

PROJECT
inform

December 9, 1996

The Honorable Bill Clinton
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500
VIA FAX (202) 456-2461

Dear President Clinton:

On behalf of Project Inform, I urge you not to propose any cuts to the Medicaid program in your FY 1998 budget. Project Inform is a national HIV/AIDS research and treatment information/advocacy organization serving over 80,000 constituents through our hotline, publications, and national town meetings. We are also a member of the Emergency Coalition on Medicaid.

We greatly appreciate your strong leadership last year in opposing Congressional attempts to reduce Medicaid spending and to eliminate entitlement status. As you know, Medicaid is a lifeline for people living with HIV/AIDS. The program provides basic health care services to 90% of all children with HIV disease, and at least 40% of all adults with AIDS. Reductions in Medicaid spending would worsen the health of people living with HIV/AIDS by taking away their guarantee to essential services, such as preventive care, prenatal care, and prescription medications. People with AIDS who lose Medicaid health coverage would be forced to seek more expensive care in hospital emergency rooms.

With states currently grappling with implementing welfare reform legislation, we feel that social service and health organizations could not handle reductions in Medicaid spending or major policy changes. While we recognize the need for the Medicaid program to be reviewed, it must be done thoughtfully and with the needs of those living with life-threatening illnesses in mind. Please continue your role in protecting America's most vulnerable citizens by opposing any efforts to cut Medicaid spending.

Sincerely,



Anne Donnelly
Public Policy Director

cc: Secretary Donna Shalala
Carol Rasco
Franklin Raines
Chris Jennings
Nancy Ann Min
Bill White
Patsy Fleming
Jeffrey Crowley



Consortium for Citizens with Disabilities

Health Task Force Co-Chairs

Jeff Crowley (202) 898-0414

Bob Griss (202) 847-4408

Kathy McGintley (202) 785-3388

John Paleniczek (202) 336-6068

Peter Thomas (202) 466-6550

December 9, 1996

The President
The White House
Washington, DC 20500

Dear Mr. President:

We are writing as Co-Chairs of the Health Task Force of the Consortium for Citizens with Disabilities (CCD). We believe that the leadership you demonstrated in protecting Medicaid is one of the greatest accomplishments of your first Administration. We urge you to continue safeguard the health care safety net for people with disabilities by not proposing financing cuts and policy changes to the Medicaid program as part of your FY 1998 federal budget proposal.

We understand that you feel committed to proposing a budget plan that will achieve a balanced budget by 2002. Nonetheless, we are troubled that in the past year: low-income people with disabilities have had their cash assistance benefits limited and changed through welfare reform; new limits have been placed on the duration during which individuals may receive Food Stamps; tens of thousands of children with disabilities will lose access to SSI benefits; and persons with substance abuse treatment needs have twice seen legislation passed that limits their access to public services. It would be unconscionable to weaken the health care safety net that supports these and millions of other vulnerable persons when similar sacrifices have not been asked of other segments of the population. Given that cuts to social security and additional Department of Defense budget reductions are not being considered at this time, balancing the budget is essentially impossible without making cuts to programs that are greatly valued by a large number of the American people. We hope that you share our belief that the burdens imposed by reducing federal expenditures must be fairly distributed and must not fall disproportionately on the most vulnerable members of our society.

We believe that it would be wrong and terribly harmful to propose cuts to Medicaid in FY 1998. The projections for the growth of Medicaid that fueled much of the budget controversy last year have not materialized. While it is not known if the low growth rate in Medicaid expenditures will persist into the future, we do know that the low growth rate of Medicaid does allow for some breathing room in order to spare Medicaid from potentially harmful policy changes. The low growth rate of Medicaid over the last year signals that time is available to allow states to continue to experiment

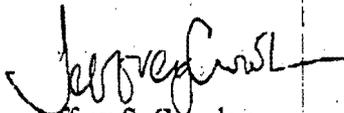
with more efficient and effective health care delivery systems that have been taking place under the waiver authority granted to numerous states by the Health Care Financing Administration. Federal policy should encourage states to take seriously their responsibilities to their vulnerable residents. Cutting Medicaid and changing the program's structure has the potential to undermine state efforts to improve their programs and this could severely limit access to vital health care services for millions of Americans with disabilities and others.

Many of our member organizations supported your Medicaid reform proposal last year that contained per capita caps. At the time, this support was based on our belief that per capita caps are preferable to block grants because they protect an individual entitlement to health care services. We recognized then and continue to believe that per capita caps have serious drawbacks. For people with disabilities, a significant problem with per capita caps is that states with large numbers of people with disabilities whose annual health care costs exceed the cap will be unfairly burdened and this will create powerful incentives to underserve persons with the most extensive health care needs.

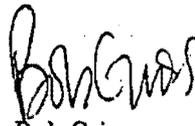
For example, AIDS is just one disabling condition where the average cost to states to provide high quality and medically necessary health care could easily exceed the average health care costs for all people with disabilities by four or five fold. AIDS is also a disorder that is not evenly distributed, but which is concentrated in a few high impact states. States with large numbers of Medicaid recipients in nursing homes and intermediate care facilities for people with mental retardation and related conditions (ICFs-MR) or on waiting lists for long-term services also stand to be adversely impacted by per capita proposals. Persons who are mentally retarded and others living in institutions are especially vulnerable to inappropriate denials of care that are made simply to reduce health care costs because these individuals are the least able to complain and advocate for their needs. All people with disabilities in the Medicaid program are threatened by per capita caps or other policies that underfund or place arbitrary limits on necessary health care services.

We are hopeful that you will continue your record of leadership on this issue by submitting a budget proposal that does not seek to cut Medicaid--cuts that no matter how carefully conceived would seriously compromise Medicaid as a reliable source of health care for people with disabilities.

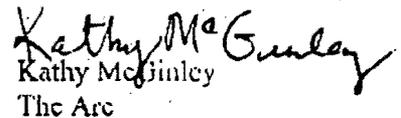
Sincerely,



Jeffrey S. Crowley
National Association of
People with AIDS



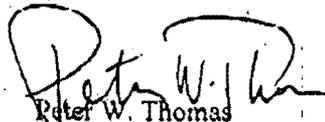
Bob Griss
Center on Disability
And Health



Kathy McGinley
The Arc



John Paleniczek
American Psychological
Association



Peter W. Thomas
Powers, Pyle, Sutter and
Verville, representing the
Brain Injury Association

*Long Term Care Tax Clarification
File*

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Congress of the United States

JOINT COMMITTEE ON TAXATION
1918 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-8483
(202) 225-3621

Honorable Nancy L. Johnson
U.S. House of Representatives
Washington, DC 20515-0706

MAR 14 1996

Dear Ms. Johnson:

This is in response to your letter dated March 6, 1996, requesting information about the long-term care provisions contained in the Balanced Budget Act ("BBA").

The long-term care provisions contained in the BBA would allow long-term care insurance premium payments to be tax deductible for individuals, to the extent that total medical expenses, including those premiums, exceed 7.5 percent of adjusted gross income. The BBA would limit the amount of annual premiums for long-term care insurance that could be taken into account for purposes of this deduction, ranging from a limit of \$200 in the case of an individual not more than 40 years old to \$2,500 for an individual more than 70 years old. In addition, unreimbursed expenses for qualified long-term care services would also be deductible to the extent that total medical expense deductions including long-term care expenses exceed 7.5 percent of adjusted gross income. The BBA also provides that the Federal income tax reserve method applicable for a long-term care insurance contract issued after December 31, 1995, would be the one-year full preliminary term method.

The exchange of a life insurance contract, or an endowment or annuity contract, for a qualified long-term care insurance contract would not be taxable under the BBA. In addition, the BBA would allow distributions from individual retirement arrangements and distributions attributable to elective deferrals to qualified cash or deferred arrangements, tax-sheltered annuities, nonqualified deferred compensation plans of governmental or tax-exempt employers, and section 501(c)(18) plans to be used to pay premiums for long-term care insurance without being subject to the 10-percent additional income tax on early withdrawals. Employer contributions for long-term care insurance premiums would be excluded from gross income under the BBA. Payments under all per diem contracts up to \$175 per day would be excluded from gross income. Payments under reimbursement policies would be fully excludable from income. Finally, the BBA would allow self-employed individuals to deduct long-term care insurance premiums to the same extent that they can deduct health insurance.

Assuming the proposal generally would be effective for taxable years beginning after, and contracts issued after,

Congress of the United States

JOINT COMMITTEE ON TAXATION

Washington, DC 20515-6453

Honorable Nancy L. Johnson
U.S. House of Representatives

Page Two

December 31, 1995, we estimate the BBA long-term care provisions would have the following effect of Federal fiscal year budget receipts:

Item	Fiscal Years [Billions of Dollars]	
	1996-2000	1996-2002
Deduction for long-term care expenses.....	-1.1	-1.8
Deduction for long-term care insurance premiums.....	-0.7	-1.1
Permit insurance companies to use 1-year preliminary term reserve.....	-0.9	-1.0
Exclude employer contributions from gross income.....	-0.2	-0.3
Allow tax-free exchange of life insurance contracts.....	-0.6	-1.1
Allow penalty-free withdrawals from IRAs and certain deferred compensation plans.....	[1]	[1]
Permit self-employed to deduct long-term care insurance premiums.....	-0.2	-0.6
\$175 per day cap on per-diem contract benefits.....	[2]	[2]
TOTAL.....	-3.7	-5.7

[1] Loss of less than \$100 million.

[2] Gain of less than \$100 million.

I hope this information is helpful to you. If we can be of further assistance in this matter, please let me know.

Sincerely,

Kenneth J. Kies

V. TREATMENT OF LONG-TERM CARE INSURANCE

Present Law

In general

Present law generally does not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of long-term care contracts and services is unclear. Present law does provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during the taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from the gross income of the employee (sec. 106). In addition, amounts received by an employee under such a plan generally are excluded from gross income to the extent that the amounts received are paid, directly or indirectly, to reimburse the employee for expenses for the medical care of the employee, the employee's spouse, or a dependent of the employee (sec. 105). For this purpose, expenses incurred for medical care are defined in the same manner as under the rules regarding the deduction for medical expenses.

A cafeteria plan is an employer-sponsored arrangement under which employees can elect among cash and certain employer-provided qualified benefits. No amount is included in the gross income of a participant in a cafeteria plan merely because the participant has the opportunity to make such an election (sec. 125). Employer-provided accident or health coverage is one of the benefits that may be offered under a cafeteria plan.

A flexible spending arrangement (FSA) is an arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care, and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. Under proposed Treasury regulations, a maximum amount of reimbursement is not substantially in excess of the total premium if such maximum amount is less than 500 percent of the premium. An FSA may be part of a cafeteria plan or provided by an employer outside a cafeteria plan. FSAs are commonly used to reimburse employees for medical expenses not covered by insurance. If certain requirements are satisfied³, amounts reimbursed for nontaxable benefits from an FSA are excludable from income.

Health care continuation rules

The health care continuation rules require that an employer must provide qualified beneficiaries the opportunity to continue to participate for a specified period in the employer's health plan after the occurrence of certain events (such as termination of employment) that would have terminated such participation (sec. 4980B). Individuals electing continuation coverage can be required to pay for such coverage.

Description of Proposal

Tax treatment and definition of long-term care insurance contracts and qualified long-term care services

Exclusion of long-term care insurance proceeds

A long-term care insurance contract generally would be treated as an accident and health insurance contract. Amounts (other than policyholder dividends or premium refunds) received under a long-term care insurance contract generally would be excludable from gross income as amounts received for personal injuries and sickness, subject to a cap of \$175 per day, or \$63,875 annually on per diem contracts only. If the aggregate payments under all per diem contracts with

³ These requirements include a requirement that a health FSA can only provide reimbursement for medical expenses (as defined in sec. 213) and cannot provide reimbursement for premium payments for other health coverage and that the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage.

respect to any one insured exceed \$175 per day, then the excess would not be excludable from gross income. The dollar cap would be indexed by the medical care cost component of the consumer price index.

Exclusion for employer-provided long-term care coverage

A plan of an employer providing coverage under a long-term care insurance contract generally would be treated as an accident and health plan; however, coverage under a long-term care insurance contract would not be excludable by an employee if provided through a cafeteria plan; similarly, expenses for long-term care services could not be reimbursed under an FSA.⁴

Self-employed individuals' long-term care insurance

The present-law 30 percent deduction for health insurance expenses of self-employed individuals would be phased up to 50 percent under the proposal. Because the bill would treat payments of long-term care insurance premiums in the same manner as payments of health insurance premiums, the self-employed health insurance deduction would apply to long-term care insurance premiums under the proposal.

Definition of long-term care insurance contract

A long-term care insurance contract would be defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements would be that (1) the contract is guaranteed renewable, (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed, (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits, and (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses).

A contract would not fail to be treated as a long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses during the period.

⁴ The proposal would not otherwise modify the requirements relating to FSAs. An FSA is defined (as under proposed regulations) as a benefit program providing employees with coverage under which specified incurred expenses may be reimbursed (subject to maximums and other reasonable conditions), and the maximum amount of reimbursement that is reasonably available to a participant is less than 500 percent of the value of the coverage.

Medicare duplication rules

The proposal would provide that no provision of law shall be construed or applied so as to prohibit the offering of a long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under Medicare. Thus, long-term care insurance contracts would not be subject to the rules requiring duplication of Medicare benefits.

Definition of qualified long-term care services

Qualified long-term care services would mean necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

A chronically ill individual would be one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days⁵ due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living would be eating, toileting, transferring, bathing, dressing and continence.⁶

A licensed health care practitioner would be a physician (as defined in sec. 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Long-term care insurance premiums treated as medical expenses

Long-term care insurance premiums that do not exceed specified dollar limits would be treated as medical expenses for purposes of the itemized deduction for medical expenses.⁷ The

⁵ The 90-day period would not be a waiting period. Thus, an individual could be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days.

⁶ Nothing in the proposal would require the contract to take into account all of the activities of daily living. For example, a contract could require that an individual be unable to perform (without substantial assistance) 2 out of any 5 such activities, or for another example, 3 out of the 6 activities.

⁷ Similarly, within certain limits, in the case of a rider to a life insurance contract, charges against the life insurance contract's surrender value that are includible in income would be treated as medical expenses (provided the rider constitutes a long-term care insurance contract).

limits are as follows:

<u>In the case of an individual with an attained age before the close of the taxable year of:</u>	<u>The limitation on premiums paid for such taxable years is:</u>
Not more than 40	\$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

For taxable years beginning after 1997, these dollar limits are indexed for increases in the medical care component of the consumer price index. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be directed to develop a more appropriate index to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limits as early in the year as they can be calculated.

Long-term care riders on life insurance contracts

In the case of long-term care insurance coverage provided by a rider on, or as part of, a life insurance contract, the requirements applicable to long-term care insurance contracts would apply as if the portion of the contract providing such coverage were a separate contract. The term "portion" would mean only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. The guideline premium limitation applicable under section 7702(c)(2) would be increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, less any such charges, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury regulations would provide for appropriate reduction in premiums paid (within the meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract.

Health care continuation rules

The health care continuation rules would not apply to coverage under a long-term care insurance contract.

Inclusion of excess long-term care benefits

In general, the proposal would provide that the maximum annual amount of long-term care benefits under a per diem contract that is excludable from income with respect to an insured

who is chronically ill cannot exceed the equivalent of \$175 per day for each day the individual is chronically ill. Thus, the maximum annual exclusion for long-term care benefits with respect to any chronically ill individual would be \$63,875 (for 1996). Long-term care benefits for this purpose would include payments and other benefits received under a long-term care insurance contract (to the extent otherwise excludable under section 7702B(b) as added by the proposal. If the insured is not the same as the holder of the contract, the insured may assign some or all of this limit to the contract holder at the time and manner prescribed by the Secretary.

A payor of long-term care benefits (as defined above) would have to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. A copy of the report would have to be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee would be subject to the generally applicable penalties for failure to file similar information reports.

Consumer protection provisions

Under the proposal, long-term care insurance contracts, and issuers of contracts, would be required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993). The policy requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. The proposal would also provide disclosure and nonforfeiture requirements. The nonforfeiture provision would give consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums. The requirements for issuers of long-term care insurance contracts would relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax would be imposed equal to \$100 per policy per day for failure to satisfy these requirements.

Nothing in the proposal would prevent a State from establishing, implementing or continuing standards related to the protection of policyholders of long-term care insurance policies, if such standards are not inconsistent with standards established under the proposal.

Effective Date

The provisions defining long-term care insurance contracts and qualified long-term care services would apply to contracts issued after December 31, 1996. Any contract issued before January 1, 1997, that met the long-term care insurance requirements in the State in which the

policy was situated at the time it was issued would be treated as a long-term care insurance contract, and services provided under or reimbursed by the contract are treated as qualified long-term care services.

A contract providing for long-term care insurance could be exchanged for a long-term care insurance contract (or the former canceled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange.

The issuance or conformance of a rider to a life insurance contract providing long-term care insurance coverage would not be treated as a modification or a material change for purposes of applying sections 101(f), 7702 and 7702A of the Code.

The provision relating to treatment as a medical expense of eligible long-term care premiums would be effective for taxable years beginning after December 31, 1996.

The provisions relating to the maximum exclusion for long-term care benefits and reporting would be effective for taxable years beginning after December 31, 1996. Thus, the initial year in which reports will be filed with the IRS and copies provided to the payee would be 1998, with respect to long-term care benefits paid in 1997.

Long-Term Care Tax Clarification File

PRIVATE LONG-TERM CARE PROVISIONS

Discussion on Issues

The long-term care provisions in the amendments by Senators Dole and Roth have the following shortcomings:

1. Needed consumer protections for all long-term care insurance policies would not be required. The long-term care amendment by Senators Dole and Roth would require that tax qualifying policies meet key consumer protection requirements. However, this amendment does not require that all long-term care insurance policies meet these requirements. Requiring minimum standards for one set of policies but not for another creates a two-tiered insurance market that leaves consumers, particularly the unemployed poor elderly, vulnerable.

Limiting the applicability of standards to policies that receive tax favored treatment is a reasonable approach with respect to the employer based market. However, almost 90% of long-term care insurance sales have been to individuals, not groups. Individual consumers are quite vulnerable to abusive sales practices by unscrupulous agents. Agents could offer policies that fail to provide needed consumer protection at a very low cost, thus, inducing consumers to purchase policies that in reality provide little, if any protection against the costs of long-term care.

The NAIC has adopted a position that all long-term care insurance products meet minimally acceptable consumer protection requirements. The Department agrees with this position. In addition, minority staff from both the House and Senate have recently called inquiring about consumer protections needed for private long-term care insurance products and have questioned the adequacy of the protections in recently proposed Congressional bills. House staff encouraged the Administration to establish a position on consumer protection standards for long-term care insurance and indicated that several members are interested in this issue.

2. There is no effective enforcement mechanism for all long-term care requirements. The amendments make the IRS responsible for enforcing non-compliance with insurer marketing standards. The marketing standards the IRS would be required to monitor include the use of appropriate application forms; whether appropriate action was taken in response to information obtained in these applications; whether agents engaged in unfair, misleading or high-pressured sales tactics; whether any person misrepresents a material fact; and other marketing requirements. Not only does the IRS not have the expertise to make these assessments, it does not have the manpower needed to monitor these practices.

In addition, while tax qualifying policies would be required to comply with key consumer protection requirements, the amendment does not require any enforcement of these provisions. For example, the amendment includes important consumer protections such as an offer of inflation protection and non-forfeiture benefits, and protections against unintentional lapses. However, by not monitoring compliance and enforcing incidents of noncompliance, the promise

of these needed consumer protections may be imaginary.

3. The amendments permit the sale of illusory long-term care insurance benefits. In addition to allowing persons with severe cognitive impairment to qualify for tax preferred treatment when using long-term care services or a qualified long-term care insurance policy, the amendment also permits persons to qualify for tax-preferred treatment if they are impaired in at least 2 out of 6 activities of daily living (ADLs) impairments and use qualified long-term care services or insurance products. The amendment identifies the 6 ADLs as eating, toileting, transferring, bathing, dressing, and continence and states, "Nothing ... shall be construed to require a contract to take into account all of the preceding activities of daily living". However, this language permits insurers to establish extremely stringent triggering criteria, thus making the long-term care insurance protection illusory.

Impairments in ADL occur in a hierarchical fashion. Specifically, persons are likely to become impaired first in bathing, next in dressing, then toileting, transferring and last eating. Thus, if insurers limit eligibility for long-term care insurance products to persons who are impaired in eating and transferring, many otherwise severely disabled persons would be denied needed long-term care insurance benefits. Clearly, persons who are unable to bathe, dress, toilet and who are incontinent are severely impaired. Nonetheless, this amendment would permit insurers to market products that would deny coverage needed by these individuals. In addition, trying to educate consumers about the impact of varying ADL triggers on the availability of insurance coverage is a daunting task. As a result, consumers will likely be confused and surprised to discover that needed long-term care coverage is unavailable when needed.

In addition, incontinence is not an activity of daily living. Rather, incontinence is a medical condition that may be addressed through medical interventions. Further, limitations in toileting encompasses certain elements of incontinence. Thus, to minimize consumer confusion and to make clear that the eligibility trigger is due to functional impairments, the list of triggering ADL impairments should be limited to 5, with incontinence eliminated from the list.

4. Non-forfeiture benefits. Long-term care insurance is a product that is significantly prefunded. Insurers and policyholders anticipate that it will be years before a consumer will need long-term care benefits provided under a policy. Over the course of these years, policyholders make premium payments in amounts that insurers have estimated to be adequate to cover the costs of covered long-term care benefits. In estimating needed premium amounts, insurers make a number of assumptions including the number of persons who will retain or lapse their policies, the amount of time over which policies will be retained or when they will lapse for nonpayment, and the number of persons who are likely to go into benefit status. From the consumer's perspective most do not anticipate the future possibility of being unable to make premium payments. However, given the length of time over which long-term care insurance is funded, a consumer's financial status can and does change. For example, the death of a spouse can make long-term care insurance premiums unaffordable. When a person stops making premium payments after an extended period of time, the consumer has lost and the insurer has gained a considerable investment.

Optional non-forfeiture benefits is a mechanism to address this problem. This amendment requires insurers to offer consumers an optional nonforfeiture benefit which permits consumers to recover some of their investment that would otherwise be lost if they stop making premium payments. Nonforfeiture benefits allows consumers, who elect (and pay) for this benefit, but who stop making premium payments after some period of time to still receive some reduced long-term care coverage.

However, the amendment by Senators Dole and Roth, permit insurers to adjust the premium payment and to reduce the amount of long-term care coverage that a person receives, even after they have lapsed their policy and are using their non-forfeiture benefit. Permitting insurers to alter non-forfeiture benefits for individuals who are using that benefit is extremely unfair to consumers when they are most vulnerable.

Technical Fixes:

1. Problem -- Consumer protections are needed for all long-term care insurance policies. In fixing the current law prohibition on the sale of long-term care insurance policies that duplicate Medicare or Medicaid benefits, permit the sale of "qualified" long-term care insurance policies that coordinate with these programs. This change would permit the sale of qualified policies and prohibit the sale of unqualified policies. The Secretary of HHS would have to define "qualified policies".

2. Problem -- Enforcement mechanism for all long-term care requirements. No technical fix.

3. Problem -- The sale of illusory long-term care insurance benefits. Change required benefit trigger an individual must be impaired in at least 3 out of 5 activities of daily living (i.e., eating, transferring, dressing, bathing, and toileting). A 3 out of 5 trigger ensures that persons receiving tax qualified benefits are severely impaired, still gives insurers flexibility in targeting a specific standard, and provides consumers with at least some promise that when they are very impaired their private benefit will be available.

4. Problem -- Non-forfeiture benefits. On page 32, line 10 strike the words, "subsequent to being initially granted" and insert the phrase "prior to lapse". The new sentence would read:

The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted ~~subsequent to being initially granted prior to lapse~~ only as necessary to reflect changes in claims, persistency, and interest...

New Program for Home and Community-based Care: Low Option

- o **Who is Eligible?** This new demonstration program would allow states to expand home and community-based services to people with severe disabilities of any age without regard to income. States could elect to serve only one target group, e.g., the frail elderly, or some target groups, e.g., the elderly and children. States could also elect to target certain geographic areas within the state, e.g., rural areas, a particular region, or SMSA.
- o **What Benefits Would They Receive?** States would decide which services to offer. A broad array of home and community-based services would allowed including cash payments and vouchers, services in residential settings, e.g., assisted living, assistive devices, etc.
- o **How Much Would Eligible Families Pay?** States could elect to impose copayments or deductibles based on income.
- o **How Much Would the Federal Government Pay?** Each state would receive a fixed allocation, based on the number of persons with severe disabilities in the states. State matching requirements would be modest. The program would cost \$15.4 billion over FY1997-FY2005 with no phase-in period. The capped Federal payment would be increased by the level of inflation each year so that the program would cost \$6.2 billion over FY1997-FY2000 and \$9.2 billion over FY2001-FY2005.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages ▶

To JENNINGS	From THORPE
Dept./Agency	Phone #
Fax #	Fax #

New Program for Home and Community-based Care: High Option

- o **Who is Eligible?** All persons with severe disabilities would be eligible. The Federal government would define eligibility criteria.
- o **What Benefits Would They Receive?** States would decide which services to provide. A broad array of home and community-based services including cash payments would be permitted. States would not have enough funds to serve all persons during the phase-in, so benefits would be limited until the phase-in was completed.
- o **How Much Would Eligible Families Pay?** A sliding copayment scale would be used. No copayments or deductibles would be charged to those with incomes below 150% of the poverty level. Those with incomes above 400% of poverty would pay a 40% copayment and a \$600 annual deductible.
- o **How Much Would the Federal Government Pay?** The program would cost \$65.3 billion over FY1998-FY2005 with no phase-in period. The capped Federal payment would be increased by the level of inflation each year so that the program would cost \$8.3 billion over FY1998-FY2000 and \$57 billion over FY2001-FY2005. States would be required to provide modest matching funds.

Raise The Asset Limit For Nursing Home Residents

- **Who is Eligible?** All unmarried nursing home residents with assets up to a specified level.
- **What Benefits Would They Receive?** Unmarried persons would be able to keep \$12,000 in assets instead of the current \$2,000 and qualify for Medicaid nursing home benefits. However, they would still have to spend down all of their income as they do now.
- **How Much Would Eligible Families Pay?** There would be no copayments, since all unprotected assets and any income would be spent down, except for a monthly personal needs allowance.
- **How Much Would The Federal Government Pay?** To avoid an unfunded mandate, the Federal Government would pay all of the additional costs. It would cost \$2.4 billion over FY1996-FY2000, \$3.3 billion over FY2001-FY2005, for a total of \$5.7 billion over FY1997-FY2005.

Private Long Term Care Insurance Tax Clarifications

- o **Who is Eligible?** All persons who pay income taxes would be eligible. All businesses would be eligible.
- o **What Benefits Would They Receive?** All persons who pay income taxes would be able to treat qualifying long term care expenses and insurance premiums as medical expenses. Employers would be able to treat their premium contributions as business expenses.
- o **How Much Would Eligible Families Pay?** No copayment requirements.
- o **How Much Would the Federal Government Pay?** The Federal Government would lose \$1 billion in tax revenue over the period FY1997-FY2000, \$1.8 billion over FY2001-FY2005, for a total of \$2.8 billion over FY1997-FY2005.

Tax Credit For Persons With Disabilities Who Work

- o **Who is Eligible?** All persons with disabilities who work.
- o **What Benefits Would They Receive?** Individuals with qualifying disabilities would receive a credit for half of their work-related personal assistance expenses, up to \$15,000 in expenses. This benefit would begin to phase out above \$50,000 adjusted gross income.
- o **How Much Would Eligible Families Pay?** No copayment requirements.
- o **How Much Would The Federal Government Pay?** It would cost \$.4 billion in lost tax revenue over the period FY1997-FY2000, \$.9 billion over FY2001-FY2005, for a total of \$1.3 billion over FY1997-FY2005.

Appendix

Program to Expand Home and Community based long-term care.

This demonstration program would enable states to expand community based long-term care to new groups of persons with severe disabilities, or offer new services, or other expansions. States would define the population, services, and other parameters of the demonstrations. Each state would receive a fixed allocation, determined based on the number of severely disabled individuals in the state. States would not be allowed to means test this program. (Estimated FY1997-FY2005 cost: \$15.4 billion)

If this demonstration program were made available to the states it would provide funding of about \$1.5 billion in FY1997, and if the funds were allocated to the states according to the number of persons with severe disabilities in each state, the following amounts would be allocated:

State	New Federal Allocation (millions)	Current Law Spending for Persons with Severe Disabilities (millions)
Florida	\$101	\$157
Mississippi	\$22	\$24
Missouri	\$33	\$129
New York	\$121	\$2539
Wisconsin	\$26	\$230

The impact of a such a program would be significant, but varied across the states. For example, although the program would provide an amount to New York which is 5% of their baseline spending under Medicaid and state-only programs, it would allocate an amount to Mississippi which is 92% of their baseline spending for home and community-based services. Other states would fall between these extremes.

This paper lists several options which can be combined into 2 packages. The difference between the 2 packages is that the first one contains a modest expansion of HCBS which is fully phased-in in FY1997. The second has a much more ambitious HCBS program which was in the Senate Leadership Proposal (Mitchell). This program has a very low initial phasein, but it reaches a level of \$17.3 billion in FY2005. If the program began in FY1999 instead of FY1998 it would cost \$48 billion over FY1999-FY2005.

Each package also contains a proposal to raise the assets that unmarried nursing home residents will be able to keep and still maintain Medicaid eligibility. There is also a set of tax incentives to promote the growth of private long term care insurance, and a tax credit to support the personal assistance needs of persons with disabilities who work.

Estimated Program Costs FY1997-FY2005
(Billions of Dollars)

Package	Low	High
Expand HCBS	\$15.4	\$65.3
Raise Asset Limit	\$5.7	\$5.7
LTC insurance Tax	\$2.8	\$2.8
PAS Tax Credit	\$1.3	\$1.3
Total	\$25.2	\$75.1

**MEDICAID/HEALTH CARE INVESTMENT
PRESENTATION**

12/20/96

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Our FY 97 Budget

- OMB: \$59 billion over 6 years
CBO: \$54 billion over 6 years
- Per capita cap on growth rates
- Disproportionate Share Hospitals (DSH)
 - Cuts and retargets DSH funding
 - Large and small "pools" that offset DSH cuts
- Expands State flexibility

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What Has Changed: Large Medicaid Baseline Reductions

(Fiscal Years, Dollars in billions)

	1997 - 2002	Change Relative to April 1996 Baseline
OMB April 1996 Baseline	774	
OMB June 1996 Baseline	750	-24
OMB December 1996 Baseline	702	-72
Republicans' FY 97 Budget	731	

Note: The President's FY 97 Budget saved **\$59 billion** relative to the April 1996 Baseline.
The Republicans' FY 97 Budget saved **\$72 billion** relative to the April 1996 CBO Baseline.

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CONFLICTING PRESSURES

- **Balanced Budget Pressures**
- **Budget Table:** Currently Carrying \$30 billion over 5 years and \$17 billion in 2002
- **Democratic Governors/Base Democrats and Groups**
- **Health Investments**

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Options for Alternative Medicaid Policies
FY 1998 President's Budget Baseline Scoring
(Dollars in Billions)

	<u>5-Year Total</u> <u>1998-2002¹</u>	<u>6-Year Total</u> <u>1998 - 2003²</u>
FY 98 President's Budget Baseline	603.2	753.9
Per Capita Growth	5.5%	5.7%

Option A: Moderate Per Capita Cap/Large DSH Hit		
Total Savings	-27.7	-42.2
Total Savings in FY 2002	-10.7	
<u>Savings From:</u>		
Per Capita Cap* ³	-7.2	-13.8
Net DSH Savings	-20.5	-28.5
Resulting Per Capita Growth Rate	3.8%	4.0%
*Growth Index of Per Capita Cap	4.9%	4.9%

¹ Growth rates for the five-year total are measured from FY 1997 - 2002.

² Growth rates for the six-year total are measured from FY 1997 - 2003.

³ Per Capita Cap does not produce savings until FY 2000.

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Options for Alternative Medicaid Policies
FY 1998 President's Budget Baseline Scoring
(Dollars in Billions)

	5-Year Total <u>1998-2002</u> ¹	6-Year Total <u>1998 - 2003</u> ²
FY 98 President's Budget Baseline	603.2	753.9
Per Capita Growth	5.5%	5.7%

Option B: Moderate Per Capita Cap/Less Severe DSH Hit		
Total Savings	-22.4	-36.0
Total Savings in FY 2002	-9.7	
<u>Savings From:</u>		
Per Capita Cap* ³	-7.2	-13.8
Net DSH Savings	-15.2	-22.2
Resulting Per Capita Growth Rate	4.0%	4.1%
*Growth Index of Per Capita Cap	4.9%	4.9%

¹ Growth rates for the five-year total are measured from FY 1997 - 2002.

² Growth rates for the six-year total are measured from FY 1997 - 2003.

³ Per Capita Cap does not produce savings until FY 2000.

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Options for Alternative Medicaid Policies
FY 1998 President's Budget Baseline Scoring
(Dollars in Billions)

	5-Year Total <u>1998-2002</u>¹	6-Year Total <u>1998 - 2003</u>²
FY 98 President's Budget Baseline	603.2	753.9
Per Capita Growth	5.5%	5.7%

Option C: Moderate Per Capita Cap With No Savings/Less Severe DSH Hit		
Total Savings	-15.2	-23.7
Total Savings in FY 2002	-7.1	
<u>Savings From:</u>		
Per Capita Cap*	0.0	0.0
Net DSH Savings	-15.2	-23.7
Resulting Per Capita Growth Rate	4.4%	4.7%
*Growth Index of Per Capita Cap	6.0%	6.0%

¹ Growth rates for the five-year total are measured from FY 1997 - 2002.

² Growth rates for the six-year total are measured from FY 1997 - 2003.

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Options for Alternative Medicaid Policies
FY 1998 President's Budget Baseline Scoring
(Dollars in Billions)

	5-Year Total <u>1998-2002</u>¹	6-Year Total <u>1998 - 2003</u>²
FY 98 President's Budget Baseline	603.2	753.9
Per Capita Growth	5.5%	5.7%

Option D: Moderate Per Capita Cap With No Savings/Moderate DSH Hit		
Total Savings	-10.2	-16.2
Total Savings in FY 2002	-4.6	
<u>Savings From:</u>		
Per Capita Cap*	0.0	0.0
Net DSH Savings	-10.2	-16.2
Resulting Per Capita Growth Rate	4.8%	5.0%
*Growth Index of Per Capita Cap	6.0%	6.0%

¹ Growth rates for the five-year total are measured from FY 1997 - 2002.

² Growth rates for the six-year total are measured from FY 1997 - 2003.

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Health Care Coverage Initiatives

	Coverage by End of 2000	Cost in FY 02	5 Year Cost (FY 98 - 02)
Kennedy Kids' Package (75 cent cigarette tax)	6 to 7 million children	\$8 to \$9 billion	\$24 billion
1. Workers' In Between Jobs	700,000 children (2.3 million adults)	\$3 billion	\$3 billion*
2. Expanded Medicaid Outreach (Not likely to be included in the budget)			
A: 33% success rate	1 million children	\$736 million	\$2.4 billion
B: 66% success rate	2 million children	\$1.5 billion	\$4.7 billion
3. Enhanced State Partnerships	1.5 million children	\$750 million	\$3.75 billion
4. 12 Month Eligibility Option	1.25 million children	\$1.1 billion	\$3.5 billion

Note: All numbers are based on preliminary HHS estimates and are subject to change.

* There is no increase in the five-year number for this initiative because the current budget tables are carrying financing for this package from FY 98 - 01.

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Health Care Coverage Packages

Package	Coverage by End of 2000	Cost in FY 02	5 Year Cost (FY 98 - 02)
A. Includes: *Workers' In Between Jobs; *Expanded Medicaid Outreach (66% success rate); *Enhanced State Partnerships; & *12 Month Eligibility Option.	2.3 million adults 5 million children	\$6.4 billion (\$4.9b in budget)	\$15 billion (\$10.3b in budget)
B. Includes: *Workers' In Between Jobs (less FY 02 financing); *Expanded Medicaid Outreach (66% success rate); *Enhanced State Partnership; & *12 Month Eligibility Option.	2.3 million adults 5 million children	\$3.4 billion (\$1.9b in budget)	\$12 billion (\$7.3b in budget)
C. Includes: *Workers' In Between Jobs (less FY 02 financing); *Expanded Medicaid Outreach (66% success rate); & *Enhanced State Partnerships or 12 Month Eligibility Option.	3.5 million children	\$2.3 to \$2.6 billion (\$0.8b to \$1.2b in budget)	\$8.3 to \$8.5 billion (\$3.6b to \$3.8b in budget)
D. Includes: *Workers' In Between Jobs (less FY 02 financing); *Expanded Medicaid Outreach (33% success rate); & *Enhanced State Partnerships or 12 Month Eligibility Option.	2.0 to 2.5 million children	\$1.5 to \$1.8 billion (\$750m to \$1b in budget)	\$5.9 to \$6.1 billion (\$3.5b to \$3.7b in budget)

Note: All packages are based on preliminary HHS estimates and are subject to change. There is likely to be some double counting. However, the 1 million children expansion that is already in the baseline should act as a rough offset.

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MEDICAID PRESENTATION

12/16/96

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Our FY97 Budget

- OMB: \$59 billion over 6 years
CBO: \$54 billion over 6 years
- Per capita cap on growth rates
- Disproportionate Share Hospitals (DSH)
 - Cuts and retargets DSH funding
 - Large and small "pools" that offset DSH cuts
- Expands State flexibility

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PRESERVATION

What Has Changed: Large Medicaid Baseline Reductions
(Fiscal Years, Dollars in billions)

	1997 - 2002	Change Relative to April 1996 Baseline
OMB April 1996 Baseline	774	
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OMB December 1996 Baseline	705 - 715	- 59 - 69
Republicans' FY 97 Budget	731	

Note: The President's FY 97 Budget saved \$59 billion relative to the April 1996 Baseline
The Republicans' FY 97 Budget saved \$72 billion relative to the April 1996 CBO Baseline

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What Has Changed (Cont.)

- Reasons for decline in baseline
 - Block grant budgeting
 - Overall decline in inflation
 - Decline in enrollment
 - Managed care utilization
- Providers squeezed in private sector and the welfare law's legal immigrant ban may increase level of uncompensated care
- Now only 4 ways to achieve savings: a block grant, lowering the federal match, a per capita cap, and DSH

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Per Capita Cap

- Original reasons for per capita cap
- Strength
 - Fiscal discipline
 - Protects enrollment
- Weakness
 - Growth already constrained by match, although the program's always at risk due to state financing "schemes"
 - Varied impact on states (see Figure 1)
- Congressional, governors, and interest group views

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TOTAL STATE PER CAPITA COSTS FOR FY 1995 (In Descending Order)
 (Total Computable Costs excluding DSH)

	FY95 Actual Dollars	Average Annual Growth from FY 90-95
NY	\$7,454	4.9%
OR	\$7,116	17.4%
NH	\$6,800	2.2%
DC	\$6,500	6.4%
RI	\$6,129	-4.5%
CT	\$6,026	7.9%
MN	\$6,021	-17.8%
MA	\$5,835	1.1%
ND	\$5,658	1.7%
NJ	\$5,521	3.6%
MD	\$4,840	5.2%
SD	\$4,832	4.1%
WI	\$4,822	7.3%
ME	\$4,715	5.2%
DE	\$4,663	9.4%
MT	\$4,573	5.3%
NE	\$4,552	7.2%
IA	\$4,424	6.7%
PA	\$4,323	7.8%
LA	\$4,308	9.5%
AK	\$4,202	-3.4%
WY	\$4,130	8.1%
OH	\$4,119	8.6%
AR	\$4,094	8.3%
CO	\$4,078	10.2%
WV	\$4,028	16.0%
MI	\$3,948	6.8%
KS	\$3,943	4.2%
NV	\$3,922	1.7%
NC	\$3,770	3.8%
UT	\$3,765	3.7%
WA	\$3,654	3.1%
TN	\$3,461	9.0%
ID	\$3,441	-1.2%
FL	\$3,433	1.8%
IL	\$3,360	9.6%
VT	\$3,343	2.4%
SC	\$3,335	0.2%
KY	\$3,289	5.7%
OK	\$3,255	1.6%
TX	\$3,202	5.2%
AL	\$3,194	5.6%
NM	\$3,170	4.8%
VA	\$3,165	0.5%
IN	\$3,088	-9.4%
MO	\$3,041	5.5%
GA	\$2,995	2.0%
AZ	\$2,908	6.1%
MS	\$2,863	12.5%
CA	\$2,461	4.2%
HI	n/a	12.6%

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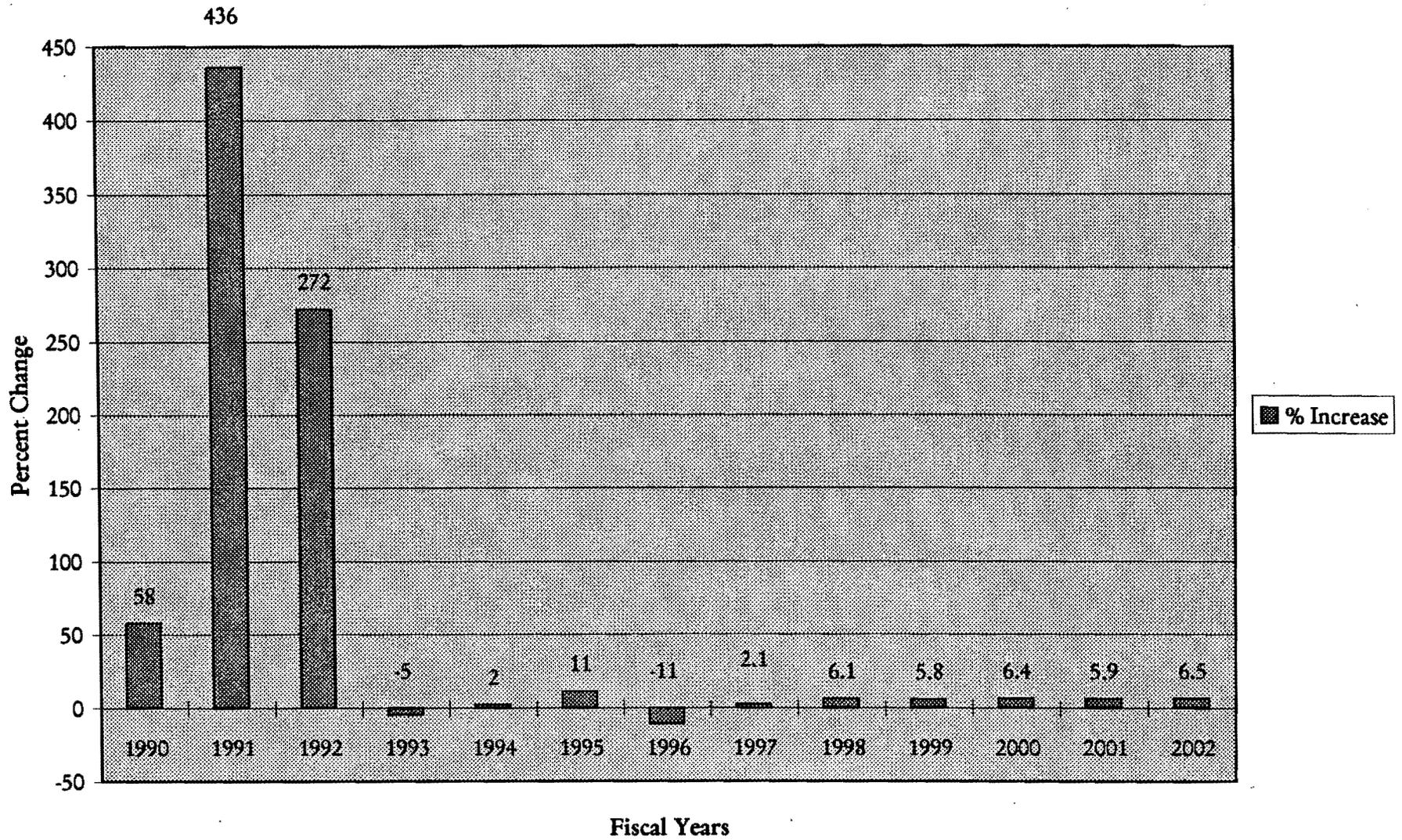
Figure 1

Disproportionate Share Hospitals

- History of program (see Figure 2)
 - 1991 and 1993 agreements
 - High DSH states dependent (see Figure 3)
 - Policy justification remains for DSH savings
- Where we were: DSH savings and retargeting, pools
- What has changed
 - Baseline similar
 - No alternative to compare to state by state
- Discussion
 - Original reasons for DSH savings
 - Strength: protects enrollment
 - Weakness: varied impact on states
 - Congressional, governors and interest group views
 - Reasons for and against

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Percentage Change in DSH Spending



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Figure 2

**Disproportionate Share Hospital (DSH) Spending
Federal Spending and Percent of Total Spending, FY 1995
Sorted by States with Largest or Largest Proportion of DSH Spending**

	Federal Spending (Dollars in Millions)		DSH as % of Total Medicaid
Total	9,950		13%
New York	1,512	New Hampshire	39%
California	1,096	Louisiana	31%
Texas	958	Missouri	26%
Louisiana	865	New Jersey	24%
New Jersey	547	Colorado	23%
Pennsylvania	521	South Carolina	22%
Missouri	436	Alabama	21%
Ohio	382	California	19%
South Carolina	311	Maine	17%
Alabama	294	Rhode Island	17%
Massachusetts	288	Texas	17%
North Carolina	278	Connecticut	16%
Georgia	255	Indiana	16%
Michigan	249	Nevada	16%
Connecticut	204	Mississippi	12%
Illinois	202	New York	12%
Florida	188	Washington	12%
Washington	174	Georgia	11%
Mississippi	143	Massachusetts	11%
Kentucky	137	North Carolina	11%
Indiana	124	Pennsylvania	11%
Maine	105	Vermont	11%
Colorado	83	Kentucky	10%
Arizona	81	Ohio	10%
Maryland	72	Michigan	9%
West Virginia	64	Arizona	8%
Rhode Island	62	Kansas	8%
New Hampshire	52	Illinois	7%
Kansas	52	Maryland	7%
Nevada	37	Virginia	7%
Virginia	34	Alaska	6%
District of Columbia	23	District of Columbia	6%
Oregon	20	Florida	5%
Vermont	18	Delaware	2%
Oklahoma	16	Oklahoma	2%
Minnesota	16	Oregon	2%
Alaska	10	West Virginia	2%
Wisconsin	7	Idaho	1%
New Mexico	5	Minnesota	1%
Nebraska	4	Nebraska	1%
Iowa	4	New Mexico	1%
Delaware	4	Utah	1%
Utah	3	Wisconsin	1%
Arkansas	2	Iowa	0%
Idaho	1	North Dakota	0%
North Dakota	1	Arkansas	0%
South Dakota	1	South Dakota	0%
Montana	0	Hawaii	0%
Hawaii	0	Montana	0%
Tennessee	0	Tennessee	0%
Wyoming	0	Wyoming	0%

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Figure 3

NOTES: 1995 spending from HCFA 64 forms; percent of total from CRS, 1996.

Other Initiatives with Implications for Medicaid

- Financing of proposed changes in the welfare law
- Financing of children's initiative

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Potential Children's Health Initiatives

Options	Cost	Population Served
Workers in between jobs	Need \$3 billion more in 2002	3 million Americans, including 700,000 kids
Medicaid outreach	Probably in the \$500 to \$800 million a year range	About 1 million children (more successful outreach would cover more children and cost more money)
State flexibility options	Currently unknown	Because of popularity with states, some significant increase in children's coverage likely
Grants to states for public/private partnerships	\$100 million	180,000 children, increasing in proportion with funding
Public health investment for services	\$100 million	An added 450,000 children served in community health centers, increasing in proportion with funding
Investment package without specific policy	\$2 billion a year	2 to 5 million children either provided insurance or increase access to services

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Medicaid Options

- Our budget tables are currently carrying about \$30 billion in Medicaid savings. This is prior to final scoring of current Medicaid policy.
- DSH: probably can produce between \$5 and \$20 billion
- Per capita: may or may not achieve significant savings -- waiting on scoring. (fiscal discipline back-up still desirable).

Medicaid Options

- 1) Per capita cap plus DSH savings to plug deficit hole
- 2) No savings for balancing the budget, but use savings from program (most likely DSH) for health investments
- 3) Savings from DSH plus per capita cap to be split between deficit reduction and new investments.