

**THE REPUBLICAN MEDICAID PROPOSALS ONLY PRETENDED
TO PROTECT SENIORS FROM SPOUSAL IMPOVERISHMENT**

I. Current law protects spouses and their families from poverty. Federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to qualify for Medicaid:

- States must let spouses keep income equal to 150% of the national poverty level -- about \$15,000 per year.
- States must let spouses keep a minimum amount of their assets. The minimum is set by the state and may range from about \$15,000 to \$75,000. The value of the spouse's home and car are not counted toward the asset limit, which protects spouses from having to sell these items to qualify for Medicaid.
- Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.

II. Earlier versions of the Republican Medicaid Block Grant proposals repealed these spousal impoverishment protections. Under the initial House and Senate Republican plans, any state government could force people whose husbands or wives have to go into nursing homes to give up their car, their furniture -- even their home before their spouse can qualify for any medical support.

III. The President protested the elimination of these protections.

"Congress should strip these outrageous provisions from the budget bill. They're inconsistent with our core values. They're not what America is all about, and they are certainly not necessary to balance the budget." -- President Clinton, Radio Address, September 30, 1995

IV. Responding to the President's criticisms, Republicans modified their plans. But they only passed an empty shell -- their bills still did not protect against spousal impoverishment.

- Since both bills repeal the current Medicaid guarantee of nursing home care, there is also no guarantee of spousal impoverishment protections.
- Both House and Senate bills repeal current national requirements for beneficiary rights to notification, administrative hearings, and appeals.
- Under the House bill, eligible individuals who are not receiving the spousal impoverishment protections can no longer sue the State to obtain these essential protections. Specifically, Section 2117 of the House bill states: "no person (including an applicant, beneficiary, provider, or health plan) shall have a cause of action under Federal law against a State in relation to a State's compliance (or failure to comply) with the provisions of this title or of a MediGrant plan."
- Both House and Senate bills made it more difficult for the Federal government to ensure that States comply with any beneficiary protection requirements.

V. The vetoed Republican budget still did not protect spouses. It adopted the House proposal that eliminated the ability of individuals to enforce spousal impoverishment protections in federal court when they believe that have been wrongfully denied, *making the protections unenforceable*. It also still made it more difficult for the federal government to ensure that states protect spouses. Moreover, it also still repealed the Medicaid guarantee of nursing home care.

constructive ideas

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math more efficient & as possible.

Chris He also wants to see certain

that open up ideas & suggestions

Julie needs more suggestions

cost & quality

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MEDICAID FY 1998 LEGISLATIVE PROPOSALS

IMPACT OF REMOVAL OF PER CAPITA CAP

This paper reviews the impact of the removal of the per capita cap under the Budget Agreement on the FY 1998 President's Medicaid legislative proposals. The proposals are categorized as NGA proposed "budget savers", legislative proposals in our package requiring discussion, and legislative proposals in our package that should be retained. Where possible both the cost estimates prepared by HCFA's actuaries and CBO have been included.

NGA "BUDGET SAVERS" TO BE CONSIDERED.

NGA has proposed a number of policy objectives, which the Governors believe will attain a significant amount of Medicaid savings. NGA has not specifically indicated how much savings each proposal would attain. Where appropriate, we have listed HCFA's OACT and CBO's scoring of these issues.

- ◆ **Repeal Boren Amendment.** This proposal would modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). A public notification process provides an opportunity for review and comment would be added, which should result in more mutually agreeable rates. (OACT estimate, \$.4 billion in savings; CBO estimate, \$1.2 billion in savings)

HHS Position: This provision was included in the President's Budget.

- ◆ **Eliminate cost-based reimbursement for (non-Indian) health clinics and FQHCs.** An increasing number of States are moving their Medicaid populations into managed care plans. As FQHCs/RHCs make the transition to managed care and contract with plans or develop their own plans, it is appropriate to eliminate cost-based reimbursement and let plans and centers negotiate mutually acceptable payment rates. (OACT estimate, \$.3 billion in savings; CBO estimate, \$.4 billion in savings)

HHS Position: This provision was included in the President's Budget.

- ◆ **Managed care for dually eligible.** The NGA urges greater reliance on managed care for dual eligibles, with the goals of reducing costs while serving beneficiaries in a more coordinated, effective manner. (No OACT estimate; CBO estimate, \$700 million in savings)

HHS Position: Strongly oppose, prefer demonstrations only. HCFA is working

extensively with States on a number of demonstrations in this area. We welcome discussion on how to structure programs to meet the goal of reducing costs while improving services to these beneficiaries. This Administration strongly supports maintaining beneficiaries' rights under Medicare and any proposal should include protections of beneficiaries' right to freedom of choice.

- ◆ **Provider selectivity.** To clarify that there is no defacto entitlement for providers to participate in the Medicaid program in the fee for service environment, this proposal would support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through provider selectivity.

HHS Position: Oppose. States already have sufficient flexibility under current law (section 1915(b)(4)) to implement provider selectivity and the Department would not support this proposal at this time.

- ◆ **Reimbursement rates for QMBs and the dually eligible.** States want statutory clarification that, if they must pay Medicare deductibles and coinsurance, they should be allowed to pay based on the Medicaid rate and not based on the Medicare rate. Under recent judicial interpretations, many States have been forced to pay based on the Medicare rate, which is typically higher and which therefore increases State costs for this population. (No OACT estimate; CBO estimate, \$600 million in savings --\$5 billion in Federal Medicaid savings offset by \$4.4 billion in Medicare costs. State savings of \$3.7 billion).

HHS Position: HCFA opposes. This would entail a cost shift from Medicaid to Medicare and would affect Budget Agreement. [Note: We believe it would not be appropriate to legislatively overrule the prevailing court decisions on this issue.] We believe that the CBO estimate is severe, and probably assumes all States would be affected with the maximum cost impact.

- ◆ **Cost sharing.** Significant Medicaid savings could be realized through a number of cost-sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages \$5 monthly, over \$2 billion in Medicaid savings would be generated annually, contributing significantly to efforts to avoid any cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or in institutions would yield additional savings. Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from \$6 to \$28 per month. Between December 1995 and January 1997, Oregon has collected over \$7 million in premiums from its expanded eligibility group of approximately 75,000 households. (CBO estimates no savings without

enforcement provision)

HHS Position: Oppose. HCFA opposes imposing more cost-sharing obligations on current beneficiaries than are permitted under current law, except for the change for HMOs in the President's Budget.

- ◆ **EPSDT.** Governors, Congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered by Medicaid's package of mandatory and optional benefits. (CBO estimate, no savings from study)

HHS Position: To date, States have not demonstrated that the EPSDT benefit package has created a significant financial burden on States. Preventive services for children result in better health outcomes and cost-effectiveness. Childhood immunizations, for example, are one of the most cost effective prevention interventions. Data from a 1995 CDC report indicate that DPT vaccinations save \$29 for every \$1 spent and MMR vaccinations save \$21 for every \$1 spent. Given the research on the significant value of preventive services for children related to both health care outcomes and cost effectiveness, we support maintaining the EPSDT program requirements under current law.

- ◆ **Fraud and abuse.** The NGA urges expansions of aggressive new State-based strategies to combat fraud and abuse. Specifics are absent. The NGA notes that there is an administrative concern regarding whether States have adequate authority to proceed without additional clarification from HCFA. (CBO estimate, no savings without more specifics)

HHS Position: HCFA and the Inspector General will continue to work with States to aggressively combat fraud and abuse in the Medicaid program. In fact, the Administration currently is developing a series of proposals to reduce fraud and abuse. This package will help the Federal government and State governments save money.

LEGISLATIVE PROPOSALS IN OUR PACKAGE REQUIRING DISCUSSION.

The following proposals were included in the President's Budget, but are being highlighted in this section for further discussion as a result of the cost implications imposed by recent budget agreement as well as other emerging policy issues which have encouraged us to reexamine some of our original proposals.

- ◆ **Eliminate unnecessary personnel requirements.** This general provision simplifies the current, excessively detailed, and ineffective Federal rules regarding administrative issues.

Concern: This proposal was controversial as it related to the Texas TIES proposal.

- ◆ **Modify upper payment limit for capitation rates.** The current Medicaid upper payment limit for managed care contracts (i.e., 100% FFS) 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. (OACT suggests that legislative language be revised to ensure that this is cost-neutral.)

Concern: Without the per capita cap or other methods to control costs, this might be scored by CBO with significant costs.

- ◆ **Nominal copayments for HMO enrollees.** The proposal brings 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 also allows 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.

Concern: For beneficiaries who are high utilizers, even this proposal could be burdensome.

- ◆ **State option for six-month guarantee eligibility for all individuals enrolled in managed care.** This proposal would provide stable health care coverage for individuals who may lose eligibility due to changed circumstances. (OACT estimate, cost \$.4 billion)

Concern: Without the per capita cap, this proposal would be expected to be scored by CBO with some costs; This needs to be scored in interaction with the kids initiatives.

- ◆ **Managed Care and DSH Interaction.** The Administration's DSH legislation proposes that all DSH payments should be made directly to hospitals, and not to managed care arrangements. This provision would assure that DSH payments are being used to compensate hospitals providing care to the uninsured.

Concern: This provision is viewed as important to Federal oversight and needs to be included in DSH policies.

- ◆ **FQHC/RHC Pool as a part of DSH Legislation.** The Administration's DSH legislation included a pool for FQHCs and RHCs providing care to the poor and insured. This pool eased the concerns with the proposed elimination of cost-based reimbursement to FQHCs, and partially addressed the FQHCs concerns with the continuing existence of uninsured populations getting care in health clinic settings.

Concern: The Budget Agreement appears to have dropped this provision. We believe that the Administration should continue to advocate for inclusion of this pool.

- ◆ **Establish a Federal Payment Commission.** Studies conducted by such a commission

would have been vital to understanding the workings of and improvement options for a per capita cap. Without the cap, however, such a commission would likely just revisit ground covered by many other students of Federal-State matching formula.

Concern: Another study could be useful to respond to demands to make the matching formula more fair. It might also be viewed as doing nothing of substance.

- ◆ **Strengthen Medicaid Eligibility Quality Control (MEQC).** This proposal was specifically crafted with a per capita cap in mind. Other approaches to ensuring that States make appropriate determinations of Medicaid eligibility make sense under the current financing arrangements.

Concern: Even though the current MEQC system has not been useful, added oversight might be valuable.

- ◆ **Allow enrollment expansion without demonstration waivers up to 150% of poverty.** This provision would give States increased flexibility to expand to new populations. This could dramatically increase Federal Medicaid spending in the absence of the spending constraints imposed by the per capita cap and without the kind of Federal oversight and requirement that expansions be cost neutral. (OACT estimates this could cost several billion dollars.)

Concern: Even though this proposal includes a "budget neutral" provision, CBO is likely to assume increased costs.

PROPOSALS THAT ARE NO LONGER NECESSARY.

- ◆ **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities.** This proposal was passed in the House and Senate and was signed by the President on May 15, 1997.
- ◆ **Limit 1902(r)(2) eligibility flexibility to 150% of poverty.** The provision to limit 1902(r) would not be needed. States would not have the incentives to "game" the current law State options to expand to higher income groups under section 1902(r)(2) without the per capita cap.
- ◆ **Per capita cap Transition Pool.** The per capita cap included a \$1 billion transition pool. Without the per capita cap, we recommend the transition pool be eliminated not only because it was funded from the per capita cap budget item, but because it was set up explicitly to help States and providers during the transition to the per capita cap, which has now been taken off the table.

LEGISLATIVE PROPOSALS THAT SHOULD BE RETAINED.

The proposals listed in this category are viewed as non-controversial. They include those proposals that should remain in the Administration's legislative package, those proposals that are no longer needed because the per capita cap was dropped, and the proposals included in the Budget Agreement that have not been discussed as part of the DSH or children's proposals.

Administrative Simplification/Improvements

- ◆ **Eliminate OB/Peds physician qualification requirements.** This provision is needed to reduce administrative burden on States. The minimum provider qualification requirements 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).
- ◆ **Eliminate annual State reporting requirements for certain providers.** This provision is needed to reduce administrative burden on States. The current provision links access to payment rates. Payment rates are not an adequate measure of access. States have had difficulty obtaining appropriate data to adequately measure access. The data States have been able to report does not reveal much regarding access.
- ◆ **Eliminate Federal requirements on private health insurance purchasing.** The current provision should be made optional not a requirement. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. This is true even without per capita spending limits.
- ◆ **Simplify computer systems requirements.** This provision moves in the direction that Medicaid systems should be moving irrespective of how Federal financing is determined. Current detailed requirements for system design were developed for an earlier time in which technology was relatively 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 to show that their State-designed MMIS system meets performance standards established under an outcome-oriented measurement process.
- ◆ **Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).** This provision is needed because it reduces duplication. 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. (Note: This proposal is in the budget agreement).

- ◆ **Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).** This provision is needed to provide alternatives to complete termination. 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 that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.
- ◆ **Eliminate repayment requirement for alternative remedies.** 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.

Managed Care Improvements

- ◆ **Convert managed care waivers (1915(b)) to State Plan Amendments;** guarantee IHS, tribal, and urban Indian organization providers the right to participate and make them the default assignment for Indian eligibles that do not choose another provider. (OACT estimate, \$.1 billion in savings; CBO estimate no savings)
- ◆ **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule.** 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. This 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, will define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures will 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 enhances 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.

- ◆ **State option for six-month lock-in in risk-based arrangements.** States would be able to streamline administration and increase the stability of health care coverage. Providers would be more willing to participate in Medicaid.

Concern: Without the per capita cap, this proposal would be expected to be scored by CBO with some costs.

- ◆ **Change threshold for federal review of contracts.** Provides greater State flexibility in management and oversight of Medicaid managed care programs. Reduces the number of managed care plan contracts requiring HCFA review and approval.

Program Enhancements

- ◆ **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. This provision is needed to encourage disabled beneficiaries to return to work. Despite existing work incentives in SSI, fewer than ½ 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.
- ◆ **Require all States to participate in MSIS information system.** All States would be required to participate in Medicaid Statistical Information System (MSIS) program. MSIS permits collection and analysis of person-based data on eligibles, recipients, utilization and payment for services covered by State Medicaid programs. Currently, 29 States participate MSIS.
- ◆ **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities.** Federal funding continues to be necessary 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. (OACT estimate, cost of \$.2 billion)
- ◆ **Grant Programs for All inclusive Care for the Elderly (PACE) permanent provider status.** The proposal to make the PACE program a permanent provider of Medicare and Medicaid services was crafted independent of the financing structure. It has been scored by CBO as a "no cost" to Medicaid for the past two years.

- ◆ **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments.** Giving States increased flexibility to provide home and community-based services as an option under a State's plan would shift the focus in long-term care away from reliance on institutional care and toward more desirable and cost-effective community-based care. This proposal is intended to remove the burden on the States, by eliminating the constant and costly necessity of renewing the waivers, while ensuring high quality. This proposal has been around for several years, and was developed in the absence of a per capita cap. Without the per capita cap, however, some have argued that this proposal could allow for increases in State and Federal budgets. (OACT estimate, cost of \$.5 billion)

OTHER PROPOSALS INCLUDED IN BUDGET AGREEMENT

- ◆ **Increase Federal Payment Cap for the Puerto Rico and the Territories.** Federal matching for the territories has always been capped, but at amounts determined by Congress unrelated to impartial measures of need in the territories 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 the territories, it would not be appropriate to apply per beneficiary Federal spending limits to these jurisdictions. Nevertheless, some adjustment for population is called for in the territories, which have had (or will soon have) a demonstrated need for Medicaid funding beyond their caps for the foreseeable future. (OACT estimate \$250 million cost for Puerto Rico, and \$23 million for the other Territories)
- ◆ **Increased match rate for District of Columbia.** The Federal matching rate would be modified for the District of Columbia to reflect its status as a local jurisdiction rather than a State. The matching rate would change from 50% to 70%. (OACT estimate, cost of \$918 million)
- ◆ **Extension of VA sunset.** VA benefits would continue to be paid at a reduced rate to veterans who are in nursing homes and covered by Medicaid. The reduction is currently scheduled to sunset on September 30, 1998. (OACT estimate, cost of \$1.2 billion)

June 2, 1997

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GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

TO: Richard Kogan & interested people
FROM: Jeanne Lambrew *Jeanne*
RE: CONCERNS ABOUT THE ALTERNATIVE TO THE PER CAPITA CAP
DATE: December 30, 1996

Thank you for sending me your paper. I am not sure whether this is a final copy or one for review, but here are my comments on it regardless.

There are two general sets of comments: about your alternative and about your criticism of the per capita cap.

Concerns about the Alternative:

The alternative proposal is essentially an across-the-board FMAP reduction, with a partial "performance rebates" to low-cost and / or low-growth states. To the extent that budget savings from Medicaid are not achieved from states' behavioral responses to these rebates, a "backstop" causes the FMAP reduction to exceed the total amount of the rebate. This alternative will likely produce budget savings and begins to address cross-state equity issues. However, the policy also:

- **Does not protect coverage.** One of the biggest advantages of the per capita cap is that it does not create an incentive to reduce the number of people enrolled in Medicaid (since the Federal matching limit is linked to enrollment). Under the alternative, there is no such protection. All states have their FMAP reduced irrespective of the number of people covered. The FMAP reduction means that for every Federal dollar saved, state spending increases by a dollar if total spending remains constant. For states that cannot put up additional funds to cover the same services and beneficiaries, this shift of costs to states may create an incentive to reduce total spending. Since reducing coverage of high-cost beneficiaries usually produces greater savings than reducing optional benefits, states may choose the former. In fact, the "performance rebate" may encourage this since eliminating coverage for high-cost beneficiaries lowers states' average per capita cost and possibly their per capita cost growth, making them more likely to receive a rebate.¹

¹While there is component of the performance rebate that is based on enrollment, it is less important than the ratio of the states per capita costs or growth to the national average.

- **“Performance rebates” could cause a race to the bottom.** The alternative bases the net FMAP reduction on a state’s spending patterns relative to the national norm. States with per capita spending or growth that is lower than the national average get a lower FMAP reduction (or possibly an increase in their matching rates). As a consequence, states are rewarded for being lower than each other, not lower than some external standard. As more states cut their programs to receive the rebate, the average moves down, and states have to cut even more to become the lowest and get the maximum rebate. While this may produce Federal savings, it may result in the highest FMAP for states that have reduced most of their optional benefits and coverage. In contrast, the per capita cap’s Federal spending limit for each state is independent of those for other states and encourages states to maintain per capita cost growth at or just below a normative index (growth in nominal GDP plus some factor). It penalizes states that lower the number of mandatory or optional enrollees.

- **“Performance rebates” assume that the national averages are “right”.** One of my greatest concerns about last year’s block grant proposal was the assumption that some states don’t spend enough on Medicaid and should increase their spending, that other states spend too much and should be punished, and that the national average is the “right” amount of Medicaid spending. This ignores one of the fundamental features of Medicaid: it is really fifty different programs and the national average is consequently meaningless.
 - **Ignores differences in benefits.** States vary in the number of optional benefits offered and the amount, duration and scope of those benefits. Consequently, valid differences in what is covered play a major role in the variation in spending across states. For instance, most states with higher-than-average per capita costs have higher long-term care costs. While adjusting for the number of elderly and disabled in a state addresses some of this variation, it does not account for the existence of a more generous medically needy program, fewer community-based options for people with long-term care needs, or a greater number of people older than 85 years requiring institutionalization.

 - **Ignores differences in costs across states.** In order to assure access to providers, some states (like New York or Massachusetts) have to pay providers more than others. Other states (like Missouri or California) are able to cover the same services at lower rates. Does it make sense to reduce Federal matching for states whose environment is more costly, or to give extra matching to states that might be able to efficiently provide care at lower-than-average rates?

- **Assumes national average is right.** In the same way that the average per capita spending in Medicaid represents no single person's experience², the national average Medicaid per capita represents no single state's experience. Furthermore, under the alternative, the national average is endogenous to the policy, so that the more states try to be below average, the lower the average, the harder it is to get "rebates" without cutting benefits or coverage.
- **Would likely have its own "leakage" factor.** In its August 1996 Deficit Reduction book, the CBO discusses the implications of an FMAP reduction. One of the major questions posed is whether states will increase total spending to draw down the Federal funds that they would otherwise have received. For instance, a state that relies on a certain amount of Federal Medicaid dollars may add qualifying state-only spending to its Medicaid program in order to increase total expenditures and thus Federal matching payments. In fact, under this policy, a state could double its total spending and receive more matching than under current law, albeit at a lower matching rate. Under the per capita cap, the only way to get more Federal matching than under current law is to increase enrollment; otherwise, cost increases are not matched.

Criticisms of the Per Capita Cap:

From our previous discussions, you know that I agree that the per capita cap presents technical as well as political challenges. However, I think that your explicit concerns are to some extent addressed in the Administration's proposal. The following lists your concerns (in bold) and my responses.

- **Locks in the base-year spending per capita.** This is not exactly true of the Administration's proposal. There was a commission which would assume the responsibility of determining how to increase equity across states. The commission approach is probably preferable to the legislative approach since it is more immune from the political vicissitudes that have plagued other statutorily mandated state formulae. It will also allow for greater sophistication in defining what is equity, what is valid variation, and how this can be achieved over time.
- **Does not accurately adjust for valid health cost increases.** Couldn't the use of private spending growth per capita, suggested for a different use in your alternative, solve this problem within a per capita cap? We actually looked at this last year, but had concerns about the validity of the available measures of health spending growth — similar to those that you expressed in your December

² Since aged and disabled beneficiaries' per capita costs are more than 3 times higher than those of adults and children, the combined average per capita costs represents no groups' experience.

1995 memo on appropriate index factors.

- **Risks substitution of low-cost for high-cost beneficiaries.** To mitigate against this effect, the matchable spending limit was calculated by group. This means that the substitution of low-cost kids and adults for high-cost aged and disabled would actually lower the Federal matching limit, reducing the incentive. Within the four groups of people, this risk of substitution remains. However, very little savings could accrue from substituting low-cost for high-cost adults and kids, since these groups are inexpensive to begin with. And, it would probably be difficult for states to substitute low-cost for high-cost disabled and elderly, since the latter are mostly institutional residents. Research has shown that states have not had much success in using home and community-based care services as a substitute for nursing homes, since people who go into nursing homes often are there as a last resort anyway.
- **Would override waivers.** The Administration's policy explicitly preempted 1115 waivers. There was an option as to how DSH would be determined in states that had used it in their implemented demonstrations, but we only offered that option to the five states that had begun their demonstrations (not all approved waivers).

Your additional concern about the consequences of the per capita cap being too tight is, I think, a more general concern about too deep a reduction in Federal Medicaid spending. The alternative policy could have equally severe consequences if its savings target is too high. I, too, am concerned about excessive Medicaid reductions and am hoping that analysis can inform this question.

As a reminder, the per capita cap is also an FMAP reduction. States with per capita cost growth at or below the index value get the current FMAP; states with per capita cost growth above the index get reduced Federal matching payments in proportion to the excess growth. Thus, it is similar to the per capita growth component of the performance rebate, except that it sets up a normative standard for per capita cost growth that is linked to the general economy, not the average of all states' spending growth.

The crucial difference in the policies is the safeguard against coverage loss: the per capita cap has one, the alternative does not. Protecting coverage may be especially important in the coming years given welfare reform. Thus, assuming that both policies can produce equal Federal savings, the question becomes: do the advantages of the equal FMAP reduction plus performance rebates in the alternative outweigh the incentives for states to reduce coverage? In fairness, you should address this in your paper.

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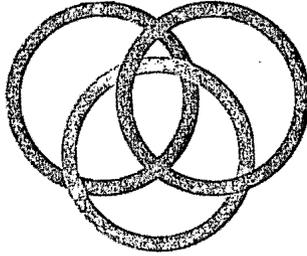
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THE WALL STREET JOURNAL
THURSDAY, MAY 22, 1997

By George Anders
Staff Reporter of The Wall Street Journal

When Congress passed a health insurance bill last summer allowing a test of medical savings accounts, marketing executive Bill Drizinik thought he saw a chance to reshape the way many Americans get medical coverage.

Today Mr. Drizinik isn't nearly so excited. For the past six months, he has championed so-called MSAs, which let people stockpile cash ahead of time for modest health bills. As a vice president for the StarMark unit of Transmark Insurance Co., he markets high-deductible insurance policies that are paired with such savings accounts to cover large medical bills. So far, however, his new sales total only about 120 people. "It's been a huge educational challenge," Mr. Drizinik says, "as he struggles to get insurance agents and consumers interested in his product."

Things weren't supposed to happen this way. Insurance lobbyists for years had entreated Congress to create tax breaks for MSAs, claiming that such a step would empower consumers and create more medical choice. Conservative lawmakers promoted such individually controlled savings accounts as a powerful counterbalance to the rising cloud of health-maintenance organizations and other forms of managed care. Texas GOP Sen. Phil Gramm has urged allowing Medicare beneficiaries to choose MSAs as a way to "turn millions of senior citizens into cost-conscious medical consumers and guardians of the federal treasury."

Four-Year Test

When the health-care bill cosponsored by former GOP Sen. Nancy Kassebaum of Kansas and Democratic Sen. Edward Kennedy of Massachusetts authorized a limited four-year test of the MSA concept, advocates predicted that this new form of health coverage would quickly sweep the nation, attracting perhaps as many as two million people this year. Instead, the MSA scoreboard is barely flickering.

In California, Wellpoint Health Networks Inc. set a goal of selling 50,000 MSA policies this year. It got started about a month ago and so far has sold a mere 33 accounts. In Kentucky, Humana Inc. says it has sold MSAs to all of 198 people so far this year. "It's very difficult to market effectively," says David Jones, Humana's chairman.

While MSA advocates continue to champion their approach, many of them

privately say they underestimated how tough it would be to turn the concept into a business success.

"There's been lots of hype about MSAs, but where's the data?" says Stephen Baruchel, a Washington state physician who is president of Washington MSA Project. In February, Dr. Baruchel predicted that medical savings accounts would attract one million to two million enrollees this year. He has slashed that forecast more than

Time Insurance Co.'s MSA ad

80% to 175,000 to 300,000 people. It was captured a bit by early projections of interest by the advocates," Dr. Baruchel says.

Greg Scandlen, a health-care consultant in Frederick, Md., says he would be surprised if total industry sales through April topped 100,000.

Official data on MSA participation won't be available until late summer, when the Internal Revenue Service is due to release enrollment figures as of April 30. Under the Kassebaum-Kennedy bill, nationwide enrollment in tax-advantaged MSAs will be limited to 750,000 policyholders, all of whom must be either self-employed or working for companies with 50 or fewer employees.

Repeal of Cap Urged

MSA backers earlier this spring urged Congress to repeal the cap, on the belief that brisk demand would soon cause applications to burst through the upper limit. Rep. William Lipinski (D., Ill.) introduced such a bill in March, contending that "demand for MSAs has far exceeded expectations." Lately, though, industry leaders have been trying to manage public

estimates in the other direction, saying they always expected delays in wooing consumers.

"As good as this is, it's taking time for people to warm up to it," says Scott Krenke, vice president for product development at Time Insurance Co. He says his company has sold slightly more than 5,000 MSA-related policies, which he terms a slow start. "Things are improving every week," Mr. Krenke maintains. Even so, he says the 750,000-policyholder ceiling is hardly a factor at this stage.

The best-known champion of MSAs, Golden Rule Insurance Co. of Indianapolis, says it has sold high-deductible insurance this year for 26,000 people covered by the new tax-advantaged savings accounts. Like many vendors, it says some of its customers didn't have health insurance before.

In general, the market has posed tougher tests than expected at every stage. Most individual and small-group policies are sold through independent agents, who typically get 7% to 10% of the first year's premiums as commission. Many of them have been lukewarm because the associated insurance policies don't bring in as much money in commissions.

In the Southwest, officials at Blue Cross & Blue Shield of Texas began to worry about MSAs' appeal when they invited 300 of their top-producing independent sales agents to special presentations on the new insurance package. Only 100 agents attended, barely half the usual turnout for such meetings.

State and federal regulations have created obstacles, too. And setting up individual savings accounts has been problematic. More than a dozen banks and other financial institutions are offering to man-

age such accounts—but most charge either set-up fees, monthly maintenance fees or both. First-year fees for accountholders can range from a low of \$12.60 as much as \$105, while promised investment yields typically are 4.5% or less.

Some MSA-affiliated insurers also find it tough to compete with low prices offered by managed-care competitors. MSAs allow consumers unlimited choice of doctors, unlike managed-care plans. But consumers using MSAs generally must pay full price for medical services, while HMOs and other managed-care plans can get discounts of 30% to 60% on doctors' visits, hospital stays and other medical costs, in return for agreeing to deal only with a preselected network.

Medical Savings Insurance Co., for example, is offering families in Anaheim, Calif., a \$452.50-a-month package. That consists of \$265 a month in insurance premiums for a health policy with a \$3,000 deductible—plus \$187.50 a month in contributions to a savings account to cover smaller bills. By contrast, a typical HMO would cost the family just \$382 a month, the company says. The MSA package qualifies for more tax deductions, but even so, its after-tax cost is about \$22 a month higher than the HMO package.

Medical Savings President Randy Suttles says he still can claim an edge, by getting consumers to focus on how much cheaper their pure insurance costs are under his setup and how much money they might be able to stockpile in the savings account. But his company has sold only a few hundred policies.

Asked if he is happy with that sales pace, Mr. Suttles says, "Well, no. We'd like to see it in the thousands and thousands."

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