfare reform)

• Include provisions to allow States more flexibility in managing Medicaid program, including repeal of Boren Amendment, converting current managed care and home/community-based care waiver process to State Plan Amendment (with appropriate quality standards), and elimination of unnecessary administrative requirements

• The gross Medicaid savings do not reflect the health care investments for children's coverage or the welfare reform adjustments

May 1, 1997

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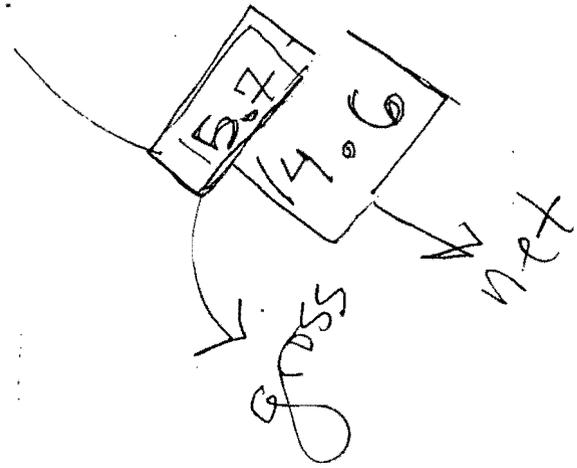
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HIGHLIGHTS OF THE PRESIDENT'S MEDICAID REFORM PLAN

Medicaid Savings and Investments

The President's plan saves approximately \$9 billion net of new investments over 5 years.

Through a combination of policies to reduce and target spending on disproportionate share hospitals (DSH) more effectively and establish a per-beneficiary limit on future Medicaid growth, the plan would save \$22 billion over five years.

Roughly two-thirds of the savings comes from a reduction in Disproportionate Share Hospital (DSH) payments and roughly one-third from the per capita cap.

In addition, the President's plan invests \$13 billion in improvements to Medicaid, including health initiatives to expand coverage for children, changes to last year's welfare reform law, and new policies to help people with disabilities return to work.

Guarantee of Coverage

The 37 million children, pregnant women, people with disabilities, and older Americans who are currently covered by Medicaid would retain their Federal guarantee of health care coverage for a meaningful set of benefits.

Per Capita Cap

Even though the overall Medicaid baseline has fallen over the past few years, Medicaid spending growth is still expected to increase by over 8 percent annually after the year 2000. To stabilize Medicaid growth, the President's budget would set a per capita cap on Medicaid spending. The cap would constrain the rate of increase in Federal matching payments per beneficiary.

The per capita cap protects States facing population growth or economic downturns because it ensures that Federal dollars are linked with beneficiaries.

DSH Payments

Federal DSH payments would be tightened without undermining the important role these funds play for providers that serve a disproportionate number of low-income and Medicaid beneficiaries.

Improved State Flexibility

The President's plan incorporates the highest-priority State flexibility requests advocated by the National Governors' Association. It:

- Repeals the "Boren amendment" for hospitals and nursing homes, to allow States more flexibility to negotiate provider payment rates;
- Eliminates Federal waiver process for States opting for managed care; and
- Allows States to serve people needing long-term care in home- and community-based settings without Federal waivers, and a number of other initiatives.

Improves Quality Standards

The President's plan maintains existing Federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities. Quality standards for managed care systems would be updated and enhanced.

Expanded Coverage for Children

The President's plan includes measures to enhance coverage for Medicaid-eligible children. It:

- Provides continuous coverage for children: The President's budget provides States with the option to extend 12 months of continuous Medicaid coverage, guaranteeing more stable coverage for children and reducing the administrative burden on Medicaid officials, providers, and families.
- Encourages outreach to help more children receive Medicaid: The Administration will work with States to develop innovative ways to reach and sign up for Medicaid some of the 3 million children who are eligible for Medicaid but are not currently enrolled.

Modifications to Welfare Reform Law

The President's plan includes provisions to ameliorate some of the effects of the welfare reform law, including:

- Exempting disabled immigrants from the ban on SSI benefits to ensure they retain their Medicaid benefits.
- Exempting immigrant children and disabled immigrants from the bans on Medicaid benefits for immigrants, and from the new “deeming” requirements that mandated that the income and resources of an immigrant’s sponsor be counted when determining program eligibility.
- Extending from 5 to 7 years the exemption from the Medicaid bans and deeming requirements for refugees and asylees.
- Retaining Medicaid coverage for disabled children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefit because of changes in the definition of childhood disability.

**Provision to Help Workers
with Disabilities**

The President’s plan recognizes that many people with disabilities want to work but they face significant barriers. The plan would help people with disabilities return to work risking their health care coverage. As a State option, SSI beneficiaries with disabilities who earn more than certain amounts could keep Medicaid. They would contribute to the cost of coverage on their income rises.

THE PRESIDENT'S FY 1998 BUDGET: PER CAPITA CAP & DSH REDUCTIONS IN THE MEDICAID PROGRAM

The President's budget saves \$9 billion in net savings over five years and takes a number of steps to preserve and strengthen the Medicaid program. It preserves the guarantee of coverage for the 37 million low-income children, pregnant women, people with disabilities, and older Americans who depend on Medicaid for basic health coverage and long-term care, while at the same time strengthening Medicaid's fiscal discipline and building on the success of the past few years in constraining excessive growth in spending.

- **Contains Important Investments in Medicaid.** The President's budget invests about \$13 billion in expanding coverage for eligible children, restoring coverage for some groups who lost it as a result of last year's welfare reform law, and contains other investments, including helping people with disabilities who earn above a certain income level retain their Medicaid coverage.
- **Recognizes That Medicaid Spending Growth Has Slowed and Achieves Modest Savings.** The \$22 billion in gross savings comes from two sources:
 - **Reducing DSH.** Two thirds of the savings, or roughly \$15 billion, comes from reducing the amount the Federal government spends on so-called "disproportionate share hospitals" (DSH).
 - **Implementing a Per Capita Cap.** One third of the savings, or roughly \$7 billion, comes from a "per capita cap" policy that will limit Federal Medicaid spending growth on a per-beneficiary basis.
 - **Funding the Transition.** These savings are net of a \$2.4 billion investment to assist States and providers in the transition to the new DSH and per capita cap policies. About \$1.4 billion over five years will be included in a supplemental fund to help cover the costs of care delivered in Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). In addition, \$1 billion over five years is reserved for a "transition pool" to assist States and safety net providers that are disproportionately affected by the new policies.
- **Reduces DSH Spending (Net Savings of \$15 Billion Over Five Years)**
 - **Controlling DSH Spending.** The Federal government will spend about \$10 billion on DSH in FY 1998, which is an important source of support for many hospitals that serve a disproportionate number of Medicaid and low-income patients. In the late 1980's and early 1990's, DSH spending was growing at double-digit rates, and was the driving force in Medicaid's high growth rates. While DSH growth has moderated--partly because of changes made by the Congress and the Administration in 1991 and in OBRA 1993--both the HCFA actuaries and CBO's analysts believe that the growth will accelerate again.

- **Freezing DSH Spending at the 1995 Levels.** The Administration's policy essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to \$8 billion in spending for FY 2000-2002. (Under the CBO baseline, DSH spending would have grown to about \$14 billion by 2002).
- **Distributing DSH Savings Fairly.** DSH savings are achieved by taking an equal percentage reduction from States' 1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY 1995 is greater than 12 percent of total Medicaid spending in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional enactments, this "upper limit" policy ensures that the few States with high DSH spending are not bearing most of the impact of the savings policy.
- **Better Targeting DSH Money.** The Administration believes that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to support better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is technically complex and could have potentially disruptive effects in some States and for providers, our policy does not specify a mechanism for targeting. We want to work with the Congress, the States, providers, policy experts and advocates to develop an appropriate targeting mechanism.
- **Helping FQHCs and RHCs Make the Transition.** To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about \$1.4 billion over five years to help cover the costs of care delivered in FQHCs and RHCs. The Administration believes that this supplemental fund will help these providers during the transition to a per capita cap, and will also compensate for our proposed repeal of cost-based reimbursement for these facilities, effective in FY 1999.
- **Implements a Per Capita Cap (\$7 Billion Net Savings Over Five Years).** Under the per capita cap policy, Federal Medicaid spending growth will be limited on a per beneficiary basis. The per capita cap is designed to maximize States' responsiveness to the health care needs of their Medicaid populations. It does this by adjusting the cap when enrollment increases when, for example, there is an economic recession. The per capita cap will work as follows:
 - **Calculating the Cap.** The cap would be the product of three components:
 - 1) State and Federal spending per beneficiary in the base year (FY 1996), including administrative costs;

- 2) An index specified in legislation (for years between the base year and the current year); and
- 3) The number of beneficiaries in the current year.

To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the elderly, individuals with disabilities, non-disabled adults, and non-disabled children. The spending for each of the four groups would be combined to establish the spending limit for the State.

Each State would be able to use savings from one group to support expenditures for other groups or to expand benefits or coverage. Once the cap is calculated, it would be multiplied by the State matching rate to determine the maximum Federal spending in each state. The Federal match would continue until the capped amount for the State is reached.

- **Determining the Index.** The index we have used is the growth in nominal GDP per capita (based on a five-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period--1998-2002--the index would allow per capita spending to increase by an average of 5 percent per year. By 1999 and subsequent years, the index will be nominal GDP per capita plus 1 percent.
- **Finding the Most Appropriate Index.** Our policy development to this point has focused on an index based on the growth in nominal GDP per capita, but we are reviewing indexes that could more precisely reflect growth in health care costs, and in particular, the volume and intensity inherent in a program that serves many low-income people. Recognizing that there is a debate about which is the most appropriate index, we intend to work with the Congress, the States, policy experts, and other stakeholders in order to facilitate the development of the best index possible.
- **Exempting Spending From the Cap.** Certain aspects of Medicaid spending not tied to individual beneficiaries or not under direct control of the States would not be subject to the cap: vaccines for children, payments to Indian health providers and Indian Health Services, DSH payments, and Medicare premiums and cost-sharing for dual eligibles and qualified Medicare beneficiaries (QMBs). On the other hand, Medicaid expenditures for services and administration delivered under Section 1115 demonstration waivers would be subject to the per capita cap.
- **Assessing the Impact of the Per Capita Cap.** After 2000, when both the HCFA actuaries and CBO's analysts have indicated that they expect Medicaid spending growth on a per capita basis to rise more rapidly again, the per capita cap would constrain Medicaid growth per-person (for non-DSH benefits and administration) to about 5 percent per year.

If the Administration and the States are successful in holding spending growth per beneficiary to about 5 percent a year during this period--which is close to the annual growth rate CBO is projecting for private insurance on a per-person basis--the per capita cap will produce little to no savings. But if the projections that per capita spending growth will rise again turns out to be correct, the Administration's policy will prevent that increase from overtaking our balanced budget.

- **Creates Transition Pool for Those Who Are Disproportionately Affected By New Policy.** We also include about \$1 billion in capped "transition pool" funding over five years to assist States and safety net providers who are disproportionately affected by the Medicaid savings policies.

HIGHLIGHTS OF THE PRESIDENT'S INITIATIVES TO MAINTAIN AND EXPAND WORKERS' COVERAGE

Because most Americans have employment-based health insurance, health care coverage is often jeopardized for workers who change jobs. In fact, over 50 percent of the uninsured lost their health insurance due to a job change. Many of these uninsured Americans are the spouses and children of workers. The President's initiative will provide temporary premium assistance to families with workers who are in-between jobs. For millions of these workers and their families this assistance could make it possible for them to maintain their health care coverage while looking for another job. This initiative is fully paid for within the President's FY 1998 balanced budget plan. In addition, to assist small businesses - which often have more difficulty providing and maintaining health care coverage for their workers -- the President has proposed to help States create voluntary purchasing cooperatives.

Funding

Invests \$9.8 billion over the budget window and is paid for in the President's FY1998 balanced budget.

Eligibility

Helps an estimated 3.3 million Americans in 1998, including about 700,000 children.

- A full subsidy would be provided up to 100% of the poverty level for and would be phased out at 240% of the poverty level.
- To assure that limited federal dollars are cost-effectively targeted, individuals who are eligible for Medicare, Medicaid or who have an employed spouse with coverage, are not eligible for this program.
- While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$30,000, for a family of four.

Coverage for Families of Workers Who Are In-Between Jobs

Helps to assure that Kassebaum-Kennedy protections against pre-existing conditions are not placed at risk because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose much of their income.

Gives States the flexibility to provide coverage in ways that best meets the needs of their populations. States would have flexibility to administer their own programs, (e.g., COBRA, a private insurance product, Medicaid, or an alternative means of coverage).

Voluntary Purchasing Cooperatives

Small businesses have more difficulty providing health care coverage for their workers because they have higher per capita costs due to increased risk and because of extraordinarily high administrative costs.

The President's budget will make it easier for small businesses to provide health care coverage for their employees, by allowing them to band together to reduce their risks, lower administrative costs, and improve their purchasing power with insurance companies.

His budget proposes to empower small businesses to access and purchase more affordable health insurance through the use of voluntary health purchasing cooperatives. This will be accomplished by providing \$25 million a year in grants that States can use for technical assistance, by setting up voluntary purchasing cooperatives, and by allowing these purchasing cooperatives to access to Federal Employees Health Benefit Plans.

WORKERS' TRANSITION HEALTH CARE INITIATIVE

The Workers' Transition Health Care Initiative is a carefully constructed, targeted and paid for program that builds on the Kennedy-Kassebaum law (The Health Insurance Portability and Accountability Act of 1996). It would provide health insurance premium assistance for an estimated 3 million Americans, including 700,000 children. According to the September 1996 Lewin Group study, the cost of health insurance coverage presents a significant barrier for many people who are in between jobs. In fact, less than 20 percent of workers elect to use COBRA, which allows the unemployed to keep their old insurance policy while looking for another job. The Workers' Transition Health Care Initiative:

- Provides temporary premium assistance for up to six months for those who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own.
- Assures that the Kennedy-Kassebaum protection against pre-existing conditions are not placed at risk because of breaks in insurance coverage. It achieves this goal by helping working families retain their health coverage through premium assistance during a time in which they lose all or much of their income.
- Strengthens the safety net for middle-income, working Americans in an increasingly mobile workforce. While low-income workers would certainly be helped by this benefit, over half of participants would come from families who previously had incomes over \$31,200, for a family of four. However, the 240% of poverty cap on assistance assures that limited federal dollars are cost-effectively targeted to those most in need.
- Gives states the flexibility to provide coverage in the way that best meets the needs of their populations. While states have the flexibility to design their own programs, this initiative is targeted only to those who would not otherwise have health care coverage. For example, individuals who are in between jobs that have access to insurance through a spouse whose employer contributes at least 50% of the cost of the premium are not eligible.
- Costs approximately \$2 billion a year and is paid for in the President's balanced budget.

QUESTIONS AND ANSWERS

Question: Isn't this just another open-ended entitlement that will be much more expensive than you assume?

Answer: The Workers' Transition Health Care Initiative is a capped entitlement to states, meaning that the federal costs can never exceed the amount specified in the legislation. Also, our analysts developed cost estimates for this program using conservative assumptions about the number of people who will participate in the program and how much health care coverage would cost per beneficiary.

Question: Aren't your estimates a bit unrealistic given the fact that this new generous benefit will cause more people to stay unemployed for the six month duration they are eligible for this subsidy?

Answer: The likelihood of people turning down a job simply so that they can keep a modest, time-limited health insurance subsidy are almost none. The vast majority of people would rather start a new job as soon as possible, even if it means giving up premium assistance for their health insurance. Our current unemployed insurance program (UI) provides evidence that most Americans, when given the option, choose work over a modest government benefit. Although UI coverage is available for 24 weeks, most leave the program after less than 17 weeks. Because the health insurance premium benefit is only \$240 a month, it would be even less likely for people to give up a job for this more modest benefit. However, extremely conservative estimates were used, including the unlikely assumption that some people would unwisely delay re-employment for a period of time.

Question: What happens if there is a recession?

Answer: This program gives states the flexibility to allow for changes in the unemployment rate. States are allowed to retain funds in low unemployment years to offset increased costs in higher unemployment years. States are given the flexibility to design a program that meets the needs of a changing economy. This proposal would also use a small portion of appropriations to establish a Federal loan fund that states could access in times of need.

Question: What are the income limits for this health insurance premium support?

Answer: Families with incomes below poverty (\$15,600 for a family of four) would get full assistance covering their premiums. The premium assistance would be phased out up to 240% of poverty, or a \$37,440 family income, for a family of four. However, since eligibility is determined on current monthly income, many families who previously had higher incomes and have little to none because of unemployment would be eligible.

Question: Why are you proposing a program that helps people who were previously insured but ignores the millions of Americans who still lack health insurance?

Answer: This program will help millions of Americans keep their health insurance. According to the Lewin Group study, the cost of coverage is a significant barrier for workers who are in between jobs. And while workers who are eligible for COBRA often cannot afford the cost of keeping their coverage, workers who were employed in firms with under 20 people are not even eligible for COBRA, so they must try and enter the difficult and expensive individual market. The Workers' Transition Health Care Initiative will give these workers access to insurance and the means to pay for it while they look for their next job.

This initiative, of course, does not resolve all of the problems in our current health care system. It will, however, provide health insurance for 3 million Americans, including 700,000 children each year. And it builds on the step-by-step approach the President is committed to pursuing.

Question: Is this another big government health care proposal?

Answer: No. This initiative is a limited demonstration that is phased out after four years. At that time, the Congress and the President can decide if it is an effective way to help Americans who are in between jobs keep their health insurance. This proposal is also already paid for in the President's balanced budget. Furthermore, this idea also has enjoyed longstanding bipartisan support. As *The Washington Times*, reported on September 6, the Dole Campaign has made clear that Senator Dole proposed a similar idea ten years ago as Senate Minority Leader.

Question: The Republicans on the Senate Budget Committee estimate that subsidizing health insurance for the full six months would cost taxpayers between \$15 and \$22 billion over six years. How do you justify your own estimates?

Answer: In their estimate, the Republican Budget Committee assumes that every individual who participates in this program will receive benefits for the entire six months of eligibility. It is ridiculous to expect that all of these workers would pass up a job simply to get this benefit for the maximum amount of time. This has never been the case with unemployment insurance and there is no reason to expect that people would remain unemployed for this even more modest benefit. Their analysis really has no bearing on this policy.

Question: The proposal mysteriously terminates in the year 2002, presumably because extending beyond 2002 would push the President's budget plan even farther out of balance."

Answer: The President's *demonstration* program is intended to determine if providing assistance to workers between jobs is a cost-effective method to assuring that individuals and their families do not lose insurance coverage while they are in between jobs. Like all other demonstration programs, the program is intentionally designed to end at a specified date. At that time, if the program is successful, Congress and the President are free to extend the demonstration or continue it as a permanent program. Ironically, this is the same mechanism that Senator Domenici himself used in the mental health parity initiative that the President supported.

Question: The Republican Budget Committee cites a provision in COBRA 1985 called 'continuation coverage' that allows the unemployed to buy into their former employer's health plan for up to 18 months while looking for another job. They then conclude that the problem, [for the unemployed], is "not a loss of health insurance, but a loss of income."

Answer: For most workers, a loss of income means a loss of health insurance. According to the Lewin Group study, less than 20 percent of eligible workers elect to use COBRA, and the cost of health insurance coverage is often a formidable barrier for those who do not. The Workers' Transition Health Care Initiative is designed to provide premium assistance to workers in between jobs, so that they do not have to forgo their health insurance while they are searching for a new job. It is important to note that firms with fewer than 20 workers do not have to provide COBRA to their former workers. For these workers, without some type of assistance, they will undoubtedly lose their health coverage.

Question: The Republican Budget Committee has asked why we don't just give the unemployed cash? They state that 'if health insurance is needed, the cash can be used to pay for COBRA continuation coverage. If health insurance is available (maybe through a spouse), the cash could be used to pay for food, housing, education, or job training.' What is wrong with this idea?

Answer: The President's proposal gives states the flexibility to provide coverage through COBRA or other private insurance. If a state shows they can provide cash to participants and still assure that participants have health coverage, then the Secretary of Health and Human Services can approve the state's program. However, States must ensure that they are providing this benefit to those individuals who would not otherwise have access to health insurance. For example, if an individual can receive health care coverage through their spouse, then they are not eligible to receive benefits from this program. States must demonstrate that the money they spend is targeted to meet the goals of this program: to help provide health care coverage for those who would otherwise lose their insurance.

Question: The Republican Budget Committee claims that the Administration is proposing to tax workers (or increase deficits) to subsidize non-workers. Is that true?

Answer: Absolutely not. The President's proposal is a part of his balanced budget proposal. As such, the costs are offset by savings in other programs. The Administration has not proposed to tax workers nor increase the deficit to pay for this program.

Question: It also states that while the President's rhetoric may lead people to believe that he is promising they will have health insurance for six months if they lose their job. In reality, he says 'up to six months'

Answer: Under the President's plan, individuals will be eligible to receive benefits for six months, if necessary. The vast majority of the people who participate in this program will not need to receive the benefit for the entire six months, as they will find a new job before they reach the six month limit.

PRESIDENT'S FY 98 BUDGET

LEGISLATIVE PROPOSALS

**MEDICARE PROPOSALS FOR BENEFICIARY IMPROVEMENTS,
MODERNIZING MEDICARE, AND FRAUD AND ABUSE
(Proposals With No Budget Impact)**

AND

**MEDICAID PROPOSALS FOR STATE FLEXIBILITY
AND NEW INVESTMENTS**

FEBRUARY 11, 1997

**MEDICARE FY98 LEGISLATIVE PROPOSALS
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- o PACE Demonstrations
- o Extend Social HMO for Three Years

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Medicare Managed Care

- o Permit Enrollment of ESRD Beneficiaries
- o Limits on Charges for Out-of-Network Services
- o Coverage for Out-of -Area Dialysis Services
- o Clarification of Coverage for Emergency Services
- o Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility
- o Modify Termination and Sanction Authority

Improved Quality

Accreditation

- o Modify the Deeming Provisions for Hospitals to Require that the JCAHO/AOA Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance
- o Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement

Survey and Certification

- o Permit Collection of Fees from Entities Requesting Initial Participation in Medicare
- o Create Authority for an Integrated Quality Management System Across HCFA Programs (Medicare and Medicaid)

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- o Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments
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PROPOSALS FOR BENEFICIARY IMPROVEMENTS, MODERNIZING MEDICARE, AND FRAUD AND ABUSE

(Proposals with no Budgetary Impact)

February 11, 1997

Beneficiary Improvements

Program Improvements

o Definition of DME

Modify the definition of DME to include items needed "for essential community activities". The Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment). Under current law, durable medical equipment (DME) is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition will encourage independent activity by disabled beneficiaries.

o PACE Demonstrations

Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail-elderly persons who live in the community.

o Extend Social Health Maintenance Organization (SHMO) Demonstrations

Extend both the first and second generation of SHMO demonstrations until December 31, 2000. SHMOs enroll a cross-section of the elderly living in community and provide standard Medicare benefits, together with limited long-term care benefits. These congressionally-mandated demonstrations are currently set to expire on December 31, 1997. A three-year extension would provide additional time to evaluate this delivery model.

Choice

Medicare Managed Care

o **Permit Enrollment of ESRD Beneficiaries**

Permit beneficiaries with ESRD to enroll in a managed care plan. Currently, while beneficiaries who develop ESRD can stay enrolled in a plan, beneficiaries with ESRD are prohibited from enrolling. ESRD beneficiaries should not have their coverage options limited because of their health status.

o **Limits on Charges for Out-of-Network Services**

Expand current limits on charges to plans by non-contracting entities for authorized services. Limits which now apply in the case of inpatient hospital, SNF, physician and dialysis services would apply in regard to all services for which there is a fee schedule or limit under fee-for-service Medicare. Apply these same limits to unauthorized, out-of-network services. Providers should not have a windfall payment as a result of providing an authorized or unauthorized service to a Medicare beneficiary enrolled in a managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

o **Coverage for Out-of-Area Dialysis Services**

Require plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area. Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and urgent care. Since services such as dialysis are foreseeable, plans have no obligation to pay for them. As a result, managed care enrollees with ESRD are effectively barred from ever leaving their home town.

o **Clarification of Coverage for Emergency Services**

Clarify the obligation of managed care plans to pay for emergency services provided to their plan's enrollees (whether through the plan or by a non-plan provider) by defining "emergency services" as services that a "prudent layperson" would, from his or her perspective, reasonably believe were needed immediately to prevent serious harm to his or her health. This clarification of Medicare policy will be helpful to states as they determine what requirements should apply in regard to emergency services provided to commercial managed care enrollees.

- o **Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility**

Authorize States, with programs approved by the Secretary, to certify whether a plan is eligible to contract with Medicare and to monitor certain aspects of plan performance. Such certification and monitoring would be subject to Federal standards. The Secretary would retain final authority in regard to contracting and compliance actions. User fees would be collected from plans for both the certification and monitoring activities. Effective 1/1/98. The proposal would eliminate certain duplication of effort that exists between States' traditional licensing role and HCFA oversight of managed care contractors.

- o **Modify Termination and Sanction Authority**

Authorize the Secretary to terminate a contract prior to a hearing in cases where the health and safety of Medicare beneficiaries are at-risk. Delete requirement for corrective action plans and for hearing and appeals prior to imposing intermediate sanctions. Conform sanctions options add by the existing sanction authority. When the health and safety of beneficiaries is at risk, HCFA should not be required to hold a hearing prior to terminating a contract. In regard to intermediate sanctions, HCFA already provides plans with the opportunity to respond to findings that the plan has committed an act subject to an intermediate sanction. Requiring a hearing and an appeal in all instances, however, would unnecessarily hinder enforcement actions.

Improved Quality

Accreditation

- o **Modify the "Deemed Status" Provisions for Hospitals to Require that the JCAHO Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance**

This would require the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to demonstrate that, under its accreditation process and standards, accredited hospitals meet or exceed all federal health and safety standards (called the Medicare "conditions of participation"). Further, the JCAHO would be required to enforce compliance with the standards and monitor those entities that are found out of compliance. Under current law, hospitals that receive JCAHO accreditation are automatically deemed to have met Medicare conditions of participation and the Secretary has no statutory authority to require the JCAHO to monitor compliance. The Omnibus Consolidated Rescissions and Appropriations Act of 1996 raised the standards for deemed status of other (non-hospital) providers by authorizing the Secretary to grant Medicare deemed status to providers if the accrediting body has demonstrated to the

Secretary that a provider category meets or exceeds all of the Medicare conditions and requirements. This proposal would bring hospital "deemed status" requirements in line with deeming requirements for other providers.

o **Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement**

This would broaden the instances when the Secretary may disclose accreditation survey information to include instances where the Secretary deems disclosure to be in the interests of beneficiary safety, quality of care, and program integrity. Under current law, the Secretary may not publicly disclose any accreditation survey result unless the information relates to an enforcement action taken by the Secretary. Such limited authority restricts the Secretary from fully safeguarding quality.

Survey and Certification

o **Permit Collection of Fees from Entities Requesting Initial Participation in Medicare**

This would permit the Secretary to charge entities (including dually-participating Medicare/Medicaid providers but excluding clinical labs under CLIA) a fee for the initial survey required for participation in the Medicare program. Under this new authority, HCFA would charge fees through its agreements with State survey agencies. As HCFA's agents, States would collect and retain these fees and apply them to their survey costs. HCFA's survey and certification budget has been held constant since 1993, while the number of entities seeking to enter the Medicare program has grown dramatically each year. This under-funding has forced HCFA to prioritize State survey workloads and has resulted in extensive delays of initial certification surveys. This proposal would allow a greater number of providers to enter the Medicare program in a timely fashion, thereby enhancing beneficiary access to, and choice of, providers. In addition, program certification allows providers to derive a financial benefit from participating in Medicare and Medicaid. Charging for initial program participation surveys is consistent with the fee-based approach for other government services.

o **Create Authority for an Integrated Quality Management System Across HCFA Programs (Medicare and Medicaid)**

This proposal would provide for a uniform authority for all Medicare and Medicaid quality management activities. A re-engineered, integrated quality management approach would include, but not be limited to: authorities for data collection, quality conditions, enforcement, publication of provider-level data, user fees, deeming flexibility, and designated accountability. Prior to full implementation of an integrated quality management system, HCFA would test out various models through demonstrations. For the last five years, HCFA has been building the foundations of a truly re-engineered

approach to survey and certification activities, which creates a new conceptual framework and reshapes many operational features of the current system and breaks through current limitations. HCFA would like to test this re-engineering concept through a demonstration.

Managed Care

o Privately Accredited Plans Deemed to Meet Internal Quality Assurance Standards

Authorize the Secretary to deem plans with private accreditation as meeting internal quality assurance requirement. This proposal, without reducing Federal standards, would eliminate certain duplication of effort that exists between private accrediting organizations' review of plans internal quality assurance programs and HCFA's own efforts.

o Replace 50/50 Rule with Quality Measurement System

Eliminate the current requirement that managed care plans maintain a level of commercial enrollment at least equal to public program enrollment, once the Secretary, in consultation with the consumers and the industry, develops a system for quality measurement. Authorize the Secretary to terminate plans that do not meet standards under the quality measurement system. Until the quality measurement system is in place, expand the Secretary's waiver authority for 50/50 (e.g., plans with good track records). The Administration believes that the 50/50 rule should be retained until an adequate quality measurement system is in place. This system, once in place, should drive contracting decisions.

Nurse Aide Training

o Permit Waiver of Prohibition of Nurse Aide Training and Competency Evaluation Programs in Certain Facilities and Clarify that the Trigger for Disapproval of Nurse Aide or Home Health Aide Training and Competency Evaluation Programs is Substandard Quality of Care (Medicare and Medicaid)

This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program. The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training

facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a result of losing a training program's approval. This proposal is also a part of the Vice-President's "Reinventing Government" initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

STRUCTURAL REFORM – MODERNIZING MEDICARE

Prudent Purchasing

Post-Acute Payment Reform

o Secretarial Authority to Create Integrated Post Acute Care Payment System, and to Collect Assessment Data

This would signal the Administration's intention to develop, in the future, a fully integrated payment system for all post-acute care services (including SNFs, HHAs, rehabilitation and long-term care hospitals). It would give the Secretary the authority to implement, through regulations, a single payment system that includes (at a minimum) a case-mix adjustment mechanism predicated on a standard core patient assessment instrument; equitable payment among provider types; budget neutrality to post-acute payments in some base year; and geographic adjustments. The uniform payment system would be built upon the prospective payment system for home health and an expanded PPS for SNF that more appropriately reflects costs across all post-acute inpatient settings, including the higher intensity of service in rehabilitation and long-term care hospitals. It would authorize the Secretary to collect any and all data, on a national basis, that would be necessary to implement such a system. There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. Despite this overlap, Medicare's current payment and coverage rules vary by setting and may create perverse incentives to treat patients in one setting rather than another in order to maximize reimbursement. A "site-neutral" integrated post-acute care payment would help to ensure that beneficiaries receive high quality care in the appropriate settings. This system would ensure that reimbursement is sufficient for all patient types, including high intensity patients who in the current environment are cared for in rehabilitation hospitals. In addition, any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues. A consistent patient classification system would allow meaningful comparisons of the diagnoses, severity, and functional limitations of patients in all these settings; permit case-mix adjustment for payment purposes; and permit greater coordination of care. ProPAC has cited the perverse incentives that currently operate under separate and distinct payment methods for post-acute care services.

Beneficiary-Centered Purchasing

In general, provide the Secretary with authority to pay on the basis of special arrangements as opposed to statutorily-determined, administered prices. This proposal has five components which are fully described below: Centers of Excellence; Competitive Bidding; Global Payments; Flexible Purchasing Authority; and Inherent Reasonableness Authority. Two years after enactment, and annually thereafter for the next three years, the Secretary would report to Congress by March 1st on the use of these new authorities, including the impacts on program expenditures and on the access and quality of services received by beneficiaries.

- + **Centers of Excellence** - Authorize the Secretary to pay selected facilities a single rate for all services (including potentially post-acute services) associated with a surgical procedure or hospital admission related to a medical condition, specified by the Secretary (The Secretary would be required by January 1, 1999 to establish Centers of Excellence for CABG surgery, other cardiac procedures and for hip and knee replacements across the country). Selected facilities would have to meet special quality standards. The single rate paid to a Center would have to represent a savings to the program. There would be no requirement for beneficiaries to receive services at Centers. However, Centers would be allowed, subject to approval by the Secretary, to provide additional services (such as private room) or other incentives (waiver of cost-sharing) to attract beneficiaries.
- + **Competitive Bidding Authority** - Authorize the Secretary to set payment rates for Part B services (excluding physician services) specified by the Secretary based on competitive bidding. The items included in a bidding process and the geographic areas selected for bidding would be determined by the Secretary based on the availability of entities able to furnish the item or services and the potential for achieving savings. Bids would be accepted from entities only if they met quality standards specified by the Secretary. The Secretary would have the authority to exclude suppliers whose bid was above the cut off bid determined sufficient to maintain access. Automatic reductions in rates for would be triggered for clinical laboratory services and DMEPOS (excluding oxygen services) if by 2001 a 20 percent reduction had not been achieved.
- + **Purchasing Through Global Payments** - Authorize the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services directed at a specific condition or need of an individual (e.g. diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME). The Secretary would select providers on the basis of their ability to provide high quality services efficiently, to improve coordination of care (e.g. disease management, case management), and to offer additional benefits to beneficiaries (e.g. prescription drugs, respite, nutritional counseling, adaptive and assistive

equipment, transportation.) Within the global payment, providers would have flexibility in how services are provided, and they may, subject to approval by the Secretary, offer additional, non-covered benefits financed through the global payment. The global rate would have to represent a savings to the program. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such arrangements and during that period would be "locked-in" for the services covered under the arrangement.

- + **Flexible Purchasing Authority** - Authorize the Secretary, after rulemaking, to negotiate alternative administrative arrangements with providers, suppliers and physicians who agree to provide price discounts to Medicare. These discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. The alternative administrative arrangements could not include any changes to quality standards or conditions of participation. The Secretary would have the authority to permit sharing of these savings with beneficiaries who use these entities - - for example, through a reduced deductible in the case of hospital services or lower coinsurance payments in the case of other services.
- + **Inherent Reasonableness Authority** - Restore Medicare's carriers authority to make "inherent reasonableness" payment changes for durable medical equipment, prosthetics and orthotics (DMEPOS) as well as surgical dressings.

Medicare's statutory framework was based on a Blue Cross/Blue Shield model from the 60's. Although payment methodologies have improved over time, current payment authority is too rigid for the fee-for-service program to meet the challenges of the 21st century. Each component of this initiative represents an approach that has been used successfully by the private sector, other government program or under Medicare's demonstration authority.

Contracting Reform

o Reform Contracting for FIs and Carriers

This proposal would end the requirement that all Medicare contractors perform all Medicare administrative activities, and would allow Medicare to contract with entities other than insurance companies. New contractors would be awarded contracts using the same competitive requirements that apply throughout the government. The proposal would give HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to beneficiary and provider services, and claims processing. It builds on the Medicare Integrity Program contracting changes established in HIPAA.

Improving Efficiency and Eliminating Overpayments

Hospitals

o Hold-Harmless for DSH

Freeze hospital-specific disproportionate share hospital (DSH) adjustments at current levels, for a period of 2 years. Require the Secretary to submit a legislative proposal to Congress by 18 months after enactment for revised qualifying criteria and payment methodology for hospitals that incur higher Medicare costs because they serve a disproportionate share of low-income patients. Without action by FY 2000, the old (current) formula would be reinstated. The current formula for identifying DSH hospitals relies on counting the number of days the hospital serves Medicare/SSI beneficiaries (as a proportion of total Medicare days) and the number of days it serves Medicaid beneficiaries (as a proportion of total days). The resulting "DSH percentage" is plugged into a formula that computes the increase in Medicare payments for DSH hospitals.

However, this measure is becoming increasingly unreliable. The recently enacted welfare reform law will have an impact both on the number of people eligible for SSI and the number of people eligible for Medicaid but not necessarily on the number of low-income individuals seeking hospital care. Furthermore, as the number of uninsured Americans increases, the reliability of this measure to reflect the a hospital's level of uncompensated care decreases. Concurrently, HCFA has lost a series of court cases on the DSH formula, resulting in varying definitions of "eligible Medicaid days" across the country. By freezing the current DSH levels for the next two years, the level of support for DSH hospitals will be sustained while the Secretary develops a proposal to refine the DSH criteria and adjustment.

Part B Issues

o Replace "Reasonable Charge" Methodology (and "Reasonable Cost" Methodology for Ambulances) with Fee Schedules

Create fee schedules, on a budget neutral basis, for the few Part B services still paid according to "reasonable charge" methodology (the most significant services affected would be ambulances, and enteral and parenteral nutrition). Specify that ambulance services provided by hospitals or "under arrangements" would also be covered by the new ambulance fee schedule, with adjustments allowed for certain "core services" that may have higher costs. This proposal will make the payment methodology consistent for all Part B services and improve administrative efficiency. Including hospital based ambulance services under the fee schedule will remove incentives for independent suppliers to evade fee schedule limits by establishing costlier arrangements with hospitals.

FRAUD AND ABUSE

o Clarify the Definition of "Homebound"

This would redefine the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home. The current definition of "confined to the home" is vague and over broad. It allows for considerable discretion in interpretation and fraud and abuse. Financial reviews show that Medicare routinely reimburses care to beneficiaries who are not truly homebound. Without a more concrete definition, this eligibility requirement is very difficult to enforce. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

o Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards

This proposal would allow the HHS Secretary to establish normative numbers of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain more control over excessive utilization. A March 1996 GAO report criticizes current statutory coverage criteria as leaving too much room for interpretation and inviting fraud and abuse.

o Requirement to Provide Diagnostic Information

Extend to non-physician practitioners, the current requirement that physicians provide diagnostic information on all claims for services that they provide. Also require physicians and non-physician practitioners to provide information to document medical necessity for items or services ordered by the physician or practitioner, when such documentation is required by the Medicare contractor as a condition for payment for the item or service. Diagnostic information is needed by Medicare's contractors to determine the medical necessity of physician services and for use in quality/outcome research. Given the need for this data, there is no reason to exclude non-physician practitioners from the current requirement to include diagnostic codes on claims forms. Also, in regard to non-physician services and DMEPOS items, suppliers providing the services and items ordered by physicians or non-physician practitioners have reported having difficulty obtaining diagnostic information required by Medicare's contractors. This proposal will clarify that the ordering physician or non-physician practitioners is required to provide such information.

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

o **Repeal Boren Amendment**

Repeal the Boren amendment for hospitals and nursing homes, while establishing a clear and simple public notice process for rate setting for both hospitals and nursing homes.

Modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to add a public notification process that provides an opportunity for review and comment, which should result in more mutually agreeable rates.

o **Eliminate cost-based reimbursement for health clinics**

Federal requirements that most Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) be paid based on costs would be removed beginning in 1999; and a capped, temporary funding pool would be established to help these facilities during the transition.

Increase Flexibility in Program Eligibility

o **Allow Budget Neutral eligibility simplification and enrollment expansion**

Enable States to expand or simplify eligibility to cover individuals up to 150 percent of the Federal poverty level through a simplified and expedited procedure. Current rules would be retained to the extent they are needed to ensure coverage for those who do not meet the eligibility criteria of the new option. Federal spending would be restrained by the per capita cap for current eligibles and such expansions would be approved only if they were demonstrated to be cost neutral (i.e. no credit for persons who were not otherwise Medicaid eligible in the determination of cap number).

This proposal enables States to expand to new groups that are not eligible under current law without a Federal waiver. Administration would be streamlined and simplified in that States would be able to use the same eligibility rules for everyone eligible under the new percent-of-poverty option in place of the current plethora of different rules for different groups. Integrity of Federal spending limits would be maintained by the cost neutrality requirement.

o **Guarantee eligibility for 12 months for children**

This proposal would permit States to provide 12-month continuous Medicaid eligibility for children ages 1 and older. (Continuous coverage was enacted for infants by OBRA 90.)

This proposal would provide stable health care coverage for children -- particularly children in families with incomes close to the eligibility income limits, who often lose eligibility for a month due to an extra pay period within a month. This proposal would also reduce State administrative burden by requiring fewer eligibility determinations.

Eliminate Unnecessary Administrative Requirements

o **Eliminate OB/Peds physician qualification requirements**

Federal requirements related to payment for obstetrical and pediatric services would be repealed. States would only have to certify providers serving pregnant women and children based on their State licensure requirements

The minimum provider qualification requirements under current law do not effectively address quality of care. In addition, current law fails to recognize all bodies of specialty certification, so certain providers are precluded from participation in Medicaid (e.g., foreign medical graduates). Congress amended the law in 1996 to include providers certified by the American Osteopathic Association and emergency room physicians.

o **Eliminate annual State reporting requirements for certain providers**

States would no longer have to submit reports regarding payment rates and beneficiary access to obstetricians and pediatricians.

Current law assumes that access is linked to payment rates. However, the State-reported data do not reveal much regarding the link between payment rates and access.

o **Eliminate Federal requirements on private health insurance purchasing**

Eliminate requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective.

The current law provision is not necessary. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. The proposed per capita spending limits increase this incentive. The current, detailed, one-size-fits-all Federal rules hinder States from designing programs that most effectively suit local circumstances.

- o **Simplify computer systems requirements**

Eliminate detailed Federal standards for computer systems design. State systems would be held to general performance parameters for electronic claims processing and information retrieval systems.

Current detailed requirements for system design were developed for an earlier time in which technology was primitive and detailed Federal rules were necessary to move States closer to what was then state-of-the-art. This is no longer the case. It is now sufficient to require States merely to show that their State-designed system meets performance standards established under an outcome-oriented measurement process.

- o **Reduce unnecessary personnel requirements**

We would work with States and State employees to replace the current, excessively detailed, and ineffective Federal rules regarding administrative issues that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.

Increase Flexibility Regarding Managed Care

- o **Modify upper payment limit for capitation rates**

Modify upper payment limit and actuarial soundness standards for capitation rates to better reflect historical managed care costs by requiring actuarial review of the rates.

The current Medicaid upper payment limit for managed care contracts (i.e., 100% of fee-for-service) is not an accurate payment measurement for Medicaid managed care plans. It does not reflect historical managed care costs and States claim it is inadequate to attract plans to participate. This proposal would modify the definition of the UPL to more accurately reflect Medicaid spending. It would also modify actuarial soundness standards.

- o **Convert managed care waivers [1915(b)(1)] to State Plan Amendments**

Permit mandatory enrollment in managed care without federal waivers. States would be able to require enrollment in managed care without applying for a freedom of choice waiver [1915(b)(1)]. States would be allowed to establish mandate enrollment managed care programs through a State plan amendment. Qualified IHS, tribal, and urban Indian organization providers would be guaranteed the right to participate in State managed care networks.

This proposal would provide States greater flexibility in administering their State Medicaid programs by eliminating the freedom-of-choice waiver application process. States would not have to submit applications for implementation or renewal. The Administration is pursuing strategies to assure quality in Medicaid managed care that are more effective and less burdensome than the assurances added through the waiver process. Guaranteeing urban Indian organization providers the right to participate in State Medicaid managed

care networks integrates ITUs into managed care delivery systems and recognizes their unique health delivery role:

o **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule**

Replace the current enrollment composition rule with a new quality data monitoring system under a beneficiary purchasing strategy with new data collection authority.

As part of the continuous effort to ensure Medicaid managed care beneficiaries receive quality care, HCFA proposes to implement a "beneficiary-centered purchasing" (BCP) strategy. BCP will replace certain current federal managed care contract requirements. The current enrollment composition rule (i.e., 75/25 rule) requires that no more than 75 percent of the enrollment can be Medicare and Medicaid beneficiaries. The current requirement is a process-related, ineffective proxy for quality. This requirement would be replaced with a quality monitoring system based on standardized performance measures.

HCFA, in collaboration with States, would define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures would be used to quantify and compare plans' quality of care, provide purchasers and beneficiaries with the means to hold plans accountable, and provide HCFA with comparable data to compare the performance of State programs to effectively hold States accountable as well.

This proposal would enhance the Secretary's ability to ensure that beneficiaries' interests are being protected as enrollment in managed care increases, and to detect and correct possible abuses by managed care plans. A more outcome oriented quality review process is vital to the Federal and State oversight of managed care plans to ensure that Medicaid beneficiaries are receiving the highest quality care possible. Data would be vital to the success of such an effort.

o **Change threshold for federal review of contracts**

Raise the threshold for the federal review of managed care contracts from the current \$100,000 threshold to \$1 million contract amount (or base threshold for federal review on lives covered by plan).

This proposal would provide greater State flexibility in management and oversight of Medicaid managed care programs. It would also reduce the number the of managed care plan contracts requiring HCFA review and approval.

- o **Nominal copayments for HMO enrollees**

Permit States to impose nominal copayments on HMO enrollees.

This proposal would bring policy on Medicaid copayments for HMO enrollees more in line with Medicaid copayments that a State may elect to impose in fee-for service settings. It would also allow HMOs to treat Medicaid enrollees in a manner similar to how they treat non-Medicaid enrollees. However, impact on beneficiaries would not be harmful since copayments, if imposed, would still have to be nominal.

Increase Flexibility Regarding Long-Term Care

- o **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments**

Give States the option to create a home and community-based services program without a Federal waiver, through a State plan amendment. This proposal would benefit States and beneficiaries by eliminating the constant and costly necessity of renewing the waivers, while ensuring a high level of care.

- o **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities**

Raise the Medicaid Federal financial participation (FFP) rate to 85 percent.

Federal funding is important to maintain both quality standards established by OBRA 87 and resulting enforcement activities. Increasing the Medicaid federal financial participation percentage to 85 percent would encourage States to increase total spending on nursing home survey and certification activities.

- o **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities. Clarify that the trigger for disapproval of nurse aide or home health aide training and competency evaluation programs is substandard quality of care (Medicare and Medicaid).**

This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program.

The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a

result of losing a training program's approval. This proposal is also a part of the Vice-President's Reinventing Government initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

o Eliminate repayment requirement for alternative remedies for nursing home sanctions

Eliminate the requirement for repayment of federal funds received if a State chooses to use alternative remedies to correct deficiencies rather than termination of program participation.

This proposal would allow States to promote compliance by employing alternative remedies on nursing facilities. This provision for alternative remedies gives States the flexibility for more creative implementation of the enforcement regulations.

o Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Eliminate the duplicative requirement for Inspection of Care (IOC) reviews in mental hospitals and ICFs/MR. The survey and certification reviews that currently take place in mental hospitals and ICFs/MR would remain in place.

Inspection of Care (IOC) reviews were originally designed to ensure that Medicaid recipients were not being forgotten in long term care facilities. The current survey process has been improved through a new outcome-oriented process that protects recipients in mental hospitals and ICFs/MR from improper treatment. Consequently, IOC reviews are no longer needed and are, in fact, in direct conflict with the revised ICF/MR survey protocol. The current requirement for two reviews (IOC and the ICF/MR survey) has become duplicative. If the IOC were eliminated, the ICF/MR survey and certification process would remain in place.

o Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Provide for alternative sanctions in ICFs/MR that already are available for nursing homes. Alternative sanctions that currently are available in nursing homes include: directed in-service training, directed plan of correction, denial of payment for new admissions, civil monetary penalties and temporary management.

Sanctions other than immediate termination were established for nursing homes under the OBRA-87 legislation, but not for ICFs/MR. This proposal would extend the alternative sanction option to ICFs/MR.

SPECIAL POPULATIONS

- o **Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid**

This proposal would give States the option of creating a new eligibility category for disabled persons to encourage them to work beyond the 1619(b) income thresholds. SSI beneficiaries who become eligible for this new category would contribute to the cost of the program by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the States.

Despite existing work incentives in SSI, fewer than 1/2 of 1 percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the most significant barriers to disabled beneficiaries returning to work or working for the first time. Under this proposal, Medicaid would be used to extend access to coverage for the working disabled who no longer qualify for health care benefits under current law.

- o **Grant Programs for All inclusive Care for the Elderly (PACE) permanent provider status**

Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail-elderly persons who live in the community.

IMPROVEMENTS RELATED TO WELFARE REFORM

Disabled Beneficiaries

- o **Retain Medicaid for current disabled children who lose SSI**

Medicaid would be retained for children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefits because of changes in the definition of disability.

Most of these children would requalify for Medicaid by meeting another eligibility category either by meeting other SSI disability listings or other Medicaid categories for non-disabled low-income children. Those who do not, and who would be grandfathered under this proposal, continue to have relatively extensive health and developmental needs which would not be met if these children lost their Medicaid coverage.

Immigrants

- o **Exempt certain disabled individuals from the ban on SSI cash assistance**

This proposal exempts immigrants who become disabled after entering this country from the recently enacted ban on SSI cash assistance for "qualified aliens", and ensures that they would retain their Medicaid benefits. The exemption would apply to immigrants who were already here on the date of enactment as well as to new arrivals.

This proposal allows States to continue providing SSI and Medicaid benefits to immigrants who become disabled and who would otherwise be cut off due to welfare reform. It protects those who can no longer be expected to work due to circumstances beyond their control.

o **Exempt immigrant children and certain disabled immigrants from the Medicaid bans and deeming requirements**

This proposal would exempt immigrant children and immigrants who are disabled after entering this country from the bans on Medicaid benefits for current and future immigrants. Immigrant children and immigrants disabled after entry would also be exempt from the new deeming requirements that mandate that the income and resources of an immigrant's sponsor be counted when determining Medicaid eligibility.

These proposals assist the most vulnerable groups of immigrants for whom lack of access to medical care may produce long-term negative consequences and whose medical care may result from an unexpected injury or illness that occurs after their arrival.

o **Extend the Exemption for Refugees/Asylees from 5 to 7 Years**

This proposal would extend the exemption from Medicaid bans and deeming requirements for refugees and asylees by an additional 2 years for a total of 7 years.

Protection of refugees and asylees has been a consistent feature of U.S. immigration policy. Refugees and asylees often face challenges that other immigrants do not because of persecution. Extending the exemption for an additional two years allows for these unique circumstances and possible difficulties these individuals may have in becoming self-sufficient. In addition, more recent populations have included larger numbers of elderly individuals, who may take a longer time to adjust to new circumstances.

STRENGTHENING FINANCIAL ACCOUNTABILITY

o Establish a Federal Payment Commission

Establish a commission to review equity among the States in Medicaid financing formula (FMAP), as well as the base year and growth rates in the per capita spending limits.

The formula for determining the Federal and State contribution to the Medicaid program, which is based on per capita income in a State, has long been criticized as failing to adequately reflect State variations in their ability to raise revenues and in magnitude of State need. An impartial commission could make recommendations for a more refined formula. Similarly, once the per capita cap has an established track record, an impartial commission would make recommendations for further improvements to improve equity across States.

o Strengthen Medicaid Eligibility Quality Control (MEQC)

Modify and strengthen Medicaid Eligibility Quality Control (MEQC) system. Under a per capita cap limit on spending where Federal funding is tied to the number of beneficiaries in a State, it would become more important than ever to ensure Federal matching payments are provided to States only for their spending on people who actually meet the State's eligibility criteria. The current MEQC system is the appropriate tool for this task, but it must be modified to accommodate and measure population components of the per capita cap. States would have a reasonable error tolerance limit of three percent of enrollments, which is similar to the current tolerance limit.

o Increase Federal Payment Cap for Puerto Rico

Increase the Federal Medicaid payment cap for Puerto Rico by \$30 M, \$40 M, \$50 M, \$60 M, and \$70 M over current law for FY 1998-2002 respectively.

Federal matching for the Puerto Rico has always been capped, but at amounts determined by Congress unrelated to impartial measures of need in the Puerto Rico or their ability to contribute a share of program costs. Beginning after 1994, Federal payments are increased every year by the medical component of the CPI, but continue not to take population factors into account. Given underlying eligibility structure in Puerto Rico it would not be appropriate to apply per beneficiary Federal spending limits to Puerto Rico. Nevertheless, some adjustment for population is called for in Puerto Rico, which has had a demonstrated need for Medicaid funding beyond its cap for a number of years.

o Increase Federal payment to District of Columbia

Increase the Federal payment to the District of Columbia by changing the Federal matching rate from 50 percent to 70 percent.

This proposal would change the District's share of the costs of health care services under Medicaid from 50 percent to 30 percent. This equals the maximum amount that the District, as a local government, could be required to contribute if it were located within a State.

Cost Estimates for FY98 President's Budget Medicaid Proposals

	Cost(Savgs) In Sbill					FY98-02
	FY1998	FY1999	FY2000	FY2001	FY2002	Total
Welfare Reform Legislative Changes						
Exempt disabled from SSI ban	0.395	0.455	0.473	0.496	0.484	2.303
Exempt disabled from 5-yr ban/deeming	0.206	0.312	0.466	0.649	0.774	2.407
Exempt children from 5-yr ban/deeming	0.013	0.021	0.031	0.044	0.052	0.161
Extend refugee/asylee exemption	0.005	0.005	0.005	0.005	0.005	0.025
Sub-Total - Welfare	0.619	0.793	0.975	1.194	1.315	4.896
Children's Health Initiatives						
State Partnership Demos- MCD Outreach Impact	0.062	0.130	0.227	0.349	0.368	1.135
12-mo Continuous Eligibility for Children	0.282	0.458	0.708	1.014	1.162	3.623
Sub-Total - Children	0.344	0.587	0.934	1.362	1.530	4.758
Other Proposals						
Increase DC FMAP to 70%	0.156	0.169	0.182	0.197	0.213	0.918
Increase Payments to Puerto Rico	0.030	0.040	0.050	0.060	0.070	0.250
Extension of VA Sunset	0.000	0.300	0.300	0.300	0.300	1.200
Working Disabled	0.000	0.001	0.003	0.007	0.009	0.020
Retain MCD for curr disab children who lose SSI	0.075	0.070	0.065	0.065	0.060	0.335
Impact of Medicare Proposals						
Part B Premium	-0.012	0.050	0.136	0.243	0.385	0.801
Subtotal - Other Initiatives	0.250	0.629	0.737	0.872	1.037	3.524
GRAND TOTAL	1.213	2.009	2.646	3.428	3.882	13.178

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